MEDICAL ASSISTANCE ELIGIBILITY

Overview

May 2009

Washington State Department of Social and Health Services

Health and Recovery Services Administration

NOTE: These are guidelines only. The Department of Social and Health Services (DSHS) has responsibility for making eligibility decisions for medical benefits.

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This information is also available on the HRSA web site at:
http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicalOverview.htm

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Washington State
Department of Social
& Health Services

INTRODUCTION

This guide offers an overview of eligibility requirements for medical programs. It doesn't include all requirements or consider all situations that may arise. Please contact your local Community Services (CSO) or Home and Community Services (HCS) office for information about specific situations.

Income levels (such as those based on Federal Poverty Level (FPL), Cost of Living Adjustments (COLA), and specific program standards) change yearly, but in different months. We update this booklet yearly to reflect standard and program changes. Please understand that, while the information in this publication is current at the time of publication, some of those standards will change before the next publication date.

We list each program's identifier after each program name on the following pages.

DEFINITIONS

MEDICAID: The federally matched medical aid programs that cover the Categorically Needy (CN) and Medically Needy (MN) programs.

HEALTH AND RECOVERY SERVICES ADMINISTRATION (HRSA): The single state agency responsible for providing access to medical care for Washington's most vulnerable residents.

CATEGORICALLY NEEDY (CN): The federally matched Medicaid programs that provide the broadest scope of medical coverage. Persons may be eligible for CN only, or may also be eligible for cash benefits under the SSI (Supplemental Security Income) or TANF (Temporary Assistance for Needy Families) programs. CN includes full scope of coverage for pregnant women, children, the aged, blind, and persons with disabilities.

FEDERAL POVERTY LEVEL (FPL): A guideline for determining governmental program eligibility based on the Consumer Price Index guide from the year just completed. Some medical program eligibility limits are based on a percentage of the FPL.

FEE-FOR-SERVICE: The term used when a client is able to get care from doctors and other medical providers who will accept the HRSA medical coupon called a Medical ID card, without membership in a managed care program or health maintenance program.

HEALTHY OPTIONS: The name of the HRSA's Washington State managed care program.

MANAGED CARE: A prepaid comprehensive system of medical and health care delivery provided through a designated health care plan that contracts with HRSA.

MEDICAL CARE SERVICES (MCS): The state-funded medical program that provides limited medical benefits to persons eligible for General Assistance-Unemployable (GA-U) cash assistance or the Alcohol and Drug Addiction and Treatment and Support Act program (ADATSA). Income and resource limits are more restrictive than for the family CN medical program. MCS does not cover out-of-state medical care.

MEDICALLY NEEDY (MN): The federally matched Medicaid Program for the aged, blind, or persons with disabilities, as well as pregnant women, children, and refugees. It provides slightly less medical coverage than CN, for those with income and/or resources above CN limits.

TANF: The Temporary Assistance for Needy Families program, offering cash and other benefits to families in need.

WORKFIRST: Washington State's Welfare to Work program from federal TANF legislation. It replaced the former AFDC program.

ANTICIPATED CHANGES FOR 2009-2010

WHAT CHANGES ARE EXPECTED?

- DSHS will update the (20 year) old Legacy MMIS (Medicaid Management Information System) payment system, changing to a new system (ProviderOne) in late 2009. Because of this change, DSHS will be able to process payments faster and store more information. Business will be a little different with the new system.

  Customers won't receive a monthly Medical Identification (ID) Card for their household. ProviderOne will send each individual customer, whether adult or child, a permanent, plastic card, called a Services card. When people stop receiving Washington Medical Assistance, they should keep the card. If they ever receive Washington Medical Assistance again, they can use the same card.

  There is no program identifier on the Services card. Providers will be able to use a card reader to see that their patient is a current Medical Assistance customer. It is a good idea for customers to always carry this card with them, in case they need to get a prescription or visit a medical provider. However, a Services Card is not required to receive medical services.

FAMILY PROGRAMS

TANF (TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (F01)) and FAMILY MEDICAL PROGRAM (F04): These programs provide aid to children and the adult(s) who care for them. Families with eligible dependent children under the age of 19, whose net income and countable resources are below TANF limits may receive both TANF cash benefits and CN medical. TANF cash benefits are restricted to 60 months maximum in a lifetime.

A family may choose to receive only CN medical and save their TANF eligibility months for the future.

In determining net income, we deduct 50% of the family's earnings, actual child care costs, and court ordered child support paid out by the family.

For medical eligibility, a family with children may have $1,000 in resources at the time of application. Once the family is eligible, there is no resource limit while the family continues to receive only medical.

SPECIAL SITUATIONS: Clients who are **not** eligible for cash benefits **but are eligible** for medical coverage include:

- Persons who are not cooperating with WorkFirst activities;
- Teen parents who are not in an approved living situation or are not meeting school requirements;
- Persons who have reached the 60-month TANF cash benefit limit.

MEDICAL EXTENSION BENEFITS (MEB, F02, F03): There are two Medical Extension Benefit (MEB) programs, sometimes called Transitional Medical Assistance (TMA). In one program, (FO2), families are eligible for up to 12 months of extended CN medical benefits, when earned income increases above program standards. All non-pregnant adults must pay a premium during the second six months, if the family's countable income is over 100% of the FPL. American Indians/Alaska Natives are exempt from premium payments.

In the other program, (F03), families are eligible for up to 4 months of extended CN medical benefits when their cash benefits stop due to receipt of increased child support.

