State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
CN 712
TRENTON, NEW JERSEY 08625
(609) 588-2600

ALAN J. GIBBS
Commissioner

SAUL M. KILSTEIN
Director

**MEDICAID COMMUNICATION NO:** 92-31 **DATE:** 12/31/92

**TO:** County Welfare Agency Directors

**SUBJECT:** Automated Medicaid Application Processing at Hospital Sites

The Division of Medical Assistance and Health Services (DMAHS) is pleased to announce a standardized packet of System Generated Facsimile (SGF) forms which may be used for Medicaid intake processing at hospital provider sites. An initial project is currently underway for patients admitted to the UMDNJ University Hospital. The Division strongly encourages counties to consider the application of evolving technology designed to facilitate and expedite access to Medicaid coverage.

Under the existing model, developed by Essex County and approved by the Division, the hospital staff or its agents will be screening inpatients at admission to determine the potential for Medicaid eligibility and where indicated, will be responsible for generating a SGF application and collecting the accompanying documentation prior to forwarding the completed package to the appropriate county welfare agency for final disposition. The applicants will receive a copy of all forms which were generated on their behalf, i.e., PA-1C or application form(s).

It is anticipated that successful implementation of this system will dramatically reduce manual processing of applications and related documentation, expedite the eligibility process, improve access for individuals who may qualify for Medicaid coverage, and be a positive factor in fulfilling the county's responsibility in the outstationing mandate.

At this time, the Division has approved the following facsimile forms package for use in the system:

1) PA-1C Public Assistance Inquiry;
2) FD-74 Application for Payment of Unpaid Medical Bills;
3) FD-335 New Jersey Care Pregnant Women and Infants;
4) PA-1JM Application and Affidavit for Public Assistance; and
5) PA-1G Application and Affidavit for Medical Assistance.

A facsimile package and key is attached. In reviewing the documents, note that basically the modifications relate to:

1) Change in completion instructions from manual mode to systems mode;

2) Elimination of questions that do not relate to Medicaid, i.e., Food Stamps, alien sponsor deeming;

3) Incorporation of forms specific signature requirements, including a universal certification statement; and

4) A new forms control numbering system added to the lower right hand corner. The first three letters, "SGF", indicates "Systems Generated Facsimile", the next two digits identify the vendor (41 is assigned to MedE America, Inc.), the last four digits is the approval date (MMYY), which is form specific and as such, may be different among the various forms and vendors.

With the advancement of this technology, it is possible that you will be approached by vendors with requests to cooperate in the initiation of similar systems. Please be advised that prior to operationalizing such arrangements, the vendor must obtain approval from the Division for the forms which they intend to incorporate in the system. Likewise, they must work with the county welfare agencies serving patients in the contracted facilities to develop the external processes necessary to implement the application(s) transmission.

If you have any questions about this initiative, please contact Sandra Stangil, Office of Eligibility and Policy Operations, at (609) 588-2556.

Sincerely,

for Saul M. Kilstein
Director

SMK:Ss
Attachments
c: Nicholas R. Scalera, Director
Division of Youth and Family Services

Marion E. Reitz, Director
Division of Family Development

MED E AMERICA INC. APPLICATION FORMS...CHANGES
FROM ORIGINAL FORMS

**KEY**

Form PA-1C

Page 1. Number 9. **Referring Physician** changed to **Attending Physician**

Page 2. Number 18. **What inquiries have been made regarding financial responsibility for the hospital bill?** changed to **Do you or anyone for whom you are requesting assistance now receive or have received AFDC, SSI, GA or FS in New Jersey or any state during the past twelve months? Yes( ) No( ) If "Yes", complete the following:**

| Case Name(s) | Type(s) of Assistance | State, County or Municipality | From Date To Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Page 2. Number 19. eliminated on Med E America Inc. form is **Does patient, patient's authorized agent, or relatives know that an inquiry is being made for the previously checked program?Yes ( ) No ( )**

Page 2. Number **20** on original changed to Number **19.** Number 21. changed to Number **20**

Page 2. Number 22. eliminated on Med E America Inc. form is **The above patient is being cared for in the hospital since _____ on a ward service or general service basis as to professional and other personal services and I believe that such a patient may be eligible for the previously checked program.**

