

Phase II - Student Guide

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Module I Review

Take this time to write out anything to help jog your memory regarding Phase I application to case process for Energy and FNS. What are the similarities between the two and what are the differences.

[illegible]

ENERGY NOTES	FNS NOTES

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Writing Narratives

Purpose:

The goal of _____ and writing narratives is to minimize Quality
A _____ errors. Documentation is mandated by NC Policy and is crucial.

Common Errors Identified:

- Missing narrative
- Narrative does not detail _____ taken on the case/application
- _____ not placed as per policy requirements
- Policy requirements not included in the narrative

Definition of Documentation/Narration: According to the state:

“Documentation means the type of verification and a summary of the information obtained has been entered in the appropriate evidence in NC FAST. It must be detailed so that a County, State, or Federal reviewer is able to determine the reasonableness of determination.” - Integrated Eligibility Manual

How to Write a Quality Narrative:

Key Questions to Address:

- Who?
- _____?
- When?
- Where?
- _____?
- How?

To write an effective narrative, include all conversations, leads (information known to and available to the agency), information, and verifications that led to the action taken. Always strive to ask better questions.

Module 2-3 FNS – Processing Changes

FNS – Processing Changes

What are Changes?

A change refers to _____ reported information during a certification period. This change can lead to an increase, decrease, or no adjustment in allotments.

The date the Change Report is received:

- The date of the change is reported How
 - telephone, email, or fax,
 - office visit to report a change
 - reported to Work First Family Assistance (WFFA)
 - changed information is entered into NC FAST, and a task is created
 - reported by a third party

_____ will generate and mail the DSS _____ at application and recertification disposition. If NC FAST fails to generate the DSS _____, the worker must generate and mail/give the form to the FNS unit.

The DSS _____ provides the following information to the FNS unit:

- a) Explains the income reporting requirement for the appropriate FNS unit size and identifies the maximum income amount.
- b) It indicates that the household has no further income reporting requirements when the household's income exceeds the 130% maximum allowable gross income limit.
- c) Instructs the household to add the gross amount of all sources of income to get the total amount of monthly income (wages, WFFA, child support, SSI, unemployment benefits {UIB}, Social Security, Veterans benefits, disability payments, income of new household members, etc.) on the last day of the month.
- d) Explains that the agency will react to all changes that become known to the FNS worker from any other programs/units.

Households Required to Report Changes:

Please note the following information can change depending on updates to FNS policies.

- Households whose income is under the maximum income limit for their household size are required to report changes that put them over that maximum income limit.
This is calculated by a percentage amount.
- Households who are over the maximum income limit for their household size are NOT required to report changes.

- FNS units are required to report changes by the 10th of the month, following the month of change.
- This reporting limit will not change during the certification period regardless of changes in household size that may occur.

Evaluating the Changes

Evaluate and react, as appropriate to the following changes, within ten calendar days of receipt of the change:

- Changes the household is required to report based on reporting requirements
- Changes known to Work First
- Changes reported directly to the FNS worker from all programs within DSS
- Changes that become known to the agency are defined as new/changed information recorded in NC FAST and a task is generated to the FNS worker

Reacting to a Change

When a change is reported:

- Determine how the change affects the FNS unit's eligibility or benefit level within calendar days of the date the change was reported to the agency.
- If multiple changes are reported on the same day, determine the cumulative effect and act accordingly.
- Determine if additional verification is required unless the change is considered verified upon receipt.
 - If the information is questionable, it is not considered verified upon receipt and must be verified prior to reacting to the change.
 - Verified upon receipt means that information is not questionable, and the provider is the primary source of the information but not limited to:
 - BENDEX (Beneficiary and Earnings Data Exchange), SSA (Social Security Administration) benefits and payments of Medicare premiums from the SSA.
 - SDX (State Data Exchange), SSI (Supplemental Security Income) benefit from the SSA.
 - SAVE (Systematic Alien Verification for Entitlements), from the Bureau of Citizenship and Immigration Services (BCIS).
 - Employment and Training (E&T) compliance information, received from Division of Employment Security (DES).

- Intentional Program Violations (IPVs), received from Program Integrity staff.
 - Non-cooperation with Quality Control (QC), received from QC staff.
 - UIB (Unemployment Insurance Benefits), received from DES.
 - Death matches, verified from Vital Records (provided monthly); or Prison matches verified from Department of Corrections (DOC) (provided quarterly).
- Send DSS-8650A if additional information is required and give the FNS unit 10 calendar days to provide.

The following Notices are used when reacting to changes:

Forms/Notices	
<i>Change Report Form –</i> DSS 8550	Sent so clients can report changes in a household's circumstances that could affect their eligibility for benefits.
<i>Effect of Change –</i> DSS 8562	Sent to notify the client of either <u>no change</u> in their benefits when the change is reported by the client or when the change results in an <u>increase</u> in benefits.
<i>Confirmation of Voluntary Termination of Benefits –</i> DSS 8632	Sent when the FNS unit requests in writing or verbally to reduce or terminate its benefits, or when the caseworker receives notification that the FNS unit has moved out of state.
<i>Notice of Adverse Action –</i> DSS _____	Sent when a reported or discovered change <u>decreases or terminates</u> a FNS Unit's benefits. The FNS unit must be given 10 business days' notice before benefits can be decreased or terminated. The change can be made the month after the month in which the Notice of Adverse Action expires.
<i>Documents Needed to Complete Your Application—</i> DSS 8650A	Sent in addition to an interview, when an applicant applies for FNS benefits. It is given to obtain certain documentation to process the application.

Change Process

- Enter the change into NC FAST -CCE using the appropriate evidence.
- Add verifications.

- Run an Eligibility check from the Check Eligibility tab checking the applicable program.
- Toggle into the decision and verify the new ongoing monthly amount and compare it to the Trial Budget.
- Apply Changes
- Return to the Eligibility Check & view the “*Changed Decision.*” Click on the “*Coverage Period*” to make sure it is correct.
- Once the ongoing allotment has been verified as correct, click on the ellipsis and select “*Accept with Timely.*”
- This will cause the system to look at the 10-day Notice of Adverse Action (NOAA) timeframe (10 business days) and adjust the allotment start date accordingly.
- The pop-up appears. Select “Yes.”
- Navigate to the “*Determination Tab*” within the FNS PDC. Look for the “*Determination Status.*” If it shows as “*Postponed,*” note the “*Held To Date.*” This date should be the first day of the month when the change will take effect. The “*Coverage Period*” will display the ongoing amount for that specific time period.
- Generate the DSS-8553 NOAA from the Case Details Tab, Communications
 - DSS-8553 NOAA Information:
 - For System generated NOAA’s the timeframe is actually 12 working days from the date of keying because the system takes into consideration that the notice will not go out until the following day through “overnight batching.”
 - When a Manual NOAA is sent, it is generated and mailed the same day, therefore the timeframe only needs to be 11 business days.
- Address any over/underpayments that are generated.
- If underpayment is valid, approve and submit for approval.
- If overpayment is valid, complete and submit a program integrity referral.
- If either the underpayment or overpayment are not valid, evaluate and address it appropriately.

Verifications

Mandatory	Required	Non-Required
If verification of the following is not provided	If verification is unavailable for a required verification,	The following non-required verifications are used to

at a change, the case must be denied for failure to provide information.	the client's statement may be used as verification to deny, reduce, or terminate FNS benefits.	determine benefit levels but are not eligibility requirements.
Identity	Student Status	Utility Expense
Residency (Non-Categorically Eligible HH only)	Voluntary Quit	Mortgage or Rental Expense
Citizenship/Alien Status	Work Registration/ABAWD Status	Property Taxes/Insurance
Household Size/Composition	Disability	Medical Expenses
Gross Non-exempt Income	Controlled Substance Felons/IPV	Legally Obligated Child Support Payments
Enumeration	Resources	Child Care Expenses

Helpful Chart

The following chart is a summary of the changes, however, not to be used in the place of policy. The chart indicates if verification is required or if client statement (C/S) can be used as verification unless questionable.

Action Area of Policy	Application Approval	Application Denial	Recertification Approval	Recertification Denial	Change (Increase or Termination)
Mandatory Verifications:					
Identity	Required	Required	Required	Required	Required
Residency	Required	Required	Required	Required	Required
Citizenship / Alien Status	Required	Required	Required	Required	Required
Household Size	Required	Required	Required	Required	Required
Household Composition	Required	Required	Required	Required	Required
Enumeration	Required	Required	Required	Required	Required
Gross Non-exempt Income	Required	Required	Required	Required	Required
Required Verifications:					
Student Status	Required	C/S	Required	C/S	C/S
Voluntary Quit	Required	C/S	Required	C/S	C/S
Work Registration	Required	C/S	Required	C/S	C/S
Disability	Required	C/S	Required	C/S	C/S
Controlled Substance Felon	Required	C/S	Required	C/S	C/S
Previous Disqualifications	Required	C/S	Required	C/S	C/S
Resources	Required	C/S	Required	C/S	C/S

No Change In Eligibility or Benefit

1. **Obtain Necessary Verifications**
2. **Notify the FNS Unit**
3. **Reporting Requirements**

Documentation

Documentation is crucial when working on FNS (Food and Nutrition Services) cases for several reasons:

1. **Accuracy and Consistency**
2. _____
3. **Compliance**
4. _____
5. _____
6. **Support for Decisions**

Module 4 FNS – Processing Reviews

FNS – Processing Recertifications

Monthly, NC FAST selects active cases that are subject to Simplified Reporting with a certification period that expires the following month and generates and mails the FNS unit a DSS – _____, Food and Nutrition Services (FNS) Notice of Expiration and Recertification Form. Cases are selected on the _____ calendar day of the month unless it falls on a holiday or weekend.

Certification Period

Once the application is processed, the certification period, the number of months they are eligible for, is determined by the household's situation. They will be eligible for either ____ or ____ months.

Entering Recertification into NC FAST

Food & Nutrition Services - [User Profile]

Food & Nutrition Services
Income Support
Legacy Case ID
Transitional
Expedited
Last Payment
Last Payment Date
Start Date

Head of Household 41 years
Member 43 years
Member 17 years

Home Determinations **Certifications** Groups Financials Appeals Case Details Events Administration FSIS Benefit History

Certification Periods
Recertifications
Interviews

Recertification

New...

Date Received	Completion Date	Method	Status	New Cert Start Date
		Paper, E-mail, Fax	Completed	
		Paper, E-mail, Fax	Completed	
		In-Person	Completed	

At recertification the “_____” is selected in the process of starting the recertification in NC FAST.

1. Click the _____ tab
2. Click on *Recertification* folder
3. Click the *New* hyperlink

Mandatory fields

1. Date Received – date the recertification is received by the agency.
2. Method – should reflect in the manner the form was received.
3. Next Certification Period Start Date – this will prepopulate the 1st day of the next certification period.
4. Registration Request – Did the client mark they wanted to register to vote (only can be answered once and can’t be edited).
5. Date Required Information Provided – the date the final evidence was received.

