I. DEFINITION AND PURPOSE

Form H1000-B is a three-part document of "unit set" construction. The assigned case number and sequence number appear on all copies of the Form H1000-B to establish a control on the form. Carbons between the parts permit one-time entry of required information. All the parts are held together by stubs allowing the form to be separated and the carbons removed.

A. Part One, Record of Case Action, is a computer-printed, full-page sheet. It is used to:
   1. Reflect the most current information in the computer file.
   2. Serve as the local office record of the previous case action.
   3. Verify the accuracy of information entered on the previous Forms H1000-A or H1000-B.

B. Part Two, Input, is a full-page sheet used for handwritten entries during the redetermination process. It is used to:
   1. Report changes in the information stored in the computer file.
   2. Report the disposition of a redetermination.
   3. Serve as an authorization to issue, change, or cancel benefits.
   4. Furnish data for reports used by the Texas Health and Human Services Commission (HHSC), U.S. Department of Health and Human Services and the U.S. Department of Agriculture.

C. Part Three, Case Record Copy, is a full-page sheet identical to Part Two, Input. All items entered on the Input are duplicated on the Case Record Copy. It is used to:
   1. Provide a case record copy of the information submitted on the Input for audit purposes.
   2. Verify the accuracy of the information reported on the next sequence Form H1000-B.
II. REPORTING CYCLE

A. When an Input is processed:
   1. The computer file is updated.
   2. Client benefits or reports are generated.
   3. The next sequence Form H1000-B packet is returned to the submitting worker.

B. When the worker receives a Form H1000-B packet:
   1. The Record of Case Action is validated against the last sequence Case Record Copy and warning messages are reviewed.
   2. Corrections are made if necessary.
   3. The Form H1000-B packet is filed in the case record.

C. When a redetermination is made:
   1. The Form H1000-B Input and Case Record Copy are separated from the Record of Case Action. The Input is completed in red ballpoint pen.
   2. The Input is separated from the Case Record Copy, batched, and submitted to the local teleprocessing center or designated staff.
   3. The Case Record Copy is filed in the case record.

D. The cycle begins again.
III. RECORD OF CASE ACTION DETAILED INSTRUCTIONS

A. Procedure

The Form H1000-B Record of Case Action resembles the Form H1000-A/B Input. It is a copy of the most current information in the computer file, and it reflects the results of the last update. When a Form H1000-B packet is received, the Record of Case Action is used to validate the last information entered into the system and is retained as a permanent record. Note: The six-digit number to the left of Item 05 is a sequence print number for state office use only.

When an initial application or active case is denied, the turnaround document is printed on plain paper instead of the Form H1000-B, unless there is an overpayment history. This plain paper Form H1000-B cannot be used again. If the individual applies again, a new Form H1000-A set must be used.

B. Record of Case Action Entry Details

All items previously entered on the Notice of Application (NOA) or Form H1000-A Input are defined in the Form H1000-A instructions. The following are definitions specific to the Form H1000-B Record of Case Action.

Section I

ITEM 01: Case Number
9 Numeric
002345678

ITEM 03: Sequence No. (SEQ)
2 Numeric
02

Computer printed. The first time a case is certified, a case number is assigned. This number is printed on all later Forms H1000-B.

Computer printed. The chronological number of the form is printed in this space. The initial Form H1000-B from the Form H1000-A Input is always sequence "02." Only the most current sequence can be used to report information. The sequence number from the Input numbered "99" will be "02."
ITEM 05: Print Date
MM:DD:YY
01:08:9X

ITEM 18-23: See Form H1000-A instructions.

Note: Temporary address information cannot be changed by entering only the changed item(s). To change any of these items, all must be re-entered. To delete Items 18-23, enter a pound sign (#) in Item 18. Item 19 can be individually deleted with a pound sign.

ITEM 24: Residence Address
30 Alpha/Numeric
1716 Way Rd. Blum
or
QI-1

See Form H1000-A instructions for residence address (when different from mailing address) and identification of QI-1 cases.

Section II

ITEM 32: Client Number
9 Numeric
187654321

Computer printed. The client number assigned to the individual is printed in this space. If an initial application is denied, a client number is not assigned.

ITEM 37: Social Security Account Number
10 Alpha/Numeric
450:99:1234V

Computer printed. The nine-digit Social Security account number (SSN) entered by the worker is printed in this space. After the nine-digit entry, there is a space to indicate the validation of the SSN. The following codes are computer printed.

V – entered by HHSC worker.
* – validated by SSA
An asterisk indicates the SSN cannot be changed on Form H1000-B. If the worker determines that the number is incorrect, he submits Form H1270, SAVERR Data Integrity Notification, giving the correct SSN to Data Integrity Section. Data Integrity Section staff notify the worker when the number has been changed.

Note: To delete the "V," enter the SSN plus a pound sign (#). To delete an SSN that has not been validated by SSA, use zero (0).

ITEM 38: Social Security Claim Number 12 Alpha/Numeric 450:99:1234:A1

Computer printed. The Social Security claim number (SSCN) entered by the worker is printed in this space. After the claim number, a code is printed in the last position to indicate if the state is paying Medicare premiums for the individual or if the individual has private medical insurance. The following codes are used:

0 - No insurance
1 - Medicare premium paid by state
2 - Private medical insurance
3 - Private medical insurance and Medicare premium paid by state

The presence of a code 1 or 3 indicates the number has been validated by SSA and cannot be changed on Form H1000-B. If the worker determines that a validated number is incorrect, he submits a memorandum with the correct number to SMIB Unit, Data Integrity Section, State Office, Y-922. Data Integrity Section staff notify the worker when the change has been made.
Section III, Client Case Information

ITEM 40: Status in Group
6 Alpha/Numeric
1P

Computer printed. The primary/secondary status-in-group codes entered by the worker are printed in this space.

Refer to Form H1000-A instructions for code explanations, should the reported status-in-group code(s) require change or correction.

ITEM 41: ESP
Enter the level of evidence used to document citizenship:
1 – Primary Evidence of Citizenship and Identity Used
2 – Second Level of Evidence of Citizenship Used
3 – Third Level of Evidence of Citizenship Used
4 – Fourth Level of Evidence of Citizenship Used
5 – Affidavit for Citizenship Used

ITEM 46: Medical Effective Date
MM/DD/YY
11:01:94

Form H1000-B can be used to change an already existing medical effective date (MED). The revised MED cannot be more than six months earlier than the Form H1000-B current process month.

Note: If the client is MQMB or MSLMB, the existing MED cannot be corrected using Form H1000-B. Submit Form H1000-A, code 090, to add the earlier coverage.

To change a MED to a date more than six months prior to the current process month, when the type coverage changes, submit Form H1270, SAVERR Data Integrity Notification, requesting a force change.

Form H1000-A must be used to add coverage where none previously existed and the coverage is more than six months prior to the current process month completed. Use the existing client number. Use simultaneous open and close procedures outlined in Form H1000-A instructions and for situations involving Type Program 11.

In exception cases, when the coverage to be added exceeds the two-year rule (computer edits will not accept a MED that is more than two years prior to the Form H1000-B current process month), submit Form H1270, SAVERR Data Integrity Notification, requesting a force change.

Note: Do not send Form H1270, SAVERR Data Integrity Notification, to force change coverage until all Form H1000-A and 1000-B options to add earlier coverage have been used.
ITEM 50: Warning Messages
8 Alpha/Numeric
008GTNOW

Explanation of example:
Item 08 (Date Filed) is greater than current date.

006EC305

Explanation of example:
Item 06 (Budgeted Job Number) equals error code number 305.

