VDH
Division Disease Prevention
Health Care Services
Peer Review Team

Client Eligibility

POLICY: Clients will meet eligibility criteria to receive Ryan White CARE ACT Title II funding.

BACKGROUND:
The Ryan White Care Act states that "the State will ensure that grant funds are not utilized to make payments for any item or service to the extent that payment has been made or can reasonably be expected to be made with respect to that item or service under any State compensation program, under an insurance policy or under any Federal or State health benefits program or by an entity that provides health services on a prepaid basis."

CRITERIA:
1. Proof of HIV status present on the consumers record
   - For clients who are not receiving medical services, a written statement signed and dated by a licensed prescriber (MD, DO, PA, NP) or other professional staff person affiliated with the HIV primary care site (such as RN, social worker, or case manager) is adequate proof of diagnosis
   - Documentation of Western Blot Test result must be present on record for Primary Medical Care
2. Proof of income present on record
   - Current criteria are that the consumer must meet 300% of the Federal Poverty Level.
   - In Northern region the criteria is 333% of the Federal Poverty Level
     - Copy of paycheck stub present on chart or verification of income present on the record
     - When salary statement is not available annual tax returns are acceptable
     - Statement of no income
     - statement from Virginia Employment Commission denying unemployment compensation
   - If consumer claims they have no income, but are receiving support (food, shelter, etc.) from another person. A sign statement from this person should be present on the record.
3. Verification of Insurance
   - If a client has third party coverage, a copy of the benefits should be included in the record. If the insurance policy shows a service is covered, the client must submit a denial letter from the insurance company before Title II funding can be used.
   - Each agency that provides Title II services must assess each client annually for third party health care coverage. This assessment must include, at a minimum, Medicaid, and in addition where applicable, Medicare, Veterans benefits, private health insurance, and Medicaid Waiver.
   - All consumers must provide proof of their income to insure they meet financial guidelines to qualify for Ryan White funding

- If a client is eligible for coverage under a third party payer for any service, Title II funds can not be used to pay for that service, even if that is the client's preference. For example, a veteran cannot refuse to use his Veteran's benefits for health care because he prefers a doctor that lives closer to him. A Medicaid recipient may not ask for Title II to pay for transportation because of the difficulty in utilizing the Medicaid transportation system arrangements.

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4. Must have proof of application to Medicaid or approved reason for not applying
    - Documentation by provider that consumer does not meet the requirements to receive Medicaid
    - To assess whether or not a client is eligible for Medicaid coverage, the agency may require the client to apply for Medicaid at the Department of Social Services. Services may be provided while eligibility is pending, but once eligibility is determined, the agency needs to have a copy of the denial letter in the client's file.
    - Alternatively, the agency may pre-screen the client using the Medicaid eligibility determination short form that is attached. If using the short form and the client is determined to need to apply for Medicaid, a denial letter must be received for the client to continue to receive services.
    - Copy of Denial letter
    - Proof that Medicaid has been applied for

DOCUMENTATION:

- Eligibility for Title II services must be clearly documented in the client's record, including an annual reassessment.

- A completed Medicaid eligibility determination short form or a Medicaid denial letter is required.

  For clients with other third party coverage, a copy of benefits must be in included in the record. For Title II funds to be used for a covered service, the record must include a denial from the third party payer.

REGIONAL POLICIES:

- Regional policies must be in compliance with state policy.

MEDICAID REFERRAL ASSESSMENT FORM

Date:____________ Assessment completed by_________________________________
Referred to DSS____________________

Name ____________________________________ Date of Birth__________

Social Security Number_____________________________
If no SS#, are you eligible to apply for a Social Security Number? Yes_ No

If no, client will NOT qualify for Medicaid. Can proceed with RW services.

Have you ever applied for Medicaid? Yes_____ No
When? __________________
Has income decreased since you last applied? Yes_ No_

If yes, compare current income to poverty chart. If below 100% of poverty level, refer to DSS.

Current annual income for family unit____________________________________
Family unit is legal unit, e.g., husband-wife-kids. If client lives with significant other or is an adult and lives with parents, use client's income only.
Compare current income to poverty chart. If below 100% of poverty level, refer to DSS.

Female with minor children (under 18) in home? Yes_____ No _____
If yes refer to DSS (may qualify for Medicaid)

Is client 65 or older? Yes_____ No _____ Blind? Yes_____ No_____
If yes, refer to DSS

Is client disabled? Yes_____ No _____
If yes, refer to both DSS and to social security for SSI application.

Has client applied for SSI or disability and been denied? Yes_____ No _____
If yes, when?______________ Is client appealing the denial? Yes_____ No____
If No and the denial is recent, refer to the Social Security Administration to appeal.

Has your physical condition gotten worse since you applied for disability or SSI?
Yes_____ No_____
If yes, refer back to Social Security Administration to apply.

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