Interviews

If the interview is required:

1. Contact the FNS unit by telephone to conduct the recertification interview. If the household cannot be contacted by phone a DSS 8650 must be mailed with a scheduled appointment.
2. Main the FNS unit DSS _____, Notice of Information Needed, with a scheduled appointment. The DSS _____ must include a specific date, time, and method of the interview (telephone or face-to-face). The appointment may be either a telephone or office interview. Other information CAN be requested on DSS _____.

Home Determinations **Certifications** Groups Financials Appeals Case Details Events Administration FSIS Benefit History

Certification Periods **Recertification** Interviews

New... [Refresh] [Print] [Help]

Date Received	Completion Date	Method	Status	New Cert Start Date	
7/10/2024		Phone	In Progress	8/1/2024	...
7/5/2023	7/24/2023	Paper, E-mail, Fax	Completed		Close...
7/5/2022	7/20/2022	Paper, E-mail, Fax	Completed		Submit...
7/9/2018	7/10/2018	In-Person	Completed		Delete...
					Add Interview...

3. Navigate to the Certification Tab/Recertification tab.
4. Click the 3 ellipses beside the current recertification
5. Click Add Interview and a “New Interview”

New Interview [Help] [Close]

* required field

Subject * Location

Start * End *

Priority *

Notes

Module 5-6 FNS - Processing Reviews Continued

Recertification Changes

What to look for:

- Review and compare the DSS-_____ to the information that is active on the Income Support Case Evidence Dashboard
- Look for any changes from the last action taken on the case at the previous application, recertification or change.
- Read all the narrative on the HOH Person Page from the last recertification/application until now.
- Run OVS and compare the information to the updated hits showing up for all household members and address those prior to processing the recertification.

Change

What to do?

Change

What to do?

Household Composition	Verify if questionable	Earned/Unearned Income	Verify income using the 30 days prior to provided date
Authorized Representative	New DSS-1688 must be filled out at each recert	Child Support Income	Verify and update
Citizenship	Verify new members and run SAVE for Documented Aliens	Child Support Expense	Verify and update
Student Status	Confirm eligibility and update if changed	Shelter Expenses	Compare and update if changed
Enumeration	Verify new Social Security Numbers	Childcare Expenses	Verify and update
ABAWD	Check Time Limits for used months	Medical Expenses	If source or amount changed more than \$25- update and verify
Work Requirements	Verify status and update if changed	Reported or Discovered Change	Verify and update

Managing Evidence

- **End date** evidence exists that is no longer current on the last day of the certification month.
- **Start date** the new current evidence on the first day of the new recertification month.
- **End date** any existing evidence on the last day of the month if you will not be adding new evidence to replace the old.
- **Run OVS** for all household members and address any discrepancies.

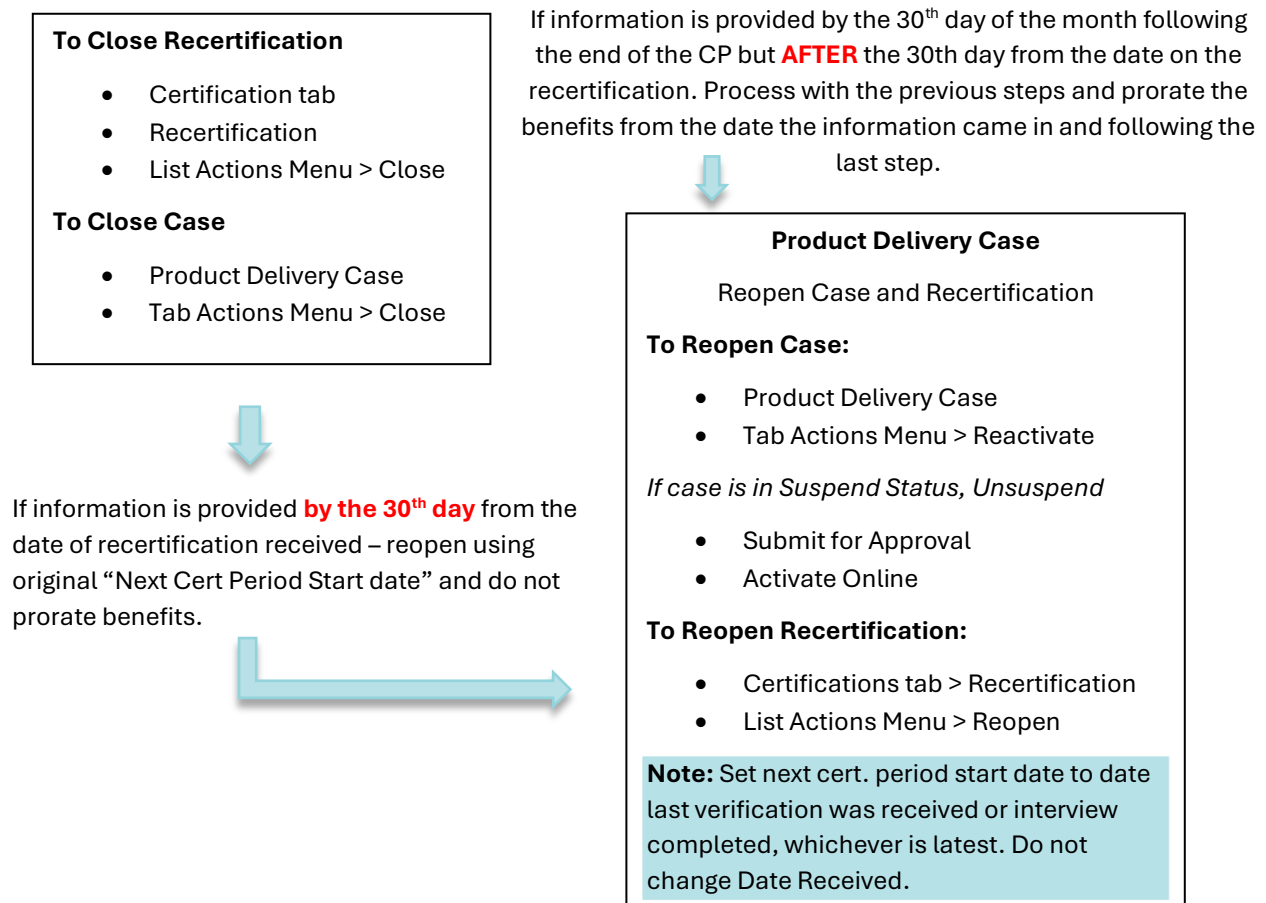
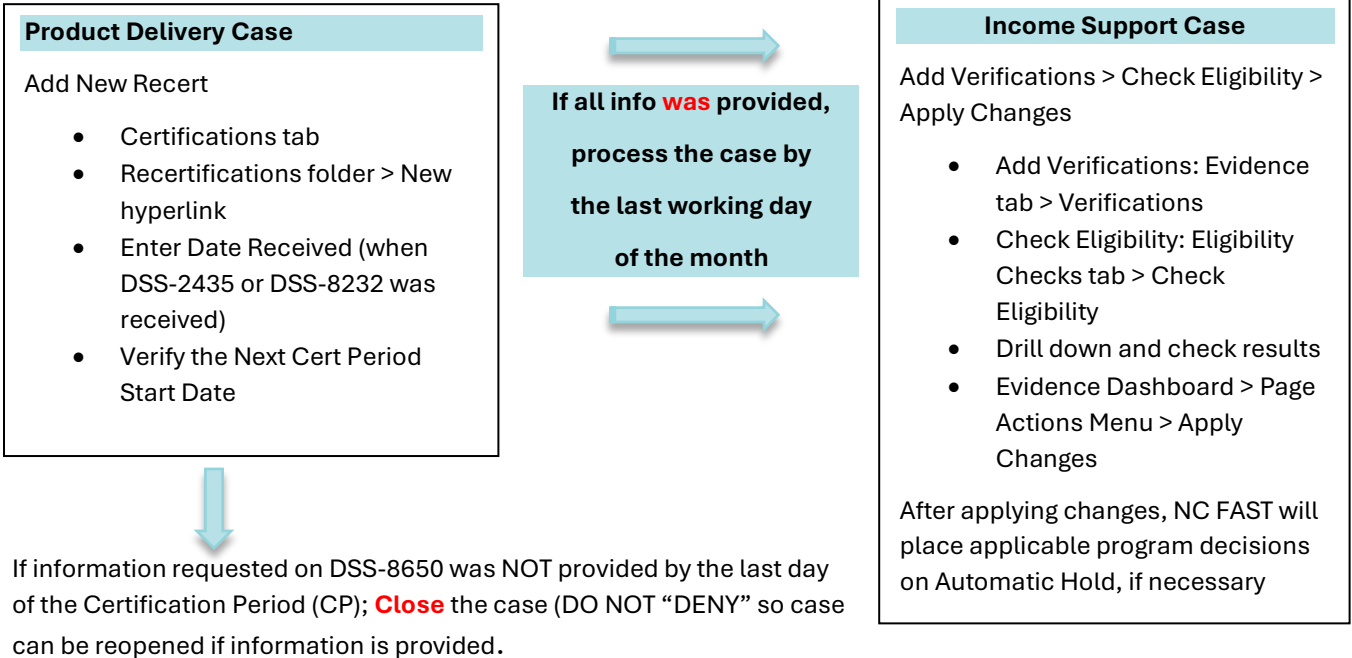
Time Standards