Section IV, Adjusted Gross Income Calculations

ITEM 51: Total Earned
7 Numeric
140:65

Computer printed. This item is the sum of the entries in Column 42B, Gross Earned Income, for the eligible individual(s).

ITEM 52: Total RSDI
5 Numeric
165:00

Computer printed. This item is the sum of the entries in Column 43, Retirement, Survivors, and Disability Insurance (RSDI), for the eligible individual(s).

ITEM 53: Total VA
5 Numeric
100:10

Computer printed. This item is the sum of the entries in Column 44, VA Benefits, for the eligible individual(s).

ITEM 57: Total Income
5 Numeric
405:75

Computer printed. This item is the sum of the entries in Items 51 through 56.

ITEM 58: Deductions
6 Numeric
52:12

Computer printed on Form H1000-B. If amount has changed or this is a new entry, see Form H1000-A, Instructions.
Section V, Case Budget

This section reflects the MAO budget calculations.

MAO Unmet Need

Items 71-73A report the budget for aged, blind, or disabled individuals in non-vendor living arrangements (Base Plans 13 or 20).

**ITEM 72:** Adjusted Gross Income  
7 Numeric  
249:24  

Computer printed. This item is taken from Item 59, Adjusted Gross Income.

**ITEM 73A:** Unmet Need  
7 Numeric  
71:25  

Computer printed. This item is the result of subtracting Item 72 from Item 71.

MAO Applied Income

Items 74-77B report the applied income calculations for an aged, blind, or disabled individual living in a Title XIX facility.

**ITEM 74:** Available Income  
7 Numeric  
301:25  

Computer printed. This is the case income used to compute applied income. For the case of an individual, a couple, or companion, this item is the sum of Items 51, 52, 53, 55, and 56.

**ITEM 76:** Income for Spouse  
7 Numeric  
177:80  

When computer calculated, this item is the amount of income diverted to meet the needs of the ineligible spouse. **Note:** This item will be zero (0) when Item 73B, Spouse Total Income, is more than the spousal maximum income allowance. When worker override (SIG N) is used, this amount is the amount entered by the caseworker.
**Section VI, Simplified Nutritional Assistance Program (SNAP) Case**

SNAP only.

**Section VII, Public Assistance Withholding (PAW)**

Make no entry.
Section VIII, PA Case Information

ITEM 139: Special Review Date
07:14:97

Enter the planned date of any contact before the date of the next periodic review. A special review date may not be more than 12 months in the future.

Note: Overdue Special Review dates (due date greater than current process date) will be retained when Form H1000-B processes for a Category 1, 3, or 4 case.

Reminder: To delete Item 139, Special Review Date, enter a pound sign (#) in Item 140, Special Review Code. This entry will delete the information in Items 139 and 140.

ITEM 140: Special Review Code
1 Numeric
5

Enter the appropriate code to indicate the type of special review needed.

4 – Management
5 – Income changes anticipated
6 – Living arrangement change anticipated
7 – Medical review
8 – Household change anticipated
9 – Other
# – Delete Special Review

ITEM 141: Periodic Review Date
06:06:9X

Computer printed. This item is the computer-calculated date of the next required periodic review. The date is always 12 months from the date the worker signed the previous complete review. If incorrect, this item may be corrected.
ITEM 142: Hold Cd. Date Alpha/Numeric MM:YY

1

Enter the appropriate hold or release code. Do not enter an effective month. The effective month is computer calculated and is always the next process month (the month following the applicable cutoff date).

Worker Hold Codes:

1 – Hold, unable to locate
5 – Hold, Notice of Adverse Action expires after cutoff. Do not put a case on Hold to raise the applied income.

Worker Release Codes:

0 – Release, mail or cancel medical benefits using information on this form.

STATE OFFICE USE ONLY

Data Integrity Codes:

C – Hold, moved
D – Hold, deceased
E – Hold, unclaimed

State School Dates/ CA Date

Items 149 through 151 contain space to report two separate actions and are multipurpose.

To Report State School Dates

Items 149 through 151 are used to report the beginning and ending dates for state school coverage.

To Report CA Date

Items 149 and 150 are used to report the beginning date for CA coverage when the individual is transferred from another Medicaid program

Items 149 and 151 are used to report the ending date for CA coverage when the individual is transferred to another Medicaid program

To Report End Date When Transferring From Type Program 23

Items 149 and 151 are used to report the ending date for Type Program 23 coverage when the individual is transferring to another Medicaid program (except Type Program 24).
ITEM 149:  
Code
1 Numeric
2

Enter the code that describes the type of action reported.

1 – Nursing facility retroactive applied income
2 – State School coverage (Base Plan 16), open
3 – State School coverage (Base Plan 16), open and close
4 – State School coverage (Base Plan 16), close
5 – CA coverage, open or close
9 – Type Program 23 coverage, close

ITEM 150:  
From
MM:DD:YY
10:01:9X

To Report State School (Base Plan 16) Coverage Dates

When transferring to the state school base plan (BP 16) from any other base plan, enter the beginning date of state school coverage.

To Report CA Coverage Dates

To report the start of CA coverage, Type Program 14, Base Plan 20, enter the beginning date of CA eligibility. This date cannot be a future date, except when transferring from Type Program 24 (QMB) to CA.

For examples and more detailed information, refer to Form H1000-B, Instructions, V. INPUT MINIMUM ENTRY REQUIREMENTS, B. Special Situations, 4. Type Program/Base Plan Changes for CA MAO.

Reminder: The beginning date of new coverage cannot precede or equal the latest OPEN/CLOSE date on the SAVERR Client Eligibility file. If an overlay must be done (and the change does not result in lesser benefits), submit Form H1270, SAVERR Data Integrity Notification, requesting the force change.

Edits do not allow a future date to be entered in Item 151. This is any date including or following the current process date.

The last day of eligibility being reported cannot precede or equal the latest OPEN/CLOSE date on the SAVERR Client eligibility file. If an overlay must be done (and the change does not result in lesser benefits), submit Form H1270, SAVERR Data Integrity Notification, requesting the force change.

**To Report the Discharge from a State School (Base Plan 16)**

Enter the day before the date of discharge to report a denial because of final discharge from a state school Title XIX-approved ward. Medicaid eligibility is denied effective the date entered in Item 151. Note: Make no entry if denial is not because of discharge.

Enter the day before the date of discharge from a state school Title XIX-approved ward to report a change from the state school base plan (Base Plan 16) to any other base plan. Regular Medicaid coverage begins the day after the date entered in Item 151.

**To Report a Transfer from CA Eligibility to Another Medicaid Program**

Enter the last day of eligibility for CA. Regular Medicaid coverage begins the day after the date entered in Item 151.

For examples and more detailed information when transferring to/from CA, refer to Form H1000-B, Instructions, V. INPUT MINIMUM ENTRY REQUIREMENTS, B. Special Situations, 4. Type Program/Base Plan Changes for CA MAO.

**To Report a Transfer from Type Program 23 to Another Medicaid Program (Except Type Program 24)**

Enter the last day of eligibility for TP 23. The new program coverage begins the day after the day entered in Item 151. If the client has admitted to a nursing facility, etc., the TP 23 ending date will be the date preceding the facility admission date.
Section IX, Recoupment

Temporary Assistance for Needy Families (TANF) only.

Section X

No new items. See Form H1000-A instructions.

