NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 NORTH PEARL STREET, ALBANY, NEW YORK 12243

BARBARA B. BLUM
Commissioner

[An Administrative Directive is a written communication to local Social Services Districts providing directions to be followed in the administration of public assistance and care programs.]

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL NO.: 82 ADM-6
[Medical Assistance]

TO: Commissioners of Social Services

SUBJECT: Implications of the Vailes v. Blum and Mehler v. Blum Court Decisions
1. Determination of Household Size
2. Budgeting of Restricted Income of a Minor Child

DATE: February 26,1982

SUGGESTED DISTRIBUTION: All Medical Assistance Staff

CONTACT PERSON: Any questions concerning the content of this release should be directed to Hariette Meizner at 800-342-3715, extension 4-9141, or in New York City 212-488-7271 or 488-7032. Any questions concerning reimbursement, claiming or fiscal should be directed to the Bureau of Local Financial Operations. Upstate - Richard Radzyminski, 1-800-342-3715, ext. 4-0192 and Metropolitan -Anthony Funigiello at (212) 488-4516.

PURPOSE

The purpose of this directive is to advise local social services districts of changes in the methodology used to budget medically needy cases which involve children with restricted income as a result of the decision and order in Mehler v. Blum. This directive will also provide instructions for carrying out the provisions of the orders in Mehler v. Blum and Vailes v. Blum.

II. BACKGROUND

Under current policy, if an application is filed on behalf of only certain members of a family household as defined by Department Regulation 360.23 (g) their eligibility is determined based on their pro-rated share of the needs of the entire household. The Court of Appeals held in Vailes v. Blum that a local district may not count anyone in the household other than

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Social Services Law and Other Legal References	Bulletin/Chapter Reference	Miscellaneous Reference
79 ADM-71		360.5(b) (1) (xxi) 360.23 (g) 360.25		Bulletin 182	Dear Commissioner Letter, dated 8/7/81 Mailgram, dated 11/13/81

DSS-296 (Rev. 5/78)

the applicant(s) and those persons legally responsible for them. Department Regulations 360.23(g) and 360.25 are in the process of being revised to reflect this change in policy.

On October 6, 1981, and November 13, 1981, you received correspondence concerning the Mehler v. Blum court decision. As a result of this decision, local social services districts were prohibited from applying the budgetary methodologies that are contained in Sections IV B, IV D, V and examples #2, 3, 4, 5, and 6 in Administrative Directive 79 ADM-71, "Budgeting of Restricted Income in MA-Only Households." You were further advised of the procedures to be used to identify/notify members of the Mehler class.

III. PROGRAM IMPLICATIONS

In the Mehler v. Blum Decision, the U.S. District Court for the Southern District of N.Y. established a class of individuals who are affected by the order. This class consists of all persons in the State of New York who have been, are now, or may in the future be recipients of Medicaid as medically needy and who reside in households where there are minor children who receive or for whom there is received restricted income.

For members of this class the Court decided that this Department's policy of prorating in cases involving minor children with restricted income is invalid. In addition, the Court further required the Department to identify and notify all class members of their right to have their benefits recomputed upon request for the 12 month period prior to such request. It is important to note, however, that in no event can this recomputation be done for a period earlier than three months prior to the original application date.

As a result of the court order, local social services districts are required, after notification to class members who were affected and upon their request, to provide the members of the class with retroactive relief, as appropriate.

As a result of recent court decisions and orders, local social services districts shall use the following principles:

A child who receives income (i.e., OASDI, Veterans Benefits, Child Support) may be included in the medical assistance unit, even when the child's income is sufficient to meet the child's needs under Medicaid standards. The choice of whether to include the child in the Medical Assistance unit is the applicant's (caretaker relative). The applicant, after being given an explanation of the advantages and disadvantages will decide whether to include the child in the Medical Assistance unit. If the child is included, all of his or her income will be considered income to the Medical Assistance unit in determining Medicaid eligibility (except where income is specifically disregarded in accordance with existing regulations).

In all situations in which a child receives income in excess of his or her needs, the applicant has the right to include or exclude the child in the Medicaid application. Thus, the applicant may choose to include in the Medicaid unit only those children for whom medical care is required. In

addition, the applicant may withdraw an application or have a case closed for any or all members of the Medicaid unit at any time. Thus, a local social services district may not require that the child be included in the Medicaid unit with the result that all of the child's income will be considered in determining the family's eligibility. Local social services districts shall inform the applicant of all alternatives to assure that the choice of whether to include the child in the Medicaid unit is made in the child's best interest.

IV. REQUIRED ACTION

As a result of the Decision and Order in Mehler v. Blum a number of actions were required on the part of local social services districts. These are as follows:

A Identification/Notification of Members of the Class of their Right to Recomputation of Benefits for the 12 Month Period

1. Closed/Denied Cases

a. A local social services district can identify the individual members of the closed or denied class and send them the "State Mandated Notice to Affected Class Members" (Attachment III).

