

FINANCIAL ASSISTANCE

CHAPTER 5

This chapter addresses the availability of certain financial assistance programs that may be utilized by Missourians with disabilities. Due to the space limitations of this handbook, only the Supplemental Security Income, Medicare and Medicaid programs are discussed in detail in this chapter. Other financial assistance programs may be available, and details of these programs may be obtained from the local Social Security office and the local Family Services office.

As these programs are governed by statute or regulation, they are constantly susceptible to change. Simply because benefits are denied on the first application does not mean benefits will be denied on a second application. There is no limit on the number of applications one may make for these benefits.

SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND AND DISABLED

Supplemental Security Income for the Aged, Blind, and Disabled (SSI) is a financial assistance program funded through federal tax revenues. It is administered by the Social Security Administration (SSA), even though it is not Social Security. SSI is designed to secure an income floor for eligible persons with disabilities. To apply for SSI, a person should contact the local Social Security office.

There are three basic eligibility tests that must be met by an individual before participation in the SSI program. They are the Disability Test, Income Test, and Resources Test.

Disability Test

For purposes of SSI, an adult who is unable to engage in any substantial gainful activity (SGA) because of any medically determinable physical or mental impairment, which can be expected to result in death or can be expected to last for a continuous period of not less than twelve months, is eligible for SSI in regard to disability. For a child to be eligible for SSI under the Disability Test, he/she must have a medically determinable physical or mental impairment that results in marked or severe functional limitations, or can be expected to result in death, or has lasted or is expected to last for at least 12 continuous months. (www.ssa.gov). Additionally, there is no minimum age requirement for eligibility under SSI.

Income Test

Income for purposes of SSI is determined through a structure similar to that for income tax purposes, in that certain items of income are regarded as income while other items of income are disregarded. Currently (2004), the Income Test is met when Regarded Income, less

appropriate deductions for Disregarded Income, is less than \$564.00 per month for an eligible individual or \$846.00 per month for an eligible couple. These amounts change on an annual basis.

Regarded Income includes:

1. Wages, net earnings from self-employment, annuities, pensions, Social Security benefits, prizes, rents, interest, dividends, etc.;
2. Income of a non-eligible spouse living with the recipient;
3. Income of the parent(s) of an eligible child under age 18 (up to age 22 if the child is a student) if such child lives with the parent(s); and
4. A portion of an ineligible member's income. Through a process called "deeming," part of an ineligible member's income is considered available to the eligible person. The amounts of income "deemed" to the recipient vary with the relationship of the ineligible member. Information regarding specific dollar amounts may be obtained from the local Social Security office.

Disregarded Income includes, but is not limited to:

1. Earned income of an eligible student, under age 22 and not married, up to \$1370 a month subject to a maximum limit of \$5520 in a calendar year;
2. One-third of child support payments made by an absent parent for the support of an eligible child;
3. The first \$20 per month of income. This dollar amount is the same for both eligible individuals and eligible couples;
4. The first \$65 of earned income per month plus one-half the remainder of earned income in a month. The dollar amount is the same for both eligible individuals and eligible couples (This amount may be increased by the unearned income exclusion if there is no unearned income.);
5. Earned or unearned income if it is necessary to fulfill an approved plan to achieve self-support (PASS);
6. Refunds of income taxes;
7. State supplementation to SSI;
8. Education scholarships, grants and fellowships;
9. Home produce grown for personal consumption;
10. Certain benefits excluded by federal statutes, such as, but not limited to, the bonus value of food stamps purchased; and
11. A special deduction for ordinary and necessary work expenses of a person with blindness. This deduction is available to the blind only.
12. The value of deduction impairment-related work expenses for items or services an individual with a disability needs in order to work.