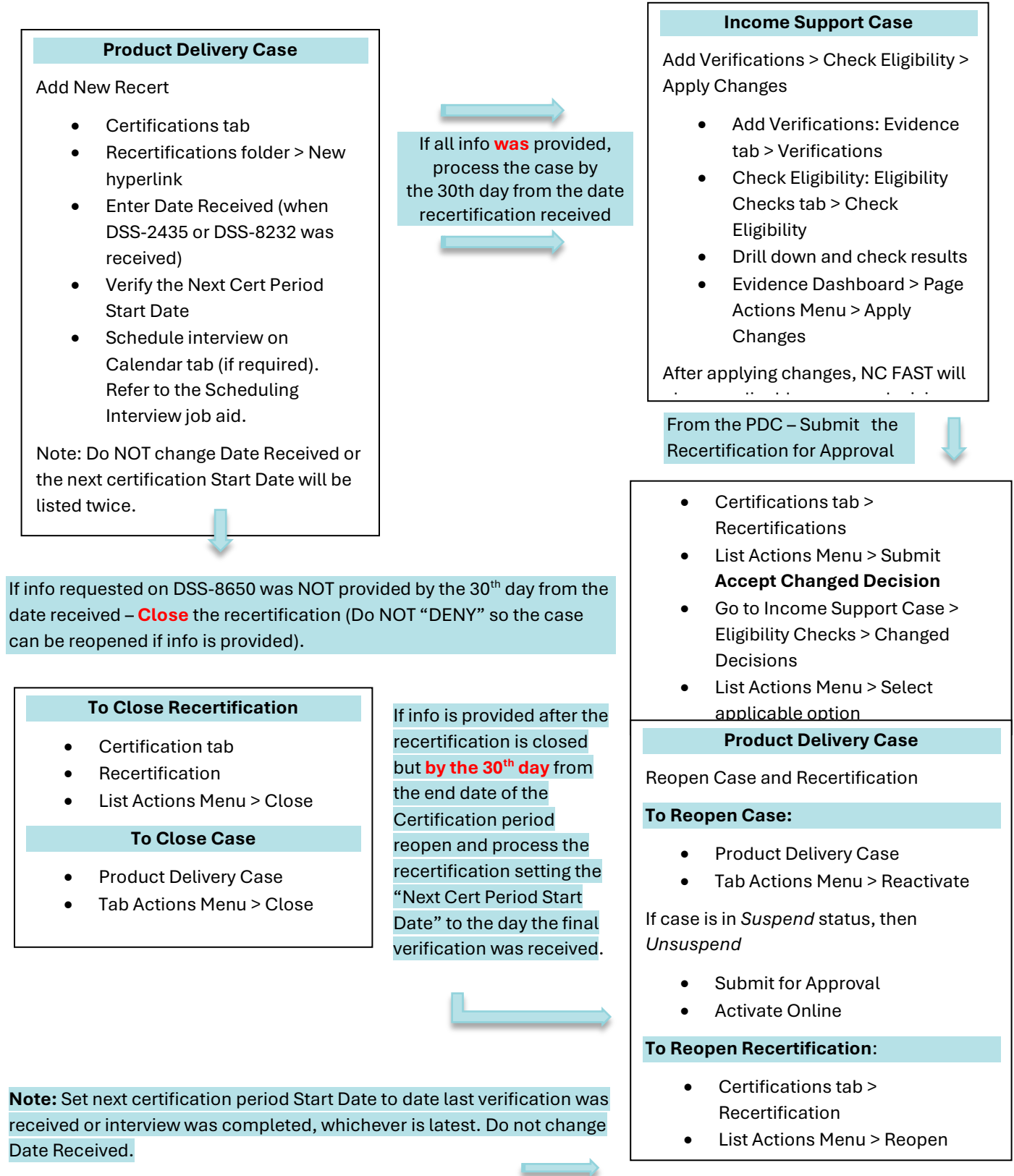
Timely: Must be completed by the last working day of the final month of the certification period.

Untimely: Must be completed within 30 calendar days from the date the recertification is received. If the 30th day falls on a weekend or holiday, the due date will be the next working day.

Late: Must be completed within 30 calendar days, or within 4 calendar days if expedited. If the 30th day falls on a weekend or holiday, the due date will be the next working day.

Timely Recert in NC FAST Flowchart







North Carolina Families Accessing Services through Technology

[illegible]

Late Recert in NC FAST Flowchart

Product Delivery Case

- Tab Actions Menu > Unsuspend
- Tab Actions Menu > Close

Note: Use Close Reason
Recertification not received.

Add a "Short App"
From the Income
Support Case.



Income Support Case

Add application & submit

- Tab Actions Menu > Add application (short form)
 - Answer all applicable questions paying closing attention to expedited information.
 - Submit Application
- Add additional Household Members to Income Support Application on Clients Tab > New



This will create an Income Support Application attached to the original Income Support Case.

If info requested on DSS-8650 was provided by the 30th day.



Income Support Application

Enter and Verify all evidence.

Note: Adding/updating evidence must be completed even if all verifications have not been received.

- Evidence Dashboard (Evidence tab)
 - Update existing evidence and/or add new evidence
 - Add Verifications (Evidence tab > Verifications)
- Check Eligibility
 - Eligibility Checks Tab > Check Eligibility
 - Drill down, examine results carefully
- If correct, Evidence Dashboard > Page Actions Menu > Apply Changes

Product Delivery Case

Tab Actions Menu >
Activate Online

Income Support Application

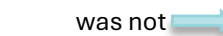
Schedule the interview (if applicable) on the Income Support Application.

When an application is completed, NC FAST creates new Head of Household (HOH) evidence. This information must be discarded.

Evidence Tab

- HOH evidence
 - Discard the new duplication HOH evidence created by NC FAST.
- Household Relationship evidence
 - Discard the new duplicate relationship evidence if created by NC FAST.
 - Discard ALL duplicate evidence on the Evidence Dashboard created by NC FAST

If info requested on the DSS-8650 was not provided by the 30th day



Income Support Application

If denying late recertification for missed interview:

- Programs tab
- List Actions Menu > Deny

If denying application for failure to provide info on the 30th day.

- Check Eligibility – Eligibility Checks Tab > Check Eligibility
- Evidence Dashboard > Page Actions Menu > Apply Changes – Including unverified evidence
- Tab Actions Menu > Ready for Determination
- Tab Actions Menu > Review Eligibility Result > Deny

Module 7 Review & Assessment

Checklist:

Check off each item that you are proficient in:

- ☐ Navigating NC FAST
 - ☐ Searching for Persons
 - ☐ Registering a Person
- ☐ Understanding the FNS application to Case Process
 - ☐ Utilizing the Evidence Dashboard
 - ☐ Processing and Determinations
 - ☐ Managing Forms and Notices
 - ☐ Accurate Documentation
- ☐ Understand and Entering Changes on the Evidence Dashboard
- ☐ Managing Recertifications

Assessments

Your knowledge will be assessed with the following assessments:

- FNS Assistance application to case process
- Changes
- Reviews

Module 8 Introduction to Medicaid

History of NC Medicaid

1. **Establishment:** Medicaid was created as a joint federal and state program under the Social Security Amendments of 1965. North Carolina formally adopted Medicaid in January ____.
2. **Purpose:** The program was designed to provide health coverage for low-income individuals, including adults, children, pregnant women, seniors, and people with disabilities.
3. **Growth and Impact:** Over the years, Medicaid has expanded to cover a significant portion of North Carolina's population. As of _____, it supported the health and well-being of 2.2 million North Carolinians and covered more than 65,000 births annually.
4. **Medicaid Expansion Debate:** The debate over Medicaid expansion has been a contentious issue in North Carolina. While some argue that expansion would bring more federal funds and improve health outcomes, others are concerned about the potential costs and impacts on the healthcare system.

5. **Recent Developments:** In recent years, North Carolina has made strides in integrating physical and behavioral health, promoting value-based payment, and addressing non-medical drivers of health like housing stability and food security.

What is Medicaid?

Medicaid is a health insurance program designed to assist low-income individuals and families who cannot afford healthcare costs.

Types of Medicaid in North Carolina

- **Family and Children's Medicaid:** This program supports low-income parents/caretakers, pregnant women, and children in North Carolina. With the expansion of NC Medicaid, it now also includes individuals aged _____ - _____.
- **Adult Medicaid:** This program serves individuals who are _____ and older, disabled, blind, or receiving Medicare A/B.

NC Medicaid offers various programs to help cover some or all healthcare costs, depending on the individual's or family's income and, in some cases, resource limits.

Funding and Administration

Medicaid is jointly funded by the federal government and individual states.

- **State Administration:** Each state establishes and administers its own Medicaid programs, determining the type, amount, duration, and scope of services within broad federal guidelines.
- **Mandatory and Optional Benefits:** States are required to cover certain "mandatory benefits" (e.g., inpatient hospital stays) but can choose to provide additional "optional benefits" (e.g., hospice care). Each state must meet minimum federal requirements but can offer extra coverage beyond these mandates.

NC Medicaid's Covered Services

NC Medicaid provides a range of services to meet the health needs of eligible individuals and families, ensuring they receive necessary medical care within the program's guidelines.

How to Apply for NC Medicaid

Individuals can submit applications through the following ways:

- **In person** – applicants can present in person to apply for themselves, their family or another person for whom they are the legal/authorized representative for Medical Assistance. Individuals may apply for all Medicaid programs at their local department of social services.
- **Mail**- individuals may apply by mail by downloading the DHB-5200 application for Health Coverage & Help Paying Coasts and all the appropriate appendices at:

<https://www.ncdhhs.gov/dma/medicaid/applications.htm> and mail it in or drop it off at their local department of social services.

- Online -ePASS – individuals can apply for benefits online through ePASS (Electronic Pre-Assessment Screening Service) at <https://www.epass.nc.gov>.
- Federally Facilitated Marketplace (FFM) – individuals can apply online for Insurance Affordability programs through the FFM at <https://www.healthcare.gov/>
- Fax – Individuals may fax the completed DHB-_____ to the appropriate local department of social services
- Email - Individuals may email the completed DHB-_____ to the appropriate local department of social services
- Phone – individuals may apply by telephone by calling their local department of social services.

Application Guidelines

A Medicaid application is considered complete if it meets the following criteria:

1. It is legible.
2. It is signed by an authorized individual on behalf of the applicant.
3. It includes a _____.
4. It provides the full name, sex, and date of birth for at least one applicant.
5. It indicates that at least one person on the application is marked as “_____.”

If any of these criteria are not met, the application is deemed “_____.” In such cases, the application is marked as “_____,” and the application date is protected while verifications are pursued to complete the application. The exception to this process is if no one on the application is marked as applying; these applications are keyed and then “_____.”

Who Can Apply for Medicaid?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medicaid Application Submission Guidelines

Medicaid applications must be signed to be considered valid. The date the signed application is received by the local agency is recorded as the application date. The only

exception to this rule is for telephone applications, where the application date is the date of the telephone interview.

Requirements for F&C Medicaid Programs – Determining Eligibility

Before evaluating program-specific criteria, each Medicaid applicant must meet certain basic requirements. These prerequisites apply universally, regardless of the specific Medicaid program being considered. Only after these basic requirements are satisfied can eligibility be determined.

If an applicant fails to meet these basic requirements, the caseworker cannot proceed with evaluating eligibility under specific program guidelines such as MAF (Medical Assistance for Families with Dependent Children), MIC (Medicaid for Infants and Children), MPW (Medicaid for Pregnant Women), or MXP (MAGI Adult Group Medicaid Expansion). These requirements are applicable only to individuals seeking Medical Assistance benefits for themselves.

Basic Requirements for All NC Medicaid Programs:

- ✓ Citizenship or Immigration Status: Must be a U.S. citizen or a qualified alien (with exceptions).
- ✓ Proof of Identity: Must provide proof of identity.
- ✓ Residency: Must be a resident of North Carolina.
- ✓ Medicaid from Another State: Cannot be receiving Medicaid from another state (with exceptions).
- ✓ Social Security Number (SSN): Must provide a valid SSN or apply for one if eligible.
- ✓ Inmate Status: Must not be an inmate of a public institution (e.g., state prison).
- ✓ Income Requirements: Must meet income requirements.

These foundational criteria ensure that only eligible individuals proceed to the next stage of the Medicaid application process.