Page 2. Number 23. on original
**Signature:_____ Title:_____ Date:_____**
changed to Number 21. on Med E America Inc. form
**Hospital Contact:_____ Phone #: (___)_____**
**The above information has been provided by the individual named below.**

Page 2. eliminated on Med E America Inc. form is

PLEASE READ CAREFULLY BEFORE SIGNING

**I understand that I must furnish certain information to the SSA/DO or the County Welfare Agency to establish eligibility and extent of need for Supplemental Security Income Benefits or public assistance, and that the appropriate agency will help to secure this information and verify it. I will supply complete and accurate information, within my knowledge, to representatives of the SSA/DO or the County Welfare Agency. I hereby authorize and direct my relatives, physician, hospital, employers, bankers,**

**and any other person having information concerning the persons named above to furnish complete details to the appropriate agency investigating my application for or receipt of assistance.**

**"I further authorize the Social Security Administration to release benefit information and entitlement dates to the hospital whose name appears on the reverse of this form. I understand the hospital will only use this information for purposes of establishing my eligibility to Medicaid."**

Page 2.
**Signature:**_____ **Relationship**_____ **Date:**_____
on original is changed to
**Name:**_____ **Relationship:**_____ **Date:**_____
**(Person medical Provider interviewed)**

Form FD-74

Page 1. First paragraph added at the end of paragraph is **or Medicaid.**

Page 1. Number 4. added after County of Residence is **/Name of Agency**

Page 1. Number 7. added is Is the applicant a single person with no other household members? Yes ( ) No ( )

Page 1. Number 7a. has been added to Med E America Inc. form replacing Number 7. on original. **If the applicant has applied for Aid to Families with Dependent Children (AFDC) or Assistance to Families of the Working Poor (AFWP), list the full names, ages and relationship of each dependent child or eligible person(s) living with the applicant.** changed to **If the applicant has applied for Aid to Families with Dependent Children (AFDC) or Assistance to Families of the Working Poor (AFWP), or New Jersey Care...Special Medicaid Programs, list the full names, ages and relationship of each dependent child or eligible person(s) living with applicant. If the applicant is applying for Medicaid in any adult categories, list the full name and date of birth of any spouse.**

Page 1. PART II - MEDICAL INFORMATION A. **REVERSE SIDE** changed to **NEXT PAGE**

Page 2. Number 12. **I certify that the above information is true and correct to the best of my knowledge and that no facts have knowingly been omitted. I understand that my application may be investigated and I agree to cooperate in such an investigation. I further understand that the law provides for fine or imprisonment, or both, for a person hiding facts or not telling the truth.** changed to **The above information has been provided by the individual named below. A copy of a signed certificate is attached.**

Page 2. Number 12.

| **Signature of Applicant** | **Relationship to Applicant** | **Date** |
|---|---|---|

changed to

| **Name** | **Relationship** | **Date** |
|---|---|---|

Page 2. bottom eliminated on Med E America Inc. form is
**MAIL THIS COMPLETED APPLICATION, TOGETHER WITH COPIES OF ALL UNPAID MEDICAL BILLS, TO THE RETRO-ACTIVE ELIGIBILITY UNIT, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, CN-712-10, TRENTON, NJ 08625.**

FD-335

Page 1. above Number 1. eliminated on Med E America Inc. form is
**APPLICANT: Please use a pen to complete this form carefully and accurately. IF YOU ARE NOT SURE OF ANY ANSWER LEAVE THE SPACE BLANK. If you have any questions, ask the County Welfare Worker. DO NOT WRITE IN THE SHADED BOXES**

Page 1. Number 5. eliminated on Med E America Inc. form is **Yes( ) No( )**

Page 1. below Number 6. eliminated on Med E America form is
**NOTE: The submission of Social Security Numbers (SSNs) for all household members is mandatory in accordance with 42 USC 1320b-7. Your SSN will be used to check the identity of household members, prevent duplicate participation and facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits to make sure your household is eligible for Medicaid/New Jersey Care. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Medicaid/New Jersey Care programs. Such persons maybe subject to criminal action, administrative claims and/or possible loss of benefits. Failure to file for a SSN may result in disqualification for Medicaid/New Jersey Care.**

