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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 14-0001 MM7

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 10, 2015

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

Enclosed is an approved copy of Nevada State Plan Amendment (SPA) 14-0001. This SPA was submitted to my office on March 31, 2014 to allow qualified hospitals to determine individuals presumptively eligible (PE) for Medicaid based on preliminary information.

The effective date of this SPA is January 1, 2014. Enclosed are the following approved state plan pages to be incorporated within your approved state plan:

- S21, Pages 1-3
- Hospital PE Application
- Hospital PE Training Materials

Please note that there is also a companion letter included in this approval package. This companion letter addresses the need for Nevada to establish a system to process a PE period on the date the hospital PE determination is made and to be able to automatically end a PE period on the date of a full Medicaid determination, if a full Medicaid application is filed. Otherwise, the PE period must end on last day of the month following the month in which the determination of presumptive eligibility was made.

If you have any questions, please have your staff contact Peter Banks at (415) 744-3782 or at Peter.Banks@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Marta Jensen, Administrator, DHCFP

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
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DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

September 10, 2015

Richard Whitley, Director
Department of Health and Human Services
4126 Technology Way, Suite 100
Carson City, NV 89706

Dear Mr. Whitley:

This letter is being sent as a companion to our approval of Nevada State Plan Amendment (SPA) NV-14-0001, which proposes to implement presumptive eligibility (PE) conducted by hospitals in the Medicaid State Plan in accordance with the Affordable Care Act. This amendment was submitted on March 31, 2014, with an effective date of January 1, 2014.

Section 1902(a) of the Social Security Act (the Act) requires that states have a State Plan for medical assistance that meets certain Federal requirements that set out a framework for the State program. Implementing regulations at 42 Code of Federal Regulations (CFR) 430.10 require that the State Plan be a comprehensive written statement describing the nature and scope of the State's Medicaid Program and that it contain all information necessary for the Centers for Medicare & Medicaid Services (CMS) to determine whether the plan can be approved to serve as the basis for Federal financial participation (FFP) in the state program. While the SPA is approvable, CMS' analysis determined that additional changes related to the state's implementation of the hospital presumptive eligibility provision are needed.

42 CFR 435.1101 specifies that a period of PE "ends with the earlier of – (1) In the case of a child on whose behalf a Medicaid application has been filed, the day on which a decision is made on that application; or (2) In the case of a child on whose behalf a Medicaid application has not been filed, the last day of the month following the month in which the determination of presumptive eligibility was made." This requirement for period of presumptive eligibility applies to children under 42 CFR 435.1102, to other populations according to 42 CFR 435.1103, and to individuals determined presumptively eligible by hospitals according to 42 CFR 435.1110.

Pursuant to these regulations, Nevada ("the state") must start a PE period when the hospital PE determination is made. The start date should not be made retroactive to the beginning of the month or another date.

Further, the state must end a PE period when a full Medicaid determination is made, if a full Medicaid application is filed. Otherwise, the PE period must end on last day of the month following the month in which the determination of presumptive eligibility was made. . Individuals found eligible for Medicaid are transitioned to coverage pursuant to the state's policies regarding enrollment and retroactive coverage. For individuals denied Medicaid eligibility, the PE period

must end on the date of the full Medicaid determination and cannot extend to the end of the month or further.

Nevada is not able to start a PE period on the date that the hospital PE determination is made. Further, Nevada is not able to automatically end a PE period on the date of a full Medicaid determination. To correct this issue, the state is manually monitoring enrollees in the state's hospital PE program. The state will claim Federal Financial Participation (FFP) only for claims submitted during a PE period as defined in 42 CFR 435.1101. For claims that occur outside of the PE period as defined in 42 CFR 435.1101, the state will not claim FFP. The state described this approach on August 12, 2015 and said it would conduct an analysis of claims and apply this approach starting in January 2015, i.e., the first date that hospitals started performing the hospital PE determinations. The state intends to perform this manual monitoring and FFP adjustment step until the logic can be embedded into the state's Medicaid Management Information System.

Within 30 days of this letter, please reply to CMS to confirm receipt and agreement to the description in this letter, including effective dates. If you have any questions about this letter or need any additional information, please contact Peter Banks of my staff at either 415-744-3782 or by email at Peter.Banks@cms.hhs.gov.

Sincerely,

/s/

Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Marta Jensen, Administrator, DHCFP

Medicaid State Plan Eligibility

NV.0880.R00.00 - Jan 01, 2014

Control Panel

General Information

File Management

Tribal Input

Summary (CMS179)

Medicaid State Plan Eligibility: Summary Page (CMS 179)

State/Territory name: Nevada

Transmittal Number:

Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

NV-14-0001

Proposed Effective Date

01/01/2014 (mm/dd/yyyy)

Federal Statute/Regulation Citation

42 CFR 435.1110

Federal Budget Impact

Federal Fiscal Year		Amount
First Year	2014	$ 0.00
Second Year	2015	$ 0.00

Subject of Amendment

Character Count:73 out of 2000

New state plan amendment section S21 Presumptive eligibility by hospitals

Governor's Office Review

- (●) Governor's office reported no comment
- ( ) Comments of Governor's office received

Describe:

○ No reply received within 45 days of submittal

○ Other, as specified

Describe:

Signature of State Agency Official

Submitted By:	Robyn Heddy
Last Revision Date:	Aug 28, 2015
Submit Date:	Mar 31, 2014

BACK CONTINUE

Medicaid Eligibility

State Name: Nevada

OMB Control Number: 0938-1148

Transmittal Number: NV - 14 - 0001

Expiration date: 10/31/2014

Presumptive Eligibility by Hospitals — S21

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

(●) Yes ( ) No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☒ A qualified hospital is a hospital that:

☒ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

☒ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

(●) Yes ( ) No

☒ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

- ☒ Pregnant Women
- ☒ Infants and Children under Age 19
- ☒ Parents and Other Caretaker Relatives
- ☒ Adult Group, if covered by the state
- ☒ Individuals above 133% FPL under Age 65, if covered by the state
- ☒ Individuals Eligible for Family Planning Services, if covered by the state
- ☒ Former Foster Care Children
- ☒ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state
- ☐ Other Family/Adult groups:
- ☐ Eligibility groups for individuals age 65 and over
- ☐ Eligibility groups for individuals who are blind
- ☐ Eligibility groups for individuals with disabilities
- ☐ Other Medicaid state plan eligibility groups
- ☐ Demonstration populations covered under section 1115

Medicaid Eligibility

The state establishes standards for qualified hospitals making presumptive eligibility determinations.

