Par.1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 510-03 and 510-05

Par. 2. **Effective Date** – Changes included in this manual letter are effective on or after April 1, 2023 unless otherwise indicated.

Policy Chapter 510-03 & 510-05

Application and Review section of the ACA and Non-ACA manual. Application section was updated with corrected list of applications. Non-ACA application manual section was also updated with the list of applications. The review section in the ACA manual has been updated. The review section of the Non-ACA manual was updated to include the Passive Review process.

Application and Review 510-03-25-05 & 510-05-25-05

1. Application.
    a. All individuals wishing to make application for Medicaid must have the opportunity to do so, without delay.
    b. A relative or other interested party may file an application on behalf of a deceased individual to cover medical costs incurred prior to the deceased individual's death.

c. An application is a request for assistance on a prescribed form designed and approved by the North Dakota Department of Health and Human Services.

d. There is no wrong door when applying for Medicaid or any of the Healthcare coverages. The experience needs to be as seamless and with as few barriers as possible.

e. North Dakota Medicaid applications must be maintained electronically in the case file.

f. A prescribed application form must be signed by the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsible for the applicant.

- An application is considered signed if the signature is found anywhere on the application, other than to answer a question.

g. The date of application is the date an application, signed by an appropriate person, is received at a zone office, the Medical Services Division, a disproportionate share hospital, or a federally qualified health center. The date received must be documented.

- Applications received electronically are considered received based on the time/date stamp
- Applications received in person must be date stamped as received when the individual delivers it to the zone office.
- Applications left in a drop box refer to policy at 448-01-15-10

Note: Applications must be registered in the eligibility system as soon as possible upon receipt, but no later than the fifth day

following receipt. Applications will be considered received on the day submitted.

h. An application is required to initially apply for Medicaid, to re-apply after a Medicaid application was denied, to re-apply after a Medicaid case has closed, or to open a new Medicaid case for a child who has been adopted through the state subsidized adoption program.

i. Zone offices must accommodate any recipient requesting to have a face-to-face or telephone interview when applying for Medicaid. However, an interview is not required to apply for assistance.

j. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipient must be furnished.

Acceptable forms for applying for Medicaid:

i. The Department's online "Application for Assistance", located at https://applyforhelp.nd.gov

ii. The electronic file received by the state from the Federally Facilitated Marketplace (FFM) containing the single streamlined application; or

iii. The SFN 1909 "Application for Health Coverage and Help Paying Costs"; or

iv. Telephonic applications utilizing any one of the prescribed applications; or

v. SFN 405, "Application for Assistance"; or

vi. SFN 641, "Title IV-E/Title XIX Application-Foster Care"; or

vii. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "Hospital" stamped on the front page; or

viii. Interstate Compact on Adoption and Medical Assistance (ICAMA) for 6.01 "Notice of Medicaid Eligibility/Case Activation" stating North Dakota is responsible for the Medicaid coverage of the specific child; or

ix. SFN 958, "Health Care Application for the Elderly and Disabled". However, notification must be sent to the individual requesting information needed to make the ACA eligibility determination; or

x. SFN 1803, "Subsidized Adoption Agreement"; or

xi. The Low-Income Subsidy (LIS) file from SSA

2. Review

A review requires the evaluation of all financial and non-financial requirements affecting eligibility. This will include, but is not limited to, reviewing income, household composition, health insurance coverage, and alien status, listed in the casefile, reported, and verified on the most recent application or review form, and verifications received from all electronic sources.

Information that is not subject to change, such as US citizenship, date of birth, SSN, etc., does not usually need to be reviewed. However, if questionable, the information needs to be verified.

a. Passive Reviews: A Passive Review is the annual twelve-month review of eligibility. Information available in the casefile is reviewed along with available electronic verification sources.

- PASSES Reasonable Compatibility - If able to renew eligibility based on the information available, the case is processed, and the household must be notified of the eligibility determination and basis of eligibility.

    - The individual/household must inform the agency if any of the information contained in the notice is inaccurate. The individual is not required to sign and return such notice if all information in the notice is accurate.

- FAILS Reasonable Compatible - A passive review verification notice and prepopulated review form needs to be sent.

