STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

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Commissioner

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QUALIFIED PROVIDER APPLICATION

The New York State Department of Health (NYSDOH) invites interested agencies meeting the criteria described below to apply for designation as qualified providers (QP) in order to determine presumptive eligibility Medicaid for pregnant women.

WHY APPLY TO DETERMINE PRESUMPTIVE ELIGIBILITY?

The Medicaid Program provides certain health care services to pregnant women and infants younger than one year of age with family incomes at or below 200% of the federal poverty level. The presumptive eligibility determination takes minutes for the trained provider and it provides Medicaid coverage until the local department of social services (LDSS) makes a final eligibility determination. It enables the pregnant woman to seek prenatal care early in her pregnancy. It ensures provider reimbursement for services provided before final Medicaid eligibility is determined. It assists the pregnant woman to begin the Medicaid application process. During the period of presumptive eligibility the pregnant woman may receive a broad array of necessary Medicaid reimbursed ambulatory care services.

WHAT IS INVOLVED IN DETERMINING PRESUMPTIVE ELIGIBILITY?

Presumptive eligibility is a means of immediately determining Medicaid eligibility for pregnant women. Under this determination process, the qualified provider performs a brief assessment of a woman's financial status and, based upon guidelines established by the State Department of Health, determines whether or not the woman can be presumed financially eligible for Medicaid.

The qualified provider is also required to notify the appropriate local social services district(s) of clients found presumptively eligible and to forward the Medicaid application to the appropriate district(s). The local district will assign a Medicaid Client Identification Number (CIN) and will be responsible for a full Medicaid eligibility determination based on the pregnant woman's completion of the application process.

WHO MAY APPLY?

Federal and State rules for presumptive eligibility allow only certain health care providers to make presumptive eligibility determinations. The qualified provider must be a NYSDOH - certified Prenatal Care Assistance Program (PCAP) provider; a local

department of health; a public health nursing service; an Article 28 clinic either freestanding or hospital-based; or a Certified Home Health Agency.

Training is on-line and web based at www.bsc-cdhs.org./qpt/. If you need technical assistance on the training, please contact either Sally Speed or Lou Mang from the Center for Development of Human Services (CDHS), SUNY Buffalo State College at (716) 876-7600.

The training requirement **must** be met by staff prior to submission of the application to the State Department of Health.

HOW DOES THE AGENCY APPLY?

Complete the enclosed application per accompanying instructions. Mail it to:

New York State Department of Health
Office of Medicaid Management
Division of Consumer & Local District Relations
99 Washington Avenue
Suite #826
Albany, NY 12260

Attention: QP Application Review

HOW WILL THE AGENCY BE INFORMED REGARDING FINAL DECISION?

If additional information is needed regarding the application process you may call the Bureau of Maternal & Child Health, in the Office of Medicaid Management, directly at (518) 486-6562. The application will be reviewed and notice of disposition will be sent by the NYSDOH.

For questions on Presumptive Eligibility for clients who do NOT reside in New York City, contact the local social services district of the client; for clients who are residents of New York City, contact HRA/Medical Assistance Program (MAP), Office of Eligibility Information Services at 212-273-0047.

INSTRUCTIONS FOR COMPLETION OF QUALIFIED PROVIDER APPLICATION

SECTION A - APPLICANT IDENTIFYING INFORMATION

1. APPLICANT NAME - THE APPLICANT MUST BE A MEDICAID PROVIDER IN ACTIVE STATUS AND WILL BE RESPONSIBLE FOR THE QUALIFIED PROVIDER ACTIVITIES. USE NAME AS ENROLLED IN MEDICAID.

2. ADDRESS, CITY, STATE, ZIP CODE - THE ADDRESS AT WHICH MAIL WILL BE RECEIVED.

3. TYPE OF ORGANIZATION - INITIAL THE SINGLE MOST APPLICABLE DESCRIPTION OF THE ORGANIZATION.

4. CHIEF EXECUTIVE OFFICER - NAME AND TITLE OF THE INDIVIDUAL IN OVERALL CHARGE OF THE ORGANIZATION.

5. APPLICATION CONTACT PERSON - THE NAME AND TITLE OF THE INDIVIDUAL WHO SHOULD BE CONTACTED FOR ADDITIONAL INFORMATION ON THE APPLICATION.

