Appendix A

1. Date of Request

For new applicants:

- To maintain the original DOR, the person's application form must be received by the agency no later than 45 calendar days from the DOR. If the application is not received within 45 days, the date the application is received becomes the new DOR.

**NOTE**

If the 45th day falls on a weekend or holiday, the application must be received the following business day.

- In the ONE Applicant Portal, the Date of Request is established at the point the application is submitted.

- In the ONE Worker Portal, the Date of Request is labeled as the ‘Date of Request’ and is initially entered on the Application Registration screen when first setting up an Application/Case in ONE.

- When a new application is initially entered in the ONE Worker Portal, individuals entered during Application Registration must identify if they are requesting coverage and that they want to continue the intake process for the application on the Program Request Screen. These steps set the DOR for the applicant and generate a ONE case number.

- See where the “Date of Request” is entered in the ONE system (Example 1)

- See where “Requesting Coverage” and the “Do you want to continue the intake process for this application” questions are in the ONE system (Example 2)
• For ongoing recipients:
  – The DOR is the date the client notifies the agency of a change that would require a new eligibility determination, such as reporting pregnancy; or
  – The date the agency initiates a renewal

  (a) When the agency initiates a renewal the DOR can be found on the notice sent to the client. This can be viewed in the “Completed” notices on the ‘View Correspondence’ screen in ONE.

✓ See the “View Correspondence” screen, (Example 3)

• For a newly requesting applicant on an existing ONE case, or for a Reactivated ONE case:
  – The DOR is labeled as the ‘Date Requested’ for newly requesting applicants and is entered on the ‘Program Request’ screen.

  (a) Applicants must also select ‘Yes’ to ‘Requesting Aid’ on the same screen in order for the ONE system to determine eligibility.
  – The DOR is labeled as the ‘Request Date’ for a Reactivated case and is entered on the ‘Program Maintenance’ screen.

✓ See where the “Date Requested” and “Requesting Aid” are entered in the ONE system (Example 4)

✓ See where the “Request Date” is entered in the ONE system (Example 5)

2. Retroactive Medical

• If a benefit group requests and is eligible for retroactive medical benefits, the earliest date they can be eligible is the first of the month, three months before the month in which the DOR is established. For example, if the benefit group requests benefits on July 10, eligibility may begin as early as April 1;

• Retroactive Eligibility is determined on a month-by-month basis. For example, if the benefit group requests benefits on August 10, the earliest date they may be
eligible for benefits is May 1. Eligibility is established separately for May, June and July. A client may be eligible for some or all three of the months.

**Example:** Mallory is applying for medical benefits for herself and her two children with a DOR of 08/10/17 and is determined eligible for PCR. She reports that in the last week of May, she was seen while she was uninsured at an urgent care clinic, with no other medical services received since then. The worker selects the month of May on the Program Request screen and ONE determines that she is eligible for retroactive medical. ONE will approve retro for the entire month of May.

- There is no time limit for when a participant can request retroactive benefits.

**Example:** Julie is initially determined eligible effective October 1, 2016. In September 2017, Julie calls and asks for retroactive benefits for August 2016. The agency can consider this request and determine eligibility even though more than a year has passed since her initial determination.

- In ONE, retroactive medical can be requested on either the ‘Program Request Summary’ screen during Application Registration or on the ‘Program Request’ screen during Data Collection. It is referred to as “Prior Months Coverage” in ONE.

![See where the “Prior Months Coverage” are selected in the ONE system](Example 6)

3. **Head of Household**

- In the ONE Worker Portal, the Head of Household is the individual entered during Application Registration on the ‘Application Registration’ and ‘Individual’ screens.

![See where the Head of Household is initially entered in the ONE system](Example 7)

- For an application submitted via ONE, Applicant Portal, the individual identified as the primary contact must electronically sign the application and will be identified as the Head of Household.
For an application submitted by means other than the Oregon Eligibility (ONE) system Applicant Portal, the contact who signs the application is not necessarily the head of household. The application must be signed by one of the following:

- The primary contact;
- At least one caretaker relative or parent in the household group;
- The primary contact when there is no parent in the household group; or
- An authorized representative.

(a) Signatures may be accepted either handwritten, electronic, or telephonic.

4. Authorized Representative

A person or family may use an authorized representative to complete the application for them if needed. If the applicant is a child or incapacitated, a signature from a person acting responsibly on their behalf can be accepted without needing a signed MSC 231. For all others, a signed MSC 231 must be received before an application can be processed when it is signed by someone other than the applicant.

