Human Resources Administration
Department of Social Services

OFFICE OF POLICY, PROCEDURES, AND TRAINING

James K. Whelan, Executive Deputy Commissioner

Stephen Fisher, Assistant Deputy Commissioner
Office of Procedures

POLICY DIRECTIVE #18-06-EMP

(This Policy Directive Replaces PD #18-01-EMP)

MEDICAID PLAN OF SELF SUPPORT FOR SAFETY NET PARTICIPANTS WITH SPECIAL NEEDS

Date:	**SubTopic:**
March 22, 2018	Medicaid Plan of Self Support

AUDIENCE

The instructions in this policy directive are for staff at the Union Square Job Center, Residential Treatment Service Center (RTSC), Substance Abuse Service Center (SASC), and informational for all other staff.

REVISIONS TO THE PRIOR DIRECTIVE

This policy directive is being revised to inform staff that:

- Any references to the Tracking and Review Unit (TRU) have been removed.
- The Substance Abuse and Service Center (SASC) Unit encompasses the services previously provided by the Tracking and Review Unit (TRU).
- Information on the Outpatient Treatment Programs (OTP) and Comprehensive Services Model (CSM) vendors were added.
- Any references to the Residential Treatment Centers have been updated to the Residential Treatment Programs (RTP).
- The Medicaid Plan of Self Support (MA/PSS) application can be faxed to the Residential Treatment Service Center (RTSC), as long as the original application is to follow.
- The FIA Transmittal to MAP and MAP Response to FIA (**MAP-649P**) form was updated.

POLICY

The MA/PSS allows Medicaid coverage to continue for one year after a CA case is closed due to employment

The Medicaid Plan of Self Support (MA/PSS) enables childless Safety Net Assistance (SNA) participants with special needs, who become ineligible for continued Cash Assistance (CA) because their earned income is sufficient to meet their needs, to continue ongoing medical, mental health or substance abuse treatment. The medical assistance can continue for up to one year after a SNA special needs case is closed due to earned income.

BACKGROUND

The goal of MA/PSS is to offer participants whose employment income is at a level high enough to close their CA case an incentive to retain and improve their job opportunities. MA/PSS enables employed single individuals and childless couples to meet their medical costs for one year while they locate jobs that offer them adequate health insurance. All participants served by the Family Independence Administration's (FIA) Special Needs Region or HIV/AIDS Services Administration (HASA) are eligible for MA/PSS.

Eligibility Requirements

In order to be eligible for the MA Plan of Self Support, the participant must:

- be serviced by HRA's Special Needs Region or by HASA;
- not meet the Social Security Administration criteria for Social Security Disability (SSD) or Supplemental Security Income (SSI);
- report his/her employment income to the treatment program and HRA within ten (10) days of receiving his/her first paycheck;
- be ineligible for continued Cash Assistance (CA case closed) as a result of employment earnings;
- have a documented need for continued medical, mental health, or substance abuse treatment, that is not covered by the individual's employer or any other provided medical insurance;
- comply with all medical, mental health, or substance abuse treatment services.

REQUIRED ACTION

Where is the Plan Initiated?

Revised

The MA Plan of Self Support application process can be initiated at the:

- Residential Treatment Programs (RTP);
- Outpatient Treatment Programs (OTP);
- Comprehensive Services Model (CSM) vendors; or
- Substance Abuse Service Center (SASC).

Applying at RTP

The MA/PSS Application Process for Individuals in Residential Treatment Programs (RTP)

The RTP staff will:

- discuss the MA Plan of Self Support (MA/PSS) with the participant, and if he/she wishes to participate, request a MA Plan of Self Support Package from the Residential Treatment Service Center (RTSC).

The MA Plan of Self Support Package

The package contains the:

- Plan of Self Support (**M-696a**),
- Plan of Self Support Agreement for Medicaid (**M-696b**),
- Third Party Data Sheet (**LDSS-4198**).

