## Background

A denial occurs when the applicant/beneficiary is determined not to be eligible to CMS benefits.

## Policy:

### A: Denial

The worker enters the applicant/beneficiary information directly into the CMS IT system to determine the applicant's/beneficiary's CMS eligibility. When the applicant/beneficiary is determined not to be eligible to CMS benefits, the denial NOA is sent to inform the applicant/beneficiary of the denial and reason for the denial.

### B: Verifications not received

Lack of Information

Applications are NOT to be denied solely because the worker has not received all required verifications within given deadlines. Refer to 02.06 for verification requests and timeframes.

Failure to Provide

A denial occurs when the applicant/beneficiary fails to provide essential information to determine CMS eligibility.

Applicant Provides After the Denial

- Verifications received **within 10 calendar days** of denial notice will be considered timely. When some verification documents are still missing or denial is now for a different reason due to the processing of received verifications, advise applicant that the denial stands and the need to reapply.
- Applicant/beneficiary contact the County **within 10 calendar days** of denial notice to request more time to provide verifications. Verify good cause and allow additional time to provide.
- When verifications are received **more than 10 calendar days** after the denial notice date, advise the applicant/beneficiary either verbally or in writing that the denial will stand and they may reapply. Document the verbal contact in case comment or scan a copy of any written contact in the case file.

**Note:** A Supervisor may approve rescission of the denial under extenuating circumstances. Extenuating circumstances could include an applicant who has been hospitalized, or had a similar family emergency, and contacts the worker within a day or two after the emergency is over.

### C: Excess Income

Income is a CMS eligibility factor. The worker inputs the applicant information directly into the CMS IT System. The system will determine whether or not the CFBU is within the CMS income limits and to which CMS eligibility category (CMS or CMS Hardship) the applicant may be certified for.

When the applicant is not eligible to CMS due to excess income (more than 165% FPL up to and including 350% FPL) and is otherwise eligible, the applicant may apply for a CMS Hardship Evaluation (Refer to Article 13 for additional information). The worker shall advise the applicant of the repayment agreement and the 10-day deadline in which to provide any pending verifications.

When denying the application for excess income (more than 350% FPL), it is imperative that the correct CFBU size as well as both the total gross and the net countable income used in the determination are reflected.

**D: Excess Property**
When an applicant/beneficiary has been determined to have excess property, the worker will:

- Deny the application; and
- Send an automated denial NOA informing the applicant that CMS has been denied because of excess property, and giving the applicant the opportunity to spend the excess.

The applicant has 30 days from the date of the notice to pay allowable expenses and to submit receipt(s) to the worker. The certification period begins the month of application as long as all other eligibility factors are met.

**E: Failure to Attend Appointment**
Referrals decentralized from HOS which do not meet the HOS Policy and Procedures Manual (PPM) criteria are scheduled an eligibility appointment with a Non-HOS worker. If the applicant fails to show to their scheduled Intake appointment, the worker will deny the application for failure to attend appointment, if good cause is not determined.

**F: Loss of Contact**
An application for CMS is to be denied if, after reasonable attempts to contact the applicant/beneficiary, the worker determines that there is loss of contact. Reasonable attempts consists of, but are not limited to a telephone call, and sending a written request allowing individual 10 days to confirm whereabouts.

**G: Application Withdrawn**
An applicant or person authorized to act on behalf of the applicant (AR) can request a withdrawal of an application for CMS benefits, by:

- Submitting a signed statement indicating the request for withdrawal; or
- Making an oral request for withdrawal.

Note: It is not necessary to wait for the written request before the withdrawal action is taken.

When an oral request is made, the worker asks that a written request be sent. If the applicant/AR fails to return a written request for withdrawal and later disputes the oral request, and there is no other basis for the denial, the worker will immediately rescind the denial action, otherwise, the denial will be considered valid.

**Other Program Impact:**
None

**Reference(s):**
None

**Sunset Date:**
This policy will be reviewed for continuance by 04/30/2022.

**Release Date:**
April 04, 2016