Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
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Eligibility Operations Memo 09-05
April 1, 2009

TO: MassHealth Eligibility Operations Staff

FROM: Russ Kulp, Director, MassHealth Operations

RE: **Prepopulated Eligibility Review Form**

Introduction

Federal regulations require that MassHealth conducts annual eligibility reviews. To support this requirement and help members with the annual review process, MassHealth is providing, to selected households, an Eligibility Review Form (ERV) that is "prepopulated" with the most recent household information. The implementation of this new ERV — the Prepopulated ERV (PPE) — is outlined in this memo.

Prepopulated ERV Overview

The Prepopulated ERV (PPE) is designed to provide a member with the household information that is currently on MA21. The member will have the opportunity to review the existing information and make corrections as needed. In addition, the PPE will allow a member to report any new information about their household. A household selected for the PPE process will get the PPE in place of a blank ERV.

The PPE will include information on all members who are still active in the household, whether they are open, closed, or pending. Active members are those who **do not** have a family group number of 00. Households with multiple family groups or with a head of household (HOH) not coded as "self 1" will be excluded from selection for the PPE process.

The pilot for the PPE will select Commonwealth Care-households only.

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Prepopulated ERV Format

The member's address that will be printed on the PPE is the residential address. The other fields on the PPE that will be prepopulated are

- **HOH event** — Head of Household and Other Family Members;
- **EIN event** — earned income records under Current Working Income section;
- **UIN and REN events** — unearned income records under the Current Nonworking Income section, including rental income;
- **HIN event** — health insurance records under Current Health Insurance section, including private health insurance and Medicare; and
- **DDU event** — members under the Injury, Illness, or Disability section (only those members who are already disabled).

Under the Proof of Citizenship/National Status and Identity section, only those family members who are citizens will be listed. The following will be prepopulated in the Proofs We Need column:

- **Citizenship** — if proof of citizenship is needed;
- **Identity** — if proof of identity is needed;
- **Citizenship an Identity** — if proof of both citizenship and identity is needed;
- **None** — if no proof of citizenship and identity is needed.

In any section that contains social security numbers, only the last four digits will be printed and the other digits will be replaced by Xs. At this time, health insurance claim numbers cannot be truncated.

PPE Mailing

In addition to the PPE form, the mailing will include the following forms:

- Eligibility Representative Designation (ERD);
- Affidavit of Parent or Guardian on Identity of Child under Age 16; and
- UNIV-5 (Babel).

A sample PPE is attached. Only the sections that could be prepopulated have been reproduced for this example. An actual PPE also contains the entire ERV form, including the sections that will not be prepopulated, such as the cover sheet and instructions.

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MEC Responsibilities

Starting in March 2009, MA21 will generate the new PPEs and send them to Commonwealth Care-only households. For the initial pilot, the PPEs will be processed at the Taunton MassHealth Enrollment Center (MEC).

When the PPE is received at the MEC, staff will record the receipt in MA21 for processing. This action will reactivate the eligibility time for the Commonwealth Care member.

PPEs are to be processed following the current procedures for processing ERVs.

Questions

If you have any questions about this memo, please have your MEC designee contact the Policy Hotline.

Sample of Prepopulated Areas on the PPE

A. Head of Household and Other Family Members:

Head of Household

1. Name: **REVIEW, JOHN**
SSN: **XXX-XX-1234** Date of birth: **05/01/1955**

Street: **1 MAIN STREET**
City: **BOSTON**
State: **MA** Zip: **02111**
Phone #:(Home/Cell) **617-222-3333** (Work) **617-333-4444**
Does this person want benefits? ( )Yes ( )No

Enter address and phone # below if different
Home address
Street: ____________________________ City: ________________________
State: ___ Zip: ________ Phone #: (Home/Cell) _________ (Work): __________
Mailing address (if different from home address or living in a shelter)
Street: ____________________________ City: ________________________
State: ___ Zip: ________ ( ) Homeless

Other Family Members

2. Name: **REVIEW, WIFE**
SSN: **XXX-XX-3456** Date of birth: **05/01/1948**
Relationship to head of household: **SPOUSE**
Is this person still living in this household? ( )Yes ( )No
Does this person want benefits? ( )Yes ( )No