Resources Test

Resources are cash and any items owned by an individual that can be sold or exchanged for cash. Some examples are land, life insurance, personal property, deemed resources and automobiles. Resources consist of real and personal property that have a cash value that may be realized by a person upon sale or exchange of the asset. Similar to the Income Test, certain resources (called “Permissible Resources”) are disregarded under the Resources Test. Cash is a resource. Resource limits (beyond “Permissible Resources”) are \$2,000.00 for an individual and \$3,000.00 for a couple. The limit for couples is the same notwithstanding the eligibility status of the spouse of an eligible person.

Permissible Resources include:

1. The home in which the individual lives and the land the home is on;
2. Household goods and personal property that are not worth more than \$2000.00;
3. One wedding ring and one engagement ring;
4. Burial spaces for an individual and his/her immediate family;
5. Burial funds for an individual and his or her spouse, each valued at \$1500.00 or less;
6. Life insurance policies with a combined face value of \$1500.00 or less;
7. One car, regardless of value if it is:
 - a. necessary for employment or medical treatment,
 - b. modified for use by an individual with a disability, or
 - c. necessary because of climate, terrain, distance or other factors to perform essential daily activities.

These and other permissible resources can be found listed on the Social Security Administration's website: www.ssa.gov/notices/supplemental-security-income. The Administration establishes regulations under which excess resources may be disposed of to establish eligibility. Resources of a non-eligible spouse or of the non-eligible parent(s) of an eligible child are normally “deemed” to the recipient in a fashion similar to the “deeming” of income as previously discussed.

Benefits

Once eligibility has been established, an eligible individual or couple is entitled to benefits. If the eligible person is without an eligible spouse, the basic benefit level is \$564.00 per month. However, if the eligible person has an eligible spouse, they are referred to as an eligible couple. The basic benefit level of an eligible couple is \$846.00 per month.

In addition to the amount of the basic benefit level, eligible persons may retain the disregarded income previously discussed. Income in excess of disregarded income reduces the benefit level dollar for dollar. If such excess is greater than the basic benefit level, the person is not eligible for SSI benefits.

Emergency Advance Payments of the SSI Federal Benefit rate plus any Federally Administered State supplement; the total amount of benefits due; or the amount requested for the emergency, whichever is less, may be available to new applicants. The applicant must present strong evidence of eligibility and of financial need before the first monthly check can arrive. The amount of the Emergency Advance Payment will be deducted from the benefits in up to six monthly installments. Presumptive Disability and Blind Payments may be available to the applicant as well. You may be eligible to receive SSI benefits right away on the basis of a presumptive disability or blindness determination if you have one or more of the medical conditions listed at <http://www.ssa.gov/notices/supplemental-security-income/text-expedite-ussi.htm>. This payment is available in the time it takes for a determination of disability or blindness to be made.

Possible eligibility for other public assistance programs such as Missouri Crippled Children's Service should be researched.

State Supplementation of SSI

There is a mandatory state supplementation to SSI in an amount that will provide the same level of payment as existed before 1974 on the state assistance rolls. This mandatory supplement exists only for those persons who were on the state assistance rolls as of December 1973 and have continued residency and eligibility in the state since that time. Each state has an option to further supplement federal benefits under SSI. This option has been exercised in Missouri.

Work Incentives

Work Incentive provisions include, but are not limited to: (1) Impairment-related Work Expenses; (2) Work Expenses of Individuals with Blindness; (3) Plan for Achieving Self-support (PASS); (4) Continuation of cash and Medicaid benefits under § 1619 (a) and (b) of the Social Security Act; (5) Expedited Reinstatement of Benefits. Contact the nearest Social Security office for details.

According to the Social Security Handbook, a number of work incentive provisions have been incorporated into the SSI program. They enable individuals with disabilities to return to work or to increase their levels of work activity without the loss of SSI disability status and/or to have their SSI benefits protected from reduction based on the increased earnings. In most states, continuation of Medicaid coverage is permitted after cessation of cash payments.

Persons with disabilities and under the age of 65 will be referred to state agencies for appropriate vocational rehabilitation services. Persons who refuse such services without good cause will be denied eligibility for SSI benefits.