(•) Yes ( ) No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Description of standards: 90% of all individuals determined presumptively eligible by the hospital must submit an application prior to the end of the presumptive eligibility period.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Description of standards: 94% of presumptive eligibility decisions must be correctly determined based on State HPE policies and must be entered into the portal correctly from information gathered.

☒ The presumptive period begins on the date the determination is made.

☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☒ Periods of presumptive eligibility are limited as follows:

( ) No more than one period within a calendar year.

( ) No more than one period within two calendar years.

( ) No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

(•) Other reasonable limitation:

	Name of limitation	Description	
+	No more than one PE period in 24 months	The system was designed to allow PE once every 24 months.	X

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

(•) Yes ( ) No

( ) The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

(•) The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

An attachment is submitted.

☒ The presumptive eligibility determination is based on the following factors:

☒ The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

☒ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

☑ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20140415

Application for Presumptive Eligibility for Medicaid

Use this form to find out quickly if you qualify for presumptive eligibility for Medicaid. Presumptive eligibility offers you and your family immediate access to health care while you apply for regular Medicaid or other health coverage.

To find out if you qualify for regular Medicaid or other health coverage, you must complete and submit an Application for Health Insurance to the Division of Welfare and Supportive Services. While you wait to learn if you qualify for regular Medicaid or other health coverage, you can get your health services through the presumptive eligibility program.

You can apply for medical assistance online at www.dwss.nv.gov

You can complete a paper application and submit by mailing the application to:

Division of Welfare and Supportive Services
PO Box 15400
Las Vegas, NV 89114

Who can qualify for presumptive eligibility for Medicaid?

You can qualify for presumptive eligibility for Medicaid if you meet all of these rules:

- Your income is below the federal poverty level for a family of your size
- You are a U.S. citizen, U.S. national, or eligible immigrant
- You do not already have Medicaid
- You have not had presumptive eligibility for Medicaid in Nevada in the past 24 months
- You are in one of the groups that qualifies for presumptive eligibility for Medicaid:
  - Children under age 19
  - Parents and caretaker relatives
  - Pregnant women
  - Other adults age 19-64
  - Aged Out of Foster Care

Need help with your application?

You can get personalized assistance completing your application from community partners or local division staff.

Find a location nearest your home:
Visit www.dwss.nv.gov and choose contact us, or call 1-800-992-0900 (voice) or 1-800-326-6888(TTY)

1 Tell us about yourself

We ask for this information so that we can contact you about this application.

Name (first, middle last)

Home address (leave blank if you don't have one)

City | State | ZIP Code

Mailing address (if different from home address) *You must have a mailing address*

Phone number (if you have one) | Email address (if you have one)

2 Tell us about your family

List yourself and the members of your immediate family who live with you. Include your spouse and your children, under age 19, if they live with you.

Name (first, middle, last)	Relationship to you	Gender	Date of Birth (XX/XX/XXXX)	Applying for presumptive eligibility for Medicaid? (Yes or No)	Already had Medicaid? (Yes or No)	Social Security Number (optional)	U.S. Citizen, U.S. National, or eligible immigrant? (Yes or No)	Resident of Nevada? (Yes or No)
					Answer for family members who are applying. If a person is not applying, these questions are optional, but providing the information can speed up the application process.			
(Same as above)	Self							

3 Other questions

Answer these questions for yourself and your family members listed in Section 2. Your answers will make it easier to find out if you and any family members qualify.

Is anyone applying for presumptive eligibility pregnant? ☐ Yes ☐ No

If yes, who? _____ Expected due date?_____ How many babies does she expect?_____

Is anyone who is applying for presumptive eligibility for Medicaid receiving Medicare? ☐ Yes ☐ No

If yes, who? _____

Has anyone applying for presumptive eligibility for Medicaid, if under the age of 26, ever been in foster care in the state of Nevada? ☐ Yes ☐ No

If yes, who? _____ Age when they left the program: _____

4 Tell us about your family's income

Write the total income before taxes are taken out for all family members listed in Section 2.

⇩ Job income *For example, wages, salaries, and self-employment income.*

Amount $ _____ How often? (*check one*) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

Amount $ _____ How often? (*check one*) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

⇩ Other income *For example, unemployment checks, alimony, or disability payments from the Social Security Administration (SSDI). Do not include Supplemental Security Income (SSI payments) or any child support you receive.*

Amount $ _____ How often? (*check one*) ☐ Weekly ☐ Biwee

Amount $ _____ How often? (*check one*) ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Yearly

5 Health Plan Selection

Families who live in urban Washoe County or urban Clark County are covered by a managed care organization (MCO). You are being asked to choose one of the following health plans. If you do not indicate a health plan preference on your application, we will choose a plan for you. Your choice of health plan does not guarantee acceptance into the Nevada Medicaid or Nevada Check Up program. We might not honor your choice of plans if you or any family members have been enrolled in one of our current managed care organizations. Once enrolled, families will receive a member handbook explaining the health plan benefits and can contact the numbers below for information regarding the health plans.