STATE FAMILY ASSISTANCE (SFA): SFA is the state-funded cash program for legal immigrant families who do not meet eligibility requirements for federal programs due to citizenship or immigration status. Children receiving SFA are eligible for our state-funded Apple Health for Kids Programs. Adults on SFA are encouraged to apply for Basic Health by calling 1-800-826-2444.

INCOME LIMITS

TANF Families With Dependent Children and Family Medical Program

Effective July 1, 2008:

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT
1	$359
2	$453
3	$562
4	$661
5	$762
6	$866
7	$1,000
8	$1,107

PREGNANCY AND WOMEN'S HEALTH

There is no resource limit for the pregnant women's CN medical program (P02). The income limit is 185 percent of the Federal Poverty Level (FPL). Pregnant women can be eligible at any time during pregnancy. Once eligible, women's eligibility continues throughout the pregnancy and postpartum period, regardless of changes in income. Women who apply for medical coverage after the baby's birth don't qualify for the postpartum extension, but may qualify for help paying costs relating to the baby's birth, if the application is within 3 months after the month of the birth.

To determine a pregnant woman's family size, count the number of household members, adding one for each verified unborn child. EXAMPLE: A woman living alone, who verifies she is pregnant with twins, is considered a three-person family.

Effective April 1, 2009:

NUMBER OF PEOPLE	CN MONTHLY INCOME LIMIT*
1	NA
2	$2,247
3	$2,823
4	$3,400
5	$3,976
6	$4,553
7	$5,130
8	$5,706
Add $577 for each additional household member	

* Pregnant women with income above 185% FPL may be eligible for the MN program.

NON CITIZEN PREGNANT WOMEN (P04): Pregnant women are eligible for CN scope of care under the non-citizen pregnant women's program if they aren't eligible for Medicaid because of citizenship or immigration status. This includes undocumented pregnant women.

POSTPARTUM EXTENSION (no separate program identifier): The postpartum extension provides full scope medical coverage for women who receive medical benefits at the time their pregnancy ends. This allows continued medical coverage through the end of the month that contains the 60th day after pregnancy ends (e.g., pregnancy ends June 10, medical benefits continue through August 31). Women receive this extension regardless of how the pregnancy ends.

MEDICALLY NEEDY PREGNANT WOMEN (P99): Pregnant women with income over 185% FPL may be eligible for MN benefits after incurring medical costs equal to the amount of family income that is above the standard. The program identifier on the Medical ID card is P99. For more explanation of Medically Needy benefits, please see that section of this publication.

FAMILY PLANNING EXTENSION (P05): The family planning extension provides an additional 10 months of medical coverage after pregnancy to citizen and qualified alien women for family planning services only. Women receive this extension regardless of how the pregnancy ends. The extension follows the postpartum coverage for eligible women who received medical benefits for the pregnancy.

TAKE CHARGE (P06): This Family Planning program (for both men and women) began in July 2001. The program covers pre-pregnancy family planning services, helping participants take charge of their lives and prevent unintended pregnancies.

Both women and men may be eligible if:

- Their family income is at or below 200 percent of FPL.
- They either:
  - > Don't have health insurance coverage, or
  - > Their current health insurance coverage doesn't fully cover comprehensive family planning benefits.

Effective April 1, 2009:

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT*
1	$1,805
2	$2,429
3	$3,052
4	$3,675
Add $624 for each additional household member	

Coverage under TAKE CHARGE includes:

- Annual examination.
- Family planning education and risk reduction counseling.
- FDA-approved contraceptive methods including: birth control pills, IUDs, and emergency contraception.
- Over the counter contraceptive products, such as condoms and contraceptive creams and foams.
- Sterilization procedures.

Access services through local clinics, doctors' offices, and pharmacies that are participating in TAKE CHARGE. For a list of providers by area, call the toll-free Family Planning Hot Line at 1-800-770-4334.

Find additional information on the DSHS Web site at http://fortress.wa.gov/dshs/maa/familyplan/.

BREAST AND CERVICAL CANCER TREATMENT PROGRAM

BREAST AND CERVICAL CANCER TREATMENT PROGRAM (S30): Medical coverage for women diagnosed with breast or cervical cancer, or a related pre-cancerous condition, through the Department of Health's (DOH) Breast and Cervical Health Program (BCHP) or by the Breast and Cervical Early Detection program funded by the Centers for Disease Control (CDC). The DOH screening program establishes income and resource eligibility. Coverage continues throughout treatment for the condition.

A woman is eligible if she:

- Is under age 65;
- Has been screened by the BCHP or the CDC-funded program;
- Requires treatment for breast or cervical cancer, or a pre-cancerous condition found through the screening; and
- Doesn't have other insurance.

For more information, see the Department of Health Web site at http://www.doh.wa.gov/wbchp/default.htm.

APPLE HEALTH FOR KIDS PROGRAMS

CATEGORICALLY NEEDY (CN) for newborns (F05). A newborn is automatically eligible for 12 months' CN coverage if the mother received state medical benefits at the time of the child's birth, the child remains living with the mother, and is a Washington resident. There are no income or resource limits for this program.

APPLE HEALTH FOR KIDS PROGRAMS (F06): A 2007 law allows all Washington resident children under age 19, living in families whose income is at or below 200% FPL, access to CN scope of care health coverage. Children ineligible for the Medicaid program due to citizenship or immigration issues receive the same scope of care funded by the state. There is no resource limit for these programs.