Program Specific Requirements

These requirements apply to specific F&C Medicaid programs:

- **Child Under Age 21:**
 - Birth to age 19: MAFC, MICN/1, and MAFM

- Age 19/20: MAFN and MAFM
- **Aged 19-64:** MXP
- **Over Age 21:** Must meet kinship and living arrangement requirements to be evaluated as a “caretaker” (MAFC, MAFM)
- **Pregnant:** MPW, MAFM
- **Not Pregnant:** MXP, MAFD
- **Medicare Part A and/or B:** Must not be entitled to or enrolled in Medicare Part A and/or B (MXP only)
- **Parent/Caretaker of a Child Under Age 21:** The child must currently be enrolled in health coverage that provides Minimum Essential Coverage (MEC) (MXP only)
- **Resource Requirements:** Must meet resource requirements if required by the Medicaid program (MAF/M only)

These criteria ensure that applicants are evaluated appropriately based on their specific circumstances and the Medicaid program they are applying for.

Verifying Basic Requirements Electronically

The agency must verify all possible information through electronic sources. Caseworkers are required to use the Online Verification System (OVS) for every application and recertification of Medicaid applicants/beneficiaries (a/b). OVS provides access to data from various sources, including the Social Security Administration, NC Employment Security Commission, Child Support Services, and NCDMV.

Additionally, caseworkers must use The Work Number (TWN) at every application and recertification for Medicaid a/b. However, TWN is only used for household members aged 14 or older.

For verifying the immigration status of documented immigrants, caseworkers must run the Systematic Alien Verification for Entitlements (SAVE) at every application and recertification. SAVE is only used for applicants/beneficiaries reported as documented immigrants and not for U.S. citizens or undocumented immigrants.

The agency is required to utilize these systems (OVS, TWN, SAVE) before requesting additional verifications from the applicant. Although not classified as “Electronic Sources/Verifications,” caseworkers should also attempt to obtain verifications through the register of deeds and vital records before asking the a/b to provide further documentation. These databases can be particularly useful for locating birth certificates to verify citizenship or to obtain residency verification for an application.

Post Eligibility Requirements

Reference: MA-3205 Family and Children's Medicaid, Health Benefits/NC Medicaid – Post Eligibility Verification.

Certain requirements are only necessary **after eligibility has been established and Medicaid has been authorized**. These verifications are not requested or required from the applicant until that point.

The following are requirements for coverage but are considered Post Eligibility Verifications:

- **Third Party Recovery (TPR):** Verification of other insurance.
- **Application for Other Potential Benefits:** This includes Unemployment Insurance Benefits (UIB), Social Security Administration (SSA) benefits, and Retirement, Survivors, and Disability Insurance (RSDI).
- **Cooperation with Child Support:** Generally, adults applying for Medical Assistance (MA) for themselves must cooperate with Child Support if they have a child in the home who is also receiving Medical Assistance, and the child has a parent residing outside the home (absent parent).

Basic Requirements

Reference: MA-3332 Family and Children's Medicaid, Health Benefits/NC Medicaid – Citizenship.

1. Each individual requesting Medicaid Assistance (MA) must provide or cooperate in obtaining proof of citizenship and identity. Once documented, no further requests are made unless the documents become questionable.
2. Immigrants who do not meet the citizenship requirement or have satisfactory immigration status are eligible for Medicaid only for emergency medical services.
3. Newborn babies born in the U.S. whose mother is covered by Medicaid for the delivery are exempt from having to provide further verification of citizenship and identity.

Who is a US Citizen?

US Citizen is:

- **Any person born** in one of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Mariana Islands, American Samoa, or Swain's Island.
- **Any person born outside** of the United States to a US citizen.
- **Any person born outside** of the United States who has been approved by USCIS as a naturalized citizen.

- **Any person born outside** of the United States who was under the age of 18 on February 27, 2001, and meets all the following criteria:
 - While under the age of 18, they resided permanently in the United States in the legal and physical custody of a US citizen parent.
 - Had at least one US citizen parent (by birth or naturalization).
 - Was a lawful permanent resident before the age of 18.

Verifying U.S. Citizenship with OVS

Caseworkers should first attempt to verify U.S. citizenship electronically via OVS, as it is the preferred verification source. Here's how to demonstrate this process to students:

1. Navigate to the **Online Data** tab on the application/case.
2. Select the **OVS Folder** on the left-hand side of the screen.
3. Click **Request Online Data**.
4. Toggle into the results, then click the **List Actions Menu** to view the OVS results and check if U.S. citizenship is verified.

Who is an Immigrant?

Individuals who reside in the U.S. but are not U.S. citizens are considered immigrants. Here are the different categories:

- **Documented Immigrants:** Immigrants who possess valid documentation.
- **Undocumented Immigrants:** Immigrants in the U.S. without proper documentation, in violation of U.S. immigration law.
- **Qualified Aliens:** Individuals with certain lawful statuses.
- **Non-qualified Aliens:** Immigrants who do not meet the specific requirements of a qualified alien for Medicaid purposes.

Please note there is much more detailed information regarding qualified aliens and non-qualified aliens that we will not delve into for the sake of time.

Common Immigration Documents

The following are examples of the most common documents provided:

- 1-551 Permanent Resident Card
- I-776 Employment Authorization Card
- 1-94 Arrival/Departure Records
- Foreign Passports
- I—688 Employment Authorization Document

Verifying Immigration Status with SAVE

For any applicant or beneficiary (a/b) who attests to being a documented immigrant, the SAVE system must be used at every application and recertification. The verification should be saved to the a/b's file. The primary method to access this information is through NC FAST, but it can also be retrieved via the online service outside of NC FAST if necessary.

Exception: Trafficking Victims - Trafficking victims, who are survivors of severe human trafficking, along with their immediate family members (spouse and/or children), are exempt from the five-year bar. They should be evaluated for regular (full) Medicaid.

Here's how to demonstrate this process to students:

1. Open the Insurance Affordability application (IAA) or Insurance Affordability (IA) for recertification/COC.
2. Verify "Citizenship Status" and "DHSID Details" on the Evidence Dashboard.
3. Click the Online Data Tab and select the SAVE folder.
4. Click the Request SAVE Data hyperlink on the SAVE Data Requests page.
5. In the SAVE Data Request Wizard, check the box next to the individual(s) and click Next.
6. Skip the attachments page and click Next on the summary page.
7. Check the SAVE folder for responses. If there's an error, retry the request.
8. Click the toggle next to the date to view SAVE responses.
9. Click the List Actions Menu next to the household member and select View.
10. Review the SAVE data to confirm the immigration status and potential benefits eligibility.

Residency Requirements for NC Medicaid

To be eligible for NC Medicaid, applicants must meet specific criteria, including residency requirements. Here's a clearer breakdown:

1. **Residency Verification:** Applicants must be residents of North Carolina, and the agency must verify this residency.
2. **Residency Criteria:**
 - **Physical Presence:** The applicant must be physically present in North Carolina with the intent to reside here, **or**
 - **Job Commitment:** The applicant has entered the state with a job commitment, **or**
 - **Job Seeking:** The applicant is actively seeking employment in North Carolina.

3. **Proof of Residency:** Verification of residency must be obtained by the county or provided by the applicant.

The *DHB-5152* North Carolina Residency Declaration can be completed by either:

- a. **An individual who has social, family, or economic ties with the applicant** and has personal knowledge of the applicant's intent to reside in North Carolina for employment purposes or with a job commitment, **OR**
- b. An applicant who **self-attests** to being **homeless**.

Household Composition

The Affordable Care Act (ACA) redefined the criteria for determining household composition and countable income for Family and Children's Medicaid applicants. This two-fold change involved:

1. **Redefining the MAGI Household:** Adjusting how individuals are included in the applicant's Modified Adjusted Gross Income (MAGI) household.
2. **Updating Countable Income Types and Disregards:** Modifying the types of income considered and the disregards allowed during the eligibility determination process.

MAGI Medicaid Budgeting

MAGI Medicaid budgeting is now based on the individual's tax filing status or a modified set of rules if the individual does not file taxes or meets one of the three possible exceptions.

1. To determine eligibility under the MAGI budgeting methodology, the applicant must provide information on how taxes will be filed the next time taxes are due.
2. MAGI has changed the categories of countable income and allowable deductions.
3. If an individual meets an "exception," they move from eligibility determination under "tax filer" rules to determination under "non-filer" rules.
4. MA-3306 addresses these changes. Please review this policy section and refer to it for any questions regarding these changes.

MAGI Counting Income – Tax Household Chart

The MAGI (Modified Adjusted Gross Income) Counting Income Chart for North Carolina's Department of Health and Human Services (NC DHHS) is a crucial tool for determining whose income counts in various household scenarios, such as tax-filer or non-filer households. This chart is essential for understanding eligibility for Medicaid and other health benefits.

Caseworkers will use the results from the MAGI Household Composition Chart to determine the applicant's placement on the Counting Income – Tax Household Chart (refer to the chart in the Forms and Notices folder).

- For tax filers and tax dependents who do **not** meet an exception, caseworkers will use the “Counting Income using Tax Household Rules” columns (Columns 1 or 2).
- For non-filers or tax dependents who **do** meet an exception, caseworkers will use the “Counting Income using Non-filer Household Rules” columns (Columns 3, 4, or 5).

This chart determines which MAGI household members’ income will be counted in the applicant’s eligibility determination, based on whether the applicant is in a “tax filer household” or a “non-filer household.”

- Even if a person’s income should be counted, the caseworker must still determine if the individual’s specific income type is “countable” for MAGI Medicaid budgeting.

MAGI budgeting DOES NOT apply to:

- Supplemental Security Income (SSI) recipient
- Medicaid for the Aged Blind and Disabled (MAA, MAD, MAB) and Medicare Qualified Beneficiaries (MQB)
- Individuals requesting home and community-based services such as Community Alternative Program (CAP), Program for All Inclusive Care for the Elderly (PACE), and long-term care (including Family and Children’s program if long term care budgeting applies)
- Medically Needed (all programs including State Foster Home Fund (HSF) and Medically Needy Medicaid for Families (MAF/M)).

Child Support

To receive Medicaid, under most aid program/categories, when the applicant/beneficiary is a parent OR caretaker, they must cooperate with the local Child Support Services Agency in identifying any absent parents of children in the home who are applying for or already receiving Medicaid.

Child support requirements apply to both MAGI and Traditional budgeting methodologies for Family & Children’s Medicaid.

When to send an IV-D Referral:

- The minor child has a parent/parent(s) not living in the home **AND**
- The caretaker is receiving Medicaid for himself/herself & the child(ren) **OR**
- The caretaker is not applying for or receiving Medicaid but applies for child(ren) only **AND** requests services through Child Support Enforcement **AND** agrees to cooperate.

The IV-D referral is a communication tool, within NC FAST, between NC Medicaid and Child Support Services.

Remember there are always exceptions for sending and not sending the IV-D referral.

Confidentiality

According to North Carolina General Statutes, it is unlawful to obtain, disclose, use, authorize, or permit the use of any personal information of individuals applying for or receiving public assistance, except for the administration of public assistance and social services programs.