Appeals Process

If an applicant has been denied assistance or if a recipient has suffered an adverse determination by the Social Security Administration, he/she may contact the local Social Security office in writing, requesting a reconsideration conference. A notice of the SSA decision will be sent to an individual regarding a decision made by SSA. If the decision is not in favor of the individual, the notice will also include information about how to appeal the decision.

If the SSA decides that a person who has been receiving benefits is no longer eligible, the SSA will send a letter informing the person of the cessation of benefits. An appeal must be made

within 60 days of the receipt of the notice of initial determination. If an individual appeals within 10 days, he/she may continue to receive the same amount of SSI benefits until a determination is made on the appeal, as long as the individual's income and resources do not exceed the SSI limits. The Administration may set up a time and place for a conference. Notice of the conference shall be mailed to the applicant/contestant at least 10 days before the conference. There are three types of conferences: Case Review, Informal Conference, and Formal Conference.

Case Review

After the applicant is given an opportunity to present oral or written evidence to an official of the Administration, a Case Review shall consist of a thorough review of all evidence of record, including new evidence presented by the contestant or his representative or evidence otherwise obtained by the Administration. This review is conducted by an employee of SSA who was not involved in the initial determination. This is the only option for individuals appealing an issue related to the medical aspects of a disability denial of an initial application.

Informal Conference

An Informal Conference uses the same procedures as the Case Review, and provides the contestant or his representative an opportunity to present witnesses and to review all evidence of record. A summary record of the proceedings must be prepared by the Administration and placed in the applicant's case file.

Formal Conference

If a person is already a recipient of SSI benefits and then suffers an adverse determination by the Administration, he is entitled to a Formal Conference. The procedural safeguards of a Formal Conference are much greater than either the Case Review or the Informal Conference. Procedural safeguards included in the Formal Conference are that the:

1. Presiding Administration official must have had no connection with the initial adverse determination;
2. Contestant may present witnesses and written evidence;
3. Contestant may request the Administration to subpoena documents and adverse witnesses;
4. Contestant has the right to cross examine the witnesses;
5. Summary record of the proceedings must be prepared by the Administration and placed in the contestant's case file; and
6. Contestant may review all evidence of record.

After any reconsideration conference, notice of the reconsidered determination shall be mailed to the contestant. This notice must give the basis of the determination and inform the contestant of his/her right to appeal the determination.

Administrative Hearing

The reconsidered determination is final unless it is appealed within 60 days of receipt of the notice. To initiate an appeal, there must be a written request for a hearing given to the Administration.

The request for a hearing must be signed by the contestant and must contain the:

1. Contestant's name and Social Security number;
2. Name and Social Security number of the contestant's spouse (if any);
3. Reasons for disagreeing with the reconsidered determination;
4. Statement of additional evidence to be submitted. Documentary evidence to be presented at the hearing should be presented with the request or within 10 days thereafter; and
5. Name and address of the contestant's representative (if any).

The presiding officer of a hearing must be an Administrative Law Judge (ALJ) of SSA's office of Hearing and Appeals. The decision of the presiding officer must be issued within 90 days of the filing of the request for a hearing unless the case involves a dispute over the existence of disability. Notice of this decision must be sent to the applicant/contestant.

Appeals Council Review

The decision of the presiding officer of the hearing is final unless the contestant appeals the decision within 60 days from receipt of the notice. This appeal may be initiated by sending a written request for an Appeals Council Review to SSA, enclosing any documents or evidence the contestant wishes to be considered.

An Appeals Council Review consists of a review of the entire record, including additional written evidence submitted by the contestant. The Appeals Council can grant, deny or dismiss an individual's case for review. The review may include oral argument or the submission of written brief.

The Appeals Council may:

1. Affirm, modify, or reverse the hearing decision;
2. Send the case back for a rehearing; or
3. Dismiss the request.

Notice of this decision must be mailed to the contestant. The Appeals Council Review is the final step in the agency level of appeal. Any further appeal must be taken to the courts.