Effective April 1, 2009:

NUMBER OF PEOPLE	CN MONTHLY INCOME LIMIT - 200% FPL
1	$1,805
2	$2,429
3	$3,052
4	$3,675
5	$4,299
6	$4,922
7	$5,545
8	$6,169
Add $624 for each additional household member	

PREMIUM-BASED APPLE HEALTH FOR KIDS PROGRAMS (F07): The premium-based Apple Health for Kids programs provide CN scope of care for children under age 19 in families whose income is between 200% and 300% FPL. These programs don't require proof of citizenship, immigration, or assets. Children eligible for state-only funded medical benefits receive the same scope of care as those eligible for the federal/state program (SCHIP). Currently, families with income between 200% - 250% FPL whose children receive benefits from this program pay premiums of $20 per month per child (with a maximum of $40 per month per family). Families with income between 250% - 300% FPL pay premiums of $30 per month per child (with a maximum of $60 per month per family).

Effective April 1, 2009:

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT 200-250% FPL
1	$2,257
2	$3,036
3	$3,815
4	$4,594
5	$5,373
6	$6,153
7	$6,932
8	$7,711
Add $780 for each additional household member	

NUMBER OF PEOPLE	MONTHLY INCOME LIMIT 250-300% FPL
1	$2,708
2	$3,643
3	$4,578
4	$5,513
5	$6,448
6	$7,383
7	$8,318
8	$9,253
Add $935 for each additional household member	

MEDICALLY NEEDY APPLE HEALTH FOR KIDS (F99): Children under age 19 in families with income over 300% FPL may be eligible for MN benefits after incurring medical costs equal to the amount of family income above the standard. The program identifier on the Medical ID card is F99. For more explanation of Medically Needy benefits, please see that section of this publication.

FOSTER CARE / ADOPTION SUPPORT (D01, D02): Children receiving foster care or adoption support services may be eligible for CN medical benefits through this program. The child's foster care or adoption support caseworker runs this program.

REFUGEES AND ALIENS

REFUGEES (R01, R02, R03): Under the 100 percent federally funded Refugee Program, a person granted asylum in the U.S. as a refugee or asylee may receive cash benefits for a maximum of eight months. These persons automatically receive Categorically Needy (CN) medical services. Immediately after entering the U.S., families and single refugees are eligible for this program.

Eligibility for refugees/asylees that have been in the United States for more than eight months is determined the same as for U.S. citizens.

SPECIAL IMMIGRANTS: Immigrants from Iraq and Afghanistan who were granted Special Immigrant status under section 101(a) (27) of the INA are eligible for TANF, Medicaid, RCA, and RMA for 8 months from their date of entry into the United States.

ALIEN EMERGENCY MEDICAL (AEM, C04*, F09, K03, L04, S07): This is a federally funded program for non-citizen aliens with emergent medical conditions. A qualifying emergency medical condition is described in WAC 388-500-0005. The person must be categorically related to a Medicaid program (e.g., a parent with a dependent child, an adult with a disability, a blind or aged (65 or older) adult, or a child under age 19), but ineligible for Medicaid due to citizenship or alien status.

Income and resource limits are the same as for the program to which they are related, i.e., CN or MN scope of care programs for the categories listed earlier in this paragraph

- The CSO may need to refer a case to Health and Recovery Services Administration (HRSA), Division of Disability Determination Services to determine a client's disability.
- The CSO may need to refer a case to an HRSA Medical Consultant to decide if the client has an emergent medical condition.
- Persons eligible for AEM can receive medical benefits for the emergent condition and related services only. Prior authorization is required for some services.

The AEM program has a three month certification period. Organ transplants, prenatal, and school-based services are not covered under this program.

* C04 is Hospice in a Medical Institution. The AEM and Hospice must be pre-approved by the medical consultant.

AGED, BLIND, AND PERSONS WITH DISABILITIES

SSI-RELATED PROGRAMS

SSI RELATED PERSONS ARE THOSE WHO:

- Are 65 years old or older (aged).
- Meet the Social Security Administration's (SSA) definition of blind.
- Meet the SSA definition of persons with disabilities.

They may be eligible for Categorically Needy (CN) (S02) medical benefits if their income and resources are the same or lower than the standards for SSI.

Effective January 1, 2009:

NUMBER OF PERSONS	INCOME LIMIT	RESOURCE LIMIT
1	$674	$2,000
2	$1,011	$3,000

People with income and/or resources above the standards may be eligible for SSI related Medically Needy (MN, S95, S99) benefits.

SSI-ELIGIBLE CLIENTS (S01): Are those who receive federal cash benefits under the Supplemental Security Income (SSI) program. They receive CN medical coverage automatically. SSA administers the SSI program. The SSI income standard is the Federal Benefit Rate (FBR).

NUMBER OF PEOPLE	INCOME LIMIT (FBR)
1	$674
2	$1,011

HEALTHCARE FOR WORKERS WITH DISABILITIES (HWD, S08): HWD is an SSI-related CN medical program that recognizes the employment potential of people with disabilities. Under HWD, people with disabilities (aged 16 through 64) can earn more money and purchase healthcare coverage for an amount based on a sliding income scale.

HWD has no asset test and the net income limit is based on 220% of the Federal Poverty Level (FPL).

Effective April 1, 2009:

NUMBER OF PERSONS	INCOME LIMIT – 220% FPL
1	$1,986
2	$2,672

To be eligible, a person must meet federal disability requirements, be employed (including self-employment) full or part time, and pay the monthly premium.