Information NOT Considered “Confidential”

County and state agencies may release general information to anyone requesting it, provided the information does not identify specific clients. This includes:

1. Non-identifying statistical information
2. General information about the scope of any programs administered by the Division of Health Benefits (DHB)
3. Written policies relevant to the administration of the Medicaid program

Documentation

Documentation is particularly important in NC FAST (North Carolina Families Accessing Services through Technology) for several reasons:

1. **Efficiency and Accuracy:** Proper documentation ensures that all data entered into the system is accurate and up to date, which is crucial for the efficient processing of applications and services.
2. **Integrated Services:** NC FAST aims to streamline and integrate various services provided by the NC DHHS. Accurate documentation helps in coordinating these services effectively, ensuring that families receive comprehensive support.
3. **Case Management:** Detailed records are essential for effective case management. They help social workers and other professionals track the progress of individual cases, make informed decisions, and provide appropriate interventions.
4. **Compliance and Accountability:** Documentation helps ensure compliance with state and federal regulations. It also provides a clear record of actions taken, which is important for accountability and auditing purposes.
5. **Communication:** Good documentation facilitates communication between different departments and agencies involved in providing services. This ensures that everyone has access to the same information and can work together more effectively.

6. **Training and Support:** Documentation, such as instructional guides and job aids, is crucial for training staff and supporting them in using the NC FAST system effectively.

Module 9-10 MAGI Applications

Keying MAGI Applications

There are three possible outcomes for any Medicaid application:

1. **Inquiry** – a/b decides not to apply **before** signing an application
2. **Approval**
3. **Denial**
4. **Withdrawal** – a/b decides not to continue the process **after** signing an application

Application Types

Applications can be submitted for both ongoing and retroactive coverage.

Processing Timeframes

Applications can be taken for: Ongoing & retroactive coverage

Processing Timeframe: Applicants have 45 calendar days to complete their application. This period ends on the date the notice is mailed or given to the applicant/beneficiary.

Application Basics

Initial Contact

An individual or their representative has the right to apply for Medicaid on the day they visit the agency seeking medical or financial assistance.

In some cases, an appointment may be necessary for the individual to return and complete the application.

Under no circumstances should an individual or their representative be discouraged from applying for Medicaid.

Medicaid Application Dates

- **In person** – the date the application is signed by the client in the agency.
- **Mail-in or online (ePASS and/or FFM)** – the date the signed application is received by the agency.
- **Phone** – the date of the telephone interview (whether or not a signature is obtained the same way).

Complete vs. Incomplete Applications

<i>Complete</i>	<i>Incomplete</i>
The information provided is legible	The information is NOT legible
The application is signed by the applicant or representative	Signed by someone other than the applicant or representative
The application includes: <ul style="list-style-type: none"> • The name & date of birth of at least one applicant, & • Mailing address 	Missing the full name, gender, and/or date of birth of at least one applicant or does not have a complete mailing address

What to Do If an Application Is Incomplete:

1. **Contact the Applicant:** Try to reach out to the applicant to clarify any missing or illegible information.
2. **Send Notice of Incomplete Application:** If you can't contact the applicant, send the DHB-_____ Notice of Incomplete Application, a copy of the submitted application, and a DHB-_____ Request for Information to both the applicant and the individual who submitted the application (if different) within 3 business days.
3. **Request Missing Information:** Ask for all necessary information to consider the application completely.
4. **Follow Up on Verifications:** If required verifications are not received within 12 calendar days, send a second DHB-_____.
5. **Pending Application:** If verifications are still not received within 12 calendar days after the second DHB-5097, keep the application pending until the requested information is received or until the 45th day from the application date, whichever comes first.
6. **Deny Application if Necessary:** If the required verifications are not received by the 45th day and two 12-day DHB-5097s have been sent and expired, deny the application for "Failure to Provide Information."
7. **Process Complete Applications:** If the required verifications are received, process the application according to current procedures.
8. **Handle Unsigned Applications:** Unsigned applications cannot be processed. Return the application to the individual who submitted it along with the DHB-5104/DHB-5104S Notice of Incomplete Application.
9. **Document Actions:** Record all actions taken in NC FAST.

The NCF-20023 is a notice titled “Notice Regarding the Status of Your Application for Medical Assistance.” It is automatically generated by the NC FAST system and sent to applicants if their Medicaid application has not been processed within a specific timeframe—either by the 45th or 90th day after submission.

The purpose of this notice is to inform applicants about the status of their application and to ensure they are aware of any delays in processing. This helps maintain transparency and keeps applicants informed about the progress of their application.

However, the NCF-_____will not be generated if:

1. The application has been processed by the 45th day.
2. The caseworker has entered the stop processing time begin date into NC FAST.
3. The stop processing time has been entered by the caseworker into NC FAST.
4. A DHB-_____notice, titled “Your Application for Medicaid is Pending,” has already been generated in NC FAST.

Application Disposition:

The application is considered to be disposed of by the State, on the date that the notice of outcome is either given to OR mailed to the applicant, regardless of what action disposes the application.

1. **Withdrawal & Denial** – disposed the date the DSS-8109 is given or mailed to the applicant.
2. **Approval** – disposed the date the DHB-5003 is given or mailed to the applicant.

Steps to Start Application Process

Demonstrate how to start and complete the MAGI application to the case process.

1. **Register Household Members:** After registering all household members, go to the Person page for the Head of Household.
2. **Access Applications Tab:** Click the Applications tab.
3. **Begin New Application:** On the application page, click the New MAGI Application hyperlink.
4. **Select Application Type:** In the New Application Form pop-up, select the Health Care Application radio button and click Next.
5. **Insurance Affordability:** In the New Application pop-up, check the Insurance Affordability box and click Next.
6. **Getting Started:** Enter the required information in the Getting Started pop-up and click Next.

7. **Before We Start:** Enter the necessary information in the Before We Start pop-up and click Next.
8. **Information About You:** Fill in the Information About You pop-up and click Next.
9. **Suggested Home Address:** Enter the suggested home address information and click Next.
10. **More About You:** Provide additional details in the More About You pop-up and click Next.
11. **Other Household Members:** Enter information for other household members and click Next.
12. **Household Member Extra Details:** Fill in extra details for household members and click Next.
13. **More People?** Indicate if there are more people to add and click Next.
14. **Relationship:** Enter relationship details and click Next.
15. **Tax Dependent Information:** Provide tax dependent information and click Next.
16. **Additional Tax Dependents:** Repeat tax dependent information for additional household members and click Next.
17. **Household Summary:** Review all household information, make any necessary edits, and click Next.
18. **Income Information:** Enter income information for the head of household and click Next.
19. **Additional Income Information:** Provide income information for additional household members and click Next.
20. **Additional Information for Applicants:** Enter any additional information for applicants and click Next.
21. **Retroactive Medical Need:** Provide information for retroactive medical needs and click Next.
22. **Summary:** Review and edit the summary information if needed, then click Next.
23. **Additional Documentation:** Review the application details and click Next.
24. **NC Residency Declaration:** Enter the NC residency information and click Next.

Submit MAGI Application

Review Terms with Client: Caseworkers must review the terms of the application with the client before submitting.

1. **Submit Application:** In the Submit Application Form pop-up, click all applicable checkboxes and then click Submit.

Match Client

1. **Navigate to Clients Tab:** Go to the Insurance Affordability Application and click the Clients tab.
2. **Check Registration Status:** Ensure all applicants are registered. The Registered column will show “Yes” if the client is registered and “No” if not.

Review and Update Evidence

1. **Access Evidence Tab:** Click the Evidence tab to resolve issues, edit existing evidence, or add new evidence to the Insurance Affordability Application.
2. **Emergency Benefits:** When evaluating for Emergency benefits, complete the Emergency evidence and ensure the Approval Date (application date) is entered.

Add Verifications

Request Online Data and Add Manual Verifications: Review the online data and add necessary verifications.

Online Verifications

1. **Request Online Data:** Click the Online Data tab and then the Request Online Data hyperlink.
2. **Review Results:** Click the toggle next to the applicable Request Date to display more information.
3. **View Results:** To review results for each household member, click the List Actions Menu and select View.
4. **Verify Evidence:** In the Online Data pop-up for the selected applicant, check each evidence type and click Verify.
5. **Return to Evidence Tab:** The Online Data page will display. Click the Evidence tab.

Manual Verifications

1. **Access Verifications Folder:** Click the Verifications folder.
2. **Add Proof:** On the Verifications page, click the List Actions Menu next to each item to verify and select Add Proof from the drop-down.
3. **Enter Information:** In the Add Proof pop-up, enter or select the applicable information from the drop-down menu and click Save.

Check Eligibility

Determine Eligibility: Check eligibility to determine whether the client is eligible or ineligible for benefits.

1. **Navigate to Home Page:** Go to the Insurance Affordability Application home page.
2. **Check Eligibility:** Click the Check Eligibility tab, then click the Check Eligibility hyperlink.
3. **Confirm Eligibility:** In the Check Eligibility pop-up, click Yes.

Authorize or Deny Application

1. **Authorize Eligible Applicants:** If all applicants are eligible, authorize the case: a. Navigate to the Application home page. b. Click the Tab Actions Menu, then select Authorize from the drop-down menu. c. In the Authorize Program pop-up, click Save. d. Click the Related Cases tab to view the Insurance Affordability Case and Product Delivery Case.
2. **Deny Ineligible Applicants:** If all applicants are ineligible, deny the application from the Programs tab: a. Click the Programs tab. b. Click the applicable List Actions Menu, then select Deny. c. In the Deny pop-up, select Denial Reason from the drop-down menu. d. Enter comments related to the Denial Reason selected, then click Save.
3. **Mixed Eligibility:** If some individuals in the household are eligible and some are not, first deny each ineligible applicant, then authorize the application: a. Click the Clients tab. b. Review the applicant status information by toggling next to each applicant. c. Click the List Actions Menu, then select the applicable Denial Reason for each ineligible applicant.

Authorize and Activate the Application

1. Click the Tab Actions Menu, then select Authorize.

Module 11-12 MAGI Processing Changes

Factors to Consider When Addressing Reported Changes for a Beneficiary

There are several factors that determine if, how, and when to address reported changes for a beneficiary:

1. **What is the reported change?**
2. **Does the change affect the beneficiary's Medicaid eligibility according to policy?**
 - Is the beneficiary over or under age ____?
 - Is the beneficiary receiving MPW?

3. What is the timing of the change?

- Is this an ongoing change or a retroactive change?
- Was the change reported timely (within ____ calendar days)?

4. Who reported the change?

- Was this reported by the beneficiary, a legal/authorized representative, or someone else?

Reporting Changes

- Changes can be reported while an application is pending, during the certification period, or during the recertification period.
- Beneficiaries are required to report all changes within ____ calendar days of the change.
- Beneficiaries should report any changes to their situation. The caseworker will determine if and how to address these changes for the beneficiary's eligibility.
- When a change in situation is reported, the caseworker should ask if there are any other changes that have occurred in the beneficiary's situation.