Section XII

This section reports the status of the case, the form effective date, and the medical review date.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Case Status</th>
<th>Computer printed. This item reflects the current status of the case.</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 Alpha</td>
<td>ACTIVE</td>
<td></td>
</tr>
<tr>
<td>ACTIVE</td>
<td>DENIED</td>
<td></td>
</tr>
<tr>
<td>HOLD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ITEM</td>
<td>Form Effective Date</td>
<td>Time: MMM/DD/YY:01:01:9X</td>
</tr>
<tr>
<td>------</td>
<td>---------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Computer printed. This item reflects the form effective date of the previously submitted Form H1000-A/B.</td>
</tr>
</tbody>
</table>

**Form H1000-B Sequence "02"**

The form effective date is the first of the month that the Input was processed.

**Form H1000-B Sequence "03" and Above**

The form effective date is the date the action reported on the previous Form H1000-B becomes effective according to computer cutoff cycles. Date specific entries in Items 46, 150 or 151 are not affected by the form effective date.

**Note:** If you are uncertain that the change initiated in Items 46, 150 or 151 has processed correctly, review the SAVERR Client Screen before taking any further action (that is, requesting a force change, etc.).

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Medical Review Date</th>
<th>Time: MMM/DD/YY:01:13:9X</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Computer printed. If a medical review is necessary, the date of the next review is printed in this space. This date should agree with the latest Form H3035. If the date is incorrect, report the correct date to Disability Determination, State Office, W-341.</td>
</tr>
</tbody>
</table>

**Section XIII**

TANF and SNAP only.

**Section XIV, Signature Block**

Worker Initials: **DD** Date: **9-12-9X** When the Record of Case Action is received, the worker edits, initials and dates the form.
IV. INPUT AND CASE RECORD COPY DETAILED INSTRUCTIONS

A. Procedure

The Form H1000-B Record of Case Action is identical to the Form H1000-A Input. The following items are duplicated from the Form H1000-B Record of Case Action to the Form H1000-B Input and Case Record Copy.

- Item 01 – Case Number
- Item 02 – Category
- Item 03 – Sequence
- Item 09 – Case Name
- Item 32 – Client Number(s)

1. Corrections or Changes to Information Previously Reported

Changes in the case information are entered on the Input in red ballpoint pen. To report a change or correction:

   a. Circle the section number where the change is entered.
   b. If a change is in Section II or III, circle the individual line indicator in the section where the change is entered.
   c. If making a correction or change, enter the complete item.
   d. If the name and the date of birth of the same individual are changed, enter the client number in Item 50, Client Number Validator.

   Note: The following items may not be changed or corrected on the Form H1000-B:

   - Item 01 – Case Number
   - Item 08 – Date Filed
   - Item 32 – Client Number
   - Item 37 – Validated Social Security Account Number*
   - Item 38 – Validated Social Security Claim Number*
   - Item 46 – Medical Effective Date over six months old*

   To report a correction or change, refer to the instructions for these individual items or to Force Changes (Form H1000-A, Special Situations, Number 6; Form H1000-B, Special Situations, Number 16) as appropriate, for those items followed by an asterisk.

2. Deletion of Information Previously Reported

To delete an SSN that has not been validated by SSA, use a zero (0).

To delete a ”V” in the tenth digit of the SSN, enter the SSN plus a pound sign (#).

To delete an SSCN that has not been validated by SSA, use a pound sign (#).

To delete Item 139, Special Review Date, enter a pound sign in Item 140, Special Review Code. This entry will delete the information in Items 139 and 140.

To delete other non-income information, enter a pound sign in the item to be removed. Do not use a pound sign as an abbreviation for number.
To delete an individual and the information about that individual in Sections II and III, enter a pound sign in Item 33, Client Name, unless the Line A individual is being deleted because of death. See Special Situations, **Death of an Individual (Active Case)**.

To delete income information, enter a zero (0) in the item to be removed.

The following items can be changed only and **never** individually deleted:

**Section I**
- Item 02 – Category
- Item 06 – Budgeted Job Number
- Item 07 – Mail Code
- Item 09 – Case Name
- Item 13 – Mailing Address, First Line
- Item 15 – City
- Item 16 – State
- Item 17 – ZIP Code
- Item 25 – County

**Section II**
- Item 32 – Client Number
- Item 33 – Client Name
- Item 34 – Birthdate
- Item 35 – Sex
- Item 36 – Race
- Item 40 – Status in Group, Primary Code
- Item 46 – Medical Effective Date

**Section V**
- Item 71 – Total Needs
- Item 75 – Personal Needs
- Item 77A – Applied Income, first client
- Item 77B – Applied Income, second client

**Note:** A change from a vendor base plan to a non-vendor base plan (or vice versa) results in automatic deletion of the old case budget information on the turnaround document Form H1000-B.
Section VIII

Item 141 – Periodic Review Date

3. Reporting New Information

Refer to Form H1000-A Input procedures and Form H1000-B Special Situations.

4. Lost or Damaged Forms

If Form H1000-B Input is lost or damaged beyond use, submit a Form H1004, Request for Form H1000-B, to obtain an updated sequence Form H1000-B packet.

B. Input Entry Details

All items on Form H1000-B Input are discussed in the Form H1000-A instructions or in the instructions for Form H1000-B, Record of Case Action. Refer to these instructions for entry details.

V. INPUT MINIMUM ENTRY REQUIREMENTS

A. Reviews, Non-Review Activities, or Denials

The following entries are required to report reviews, non-review activities, or denials for all type programs.

Section VIII, PA Case Information

Item 131 – Type Review (TR)
Item 132 – Action Code

Section XIV

Item 188 – Signature
Item 189 – Date Signed
Item 190 – Employee Number

B. Special Situations

1. Category Changes

Make the following entries to change categories:

a. Enter the new category in the right-hand box of Item 02, Category.

b. Enter Code "I," Incomplete Review, or Code "C," Complete Review, as appropriate in Item 131, Type Review.


Note: A change from Category 3 or 4 to Category 1 cannot be made unless the birth date (Item 34) reflects the age as 65 years old or older.
2. **Type Program Changes**

   Make the following entries to change the type program:
   
   a. Enter the new type program in Item 127, Type Program.
   
   b. Enter Code "I," Incomplete Review, or Code "C," Complete Review, as appropriate in Item 131, Type Review.
   
   c. Enter Code "121," Type Program Change, in Item 132, Action Code.

   **Note:** Computer edits will not allow the following program transfers using Form H1000-B Type Program 24, Base Plan 13 to Type Program 14, Base Plan 20 or to Type Program 14, Base Plan 20 with SIG B

   **Reminder:** Do not transfer from a greater benefits program to a program with lesser benefits before the first day of the month following the greater benefits end date.

3. **Base Plan Changes**

   Make the following entries to change the base plan:
   
   a. Enter the new base plan in Item 128, Base Plan.
   
   b. If the type program or the category is also changed, make appropriate entries for type program or category changes.
   

   **Note:** For Type Program 14, the base plan may not be changed to 13 unless Status-in-Group Code "F," indicating a waiver program, is reported for the individual. For Type Program 51, the base plan may not be changed to 13 unless Status-in-Group Code "J," indicating former ICF-II status (Rider 49), is reported for the individual. Type Programs 03, 18, 22, 23, and 24 must be Base Plan 13. See Item 4 for CA situations.

   **Reminder:** If Type Program 14, Base Plan 13 waiver cases are initially certified under Type Program 14, Base Plan 20, Form H1000-B is submitted transferring the case to Base Plan 13 and entering the appropriate changes/budget adjustments.
4. **Type Program/Base Plan Changes for CA MAO**

For CA cases, if the type program is changed from 14, the base plan **must** also be changed. Base Plan 20 is only permitted with Type Program 14.