OR

b. A local social services district can send the "State Mandated Notice to Potential Class Members" (Attachment I) to a broader group which includes the affected class.

i) WMS has produced the following reports:

1. Cases closed and denied since 10/1/80 and coded as including children under 21 with excess restricted income;

2. Cases closed and denied since 10/1/80 and coded as including children under 21 (regardless of whether or not these children have income)

ii) Local social services districts own computer systems may be used to identify a broader class, such as all the medically needy or all the medically needy with children.

iii) Local social services districts through a manual review or other procedures may identify an appropriate broader category which contains the affected class.

Whichever method is utilized, notice must be sent to all members of the class who were denied or closed since November 1, 1980. These notices must be locally reproduced and cannot be locally modified. In addition, such notices to the closed and denied class members must be mailed no later than January 16, 1982. These notification procedures have previously been provided in the mailgram dated 11/13/81.

For waiver-approved local social services districts as named in the November 13, 1981 mailgram, the "State Mandated Notice to Potential Class Members" (Attachment I) in English and Spanish must be posted in public locations in each local social services district office for a period of 60 days beginning January 16, 1982.

In addition, copies of the notice must also be sent with a cover letter (see Attachment II, Notice to Agencies) to Hospitals, Clinics, HMO's, Skilled Nursing Facilities, Health Related Facilities, Community and Mental Health Centers, Public Housing Authorities, Physicians participating in the Medicaid Program, Social Security, WIC, Unemployment and Motor Vehicles, all Legal Aide or Legal Services Offices, Bar Associations, Medical Associations, Social Agencies (including the Red Cross, Salvation Army, Catholic Family Service, Jewish Family Services, Family Services, Planned Parenthood, CAP agencies, Settlement Houses and the like) and other entities and organizations likely to be in contact with class members within your district.

In New York City, a notice of the right to request recomputation (Attachment V) must be posted for 60 days beginning January 16, 1982, in the following locations:

1 - NYC Health and Hospital Corporation Hospitals
2 - Legal Services offices
3 - Legal Aide offices
4 - WIC offices
5 - NYC Housing Authority
6 - Planned Parenthood in New York

These organizations/offices in New York City must also be sent a cover letter (see Attachment IV, Notice to Agencies, New York City).

All individuals who wish to have their eligibility recomputed must request recomputation of benefits within 60 days from the date notices are mailed or if the client is responding to a posted notice, request for recomputation must be made by 3/17/82.

In addition all recomputations must be completed within 60 days of the request for such recomputation.

2. Undercare Caseload

For purposes of this directive, the undercare cases are defined as all those MA cases which were active on 11/2/81 or after.

This includes cases closed between 11/2/81 and the date of this release.

All local social services districts (including those with waivers) shall identify and notify active class members in one of the following manners:

a) Local social services districts can identify the individual members of the undercare class by a manual review.

b) Local social services districts can identify the individual members of the undercare class at the time of recertfication or next client contact, (including case closings), whichever occurs first;

c) Local social services districts may opt to utilize a mass mailout to its entire caseload;

   i) WMS has produced a report of all active cases coded as children under 21 with excess restricted income. This report can be used to make a broad mailing for the period of time your agency was on WMS.

   ii) Local social services districts own computer system may be used to identify a broader class of active cases.

   iii) Local social services districts, through a manual review or other procedure, may identify an appropriate broader category which contains the affected class.

The undercare caseload has a right to recomputation of benefits retroactive to July 1, 1981, without having to request it. This means that all affected undercare cases including those closed between 11/2/81 and the date of this release are to be rebudgeted retroactive to 7/1/81. This does not preclude the responsibility of local social services districts from recomputing eligibility prior to 7/1/81 if the affected class member makes such a request. Local social services districts must use the "State Mandated Notification Letters (Attachment I and III) as appropriate. For purposes of notification to the undercare caseload local social services districts shall insert a date which is 60 days after the date of the mailing. For example, if an agency opts to conduct a mass mailout to its undercare caseload on February 15, 1982, the date indicated on Attachment I or III would be April 16, 1982.

For those local social services districts who choose to conduct a mass mailout to its entire caseload Attachment I would be used. Those districts who opt to conduct a mass mailout at the time of each recertification cycle to all those active cases due for recertification, would likewise use Attachment I. For those districts who choose to identify and notify at the time of recertification, Attachment III would be used, providing they have already identified those individuals who are members of the class.