How a Change Can Be Reported

Changes can be reported through various methods, including but not limited to:

- Via phone, email, or in-person
- Via application submitted
- Via linked ePASS account

Timeframe for Action

Appropriate action on any changes should be completed within 30 calendar days from when the Agency learns of the change. This applies whether the change was reported by the beneficiary or discovered by the Agency through other means.

Common Changes

Many changes can impact a beneficiary's eligibility, including but not limited to:

- Change of address (in-state or out-of-state)
- Change in household composition (someone entering or leaving the household)
- Change in living arrangement
- Change in relationship status
- Change in income or employment status
- New or terminated pregnancy
- Changes in tax filing or dependent status

- Critical age changes

Changes that Negatively Impact Eligibility

When a change is discovered that could negatively impact Medicaid eligibility, and the NCF-_____ prepopulated Medicaid Renewal form is required, consider the following changes to the most recently known and verified household situation:

Income:

- Self-employment
- New income
- Decreased or increased income
- Terminated income

Electronic Sources:

- Indicate that benefits will decrease or reduce.
- Indicate that the beneficiary is ineligible for all Medicaid programs.

Household Changes:

- Tax filer status
- Household composition changes that may impact eligibility

Marital Status Changes:

- Newly married, widowed, separated, or divorced

Understanding the Month of Change

The month of change is defined as the month in which the change occurred, not the month it was reported. This applies to all types of changes.

Factors Determining When a Change is Effective

- **Current Benefit:** What is the beneficiary's current benefit?
- **Timing:** When did the change occur versus when it was reported?
- **Impact:** Would the change result in a reduction or termination of benefits?

Income Changes

Income changes are defined as:

- New, different, or additional sources of income/employment
- An increase or decrease in the rate of pay
- An increase or decrease in the required number of hours worked
- Termination of income

This applies to both earned and unearned income types.

- **New Income for CoCs:** Income that was not previously available to the household but is now or will be available during the remainder of the certification period (CP).
- **Terminated Income for CoCs:** Income from a source that has already ended, even if the individual has not received their final pay.
- **Fluctuating Income:** Fluctuating income is not considered a change.

The type of income change determines how it is addressed for a CoC.

MAGI – Processing Changes

A Medicaid beneficiary must receive notice of the outcome of any eligibility redetermination, regardless of the reason or result. The caseworker is responsible for sending a notice to the beneficiary, informing them of the continuation, reduction, or termination of their Medicaid benefits. This applies to redeterminations at the end of a certification period (Recertification) and any re-evaluation prompted by a Change of Circumstance (CoC) during the certification period.

Step 1: Complete Redetermination

Possible Outcomes:

1. Continued Eligibility:

- The beneficiary remains eligible for coverage.
 - This may be at the same benefit level as before the re-evaluation (though not necessarily the same aid program/category).
 - This may result in an increased benefit level.
 - This may result in a reduced benefit level.

2. Ineligibility:

- The beneficiary is no longer eligible for Medicaid coverage.

Notification Form:

DSS-8110 Notice of Modification, Termination, or Continuation of Benefits is used to notify the beneficiary of the redetermination outcome, whether it is a recertification or CoC (or a follow-up to a post-eligibility request). ***This form can indicate:***

- Continuation of eligibility
- Change in eligibility (increase/reduction)
- Termination of eligibility

Based on the redetermination outcome, the caseworker must determine if the notification is Adequate or Timely. Whenever possible, the DSS-_____ should be generated in NC FAST.

Adequate vs. Timely Change

Adequate Change	Timely Change
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<ul style="list-style-type: none"> • “Adequate” notification is used any time the beneficiary will either remain on the same benefit level or a transfer to a “better benefit” (increase in benefits). • The beneficiary must be informed <u>in writing</u> of a change in benefits prior to the change. • The date the Adequate notice is mailed is the date the change will be processed in NCFAST. The effective date of the change is dependent upon if the change will be a continuation, increase, reduction or termination. • An “adequate” change to a case means that there is no need per policy to give the beneficiary timely notice of the change to their Medicaid - the adequate action may take place immediately. The notification and the change may happen simultaneously. 	<ul style="list-style-type: none"> • “Timely” notification is used any time the beneficiary will either reduce in benefit or their Medicaid benefits will be terminated, except for situations noted in policy. • A “timely” change to a case means that the beneficiary must be given 10 business days’ notice prior to the action taking effect on their case. This gives the beneficiary time to dispute the action and/or request that their benefits continue until their first hearing date. • The date the change will be processed in NC FAST will be the first business day after the date the timely notice expires. The effective date of the change depends on if the change will be a reduction or termination. • During the timely notice period, the beneficiary may request a hearing and that their benefits continue until the first hearing date.
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Step 2: Determine whether notice is Adequate or Timely

Adequate DSS 8-110

- Continued coverage results in the same benefit level for the beneficiary.
- Continued coverage results in an increase in Medicaid benefit level.

Timely DSS-8110

- Continued coverage results in a reduction in Medicaid benefit level.
- Beneficiary is no longer eligible for continued Medicaid coverage (with exceptions).

Generating the DSS-8110 in NC FAST

Once all evidence has been managed, necessary verifications added, and changes applied, the case should be placed “on-hold” with the new eligibility determination.

1. **Navigate to the Eligibility Tab** on the Insurance Affordability case. This will display the new on-hold decision. Do **not** accept the hold without first reviewing the eligibility determination for accuracy.
2. **Confirm the on-hold decision** is correct, then click the List Actions Menu next to the decision.

3. **Accept the hold** either Timely or Adequately, depending on whether the beneficiary's Medicaid benefit is continuing, changing, or terminating.
4. A pop-up will appear asking if you are sure you want to accept the decision either Timely or Adequate, based on your selection. Choose the applicable answer.
5. The **Create 8110 Wizard** will appear. Enter the necessary information and click Next.
6. **Verify the information** for accuracy. If everything is correct, click Save.

Generating the DSS-8110 in NC FAST

Before creating and sending the DSS-8110, ensure you have updated and verified any necessary evidence, applied changes, and checked your eligibility determination.

1. **Navigate to the Case Details Tab** on the PDC and select the Communications folder.
2. Click on the **Page Actions Menu** and select "New Pro Forma."
3. Select the **Case Head** as the Case Participant, then click Next.
4. The **New Pro Forma Communication** screen will appear. Select **Notice** as the Type, then click Search.
5. Scroll down and click **Select** next to the appropriate DSS-8110 notice you wish to create.
6. Choose whether the notice should be **Adequate** or **Timely**, then click Next.
7. **Verify the information** for accuracy. If everything is correct, click Save.

Marking the DSS-8110 as "Sent" in NC FAST

Once the DSS-8110 is generated, it can be found in the PDC under the Case Details Tab in the Communications folder. Initially, the DSS-8110 will have a Communication Status of 'Draft-Central Print,' indicating it has been generated but not yet sent.

The caseworker has two options:

- **Leave it in Draft-Central Print:** The system will mail the notice on the next business day and update the Communication Status to "Sent-Central Print."
- **Send it manually:** The caseworker can print and mail the notice themselves, then mark it as "Sent" in NC FAST to prevent the system from sending it the next business day.

To manually mark the DSS-8110 as "Sent":

1. Click on the **List Actions Menu** for the DSS-8110 notice.
2. Click **Edit** and ensure the populated address is correct for the case head.
3. Update the **Communication Status** to "Sent."
4. Click **Save**.
5. The **Communication Status** for the notice will now show as "Sent."

Example: Removing a Household Member

A common change encountered as caseworkers is removing a household member from an active case/application.

There are several reasons we may need to remove a household member from a case.

These include but, not limited to:

- Someone moves out of the household
- Someone is deceased
- Someone is no longer required to be on the case due to age of the beneficiary and/or tax filing dependent status changes
Refer to MAGI-Removing a Person from an Insurance Affordability job aid for additional information.

Step-by-Step Instructions

1. Navigate to the applicable **Insurance Affordability** case.
2. Click the **Evidence Tab**.
3. End-date each piece of evidence for the person as appropriate:
 - Use the actual day of the month, the person left the household as the end date.
 - Evidence to end-date may include, but is not limited to:
 - Application details
 - Member relationships
 - Primary care provider – NC Medicaid Direct
 - Residency
 - Income, Deductions, Excluded Income
 - Applicant Filer Consent
 - Participant Address
 - Tax Filing Status/Tax Relationship
 - **Case only** – delete Contact Preferences (do not delete on person page)
 - Never delete the following evidence:
 - SSN Details
 - Date of Birth/Date of Death (unless the client is deceased)
 - Citizenship/DHSID Details
4. Add verifications for end-dated evidence, such as residency and income.
5. Click the **Page Actions Menu** and select **Apply Changes**.
6. Navigate to the **Participants Tab**:
 - The system may automatically end-date the individual on the Participants Tab so they no longer display on top of the Insurance Affordability. If not, do the following:
 - Click the list of actions on the Menu next to the case Member you want to end-date and select Edit.
 - Add an End date and End Reason.

- Click Save.
- 7. Click the **Eligibility Tab** and review the on-hold determination.
- 8. If the on-hold decision is correct, select **Accept with Timely** or **Accept with Adequate** as appropriate. DSS-8110 must be sent to notify the beneficiaries of any continuation, change, or termination of benefits.

Module 13-14 MAGI Processing Reviews

Key Medicaid Terms

- **Continuous Eligibility:** Once a child under 19 qualifies for full Medicaid benefits, they remain eligible for up to 12 months, regardless of changes in household composition or income. Any changes during this period are addressed at the child's recertification (or critical age review).
- **Ex-parte:** This is the process of determining Medicaid eligibility at recertification (or Change of Circumstance) using information available to the local agency. This can include electronic sources (OVS, TWN, SAVE), agency records, or third-party sources (like an employer). The ex-parte process concludes when additional information or verification is required from the beneficiary.
- **Recertification:** A comprehensive review of all eligibility factors that may change. This occurs at the end of a beneficiary's 12- or 6-month Medicaid certification period and is often referred to simply as a "Review."
- **Re-evaluation:** This involves determining future Medicaid eligibility based on current household information. Also known as "Redetermination," re-evaluations can occur during Changes of Circumstance or at Recertifications.

What is a "Recertification?"

Recertification is a comprehensive re-evaluation of all eligibility criteria that may change, such as income, deductions, and household composition. This process occurs at the end of a beneficiary's current Medicaid certification period. The caseworker assesses which program the beneficiary will qualify for in the next certification period based on their current situation, or if they will be ineligible for continued benefits.

During recertification, the caseworker must evaluate the beneficiary for all programs they might be eligible for, not just the one they are currently receiving. Recertifications are typically completed at the end of a 12-month certification period for most MAGI programs and at the end of a 6-month period for MAFM. The recertification must be completed before the end of the last month of the certification period.

Why Do We Need to Complete Recertification?

Federal regulations mandate that Medicaid eligibility be evaluated annually.