Court Appeals

If the decision of the Appeals Council agrees with the hearing determination or dismisses the request of appeal, the contestant may file a civil action in a federal district court within 60 days of:

1. Receipt of the Appeals Council's notice of its decision not to review the decision of the ALJ; or

2. Receipt of the Appeals Council's decision upholding the decision of the ALJ.

For further information on SSI or to learn of any changes in the SSI program, contact the nearest Social Security office or visit the Social Security website: www.ssa.gov.

MEDICARE

Medicare (www.medicare.gov) is a federal insurance program designed to cover outpatient and inpatient medical services to qualifying individuals: 1) who are 65 years of age or older, 2) who are disabled for more than 24 months, or 3) who have end-stage renal disease. To apply for Medicare or to obtain further information about Medicare, an individual should contact the local Social Security Administration office. There are two parts under the Medicare system. Part A is commonly known as Hospital Insurance and is funded for the most part through F.I.C.A. employment withholding. Part B is commonly called Supplementary Medical Insurance and is funded by the F.I.C.A. employment withholding and the monthly premium paid by each recipient.

The actual administration of claims is contracted out to private insurers. An Intermediary administers claims for Part A Medicare. Claims for Part B Medicare are administered by a Carrier.

Part A Medicare, Hospital Insurance

Part A, with certain limitations, is designed to help meet the costs of inpatient hospital services, post-hospital extended care services, and post-hospital home health services. An individual will not have to pay a premium for coverage if he/she or his/her spouse paid Medicare taxes while working.

An individual aged 65 or over is eligible for Part A Medicare if the person is/has:

1. Entitled to Old Age, Survivors and Disability Insurance (OASDI) benefits, commonly known as Social Security benefits;
2. A qualified Railroad Retirement beneficiary; or
3. Attained age 65 before 1968, or attained age 65 after 1967 and has not less than three quarters (quarters are consecutive three month periods beginning with the first day of the year) of coverage for each year after 1966 and before the year that he attained age 65.

An individual with a disability under age 65 is eligible for Part A Medicare if the individual, for the 24 preceding consecutive months, has been entitled to:

Social Security Disability Benefits

An individual is entitled to Social Security Benefits if the individual has:

1. Full coverage insurance. Therefore, the individual:
 - a. had not less than 20 quarters of coverage in 40 quarters ending with the quarter in which he became disabled;

- b. became disabled before age 31 and was covered for at least half of the quarters since he attained age 21, but in no event less than 6 quarters of coverage; and
 - c. would have been fully insured under OASDI benefits and he made application for such benefits; and
2. Filed an application for such benefits with the Social Security Administration; and
 3. A disability as defined by SSA; and
 4. Been disabled throughout a five-month waiting period. A waiting period is not required when the individual had previously been entitled to disability benefits, which have terminated or had a period of disability which had ceased. A period of disability is not a permanent disability, but must last or is expected to last for at least twelve months.

Child's Insurance Benefits

An individual is eligible for Child's Insurance Benefits if the individual:

1. Is the dependent child of one entitled to old age benefits;
2. Is single; and
3. Has not attained age 18 (age 19 if he is a full time high school student); or
4. Has a disability as defined by SSA, which began before he attained age 22.

Widow's or Widower's Insurance Benefits (due to disability)

An individual is entitled to Widow's or Widower's Insurance Benefits if the individual:

1. Is the widow(er) or divorced spouse (must be married ten years) of one who is fully insured; and
2. Has attained age 50, but has not yet attained age 65.

In addition, the disability must occur before either:

1. The individual had attained age 60, or (if earlier)
2. Seven years following the later of:
 - a. the month in which the wage earner died, or
 - b. the last month in which she/he was entitled to mother's or father's benefits.

