DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF SOCIAL SERVICES

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)
16 **DE Admin. Code** 2000

FINAL

ORDER

Case Processing Procedures - Applications

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Social Services initiated proceedings to amend the Division of Social Services Manual (DSSM) regarding Administrative Procedures, *specifically, Case Processing Procedures – Applications*. The Department's proceedings to amend its regulations were initiated pursuant to 29 Delaware Code Section 10114 and its authority as prescribed by 31 Delaware Code Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 Delaware Code Section 10115 in the June 2014 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced June 30, 2014 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The proposal described below amends policies in the Division of Social Services Manual (DSSM) regarding Administrative Procedures, specifically, *Case Processing Procedures – Applications*.

Statutory Authority

42 CFR §435.907, *Application*
45 CFR §206.10, *Application, determination of eligibility and furnishing of assistance*

Background

The Department of Health and Social Services is the agency designated by the State as responsible for Delaware's public assistance programs. Within the Department, the Division of Social Services (DSS) and the Division of Medicaid and Medical Assistance are responsible for administering the various benefit programs listed here:

http://dhss.delaware.gov/dss/
http://dhss.delaware.gov/dhss/dmma/

The Division of Social Services Manual (DSSM) is an integrated eligibility manual that relates to the activities of each Division's staff engaged in the direct administration of the State's public assistance programs. The Manual contains eligibility and administrative policies based on State and Federal laws and regulations that govern the programs.

Summary of Proposed Changes

Case processing guidelines are provided to ensure maximum client service. To ensure basic efficiency and timeliness in case processing agency staff must adhere to standard times frames within which required case activities must be accomplished. Adherence to these standards allows for the provision of program services on a timely basis and assures that the agencies meet federally imposed audit criteria.

DSSM 2000, *Applications*, is amended to address case processing ambiguities. DSSM policy section 2000 defines an application as including a request for medical assistance. By referencing medical assistance in this section of policy, it could be assumed that all medical assistance applications are subject to the conditions established in the 2000 section of the DSSM policy. The requirements for Medical Assistance applications are addressed in DSSM policy section 14100. This policy change removes what could be interpreted as inconsistent policy for medical assistance applications.

Medicaid policy section at DSSM 14100.5.1 provides "90 day" and "45 day" time periods for processing Medicaid applications. However, Section 2000 references applications for "medical assistance" and Section 2000.5 establishes a "30 day" timeframe for processing the application. These sections are inconsistent.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGE(S)

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities

(SCPD) offered the following observations and recommendations summarized below. The Division of Social Services (DSS) has considered each comment and responds as follows.

GACEC & SCPD

It is Council's understanding that the Disabilities Law Program (DLP) prompted this amendment by identifying to DMMA the following inconsistency in regulations covering the time frames for processing initial Medicaid applications:

Section 14100.5.1 was amended in November, 2013. It provides "90 day" and "45 day" time periods for processing Medicaid applications. However, Section 2000 also covers applications for "medical assistance" and Section 2000.5 establishes a "30 day" time frame for processing the application. These sections are ostensibly inconsistent.

DMMA responded that the reference in §2000 is incorrect and would be removed to clarify that §2000.5 is inapplicable to Medicaid.

The proposed regulation implements the above consensus. In a nutshell, §2000 is amended to clarify that policies specific to Medical Assistance applications are compiled in §14100. However, the regulation could be improved. For example, the 2000 series still contains some references to Medical Assistance (e.g. §§2002.1.1 and 2012) and there is no exclusion in §2000.5 for Medical Assistance cases. Therefore, ambiguity is still present.

DHSS could consider the following:

1) Amend the new reference in §2000 as follows: "Policies specific to Medical Assistance applications and processing time lines are found in DSSM policy section 14100."
2) Amend the title to §2000.5 as follows: "Non-Medical Assistance Filing Dates and Processing Standards". This approach is consistent with other headings which are more program-specific. See, e.g. §§2002, 2007, and 2008.

Agency Response: DSS agrees and amends the final order regulation to reflect the suggested changes.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the June 2014 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual (DSSM) regarding Administrative Procedures, specifically, *Case Processing Procedures – Applications*, is adopted and shall be final effective August 10, 2014.

Rita M. Landgraf, Secretary, DHSS

DSS FINAL ORDER REGULATION #14-30
REVISION:

2000 Applications

An application is a request for ~~financial or medical~~ assistance made by an individual, agency, institution, guardian, or other individual acting for the applicant with his knowledge and consent. An application must be formalized in writing and applicants must be interviewed by an application worker before an eligibility decision can be made.

Any person interested in applying for benefits will receive a DSS application form. These forms are available at all DSS locations. A daily log to record the names of individuals who request application forms will be maintained at each DSS location. Applications for benefits cannot be processed until applicants submit a completed application and complete the filing procedures as specified in DSSM 2001.1.

The primary responsibility for establishing eligibility resides with the client, however, the Division will take necessary action to assist the applicant to establish his eligibility for assistance.

Each applicant will be informed of the programs for which he may be eligible, of his right to a decision on eligibility within a reasonable period of time, and will be informed of his right to appeal any Division decision on eligibility.

Each applicant will have his need for assistance determined in accordance with Division standards. The income of an applicant will be considered in relation to his needs during the calendar month in which the individual applies for assistance. Only such resources as an applicant has currently available will be used in determining eligibility

Policies specific to Medical Assistance applications **[and processing timelines]** are found in DSSM policy section 14100.

2000.5 [Non-Medical Assistance] Filing Dates and Processing Standards

DSS will approve eligible applicants and send notice of acceptance as soon as possible, but no later than thirty (30) days following the application filing date. The filing date is the date the applicant completes, signs, and returns at least the first page of the application form to the correct DSS location.

Applicants who are ineligible will be sent a denial notice as soon as possible, but not later than thirty (30) days following

the application filing date. If the applicant has failed to appear for an interview and has made no subsequent contact with the agency, DSS will send a denial notice on the 30th day following the application date. The applicant must file a new application to be reconsidered for benefits.

In cases where verification is incomplete, the applicant must provide missing verification by the 30th day following the application filing date. If verification is not provided by that date, the application is denied unless this deadline does not allow the applicant at least ten (10) days to return information. (This will occur when the application interview is held 21 or more days after the application is filed.) In these situations, the application can pend beyond thirty (30) days to allow at least ten (10) days for return of missing verification.

In all cases, the client must be informed via Form 105 of the verification that is needed and of the last day that it will be accepted. The application may continue to pend for an additional ten (10) days if the client has returned all verification originally requested and is asked to obtain further verification as a result of agency error. In that situation, the application is approved when the additional verification is submitted, but benefits are issued from the date that the original verification was submitted. If verification is not provided by the deadline, a denial notice is sent to the applicant.

In cases where there is a pending claim for cash benefits (e.g., U.C.), the worker must find out if a decision regarding the claim will be made within thirty (30) days from the application filing date. If a decision is anticipated in that timeframe, the application is not approved until the decision is reached. In those cases, income from the approved claim is included when determining financial eligibility and the amount of the grant. If a decision is not anticipated within the thirty (30) day period, the worker must determine eligibility based on the clients current situation and set a control to check the claim when a decision is anticipated.

In situations where an applicant is ineligible in the month of application, but will be eligible in subsequent months because of anticipated changes, the same application is used to deny benefits in the month of application and determine eligibility in the month following the month of application. In such instances the client need not reapply.

18 DE Reg. 139 (08/01/14) (Final)