Recertifications must be completed promptly to ensure that the appropriate notice (Timely

or Adequate) can be sent and to guarantee that ongoing benefits are issued accurately and without interruption.

How Do We Complete Recertification?

Initially, the caseworker will attempt to complete the recertification via the **ex-parte** process. This involves reviewing information available to the agency to determine eligibility without requesting verification from the beneficiary. The caseworker will use electronic sources, agency records, and third-party sources. Under the ex-parte process, neither a new application nor a signed recertification is required from the beneficiary.

If the caseworker cannot determine eligibility based on the available information and needs to request verification from the beneficiary, the ex-parte process ends. The caseworker must then use the DHB-5097 form to proceed and the NCF-20020 form to obtain the necessary information/verification to determine the beneficiary's eligibility at recertification.

Recertification Reports

The caseworker must use the **MAGI Pending Recertification Details** and **Traditional Medicaid Pending Recertification Details** reports in NC FAST to ensure all cases due for recertification are completed by the last month of the certification period or that coverage is extended.

These reports list the cases in your workload with certification periods ending in the current month, next month, two months out, and three months out that require a recertification. Remember, recertifications can only be worked on two months in advance.

These reports also list overdue recertifications, meaning their certification period ended in a prior month and no recertification was completed. This can be found in the caseworker's O&M Reports in NC FAST. The caseworker should review these reports at the beginning of each month to obtain their list of cases due for recertification and begin working on the newest set of recertifications. Reports should be viewed periodically.

Timeframes

As previously stated, there is a specific timeframe for when the recertification process can be started by the case worker:

For MAGI cases:

- **MAFC/N, MICN/1, MXP, and MAFD:** The caseworker may begin the recertification process no earlier than the 10th month of the 12-month certification period.
- **MPW:** The caseworker may begin the recertification process no earlier than two months prior to the last month of the MPW postpartum period (or the last month of the certification period).

- **Auto Newborns:** The caseworker may begin the recertification process no earlier than two months prior to the last month of the Auto Newborn certification period (or the 11th month of the certification period).

Recertification Completion Timeframes

There is a specific timeframe in which recertifications must be completed:

- **Completion Deadline:** Recertifications must be completed before the end of the last month of the certification period.
- **Notice of Benefit Changes:** If benefits will decrease or terminate, the caseworker must complete the recertification and provide timely notice to the beneficiary of the reduction or termination via the DSS-8110 form no later than the timely deadline of the last month of the certification period.

It is strongly recommended that case workers begin screening their recertifications as early as possible to ensure there is enough time for any requests for information to be sent and processed, and for any required timely notices to be issued.

The recertification process starts when the recertification is marked as “in-progress” in NC FAST. It concludes when the caseworker completes the recertification in NC FAST and sends the appropriate DSS-8110 form.

Notice of Rights & Responsibilities at Recertification

In-person or telephone interviews are not required at recertification. However, the agency must provide the beneficiary with information previously given during the recertification interview, including a notice of their rights and responsibilities.

NC FAST will generate and mail the DHB-5085, “Information about your Rights and Responsibilities for Medicaid at Recertification,” on the 1st day of the 10th month of the beneficiary’s verification period.

When the case worker has in-person or phone contact with the beneficiary during the recertification process, they must explain the rights and responsibilities to the beneficiary. The caseworker must also document in the case file that the information on DHB-5085 has been explained.

Screening a Recertification Involves:

- Initiating the recertification process.
- Reviewing case and agency records for household information and any submitted verifications.
- Running electronic verifications (OVS/OLV, TWN, SAVE).
- Comparing case/agency records with electronic verifications to determine if additional verifications are needed or if eligibility can be determined.

- Sending out requests for information if needed to determine eligibility, especially if there has been a change that negatively impacts eligibility or if the available verifications suggest a reduction or termination of benefits.

Where to Start? Application vs. Recertification

Application:

- The applicant provides the agency with a statement of their current household situation (household composition, income, pregnancy, etc.) via DHB-5200 or another type of application.
- The caseworker compares this information to electronic sources and agency records to determine if additional information is needed or if eligibility can be established.

Recertification:

- There is no “base document” for the caseworker to start from.
- The agency may have had no contact with the beneficiary since their last application or recertification.
- The caseworker reviews the information in the Medicaid case and agency records to establish a starting point for re-evaluation.
- The caseworker compares this information to electronic sources.

The caseworker determines if they can complete the eligibility recertification or if additional information must be requested.

Income

New Income:

If new income starts before the recertification is completed, it is countable for the new certification period, regardless of the beneficiary’s age.

Changed Income:

If an income change occurs before the recertification is completed, the changed income is countable for the new certification period, regardless of the beneficiary’s age.

Terminated Income:

If the employment or income source terminates before the recertification is completed, the case worker will not count this information for the new certification period.

Verifications

Caseworkers are only reverifying eligibility factors that are subject to change such as:

- Income
- Household composition
- Immigration status of a Qualified Alien

IV-D Referrals/Cooperation with Child Support

If there has been a change in household composition resulting in an absent parent, or if IV-D and cooperation with child support have not been previously addressed with the beneficiary, the requirement to provide absent parent information (or Good Cause) and to cooperate with child support must be requested as part of the recertification process.

Base Periods

Base periods are the same as at application, except you should use the date the recertification was started in NC FAST instead of the application date.

- The month prior to the month the recertification was started in NC FAST.
- For income types such as self-employment or interest income that have 12-month base periods, the base period is 12 months prior to the month the recertification was started in NC FAST.

Collateral Contacts

Collateral contacts are used to support or verify necessary information to establish eligibility for a beneficiary.

- Contacts may include specific individuals, businesses, public records, or documentary evidence.
- Contacts should only be used if the recertification cannot be completed via ex-parte.
- Limit collateral contacts to those necessary to obtain the required valid information and where the beneficiary requests assistance or cannot obtain the needed information.
- If the beneficiary (or their representative) does not want the local agency to contact the necessary collateral contacts, ask them to obtain the information themselves.

How is the Requested Information Provided?

- Telephone
- Mail
- In-person
- Email/fax
- ePASS

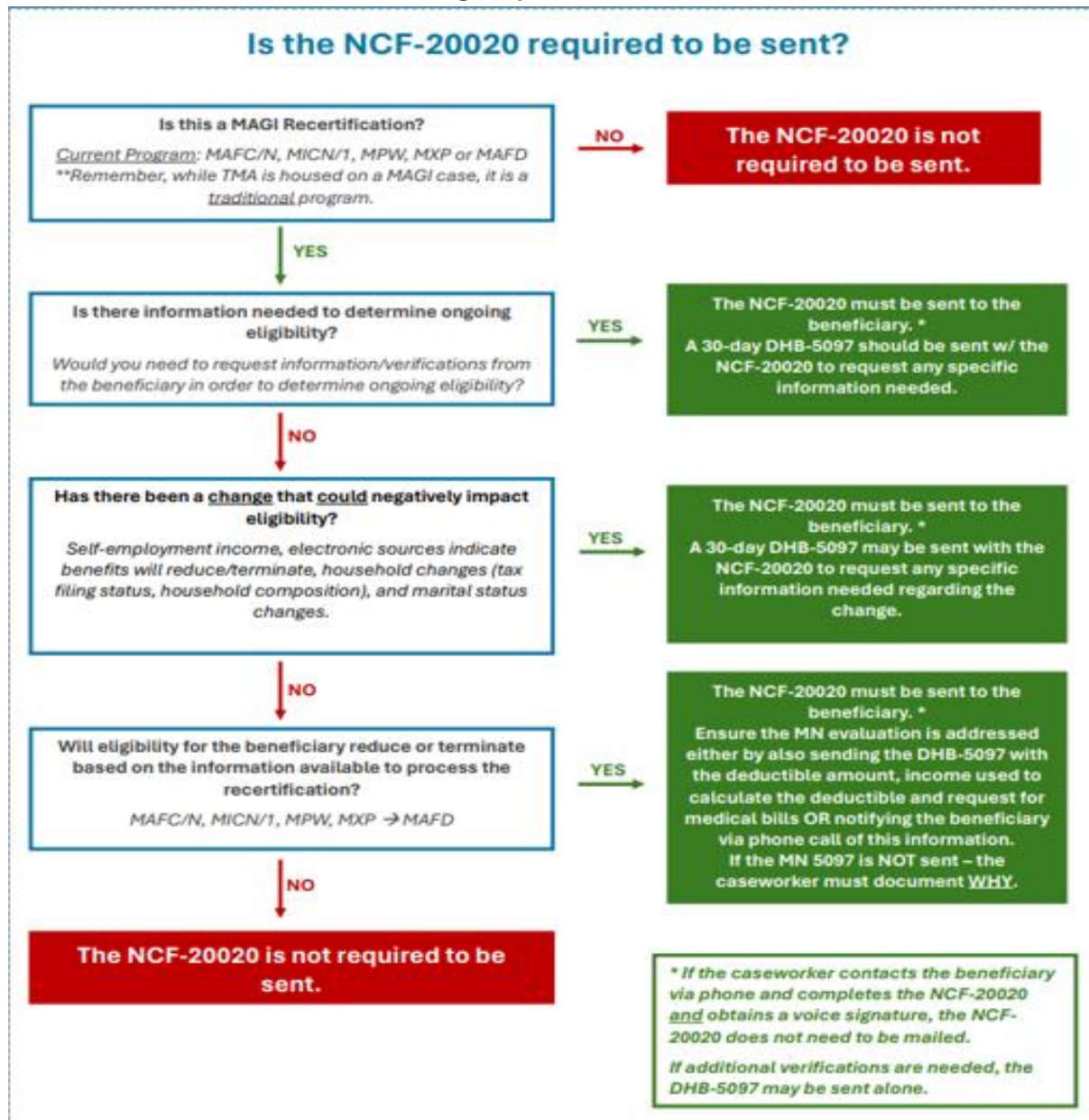
NCF-20020: Medical Assistance Renewal Notice

The NCF-20020 is a pre-populated renewal form to be used only at recertification and only for MAGI programs:

- At the end of the 12-month certification period for most MAGI programs (MAFC/N, MICN/1, MXP and MAFD),
- At the end of the post-partum period for MPW, and
- At the end of the 13-month certification period for Auto Newborn cases

The NCF-20020 is a 30-day notice used to obtain information for the beneficiary when:

1. There is an indication of a change discovered during the ex-parte process that could negatively impact eligibility of the beneficiary,
2. Continued eligibility for the beneficiary cannot be determined during the ex-parte process due to missing verification/information,
3. Eligibility for the beneficiary will decrease in benefit or terminate as a result of the information available to the agency.



The NCF-20020 must be signed in order for the agency to accept it as completed. It may be physically signed by the beneficiary, or a voice signature may be provided.

MAGI Recertification Process

Preparation:

- **Complete a case search** for the PDC due for redetermination.
- Once on the PDC, **check the case status and end-date**. The following instructions are for the timely recertification of active cases.
- **Complete a Person Page clean-up** for each and every household member on the case, not just the case head or beneficiary due for recertification.