    - To complete the review, the pre-populated review form and required verifications must be returned.
    - If both are not returned, eligibility will close the last day of the month in which the review is due.
    - The individual has 90 days after the termination to provide the pre-populated

review form and verifications. Based on the information received, eligibility must be reconsidered back to the termination date.

b. Ex Parte/Desk Reviews is a review completed when a zone office becomes aware of or has received information indicating a change.

Examples: adding a household member, processing a change in level of care, adding Medicare Savings Program coverage, when an ineligible household member is requesting eligibility, when eligibility is lost under a category (e.g., SSI to non-SSI, Expansion to ABD coverage), aligning review dates with SNAP or TANF.

- When the zone office has all information needed to determine eligibility based on a change in circumstances, a review form does not have to be sent.
- When more information is needed to determine eligibility, a request for verification along with a pre-populated review form must be sent.

Additional information when completing a Review:

- A recipient has the same responsibility to furnish information during a review as an applicant has during an application.
- An online narrative must document the completion of the review
- A review must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status.
- A review, using one of the forms identified, in acceptable review form section, is required to open a new Medicaid case for recipients who move from an existing case to their own case. (e.

g. an 18-year-old attains age 19, moves out of the parental home, on other than a temporary basis.)

- Zone offices must accommodate any recipient requesting to have a face-to-face or telephone interview for their review. However, an interview is not required to complete a review.
- Reviews must be completed and processed no later than the last working day of the month in which they are due.
- It is permissible to compete an early review of a child's eligibility for Medicaid and CHIP. However, the household may not be required to provide any information that is needed specifically for determine only the eligibility of the Medicaid and CHIP children who were determined to be continuously eligible. The family may voluntarily provide specific information but must not be required to do so.

If all factors of eligibility are reviewed:

- If the child is found to be eligible for Medicaid (other than Medically Needy), eligibility must be authorized for Medicaid and the child will be given a new 12-month continuous eligibility period.
- If the child is found to be NOT eligible for Medicaid (other than Medically Needy), the child may not be terminated at the time of the early review unless the child meets one of the state's exceptions to terminate continuous eligibility. They would remain eligible for the remainder of the original continuous eligibility period and a review would be required at that time.

Acceptable forms for completing a review:

i. A review received through the North Dakota Self Service Portal (SSP) for Medicaid
ii. System generated "Monthly/Change Report";

iii. SFN 642, "Title IV-E/Title XIX Redetermination-Foster Care" for children in Foster Care, or other confirmation from a state IV-E agency (in state or out of state) that verifies continued IV-E foster care eligibility;
iv. One of the previously identified applications; or
v. When completing a review for children eligible for subsidized adoption assistance, receipt of one of the above review forms is not required. However, the following two criteria must be verified:
   - The child remains a resident of North Dakota; and
   - Then child continues to be eligible for the subsidized adoption program
   - In addition, contact should be made with the household to determine whether the child has obtained or lost other insurance coverage.

Application and Review 510-03-25-05

~~1. Application.~~

~~a. All individuals wishing to make application for Medicaid must have the opportunity to do so, without delay.~~

~~b. A relative or other interested party may file an application on behalf of a deceased individual to cover medical costs incurred prior to the deceased individual's death.~~

~~c. An application is a request for assistance on a prescribed form designed and approved by the North Dakota Department of Human Services.~~

~~For ACA Medicaid Households, individuals can apply using one of the following prescribed applications:~~

i. The electronic file received by the state from the Federally Facilitated Marketplace (FFM) containing the single streamlined application;

ii. The single streamlined application as submitted through the North Dakota client portal;

iii. The SFN 1909, "Application for Health Coverage and Help Paying Costs";

iv. Telephonic applications utilizing any one of the prescribed applications;

v. SFN 405, "Application for Assistance"; or

vi. SFN 641, "Title IV-E/Title XIX Application-Foster Care";

vii. The Department's online "Application for Assistance", located at http://applyforhelp.nd.gov.

viii. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "HOSPITAL" stamped on the front page; or

ix. ICAMA (Interstate Compact on Adoption and Medical Assistance) form 6.01 "Notice of Medicaid Eligibility/Case Activation" stating North Dakota is responsible for the Medicaid coverage of the specified child.

x. SFN 958, "Health Care Application for the Elderly and Disabled". However, notification must be sent to the individual requesting information

needed to make the ACA eligibility determination.

xi. An application submitted through the Self-Service Portal.

d. There is no wrong door when applying for Medicaid or any of the Healthcare coverage's. The experience needs to be as seamless and with as few barriers as possible.

e. North Dakota Medicaid applications may be received, filed and maintained at any county office within the state, based on what is most convenient for the applicant or recipient.