Amerigroup: 1-800-600-4441
www.amerigroup.com

Health Plan of Nevada: 1-800-962-8074
www.healthplanofnevada.com

Please choose a health plan: _____

NOTE: If you do not choose a health plan preference, we will choose a plan for you.

For families living in the fee-for-service benefit area, services may be obtained from any Nevada Medicaid provider. If you need assistance in locating a provider, please call your local Medicaid district office:

Carson City	Reno	Las Vegas	Elko
(775) 684-3651	(775) 687-1900	(702) 668-4200	(775) 753-1191

6 Sign this form here

I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.

I swear I have honestly reported the citizenship status of myself and anyone I am applying for.

Your signature: **Date:**

7 If you qualify for presumptive eligibility for Medicaid, what happens next?

- You will get a letter from the hospital saying you were approved.

- **You can start using your presumptive eligibility for Medicaid coverage right away** for services such as doctor visits, hospital care, and prescription drugs. You can go to any health care provider who accepts Medicaid, starting the day you are approved.

    - To start using your presumptive eligibility for Medicaid, the hospital will give you a letter saying you are approved. Use the letter to get services until you get a card in the mail. The card should arrive within 7 - 10 days. If you lose the letter, you can call customer service at 1-800-992-0900.

    - If the letter says you qualify for presumptive eligibility for Medicaid because you are pregnant, you can get care at outpatient clinics or other places in the community. Presumptive eligibility for Medicaid will not cover the cost if you are admitted to a hospital.

- If you do not fill out and send the Application for Health Insurance to see if you qualify for regular Medicaid or other health coverage, your presumptive eligibility for Medicaid coverage will end on the last day of the month after the month you are approved.

    - For example, if you qualified for presumptive eligibility for Medicaid in January, it will end on the last day of February.

- **To see if you qualify for regular Medicaid or other health coverage:**

  You can apply for medical assistance online at www.dwss.nv.gov

  You can complete a paper application and submit by mailing the application to:

  Division of Welfare and Supportive Services
  PO Box 15400
  Las Vegas, NV 89114

  The hospital will give you an application.

8 If you do not qualify for presumptive eligibility for Medicaid, what happens next?

You will get a letter from the hospital saying you were not approved. You cannot appeal the hospital's decision. BUT, you can still apply for regular Medicaid or other health coverage by completing the Application for Health Insurance online at dwss.nv.gov or by telephone or on paper.

Hospital Presumptive Eligibility Training

Division of Welfare and Supportive Services

Working for the Welfare of ALL Nevadans

TN NO: 14-0001 Approval Date: 9/10/2015 Effective Date: 1/1/14

Training Objectives

- HPE Overview
- Eligible Populations
- Eligibility Period and Benefits
- Hospital Qualifications
- Becoming an HPE Provider
- The HPE Application
- Program Integrity

HPE Overview

- HPE is a process under the Affordable Care Act to connect eligible people to Medicaid
- Participating in HPE is optional for hospitals
- Hospitals must follow federal and state requirements and performance standards
- States have discretion how to operate HPE to ensure appropriate PE determinations are made

Eligible Populations

- Pregnant women (up to 165% FPL)
- Infants and children 1-5 (up to 165% FPL)
- Children 6-19 (up to 138% FPL)
- Parents and caretaker relatives (up to 138% FPL)
- Non-disabled adults, 19-64 w/o Medicare (up to 138% FPL)
- Aged out of Foster Care (not based on income)

Eligibility Criteria

- Not currently enrolled in Medicaid
- Attest to household size and income
- Attest to citizenship/ qualified immigrant status, state residency requirements
- Cannot have been enrolled via HPE within the last twenty four months

Eligibility Period

- Begins the day HPE determination made
- ***If customer completes a full Medicaid application***, HPE ends the day the DWSS full Medicaid determination is made
- ***If no Full Medicaid application filed***, HPE ends the last day of the month following HPE determination
- HPE is *only* allowed once every 24 months (and only once per pregnancy)

HPE Benefits

- Benefits are the same as those provided under Medicaid
- Federal regulations limit HPE benefits for pregnant women to ambulatory pre-natal care only (no inpatient, non-prenatal care)

Hospital Qualifications

- Is an active Nevada Medicaid provider
- Has an active HPE contract addendum in place
- Has at least one trained/certified HPE staff member
- Agrees to be listed on DHCFP website as authorized site for application assistance

Hospital Qualifications Con't

- Operates within the State of Nevada
- Agrees to make HPE determinations consistent with the departments policies and procedures
- Has not been disqualified by the agency to conduct HPE determinations
- Assists ensures 90% of applicants made eligible via HPE complete full DWSS Medicaid application before end of HPE eligibility period
- Ensures 94% of Presumptive Eligibility determinations are correctly determined based on State HPE policies and must be entered into the HPE portal correctly from information gathered.

Becoming an HPE Provider

- Register with DHCFP provider enrollment unit
- Complete a Hospital Presumptive Eligibility Contract addendum
- Hospital staff complete initial and ongoing training

The HPE Application

- Requires HPE application to be completed by applicant or responsible household member.
- HPE staff enter eligibility results into Access Nevada Presumptive Eligibility system.
- Hospital must provide written notice of eligibility determination to the applicant.
- The HPE application cannot be approved if applicant is over income or does not meet citizenship/residency requirements.