Page 2. Number 12. eliminated on Med E America form is the word **you** and also **Yes( ) No( )** added is the word **other**

Page 2. Number14. eliminated on Med E America form is **Yes( ) No( )** added is **How often:**

Page 2. Number 15. eliminated on Med E America form is **If no one receives income from these sources, enter "NO."**

Page 3. Number 16. **Circle "Yes" or "No" after each item to show if any of the applicant household receives money from any of these sources. If you have any "Yes" answers, give the details as requested concerning the income source in the space provided, or on the reverse side if additional space is needed.** changed to **Does anyone in the applicant household receive money from any of these sources. If "Yes", give the details as requested.**

Page 3. Number 18. this question is eliminated on Med E America form
**If your children's stepparent is not applying for assistance, and lives with you, answer the following:**
**A. Stepparent's name**_____
**B. His/her gross monthly unearned income $**_____**from**_____
**C. His/her gross monthly earned income $**_____**from**_____
**D. Number of tax dependents claimed by this stepparent.(Include only those dependents who are not listed as applicants for or are not receiving AFDC)**
_____
**E. Amount of support payments made to individuals residing outside the home $**_____**per**_____

Page 4. Number 21. **In column B,** is changed to **In the code column, I. married but involuntarily separated, for example: mental institution, jail, nursing home, etc.** is changed to **I. married but involuntarily separated. ex: Jail, institution, etc.**
eliminated on Med E America form is **under the parents name.**

Page 4. Number 22. eliminated on Med E America form is **Yes( ) No( )** in four spots

Form PA-1J

Page 1. Above SECTION I eliminated on Med E America form is
**APPLICANT: Please use a pen to complete this form carefully and accurately. IF YOU ARE NOT SURE OF ANY ANSWER, LEAVE THE SPACE BLANK. If you have any questions, ask the county welfare worker.**

**DO NOT WRITE IN THE SHADED BOXES**

Page 1. Number 3. **Home** changed to **CONTACT**

Page 1. Number 4. eliminated on Med E America form is **(NOT APPLICABLE FOR FOOD STAMP PURPOSES**

Page 1. Number 5. eliminated on Med E America form
**Do you wish to apply for the Food Stamp Program? YES( ) NO( )**
**You have the right to file an application for food stamps immediately by providing your name, address, signature and date signed. If you are determined eligible your benefits will be paid from that date. (If you file an application and provide all the necessary information about your circumstances and are found eligible, you can get food stamps within 30 days of the date the FOOD STAMP office receives your application.)**

Page 1. Number 6. eliminated on Med E America form
**Expedited processing for food stamps: If your household (you and the people who live and eat with you) has little or no income now, you may be able to receive food stamps within 5 days from the date the application is filed provided that the entire application is completed and submitted within the 5-day period. YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL DETERMINE IF YOU QUALIFY FOR THIS SERVICE:**

**A. Do you (the household) have more than $100.00 in cash, savings or checking accounts, etc.? YES ( ) NO( )**
**B. Will the household receive more than $150.00 in income for this month? YES ( ) NO ( )**
**C. Are you a migrant or seasonal farm worker household? YES ( ) NO ( )**
**D. Are all members of the household homeless? YES ( ) NO ( )**
**E. Is the amount of your household's combined monthly gross income and liquid resources (cash on hand, checking accounts, etc.) less than the amount of your household's monthly rent or mortgage and utilities? YES ( ) NO( )**

Page 1. Number 7. eliminated on Med E America form
**If you are eligible for food stamps, the stamps can be issued in your name or, if you wish to another adult in the same food stamp household If you wish them to be issued in another person's name (as head of the household) enter that person's name here: _____.**

Page 1. Number 8. eliminated on Med E America form is
**( ) AID TO FAMILIES WITH DEPENDENT CHILDREN (INCLUDING MEDICAID). You are not able to support your children or the children who are in your care.**
**( ) REFUGEE RESETTLEMENT PROGRAM (INCLUDING MEDICAID) You have entered the U.S. as a refugee from another country. Assistance under this program is limited to 4 months or 8 months from your date of entry into the U.S., as applicable.**
**( ) EMERGENCY ASSISTANCE. You lost your shelter, food, clothing and/or furniture because of fire, flood or other emergency.**