Example: Mom and one child reside in one county, and another child is attending school in another. If it is more convenient for the household to apply and maintain the case in the county where the mom resides than the county in which the child, who is a student, is residing, the county where mom resides should process and maintain that case.

f. A prescribed application form must be signed by the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

g. The date of application is the date an application, signed by an appropriate person, is received at a county agency, the Medical Services Division, a disproportionate share hospital, or a federally qualified health center. An application is considered signed if the signature is found anywhere on the application, other than to answer a question. The date received must be documented.

Applications must be registered in the eligibility system as soon as possible upon receipt, but no later than the fifth day following receipt. Applications will be considered received on the day submitted. If an application is submitted after business hours, on a weekend or holiday, the application will be considered received on the next business day.

h. An application is required to initially apply for Medicaid, to re-apply after a Medicaid application was denied, to re-apply after a Medicaid case has closed, or to open a new Medicaid case for a child who has been adopted through the state subsidized adoption program.

i. A recipient may choose to have a face-to-face or telephone interview when applying for Medicaid. However, an interview is not required in order to apply for assistance.

j. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients must be furnished to all who require it.

k. A new application is not required when a child loses eligibility under the Optional Children's Group, becomes Medicaid eligible, and there is not a break in assistance. However, an Ex Parte (desk) review must be completed.

2. Review.

A review requires the evaluation of all financial and non-financial requirements affecting eligibility, which may include income, household composition, health insurance coverage, cost-effective compliance, alien status, etc. listed in the casefile, reported and verified on the most recent application or review form, and verifications received from all electronic sources. Information that is not subject to change, such as US citizenship, date of birth, SSN, etc., does not usually need to be reviewed. However, if a recipient's Social Security Number has not been verified via

~~interface by the next scheduled review, other action must be taken to verify the Social Security Number.~~

~~Review forms are mailed to the household on the fifth to the last working day prior to the month the review is due. The form will be pre-populated with the information known to the Department as entered into the SPACES system. The household is instructed to update any information that has changed, enter any new information that is not reflected on the review form, and return the review form by the 1st day of the month in which the review is due.~~

~~The review form is not required to be returned to the county office. It is a tool used to communicate information between the county and the recipient/ household. An adverse action **cannot** be taken simply because the review form was not returned, completed or signed.~~

- ~~If a review is returned as undeliverable, the reason for the return and the information provided by the post office must be treated as a change in circumstances.~~
- ~~If the returned document includes a forwarding address in North Dakota:~~
  - ~~Update the case address in the system;~~
  - ~~Re-mail the form to the new address;~~
  - ~~Send a notice requesting verification of the change in address.~~
  - ~~Narrate the action taken~~
- ~~If the returned document includes a forwarding address outside of North Dakota:~~
  - ~~Update the household address and state residency in SPACES;~~
  - ~~Close the case; and~~
  - ~~Send notice of adverse action to the new out-of-state address.~~
  - ~~Narrate the action taken.~~

- If the returned document does not include a forwarding address:
  - Close the case for loss of contact
  - Send an adequate notice of adverse action to the last known address.
  - Narrate the action taken.

a. A recipient has the same responsibility to furnish information during a review as an applicant has during an application.

b. A review must be completed at least annually using the Department's:

i. System generated "Monthly Report";

ii. System generated "Review of Eligibility;"

iii. SFN 407, "Review for Healthcare Coverage";

iv. SFN 642, "Title IV-E/Title XIX Redetermination-Foster Care" for children in Foster Care, or other confirmation from a state IV-E agency (in state or out of state) that verifies continued IV-E foster care eligibility;

v. One of the previously identified applications; or

vi. The streamlined review received through the ND Client portal for ACA Medicaid reviews.

vii. When completing a review for children eligible for subsidized adoption assistance, receipt of one of the above reviews forms is not required. However, the following two criteria must be verified:
  - The child remains a resident of North Dakota; and
  - The child continues to be eligible for the subsidized adoption program.