Refer to PD #01-04

- complete the Plan of Self Support (**M-696a**) form;
- have the participant complete the Plan of Self Support Agreement for Medicaid (**M-696b**) form. It must be signed by the participant and a program designee;
- complete a Third Party Data Sheet (**LDSS-4198**), if there is an employer sponsored health plan;
- forward the entire package, by messenger, to the RTSC for processing. The MA/PSS application should be the original document, but it can also be faxed, as long as the original MA/PSS application is to follow.

Revised

The Residential Treatment Service Center (RTSC)

RTSC Actions Once MA/PSS is Received

When the RTSC receives the MA Plan of Self Support (MA/PSS), the JOS/Worker will:

- enter action code **203M** (application for MA/PSS received) in NYCWAY;
- enter the **FIA3A** in NYCWAY (unless it has already been entered), which will automatically re-budget the case;
- forward the MA/PSS package to the SASC Unit, if the case is no longer eligible for CA due to employment.

Applying at OTP/CSM Vendors

The MA/PSS Application Process for Individuals Serviced by Outpatient Treatment Programs (OTP) or Comprehensive Services Model (CSM) Vendors

Revised

The MA Plan of Self Support (MA/PSS) application process for participants in outpatient treatment programs or those receiving assistance from CSM vendors mirrors the process for individuals in Residential Treatment Programs (RTP), except that:

Revised

- the MA/PSS package is completed by the participant and a Worker from the outpatient treatment program or CSM vendor;
- the MA/PSS package is forwarded directly to the SASC Unit, instead of to the RTSC (see section on the SASC Unit, below); and
- the SASC Unit enters the **FIA3A** in NYCWAY.

Responsibilities of SASC Unit

Substance Abuse Service Center (SASC) Unit

Revised

The SASC Unit will review the MA/PSS to ensure that all requisite paperwork is complete and:

- verify that the CA case is closed, and if so, determine if it is due to employment income;
- enter action code **203M** (application for MA/PSS received) in NYCWAY to indicate receipt of the MA/PSS application, followed by action code **203S** (application for MA/PSS approved), if the MA/PSS application was approved.

  Note: In order for the MA/PSS application to be considered for approval, the participant cannot earn more than the minimum wage for a 40 hour work week, and cannot be in receipt of medical insurance through his/her employer.

Refer to PB#16-97-EMP

- forward the MA/PSS package, along with the FIA Transmittal to MAP and MAP Response to FIA (**MAP-649P**) form, to the Separate Determination Unit at MAP to process the participant's MA-only case.

Denial of MA/PSS	If the SASC Unit determines that the participant is ineligible for the MA/PSS, they will: • notify the worker at the treatment program or CSM vendor who initiated the request by phone or email, and indicate the reason for denial at the bottom portion of the **M-696a**. • advise the worker at the treatment program or CSM vendor that the participant may re-apply once the eligibility issue is resolved.
Continuance of MA/PSS If Treatment is Completed	If the treatment program or CSM vendor notifies the SASC Unit that the participant no longer requires treatment, the MA/PSS will continue until the 12-month period expires, thus ensuring the ability of the participant to obtain substance abuse treatment in case of a relapse.

PROGRAM IMPLICATIONS

Paperless Office System (POS) Implications	JOS/Workers can: • access NYCWAY to make required changes by using the WMS plug  ; • enter Third Party Health Insurance (TPHI) information in the "Wages, Salary, Including Overtime; Commissions, Training Programs, Tips?" drop-down on the Income window; • print out the **LDSS-4198** in the Print Forms window; • scan the completed **LDSS-4198** into the electronic case record; • scan the signed **M-696b** into the electronic case record; and • scan all non-POS generated forms and notices, signed by the participant, into the electronic case record.
Supplemental Nutrition Assistance Program (SNAP) Implications	Employed participants in outpatient substance abuse treatment or Residential Treatment Centers will have their earned income budgeted to determine continued eligibility for SNAP.
Medicaid Implications	Eligible participants who continue to comply with the MA Plan of Self Support (MA/PSS) requirements will continue to receive Medicaid for a period of not more than 12 months.