Page 1. Number 9. eliminated on Med E America form is
**SIGNATURE:** _____ _____
**(SIGNATURE OF PERSON INITIATING APPLICATION) (DATE SIGNED)**

Page 2. SECTION II Number 10. eliminated on Med E America form is
**For Food Stamp purposes, people who live, purchase food and eat with you should be counted as household members.**

**NOTE: The submission of of Social Security numbers (SSN's) for all household members is mandatory under the Food Stamp Act of 1977 as amended by section 1327 of Public Law 97-98 and Public Law 93-647 requires the submission of SSN's for all individuals applying for AFDC. Your SSN will be used to check the identity of household members, prevent duplicate participation and to facilitate making mass changes. Your SSN will also be used in computer matching and program reviews or audits to make sure your household is eligible for food stamps and AFDC as well as other Federally assisted programs. These procedures are designed to identify persons who fraudulently or wrongfully participate in the Food Stamp and/or AFDC programs. Such persons maybe subject to criminal action, administrative claims and/or possible loss of benefits. Failure to file for a SSN may result in disqualification for food stamps and/or AFDC benefits.**

Page 2. Number 10. added to Med E America Inc. form is **or Date Applied** under Social Security Number in the listing of applicants

Page 3. SECTION III Number 12. eliminated on Med E America form is **(NOT APPLICABLE FOR FOOD STAMP PURPOSES)**

Page 5. Number 20. **Circle one:** is changed to **Check one:** in two places in this question eliminated on Med E America form is **Day paid: Sun., Mon., Tue., Wed., Thur., Fri., Sat.** in two places

Page 8. Number 32. eliminated on Med E America form is
**If your children's stepparent is not applying for assistance, and lives with you, answer the following:**
**A. Stepparent's Name**_____
**B. His/her gross monthly earned income $**_____**from**_____
**C. His/her gross monthly unearned income $**_____**from**_____
**D. Number of dependents claimed by this stepparent. (Include only those other dependents who are not listed as applicants for or receiving Public Assistance.)**_____.
**E. Amount of support payments made to individuals residing outside of the home $**_____**per**_____.

Page 8. Number 33. eliminated on Med E America form is
**Complete the following if a sponsored alien applicant has been in this country for less than 36 months and the sponsor is not an agency or a recipient of AFDC or SSI:**
**A. Date of affidavit of support signed by sponsor**_____.
**B. Value of sponsor's and his or her spouse's resources is $**_____.
**C. Sponsor and his/her spouse have gross income of $**_____**per**_____.
**D. Number of sponsor's dependents (who do not receive AFDC or SSI)**_____.
**E. Amount of support payments made by sponsor to individuals not living in the sponsors's home. $**_____**per**_____.

Page 9. Number 36. eliminated on Med E America form is
**Answer the following by circling "Yes" or "No" and filling in the appropriate blanks.**

Pages 12 thru 15 relate to Food Stamps and Home Energy Assistance only and have been eliminated on Med E America form.

PA-1G

Page 1. INSTRUCTIONS: eliminated on Med E America form **PLEASE PRINT YOUR ANSWERS AND DO NOT WRITE IN THE SHADED BOXES.**

Page 1. SECTION I Numbers 4.,8.and 9. eliminated on Med E America form is
**( ) Yes ( ) No**

Page 3. SECTION IV Number 2. eliminated on Med E America form is
**( ) Yes ( ) NO** in three places and **(IF OWNERSHIP OF MORE THAN ONE PROPERTY, REGARDLESS OF WHERE IT IS SITUATED, LIST AND GIVE DETAILS AS REQUESTED ABOVE. IF YOU NEED MORE ROOM, USE THE BACK OF THIS FORM.)**

Page 4. Number 2. B.,C.,E. and F. eliminated on Med E America form is
**( ) Yes ( ) No**

Page 4. Number 3. **24 months** is changed to **30 months** and eliminated on Med E America form is **( ) Yes ( ) No**

Page 6. Number 3., 4., 5. and 6. eliminated on Med E America form is
**( ) Yes ( ) No**