In addition contact should be made with the household to determine whether the child has obtained or lost other insurance coverage.

c. When a review is due for an ACA individual, the individual does not provide the review form or requested information and loses eligibility **if the renewal form and all information to determine eligibility is submitted within 90 days after the termination, eligibility must be reconsidered back to the termination date.**

> **Example**: A case closed June 30 as the household did not submit their review, which was due in June. On September 5th, the household provided their Review Form and verification of income and expenses for July and August. Since the household provided the review form and all verifications within 90 days, eligibility must be determined back to the 1st day of the month following the month the case closed, July 1st.

When the review form is received on the 90th day but is incomplete or does not include all of the requested verifications, the review must be denied and the individual informed that they must reapply.

When the review form is received during the 90 day period but does not include verification for one or more of the months during the 90 day period:

- If the verification is not received for any month other than the month the review is received or the month prior to the month the review was received, the review must be completed and eligibility determined for the months the information was received. The months in which the verifications were not received must be determined not eligible. Should the individual provide the verifications during the 12 month period after the month that was

determined ineligible, eligibility can be determined.

Note: For eligible months prior to January 1, 2020, regardless of when the review is received during the 90 day period, if the child is determined eligible for Healthy Steps, eligibility can only be reinstated effective the 1st day of the month following the month of the determination.

For eligibility months on or after January 1, 2020, eligibility may be established for any month in the 90-day period from date of closure.

- If the verification is not received for the month the review was received or the month prior to the month the review was received, but was for any month between the case closure and review receipt date, eligibility can be determined for the months the information was received. However, the case must be closed at the end of the month for which the verifications were received.

Note: If any children were determined 'CE' eligible, they will remain eligible. However, the caretaker's eligibility would end.

If a household submits an incomplete review on or after the 85th day after case closure for 'Non-Receipt' or 'Incomplete' review, a notice is not required to be sent to the household. However, an attempt to contact the household (by telephone or email, if applicable) must be made. If the information is not received by the 90th day the case will remain closed and a new application must be mailed to the household along with information explaining the need to reapply. Documentation of the Eligibility Workers actions must be included in the electronic narrative.

Note: If the Eligibility Worker sends a notice requesting the information, the household must be allowed 15 days to provide the requested information. The period of time to submit the information must be honored, even if it exceeds the 90th day.

When the review form is received after the 90th day, the case will remain closed and a new application must be sent to the household along with information explaining the need to reapply.

d. Ex Parte Reviews: In circumstances where a desk review is appropriate, such as when adding a child, moving to Transitional Medicaid Benefits, processing a change in the level of care, aligning review dates with SNAP, or TANF, or adding Medicare Savings Programs coverage; and in which the county agency has all information needed to complete a review, eligibility may be established without a review form. When the county agency has all information needed to complete a review, continued eligibility must be established without a completed form or requiring additional information from an ACA Medicaid Household. In circumstances in which information needed to complete a review is available through SNAP or TANF, that information must be used without

again requiring that information from the individual or family. If all needed information is available, a review can be completed without requiring a review form. Care must be used to ensure all needed information is on hand. An online narrative must document the completion of the Ex Parte review.

e. Passive Reviews: A Passive Review is a process in which the recipient is only required to report changes in their circumstances. If there are no changes, the recipient/household is not required to confirm, verify or respond to the review form/notification.

The county agency must make a review of eligibility without requiring information from the ACA individual or ACA Medicaid household if able to do so based on reliable information available in the individual's account or other more current information available such as through any available electronic verification sources. In these cases, the individual/household must be notified of the eligibility determination and basis and that the individual/household must inform the agency if any of the information contained in the notice is inaccurate. The individual is not required to sign and return such notice if all information in the notice is accurate.

If the review form is not received by the 1st day of month it is due, an alert will be given informing the Eligibility Worker to complete a Passive Review. To complete the Passive Review:

a. The household's details and income must be verified through the available electronic verification source(s); and

b. A determination of reasonable compatibility of the existing information and the verified information must be completed. (See the Reasonable Compatibility Section below)

i. If the information is determined to be "reasonably compatible", continued eligibility must be determined.