LIMITED ENGLISH PROFICIENT (LEP) AND DEAF/HARD-OF-HEARING IMPLICATIONS

Staff must obtain appropriate interpretation services for individuals who are Limited English Proficient (LEP) or deaf or hard-of-hearing. Please refer to PD #16-14-OPE and PD #17-19-OPE for detailed instructions.

FAIR HEARING IMPLICATIONS

Avoidance/ Resolution

Ensure that all case actions are processed in accordance with current procedures and that the electronic case files are kept up to date. Remember that applicants/participants must receive either adequate or timely and adequate notification of all actions taken on their case.

Conferences at Job Centers

An applicant/participant can request and receive a conference with a Fair Hearing and Conference (FH&C) AJOS/Supervisor I at any time. If an applicant/participant comes to the Job Center requesting a conference, the Receptionist must alert the FH&C Unit that the individual is waiting to be seen. In Model Offices, the Receptionist at Main Reception will issue an FH&C ticket to the individual to route him/her to the FH&C Unit and does not need to verbally alert the FH&C Unit staff.

The FH&C AJOS/Supervisor I will listen to and evaluate any material presented by the applicant/participant, review the case file and discuss the issue(s) with the JOS/Worker responsible for the case and/or the JOS/Worker's Supervisor. The AJOS/Supervisor I will explain the reason for the Agency's action(s) to the applicant/participant.

If the determination is that the applicant/participant has presented good cause for the infraction or that the outstanding Notice of Intent (NOI) needs to be withdrawn for other reasons, the FH&C AJOS/Supervisor I will Settle in Conference (SIC), post Action Code **820** (Good Cause Granted) or **820H** (Good Cause Granted for Wellness, Comprehensive Assessment, Rehabilitation and Employment [WECARE] infractions), refer the applicant/participant back to the JOS/Worker by posting Action Code **10FH** or **16FH** (for referrals back to WeCARE), and enter detailed case notes in New York City Work, Accountability and You (NYCWAY). The AJOS/Supervisor I will forward all verifying documentation submitted by the applicant/participant to the appropriate JOS/Worker for corrective action to be taken.

In addition, if the adverse case action still shows on the "Pending" (**08**) screen in WMS, the AJOS/Supervisor I must prepare and submit a Fair Hearing/Case Update Data Entry Form (**LDSS-3722**), change the **02** to **01** if the case has been granted Aid to Continue (ATC), or prepare and submit a PA Recoupment Data Entry Form – WMS (**LDSS-3573**) to delete a recoupment. The AJOS/Supervisor I must complete a Conference Report (**M-186a**).

If the participant fails to show good cause for the infraction or if it is determined that the Agency's action(s) should stand, the AJOS/Supervisor I will explain to the applicant/participant why he/she cannot SIC. The AJOS/Supervisor I must complete Form **M-186a**.

Should the applicant/participant elect to continue his/her appeal by requesting a Fair Hearing or proceeding to a hearing already requested, the FH&C AJOS/Supervisor I is responsible for ensuring that further appeal is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Conferences at NCA SNAP Centers

If an applicant/participant comes to the NCA SNAP Center and requests a conference, the Receptionist must alert the Center Director's designee that the applicant/participant is to be seen. If the applicant/participant contacts the Eligibility Specialist directly, advise the applicant/participant to call the Center Director's designee.
In Model Offices, the Receptionist at Main Reception will issue an SNAP Conf/Appt/Problem ticket to the applicant/participant to route him/her to the NCA SNAP Reception area and does not need to verbally alert the Site Manager. The SNAP Receptionist will alert the Center Director once the applicant/participant is called to the NCA/SNAP Reception desk.

The Center Director's designee will listen to and evaluate the applicant's/participant's complaint regarding the case closing. The applicant/participant must provide current verification of address to resolve the issue. After reviewing the documentation, case record, and discussing the issue with the Group Supervisor/Eligibility Specialist, the Center Director's designee will decide to resolve or defend the case based on all factors and whether the case was closed correctly.