3. Name: **REVIEW, DAUGHTER**
SSN: **XXX-XX-7890** Date of birth: **05/15/1999**
Relationship to head of household: **CHILD**
Is this person still living in this household? ( )Yes ( )No
Does this person want benefits? ( )Yes ( )No

4. Name: **REVIEW, SON**
SSN: **XXX-XX-1234** Date of birth: **05/15/1997**
Relationship to head of household: **CHILD**
Is this person still living in this household? ( )Yes ( )No
Does this person want benefits? ( )Yes ( )No

B. Proof of Citizenship/National Status and Identity:

Proof of Citizenship/National Status and Identity

Federal law requires us to get proof of U.S. citizenship/national status and identity for all individuals applying or having their eligibility reviewed for benefits who claim to be U.S. citizens/nationals. You have to give us this proof only once. If you have not given us these proofs before, please see the insert that came with this notice for complete information about acceptable proofs of U.S. citizenship/national status and identity. The insert also provides exceptions for those individuals who may not have to provide this proof.

Below is a list of the family members we have on file who claim to be U.S. citizens/nationals. The information we need for each family member is listed under "Proofs We Need." If we already have this information, or we do not need proofs at this time, "none" will be listed.

Name	Date of Birth	SSN	Proofs We Need
REVIEW, WIFE	**05/01/1955**	**XXX-XX-1234**	**Citizenship and Identity**
REVIEW, CHILD	**05/01/1955**	**XXX-XX-1235**	**Identity**

C. Current Working Income:

Current Working Income

Please review the current income we have on file and answer the questions (Yes or No).

If you are still working, please send proof of income, like a copy of two recent pay stubs. If self-employed, see the MassHealth Member Booklet for more information about the needed proof.

1. Name of person working: **REVIEW, JOHN**
   Employer name: **BANK OF AMERICA**
   Employer address: **100 MAIN ST**
   City: **BOSTON** State: **MA** Zip: **02111**

   Do you still work at this job? ( )Yes ( )No
   If **yes**, number of hours per week? ____ Weekly pay before deductions: $ ______
   Is health insurance offered that would cover doctors' visits and hospitalizations? ( )Yes ( )No

If you answered **no** to the above question, was health insurance offered in the last six months? ( )Yes ( )No

D. Current Nonworking Income (including rental income):

Current Nonworking Income

Please review the current nonworking income we have on file and answer the questions (Yes or No). Send proof of this income if you still get this income. You do not have to send proof of social security or SSI income.

1. Name of person: **REVIEW, JOHN** Type of income: **PENSION**
   Monthly amount: $**400.00** **Do you still get this income? ( )Yes ( )No**
   If amount has changed, monthly amount before taxes: $__________

2. Name of person: **REVIEW, WIFE** Type of income: **PENSION**
   Monthly amount: $**300.00** **Do you still get this income? ( )Yes ( )No**
   If amount has changed, monthly amount before taxes: $__________

3. Name of person: **REVIEW, WIFE** Type of income: **RENTAL**
   Property address: **1100 MAIN ST BOSTON MA 02111**
   Net monthly amount: $**300.00** **Do you still get this income? ( )Yes ( )No**
   If amount has changed, net monthly amount: $__________

E. Proof Current Health Insurance:

Current Health Insurance

Please review the current health-insurance information we have on file and answer the questions (Yes or No).

1. Policyholder name: **REVIEW, JOHN** Policy number: **1235453456**
   Insurance company name: **BLUE CROSS BLUE SHIELD**

   Policyholder contribution to premium: $**100.00** Frequency: **MONTHLY**
   Names of covered family members:
   REVIEW, JOHN **REVIEW, WIFE**
   REVIEW, DAUGHTER **REVIEW, SON**

   Are you or any of your family members still covered under this health insurance? ( )Yes ( )No If **no**, what date did it end? ___/___/___

F. Injury, Illness, or Disability:

Injury, Illness, or Disability

Our records indicate that the following members have already been determined disabled:

REVIEW, JOHN **XXX-XX-1234**
REVIEW, WIFE **XXX-XX-3456**