Mother's or father's benefits arise when the mother or father is under age 65 and is the spouse of a retired or disabled worker and the child is either under age 16 or is disabled and receives Child's Insurance Benefits or the month in which previous eligibility ceased because the disability ceased.

More information about this type of insurance benefit can be found at:

<http://www.ssa.gov/survivorplan/ifyou2.htm>.

Railroad Retirement Benefits

Part A Medicare is also available to individuals who are not in any of the above categories, but who do have "end stage" renal disease requiring a kidney transplant or dialysis, and who are fully or currently insured under Social Security or employees who qualify for Railroad Retirement.

Part B Medicare, Supplementary Medical Insurance

Part B Medicare or, as it is more commonly known, Supplementary Medical Insurance, is designed to help meet the costs of medical attention such as physician services, physical therapy, prescribed medicines that cannot be self-administered, and rental or purchase of durable medical equipment (including wheelchairs, hospital beds and oxygen tents). An individual is automatically eligible for Part B Medicare if he is entitled to Part A Medicare. If an individual is over age 65 but is not eligible for Part A Medicare, that individual may still obtain Part B Medicare coverage if he applies for enrollment in Part B Medicare during the first three months of any year. Part B coverage for a Part A Medicare recipient begins July 1 that year. However, an individual may decline or refuse Part B Medicare by contacting the Social Security Administration in writing, informing them of this refusal.

There is no requirement that all doctors and hospitals participate in the Medicare program. Therefore, it is important that an individual check with the doctor or hospital before accepting services to determine if Medicare will cover the services.

Appeals Process

If an individual feels that his eligibility for Medicare has been wrongly decided, then he should follow the same appeals process as is set out earlier in this chapter under the heading of "Supplemental Security Income."

A different appeals process, however, exists when an eligible individual feels that his benefits under Medicare have been wrongly denied. There is also a difference in this appeals process depending on whether the benefits denied are claimed to be due under part A Medicare or Part B Medicare.

Appeals

If an individual disagrees with an initial determination made in regard to their Medicare Part A, he or she may request a reconsideration. Requests for reconsideration must be made in writing and filed at a Social Security or a Center for Medicare or Medicaid Services (CMS) office within 60 days after receipt of the initial determination. CMS will provide the reconsidered determination in writing to an individual's last known address. Specific reasons for the decision will be provided.

If the individual disagrees with the reconsidered determination, he or she may request a hearing if the amount in controversy is \$100 or more. Additionally, if an individual files for a hearing (considering the amount requirement), the procedures of a Part A hearing are the same as those for an SSI hearing. The Departmental Appeals Board (DAB) may review the decision of the ALJ at the hearing level. The DAB may deny, dismiss or accept review.

An individual may appeal the decision of an ALJ (if DAB denied or dismissed review) or a decision of DAB to federal district court if the amount in controversy is \$1000 or more. For more information on Medicare, visit www.medicare.com.

Part B

When an initial determination is made in regard to Part B 42 CFR 405 H., it is made by a carrier. A carrier is an organization that has a contract to make determinations regarding Part B Medicare. The carrier will provide written notice of the initial determination reviewed. In addition, he or she should make such request in writing to the carrier, SSA or CMS. In some instances, the individual may be able to request a review by calling the carrier. The carrier will designate a phone number for this purpose. An individual must file for review within 120 days of the date of the initial determination. An individual will have a reasonable opportunity to submit written evidence during the review period. The carrier will provide the individual with a notice of review determination. If the individual disagrees with the determination, he or she may request a carrier hearing.

A carrier hearing is the next step in the appeals process. In order for a carrier hearing to be held, the amount in controversy must be \$100 or more. A carrier hearing must be requested in writing. The request must be filed with the carrier or an office of SSA or CMS. The notice of review determination will explain how long the individual has to appeal. Once an individual has requested a carrier hearing in writing, he or she will receive a notice of hearing that outlines the time and place of the hearing and the specific issues to be addressed at the hearing. After the hearing, the carrier hearing officer will issue a written decision including findings of fact, statement of reasons and notification of the right to a hearing in front of an ALJ. An ALJ will hear a case only if there is \$500 or more in controversy.