The Center Director's designee is responsible for ensuring that further appeal by the applicant/participant through a Fair Hearing request is properly controlled and that appropriate follow-up action is taken in all phases of the Fair Hearing process.

Evidence Packets	All Evidence Packets must contain a detailed history (e.g., copies of POS "Case Comments" and/or NYCWAY "Case Notes," History Sheet [**W-25**]), copies of relevant WMS screen printouts, notices sent, and other documentation relevant to the action taken.

REFERENCES

18 NYCRR 352.20
GIS 05 MA/015
Social Services Law 165

RELATED ITEMS

PB #16-97-EMP
PD #01-04
PD #15-10-ELI

ATTACHMENTS

Please use Print on Demand to obtain copies of forms.

LDSS-4198	Third Party Data Sheet (Rev. 08/06)
M-696a	Plan of Self Support (Rev. 2/14/18)
M-696b	Plan of Self-Support Agreement for Medicaid (Rev. 2/14/18)
M-696b (S)	Plan of Self-Support Agreement for Medicaid (Spanish) (Rev. 2/14/18)
MAP-649P	FIA Transmittal to MAP and MAP Response to FIA (Rev. 2/26/18)

LDSS-4198 (8/06)

Policy Sequence #

☐ APPLICATION ☐ ENROLLMENT
☐ RECERTIFICATION ☐ TERMINATION

THIRD PARTY DATA SHEET

SECTION I: CLIENT IDENTIFICATION INFORMATION

CASE NAME (Last)	First	MI	CASE NUMBER

*CIN	RECIPIENT'S LAST NAME	F I	*REL

RELATIONSHIP TO POLICYHOLDER

REL CODE	DESCRIPTION
1	SELF
2	SPOUSE
3	CHILD
4	OTHER
5	CUSTODIAL CHILD
6	STEPCHILD
7	IV-D CHILD
8	IV-D SPOUSE

SECTION II: ESSENTIAL INSURANCE INFORMATION

INSURANCE COMPANY NAME

GOOD CAUSE

BEGIN	END
M M / D D / Y Y Y Y	M M / D D / Y Y Y Y

CLAIMING ADDRESS OF INSURANCE COMPANY	CITY	STATE	ZIP CODE

*INS. CD	**POLICY NUMBER	COVERAGE *BEGIN	COVERAGE END
		M M / D D / Y Y Y Y	M M / D D / Y Y Y Y

GROUP NO.	*Medicare HMO IND Y	*Medicare HMO IND N	EMPLOYER ID	BENEFIT PKG

***Coverage (at least one must be checked)**

☐ 01 – COMP MED A	☐ 09 – NURSING HM	☐ 17 – SUB AB INP
☐ 02 – COMP MED B	☐ 10 – DRUG RECOVERY	☐ 18 – SUB AB OUT
☐ 03 – INPATIENT	☐ 11 – DRUG MAJOR MED	☐ 19 – PSCH INPAT
☐ 04 – HOME HLTH	☐ 12 – DRUG COPAY	☐ 20 – PSCH OUT
☐ 05 – EMRG ROOM	☐ 13 – DME	☐ 21 – XRAY
☐ 06 – CLINIC	☐ 14 – TRANSP	☐ 22 – HOSPICE
☐ 07 – PHYS HOSP	☐ 15 – DENTAL	
☐ 08 – PHYS OFFIC	☐ 16 – OPTICAL	

POLICY SOURCE

- ☐ A. COBRA Premiums Only
- ☐ B. AIDS Program
- ☐ C. LDSS Pays Carrier
- ☐ D. LDSS Pays Employer
- ☐ E. LDSS Reimburses Client
- ☐ F. IV-D Court Ordered
- ☐ G. Absent Parent Voluntary
- ☐ H. Employment
- ☐ I. Union
- ☐ J. Fraternal Organization
- ☐ K. Tuition Fee
- ☐ L. Private Pay
- ☐ M. Accident (Not Workers Comp Related)
- ☐ N. Other
- ☐ O. Military Service
- ☐ P. Workers Compensation
- ☐ Q. Retirement Benefit
- ☐ Not Applicable

*POLICY HOLDER'S NAME First	Last	*SEX	**SSN

POLICYHOLDER'S ADDRESS	CITY	STATE	ZIP CODE

COMMENTS:

CASE NO.