- The primary contact;
- An individual age 18 or older who is included in the household group with the primary contact, head of household (see OAR 461-001-0015), or primary person (see OAR 461-001-0000), for all programs with which the primary contact, head of household, or primary person participates;
- An individual given legal guardianship or power of attorney for an individual age 18 and older;

To designate an authorized representative, the participant must complete the Authorized Representative and Alternate Payee (MSC 231) form at the time of the application or at any time the client requests a change. If health information is to be disclosed, an Authorization for Disclosure, Sharing and Use of Information (MSC 3010) is also required. A request for these designations can be completed via:

- The internet;
- Email;
− Mail;
− Telephonic recording;
− In person; or
− Other electronic means.

- The Agency does not recognize an individual or organization as an authorized representative until we have received a signed MSC 231 or telephonically recorded signature for the MSC 231, as allowed per above.

**NOTE**

*New applications for a child or incapacitated person are allowed to be signed by a person acting responsibly on behalf of the child or incapacitated individual without needing a signed MSC 231.*

- Effective 3/1/19, an authorized representative for one program is now the authorized representative for all programs and benefits with the same head of household, primary person, or primary contact, except for the TA-DVS program. Long-term care services have an exception in some cases (an individual’s long-term care services provider cannot be their authorized representative for long-term care services).

- Authorized representatives must be age 18 or older. The attestation of age on the MSC 231 is acceptable to confirm that the authorized representative is an adult; verification is not required unless it is questionable.

- Upon a client designating an authorized representative, workers should determine if the client is receiving any other DHS benefit(s) and ensure that all programs and eligibility systems are updated with the authorized representative’s information.

- An authorized representative/alternate payee can be requested in the ONE Worker Portal during Application Registration (on the ‘Application Registration’ screen) or during Data Collection on the ‘Application Information’ screen.
NOTE

It is advisable not to enter an authorized representative or alternate payee in the Worker Portal (based on a paper or phone application) until the MSC 231 is returned. However, the Worker Portal will be updated with unverified authorized representative name when a client requests an authorized representative through the Applicant Portal. In this case, a task will be generated for a worker to mail the MSC 231. If/when the MSC 231 is received, a verification type should be entered for the authorized representative. No information should ever be released to an authorized representative with an unverified status.

- Authorized representatives are assigned in ONE according to case number and apply to all programs received by an individual/family on that case. If an individual designates an authorized representative and is the head of household on multiple ONE cases, the authorized representative should be added to all of the cases on which they are the head of household (except TA-DVS).

- To associate a Community Partner to an individual’s case, the agency must receive a signed MED 6610. However, if a Community Partner enters an application for the client via the ONE Applicant Portal, they are able to complete the association and will not have to supply the MED 6610 to the Agency. The Community Partner must keep a copy of the MED 6610 on file for six years.

5. Community Partners
See where the Community Partner question is asked during Data Collection (Example 11)

See where to select a Community Partner in the ONE system. (Example 12)

- To locate a Community Partner based off of location, click here or go to healthcare.oregon.gov.

- The associated Community Partner can be viewed on the ‘Case Summary’ screen.

See where if a Community Partner is associated to a case in the ONE system. (Example 13)

6. Missing Information

- State resources must be used to obtain items of information (such as a Date of Birth, Address or Social Security Number) when they are available.

- When there is missing information from an application (or if completing a phone interview and the participant does not have the necessary information to get to an eligibility determination) an automated or manual request for information must occur.
  - The due date is 15 calendar days from the date of notice.

- The agency may extend the processing timeliness standard of 45 days for new applications and 30 days for renewals if there is an administrative or other emergency beyond the control of the Agency.

See case missing information in the ONE system. (Example 14)

See individual missing information in the ONE system. (Example 15)

7. Notices

- Notices can be system generated or sent manually.
• A decision notice must do all the following:
  
  - Specify the action being taken (denial, closure, reduction, approval);
  
  - Give the effective date and reason for action;
  
  - Inform the client of their right to a hearing before an impartial person. This includes the following:
    
    (a) Specifying the method and time frame for requesting a hearing;
    
    (b) Informing the client of their right to representation (including legal counsel);
    
    (c) Informing the client about availability of free legal help; and
    
    (d) Informing the client of their right to have witnesses testify on their behalf.

• Cite the administrative rule that supports the action being taken on the case.

• Approval and reduction notices must also include:
  
  - The level of benefits approved;
  
  - Changes that must be reported; and
  
  - The process for reporting changes.

• For notices generated by ONE:
  
  - After a case is authorized, the notices can be viewed in the ‘Pending’ correspondences.
  
  - If needed, a notice can be deleted while it is still pending. If this is done, it may be necessary to send a manual notice. For example, if benefits need to be ended effective the last day of the current month and it is after ONE cut-off logic.
  