**Note:** See Items 7 through 12 for situations involving QMB, MQMB, SLMB, or MSLMB on an ongoing MAO case.

To transfer a case from Type Program 14, Base Plan 20, to Type Program 14 with Base Plan 10, 15, or 16, make the following entries:

a. Enter personal needs in Item 75 and applied income in Item 77A (and 77B, if appropriate).

b. Enter the new base plan in Item 128.

c. Enter Code "I" or Code "C" as appropriate in Item 131, Type Review. Enter Code "110" in Item 132, Action Code.

d. Enter Code "5" in Item 149 and the last day of CA eligibility in Item 151. Item 151 should be the day preceding the day the individual becomes eligible for regular Medicaid coverage.

e. If the new base plan is 16, enter Code "2" on the second line in Item 149 and the date of institutional eligibility on the corresponding line in Item 150.

To transfer from Type Program 14, Base Plan 20, to a waiver program (Type Program 14, Base Plan 13), make the following entries:

a. Add the appropriate code to Item 40, Status-in-Group, Code "F."

b. Enter the new base plan in Item 128.

c. Enter Code "I" or code "C" as appropriate in Item 131, Type Review. Enter Code "110" in Item 132, Action Code.

d. Enter Code "5" in Item 149 and the last day of CA eligibility in Item 151. Item 151 should be the day preceding the day the individual becomes eligible for waiver program coverage.

To transfer a case from Type Program 14, Base Plan 20, to Type Program 03, 18, or 22 with Base Plan 13, make the following entries:

a. Enter the appropriate income limit in MAO Unmet Need.

b. Enter the new type program in Item 127.

c. Enter Base Plan 13 in Item 128.

d. Enter the amount of the exempt RSDI increase for the eligible individual(s) in Item 130 and the appropriate amount in Item 58, Deductions.

e. Enter Code "I" or Code "C" as appropriate in Item 131, Type Review. Enter Code "121" in Item 132, Action Code.

f. Enter Code "5" in Item 149 and the last day of CA eligibility in Item 151. Date cannot be a future date.
To transfer a case to Type Program 14, Base Plan 20, CA from Type Program 14, Base Plan 10, 13, or 15:

1a. Deny the active case.

1b. Open Type Program 14, Base Plan 20 benefits with Form H1000-A. Set Item 46, Medical Effective Date, as the first day of the month following the effective date of the denied case.

-or-

2a. Place case on hold:
   1. Enter Code "I" or Code "C" as appropriate in Item 131, Type Review. Enter Code "110" in Item 132, Action Code.
   2. In Item 142, Hold Code, enter "5" under the CD heading.

2b. On the first day of the Form H1000-B Hold Month:
   1. Enter Type Program 14 in Item 127 (if appropriate).
   2. Enter Base Plan 20 in Item 128.
   3. Enter Code "I" in Item 131, Type Review. Enter Code "110" (or "121" if changing the type program) in Item 132, Action Code.
   4. Enter Code "0" in Item 142, Hold Code, under CD, to release the hold.
   5. Enter Code "5" in Item 149. Enter the first day of the Form H1000-B Hold month in Item 150, as the beginning date of CA services.
   6. If transferring from a waiver program, delete waiver SIG from Item 40.
   7. Make all other necessary budget changes.

Example: Adverse Action Ending Before Cutoff

06-01-97 Form H4808 sent to transfer case from TP 14, BP 13 to TP 14, BP 20.
06-12-97 12-day-hold appeal period ends.
   Form H1000-B submitted placing case on hold effective 7-01-97 (see #2a. above).
   Note: If TP 14, BP 13 case is CBA, the hold period may be 14 days instead of 12 days.
07-01-97 Form H1000-B submitted releasing hold and transferring case to TP 14, BP 20 (see #2b. above). Item 150 = 07-01-97

Example: Adverse Action Ending After Cutoff in Current Month

06-15-97 Form H4808 sent to transfer case from TP 14, BP 10 to TP 14, BP 20. Form H1000-B submitted placing case on hold effective 07-01-97 (see #2a above). 12-day hold period ends 06-27-97 (after cutoff).
07-01-97 Form H1000-B submitted releasing hold and transferring case to TP 14/BP 20 (see #2b above). Item 150 = 07-01-97
Example: Adverse Action End Date Falling in Next Month

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-20-97</td>
<td>Form H4808 sent to transfer case from TP 14, BP 15 to TP 14, BP 20</td>
</tr>
<tr>
<td>07-02-97</td>
<td>12-day-hold appeal period ends</td>
</tr>
<tr>
<td></td>
<td>Form H1000-B submitted placing case on hold effective 08-01-97 (see #2a. above)</td>
</tr>
<tr>
<td>08-01-97</td>
<td>Form H1000-B submitted releasing hold and transferring case to TP 14, BP 20 (see #2b. above). Item 150 = 08-01-97</td>
</tr>
</tbody>
</table>

Note: In all of the above examples the client is being transferred from a full coverage Medicaid program to a program with lesser benefits. Use of either of the procedures will ensure that regular Medicaid coverage is not retroactively eliminated after benefits have been authorized (which would then require a force change to reinstate coverage dates) and will release Form H3087, Medicaid Identification, for the months prior to the change effective date when appropriate.

To transfer a case to Type Program 14, Base Plan 20, CA from Type Program 03, 18, or 22 with Base Plan 13:

1a. Deny the active case.

1b. Open Type Program 14, Base Plan 20 benefits with Form H1000-A. Set Item 46, Medical Effective Date, as the first day of the month following the effective date of the denied case.

-or-

2a. Place case on hold:
   1. Enter Code "I" or Code "C" as appropriate in Item 131, Type Review. Enter Code "110" in Item 132, Action Code.
   2. In Item 142, Hold Code, enter "5" under the CD heading.

2b. On the first day of the Form H1000-B Hold Month:
   1. Enter Type Program 14 in Item 127.
   2. Enter Base Plan 20 in Item 128.
   3. Enter zero (0) in Item 130, RSDI Increase, and in Item 58, Deductions.
   4. Enter Code "I" in Item 131, Type Review. Enter Code "110" (or "121" if changing the type program) in Item 132, Action Code.
   5. Enter Code "0" in Item 142, Hold Code, under CD, to release the hold.
   6. Enter Code "5" in Item 149. Enter the first day of the Form H1000-B Hold Month in Item 150, as the beginning date of CA services.
   7. Make all other necessary budget changes.
Example: Adverse Action Ending Before Cutoff

06-01-97  Form H4808 sent to transfer case from TP 22, BP 13 to TP 14, BP 20
06-12-97  12-day-hold appeal period ends
          Form H1000-B submitted placing case on hold effective 07-01-97 (see #2a. above)
07-01-97  Form H1000-B submitted releasing hold and transferring case to TP 14, BP 20 (see #2b. above). Item 150 = 07-01-97

Example: Adverse Action Ending After Cutoff in Current Month

06-15-97  Form H4808 sent to transfer case from TP 18, BP 13 to TP 14, BP 20. Form H1000-B submitted placing case on hold effective 07-01-97 (see #2a above). 12-day hold appeal period ends 06-27-97 (after cutoff).
07-01-97  Form H1000-B submitted releasing hold and transferring case to TP 14, BP 20 (see #2b above). Item 150 = 07-01-97

Example: Adverse Action End Date Falling in Next Month

06-20-97  Form H4808 sent to transfer case from TP 03, BP 13 to TP 14, BP 20
07-02-97  12-day-hold appeal period ends
          Form H1000-B submitted placing case on hold effective 08-01-97 (see #2a. above)
08-01-97  Form H1000-B submitted releasing hold and transferring case to TP 14, BP 20 (see #2b. above). Item 150 = 08-01-97

Note: In all of the above examples the client is being transferred from a full coverage Medicaid program to a program with lesser benefits. Use of either of the procedures will ensure that regular Medicaid coverage is not retroactively eliminated after benefits have been authorized (which would then require a force change to reinstate coverage dates) and will release Form H3087, Medicaid Identification, for the months prior to the change effective date when appropriate.

