Human Resources Administration
Department of Social Services

Medical Insurance and Community Services Administration (MICSA)

MEDICAID ALERT

July 31, 2019

Reapplication and Renewal Grace Period

The purpose of this alert is to reiterate to Providers, Hospitals, Client Representatives, Community-Based Organizations and Advocates of the existing policy regarding reapplications, renewals and the recertification grace period.

Reapplication: When an application is denied for failure to provide required documentation, a reapplication may be submitted within 30 days of the denial and a new written application on "the State prescribed form" (DSS-4220) is not required. However, the reapplication must include the missing required documentation that caused the initial denial. The reapplication does not preserve the initial application date. The date that the reapplication is received is the new application date.

Renewal/Recertification grace period: When a case is closed for failure to recertify, the client may submit the renewal form within 30 days of the closing and the agency will process the renewal form and re-open the case, if the client is eligible. If more than 30 days have passed since the case was closed, then a new application must be submitted.

Background: According to New York State Medical Assistance Reference Guide (MARG), a reapplication for Medicaid is an application for a former recipient whose eligibility was terminated or an applicant whose previous application was denied by the district. A reapplication for Medicaid must be completed as accurately as a new application.

When an applicant is denied and reapplies within 30 days, a new written application on "the State prescribed form" is not required. In this situation the date of the reapplication is the date that a written request for reapplication is received.

When a reapplication is made, any previous application or record available in the local district is used for reference and documentation of eligibility factors not subject to change (e.g. date of birth). This includes verified information found in the Welfare Management System (WMS) in an opened or closed case record. If documentation is available in the record, it can be used to verify or supplement data the applicant has available. In every case, the reapplication must be as complete and accurate as an original application. Factors relating to eligibility must be verified and documented. If the reapplication is made within 30 days of a previous case closing attestation rules apply.

This process applies to renewals or recertification for Medicare Saving Program (MSP), Disabled, Aged and Blind (DAB) as well as the MAGI-like consumers. MAGI like groups are also given a grace period of up to 30 days after the closing date of their renewal case to submit the renewal or a new application to any local Medicaid office with renewal easements (as of 2008 New York State implemented an attestation policy for families with children, Single Adults, childless couples now known as MAGI as of the Affordable Care Act implementation of 2014).

As of March 2011, New York State expanded the attestation policy to the DAB population including those in receipt of Community-based long-term care. As of the previous mentioned date this population can attest to income, resources and a change of residency at renewal.

In addition, the DAB population can mail their renewal form in the envelope received; the program will honor the receipt of the form within the 30 days previously mentioned and reopen the case.
If the consumer seeks to reapply after/past the 30 day grace period, the renewal form cannot be used. The consumer must then complete a new application with documentation.

PLEASE SHARE THIS ALERT WITH ALL APPROPRIATE STAFF

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Medical Assistance Program• Office of Eligibility Information Services • 785 Atlantic Avenue, Brooklyn, NY 11238
Steven Banks, *Commissioner* **♦ Karen Lane Executive Deputy Commissioner ♦Maria Ortiz-Quezada**, *Director of EIS*