  - Each night, notices initiated by the system during that day are sent to the print plant to be printed and mailed. These can then be viewed in the ‘Completed’ correspondences.

✅ See the “View Correspondence” screen in the ONE system. (Example 16)
• Electronic notices

Individuals must be given the option to receive notices either by regular mail or electronically. Individuals who choose to receive electronic notices, and who have an online account with the ONE Applicant Portal, will receive a confirmation of this decision by postal mail. Once electronic notification is chosen and the confirmation is mailed, ONE will:

- Post notices to the individual’s Applicant Portal Message Center within one business day of the date on the notice;
- Send an electronic alert to the individual that a notice has been posted to their electronic account.

(a) In ONE, applicants can choose to receive electronic notification via email OR email and SMS text.

If an electronic communication is undeliverable, ONE will send the notice again via postal mail, within three business days of the failed communication.

- See the preferred method for receiving notices questions on the “Contact Information” screen in the ONE system. (Example 17)

- See the confirmation notice sent by postal mail in the ONE system. (Example 18)

8. Reported changes

• The Date of Request for a reported change is the date the participant reported the change.

• When reported changes result in a closure or reduction, the effective date of the eligibility change follows ONE cut-off logic:

  - If the determination is made on or before the 15th of the month, the change is effective the first of the next month; or
  - If the determination is made on or after the 16th of the month, the change is effective the first of the month following the next month.
- Exceptions to this logic:

(a) A participant becomes incarcerated (suspension effective the day after incarceration begin date)

(b) A participant becomes deceased (closure effective the date of death).

(c) CAWEM Prenatal participants reduced to CAWEM the day after the pregnancy ends.

- For participants who report a pregnancy, the effective date for pregnancy-related benefits is the first of the month in which the pregnancy was reported, or the date the first prenatal service was received. You do not need to pend to determine when the first prenatal service was received but can use that date if the participant or provider call to report a service was received prior to the first of the month in which the pregnancy was reported.

- For participants who report a change that results in their eligibility moving from a CAWEM, CAWEM Plus or Cover All Kids benefit to a MED Plus benefit, the effective date of the MED Plus benefit is the date the change is reported.

- If not in a renewal period, a redetermination due to a reported change does not establish a new 12-month eligibility period.

- If additional information is needed to complete processing the reported change, the Request for Information (RFI) can only request information related to the reported change.

- Reported changes are performed in ONE by selecting ‘Report a Change’ on the Case Summary screen.

| ✓ | See the “Report a Change” button in the ONE system. (Example 19) |

9. Renewal

Automated Renewal:

- Cases that are in Active/Approved status may be selected for Automated Renewal.
• Cases that move successfully through Automated Renewal will receive one of the following notices:
  
  - Automated Renewal Notice of Eligibility (NOE) (MED 048). This notice informs the household of the eligibility results of the Automated Renewal determination. This notice also includes a case summary (MED 047), and requests the client review it for accuracy, and report to the Agency if changes or updates need to be made.
  
  - Automated Renewal Request for Information (RFI) (MED 049). This notice is generated if, during the verification batch processes, case information is discrepant or cannot be verified, and the client is requested to provide such verification. This notice also includes a case summary, and requests the client review it for accuracy, and report to the agency if changes or updates need to be made. The reply-by deadline for Automated Renewal RFI aligns with that of Active Renewals for the target renewal month. The Automated Renewal RFI may be sent along with the Automated Renewal NOE if the case is soft-pended.

Active Renewal:

• Cases not in Active/Approved status will be target for Active Renewal and mailed the Active Renewal letter (MED-044) along with a case summary. The client must respond and has the option to:
  
  - Confirm all information in the case summary is accurate, and confirm there are no other changes to report; “No change renewal”, or
  
  - Identify inaccurate or missing information in the case summary and use the included forms to report such information.

• When processing an Automated or Active Renewal results in approval, a new 12-month eligibility period is established. The first month of the new eligibility period is the month following the renewal month.

• There are instances in which manual follow up / completion of the No Change Renewal will still be needed. When this occurs, an ‘Automated Renewal Needs Review’ task will be generated and sent to the ‘Renewal Needs Review’ Queue for review and action by workers.

• A participant who is identified as a non-responder to the Active renewal or an RFI will be terminated and closure notices will be generated by the ONE system. A participant is identified as a non-responder if:
  
  - A Renewal has not been initiated or completed via Worker Portal
- A Renewal has not been submitted via Applicant Portal
- The renewal date has not been updated by any other means
- There is no outstanding RFI or task indicating an unprocessed response