

WORK FIRST FAMILY ASSISTANCE TERMINATION/DENIAL SECOND PARTY REVIEW SHEET

Were **any** individual(s) terminated/denied/deleted for one of the following reasons? _____

1. Moved out of state
2. Deceased
3. Requested termination/withdrawal of **Medicaid** in writing (reason documented)
4. Inmate of a public institution
5. Unable to locate
6. Adult recipient doesn't cooperate with child support and good cause is not established
7. Approved for SSI

Does the case file contain sufficient documentation to justify termination/denial/deletion for this reason? YES NO

If yes, no further evaluation for Medicaid is necessary. If the termination/denial/deletion reasons listed above do not apply to **all** members of the assistance unit, proceed:

WORK FIRST FAMILY ASSISTANCE (WFFA) TERMINATIONS

- | | | | |
|------|---|-----|----|
| I. | 4 Month Transitional | | |
| | Was termination due to receipt of child support? | YES | NO |
| | If yes, was 4 month transitional properly evaluated? (See criteria for transitional Medicaid in MA-3356) | YES | NO |
| II. | Extended Medicaid/Job Bonus | | |
| | Was termination due to receipt of earned income? | YES | NO |
| | If yes, was case properly evaluated for extended Medicaid? (See criteria for extended Medicaid in MA-3357) | YES | NO |
| III. | MAF-C | | |
| | Was the case transferred to MAF-C? | YES | NO |
| | Was the correct certification period given based on the WFFA payment review period? | YES | NO |
| IV. | Continuous Eligibility | | |
| | Were all individuals under age 19 evaluated properly for continuous Medicaid? | YES | NO |
| | Was the correct certification period given to the continuous case based on the last WFFA payment review period? (12 months from last review)? | YES | NO |
| V. | Were all remaining members of the assistance unit properly evaluated for all Medicaid programs (including MPW, MAABD and NC Health Choice)? | YES | NO |
| | Is there documentation in the case about potential pregnancy/disability/over age 65? | YES | NO |
| | If Medically needy, is there appropriate documentation to show that the deductible was explained, calculated correctly, and old, current and anticipated medical expenses properly evaluated? | YES | NO |
| VI. | Was individual/ family evaluated/transferred to Medicaid prior to WFFA termination? | YES | NO |

| | | | |
|-------|---|-----|----|
| VII. | If this is a Benefit Diversion case, was an ex parte review completed? | YES | NO |
| | Was it completed timely? | YES | NO |
| | Were there new earnings during the Benefit Diversion period? | YES | NO |
| | If yes, was the case properly evaluated for extended Medicaid? (See criteria for extended Medicaid in MA-3357) | | |
| VIII. | Was WFFA terminated for failure to complete a review? If so, was the case transferred to MAF-C? | YES | NO |
| | Was continuous eligibility for children correctly evaluated? | YES | NO |
| | Is there documentation in the case about potential pregnancy for the caretaker? | YES | NO |
| | Is there documentation in the case about disability/SSI protected status? | YES | NO |
| IX. | Was an ex-parte or full review correctly chosen, based on case status? | YES | NO |
| X. | Was eligibility correctly determined for everyone (i.e., budgets correct, etc.)? | YES | NO |
| XI. | Was the appropriate notice given at end of evaluations? | YES | NO |

WORK FIRST FAMILY ASSISTANCE DENIALS

| | | | |
|-------|---|-----|----|
| I. | Is there documentation to show that all programs (including Adult Medicaid programs) were considered/explained? | YES | NO |
| II. | Is there documentation to show that all family members were considered? | YES | NO |
| III. | If Medicaid was approved, was this done at the same time WFFA was denied? | YES | NO |
| IV. | Was the Medicaid evaluation completed prior to the 45 th day? | YES | NO |
| V. | Was eligibility for Medicaid correctly determined for each individual? | YES | NO |
| VI. | If Medically needy, is there appropriate documentation to show that the deductible was explained, calculated correctly, and old, current and anticipated medical expenses properly evaluated? | YES | NO |
| VII. | Was the need for retroactive coverage/old bills properly addressed and evaluated appropriately? | YES | NO |
| VIII. | If a/r did not apply for WFFA on the day he requested assistance, (ex. required to go to IV-D, First-Stop, etc.) is there documentation to show that he was given the opportunity to apply for Medicaid on that same day? | YES | NO |

Signature of Second Party Reviewer

Signature of Second Party Reviewer

Date

Date

Figure 4