NOTE: All class members, including the undercare caseload, are entitled to a recomputation of benefits for the preceeding 12 month period, if requested within 60 days of notification of this right. In order to treat the undercare caseload in an equitable manner, local social services districts must recompute MA eligibility for the undercare caseload retroactive to 1/16/81, if so requested within the 60 day period, regardless of when notification was sent. This means that recomputation for the under care caseload is retroactive to 1/16/81 for those individuals who request recomputation within the 60 day period and retroactive to 7/1/81 for those persons who do not respond to the notice within the 60 day period. For this reason we suggest that you provide notification to the undercare caseload as soon as possible.

B. Budgeting

The following budgetary procedures shall be applied in all cases involving children with restricted income:

1. Family household size will be determined by counting only those persons applying, and those legally responsible relatives residing with persons who are applying. (See examples #1, 2, and 3)

2. If an application is received on behalf of the parent(s) only, they shall be considered as a separate household. Non-applying children, whether or not they are minors, will not be considered in any way in determing the appropriate income/resource exemption level. (See example #1.)

3. If an application is received on behalf of the parent(s) and only some of the children in a family, the parent(s) and the applying children will be considered as a separate household. The non-applying children will not be considered in any way in determining the case count and the appropriate income/resource exemption level. (See example #2.)

4. If an application is received on behalf of some of the children only, the household size will be based on the applying children and the parent(s) who are legally responsible for them and residing in the same household, except as noted in #8 below. For example, the mother of three children applies for medical assistance for two of the children only, but not herself or the third child. The household size is determined by the two children (the applicants) and the mother (the legally responsible relative). Thus, the actual income/resource exemption level used in determining the two children's eligibility for medical assistance would be three(3).

5. If the application is received on behalf of the parent(s) and all of the children, household size will be based on all those persons in the family unit. For example, the mother of three children applies for the entire family. The household size used would be the income/resource exemption level for four(4). Total income of the family (including any child's restricted income) would be compared to this level. (See example #2.)

6. The income/resources of a legally responsible relative who resides in the same household as the applicant/recipient shall, be applied when determining the eligibility of the child as well as themselves, except as noted in #8 below.

7. If an application is received on behalf of some or all of the children in a family, in which some members are in receipt of an ADC or HR cash grant, the household size is determined by counting only those persons applying for Medicaid. This means that the cash recipient residing in the same household as the applicant and all of his/her income is considered invisible when determining eligibility for the applying individuals. (See example #4.)

   NOTE: It should be noted that the policy contained in the preceding paragraph differs from the procedures contained in the Dear Commissioner letter dated 8/7/81 (page 2, paragraph 1). In that letter you were advised that if the parent is in receipt of a cash grant prorating would be used to determine Medicaid eligibility for the children. This policy was based on our understanding of the Vailes v. Blum decision at the time the Dear Commissioner letter was released. Subsequent to this, the policy of prorating was declared invalid by the Court, necessitating this change.

8. If an application is received in which some of the members are in receipt of an SSI cash grant those SSI recipients and their income are treated as invisible when determining eligibility for the applicants.

9. When determining Medicaid eligibility for the retroactive period, medical assistance income and resource standards in effect at that time shall be used.

10. In no instance will the MA(PA) income exemption level be based on a prorata share.

11. All applicants/recipients shall have an informed choice as to the budgetary methodology applied in determining their eligibility or the eligibility of their dependents for Medical Assistance. Therefore, in instances in which a family has been determined to have excess income due to the restricted income of a minor child, they shall have the option of not applying for this child which may result in eligibility for the remaining members. (See example #2)

12. The procedures outlined above shall likewise be followed for resources.

C. WMS/MMIS Implications

The following special system processing procedures are recommended:

1. Prospective Case Processing

For cases where the child with restricted income is included in the MA household unit, any excess income would now be entered as an MA Case Payment Type of 1 (MA Case Applicable Excess) and Amount on page 22 of the WMS workbook (screen 05) as opposed to the previous method of using the MA Individual Payment Type of 2 (Excess Restricted Income) and Amount.

If the child with restricted income has been registered on the application and the family chooses not to include the child in the household, Full Data Entry can be completed by not data entering the child with Restricted Income. Application Registry Maintenance is not necessary since the system permits Full Data Entry of any subset of individuals that are on the Application Register.

2. Retrospective Case Processing

To enable MMIS to process payment for unpaid claims of those individuals found to be retrospectively eligible after rebudgeting, the eligibility information must be entered through WMS. For all of the following procedures it is important to note that:

In no case should coverage be given more than three months prior to the actual month of application.