Submitting HPE Applications

- Step 1: Identify potential PE candidate and check EVS system to determine if individual has current eligibility
- Step 2: Applicant to complete streamlined PE application
- Step 3: Interview applicant for attestations and complete eligibility determination
- Step 4: Enter presumptive eligibility determination into Access Nevada Presumptive eligibility system (Note: this is formal notification to the State)
- Step 5: Provide an HPE Notice of Decision on hospital letterhead
- Step 6: Encourage client to complete full Medicaid application. If possible schedule process with available resources or provide instructions on possible methods of submission. (Note: Handouts available in class)

The HPE Notice of Decision

- Hospital provides HPE Notice of Decision explaining whether applicant is eligible
- Notice must explain:
  - If denied, reason for denial and that no appeal right are available.
  - If approved, identify the
    - HPE time period, including exact date applicant was determined eligible
    - Date the full application must be submitted to continue coverage
    - Appointment time to complete full Medicaid application (if applicable)

Reimbursement

- All claims for HPE services will be submitted to DHCFP and reimbursed on a fee-for-service basis
- No payments are made for completing HPE determinations
- No payments are made for completing full Medicaid applications
- Can not charge applicants to apply for HPE or assist with full Medicaid applications

Program Integrity

- HPE is a powerful tool- hospital staff have authority to determine eligibility for Medicaid
- DWSS and DHCFP have a fiduciary duty to ensure taxpayer funds are appropriately spent
- State reimbursement rates remain at regular Medicaid rates during the presumptive eligibility period regardless of HPE determination, creating potential losses to general funds if eligibility determinations are incorrect.

Program Integrity Reporting Con't

- The DWSS Performance Review and Evaluation Unit(PRE) will monitor and identify trends in order to conduct additional investigations and take necessary corrective action

Program Integrity Reporting

- DWSS will generate monthly reports with the following information:
- Number of HPE applications by:
  - Specific hospital facility
  - Percentage of HPE individuals who completed a full Medicaid application before the end of the PE period.
  - Percentage of PE decisions determined accurately based on DWSS factors of eligibility.

Program Integrity Con't

- PRE will perform regular on-site audits of HPE qualified hospitals
- PRE will inspect records, policies and procedures, documentation and compliance with HPE requirements
- If PRE audit results in open Medicaid investigation for fraud, waste, or abuse, the department may implement disciplinary action

Hospital Disqualification

- Federal regulations allow states to disqualify hospitals from participating in HPE for failure to meet standards:
  - 90% of all individuals made presumptively eligible must submit a regular application before the end of their HPE period
  - 94% of all Presumptive Eligibility decisions must be correctly determined based on State HPE policies and must be entered into the portal correctly from information gathered.

Hospital Disqualification Con't

- Qualified hospitals not meeting the above-stated standards will be placed on a corrective action plan (CAP) and will be given one calendar quarter from the date of the CAP to come into compliance

- Hospital will be disqualified if after completion of the CAP and additional training, the State determines the hospital is not capable of making HPE determinations in compliance with standards

Questions?

Presumptive Eligibility

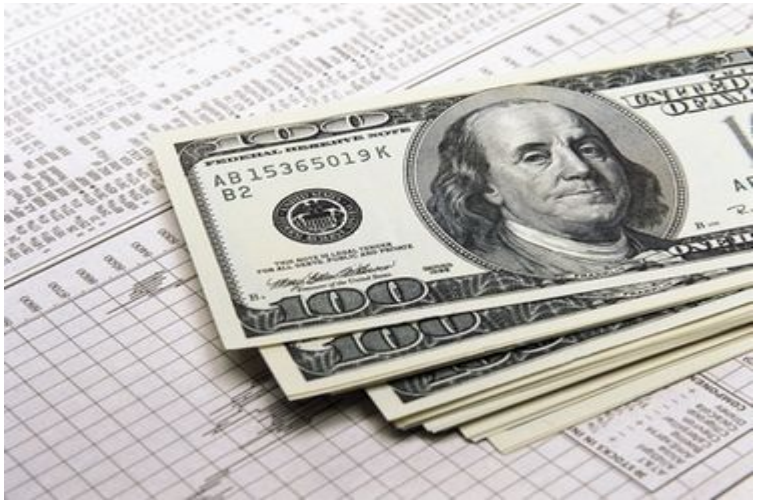
Non-Financial Factors

TN NO: 14-0001 Approval Date: 9/10/2015 Effective Date: 1/1/14

Questions about this material? Send an e-mail query to Training. We will respond within 48 hours as well as post your question and answer to the FAQ section which can be found at the end of this e-learning module.

Non-Financial Factors

Factors to Presumptive Eligibility



Financial **Factors**

Non – Financial **Factors**

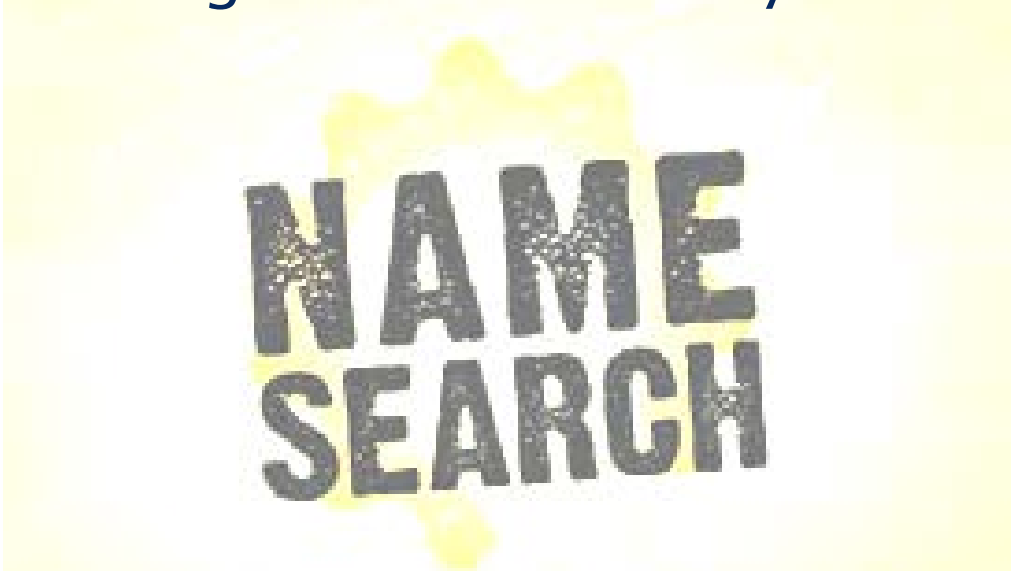
Non-Financial Factors

Name of Individual	
Age	Residency
Relationship	Household Composition
Citizenship	Social Security Number*
Identification	Pregnancy

*Providing a Social Security Number or Tax ID number is not required for a PE determination.