An ALJ hearing is the next step in the appeals process. A request for an ALJ hearing must be made within 60 days from the receipt of the carrier hearing decision. The request must be filed with the carrier that issued the decision or a SSA office. Except for the requirement of the amount in controversy, the ALJ hearing process is the same as that described for a SSI hearing.

The next level of appeal after the ALJ hearing is the DAB review. In order for the DAB to review a case, there must be \$1000 or more in controversy. The DAB can accept a case for review, deny review or dismiss.

A decision of the DAB or an ALJ decision that was not reviewed by the DAB can be taken to federal district court. The amount in controversy must be \$1000 or more for court review.

An individual needs to be aware that in some circumstances, a court cannot review the decision. If you have questions regarding Medicare or the appeals process, you should contact a Social Security Administration office or your Medicare carrier.

Notice of the hearing shall be sent to the claimant-contestant containing information as to the time and place of the hearing, specific issues to be determined, matters on which findings will be reached and conclusions will be made, and the procedures to be followed at the hearing. At the hearing, the contestant's has a right to:

1. Representation;
2. Submit both written and oral testimony (NOTE: the hearing officer does not have the authority to subpoena witnesses);

3. Examine witnesses;
4. Present oral arguments and/or written statements of facts or law;
5. Object to admission of evidence; and
6. Have an impartial and disinterested hearing officer.

The hearing officer shall make his decision, put it in writing and send a copy to the contestant. At this time, the contestant may also obtain a copy of the record of the hearing proceedings if he pays the copy costs.

The hearing is the final stage of the Part B Medicare appeals process at the Carrier level and is final and binding unless the hearing determination is revised. Grounds to revise a hearing determination include good cause which might include new and material evidence, clerical errors in computations, error on face of the evidence used in the determination, or if the decision was procured by fraud.

MEDICAID

Medicaid is a federal-state program designed to assist low-income individuals who are aged, blind, disabled, children under age 19, parents of children under 19, pregnant women, refugees, and women receiving treatment for breast or cervical cancer in meeting the costs of medical services. Medicaid is provided to those individuals who meet financial and other categorical eligibility criteria. In Missouri, there are also state-funded programs available to individuals who do not meet eligibility criteria for the federally matched (joint state and federal funded) categories of assistance.

The Medicaid program is administered by the Department of Social Services (DSS), with eligibility determined by the Family Support Division. The Division of Medical Services administers benefits, and payment for services. Laws, rules and regulations established by both the federal and state government govern the eligibility process. Information on application of the rules based on an individual's particular situation may be obtained through the local office of the Family Support Division.

Federally matched categories of (health care) assistance include:

1. **Medical Assistance (MA)** for persons who are elderly, blind or have a disability: Provides coverage for persons who are elderly (age 65 or over), disabled or blind. Persons under age 65 must meet the Supplemental Security Income (SSI) definition of disability or the state definition of blindness. The non-spenddown income limit is 90% of the federal poverty level for individuals and for married couples. Persons with income above the non-spenddown income limit must incur medical expenses (spenddown) equal to the amount their income exceeds the limit before they are eligible. Persons who must meet a spenddown have the option of paying the monthly spenddown amount to the Division of Medical Services, much like an insurance premium payment.

2. **Medical Assistance for Disabled Children:** A child who meets the SSI definition of disability may be eligible for the Medical Assistance (MA) program. The income and resources of the parents are taken into consideration.