In no case should the coverage date be entered for a time period prior to the date the district was implemented in MMIS.

a. Denied and Closed Cases

For those cases in the affected class of people who are found eligible, Application Registry and Full Data Entry must be completed. For denied or closed cases which are to be given retroactive coverage, the application date used in the Application Registry process should be the date that the client requested a budget recomputation. Authorization dates should be for a current period, i.e., beginning no earlier than three months prior to the WMS month of application. If MA coverage is to be provided more than 3 months prior to the WMS application month, the appropriate MA coverage "From" date on page 22 of the WMS Workbook would need to reflect this past period. In such cases, the system will produce error number 562 during Full Data Entry. This error should be overridden using normal Overide procedures and Overide Reason Code 03 - Court Decision.

b. Currently Active Cases

Budget recomputation for currently active cases may create the need to enter retroactive coverage data. For those cases where retroactive coverage is contiguous to the current coverage dates the coverage "from" date on screen 05 should be changed to cover the past period. For instances of intermittent retroactive coverage, the coverage "From" and "To" dates will need to be changed to reflect the coverage for those appropriate periods. If error 573 is encountered it should be overridden as previously described.

D. Retroactive Relief to Class Members - Medical expenses for care, services and supplies covered under the Medical Assistance program at the time medical services were rendered, shall be reimbursable for those class members whose recomputation of benefits results in eligibility for or a reduced liability for such coverage.

Payment of reimbursable bills shall be at the rate or fee provided by Medicaid at the time the service was rendered.

For paid bills, payment will be made to the applicant, recipient or representative (anyone who made payment on behalf of the individual). Unpaid bills will be reimbursed to the individual or organization that provided care, services or supplies.

Local social services districts shall keep the following records.

1) A record of the number, and names, of the individual members of the affected class;

2) A listing of each notification made to recipients and the dates sent;

3) A listing of the number of requests, and names, for recomputations received from potential eligibles;

4) A listing of the number of requests, and names, for recomputations received from individuals in undercare cases;

5) The dates of the requests for both 3 and 4 above;

6) A record of any withdrawls of above requests;

7) A listing of the results of recomputations: a) newly established eligibility (by individuals, rather than cases), and b) any changes in the amount of excess income (per individual).

8) A list of affected class members who have paid medical bills for the period they are eligible for direct reimbursement.

E. Reimbursement Procedures

The local district is responsible for performing the following procedures:

1. Identification and notification of class members and recomputation of benefits as outlined in Section IV.A and IV.B of this Administrative Directive.

2. Determinations of eligibility for retroactive payment or reimbursement shall be approved or disapproved within 60 days of submission of medical bills by eligible class members.

3. Issuance of written notices within 60 days of receipt of medical bills to eligible class members whose recomputation of benefits results in eligibility or reduced liability for such coverage. This notice must include the following:

   a. Action to be taken.

   b. Reason for the action.

   c. Right to a fair hearing.

   Local districts have the option of processing claims and issuing payments for direct reimbursement to eligible class members or of having the State Department of Social Services process the claims and issue the required payments.

F. Required actions for Local Districts that elect to process claims and issue payments for direct reimbursement to eligible Mehler class members.

Medical expenses for care, services and supplies covered under the Medical Assistances Program at the time medical services were rendered, shall be reimbursable for eligible class members under certain conditions.

1. Conditions of Reimbursement Period

   a. Eligible members of the under care caseload who request recomputation within the 60 days of notification of this right must have paid or unpaid medical bills incurred during the eligible period reviewed for payment/reimbursement retroactive to 1/16/81 (but in no event more than 3 months prior to the original application date).

   b. Eligible members of the under care caseload who do not respond to the notice within the 60 day period, must have paid or unpaid medical bills incurred during the eligible period reviewed for payment/reimbursement retroactive to 7/1/81.

   c. Eligible members whose cases have been denied or closed since 11/1/81 who request recomputation within 60 days of notification of this right, must have paid or unpaid medical bills incurred during the eligible period reviewed for payment/reimbursement for the 12 month period prior to such request (but in no event earlier than 3 months prior to the original application date).

d. Medical bills incurred by eligible members for periods exceeding 3 months prior to the original application date are excluded from consideration for payment/reimbursement.

2. Conditions of Payment/Reimbursement of bills

a. Payment shall be made at the rate or fee provided by Medicaid at the time the service was rendered.

b. For paid bills, reimbursement will be made to the applicant, recipient or individual who made payment on behalf of the applicant or recipient. Submission of documentary proof of having incurred reimbursable bills, including proof of payment (copies of receipts or cancelled checks) is required.

c. Unpaid bills will be paid to the individual or organization that provided the care, services or supplies for which payment is sought. Whenever possible, the provider of service should be instructed to submit a claim to MMIS to receive payment for an eligible unpaid bill.

d. There is no requirement that the care, services or supplies must have been obtained from a provider enrolled in the Medicaid program at the time bills were incurred or paid, at the time payment or reimbursement is sought. However, all providers must have been lawfully permitted to provide such care, services and supplies, at the time it was rendered.