5. Active CA Case with Suspended SSI Eligibility

When SSI eligibility is reported in suspense for an active CA case on the RG-03, Client File Referral Report, the worker must deny CA eligibility.

Active CA cases with suspended SSI eligibility are monitored by Data Integrity Section, State Office. When Form H1000-B denial action has processed, Data Integrity Section corrects the SAVERR eligibility file to show regular Medicaid coverage beginning the effective date of SSI eligibility.

If the worker discovers the client's SSI eligibility (and suspense status) prior to receipt of an RG-03, the denial of CA is initiated. The worker then notifies Data Integrity Section of the termination of CA due to SSI eligibility. Data Integrity Section will correct the SAVERR eligibility file to show regular Medicaid coverage beginning the effective date of the SSI eligibility. The following information should be provided to Data Integrity Section:

- Client name
- Client number
- CA end date
- SSI BEGIN date
6. **Reporting State School Coverage**

   Items 149 through 151 are used to report the beginning and ending dates for state school coverage (Base Plan 16). Entries are required in these items when the following actions are taken:

   a. A change from any other base plan to a state school base plan (16) – Enter Code 2 in Item 149 and the beginning date of state school coverage in Item 150. Note: This date cannot precede the current medical effective date.

   **Example:** An individual is discharged from an ICF-MR facility on 10-15-9X and enters a state school on the same day.

   The following Form H1000-B entries are made:
   
   Item 128 – Base Plan (16)  
   Item 131 – Type Review ("I" or "C" as appropriate)  
   Item 132 – Action Code (110)  
   Item 149 – Code (2)  
   Item 150 – From (10159X)

   b. A change from a state school base plan (16) to any other base plan – Enter Code 4 in Item 149 and the day before the date of discharge from the state school in Item 151.

   **Example:** An individual is discharged from a state school on 11-10-9X and enters an ICF-MR facility on the same day.

   The following Form H1000-B entries are made:
   
   Item 128 – Base Plan (15)  
   Item 131 – Type Review ("I" or "C" as appropriate)  
   Item 132 – Action Code (110)  
   Item 149 – Code (4)  
   Item 151 – Thru (11099X)

   c. Denial of a state school case (Base Plan 16) because of a final discharge from the state school – Enter Code 4 in Item 149 and the day before the discharge date in Item 151.

   **Example:** An individual in a state school is discharged on 12-4-9X to reside with his parents.

   The following entries are made:
   
   Item 132 – Action Code (092)  
   Item 149 – Code (4)  
   Item 151 – Thru (12039X)

   In addition, these items may be used to add a prior closed period of state school coverage. Enter Code 3 in Item 149, the beginning date of state school coverage in Item 150, and the last day of state school coverage in Item 151. **Note:** A closed retroactive period of state school coverage can only be added as a new period of eligibility and also requires a change in the medical effective date. If a correction is needed to show state school coverage during an earlier period for which medical eligibility has already been established, report the situation via submission of Form H1270, SAVERR Data Integrity Notification. Data Integrity Section staff will adjust the individual's medical history file to show the correct dates of prior state school coverage.
7. **Adding or Deleting QMB or SLMB on an Ongoing MAO Case**

   A change from dual MAO/QMB or MAO/SLMB eligibility to regular MAO eligibility (without QMB or SLMB) and vice versa is done by deleting or adding the secondary SIG codes Q or B and entering Action Code 121 in Item 132.

   For type program transfers of MQMB to or from MSLMB, see Item 12.

   **Reminder:** The effective date for a program change is governed by Form H1000-B process date with respect to cutoff. To report correct information that cannot be processed because of computer edits, see Item 16, Force Changes.

8. **Type Program/Base Plan Changes for SLMB or QI-1 MAO (Type Program 23)**

   For TP 23 cases (SLMB or QI-1), if the type program is changed, the base plan may also be changed. Only Base Plan 13 is permitted with Type Program 23. A Social Security Claim Number, Item 38, must always be entered on TP 23 cases. Entries in Items 149 and 151 are required on all transfers out of TP 23.

   Do not use Code B with the following type programs:
   - 03, 11, 12, 18 – eligible individuals automatically are enrolled in Buy-In
   - 11 – no Buy-In for SSI three-months-prior
   - 22 – cannot be entitled to Medicare
   - 23 – SLMB only, no regular Medicaid
   - 24 – QMB (income below minimum SLMB limit)
   - 30 – cannot be dually eligible for SLMB

   A person is not eligible for SLMB coverage if the person is:
   - in the custody of penal authorities; or
   - over 20 years of age and under 65 years of age and resides in an institution for mental diseases (IMD).

   **Note:** Persons age 65 or older residing in an IMD may be certified for SLMB, if all eligibility criteria are met. Persons of any age residing in state supported living centers may be certified for SLMB, if all eligibility criteria are met.

   SLMB ongoing and prior coverage is available for ICF/MR and state supported living center residents. SAVERR edits will allow Status-in-Group Code B for any TP14 and no misspent funds will occur.

   Things to consider when needing Status-in-Group Code B due to zero applied income or co-payment:
   - §1915(c) Waiver Program
   - Spousal budget
   - Withholding Vendor Payment
Appendix II – Form H1000-B MAO Instructions

Item 131 – Type Review ("I" or "C" as appropriate)
Item 132 – Action Code (121)
Item 149 – Enter Code "9" to close TP 23 coverage (except when transfer is to TP 24)
Item 151 – Enter the last day of TP 23 coverage. This will usually be the day before admission date to nursing facility, ICF-MR group home, or state school.

To transfer a case from SLMB to QI-1, make the following Form H1000-B entries:

Item 24 – Residence Address (enter QI-1)
Item 43 – RSDI (Enter "bogus" RSDI amount for current calendar year. Delete all other income sources.)
Item 131 – Type Review ("I" or "C" as appropriate)
Item 132 – Action Code (110)
Form H3081 – Submit completed form to state office reporting QI eligibility information

To transfer a case from QI-1 to SLMB, make the following Form H1000-B entries:

Item 24 – Residence Address (enter # to delete QI-1 entry)
Item 43 – RSDI (Enter actual RSDI amount, as well as any other income amounts the client may have in the appropriate Item areas.)
Item 131 – Type Review ("I" or "C" as appropriate)
Item 132 – Action Code (110)

Note: When transferring to/from SLMB and QI-1, do not hold Form H1000-B for the 12-day adverse action/appeal period. The client's benefits are not changing. The program transfer represents a change in the funding source for the Medicare Part B premium, not the benefit itself.

To transfer a case from QI-1 to Type Program 14, Base Plan 20, make the following Form H1000-B entries:

Item 24 – Residence Address (enter # to delete QI-1 entry)
Item 40 – Secondary Status-In-Group (SIG) enter "B" if CA coverage will be opened with a retroactive date. This will ensure that QI-1 benefits are retained through the adverse action end date (as shown on Form H4808) and will retain an accurate QI-1 Buy-In tracking record. Note: When Form H1000-B turnaround is received, delete SIG B if the client is not SLMB eligible.
Item 43 – RSDI (Enter actual RSDI amount, as well as any other income amounts the client may have in the appropriate Item areas.)
Item 127 – Type Program (14)
Item 128 – Base Plan (20)
Item 131 – Type Review ("I" or "C" as appropriate)
Item 132 – Action Code (121)
Item 149 – (First Line) Enter code "9" to end TP 23
Item 151 – Enter the day before new coverage is to begin (day before CA services begin)
Item 149 – (Second Line) Enter code "5" to start CA
Item 150 – Enter the day CA services are to begin

To transfer from any MAO program to QI-2, deny Form H1000-B using code 099. Complete Form H3081, QI Transaction Report, and submit to state office for manual processing of QI-2 benefits.
9. Medicaid-Specified Low-Income Medicare Beneficiaries (MSLMB)

Certain clients eligible for Medicaid may also qualify for SLMB.