3. **Medical Assistance for Workers with Disabilities (MA-WD):** Medicaid covered employed persons with disabilities who are age 16 through 64. The disability requirement is the same as that for the Medical Assistance program, except a person may be eligible for MA-WD even if that individual earns more than the amount allowed for SSI or Social Security disability benefits.
4. **Supplemental Nursing Care:** Provides a state grant and Medicaid to elderly, blind, and disabled persons in licensed residential care facilities and non-Medicaid nursing facilities.
5. **Supplemental Aid to the Blind:** Provides state cash grants and Medicaid to needy blind persons.
6. **Conversion Supplemental Payments (SP):** Provides a state cash grant and Medicaid to persons receiving a cash grant under Old Age Assistance (OAA); Permanently and Totally Disabled (PTD) or Aid to the Blind if the conversion to SSI would have resulted in a loss of income.
7. **Nursing Facility Vendor Payments:** Direct payment to the nursing facility for the cost of care for Medicaid claimants certified as needing such care. Vendor payments can be made on behalf of:
 - a. persons in Nursing certified to accept Medicaid payments;
 - b. persons age 65 and over in state mental hospitals (if medically certified) or in such care;
 - c. eligible children under age 21 in Joint Commission on Accreditation of Hospital Psychiatric Facilities (JCAH);
 - d. eligible persons certified for care in an Institution for the Mentally Retarded (IMR).
8. **MC+ (Medicaid) for Children:** Infants under the age of one whose family income does not exceed 185% of the federal poverty level may be eligible; children under the age of 6 at 133%; and children ages 6 through 18 at 100%.
9. **MC+ for Kids, Missouri's State Children's Health Insurance Program (SCHIP):** Uninsured children under age 19 with gross family income below 300% of the federal poverty level.
10. **Medical Assistance for Families (MAF):** Provides coverage to low-income families with children whose income does not exceed 75% of poverty.
11. **Transitional Medical Assistance (TMA):** Provides coverage to a family for up to 12 months, after the closing of MAF case due to employment or increased earnings.
12. **Extended Transitional Medical Assistance:** Provides up to an additional 12 months of coverage for uninsured adults whose income does not exceed 100% of poverty after eligibility for TMA ends.
13. **MC+ (Medicaid) for Pregnant Women (MPW):** Provides coverage to pregnant women whose family income does not exceed 185% of poverty.
14. **Extended Women's Health Services:** Up to 12 months of women's health services for uninsured women who lose MPW coverage two months after a pregnancy ends.

- Coverage is limited to family planning, and testing and treatment of sexually transmitted diseases.
15. **Newborn-Automatic Eligibility:** Newborns are automatically eligible for assistance if their mother is receiving a federally matched category of assistance at the time of birth.
 16. **Qualified Medicare Beneficiary:** Pays for Medicare premiums, deductible and coinsurance for eligible persons enrolled in Medicare Part A.
 17. **Medical Assistance for women receiving Breast or Cervical Cancer Treatment (BCCT) program:** Medicaid coverage for uninsured women under age 65 screened for breast or cervical cancer by Missouri's Breast and Cervical Cancer Control Project (BCCCP). NOTE: The BCCCP Program has requirements including income limits that must be met to get the screening.
 18. **Refugee Assistance:** Persons who are admitted to the United States with an immigration status of refugee or asylee may qualify for a short period of time (8 months from date of entry) in order to establish self-sufficiency if they do not meet eligibility for another category.
 19. Children in the custody of the DSS Children's Division who are in foster homes or other out-of-home placements are medically covered.
 20. **Medical Assistance for Children in Care:** Children in the custody of Division of Youth Services (DYS) or a juvenile court.
 21. Children approved for an adoption subsidy by the DSS Children's Division.

State Only Funded Categories of Assistance include:

- **Blind Pension:** Provides a state grant and medical coverage to persons who do not qualify for Supplemental Aid to the Blind and who are not eligible for SSI.
- **General Relief (GR):** Provides state medical coverage to needy and medically unemployable adults who cannot qualify under any other type of assistance.

Medicaid Coverage

Your Medicaid eligibility may start on a date before you applied. If your eligibility was approved after you got some services, the provider has a choice of whether to bill Medicaid or to bill you. It is your responsibility to tell the provider you had Medicaid. You should ask the provider to bill Medicaid.