6. CONTACT'S TELEPHONE/E MAIL ADDRESS - THE TELEPHONE NUMBER OF THE CONTACT PERSON, AND IF APPLICABLE, THE E MAIL ADDRESS.

7. MEDICAID PROVIDER ENROLLMENT INFORMATION

   A. MEDICAID ID NUMBER(S) - THE APPLICANT MUST BE AN ENROLLED MEDICAID PROVIDER. ENTER PROVIDER ID NUMBER(S).

8. LIST ALL SERVICE SITES AT WHICH QUALIFIED PROVIDER ACTIVITIES WILL BE CONDUCTED.

9. LIST ALL MANAGED CARE ORGANIZATION(S), PCAPS AND MOMS WITH WHICH THE APPLICANT HAS AN AFFILATION OR/AND AN AGREEMENT TO PROVIDE CARE TO REFERRED MEDICAID ELIGIBLE PREGNANT WOMEN.

10. LIST ADDRESS(S), AND IF AVAILABLE, E MAIL ADDRESS(S), FOR THE DIRECT SERVICE SITES(S) TO RECEIVE DIRECT MAILINGS FROM THE STATE DEPARTMENT OF HEALTH.

SECTION B - LIAISON AND TRAINING

1. LOCAL SOCIAL SERVICES DISTRICT(S) – LIST THE LOCAL SOCIAL SERVICES DISTRICTS THAT YOU ANITICPATE THE MAJORITY OF YOUR CLIENTS WILL BE REFERRED TO FOR A FINAL MEDICAID ELIGIBILITY DETERMINATION. NOTE; YOU MAY TAKE AN APPLICATION FROM A CLIENT FROM ANY SOCIAL SERVICES DISTRICT.

2. TRAINING QUALIFICATIONS - ENTER THE NAME(S) OF STAFF WHO HAVE COMPLETED THE TRAINING AND THE DATE IT WAS COMPLETED.

SECTION C - ASSURANCES

THE ASSURANCES MUST BE SIGNED BY AN INDIVIDUAL WITH SUFFICIENT AUTHORITY TO ASSURE THAT THE ACTIVITIES LISTED IN THIS SECTION ARE CARRIED OUT.

MEDICAID QUALIFIED PROVIDER APPLICATION

SECTION A - APPLICANT IDENTIFYING INFORMATION

1. APPLICANT NAME_____

2. ADDRESS _____

   CITY _____ STATE _____ ZIP_____

3. TYPE OF ORGANIZATION

   _____ NYSDOH-CERTIFIED PCAP PROVIDER

   _____ ARTICLE 28 FACILITY

   _____ COUNTY HEALTH DEPARTMENT

   _____ PUBLIC HEALTH NURSING SERVICE

   _____ CERTIFIED HOME HEALTH AGENCY

4. CHIEF EXECUTIVE OFFICER_____

   TITLE_____

5. APPLICATION CONTACT PERSON_____

   TITLE_____

6. CONTACT'S TELEPHONE_____

   E-MAIL ADDRESS _____

7. MEDICAID PROVIDER ENROLLMENT INFORMATION

   MEDICAID ID NUMBER(S) _____

8. SERVICE SITES_____

   _____

9. PLEASE LIST ADDRESSES/E MAIL ADDRESSES FOR ALL SERVICE SITES THAT WILL FORWARD MEDICAID PRESUMPTIVE ELIGIBLITY INFORMATION TO THE LDSS.

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10. PLEASE LIST ALL MANAGED CARE, PCAP AND MOMS AFFILIATION(S)

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SECTION B – LIASON & TRAINING

1. LOCAL SOCIAL SERVICE DISTRICT(S)

_____

_____

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2. THE PRESUMPTIVE ELIGIBILITY ON-LINE TRAINING WAS COMPLETED BY THE FOLLOWING STAFF ON THE DATES LISTED BELOW:

NAME DATE

_____

_____

SECTION C – ASSURANCES

1. WE ASSURE THE PREGNANT WOMAN'S RIGHT TO CHOOSE THE PROVIDER OF PERINATAL CARE SERVICES AND ANY OTHER SERVICES TO BE PROVIDED UNDER THE MEDICAL ASSISTANCE PROGRAM.