Cost of Enrollment: To receive HWD benefits, enrollees pay a monthly premium determined from a percentage of their income. The premium will never exceed 7.5% of total income, and may be less. American Indians and Alaska Natives are exempt from paying premiums for HWD.

LONG-TERM CARE (LTC) and HOSPICE

LONG-TERM CARE (LTC), COMMUNITY OPTIONS PROGRAM ENTRY SYSTEM (COPES, C01), NEW FREEDOM (C01), FOUR DIVISION OF DEVELOPMENTAL DISABILITIES (DDD) WAIVERS (C01), PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) (C01), HOSPICE (C01, C95, C99), FAMILY LTC (K01, K95, K99), MEDICALLY NEEDY RESIDENTIAL AND IN-HOME WAIVERS (MNRW) (G95), MNIW (S95), NURSING FACILITY LTC (L01, L02, L95, L99): The federally matched LTC programs fit individual needs and situations. Home and Community Based (HCB) Services such as COPES and DDD waivers, enable people to continue living in their homes with assistance to meet their physical, medical, and social needs. When these needs can't be met at home, care in a residential facility or nursing facility (NF) is available.

Income limits for LTC programs vary depending on the services needed, living situation, and client marital status. Most clients must pay a portion of their income toward the cost of LTC services. We call this "participation". Income may be allocated to a spouse and any dependents in the home. A client living at home keeps some income for home maintenance and personal needs. Clients who reside in nursing or residential facilities (adult family homes, group homes, and assisted living facilities) keep a small personal needs allowance (PNA) for clothing and incidental expenses. They also pay a set amount toward the cost of their room and board. The amount of income that remains after deductions for personal needs, room and board, allocations, health insurance premiums, and any other allowable deductions is the client's participation amount.

LTC resource limits also vary, depending on specific factors (such as marital status). All resources of both spouses are considered together. Certain resources are excluded (not counted toward the resource limits), such as household goods, personal effects, a car, home equity (up to a set limit) and life insurance with a face value of $1,500 or less. Most burial plots, prepaid revocable burial plans not exceeding $1,500, and irrevocable burial plans, are also excluded.

A Community Spouse (CS) keeps resources according to spousal impoverishment legislation. The Institutional Spouse (IS) keeps the same resources indicated in the table for the Aged, Blind, and Persons with Disabilities.

A different income standard is used to determine eligibility for Categorically Needy (CN) or Medically Needy (MN) LTC services coverage. The standard is 300 percent of the Federal Benefit Rate (FBR), called the Special Income Level (SIL). Gross income at or below the SIL allows approval of CN eligibility for either NF or HCB services. If income is above the SIL, MN eligibility with a spenddown may be considered for NF services or one of the MN HCB waivers. Different rules are used to determine eligibility and participation when both spouses receive LTC services. The local Home and Community Services (HCS) worker can provide this information as needed.

Effective April 1, 2009:

INSTITUTIONAL STANDARDS	INCOME LIMIT
Medicaid SIL	$2,022.00
PNA GA-U/GA-X	$41.62
All other PNA in Medical Institutions	$57.28
PNA state veterans home	$160.00
DDD & MPC PNA in ALF	$62.79
COPES maintenance w/o community spouse	$903.00
COPES maintenance with community spouse	$674.00
COPES maintenance in ALF	$674.00
Housing maximum	$903.00
Community Spouse Maintenance	$2,739.00
Community spouse income and family allocation	$1,750.00
Community spouse excess shelter allowance	$525.00
Utility standard	$384.00
Spousal resource maximum	$45,104
Spousal share exception up to	$109,560
Statewide monthly private nursing home rate	$6,589.00

MEDICARE SAVINGS PROGRAMS

DSHS may pay the Medicare premiums for certain clients who are aged, blind, or with disabilities. Medicare Savings Programs (MSP) have higher income and resource limits than other programs.

QUALIFIED MEDICARE BENEFICIARY (QMB, S03): The client must be entitled to, or enrolled in Medicare Part A. Income must be at or below 100 percent of the Federal Poverty Level (FPL). Under QMB, DSHS pays for Medicare Part A premiums if not free, and Medicare Part B premiums, deductibles, and co-payments.

SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB, S05): The client must be entitled to, or enrolled in, Medicare Part A. Income must be between 100 percent FPL and 120 percent FPL. Under SLMB, DSHS pays the client's Medicare Part B premium **only**.

QUALIFIED INDIVIDUAL (QI-1, S06): The client must have applied for, or enrolled in, Medicare Part B, not be eligible for any other Medicaid coverage, and have income between 120 percent and 135 percent FPL. Under QI-1, DSHS pays the client's Medicare Part B premium only. If a QI-1 client becomes eligible for Medicaid coverage, the QI-1 program will be closed.

QUALIFIED DISABLED WORKING INDIVIDUAL (QDWI, S04): The client must:

- Be entitled to or enrolled in Medicare Part A.
- Be a working person with disabilities.
- Have exhausted premium-free Part A.
- Have lost SSA disability benefits because of earnings over SSA's gainful activity limits.

The income limit is 200 percent FPL. DSHS pays the client's Medicare Part A premium **only**. Individuals considering this program may also benefit from information about the Healthcare for Workers with Disabilities program.