Name

Individuals names are recorded in the DWSS system according to Social Security Records



When completing name searches in IEVS always search according to what the client states their name is on their *Social Security Card

Income Levels

Household Size	AM limit	100% FPL	122% FPL	138% FPL	164%	205%	400%
1	$229	$958	$1,169	$1,322	$1,571	$1,964	$3,832
2	$296	$1,293	$1,577	$1,784	$2,121	$2,651	$5,172
3	$363	$1,628	$1,986	$2,247	$2,670	$3,337	$6,512
4	$430	$1,963	$2,395	$2,709	$3,219	$4,024	$7,852
5	$496	$2,298	$2,804	$3,171	$3,769	$4,711	$9,192
6	$563	$2,633	$3,212	$3,634	$4,318	$5,398	$10,532
7	$630	$2,968	$3,621	$4,096	$4,868	$6,084	$11,872
8	$697	$3,303	$4,030	$4,558	$5,417	$6,771	$13,212
Each Add	$67	$335	$412	$462	$549	$687	$1,340

Aid Code	Description	Income Limit
AM	Parents & Adult Caretakers	0 – AM Limit
AM1	Expanded Parent & Adult Caretakers	AM Limit – 138%
CH	Children & Pregnant Women	Child 6–18 Less than 122% Child 0–5 Less than 164% Pregnant Women Less than 164%
CH1	Expanded Children's Group for Children Under 19	123% – 138%
CA	Non Parents (19–64)	Less than 138%

Income level and Age

AO – Foster Care

This eligible category does not have a financial limit, however they must meet the definition of an individual who has "Aged out of Foster Care"

Medical Manual B-220

A. under 26 years of age; and

B. were in foster care in Nevada, under the responsibility of the state at the time they turned 18 years of age; and

C. were enrolled in Medicaid while in foster care;

https://dwss.nv.gov/pdf/Manuals/Medical/b200.pdf

Age

AM – Parents & Caretakers 19 and over
Evaluate income at the AM level

Expanded AM1 – Parents & Caretakers 19-64
Evaluate income at the 138% FPL

Age

CH – Children 0 – 5 & Pregnant Women

Evaluate income at or under 165% FPL

CH – Children 6 – 18

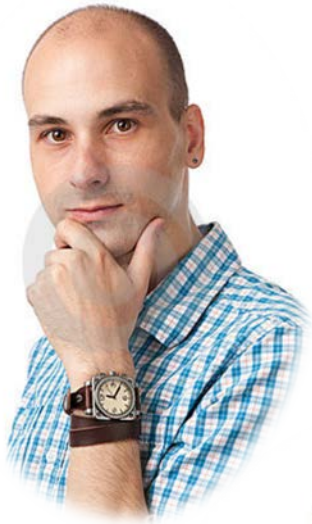
Evaluate income at or under 122% FPL

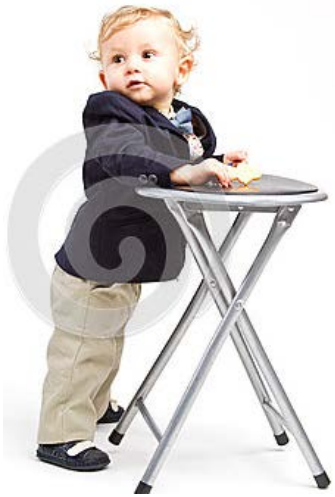
CH1 – Children 6 – 18

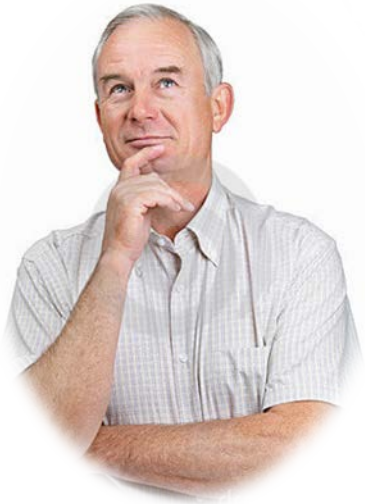
Evaluate income between123 –138% FPL

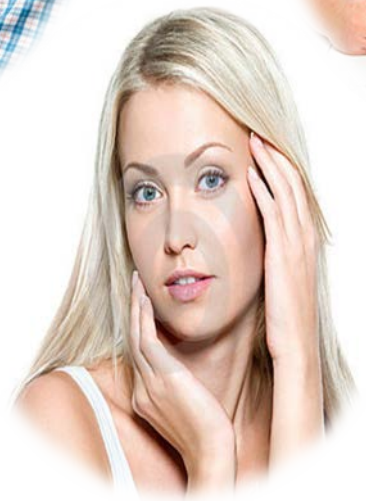
Age

Accept the client's statement for age.