Once the eligibility determination has been made, the household must be notified of the results, the basis of

the determination, and the need for the household to inform the county social service office of any information contained in the notice that is inaccurate.

ii. If the information is determined NOT to be "reasonably compatible", a 'Request for Verification' notice must be sent to the household reminding them to submit their review form, verification of the inconsistent information and any other information necessary to complete the review.

iii. If the information is not received by Advance Notice Deadline, an automatic closure notice will be sent to the household due to failure to provide the necessary information to complete the review.

iv. If the information is not received by the last day of the month the review is due, the case will close and the 90-day provision will apply.

f. A review must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status, when eligibility is lost under a category (e.g. SSI to non-SSI), or when adding an individual to an existing Medicaid case. When the county agency has all information needed to determine eligibility based on a change in circumstances, a review form does not have to be completed. When additional information is needed one of the forms identified in b. must be used. This includes when adding an individual as eligible who was previously in the household as ineligible.

g. A review, using one of the forms identified in b, is required to open a new Medicaid case for recipients who move from an existing case to their own case (e.g. an 18 year old attains age 19, moves out of the parental home, on other than a temporary basis.)

h. A recipient may choose to have a face-to-face or telephone interview for their review. However, an interview is not required in order to complete a review.

i. Reviews must be completed and processed no later than the last working day of the month in which they are due.

j. It is permissible to complete an early review of a child's eligibility for Medicaid and Optional Children's Group. However, the household may not be required to provide any information that is needed specifically for determining only the eligibility of the Medicaid and Optional Children's Group children who were determined to be continuously eligible. The family may voluntarily provide Medicaid and Optional Children's Group specific information, but must not be required to do so.

If all factors of eligibility are reviewed:

i. If the child is found to be eligible for Medicaid (other than Medically Needy), eligibility must be authorized for Medicaid and the child will be given a new 12-month continuous eligibility period.

ii. If the child is found to be NOT eligible for Medicaid (other than Medically Needy), the child may not be terminated at the time of the early review unless the child meets one of the state's exceptions to terminate continuous eligibility. The child would remain eligible for the remainder of the original continuous eligibility period and a review would be required at that time.

Application and Review 510-05-25-05

1. Application.

a. All individuals wishing to make application for Medicaid must have the opportunity to do so, without delay.

b. A relative or other interested party may file an application in behalf of a deceased individual to cover medical costs incurred prior to the deceased individual's death.

c. An application is a request for assistance :

~~Non-MAGI Medicaid Units:~~

~~i. SFN 405, "Application for Economic Assistance Programs";~~

~~ii. SFN 641, "Title IV-E/Title XIX Application-Foster Care";~~

~~iii. SFN 1803, "Subsidized Adoption Agreement";~~

~~iv. SFN 958, "Health Care Application for the Elderly and Disabled";~~

~~v. The Department's online "Application for Economic Assistance Programs";~~

~~vi. The Low Income Subsidy (LIS) file from SSA;~~

~~vii. If within one calendar month of when an applicant's Medicaid case was closed, or as part of the Healthy Steps annual review, one of the prescribed review forms (see subsection 2(b);~~

~~viii. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "HOSPITAL" stamped on the front page; or~~

~~ix. ICAMA (Interstate Compact on Adoption and Medical Assistance) form 6.01 "Notice of Medicaid Eligibility/Case Activation" stating North Dakota is responsible for the Medicaid coverage of the specified child.~~

~~Non-ACA individuals may also apply for assistance using one of the prescribed applications used for ACA Individuals. However, notification must be sent to the individual requesting verification of assets and any other information needed to make an eligibility determination.~~

d. There is no wrong door when applying for Medicaid or any of the Healthcare coverages. The experience needs to be as seamless and with as few barriers as possible.

e. North Dakota Medicaid applications may be received, filed and maintained at any county office within the state, based on what is most convenient for the applicant or recipient.