Effective April 1, 2009:

MEDICARE SAVINGS PROGRAM	FEDERAL POVERTY LEVEL (FPL)	MONTHLY INCOME LIMIT ONE PERSON	MONTHLY INCOME LIMIT TWO PERSONS
QMB	100%	$903	$1,215
SLMB	120%	$1,183	$1,457
QI-1	135%	$1,219	$1,640
QDWI	200%	$1,805	$2,429
Resource Limit	N/A	$4,000	$6,000

MEDICALLY NEEDY (MN) and SPENDDOWN

MEDICALLY NEEDY (all letter codes with 95 or 99 after the letter): Medically Needy (MN) is a federal and state funded Medicaid program for persons who are aged, blind, or have disabilities, pregnant women, or children, with income above Categorically Needy (CN) limits. MN provides slightly less medical coverage than CN, and requires greater financial participation by the client.

MN clients with income above MN limits are required to spend down excess income before medical benefits are authorized. The client spends down the excess by incurring financial obligations for medical expenses equal to the spenddown amount. **The client is responsible for paying these medical expenses.**

Effective January 1, 2009:

NUMBER OF PEOPLE	MN MONTHLY INCOME LIMIT
1	$674
2	$674
3	$674
4	$742
5	$858
6	$975
7	$1,125
8	$1,242
9	$1,358
10 or more	$1,483

SPENDDOWN: Spenddown is like an insurance deductible. It's the process used to determine the client's liability for the cost of medical care. Clients must incur medical expenses equal to their excess income (spenddown, or liability) before medical benefits are authorized. The spenddown liability is the client's financial obligation and can't be paid by the state. We compute the amount of the client's spenddown using a base period, consisting of three or six consecutive calendar months. Depending on when the client's incurred medical expenses meet the spenddown liability, the client may get medical benefits for all or part of the base period.

SPENDDOWN EXAMPLE: Applicant is a single woman, age 67. She receives $720 Social Security benefits each month and has $1,000 in savings. The client's $1,000 resources are below the resource limit of $2,000, so she is resource eligible. Her income is above MN income limits, but MN allows spenddown of excess income. She is eligible for MN when she meets spenddown.

SSA benefits (less $20 general disregard* $720 – $20)	$700
Less MN income limit	– $674
Excess income	= $26

The client can choose between a three-month and a six-month base period – whichever is better for her, considering her spenddown amount and the cost of medical bills she expects during the period. She will have to incur either $78 ($26 times 3 months) or $156 ($26 times 6 months) in medical expenses before she is eligible for MN. This is her spenddown amount. She will be responsible for these expenses; HRSA will pay for her covered medical expenses after she meets spenddown.

* General Disregard: The federal government allows $20 of the client's unearned income as a disregard when determining income limits.

GENERAL ASSISTANCE

GENERAL ASSISTANCE–UNEMPLOYABLE (GA-U, G01): GA-U is a state-funded program that provides cash benefits for persons who are physically and/or mentally incapacitated and who are unemployable for more than 90 days. We pay medical claims through the MCS program. (See DEFINITIONS.).

GENERAL ASSISTANCE–EXPEDITED MEDICAID DISABILITY (GA-X, G02): The GA-X program provides state-funded cash assistance and full scope CN medical benefits to persons who appear to meet the SSI disability criteria. Contracted doctors make the decision whether clients meet the disability criteria. General Assistance-Aged (GA-A), General Assistance-Blind (GA-B), and General Assistance-Disabled (GA-D) programs offer full scope CN medical benefits to persons who are either age 65 or older, or who meet the Social Security Administration's criteria as either blind or disabled, but who are unable to receive SSI-related medical program benefits for other reasons, such as citizenship status.

GA-U IMMIGRANTS: Immigrants determined to meet eligibility requirements for GA-U are eligible for the state-funded Medical Care Services (MCS) program.

GA-U and ADATSA Payment Standards:

NUMBER OF PEOPLE	PAYMENT STANDARD	
	WITH SHELTER COSTS	WITHOUT SHELTER COSTS
1	$339	$206
2	$428	$261

ADATSA

ALCOHOL AND DRUG TREATMENT (ADATSA, GA-W, W01, W02, W03): ADATSA is the state-funded program that provides shelter and/or medical benefits, treatment, and support under the Alcohol and Drug Addiction Treatment and Support Act for persons incapacitated from gainful employment due to drug or alcohol abuse. Limited medical benefits are provided under the Medical Care Services (MCS) program. The Division of Alcohol and Substance Abuse (DASA) administers ADATSA.

For persons waiting to get into treatment, medical care only is available through this program.

Customer Toll-Free Numbers: Alcohol Drug 24-Hour Help Line 1-800-562-1240
Washington State Alcohol/Drug Clearinghouse 1-800-662-9111

Useful Web Addresses:

Division of Alcohol and Substance Abuse Treatment Expansion
http://www.dshs.wa.gov/dasa/services/treatment/treatmentexpansion.shtml

Division of Alcohol and Substance Abuse Problem Gambling Program
http://www.dshs.wa.gov/dasa/services/OPPLR/ProblemGamblingPrgm.shtml

Division of Alcohol and Substance Abuse ABC's of ADATSA
http://www.dshs.wa.gov/pdf/hrsa/dasa/ABCsofADATSA.pdf

PSYCHIATRIC INDIGENT INPATIENT PROGRAM (PII)

Mental Health Division (MHD) created the PII (M99) program to ensure eligible clients receive continued psychiatric inpatient hospital services. The program funds voluntary community psychiatric inpatient hospital care for indigent clients who qualify.

Important: The maximum length of certification for PII is three months in any 12-month period.