Citizenship

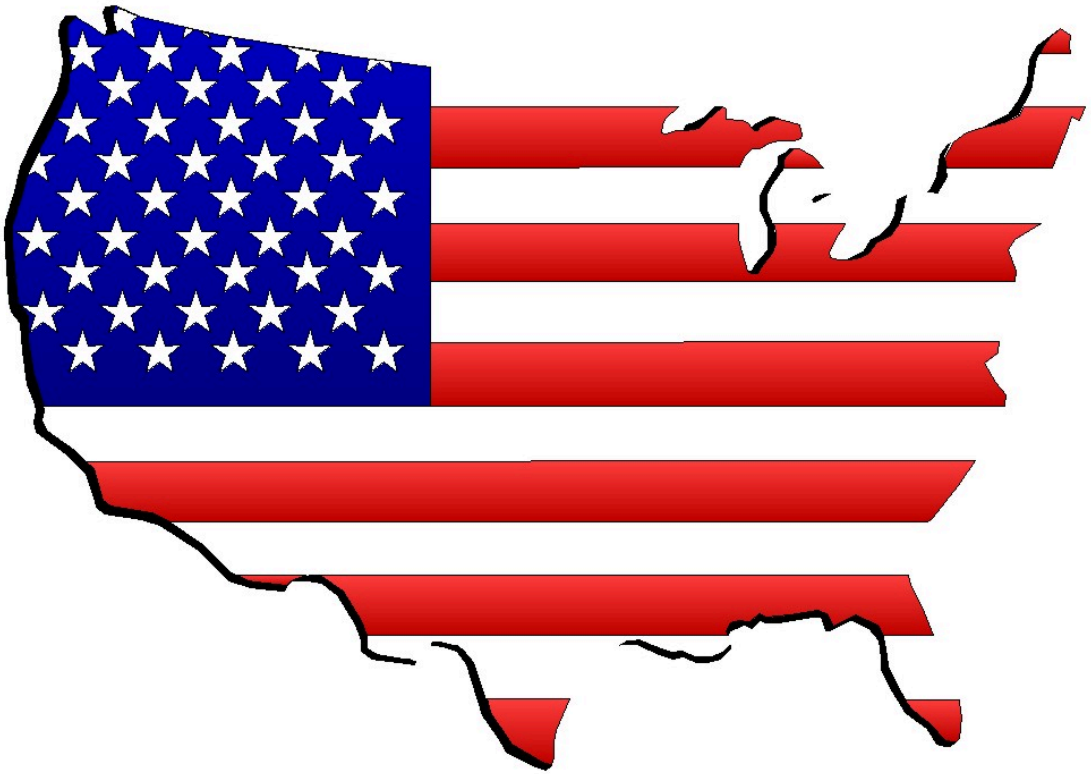
Individuals requesting medical assistance must be

- US Citizens, or
- Have legal immigration status

Upon completion of the application the Head of Household attests to the citizenship of all members

Citizenship

Client statement is accepted for both proof of US Citizenship and Lawful Presence.



Non-Citizens

Qualified Non-Citizen	An individual who was born outside of the United States and is currently residing lawfully in the US and have maintained that status for 5 years or more.*
Not Qualified Non-Citizen	An individual who was born outside of the United States and is currently residing lawfully in the US and have maintained that status for less than 5 years.*
Undocumented Non-Citizen	An individual who was born outside of the United States and is currently not residing under any lawful status.

***or has a another specialized qualifying status.**

Qualified Non-Citizens

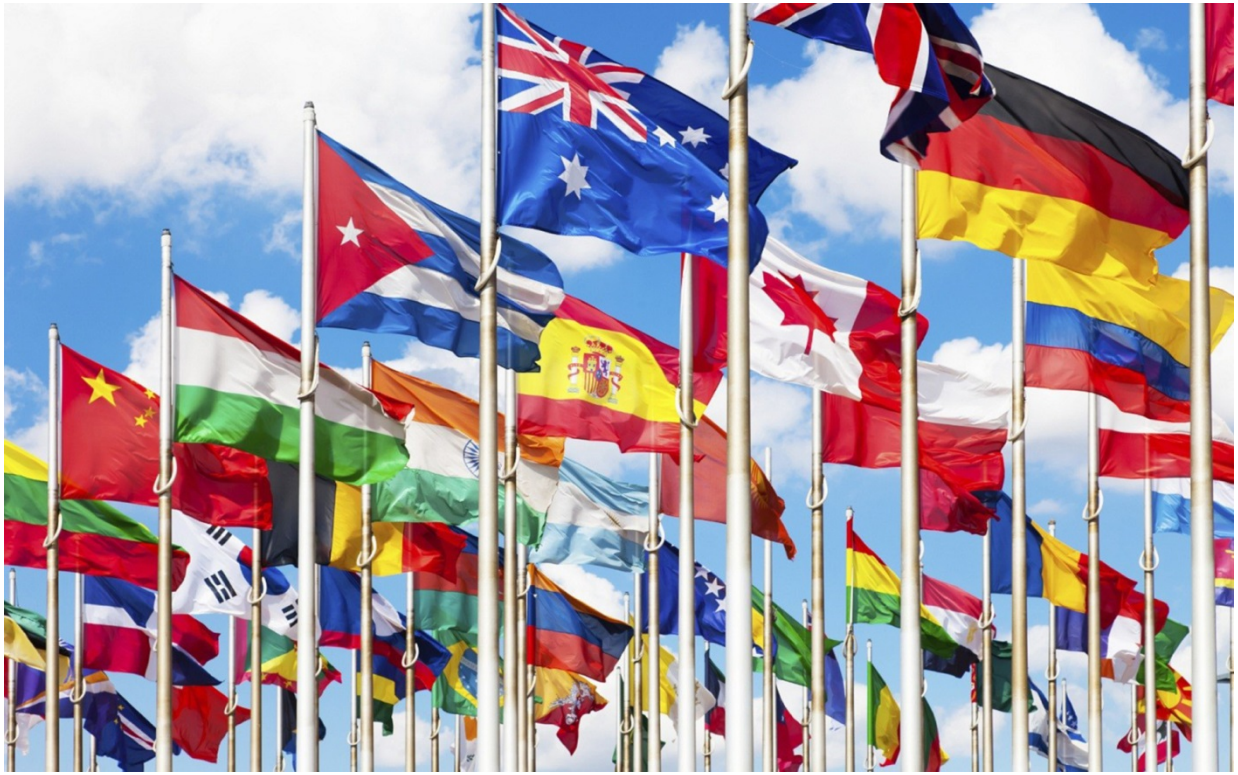
Qualified Non-Citizens	
Individuals who are residing lawfully in the US and have maintained lawful status for 5 years or more	Battered non-citizen who are residing lawfully in the US and has maintained lawful status for 5 years or more
Refugee, Asylee, Withholding Deportation, Cuban/Haitian Entrant, Amerasian immigrant	Veteran, active duty or un-remarried surviving spouse or child of a veteran
Obtains citizenship	

