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State/Territory Name: Idaho

State Plan Amendments (SPA) #: ID-CHIPSPA#15

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

OCT 0 8 2014

Mr. Matt Wimmer
CHIP Director
Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0036

Dear Mr. Wimmer:

We are pleased to inform you that your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA) number 15, submitted on June 27, 2014, has been approved. This SPA has an effective date of January 1, 2014.

In this SPA, Idaho changes the type of coverage that it is offering to targeted low-income children from the benchmark benefit package to Secretary-approved coverage, which is the same benefit package as Medicaid, including the provision of EPSDT. In addition, the state is making technical changes to its tobacco cessation and hospice benefits.

Your title XXI project officer, Ms. Victoria Collins, is available to answer questions concerning this amendment and other CHIP-related issues. Ms. Collins' contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-2176
Facsimile: (410) 786-5943
E-mail:Victoria.Collins@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Collins and Ms. Carol Peverly, Associate Regional Administrator, in our Seattle Regional Office. Ms. Peverly's address is:

Centers for Medicare and Medicaid Services
Office of the Regional Administrator
701 Fifth Avenue, Suite 1600
Seattle, WA 98104

If you have additional questions, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Cindy Mann
Director

cc:
Ms. Carol Peverly, ARA, CMS Seattle Region

MODEL APPLICATION TEMPLATE FOR

STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory:_____Idaho_____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))

/S/ **Denise Chuckovich_by Lisa Hettinger**_____**June 27, 2014**_____
Deputy Director Date
Idaho Department of Health and Welfare

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Lisa Hettinger	Position/Title: Administrator, Division of Medicaid
Name: David Taylor	Position/Title: Chief Financial Officer
Name: Matt Wimmer	Position/Title: Bureau Chief, Division of Medicaid

***Disclosure. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 09380707. The time required to complete this information collection is estimated to average 160 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, write to: CMS, 7500 Security Blvd., Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850**

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

1.1. The state will use funds provided under Title XXI primarily for (Check appropriate box) (Section 2101)(a)(1)); (42 CFR 457.70):

1.1.1 ☐ Obtaining coverage that meets the requirements for a separate child health program (Sections 2101(a)(1) and 2103); OR

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan (Title XIX) (Section 2101(a)(2)); OR

1.1.3. ☒ A combination of both of the above. (Section 2101(a)(2))

1.1-DS ☐ The State will provide dental-only supplemental coverage. Only States operating a separate CHIP program are eligible for this option. States choosing this option must also complete sections 4.1-DS, 4.2-DS, 6.2-DS, 8.2-DS, and 9.10 of this SPA template. (Section 2110(b)(5))

1.2 ☐ Check to provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3 ☐ Check to provide an assurance that the State complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42CFR 457.130)

1.4 Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Date Original Plan Submitted: February 17, 1998
Date Approved: June 15, 1998
Effective Date: October 1, 1997

Amendment #1 Description: Change income limit from 160% FPG to 150% FPG
Submitted: October 13, 1998
Approved: December 4, 1998
Effective date: July 1, 1998

Amendment #2 Description: Program design changes to-

- increase coordination of efforts across agencies
- simplify the application process, and
- improve media and outreach approaches

Submitted: March 10, 2000
Approved: March 1, 2001
Effective date: January 1, 2000

Amendment #3 Description: Technical changes to conform to model template

- Revised outreach strategies

Submitted: June 28, 2002
Approved: September 19, 2002
Effective date: July 1, 2002

Amendment #4 Description: Establish separate program
Submitted: February 25, 2004
Approved: June 10, 2004
Effective date: July 1, 2004

Amendment #5 Description: Revise benefit package of separate program
Submitted: August 30, 2004
Approved: January 13, 2005
Effective date: July 1, 2004

Amendment #6 Description: Removal of enrollment cap
Submitted: June 9, 2005
Approved: September 7, 2005
Effective date: June 1, 2005

Amendment #7 Description: Addition of child health services initiative (Healthy Schools)
Submitted: April 28, 2006
Approved: May 25, 2006
Effective date: July 1, 2006

Amendment #8 Description:

- Lower the income limit of separate program from 150% to 133%
- Remove resource limit
- Incorporate Basic and Enhanced Benchmark Benefit Packages
- Changes to premium structure

Submitted: May 5, 2006
Approved: May 25, 2006
Effective date: July 1, 2006

Amendment #9 Description:

- Addition of Wellness Preventive Health Assistance
- Addition of co-pays

Submitted: January 24, 2007
Approved: September 28, 2007
Effective date: January 1, 2007 (Wellness PHA)
February 1, 2007 (co-pays)

Amendment #10 Description:

- Addition of Substance Abuse Treatment Services
- Addition of Independent Therapists for Speech Language Pathology (SLP) Services
- Reduce limits for Psycho-Social Rehabilitation, Partial Care and Developmental Disability Agency Services

Submitted: March 17, 2009

Approved: July 15, 2013

Effective date: November 1, 2008 (Substance Abuse Treatment & SLP)
January 1, 2009 (Reduction in Mental Health & DDA)