CASE NAME

SECTION III: PREPARER INFORMATION

ELIGIBILITY WORKER	DATE	TPR WORKER	DATE

*Required Fields

**Either policy number or SSN is required

Department of Social Services
Human Resources Administration
Department of Homeless Services
Family Independence Administration
M-696a (E) 02/14/2018

Plan of Self Support

PARTICIPANT INFORMATION *Check which type of Plan of Self* MA ☐ CA ☐

Participant's Name	Social Security Number	Case Number

Address *(include house no.,street, apt. no., city, state, zip code)*

EMPLOYMENT INFORMATION FIA 3A attached Yes ☐ No ☐

Employer's Name
Employer's Address

Date Employment Began
Date Income Reported to HRA
Salary $

Please check box indicating how often income is received:
Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other ☐

HEALTH INSURANCE INFORMATION Does the participant have private health insurance? No ☐ Yes ☐ **If yes, a completed LDSS-4198 must be attached.**

Name of Carrier: _____

Does participant pay a premium? No ☐ Yes ☐ If yes, how much? $ _____ How often? _____

Is there a co-payment required? No ☐ Yes ☐ If yes, how much? $ _____ How often? _____

Does the insurance cover participant's medical needs? Yes ☐ No ☐ If no, explain: _____

MEDICAL/TREATMENT INFORMATION

Diagnosis:		**Treatment Needs:**	
Prognosis:		**Health Care Providers:**	

ALCOHOL/SUBSTANCE ABUSE TREATMENT Enrolled in treatment? Yes ☐ No ☐ Residential ☐ or Outpatient ☐

Program Name	HRA Code	Date of Admission	Expected Date of Discharge

Address	If the participant will require more than four additional months of treatment, please explain below

JUSTIFICATION FOR PLAN OF SELF SUPPORT

☐ Medical Expenses (explain): _____

☐ Employment Related Expense (explain): _____

☐ Housing Expenses (explain): _____

☐ Other Expenses (explain): _____

Recommended by:

Name (print) _____ Title _____ Agency _____

Signature _____ Date _____

(HRA use only)

CIN: _____ **Date CA Closed Employment:** _____ **Closing Code** _____

☐ **APPROVED** Participant request approved for the period of _____ to _____

☐ **DISAPPROVED**

☐ No Employment Information ☐ Participant not on CA (explain): _____

☐ No Medical Documentation ☐ Does not meet eligibility criteria (explain): _____

Name (print) **Signature** **Title** **Date**

Case Number: _____

Case Name: _____

Plan of Self-Support Agreement for Medicaid

I, _____, request approval to participate in the
Last Name, First Name (Print)

Human Resources Administration's (HRA) Plan of Self-Support.

I understand that the goal of the Plan of Self-Support is to eliminate or reduce my future need for Cash Assistance or Medicaid benefits. The plan provides the opportunity to continue my Medicaid benefits for up to one year, so I may continue to receive the medical services required to maintain employment. I understand that HRA is not required to enter into a Plan of Self-Support. Failure to comply with the objectives of the Plan of Self-Support may affect my eligibility for continued receipt of Medicaid benefits.

As a condition of participation in HRA's Plan of Self-Support, I agree:

- To continue in and comply with all medical/rehabilitation services that are being reimbursed by Medicaid pursuant to the Plan of Self-Support, if applicable.
- To continue in and comply with my substance abuse treatment as described in the Plan of Self-Support, if applicable.
- To notify HRA within 10 days of any change(s) that may affect my eligibility for medical assistance, including, but not limited to, changes in my address, employment income and compliance with treatment.