MAO cases in Categories 1, 3 and 4, who may be dually eligible for MAO and SLMB (MSLMB) are:

- Type Program 14, Base Plan 20 – frail elderly CA
- Type Program 14, Base Plan 13 (SIG F) and Type Program 19 (SIG E/non-SIG E) – certain community-based waivers
- Type Program 51 (SIG J) – Formerly ICF-II status (Rider 49)
- Category 2 (TANF), TP 40 and 55 (see Medicaid Eligibility for the Elderly and People with Disabilities Handbook, Item 3330)

Type Programs 03, 11, 12, 13, 18, 23, 24 and 30 cannot be dually eligible for SLMB. Status-in-Group Code "B" is not allowed with these Type Programs. See Item 40 of Form H1000-A instructions.

Form H1000-B (Adding SLMB to an Ongoing MAO Case)

The effective date for MSLMB at a re-determination is governed by the Form H1000-B process date with respect to cutoff. Adding prior coverage for SLMB cannot be done on Form H1000-B. On redeterminations, prior SLMB coverage can only be done by sending Form H1270, SAVERR Data Integrity Notification, requesting a force change on the SAVERR eligibility file to add SLMB coverage (up to three months).

When an MSLMB case is being transferred to MQMB, see Item 12.

Form H1000-A (Certifying an MSLMB)

A prior period of up to three months for SLMB coverage can be added on Form H1000-A (Item 129, Grant Effective Date). The Grant Effective Date cannot be prior to Item 46, Medical Effective Date, of the MAO/SLMB case. When only SLMB coverage is needed, do not send a force change request to Data Integrity Section. Instead, a second Form H1000-A must be used to report SLMB coverage (as a TP 23) for the prior period using action code 090.

Reminder: The medical effective date on applications for CA/SLMB that are eligible for three-months-prior SLMB coverage can be the same for CA and the SLMB effective date. This will avoid the need to complete two Forms H1000-A for the client to receive all benefits to which the client is entitled.
10. **Type Program/Base Plan Changes for QMB-MAO (Type Program 24)**

For QMB (Type Program 24) cases, if the type program is changed, the base plan may also be changed. Only Base Plan 13 is permitted with Type Program 24. A Social Security Claim Number in Item 38 must always be entered on TP 24 cases.

**Note:** The effective date of the new type program and medical identification change is governed by the Form H1000-B process date with respect to cutoff. Computer edits will not process to overlay coverage back to or preceding the open date of a QMB time period.

a. To transfer a case from Type Program 24, Base Plan 13, to Type Program 14, Base Plan 10, 13, 15, or 16, make the following Form H1000-B entries:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 40</td>
<td>Secondary Status-in-Group Code (Q) if dually eligible as MQMB for BP 10, 13, or 15. Secondary SIG &quot;Q&quot; is not allowed with BP 16, unless the client does not have enough income to pay their own premium amount.</td>
</tr>
<tr>
<td>Item 58</td>
<td>Zero out deduction</td>
</tr>
<tr>
<td>Item 75</td>
<td>Personal Needs</td>
</tr>
<tr>
<td>Item 77A</td>
<td>Applied Income, first client</td>
</tr>
<tr>
<td>Item 77B</td>
<td>Applied Income, second client, if appropriate</td>
</tr>
<tr>
<td>Item 127</td>
<td>Type Program (14)</td>
</tr>
<tr>
<td>Item 128</td>
<td>Base Plan (10, 13, 15, or 16)</td>
</tr>
<tr>
<td>Item 131</td>
<td>Type Review (&quot;I&quot; or &quot;C&quot; as appropriate)</td>
</tr>
<tr>
<td>Item 132</td>
<td>Action Code (121)</td>
</tr>
</tbody>
</table>

**Reminder:** Prepare Form H1270, SAVERR Data Integrity Notification, when the client transfers from a nonvendor program to TP 14/BP 10 because SAVERR processing edits do not permit entry of the correct effective dates of vendor coverage and applied income amounts for periods prior to Form H1000-B program transfer effective date. **If only an applied income adjustment is to be processed,** prepare Form H1259, Correction of Applied Income (The Amount You Pay to the Facility).

b. To transfer a Type Program 24, Base Plan 13, to a Type Program 14, Base Plan 20, make the following Form H1000-B entries:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 40</td>
<td>Status-in-Group (SIG) &quot;Q,&quot; if eligible</td>
</tr>
<tr>
<td>Item 58</td>
<td>Zero out deductions</td>
</tr>
<tr>
<td>Item 59</td>
<td>Enter client's total income (Items 51 thru 56)</td>
</tr>
<tr>
<td>Item 71</td>
<td>Enter the current institutional income limit for SIG 1 or 1, 2 cases or for SIG 1, 3 cases</td>
</tr>
<tr>
<td>Item 73B</td>
<td>Spouse Total Income - SIG 1, 2 cases</td>
</tr>
<tr>
<td>Item 127</td>
<td>Type Program (14)</td>
</tr>
<tr>
<td>Item 128</td>
<td>Base Plan (20)</td>
</tr>
<tr>
<td>Item 131</td>
<td>Type Review (&quot;I&quot; or &quot;C,&quot; as appropriate)</td>
</tr>
<tr>
<td>Item 132</td>
<td>Action Code (121)</td>
</tr>
<tr>
<td>Item 149</td>
<td>Code (5) CA coverage, open</td>
</tr>
<tr>
<td>Item 150</td>
<td>MM:DD:YY, to report the beginning date of CA eligibility</td>
</tr>
</tbody>
</table>
**Example:** An active TP 24 with a medical effective date of 11-01-9X, becomes eligible for TP 14Q, BP 20. Worker completes program transfer on 12-17-9X. Worker enters a Code 5 in Item 149 and enters 11:01:9X (same as MED for TP 24) in Item 150. The Form H1000-B turnaround indicates that the CA coverage processed to be effective 11-01-9X, but it did not because the edits will not process to overlay coverage back to or preceding the open date of a QMB time period. The SAVERR Client Eligibility screen shows that TP 14Q (BP 20) coverage actually begins 12-01-9X. A force change request must be sent to Data Integrity Section to correct the beginning date.

11. **Medicaid-Qualified Medicare Beneficiaries (MQMB)**

   Certain clients eligible for Medicaid may also qualify for QMB. MAO cases in Categories 1, 2, 3, and 4, who may be dually eligible for MAO and QMB (MQMB) are:

   Type Program 03, Base Plan 13,
   Type Program 14, Base Plan 10, 15
   Type Program 14, Base Plan 13
   Type Program 14, Base Plan 20
   Type Program 18
   Type Program 19
   Category 2 (TANF), TP 40 and 55 (see *Medicaid Eligibility for the Elderly and People with Disabilities Handbook*, Item 3330)

   The effective date of the new type program change is governed by the Form H1000-B process date with respect to cutoff.