Income and resource limits for the PII program are the same as for the Medically Needy (MN) program. Clients with excess income and/or resources above the MN limits must spend down the excess before they are eligible for PII.

The PII program pays only for emergent inpatient psychiatric care in community hospitals within the state of Washington. PII doesn't cover ancillary charges for physician, transportation, pharmacy or other costs associated with a voluntary inpatient psychiatric hospitalization. For more information, contact Christina Winans at Mental Health Division, (360) 902-0844, or by email: winanca@dshs.wa.gov.

HRSA Provider memo 03-16 can be seen at: http://fortress.wa.gov/dshs/maa/Download/Memos/2003Memos/03-16maa.pdf

Involuntary psychiatric hospitalizations (commitments) are authorized under the Involuntary Treatment Act (ITA), RCW 71.05 and RCW 71.34. Generally, there is no change in how ITA cases are handled. For those who are not eligible for medical assistance, hospitals continue to use existing procedures to bill ITA cases. That process is separate and apart from the Psychiatric Indigent Inpatient (PII) program.

EMERGENCY MEDICAL EXPENSE REQUIREMENT (EMER): PII requires $2,000 EMER per family for each continuous 12-month period before a family member can be eligible for the program. The EMER is comparable to a deductible on an insurance policy. An applicant can meet this requirement with voluntary inpatient psychiatric hospitalization **only**.

MEDICAL ID CARD

Below is a sample of the Medical ID card (sometimes called a Medical Coupon or MAID) that persons who receive medical benefits get each month.

The Medical ID card will be discontinued around the end of 2009 and will be replaced by the Services Card. See "Anticipated Changes" earlier in this publication for more information on the Services Card

Please read the back of this card.
MEDICAL IDENTIFICATION CARD
Washington State Department of Social & Health Services
This Card Valid From: 08/01/2004
To: 08/31/2004
S01
1 PO BOX 45893
OLYMPIA WA 98504-5893
2 3 4 25

Patient Identification Code (PIC)				Medical Coverage Information							
Initials	Birthdate	Last Name	ID	Insurance	Medicare	HMO	Detox	Restriction	Hospice	DD Client	Other
M-	010143	L1MAB	A								
5	6	7	8	9	10	11	12	13	14	15	16

17
18 MARJORIE LIMA BEANS
#5L
515 WASHINGTON ST
VANCOUVER WA
98660-3456
19 CNP
20
21
22 XXX XXXXXXXXX
23 XXXXXXXXXXX
24 NOT TRANSFERABLE
SIGNATURE (not valid unless signed)
SHOW TO MEDICAL PROVIDER AT TIME OF EACH SERVICE
DSHS 13-030(x)ACES(4/95)
X - XXXXXX XXXXXX XX XXXXXXX

The codes below are the medical coverage groups found in field 4 on the coupon. These codes identify the type of medical assistance the patient receives. Identification of medical coverage groups help providers determine the need for additional services such as pregnancy-related First Steps services, prior authorization requirements, or if a patient is potentially a Healthy Options enrollee.

Medical Coverage Group Codes – Field 4	Medical Coverage Group Definitions
C01, C95, and C99	HCS (COPES) waiver, DDD waivers, or Hospice medical
D01, D02	Foster Care, Adoption Support, and Juvenile Rehabilitation Services
F01, F02, F03, F04, F09, and F10	Family Related Medical including adults
F05, F06, F07, and F99	Apple Health for Kids children's healthcare programs (some with premiums)
G01	General Assistance Unemployable (GAU) cash with state Medical Care Services (MCS) for incapacitated adults
G02	General Assistance (GAX–Expedited) Aged, Blind, or Disabled (GA-A, GA-B, GA-D) – CN medical for those who can't meet the criteria for SSA or SSI cash payments, but do meet their disability criteria
G03, G95, and G99	Alternate Living, non-institutional medical
I01	Institution for the Mentally Diseased (IMD) medical
K01, K03, K95, and K99	Family long-term care medical
L01, L02, L04, L95, and L99	Long-term care, nursing facility medical
M99	Psychiatric Indigent Inpatient (PII)
P02, P04, and P99	Pregnancy related medical
P05	Family Planning only medical
P06	Take Charge family planning medical
R01, R02, and R03	Refugee Programs
S01, S02, S07, S95, and S99	SSI and SSI-related medical (Aged, Blind, or Disabled Adults)
S30	Breast and Cervical Cancer Treatment Program (BCCTP)
S03, S04, S05, S06	Medicare Savings Programs
S08	Healthcare for Workers with Disabilities (HWD)
WO1, W02, and W03	Alcohol and Drug Addiction Treatment and Support Act (ADATSA)

KEY TO MEDICAL ID CARD

AREA DESCRIPTION

1 Address of CSO.
2 Date eligibility begins.
3 Date eligibility ends.
4 Medical coverage group described in the table on the previous page.

Patient Identification Code (PIC) Segments Are:

5 First and middle initials *(or a dash (-) if the middle initial is not known)*.
6 Six-digit birth date, consisting of numerals only *(MMDDYY)*.
7 First five letters of the last name *(and spaces if the name is fewer than five letters)*.
8 Tie breaker *(an alpha or numeric character)*.