2. WE ASSURE THAT THE DOCUMENTS OF PRESUMPTIVE ELIGIBILITY DETERMINATION AND APPLICATION FOR MEDICAID WILL BE COMPLETED WITH THE PARTICIPATION OF THE CLIENT AND IN ACCORDANCE WITH STANDARDS ESTABLISHED BY THE NYS DEPARTMENT OF HEALTH. **THE DOCUMENTS WILL BE FORWARDED TO THE APPROPRIATE LOCAL DEPARTMENT OF SOCIAL SERVICES WITHIN FIVE (5) DAYS**.

3. WE ASSURE THAT WE WILL INFORM THE CLIENT WHO IS FOUND INELIGIBLE FOR PRESUMPTIVE MEDICAID COVERAGE THAT SHE CAN HAVE HER ELIGIBILITY DETERMINED AT THE APPROPRIATE LOCAL DEPARTMENT OF SOCIAL SERVICES. WE ASSURE THAT WE WILL GIVE HER THAT LOCAL DEPARTMENT'S OF SOCIAL SERVICES ADDRESS AND PHONE NUMBER IN WRITING.

4. WE ASSURE THE CONFIDENTIALITY OF ALL ELIGIBILITY-RELATED CLIENT-SPECIFIC INFORMATION OBTAINED DURING THE CONDUCT OF QUALIFIED PROVIDER ACTIVITIES AND ASSURE THAT A SIGNED RELEASE WILL BE OBTAINED FROM THE CLIENT PRIOR TO THE RELEASE OF CLIENT-SPECIFIC INFORMATION TO ANY AGENCY OR PERSON OTHER THAN THE LOCAL DEPARTMENT OF SOCIAL SERVICES TO WHICH THE CLIENT IS APPLYING FOR ASSISTANCE, THE NYS DEPARTMENT OF HEALTH AND/OR THE UNITED STATES CENTERS FOR MEDICARE AND MEDICAID SERVICES.

5. WE ASSURE THAT STAFF PERFORMING QUALIFIED PROVIDER ACTIVITIES HAVE COMPLETED PRESUMPTIVE MEDICAID ELIGIBLITY TRAINING ON-LINE PRIOR TO THE SUBMISSION OF THIS APPLICATION.

6. WE ASSURE THAT STAFF PERFORMING QUALIFIED PROVIDER ACTIVITIES HAVE CONTACTED THE LOCAL DEPARTMENT(S) OF SOCIAL SERVICES STAFF TO WHOM THEY WILL BE FORWARDING PRESUMPTIVE ELIGIBLITY APPLICATIONS

7. WE ASSURE THAT WE WILL INCLUDE IN OUR QUALIFIED PROVIDER ACTIVITIES FOR THE PREGNANT WOMAN, THE COMPLETION OF THE SCREENING CHECKLIST AND A DETERMINATION OF PRESUMPTIVE ELIGIBILITY; WHEN APPROPRIATE, THE CLIENT WILL BE ASSISTED TO COMPLETE APPLICATION FOR NEW YORK STATE MEDICAID. WE ASSURE TRANSMITTAL OF NECESSARY APPLICANT INFORMATION TO THE APPROPRIATE LOCAL DEPARTMENT OF SOCIAL SERVICES WITHIN FIVE WORKING DAYS OF THE PRESUMPTIVE ELIGIBILITY DETERMINATION.

8. WE ACCEPT THAT UPON THE DESIGNATION AS A QUALIFIED PROVIDER BY THE STATE DEPARTMENT OF HEALTH THESE ASSURANCES WILL BE EFFECTIVE.

9. WE RECOGNIZE THAT THE STATE DEPARTMENT OF HEALTH MAY CANCEL OUR PARTICIPATION AS A QUALIFIED PROVIDER AT ANY TIME, GIVING NOT LESS THAN THIRTY (30) DAYS NOTICE.

10. WE ASSURE THAT WE WILL NOTIFY THE STATE DEPARTMENT OF HEALTH WITHIN 30 DAYS OF OUR INABILITY TO CONTINUE THIS AGREEMENT AND/OR INABILITY TO PERFORM THE ACTIVITIES AS A QUALIFIED PROVIDER.

11. ORGANIZATION NAME_____

12. SIGNATURE _____

13. TITLE_____

14. DATE_____