

## Plan First: Frequently Asked Provider Questions:

### Eligibility and Enrollment

#### Income and Residency

***Q: Can a child younger than 18 years of age apply for Plan First without her/his parents' signature?***

A: A child under age 18 years is not legally able to sign his or her own Medicaid application unless he or she is legally emancipated from parents.

***Q: Is there an upper age limit on people applying to Plan First?***

A: The Centers for Medicare and Medicaid Services (CMS) will not allow states to exclude individuals based on age, sex, conception status, etc. Plan First cannot exclude someone from enrolling; however, if he/she no longer needs or wants pregnancy prevention services, then any visits or services will not be covered by Plan First.

***Q: If a patient previously had a tubal ligation, is she eligible for Plan First?***

A: The Centers for Medicare and Medicaid Services (CMS) will not allow states to exclude individuals based on age, sex, conception status, etc. Plan First cannot exclude someone from enrolling; however, if he/she no longer needs or wants pregnancy prevention services, then any visits or services will not be covered by Plan First.

***Q: Does DSS count college students' residence by where their parents live or their address at college? What about parents' income?***

A: Students under age 18 must include their parents' income unless they are emancipated. If 18 and over, they must establish residency. A dorm is considered temporary residence. In that case, students younger than age 21 must use their parents' residence and provide proof of parents' income.

Students living off-campus in their own apt/house would be considered residents of that locality, with their forms going to the local department of social services (DSS). They would not be considered living with their parents (even if on the parents' health insurance).

***Q: Does a patient under 21 living with parents but paying rent still need to show proof of the parents' income?***

A: Yes.

***Q: Can we use year-to-date (YTD) gross income from pay stub for income verification?***

- A: No.
- Most recent federal tax filing information (if available).
- Job and income information for members of your household for the month prior or the current month. Having recent pay stubs or W-2s to reference may be helpful.
- Information about other taxable income for members of your household such as unemployment benefits, Social Security payments, pensions, retirement income, rental income, alimony received, etc.

**Q: If the person has no form of income (i.e., unemployed), what documentation is needed for the application?**

A: Proof of income is not required during application process if \$0 income is reported on application. Signing the application signifies that the information provided is true. If there is still no income at time of renewal, the applicant will need a written statement.

**Q: If someone was just laid off (and living alone) and now without income or insurance, how should he/she document income on the Plan First application, given that he/she had income the previous month?**

A: He/she should report their previous month's income but then state they are currently unemployed.

**Q: Is there a required length of residency for a person to be eligible for Plan First?**

A: No. The day the applicant comes to Virginia with the intent to stay meets the residency requirement. There is no fixed address requirement for the applicant (e.g. being homeless) as long as the eligibility worker has an address to send mail to the applicant (this is worked out at local level).

**Q: What if a Plan First member's tubal ligation has failed and she gets pregnant – can she sign up for Plan First again after she delivers?**

A: If she does get pregnant after a tubal, she should tell her eligibility worker so that she gets evaluated for full-benefit Medicaid for prenatal care. Once pregnancy ends, and if not eligible for full-benefit Medicaid, she can be evaluated for Plan First again.

**Q: Will individuals enrolled in Plan First receive a Plan First card?**

A: Newly enrolled members will receive a Medicaid card in the mail to use for Plan First services. If an individual was previously enrolled in a Medicaid program, she/he will continue to use that card with the same Medicaid Identification number (a new card will be issued if requested by member). Cards can be requested by contacting the local Department of Social Services (DSS) eligibility worker.

**Q: When does an individual renew his/her Plan First coverage?**

A: Coverage under Plan First is effective for 12 months. Typically, during the 11<sup>th</sup> month of coverage, the member will receive a "renewal notice" from the local Department of Social Services (DSS). This form will need to be returned along with any verification within 10 business days.

**Q: What is the effective date of Plan First coverage?**

A: Coverage begins on the 1<sup>st</sup> of the month in which the application was received and logged by the local DSS office. For example, if the local DSS received and logged the application on April 15<sup>th</sup>, the effective date for coverage will be April 1<sup>st</sup>, pending all eligibility requirements are met.

**Q: We have had some patients want to dis-enroll from Plan First because they were told their coverage makes them ineligible for Every Woman's Life (breast and cervical cancer early detection) program. Is that right?**

A: No, that is not correct. Women on Plan First **are** eligible for Every Woman's Life, assuming they meet all other criteria. Plan First does not provide full health care coverage, so its members are therefore considered uninsured.

**Q: Where can I order Plan First brochures, applications and posters?**

A: Commonwealth Martin supplies Plan First materials at no charge. An order form for materials is located at [http://dmasva.dmas.virginia.gov/Content\\_atchs/mch/mch-pln1\\_cm\\_ordform.docx](http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-pln1_cm_ordform.docx) or call 804-780-0076.

### **Application to the Department of Social Services (DSS)**

***Q: If a patient doesn't put dates of service during the last 3 months on the application, can services provided in the retroactive period be covered?***

A: Yes. For the eligibility period to be corrected, the member would need to notify the DSS eligibility worker that she/he had a covered service in prior 3 months and provide income information for the month they had the service.

***Q. Can we fax a signed application to DSS even if not all the fields are completed?***

A. Yes. The DSS eligibility worker will follow up with the individual to get information needed to complete the application so that it can be processed. The individual would need to provide any required proof of income, etc. within the 45 day processing period or the eligibility worker may deny as incomplete. That is why it is optimal to submit an application that is as complete as possible.

***Q: We were told by our local DSS that they have 45 business days (vs. calendar days) in which to take action on a Plan First application. Is that correct?***

A: DSS has 45 calendar days in which to take action on an application. If there is a problem, please alert the Eligibility Supervisor at the local DSS.

### **WebVision (VDH staff only):**

***Q: Our local DSS won't accept a WebVision- generated application. What should we do?***

A: The DSS should accept the application if completed correctly. If this continues to be a problem, please contact [Alyssa.Murray@vdh.virginia.gov](mailto:Alyssa.Murray@vdh.virginia.gov) or the eligibility supervisor at the local DSS.

### **Renewal**

***Q: What should we do with a person whose membership in Plan First has lapsed?***

A: It is best to go back to the eligibility worker at DSS to request coverage. The DSS worker will notify the member if she/he needs to complete a new application. DSS sends a "Notice of Action" at least 10 days before termination, so you should also remind the member to be on the lookout for it.

### **Postpartum Women**

***Q: How can postpartum women apply for Plan First?***

A: There are three different possible scenarios:

- If the postpartum patient is not on Medicaid, she should complete an application for Health Coverage at [www.coverva.org](http://www.coverva.org) and submit to her local department of social services (DSS), or visit [www.commonhelp.virginia.gov](http://www.commonhelp.virginia.gov) to apply for Medicaid, FAMIS, or Plan First.
- If the postpartum patient is on Medicaid, DSS will review her case and notify her if she qualifies for Plan First coverage. She may have to provide updated income information. If she qualifies for Plan First, she will receive a letter from her local DSS that will notify her of her enrollment.
- If the postpartum patient is on FAMIS MOMS, she will need to complete a Plan First application and submit to her local department of social services (DSS).

***Q: When can a postpartum woman apply for Plan First?***

A: According to DSS policy, the local agency will deny the application if it is received 45 days or more before the requested date of coverage or 45 days or more from when her coverage as a pregnant woman in Medicaid or FAMIS MOMS ends. It seems reasonable to get her application into the local DSS when she comes in for her 6-week postpartum visit.

**For complete information about Plan First covered eligibility and enrollment, go to [www.PlanFirst.org](http://www.PlanFirst.org).**