Example: Community spouse lives in one county, institutionalized spouse in another. If it is more convenient for the household to apply and maintain the case in the county where the community spouse resides than the county in which the institutionalized spouse is living, the community spouse's county should process and maintain that case.

f. A prescribed application form must be signed by the applicant, an authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant.

g. The date of application is the date an application, signed by an appropriate person, is received at a county agency, DHS, a disproportionate share hospital, or a federally qualified health center. The date received must be documented. Applications must be registered in the eligibility system as soon as possible upon receipt, but no later than the fifth day following receipt. Applications will be considered received on the day submitted. If an application is submitted after business hours, on a weekend or holiday, the application will be considered received on the next business day.

h. An application is required to initially apply for Medicaid, to re-apply after a Medicaid application was denied, to re-apply after a Medicaid case has closed, or to open a new Medicaid case for a child who has been adopted through the state subsidized adoption program.

i. A recipient may choose to have a face-to-face or telephone interview when applying for Medicaid; however, none are required in order to apply for assistance.

j. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients must be furnished to all who require it.

2. Review.

a. A review requires the evaluation of all non-financial requirements affecting eligibility, which may include Medicaid Unit composition, health insurance coverage, cost-effective compliance, alien status, etc. listed in the casefile, reported and verified on the most recent application or review form, and verifications received from all electronic sources as well as from the recipient.

All income, assets (if individuals are subject to an asset test) and expenses must be verified at review. If an individual has provided verification of their irrevocable itemized burial contract, they will not be required to reverify the contract unless they have changed the funeral home designation. However, they will need to provide verification of any additional irrevocable itemized burial contracts that have not already been provided. If the verification can be obtained through electronic sources or is already available to the worker through other sources, the information cannot be requested from the recipient.

Information that is not subject to change, such as US citizenship, date of birth, SSN, etc., does not usually need to be reviewed. However, if a recipient's Social Security Number has not been verified via interface by the next scheduled review, other action must be taken to verify the Social Security Number.

b. A review must be completed at least annually using the Department's:

i. System generated "Monthly Report";

ii. System generated "Review of Eligibility;"

iii. SFN 407, "Review for Healthcare Coverage";

iv. SFN 642, "Title IV-E/Title XIX Redetermination-Foster Care" for children in Foster Care, or other confirmation from a state IV-E agency (in state or out of state) that verifies continued IV-E foster care eligibility;

v. SFN 856, "Adoption Subsidy Agreement - Annual Review" for subsidized adoption, or other confirmation from a state IV-E agency (in state or out of state) that verifies continued IV-E subsidized adoption eligibility;

vi. One of the previously identified applications completed to apply for another program;

vii. The on-line review through OASYS; or

viii. The streamlined review received through the state portal for MAGI reviews.

Non-ACA individuals may also complete a review using one of the prescribed review forms used for ACA individuals. However, notification must be sent to the individual requesting verification of assets and any other information needed to make an eligibility determination.

Ex Parte Reviews: For Non-ACA Medicaid Units, in circumstances where a desk review is appropriate, such as when adding an individual, processing a change in the level of care, or adding Medicare Savings Programs coverage; and in which the county agency has all information needed to complete a review, eligibility may be established without a review form. When the county agency has all information needed to complete a review, continued eligibility must be established without a completed form. In circumstances in which information needed to complete a review is available through Healthy Steps, SNAP or TANF, that information must be used without again requiring that information

~~from the individual or family. Care must be used to ensure all needed information is on hand. An online narrative must document the completion of the Ex Parte review.~~

~~c. A review must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status, when eligibility is lost under a category (e.g. SSI to non-SSI), when adding an individual as eligible who was previously in the Medicaid Unit as ineligible, or when adding an individual to an existing Medicaid case. When the county agency has all information needed to determine eligibility based on a change in circumstances, a review form does not have to be completed. When additional information is needed one of the forms identified in b must be used.~~

~~d. A review, using one of the forms identified in b, is required to open a new Medicaid case for recipients (other than children who are adopted through the state subsidized adoption program, which requires an application) who move from an existing case to their own case (e.g. a disabled child turns age 18).~~

~~e. A recipient may choose to have a face-to-face or telephone interview for their review; however, none are required in order to complete a review.~~

~~f. Reviews must be completed and processed no later than the last working day of the month in which they are due.~~