Other Qualified Non-Citizens

Qualified Non-Citizens	
A victim of trafficking and their spouses and children	The individual was receiving Title XVI SSI benefits on or before 8/22/96
Native American born in Canada possessing at least 50% blood of an American Indian race or a member of an Indian Tribe listed in E&P Manual C-700	

Non-Citizens

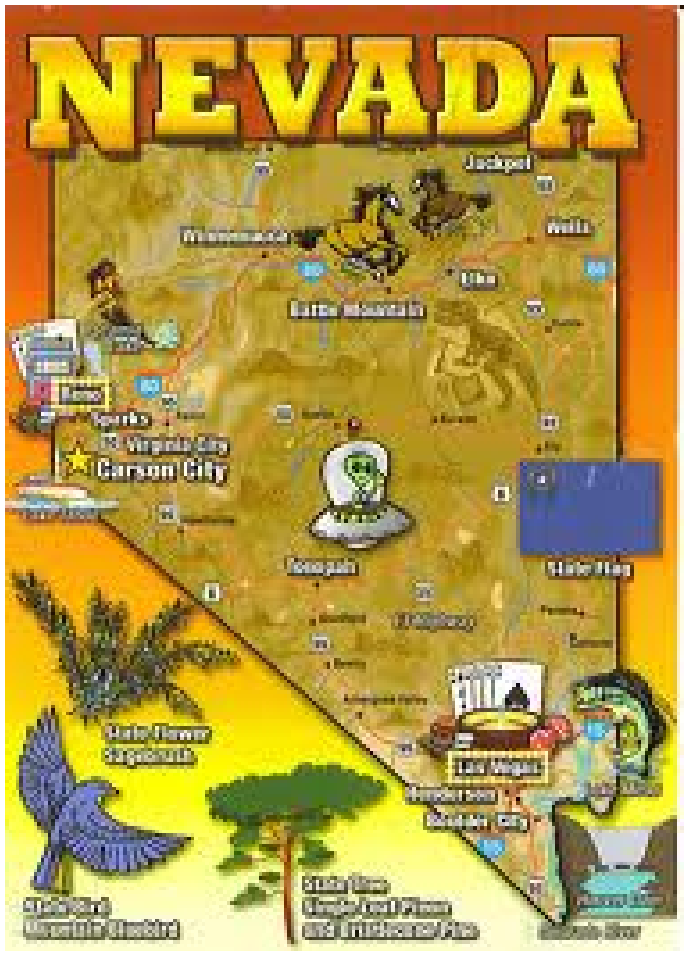
Include all non-citizens in the count when determining the assistance unit size



Residency

Clients must be living in Nevada with the intention of making Nevada their home permanently OR must be living in Nevada with a job commitment or seeking employment. Clients are not required to have a fixed place of residence to meet this requirement.

Client statement is accepted for Nevada Residency



Residency

Non-citizens who are currently admitted to the United States lawfully but only for a temporary or specified time do not meet residency requirements and will not be eligible for any assistance including Emergency Medical.

- Foreign Government Representative
- Visitors for business or pleasure including exchange visitors
- Aliens in travel status while traveling through the US
- Crewmembers on shore leave
- Foreign students; etc.

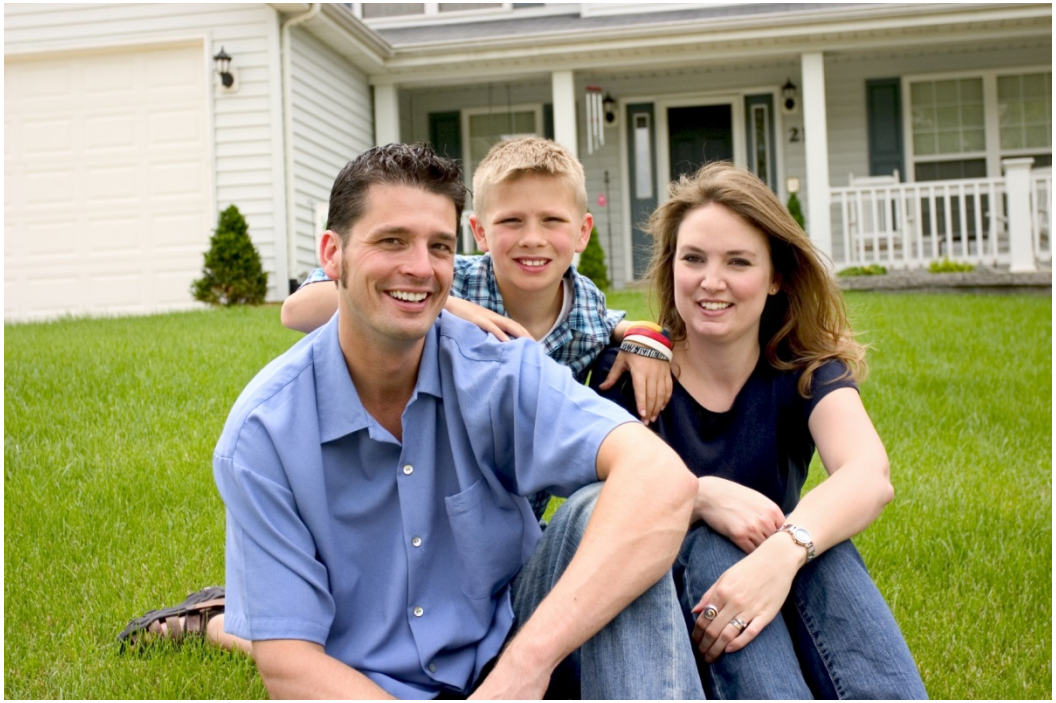
Social Security Number

Each individual (including children) seeking Medicaid, will be asked for their Social Security Number and/or tax ID number.