   **Note:** Type Programs 11, 22, 23, 24 or 30 are not allowed if there is a SIG "Q" in Item 40.

12. **Transfers Involving Changes in Benefit Programs and MQMB/MSLMB**

   For Type Programs requiring entries in Items 149, 150, and 151, the **Thru** date (Item 151) will also end the coverage for QMB or SLMB. Transfers of primary coverage programs with MQMB to MSLMB - or - from MSLMB to MQMB require special processing to ensure no gap occurs between coverage types (QMB/SLMB). To process a MQMB/MSLMB transfer in these situations:

   a. Do not change Item 40, Status in Group, codes.
   b. Enter new Type Program (Item 127) and new Base Plan (Item 128), if appropriate.
   c. Enter Code "I" or "C," as appropriate, in Item 131, Type Review. Enter "121" or "110," as appropriate, in Item 132, Action Code.
   d. Make any necessary entries in Items 149 - 151, any appropriate budget changes for the new type program, and submit Form H1000-B for processing.
   e. When Form H1000-B turnaround is received, make the appropriate change to Item 40, Status in Group.
Example: To transfer TP 14B/BP 20 to TP 19Q/BP 13, make the following Form H1000-B entries:

Item 40 – Make no change. Retain "1B" code.
Item 127 – 19
Item 128 – 13
Item 131 – "I" or "C"
Item 132 – 121
Item 149 – 5
Item 151 – MMDDYY (Thru date for CA coverage)

When Form H1000-B turnaround is received, make the following entries:

Item 40 – 1Q
Item 131 – "I"
Item 132 – 110

This procedure ensures that MSLMB transitions smoothly to MQMB with no gap in coverage months. If not followed, the transition month will not reflect either the SLMB or QMB benefit. A force change would then be required to reinstate the appropriate coverage.

For situations when a TP 14, BP 10Q client leaves the nursing home and the TP 14/BP 10 (Medicaid) coverage needs to be denied, but QMB coverage needs to be continued under TP 24 and adverse action expires after cutoff but before the end of the month, the following procedures should be followed to prevent an additional month of Medicaid benefits:

Send Form H4808, put the case on hold to deny TP 14/10 (Medicaid) coverage the end of the month. During the adverse action period, file a new NOA. After Form H1000-B is processed to deny the TP 14/BP 10Q case at the end of the month, process From 1000-A to continue the QMB effective the first of the next month to provide continuous QMB benefits. The review date needs to be updated on the Form H1000-B turnaround to prevent the review exceeding the 12-month requirement.

Note: Processing Form H1000-A before the seventh calendar day of the month prevents problems with buy-in. Submitting Form H1000-A by the third working day of the month will assure that Form H1000-A processes before the seventh calendar day of the month.

Example: Adverse Action Ending After Cutoff in Current Month But Before End of Month

04-16-01 Form H4808 sent to deny 14/10 and transfer case from 14/10Q to QMB. Form H1000-B submitted placing case on hold effective 5-1-01. File new NOA. (Hint: Putting a statement on Form H4808 that the QMB ID may be delayed is good casework practice, but is not a requirement.)

04-28-01 12-day hold period ends (after cutoff). Form H1000-B submitted to deny the 14/10Q case effective 4-30-01.

04-28-01 After Form H1000-B denial processes, submit the new Form H1000-A for TP 24 only with MED of 5-1-01.

With receipt of the Form H1000-B turnaround for the TP 24, update the review date to prevent the review exceeding the 12-month requirement.
For situations when a TP 14/BP 10B client (such as in a spousal case) leaves the nursing home and the TP 14/BP 10 (Medicaid) coverage needs to be denied, but the SLMB coverage needs to be continued under TP 23 and adverse action expires after cutoff but before the end of the month, the following procedures should be followed to prevent an additional month of Medicaid benefits:

Send Form H4808, put the case on hold to deny the TP 14/10 (Medicaid) coverage at the end of the month. During the adverse action period, file a new NOA. After Form H1000-B is processed to deny the 14/10B case at the end of the month, process Form H1000-A to continue the SLMB effective the first of next month to provide continuous SLMB benefits. The review date needs to be updated on the Form H1000-B turnaround to prevent the review exceeding the 12-month requirement.

Note: Processing Form H1000-A before the seventh calendar day of the month prevents problems with buy-in. Submitting Form H1000-A by the third working day of the month will assure that Form H1000-A processes before the seventh calendar day of the month.

Example: Adverse Action Ending After Cutoff in Current Month But Before End of Month

04-16-01 Form H4808 sent to deny 14/10 (Medicaid) and transfer case from 14/10B to SLMB. Form H1000-B submitted placing case on hold effective 5-1-01. File new NOA.

04-28-01 12-day hold appeal period ends (after cutoff). Form H1000-B submitted to deny the 14/10B case effective 4-30-01.

05-01-01 After the Form H1000-B denial processes, submit the new Form H1000-A for TP 23 only with MED of 05-1-01.

With receipt of the Form H1000-B turnaround for the TP 23, update the review date to prevent the review exceeding the 12-month requirement.

13. Three-Months-Prior Medicaid Eligibility

There are several situations when three-months-prior Medicaid eligibility may need to be added to an existing case using Form H1000-A or Form H1000-B:

a. When the case is currently active and the coverage is for one, two, or three months before the medical effective date on file (continuous coverage) and the revised MED is not more than six months earlier than the Form H1000-B current process month.

b. When the case is currently active and the coverage is for a period of time other than the one, two, or three months before the medical effective date on file (gap in coverage).

c. When an active case has been denied, but a period of prior eligibility must be reported.

d. When any of the above situations exist and prior non-CA MAO coverage must be reported before CA MAO coverage.
Continuous Coverage

In situation 13(a), one three-months-prior eligibility period may be added to the active case by submitting the Form H1000-B Input. The following entries must be made:

1. Enter the new medical effective date in Item 46.
2. Enter the number of months of prior eligibility in Item 133.
3. Enter the three-months-prior application date in Item 134. This date is the same as the date filed shown in Item 08.
4. Enter Code 110 in Item 132.
6. If the individual was in a state school for any part of the covered period, complete Items 149 through 151.
7. Sign and date the form.

Reminder: If the three-months-prior eligibility period precedes the current process month by more than six months, use simultaneous open and close procedures outlined in Form H1000-A instructions.

Note: If more than one prior period must be reported, use the following procedures.

Gap in Coverage and Denied Cases

For situations 13(b), (c), and (d) and to report any additional periods of prior eligibility, Form H1000-B may not be used. A Form H1000-A must be completed. Use the existing client number. Use simultaneous open and close procedures outlined in the Form H1000-A instructions.

Note: The worker must ensure that the period of eligibility reported is not included in part or in whole in existing coverage.

14. Death of an Individual (Active Case)

If an individual dies, use the following procedure:

a. Re-enter the original Status-in-Group code(s) plus Status-in-Group Code "X" in Item 40, Status in Group.
b. Enter the individual's date of death in Item 47, Death/Denial Date.
c. Enter the appropriate type review in Item 131, Type Review.
e. If the Base Plan is 16, enter the individual's date of death in Item 151.

15. Hold Procedures

To put a case on hold or to release a case from hold:

a. Enter Code "C," "I," or "N," as appropriate, in Item 131, Review Date.
c. Enter the appropriate code in the first part of Item 142:

- Code 1  – Unable to locate
- Code 5  – Notice of Adverse Action expires after cutoff but before the end of the current calendar month
- Code 0  – Release Hold

Do **not** enter a date in the second part of Item 142.

Do not put a case on hold to raise the applied income.

To deny a case on hold:

a. Enter the last day of eligibility in Item 47, Death/Denial Date (may be as early as the day before first day of hold effective month).