Steps to Key:

1. **Navigate to the PDC** and click on the **Certification** tab.
2. Select the **Recertifications** folder.
3. Click on **New**.
4. **Update/check the dates** for the review and enter the **Date Received**.
5. **Update the Method** by selecting **Ex-Parte**.
6. **Check the household members** that are up for review:
 - The **Next Cert Start Date** will automatically show the first day of the month following the end of the current certification period.
 - Only select those household members currently up for recertification. Remember, you can start recertifications no earlier than the 10th month of the 12-month certification period.
7. Click **Save**. The status should now show **"In Progress."**

Review the Record

- **Review the case file and agency record** for leads to income and changes. This includes any documents received or narrative entered since the last application or review.
- Answer the following questions:
 - **WHO** is in the home?
 - **HOW** are they related?
 - **WHAT** is the tax filing/dependent status?
 - Are there **NEW** household members or income sources reported since the last determined eligibility?
 - If there are questions without answers, pursue that information to complete the recertification.

- **Review the results** of all electronic verifications for leads to income and other changes. Also, review for verifications of income.

Pursues Verifications

- Make sure there is a signed 5001, 20020, or MA application on file prior to running any household member's SSN.
- Run OVS for all beneficiaries.
- Run TWN for any individual in the home who has potential for employment
- Run SAVE for any documented immigrant who is currently up for review.
- Attempt to verify information already available to the agency.
- Request information from a third party (ex. Employer).
- Be aggressive when processing.

Do not delay requesting information because you are waiting for a response from the beneficiary.

The client's failure to return information will result in the **Product Exclusion** details (found under the Household section on the Evidence Dashboard) being entered. Instructors can discuss and demonstrate but, it is not necessary for students to complete this process on their own for this training.

Once all verifications have been received continue to these next steps.

8. Go back to the PDC → **Certification** tab → **Recertification** folder.
9. Click, the **Submit** hyperlink to submit the recertification for the beneficiary.
10. Once the recertification shows in "Submitted" status instead of "In Progress," go to the **Insurance Affordability (IA)**. Click on the **Eligibility** tab and toggle into the hold to view the changed decision.
11. The determination on hold should now show applicable decision based off of evidence entered.
12. Return back to the **Evidence** tab to bring up the **Evidence Dashboard**.
13. On the **Evidence Dashboard**, manage all evidence and enter all received verifications.
14. Once all evidence has been updated, click the **Page Actions Menu** and **Apply Changes**.
 - **NEVER** delete old evidence. Always end-date evidence that is no longer accurate to the household's current situation.
15. **Income:** Enter the "Effective Date of Change" to when you want the income to start.
 - Toggle into the current income evidence.
 - Click on the **Page Actions Menu** and chose "Edit."
 - Update Employer Name if the client is still employed but has changed employers during the certification period.

- You may also update “*Frequency*” if this has changed since the last application/review.
 - Click **Next**.
 - Once you have Added the Record, there will now show multiple Income Details. “*Remove*” the old Income Details from the last application/review.
 - Comments to reflect new income calculations.
 - Click “**Next**,” then “**Finish**” to create your updated Income evidence. Once updated, you will need to add appropriate verifications.
16. After **Applying Changes** on the IA, go to the PDC.
17. On the PDC, navigate to the **Certifications** tab and then the **Recertifications** folder.
18. Click **Submit** on the upper right corner above your pending recertifications and choose the beneficiary whose review you wish to submit.
19. Return to the IA. Go to the **Eligibility** tab and toggle into results.
20. Check the determination for accuracy.
- If the determination is *INCORRECT*, you will need to go back to the recertification on the PDC and “Reject” the recert and check/update your evidence.
21. Once you have confirmed the changed determination is correct, you will accept the hold with **Timely** or **Adequate** as appropriate.
22. Accept the changed decision triggers the DSS-8110 Wizard. Complete the DSS-8110 wizard to generate your notice for the recertification.

Module 15 Processing MAGI Ex-Parte, Review of Phases I & II

Learning Point

Explanation & Importance

The North Carolina Department of Health and Human Services (NCDHHS) uses the ex-parte process to determine Medicaid eligibility. This process involves reviewing available information without requiring additional verification from the beneficiary.

Here’s a brief overview of how it works:

Automatic Review: The caseworker attempts to verify eligibility using existing data from various sources, such as state and federal databases.

No Beneficiary Action Needed: If sufficient information is available, the beneficiary does not need to provide any additional documents.

Notification: The beneficiary is notified of the outcome. If eligibility is confirmed, Medicaid coverage continues without interruption.

Follow-Up: If the caseworker cannot verify eligibility through available data, they will contact the beneficiary for further information.

Example of the caseworker part of the process

The Process

Ex-Parte Process:

- Eligibility is determined based on available records before contacting or requesting information from the client.
- All recertifications (MAGI & Traditional) must first use electronic data sources (OVS/OLV, ACTS, Dept of Commerce, SOLQ, TWN, SAVE, active/pending FNS, and/or WFFA) and available agency records to determine continued eligibility.

Caseworker Role:

- Conduct all OVS and other electronic data matches.
- Check agency records and other available program records.
- While encouraged, it is not required to verify or clarify information with a collateral contact if verification is not available.

Step-by-Step Instructions

Processing Medical Forced Eligibility Evidence Insurance Affordability Application

Caseworker Steps:

1. **Supervisor Confirmation:** Ensure supervisors confirm the use of Medical Forced Eligibility and verify determinations and policy adherence before proceeding.
2. **Navigate to Application:** Go to the Insurance Affordability Application and click the **Evidence** tab.
3. **Check Evidence:** On the Evidence Dashboard, ensure the following evidence is present for each household member:
 - Residency (check Intent to Remain)
 - Address
 - Applicant Details
 - Birth and Death Details
 - Gender
 - SSN Details
 - Citizen Status
 - Member Relationship

- Tax Filing Status
 - Primary Care Provider-NC Medicaid Direct (if known)
 - Pregnancy (if applicable)
 - Emergency (if applicable)
 - DHSID Details (if applicable)
4. **Add Medical Forced Eligibility:** In the Household evidence section, hover over Medical Forced Eligibility evidence and click the + sign. Enter/select the evidence, program type, and reason. Add comments if necessary.
 5. **Verify Evidence:** Click the **Verifications** folder, then the **Verify** hyperlink. Select the applicable verification and case participant, then save.
 6. **Check Eligibility:** Go to the **Eligibility Checks** tab and click the **Check Eligibility** hyperlink. Ensure the correct decision is displayed.

Supervisor Steps for Processing an Insurance Affordability Application

Confirm Medical Forced Eligibility: Supervisors ensure Medical Forced Eligibility is necessary, determinations are correct, and policy is followed. Caseworkers must consult their Supervisors before authorizing the Medical Forced Eligibility Insurance Affordability Application case.

1. **Authorize Application:** From the Insurance Affordability case, click the Tab Actions Menu, then select Authorize.
2. **Select Option:** Choose to create a new case or add to an existing case.
3. **Check Status:** After the Insurance Affordability Application shows a status of Closed, click the Related Cases tab.
4. **Review Related Cases:** Click the applicable reference number hyperlink.
5. **Verify Certification:** Review and verify the Product Delivery Case certification, then click the Determinations tab.
6. **Navigate to Person Page:** Once the review is complete, go to the applicable Person page.
7. **View Benefit History:** Click the Benefit History tab on the Person page to view Benefit History.

Caseworker Steps for Processing Medical Forced Eligibility Evidence

1. **Navigate to Evidence Tab:** Go to the Insurance Affordability Case and click the Evidence tab.

2. **Add Missing Evidence:** Ensure the following evidence is present for each Household Member, and add if missing:
 - Residency (check Intent to Remain box)
 - Address
 - Applicant Details
 - Birth and Death Details
 - Gender
 - SSN Details
 - Citizen Status
 - Member Relationship
 - Tax Filing Status
 - Primary Care Provider-NC Medicaid Direct (if known)
 - Pregnancy (if applicable)
 - Emergency (if applicable)
 - DHSID Details (if applicable)
3. **Add Medical Forced Eligibility:** In the Household evidence section, hover over Medical Forced Eligibility evidence and click the + sign.
4. **Enter Evidence Details:** In the New Medical Forced Eligibility pop-up, enter/select the evidence, program type, and reason. Refer to Table 1 for Aid Program/Category/Classification types.
5. **Apply Changes:** Click the Page Actions Menu, then select Apply Changes to all evidence.
6. **Check Eligibility:** If applicable, check eligibility. Refer to the MAGI Check Eligibility on an Insurance Affordability Integrated Case How to Guide.
7. **Review Determinations:** In the Product Delivery case, click the Determinations tab to review the result.
8. **Navigate to Person Page:** Once the review is complete, go to the applicable Person page.
9. **View Benefit History:** Click the Benefit History tab on the Person page to view Benefit History.

MAGI Medical Forced Eligibility Ex-parte/Admin Recertification

1. **Add New Evidence:** Add new Forced Eligibility evidence with a Start Date one day after the End Date of the previous evidence.
2. **Apply Changes:** Click the Page Actions Menu and select Apply Changes.
3. **Review Determinations:** Navigate to the Product Delivery Case and click the Determinations tab to review the result.
4. **Verify Decision:** Ensure the decision is correct, then go to the applicable Person page.
5. **View Benefit History:** Click the Benefit History tab on the Person page to view Benefit History.

Module 16 Assessment

Congratulations!!!! You have made it through the entire class. Now it's time to assess your knowledge of the topics that you have learned over the duration of this course.

Final Checklist:

Check off each item that you are proficient in:

FNS

- ☐ Understanding the FNS application to case process
 - ☐ Utilizing the Evidence Dashboard
 - ☐ Processing and Determinations
 - ☐ Managing Forms and Notices
 - ☐ Accurate Documentation
 - ☐ Understand and Entering Changes on the Evidence Dashboard
 - ☐ Managing Recertifications
 - ☐ Forms/Notices
 - ☐ Documentation

MAGI

- ☐ Understanding the MAGI application to case process
 - ☐ Utilizing the Evidence Dashboard
 - ☐ Processing and Determinations
 - ☐ Managing Forms and Notices
 - ☐ Accurate Documentation

- ☐ Understand and Entering Changes on the Evidence Dashboard
- ☐ Managing Recertifications
- ☐ Forms/Notices
- ☐ Documentation

Assessments

- ☐ FNS/CA Level I
- ☐ MAGI Level I

Career Readiness Certification

The final assessment will evaluate your understanding of the MAGI application to case process, evidence management, entering changes, and managing recertifications.

Cited Sources

- NC FAST Phase I Training Curriculum
- NCDHHS Website [NC DHHS: North Carolina Department of Health and Human Services](#)
- Buncombe County Department of Social Services Training Curriculum
- NC FAST HELP
https://ncfasthelp.nc.gov/FN_B/FN_B/server/general/projects/FAST_Help/FAST_Help.htm