3. Processing Instructions

The local district must review the bills submitted and determine the amount approved for payment (except those bills eligible for payment through MMIS) in the following manner:

a. Verify that the bill is eligible for payment or reimbursement by insuring that the dates of service fall within the coverage period.

b. Identify that the type of service is covered by Medicaid.

c. Determine the type of claim (e.g. Physician, Dental, Clinic, etc.).

d. For Fee-for-Service bills (includes physician, dental, podiatry, psychologist, therapist, laboratory, durable medical equipment, pharmacy, opthalmic, hearing aid dealer and nurse), the appropriate procedure must be determined from the description of service. For prescription drug bills, information must be obtained on the name of the drug, the manufacturer's name, the strength and quantity dispensed.

e. For rate based bills for Home Health Care Personal Care Services, Long Term Home Health Care, Transportation, Inpatient, Clinic, Residential Health Care Facility and Child

Care Agency services, the rate for the provider must be determined.

G. Required Action for Local districts that elect to have the State DSS process claims and issue payment to Mehler class recipients.

Local districts electing to have the State DSS process claims and issue payments to eligible class members, must notify the appropriate contact person in the Bureau of Local Financial Operations by no later than March 15, 1982 of this election.

The local district must forward, within 60 days of the date of submission of medical bills by the applicant or recipient, the following information:

1. A completed Payment Request Form (sample attached to this ADM) for each eligible class member.

2. Copies of all eligible bills for which payment or reimbursement is requested must be attached to the Payment Request Form.

3. Where reimbursement is sought, include documentation (copies of receipts or cancelled checks) of any payments made by the applicant, recipient or individual who made payment on behalf of the applicant or recipient. The above information should be submitted to the following address:

New York State Department of Social Services
P. O. Box 1935
Albany, New York 12201

Attention: Mehler Case

H. Claiming Procedures

1. Administrative Claiming

Claiming for the Administrative expenses associated with eligibility recomputations for Mehler class members should be considered part of the normal Medical Assistance Administrative expenses. These expenses are reported monthly on the Schedule D-4 (DSS-2347 b) as a function 4 activity. (Calculation of Medical Assistance Eligibility Determination/Authorization/Payments/Cost Shares.)

2. Direct Payment Claiming

Claiming for the expenditures for Medical Assistance under Title XIX (Medicaid) should be reported in the normal manner by item of expense on the Schedule E (DSS-157). Expenses for direct reimbursement to eligible class members should be considered the same as vendor payments for claiming purposes.

V. EFFECTIVE DATE

The provisions of this directive are to be applied to all appropriate cases in which a Medicaid application was filed on or after July 1, 1981 except for retroactive provisions which are effective November 1, 1980.

VI. OTHER

Attachment I - Notice to Potential Class Members - English and Spanish
Attachment II - Notice to Agencies - English and Spanish
Attachment III - Notice to Affected Class Members - English and Spanish
Attachment IV - Notice to Agencies, New York City - English and Spanish
Attachment V - Notice to Potential Class Members, New York City -English and Spanish
Attachment VI - Examples
Attachment VII - Mehler Transmittal Form

Russell Schwartz
Deputy Commissioner
Division of Medical Assistance

ATTACHMENT I

NOTICE TO POTENTIAL CLASS MEMBERS

As a result of a recent court decision in Mehler v. Blum the Medicaid budgeting methodology for cases involving medically needy persons who have children with restricted income has been declared illegal. Persons who may be affected by this court decision are those who for any period on or after 11/1/80 meet All 3 of the following criteria:

1. There are 1 or more minor children (under 21 years of age) in your household, for whom you are legally responsible or have assumed full support.
2. One or more of the minor children have their own income (i.e. Social Security, Veterans Benefits, Child Support etc.)
3. You applied for Medical Assistance for yourself or yourself and others and were denied or closed after November 1, 1980, because of excess income.

If you have answered yes to all the above, your eligibility for Medical Assistance may have been determined erroneously. You have a right to have your MA eligibility redetermined for the prior 12 months. To exercise that right you must request recomputation no later than 3/17/82. You can request recomputation of your case by calling your Medical Assistance worker, at the telephone number below.

_____

OR

Visit the agency at _____ during the hours of

If you do not agree with the decision made by your Medical Assistance worker, you will be told about your rights to a fair hearing at the same time you are told about the decision.

ADHERENCIA 1

AVISO A LOS INDIVIDUOS INCLUIDOS EN UNA NUEVA CLASE DE ELEGIBILIDAD DE MEDICAID

Como resultado de una reciente decision en el caso Mehler vs. Blum, el metodo para presupuestar casos de personas que necesitan servicios medicos y que tienen hijos con ingresos limitados ha sido declarado ilegal. Las personas afectadas por esta decision de la corte son aquellas, que en el periodo antes o despues del lro de noviembre de 1980, caen dentro de las tres siguientes clasificaciones:

1 - Si hay uno o mas ninos menores de 21 anos en la familia y por los cuales usted es legalmente responsable o usted ha asumido su manutencion total.

