

### State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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MEDICAID COMMUNICATION NO. 16-01 DATE: February 4, 2016

**TO:** County Welfare Agency Directors

**SUBJECT:** Self-Attestation Process for NJ FamilyCare ABD Eligibility

**Update to Medicaid Communication 13-02** 

To streamline the financial eligibility process for individuals in need of long term services and supports, the New Jersey Medicaid Comprehensive Waiver permits those who have income that is equal to or below 100% of the Federal Poverty Level (FPL) to self-attest that assets or resources have not been transferred, in lieu of the five year look-back process. This policy change was originally established in 2013 through Medicaid Communication 13-02 titled Addendum to PA-1G Medicaid Application – Transfer of Assets Self-Attestation Form.

The Transfer of Assets Self-Attestation form must be completed when an individual: 1) has income equal to or below 100% FPL; 2) is in need of an institutional level of care; and 3) has stated that no assets or resources have been transferred in the previous 60 months. It is a signed statement that outlines that anyone who reports false information will be required to reimburse the State of New Jersey for any benefits received and be subject to a period of ineligibility if applicable. Additionally, the individual may be subject to civil and criminal prosecution.

It is important to note that the form cannot be completed by anyone other than the individual, spouse, domestic partner, guardian or Power of Attorney. If none of the above listed individuals complete this form then a five year look-back will be required to be completed by the eligibility determining agency (EDA). The witness' name and signature line can be completed by anyone who is witnessing the signature. The witness has no liability and he or she is not responsible for the attested information.

Because the form is needed only when the applicant or the Medicaid recipient is determined to need an institutional level of care, the form may be distributed by the EDA or the Managed Care Organization (MCO). Please see the processes for each entity outlined below with the two different forms attached.

### Process for EDAs:

The Transfer of Assets Self-Attestation form serves as an Addendum to the PA-1G Medicaid Application. The caseworker may serve as the witness to this signed statement if they are present when it is completed by an appropriate individual.

When an EDA receives a completed Transfer of Assets Self-Attestation form for new applicants or those applying from a program not covered by managed care, it may grant eligibility without a five year look-back. The form will become part of the applicant's case file and the EDA worker will fax or email a copy to the DMAHS County Operations Unit. The fax number is 609-588-2742 and the email address is DMAHS-SelfAttestation@dhs.state.nj.us.

#### Process for MCOs:

When an individual is already receiving NJ FamilyCare ABD (non-institutional) benefits, is already enrolled in managed care, and appears to need long term services and supports, the MCO care manager is responsible for completing the clinical assessment needed to establish an institutional level of care. Because the MCO is the first point of contact in the eligibility process for long term services and supports, they shall distribute the Transfer of Assets Self-Attestation form and will notify DMAHS of the member's need for long term care. If the form is not signed while the MCO care manager is present, it will need to be returned by the NJ FamilyCare ABD recipient or their representative to the DMAHS in the self-addressed, stamped envelope provided within ten days of the care manager's contact. The form may also be faxed to the attention of DMAHS County Operations at 609-588-2742.

The MCO care managers have been provided with written instructions, a script of how to explain this process to their members, and a list of frequently asked questions. The instructions given to the recipient along with the Transfer of Assets Self-Attestation form includes a hotline phone number if further assistance is needed.

The DMAHS County Operations Unit will forward all Self-Attestation forms to the Quality Control Unit who will review a sample of cases on a quarterly basis. The EDAs shall comply with requests for information regarding these sample cases from Quality Control. When a case is found with transfers of assets, DMAHS will notify the EDA to take an adverse action as appropriate.

If you have any questions regarding this Medicaid Communication, please refer them to the Division's Office of Eligibility Field Staff representative for your agency at 609-588-2556.

Sincerely,

Valerie Harr Director

Valerie Harr

VH:km

c: Elizabeth Connolly, Acting Commissioner Department of Human Services

Dawn Apgar, Deputy Commissioner Department of Human Services

Lowell Arye, Deputy Commissioner Department of Human Services

Valerie L. Mielke, Assistant Commissioner Division of Mental Health and Addiction Services

Liz Shea, Assistant Commissioner Division of Developmental Disabilities

Joseph Amoroso, Director Division of Disability Services

Natasha Johnson, Director Division of Family Development

Cathleen D. Bennett, Acting Commissioner Department of Health

Allison Blake, Commissioner Department of Children and Families



# State of New Jersey Division of Medical Assistance and Health Services Addendum to the PA-1G Medicaid Application Transfer of Assets Self-Attestation