**Note:** Item 47 must be the last day of a month unless denial is because of death or because of the discharge of an individual from a public institution.

b. Enter Code "C" or "I," as appropriate, in Item 131, Type Review.

c. Enter the appropriate denial code in Item 132, Action Code.

16. **Force Changes**

To report correct Form H1000-A/B information that **cannot be processed because of computer edits**, use the following procedure:

a. Review coverage dates shown on the SAVERR Client eligibility file (to determine if the coverage is already reflected) prior to initiating a force change request.

b. Prepare Form H1270, SAVERR Data Integrity Notification, explaining what information needs to be changed. The notice should detail the circumstances that require processing of information that will not pass regular computer edits.

c. Send completed Form H1270 to Data Integrity Section.

Force change requests to Data Integrity Section must not include requests to **delete**, or **change to lesser coverage**, an established benefit for which the client has already received Form H3087, Medical Care Identification, and/or received other benefits. To do so would adversely affect claims payment for services provided under coverage existing prior to the change.

**Reminder:** Data Integrity Section can change existing coverage, but cannot add coverage for a period where none exists.

**Use Form H1000-A to add needed coverage whenever possible.** The coverage will be reflected on SAVERR almost immediately, providing the client with faster access to the added benefits. Data Integrity Section can then complete appropriate force change requests much more efficiently. The above situations are not all inclusive. Should a question arise as to whether a force change request is appropriate, contact Data Integrity Section for assistance.
DO NOT request a force change when one of the following situations occur:

- Add retroactive TP 24 coverage. Example: TP 24 client has MED of 6-1-97. On 9-1-97 it is determined that continuous coverage should have been given back to 1-1-97. Worker completes Form H1000-A with Item 08, File Date = current date; Item 46, Medical Effective Date = 01-01-97; Item 47, Death/Denial Date = 05-31-97; and Item 132, Action Code = 090. Worker changes Item 08, File Date, to 12-XX-96 and Item 189, Signature Date = 12-XX-96 (any date in the month preceding the MED month). Reminder: Changing Item 08, File Date, at the point of certification on Form H1000-A to an earlier date will not cause a case delinquency.

- Add retroactive coverage months that will precede the MED month (and dates are greater than six months preceding the current month). Similar to example above. Enter appropriate dates in Form H1000-A Items 46 and 47.

- To transfer a waiver client from Type Program 14, Base Plan 10 or 20 to Type Program 14, Base Plan 13 - or - to transfer from Type Program 14, Base Plan 13 to another type program/base plan. Use Form H1000-B to complete the program transfer.

- Retroactive correction of type program and/or base plan when the recipient is being transferred from a greater coverage program to a lesser coverage program. Example: TP 14/BP 10 client discharges from nursing facility to return home on 5-15-97 and CA services begin 5-16-97. Form H1000-B is submitted transferring from TP 14/BP 10 to TP 14/BP 20 effective 7-1-97, after all program transfer steps have been followed (see 4. Type Program/Base Plan Changes for CA MAO). Do not request force change of coverage from TP 14/BP 10 to TP 14/BP 20 for any part of May or June. The client remains eligible for Medicaid covered services from 5-15-97 through 6-30-97 and any force change of coverage would cause payment of these claims to reject.

- Requested coverage is already reflected on SAVERR (see a. above).

- To retroactively change the type program/base plan when a Category 2 Medicaid client enters a nursing facility. For a Category 2 "R" covered client admitted to a nursing facility who also has a valid medical necessity and Form H3618/3619 admission recorded, SAS/CMS will allow vendor payment and unlimited prescriptions. If the nursing facility stay is temporary and the client returns home before he is removed from the Category 2 case, enter the client's applied income amount in SAS for the month(s) of facility residence. If the nursing facility stay is long term, certify the client for TP 14/BP 10 effective the day after the Category 2 coverage has ended. Enter the client's appropriate applied income amount in SAS for the nursing facility residence months that the client was active Category 2.

DO request a force change when one of the following situations occurs:

- Coverage to be added is for a period over 24 months prior to Form H1000-B current process date. If any portion of the coverage to be added is within 24 months, use Form H1000-A. Request Data Integrity assistance only for the months over 24 months prior to Form H1000-A.
• QMB recipient becomes eligible for SSI. A force change request would correct the TP 13 OPEN date to coincide with the SSI BEGIN Date (after the TP 24 case was closed), not to precede the TP 24 MED. **Example:** TP 24 client is certified effective 2-1-97. He is certified for TP 13 on 6-1-97 with an SSI begin date of 5-1-97. TP 24 is denied effective 6-30-97. TP 13Q begins 7-1-97. **Force change is requested to reflect TP 13Q to begin 5-1-97.**

**Note:** This is also applicable when an SLMB or CA client becomes eligible for SSI. A force change request would correct the TP 13 OPEN date to coincide with the SSI BEGIN date (after the TP 23 or CA case was closed), not to precede the MAO MED. In CA situations, Form H2067 is sent to the appropriate CCAD worker with notification that the MAO case has been closed and SSI benefits released from SUSPENSE.

• When a community-based MAO client is transferred to a TP 14/BP 13 waiver program and waiver services have been authorized/received before the program transfer effective date (Form H1000-B processing effective date), Form H1270 is used to request that the TP 14/BP 13 coverage be made retroactive to the date that waiver services were first authorized/received. Form H1270 should be annotated as "PRIORIT." DCU staff will make every effort to process these requests as quickly as possible to ensure minimal delay in provider payments. **Note:** A force change is not necessary when transferring to or from TP 14/BP 10 and TP 14/BP 13. When transferring to TP 14/BP 13 from TP 14/BP 15, "D" coverage, complete the "Other Corrections" section of Form H1270 requesting that the **coverage code be changed to "R"** as of the date the client was authorized to begin receiving waiver services.

• QMB recipient would have been eligible for a regular Medicaid coverage type program except for excess resources. When resources have been reduced, the case is transferred to the new type program effective as of the Form H1000-B process date. A force change would request regular Medicaid coverage backed up to the month the recipient first became resource eligible for the new type program. **Example:** Client is eligible for TP 03, except for excess resources. He does meet QMB eligibility and is certified for TP 24 effective 3-1-97. Resources are reduced as of 12:01 a.m. 6-1-97 and type program is changed to TP 03 effective 8-1-97. **Force change is requested to reflect TP 03 begin date as 6-1-97.**

• When an incorrect date of death has been reported on a deceased individual. **Example:** Client's date of death is reported on Form H1000-B as 02-12-97. It is later determined that the correct date of death is 01-12-97. **Force change is requested to reflect 01-12-97 as the date of death/denial.** This insures that the Medicaid insurance premium for this individual (and possibly the Medicare premium) are not erroneously paid for any month(s) following the date of death.

• If the actual date of death was later than that reported on Form H1000-B, use a new Form H1000-A to add the needed days. **Example:** Client's date of death is reported on Form H1000-B as 02-12-97. It is later determined that the correct date of death is 02-24-97. **Use Form H1000-A to report additional days:** Item 08, File Date, will be a February date; Item 46, MED = 02-13-97; Item 47, Death/Denial Date = 02-24-97. **If the client was also MQMB/MSLMB eligible during this added period,** request a force change to reinstate the "Q."
• Any community-based recipient entering a nursing facility/ICF-MR group home/state school and later returning home before a program transfer can be completed on Form H1000-B. Once facility eligibility criteria was met, a force change request would cover facility admission date through the facility discharge date. **Example:** CA client enters nursing facility on 4-15-97 and discharges home 5-20-97. ME specialist had not initiated a program transfer to TP 14/BP 10 prior to the discharge. **Force change is requested to reflect TP 14/BP 10 from 4-15-97 through 5-20-97.**