2 - Si uno o mas de los ninos menores tienen su propio ingreso. Es decir, si reciben beneficio de Seguro Social, de Veteranos o fondos de sontenimiento (child support).

3 - Si usted solicito Asistencia Medica para usted o para usted y otros y esta le fue negada o concedida y luego quitada despues del lro de noviembre de 1980 debido a excesso de ingreso.

Si el total de estas tres clasificaciones le aplican a usted, hay la posibilidad de que su elegibilidad para asistencia de medicaid ha sido determinada equivocademente. Usted tiene derecho a que su elegibilidad para asistencia de Medicaid sea nuevamente determinada para el periodo de los de los 12 meses anteriores. Para ejercer su derecho usted debe solicitar un nuevo computo no mas tarde del 17 de marzo de 1982. Usted puedo solicitar el nuevo computo en su caso llamando al siguiente telefono _____ o visitando la agencia en _____ durante las horas de _____ a _____.

ADHERENCIA I (Continuacion)

Conjuntamente con la decision usted recibira informacion sobre su derecho a una audiencia imparcial y usted tiene el derecho a solicitar una si es que no esta de acuerdo con la decision hecha por el trabajador de Asistencia Medica.

ATTACHMENT II

NOTICE TO AGENCIES

Dear _____

As a result of a recent court decision, in Mehler v. Blum the New York State Department of Social Services policy under the Medical Assistance Program of budgeting certain cases involving children with restricted income has been declared illegal.

Consequently those Medicaid applicants or recipients who were denied or terminated Medical Assistance because of excess income, in the period between 11/1/80 and 3/17/82 are entitled to a review of their case and possible retroactive relief. In order that we reach as many applicants/recipients as possible, we request that the attached notice be duplicated and displayed in public locations throughout your agency. Pursuant to the Court Order these notices must be posted for a period of 60 days beginning 1/16/82.

Additional copies of this notice may be obtained by contacting

_____

Your cooperation in this matter is greatly appreciated.

Sincerely,

ADHERENCIA 11

AVISO A LAS AGENCIAS

Estimado _____,

Como resultado de la reciente decision de la corte en el caso Mehler vs. Blum la poliza del Departmento de Servicios Sociales del Estado de Nueva York de presupuestar ciertos casos del programa de asistencia Medicaid que concierne a ninos de ingresos limitados ha sido declarada ilegal.

Consecuentemente, aquellos solicitantes o recipientes de Medicaid que les fue negada la asistencia o que fueron suspendidos de asistencia medica por exceso de ingreso en el periodo del lro de noviembre de 1980 al 17 de marzo de 1982 tienen derecho a una revision de su caso y posiblemente a ayuda retroactiva. Para alcanzar el mayor numero de solicitantes o de posibles recipientes, pedimos que el aviso adjunto sea duplicado y expuesto en sitios publicos a traves de la agencia. En conformidad de la orden de la corte, estos avisos deben ser colocados en lugares publicos por un periodo de 60 dias a partir el 16 de enero de 1982.

Se pueden obtener copias adicionales de este aviso comunicandose con

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Su cooperacion en este asunto es muy apreciada.

Sinceramente,

ATTACHMENT III

NOTICE TO AFFECTED CLASS MEMBERS

A recent court decision, Mehler v. Blum, declared invalid the New York State Department of Social Services' policy of budgeting in the Medicaid program for medically needy applicants who have children with restricted income. You appear to be a member of the class affected by the court decision. The class is composed of all persons in the State of New York who have been, are now, or may in the future be recipients of Medicaid as medically needy who reside in households where there are minor children who receive or for whom there is received restricted income. The court order gives class members the right to request recomputation of their eligibility in accordance with the court's decision for the 12 months prior to a request for recomputation.

If you wish to have your eligibility recomputed, you must inform your local social services district no later than 3/17/82. You can request recomputation by calling your Medical Assistance worker at the telephone number below:

_____ or

by visiting the agency at _____

_____ during the hours of _____.

If you do not agree with the decision made by your Medical Assistance worker, you will be told about your rights to a fair hearing at the same time you are told about the decision.

Sincerely,

ADHERENCIA 111

AVISO A LOS MIEMBROS DE LA CLASE AFECTADA

Una reciente decision de la corte en el caso Mehler vs. Blum invalida la poliza del Departamento de Servicios Sociales del Estado de Nueva York para presupuestar a los solicitantes al programa Medicaid que tienen ninos con ingresos limitados. Aparentemente usted cae dentro de la clase afectada con la decision de la corte. La clase se compone de todas aquellas personas en el Estado de Nueva York que han sido, son o pueden ser recipientes de servicios medicos y que son parte de una familia con ninos menores que reciben directa o indirectamente ingresos limitados.