Medical Coverage Information

9 **Insurance carrier code** – A four-character alphanumeric code *(insurance carrier code)* in this area indicates the private insurance plan information.
10 **Medicare** – Xs indicate the client has Medicare coverage.
11 **HMO** *(Health Maintenance Organization)* – Alpha code indicates enrollment in an HRSA Healthy Options managed health care plan. ***(Managed health care plan is the same as HMO)***. This area may also contain the legend PCCM *(primary care case manager)*. The following ACES medical coverage groups, if not otherwise exempt, are required to enroll in Healthy Options: F01, F02, F03, F04, F05, F06, F07, and P02.
12 **Detox** – Xs indicate eligibility for a 3-day alcohol or a 5-day drug detoxification program.
13 **Restrictions** – Xs indicate the client is assigned to one physician and one pharmacist. The words "client on review" in Field 20 will also indicate restricted clients.
14 **Hospice** – Xs indicate the client has elected hospice care.
15 **DD client** – Xs indicate this person is a client of the DSHS Division of Developmental Disabilities.
16 **Other** – This area is not in use.
17 **HIC** shows an indicator for a Medicare claim number.
18 **Name** and address of client, head of household or guardian.
19 **Medical program** and scope of care indicators.
20 **Other messages** *(e.g., client on review, delayed certification, emergency hospital only)*.
21 **Telephone number and name** of PCCM or Healthy Options plan.
22 **Local field office** *(3 digits)* and ACES assistance unit # *(9 digits)*.
23 **Internal control numbers** for DSHS use only.
24 **Client's signature** – May be used to verify identity of client.
25 **Client's primary language**.

COVERED SERVICES

HRSA provides a wide range of medical services. Not all eligibility groups receive all services. Coverage is broadest under the Categorically Needy (CN) program.

Scope of Healthcare Services Table

NOTE: DSHS provides funding for a wide range of medical services. The level of medical coverage for any given client depends on the medical assistance Benefit Service Package for which the client is eligible. This table lists services that may be provided under the specific services/programs if the individual meets all the criteria required to receive the service. Some services may require prior authorization from DSHS or a DSHS-contracted managed care plan. This table is provided for general information only and does not in any way guarantee that any service will actually be covered. Benefits, coverage, and interpretation of benefits and coverage may change at any time. Coverage limitations can be found in federal statutes & regulations, state statutes & regulations, state budget provisions, and DSHS billing instructions and numbered memoranda. Clients with questions regarding coverage may call the 800 number on the back of their Client Services Card.

	Categorically Needy		Medically Needy	General Assistance		
Service/Program	CN	S-CHIP	MN	GA	ADATSA	FP/TC
Adult day health	Y	N	N	N	N	N
Ambulance (ground/air)	Y	Y	Y	Y	Y	N
Ambulatory surgery center	Y	Y	Y	R[1]	R[1]	N[1]
Blood/Blood administration	Y	Y	Y	Y	Y	N
Childbirth education	Y	Y	Y	N	N	N
Chiropractic services for children	Y	Y	Y	N	N	N
Dental services	Y	Y	Y	R[2]	R[2]	N
Crowns/Dentures	Y[3]	Y[3]	Y[3]	N	N	N
Detoxification	Y	Y	Y	R	R	N
Diabetes education	Y	Y	Y	Y	Y	N
Early periodic screening diagnosis & treatment (EPSDT) program	Y	Y	Y	N	N	N
Family planning services	Y	Y	Y	Y	Y	Y
Hearing Aids & services (audiology & exams)	Y	Y	N[4]	Y	Y	N
HIV/AIDS Case Management	Y	Y	Y	N	N	N
Home health services	Y	Y	Y	Y	Y	N
Home infusion therapy/ parenteral nutrition	Y	Y	Y	Y	Y	N
Hospice/Pediatric palliative care services	Y	Y	Y	N	N	N
Hospital services – inpatient/ outpatient	Y	Y	Y	Y	Y	N[1]
Intermediate care facility/ services for the mentally retarded (IMR)	Y	Y	Y	Y	Y	N
Kidney center / end-stage renal disease	Y	Y	Y	Y	Y	N
Maternity care & delivery services	Y	Y	Y	N	N	N
Maternity support / infant case management	Y	Y	N	N	N	N
Wheelchairs, durable medical equipment	Y	Y	Y	Y	Y	N

COVERED SERVICES

Service/Program	Categorically Needy CN	Categorically Needy S-CHIP	Medically Needy MN	General Assistance GA	General Assistance ADATSA	General Assistance FP/TC
Nondurable medical equipment (MSE)	Y	Y	Y	Y	Y	N
Enteral nutrition services	Y	Y	Y	Y	Y	N
Medical nutrition therapy	Y[4]	Y[4]	Y[4]	R[4]	R[4]	N
Mental health services (general)	Y	Y	Y	R[5]	N	N
Inpatient hospital care	Y	Y	Y	Y	Y	N
Outpatient hospital care	Y	Y	Y	R	R	N
Mental health services - children	Y	Y	Y	N	N	N
Nursing facility services	Y	Y	Y	Y	N	N
Organ transplants	Y	Y	Y	Y	Y	N
Out-of-state services (excludes boarder cities)	Y	Y	Y	N[6]	N[6]	N
Oxygen/respiratory services	Y	Y	Y	Y	Y	N
Personal care services	R	R	R	N	N	N
Physician-related services	Y	Y	Y	Y	Y	R
Prenatal Diagnosis Genetic counseling	Y	Y	Y	N	N	N
Prescription drugs*	Y	Y	Y	Y	Y	R
Private duty nursing for children	Y	Y	Y	N	N	N
Prosthetic/Orthotic devices	Y	Y	Y	Y	Y	N
Psychological Evaluations	Y	Y	Y	N[7]	N[7]	N
School medical services	Y	N	Y	N	N	N
Smoking cessation	Y	Y	Y	Y	N	N
Substance abuse services (chemical dependency	Y	Y	Y	Y[8]	Y[8]	N
Therapy – occupational, physical, speech	Y	Y	N[4]	Y	Y	N
Vision care services	Y	Y	Y	Y	Y	N