Medicaid coverage includes, but is not limited to, inpatient and outpatient hospital services, physicians' services, dental services, prescribed drugs and medicines, optometric services, independent laboratory services, podiatry, emergency ambulance services, audiology, home health care, durable medical equipment, and adult day health care.

Not all medical providers accept Medicaid. You must use Medicaid approved providers for your services to be paid by Medicaid. Medicaid can only pay providers who are enrolled. Showing your red Medicaid or MC+ card every time you get services will help to make sure you have an enrolled provider. It is the recipient's responsibility to be sure the provider knows you have

Medicaid or MC+. It is the providers' responsibility to file claims with Medicaid. Payment can only be made to the provider. More information about Medicaid can be found on the Division of Medical Services website at www.dss.mo.gov/dms or on the Family Support Division website at www.dss.mo.gov/fsd.

Appeals Process

If an individual feels his/her eligibility for Medicaid benefits has been incorrectly determined, he/she may appeal the decision of the Family Support Decision to the Division Director within 90 days of the date that the decision was made. This appeal may be initiated by calling the local Family Support Division office or filling out an appeal form (available at the Family Support Division office) and returning it to the Family Support Division office.

The Family Support Division shall give the contestant (applicant/recipient) reasonable notice of an opportunity for a Fair Hearing. This hearing is to be conducted in the county in which the contestant lives. The hearing is to be conducted by a Hearing Officer designated by the director of the Family Support Division for such purpose.

At this hearing, the contestant has the right to:

1. Be present, in person and by attorney;
2. Introduce oral and written evidence; and
3. Present and examine witnesses.

The evidence presented at the hearing becomes part of the contestant's record.

The director of the Family Support Division will render a decision based on the questions presented on the appeal. If the director rules in favor of the contestant, benefits are conferred upon the contestant from the time that the decision or the action was contested.

If the decision of the director is against the contestant, the contestant may appeal this decision to the circuit court in the county in which he resides within 90 days of the decision of the director. This appeal to the circuit court is initiated by a request from the contestant to the director to furnish a proper form of affidavit for appeal.

Upon receipt of this affidavit for appeal, the contestant must have it authorized by a Notary Public. The contestant must then file the affidavit for appeal with the director of the Department of Social Services within 90 days from the date of the appeals decision.

The director shall then certify the record of the hearing, along with the affidavit for appeal, to the circuit court in the judicial circuit in which the contestant resides where the case will be rescheduled.

The circuit court shall then try the case on the certified record of the hearing to determine whether there was a Fair Hearing granted or whether the decision of the director was arbitrary and unreasonable. If the circuit court finds that a Fair Hearing was not granted or that the director's

decision was arbitrary and unreasonable, the cause will be sent back to the director for re-determination. If the circuit court finds that a Fair Hearing was granted and that the director's decision was not arbitrary and unreasonable, it will affirm the director's decision.

If the circuit court affirms the director's decision, the contestant may appeal to one of the Missouri Courts of Appeals in the same manner as the appeal from the director to the circuit court.

MISSOURI CRIPPLED CHILDREN'S SERVICES (MCCS)

Missouri Crippled Children's Service is a program designed to render diagnostic, preventive and specialized medical care for eligible children in Missouri. In order to qualify for MCCS services, the child must:

1. Be under the age of 21 years (no minimum age);
2. Be a resident of the State of Missouri;
3. Have an organic disease, defect or condition which may hinder normal growth and development of that child, i.e., a physical handicapping condition; and
4. Meet the financial guidelines as established by MCCS. The financial guidelines fluctuate depending on the amount of income of the parents and the number of children in the potential recipient's family.

There is no charge to the child or his parents for diagnostic services obtained through MCCS. The parents are expected to help pay the costs of medical treatment if they are able to do so.

If one desires further information regarding MCCS or believes his child is eligible for MCCS services, he should contact a public health nurse or the local MCCS regional office.