La orden de la corte concede a los miembros de esta clase el derecho a solicitar un nuevo computo de elegibilidad cubriendo el periodo de los doce meses anteriores a la peticion.

Si desea que su elegibilidad sea nuevamente computada usted debe informarlo a la oficina local de servicios sociales del districto no mas tarde del 17 de marzo de 1982. Puede hacerlo llamando al trabajador de Asistencia Medica al siguiente telefono _____ o puede visitar la agencia en _____ durante las horas de _____ a

Si usted no esta conforme con la decision del trabajador de Asistencia Medica usted puede pedir informacion sobre su derecho a una audiencia imparcial.

ATTACHMENT IV

NOTICE TO AGENCIES, NEW YORK CITY

Dear _____

As a result of a recent court decision, Mehler v. Blum, the Social Services Department's Medical Assistance Program's policy for budgeting cases involving children with restricted income (prorating) has been declared invalid.

New York City was specifically excluded from this court decision because their Medicaid budgeting was not illegal. However, the court order requires posting of the attached notice.

Those Medicaid applicants or recipients who were denied or terminated from Medical Assistance because of surplus income and have one or more minor children in the household for the period between November 1, 1980 and March 17, 1982, are entitled to a review of their case and possible corrective action. Accordingly, in order that we may reach as many applicant/recipients as possible, we request that the attached notice be duplicated and displayed in public locations throughout your agency. Pursuant to the court order these notices must be posted for a period of 60 days beginnng January 16, 1982.

Additional copies of this notice may be obtained by contacting

_____

Your cooperation in this matter is greatly appreciated.

Sincerely,

ADHERENCIA IV

AVISO A LAS AGENCIAS, CIUDAD DE NUEVA YORK

Estimado _____,

Como resultado de la reciente decision de la corte en el caso Mehler vs. Blum la poliza del Departmento de Servicios Sociales del Estado De Nueva York de presupuestar ciertos casos del programa de Medicaid que concierne a ninos de ingresos limitados ha sido declarada ilegal.

La ciudad de Nueva York fue excluida en esta decision porque su metodo para presupuestar casos de Medicaid no es ilegal. No obstante, la orden de la corte requiere que este aviso sea expuesto en sitios publicos.

Consecuentemente, aquellos solicitantes o recipientes de Medicaid que les fue negada la ayuda o que fueron suspendidos de asistencia medica por exceso de ingreso en al periodo del lro de noviembre de 1980 al 17 de marzo de 1982 tienen el derecho a una revision de su caso y posiblemente ayuda retroactiva. Para alcanzar el mayor numero de solicitantes o de posibles recipientes, pedimos que el aviso adjunto sea duplicado y expuesto en sitios publicos a traves de la agencia. En conformidad con la orden de la corte, estos avisos deben ser colocados en lugares publicos por un periodo de 60 dias a patir el 16 de enero de 1982.

Se pueden obtener copias adicionales de este aviso comunicandose con

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Su cooperacion en este asunto es muy apreciada.

Sinceramente,

ATTACHMENT V

NOTICE TO POTENTIAL CLASS MEMBERS, NEW YORK CITY

As a result of the recent court decision, Mehler v. Blum, the State Medicaid procedure for budgeting the income of persons who have children with income (prorating) has been declared invalid. The New York City Medicaid program was excluded from this court decision because the NYC Medicaid budgeting procedure was not illegal. However, the court order requires the posting of this notice. If you can answer yes to all of the following questions you may be affected by this court order:

1. Do you have one or more minor children (under 21 years of age) in your household?

2. Do one or more of the minor children in your household have their own income (Social Security, Veteran's Benefits, Child Support, etc.)?

3. Are you legally responsible for the minor children in your household?

4. Did you apply for Medicaid for yourself, or yourself and other household members after November 1, 1980?

5. Was your Medicaid denied or was your Medicaid case closed because of surplus income?

In order to be affected by this court order your must answer "yes" to all five of these questions. If you answer No to any of the questions you are not affected by this court order.

If you believe that your child's income was incorrectly budgeted, you have the right to have your Medicaid eligibility reviewed for the previous year. If you wish to have your case reviewed you must request rebudgeting no later than March 17, 1982, by calling the NYC Medicaid office at (212) 594-3050.

Your Medicaid budget will be recomputed only if your child's income was not correctly applied.

ADHERENCIA V

AVISO A LOS MIEMBROS DE LA CLASE AFECTADA, CIUDAD DE NUEVA YORK

Como resultado de una reciente decision en el caso Mehler vs. Blum, el metodo utilizado por el estado para presupuestar casos de personas que solicitan Medicaid y que tienen ninos con ingresos limitados ha sido declarado ilegal, el Program de Medicaid de la Ciudad de Nueva York fur excluido en la decision de la corte, y que el metodo usado por la ciudad es legal. No obstante, la orden de la corte requiere que este aviso sea expuesto en sitios publicos. Si usted contesta "si" a todas las siguintes preguntas usted puede ser afectado (a) por esta orden de la corte.