LEGEND: Y=Yes, service is usually included;
N=No, service is usually not included;
R=Restricted with coverage limitations

* Medicare recipients receive outpatient prescriptions through their Medicare Part D plan.
[1] Services limited by parent program (e.g., Dental Program limitations, Family Planning sterilizations service).
[2] Covers only service codes as listed in the Dental Program billing instructions.
[3] Coverage requirements are located in the Dental Program billing instructions.
[4] Coverage limited to children age 20 years old and under if done through an EPSDT screening referral.
[5] Restricted to GA clients enrolled in Managed Care.
[6] Border cities are considered “in state” for GA coverage.
[7] Services covered by the local community mental health center.
[8] Service is covered directly though the Division of Alcohol and Substance Abuse (DASA).

OTHER SERVICES

- **Alien Emergency Medical (AEM)**
  The Health and Recovery Services Administration (HRSA) covers only those services necessary to treat the client's emergency medical condition.
- **QMB-Medicare Only**
  HRSA covers only the Medicare coinsurance and deductible up to the Medicare or HRSA allowed amount, whichever is less.
- **Non Emergency Medical Transportation (Brokered Transport)**
  HRSA covers non-emergency medical transportation for eligible clients to or from covered services through contracted brokers. The brokers arrange and pay for trips for qualifying DSHS/HRSA clients. Currently, eligible clients include Medicaid, S-CHIP, CHP, GA, ADATSA, and AEM.
- **Interpreter Services – Spoken languages**
  HRSA covers interpreter service for eligible clients through contracted brokers. Requests for spoken language interpreter services must be requested by Medicaid providers or authorized DSHS staff.
- **Interpreter Services – Sign Language**
  HRSA covers the cost of sign language services for eligible clients. Requests for sign language interpreter services must be requested by Medicaid providers or authorized DSHS staff and provided by DSHS-approved contractors.
- **Psychiatric Indigent Inpatient (PII) Program**
  HRSA covers voluntary psychiatric inpatient care for clients eligible under the PII program.

Customer Service Information

DSHS clients may call 800-562-3022 (option 1) for more information.
Providers may call 800-562-3022 (option 2) for more information.
Locate Medical Assistance Billing Instructions at http://maa.dshs.wa.gov/download/bi.html

Acronyms

ADATSA	Alcohol and Drug Abuse Treatment and Support Act
CHP	Children's Health Program
CN	Categorically Needy Program
FP/TC	Family Planning Only/TAKE CHARGE
GA	General Assistance
MN	Medically Needy Program
S-CHIP	State Children's Health Insurance Program

WACs dealing with Scope of Care are located at:

Healthcare – General Coverage
http://apps.leg.wa.gov/wac/default.aspx?site=388-501-0050

Healthcare Coverage – Scope of Covered Categories of Service
http://apps.leg.wa.gov/wac/default.aspx?site=388-501-0060

Healthcare Coverage – Description of Covered Categories of Service
http://apps.leg.wa.gov/wac/default.aspx?site=388-501-0065

Customer Toll-Free Numbers

Aging & Disability Services	1-800-422-3263
Alcohol Drug 24-Hour Help Line	1-800-562-1240
Basic Health Plan	1-800-826-2444
Fraud Hotline number when you suspect someone (client or provider) is committing fraud concerning DSHS cash, medical, or food benefits	1-800-562-6906
HRSA Customer Service Center (Clients)	1-800-562-3022 7 am–7 pm, Monday–Friday
TYY/TDD users only	1-800-848-5429
Medical Eligibility Determination Services (MEDS)	1-800-204-6429
TYY/TDD users only	1-800-204-6430
Pharmacy Authorization	1-800-848-2842
Provider Enrollment	1-800-562-3022 press 2, then option 5 8 am–4:30 pm, Monday–Friday 10 am–4:30 pm, Wednesday
Provider Inquiry	1-800-562-3022
Third Party Resource Hotline (Coordination of Benefits)	1-800-562-6136
Washington State Alcohol/Drug Clearinghouse	1-800-662-9111

Useful Web Addresses

Division of Alcohol and Substance Abuse	http://www.dshs.wa.gov/dasa/
Basic Health Plan	http://www.basichealth.hca.wa.gov/
DSHS Rules	http://apps.leg.wa.gov/wac/ (Washington Administrative Code)
Economic Services	https://fortress.wa.gov/dshs/f2ws03esaapps/onlinecso/cover.asp (For locating your CSO or applying for assistance (including on-line) etc.)
Eligibility A-Z Manual	http://www.dshs.wa.gov/manuals/eaz/index.shtml
HRSA Billing Instructions	http://fortress.wa.gov/dshs/maa/download/BI.html
HRSA Internet	http://fortress.wa.gov/dshs/maa/
HRSA Intranet	http://imaa.dshs.wa.gov/default.aspx
HRSA Numbered Memos	http://fortress.wa.gov/dshs/maa/download/Numberedmemos.html
ProviderOne Information	http://fortress.wa.gov/dshs/maa/providerone/
Washington State Law (RCW's)	http://apps.leg.wa.gov/rcw/