Applicant Name:				
Date of Birth:	Social Security No	Social Security No		
County:				
Home and Community Based has stated that no assets or re	pleted, signed and dated by all individual Services with income levels at or below sources have been transferred in the previous not be completed by anyone other the of Attorney.	100% of the Federal Poverty Level and ous 60 months for less than fair marke		
Please initial:				
I certify that my m	nonthly income is equal to or below \$	(100% of the Federal Poverty Level)		
<b>not</b> transferred an any assets or reso	y spouse, my domestic partner or anyone active y assets or resources for less than fair marturces during the 60 month period prior to _ome and Community Based Services). Pleas.	ket value or waived the right to receive (Date of request for		
understand that anyone who information, or causes someon benefits the Medicaid benefici	knowingly gives a false or misleading some else to do so, would be required to rein ary received incorrectly or would cause the does not prevent any other civil or criminal	tatement about a material fact in this nburse the State of New Jersey for any beneficiary to be subject to a period o		
Print Name	Signature	Date		
Relationship to Beneficiary				
Witness Print Name	Signature			



## State of New Jersey Division of Medical Assistance and Health Services (DMAHS) Transfer of Assets Self-Attestation for a Medicaid MCO Member

Member N	lame:					
Medicaid ID#:		County:	MCO:_	MCO:		
a Medicaid form certif Poverty Lo years (60 <b>than the i</b>	d Managed Care ( fies that the meml evel has stated to months) for less the individual, spous	Organization (MCO) and in the ber named above, with an inhal hat no income or resource than fair market value. <b>This</b>	need of long term income level at or s have been trar form cannot be or rdian, or Power o	ividuals who are members of services and supports. This relow 100% of the Federal asferred in the previous five completed by anyone other of Attorney. For questions e at 1-800-356-1561.		
Please init	tial:					
	I certify that my r	monthly income is equal to or below <u>\$981</u> (2016 Federal Poverty Level of				
	permitted to act or refused to rec	that I, my spouse, my domestic partner or anyone acting at my direction are to act on my behalf, including a court, <a href="https://have.not">have.not</a> transferred, given away, waived to receive any income or resources for <a href="less than fair market value">less than fair market value</a> during the period prior to (Date of request for Managed Long Term and Supports).				
knowledge material fa State of N beneficiary	e. I understand th act in this informat lew Jersey for any y to be subject to	nat anyone who knowingly on the common terms of the common	gives a false or me to do so, would eficiary received in nderstand there n	and correct to the best of my nisleading statement about a be required to reimburse the ncorrectly or would cause the may be other civil or criminal		
Print Memb	per's Name	Member's Signature		Date		
Print Witne	ess' Name	Witness' Signature	Date	Relationship to Member		
* For MC	O Use Only *	Please indicate disp	osition of form:			



## State of New Jersey Division of Medical Assistance and Health Services (DMAHS) Transfer of Assets Self-Attestation for a Medicaid MCO Member

### Medicaid MCO Member Instructions:

Attached is a Transfer of Assets Self-Attestation form for Medicaid Managed Care Organization (MCO) members seeking Managed Long Term Services and Supports (MLTSS). The financial eligibility process involves an asset/resource test which includes a five year (60 month) look-back of financial records to see if there are any transfers of assets/resources. An alternative to this lengthy process is to have the member sign a self-attestation form that states that they **did not** transfer any assets/ resources over the last five years (60 months). New Jersey has the authority to accept this attestation from individuals with incomes less than 100% of the Federal Poverty Level.

This form may only be completed by the member, their spouse, domestic partner, guardian, or Power of Attorney. These are the individuals that would have knowledge of the member's financial information. The member's name, Medicaid ID#, county of residence and MCO name are all required at the top of the form. The individual filling out this information will need to read this form in its entirety, initial and sign where indicated.

The witness' name and signature line can be signed by anyone who is witnessing the signature. The witness has no liability and he or she is not responsible for the attested information.

The Self-Attestation form is a triplicate colored form; blue for the member, yellow for the MCO and white to be sent back to the DMAHS. MCO staff or the care manager will indicate the disposition on the form and return the yellow copy to DMAHS within 5 days after their visit with the member. Should the member require additional time to review and complete the form, the blue and white form will be left with the member along with a self-addressed stamped envelope. The member (or their representative) must complete this form and return it to DMAHS - County Operations Unit within 10 business days. Listed below is where the form can be faxed or sent via regular mail. If this form is not received within 10 business days, the member's local Eligibility Determining Agency (EDA) will contact the member to initiate the five year look-back process. A member is not financially eligible for MLTSS until either the self-attestation or the five year look-back process is completed.

If you have any questions about this process please call the Medicaid Hotline at 1-800-356-1561.

The completed form may be sent via: mail to DMAHS – Attn: County Operations, PO Box 712, Mail Code 32, Trenton, NJ 08625 or; fax to DMAHS - Attn: County Operations at 609-588-2742.