1. Tiene usted uno o mas ninos menores de edad en su hogar? (menores de 21 anos)
2. Hay uno o mas ninos en su hogar que reciben su propio ingreso (beneficios de seguro social, de ceteranos o sostenimiento)?
3. Es usted legalmente responsable por los ninos menores en su hogar?
4. Ha solicitado asistencia del programa Medicaid para usted o usted y otros en su hogar despues del lro de noviembre de 1980?
5. Ha sido negado (a) asistencia de medicaid o se ha cerrado su caso de Medicaid debido a exceso de ingreso?

Para poder ser afectado (a) por esta orden de la corte usted debe contestar "si" a todas las cinco preguntas. Si usted contesto "no" a cualquier pregunta usted no es afectado (a) por esta orden de la corte.

Si usted cree que el ingreso de su nino fue presupuestado incorrectamente, usted tiene el derecho a que su elegibilidad para asistencia de Medicaid sea nuevamente determinada. Para ejercer su derecho usted debe solicitar un nuevo computo no mas tarde del 17 de marzo de 1982, llamando a la oficina de Medicaid de la ciudad de Nueva York (212) 594-3050.

Su presupuesto sera computado nuevamente si el ingreso de su nino fue computado incorrectamente.

ATTACHMENT VI

EXAMPLES

In the examples provided below assume the following:

1. The MA income Exemption Level is higher than the PA Standard of Need.

2. Net available monthly income is based on the gross income less all appropriate disregards and deductions.

3. Resources are less than the appropriate MA or PA resource levels. If resources were to exist, they would be handled in the same manner as income.

EXAMPLES

Example 1

Mother and 2 children. Each child has Social Security Income of $340 per month. The mother, who has no income of her own, requests MA for herself only.

Disposition:

Household size: 1	MA Exemption Level	$334
(For mother only)	Net Monthly Income	0
		Fully eligible

Mother is fully eligible for Medical Assistance. She should be advised that she may be eligible for a cash grant.

Example 2

Mother and 2 children. Mother applies for MA for herself and Child A and Child B who has income of $200/mo. support. Mother is employed and has net available monthly income $300.

Disposition: (a)

Household size: 3	MA Exemption Level	$492
(For mother & Child A	Net Monthly Income	500
and Child B)	Monthly Excess	$ 8

Mother and Child A and B are eligible for Medical Assistance subject to an $8 monthly excess.

Since Child B is rendering the mother and Child A ineligible subject to excess income provisions, the mother must be advised that eligibility may be achieved for herself and Child A as follows:

Disposition: (b)

Household size: 2	MA Exemption Level	$484
(For mother and Child A)	Net Monthly Income	300
	Eligible	0

If the mother chooses this method, the mother and Child A would be fully eligible. If Child B requires MA, Disposition (a) would apply; that is, the family would have an excess of $8.

Example 3

Mother, Father, and 1 child. MA Application is filed for child only. The father is employed and has net monthly earnings of $480.00.

Disposition:

Household size: 3	MA Exemption Level	$492
Legally Responsible	Net Monthly Income	480
		Child fully eligible

Should the parents request Medical Assistance at a later date, the household size would continue to be 3. However, their eligibility would be computed by comparing the income of $480 to the PA Standard need for a 3 person household, assuming there is no deprivation factor. However, even if the parents were ineligible, the child would remain eligible.

Example 4

Woman and 3 children. Woman and 2 of the children are in receipt of ADC cash. They do not have any other income. MA is requested for the third child who receives OASDI of $350/month.

Disposition:

Household size: 1	MA Exemption Level	$334
	Net Monthly Income	350
(MA applicant only)	Excess	16

Child is eligible for Medicaid subject to a $16 excess.

MEHLER TRANSMITTAL FORM **ATTACHMENT VII**

Eligible From _____ **to** _____

LOCAL DISTRICT: _____
RECIPIENT NAME: _____
RECIPIENT ADDRESS: _____
_____

MEDICAID IDENTIFICATION NO. _____

NAME & ADDRESS OF SERVICE PROVIDER	**DESCRIPTION OF SERVICE PROVIDED** (For Prescription Drugs, Show Name, Strength, & Quantity)	**DATE OF SERV. (MO/DAY/YR)**	**TOTAL BILL**	**AMOUNT PAID** (or Balance Due After Insurance Payment)	**NAME & ADDRESS OF PAYOR IF OTHER THAN RECIPIENT**

I certify that the above-named recipient is eligible for Medical Assistance benefits as a member of the Mehler v. Blum class.

_____
DATE COMPLETED

x _____
SIGNATURE OF LOCAL DISTRICT ELIGIBILITY WORKER