*Providing a Social Security Number or Tax ID number is not required for a PE determination.

Household Determination

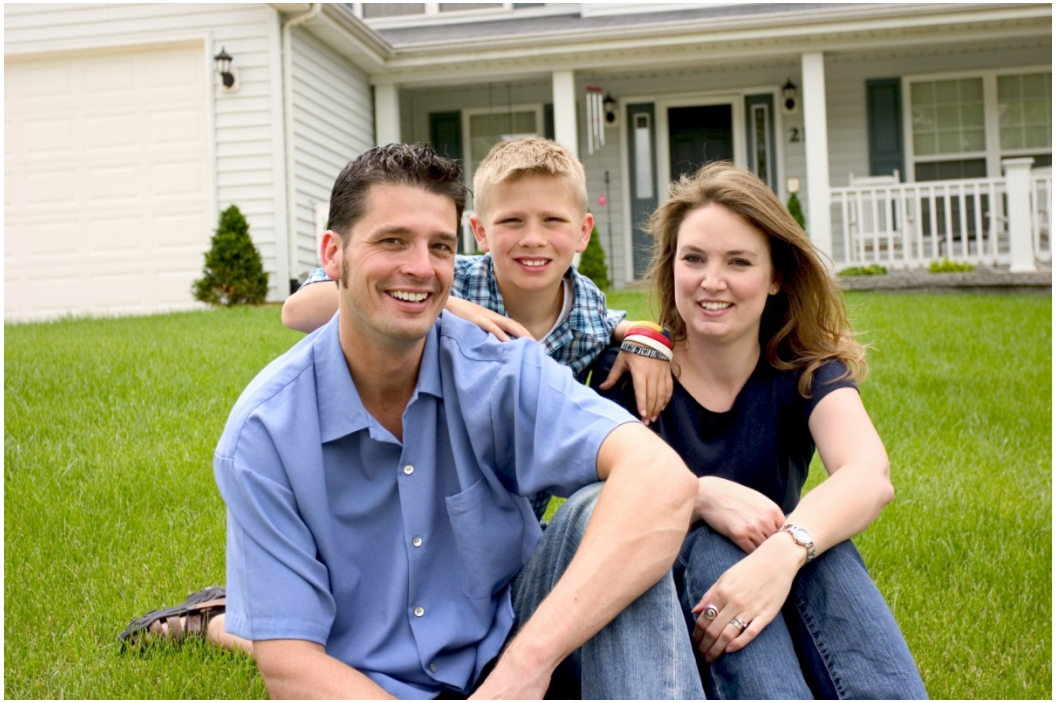
Individuals living in the same home must declare their relationship to one another.



Adults who are living with minor children of a specified degree and are the child's parent/primary caretaker will be certified under the Family Medical programs.

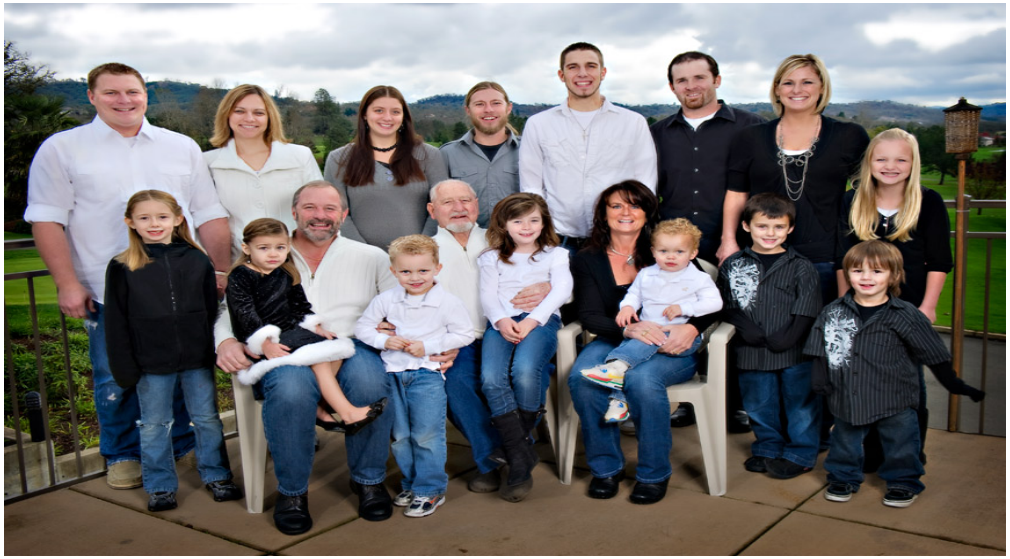
Household Determination

When establishing a household include all individuals who live at the same residence who are associated to one another by blood or by marriage.



Household Determination

Adults living with minor children who are not the primary caretaker or parent will be evaluated for CH (if pregnant) or CA



Accept client attestation (statement) of household composition.

Caretaker Relatives

Natural/adoptive/step parents and children are always included together in the same household.

Exclude any other relatives if living in the home.

If the natural/adoptive/step parent is not in the home, then include the relative caregiver in the household with the child/children they are the caring for

Pregnancy Women

Accept client attestation (statement) for pregnancy as well as number of unborn(s)

Due date must be entered with the PE determination, accept client statement for the due date.

Questions