I have read and understand this plan and agree to abide by the above conditions. Failure to abide by these conditions could result in being terminated from this plan, which would affect continued eligibility for extended Medicaid benefits.

_____
Participant's Signature

(Turn page)

Do you have a medical or mental health condition or disability? Does this condition make it hard for you to understand this notice or to do what this notice is asking? Does this condition make it hard for you to get other services at HRA? **We can help you.** Call us at 212-331-4640. You can also ask for help when you visit an HRA office. You have a right to ask for this kind of help under the law.

For Staff Only:

_____
Print Name of Individual Recommending Plan of Self-Support

_____ _____
Signature of Individual Recommending Plan of Self-Support Date

Title: _____

Agency Name: _____

Address: _____

_____

Telephone Number: _____

Fax Number: _____

Número del Caso: _____

Nombre del Caso: _____

Plan de Acuerdo de Independencia Económica para Medicaid

Yo, _____, solicito aprobación para participar
Apellido, Nombre (En letra de molde)
en el plan de Independencia Económica de la Administración de Recursos Humanos (HRA).

Entiendo que la meta de este Plan de Independencia Económica es eliminar o reducir mi necesidad futura de Asistencia en Efectivo o beneficios de Medicaid. El plan me brinda la oportunidad de continuar recibiendo Medicaid hasta por un año, para que yo pueda continuar recibiendo los servicios médicos necesarios para mantener empleo. Entiendo que la HRA no está obligada a participar en un Plan de Independencia Económica. El no cumplir con los objetivos del Plan de Independencia Económica puede afectar mi elegibilidad para continuar recibiendo beneficios de Medicaid.

Como condición de participación en el Plan de Independencia Económica de la HRA, yo acuerdo:

- si corresponde, continuar y cumplir con todos los servicios médicos/de rehabilitación a ser reembolsados por Medicaid, conforme al Plan de Independencia Económica.
- si corresponde, continuar y cumplir con mi tratamiento de abuso de sustancias como se indica en el Plan de Independencia Económica.
- notificar a la HRA dentro de 10 días de cualquier cambio(s) que puedan afectar mi elegibilidad para asistencia médica, incluyendo, sin limitarse a, cambios en mi dirección, ingreso salarial y cumplimiento de tratamiento.

He leído y entiendo este plan y acuerdo acatar las condiciones antedichas. El no acatar estas condiciones puede resultar en la terminación de este plan, lo cual afectaría mi elegibilidad continua de Medicaid extendido.

_____
Firma del Participante

(Voltee la página)

¿Padece usted una discapacidad o afección médica o psiquiátrica? ¿Le dificulta la misma entender o cumplir este aviso? ¿Le dificulta la afección recibir otros servicios de la HRA? **Nosotros podemos prestarle ayuda**. Llámenos al 212-331-4640. Usted también puede pedir asistencia al visitar las oficinas de la HRA. Conforme a la ley, usted tiene el derecho de solicitar este tipo de ayuda.

Sólo para el personal:

_____

Firma de la persona quien recomienda el Plan de Independencia Económica

_____ _____

Firma de la persona quien recomienda el Plan de Independencia Económica — Fecha

Cargo: _____

Nombre de la Agencia: _____

Dirección: _____

_____

Número de Teléfono: _____

Número de Fax: _____

FIA Transmittal to MAP and MAP Response to FIA

NYC Human Resources Administration
Department of Social Services

MAP-649p 02/26/2018

From: Substance Abuse Service Center (SASC) Unit
109 East 16th Street – 4th Floor
New York, NY 10003
929-252-6363 Fax: 212-835-7218

To: Separate Determination Unit
505 Clermont Avenue – 5th Floor
Attn: Unit Supervisor
Fax: 718-636-7799

No.	NAME OF CLIENT	CASE #	ABEL	DSS-4198	Enroll Date	MAP RESPONSE		
						REACTIVATION		NOT REACTIVATED State Reason
						FROM	TO	
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

FIA Worker Date

MAP Worker Date