Amendment #11 Description:

- Contact Lens Coverage Modification
- Mental Health Assessment Annual Limitation
- Mental Health Treatment Plan Limitation
- Collateral Contact & Partial Care Elimination
- PSR Limitation
- DDA Assessment Annual Limitation
- Incorporation of Dental Services Template (Sections 6.2-D & 10.3-D)

Amendment #12 Description: Change to Chiropractic Services Limitations
Submitted: August 29, 2011
Approved: July 15, 2013
Effective date: July 1, 2011

Amendment #13 Description: Addition of Co-payments (co-pays) for certain services
Submitted: December 31, 2011
Approved: July 2, 2012
Effective date: November 1, 2011
November 1, 2011 for Chiropractor, Optometrist and Podiatrist Services
January 1, 2012 for Physical Therapy, Occupational Therapy, Speech Therapy & Physician Office Visits

Amendment #14 Description:

- Addition of Health Homes for Chronically Ill
- Implementation of Children's Redesign Benefit Plan
- Implementation of Behavioral Health Managed Care
- Developmentally Disabled Children's Benefit Redesign
- Removal of Therapy Prior Authorization Requirements

Submitted: June 15, 2013
Approved: August 29, 2013
Proposed Effective Date: January 5, 2012 for Removal of Therapy Prior Authorization Requirements; January 1, 2013 for Health Homes; July 1, 2013 for Developmentally Disabled Children's Benefit Redesign; September 1, 2013 for Behavioral Health Managed Care

Amendments MAGI Description:
13-0013 Non Financial Eligibility
Submitted: September 13, 2013
Approved: December 12, 2013
Effective: January 1, 2014

13-0014 XXI Medicaid Expansion
Submitted: September 17, 2013
Approved: December 17, 2013
Effective: January 1, 2014

13-0015 Establish 2101(f) Group
Submitted: September 17, 2013
Approved: October 8, 2013
Effective: January 1, 2014

13-0016 MAGI Eligibility & Methods
Submitted: September 19, 2013
Approved: December 17, 2013
Effective: January 1, 2014

13-0023 Eligibility Process
Submitted: October 7, 2013
Approved: December 18, 2013
Effective: January 1, 2014

Amendment #15 ACA Changes, Tobacco Cessation, Children's Hospice
Submitted: June 27, 2014
Approved: October 8, 2014
Proposed Effective Date: January 1, 2014

1.4- TC **Tribal Consultation (Section 2107(e)(1)(C))** Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

The State used its standard negotiation (with the Tribes of Idaho) process for Tribal Consultation for this SPA. Hard copies of the Tribal notices were sent to Tribal Leaders and e-mailed to a contact list of Tribal Representatives as indicated in the table below. The notices were subsequently posted to the Idaho Medicaid-Tribes website.

SUBJECT	DATE OF NOTIFICATION	DESCRIPTION
Affordable Care Act Changes	August 2, 2013	A tribal notice, which included descriptions of the State's modification of state plan language and requirements around Medicaid eligibility related to MAGI Eligibility & Methods, XXI Medicaid Expansion, Establishing 2101(f) group and Non-financial eligibility was sent to the tribes on August 2, 2013. The proposed SPAs were discussed as part of a standing agenda item to review all Medicaid/CHIP SPAs at the Tribal quarterly meetings held August 2013, November 2013, February 2014 and May 2014.
Tobacco Cessation	September 27, 2013	A tribal notice, which included a description of the proposed changes to tobacco cessation benefits, was sent to the tribes on September 27, 2013. The SPA was discussed at the tribal quarterly meetings conducted in November 2013 and February 2014.
Children's Hospice	June 12, 2013	A tribal notice, which included a description of the proposed SPA for changes to children's hospice services, was sent to the Tribes on June 12, 2013. The SPA was discussed as part of the Tribal quarterly meetings.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)- (3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). (42 CFR 457.80(a))

Idaho is a predominantly rural state. Of Idaho's 44 counties, 17 are classified as frontier (less than 6 people per square mile) and an additional 19 are classified as rural (those that do not contain a population center of more than 20,000 people). The rural nature of Idaho has a significant impact on health care issues, including insurance enrollment and health access.

Idaho's largest ethnic minority is of Hispanic heritage. Southwest, southeast and south-central Idaho in particular have large concentrations of people with Hispanic heritage. Idaho also has five Native American tribes: the Shoshone and Bannock Tribes in eastern Idaho, the Shoshone and Paiute Tribes in Duck Valley, southwestern Idaho, the Nez Perce Tribe in north central Idaho, and the Coeur d'Alene Tribe in northern Idaho.

According to the 2004 Current Population Survey, there are 384,000 children ages 18 or under in Idaho,

of whom 33,000 are without health insurance. This is a significant decrease from earlier estimates of uninsured children (51,000 in 2003, 50,000 in 2002, and 45,000 in 2001). The number of children in Idaho living in families with incomes at or below 200% of the Federal Poverty Guideline (FPG) is 169,000, using a three-year average of Current Population Survey data from 2002, 2003 and 2004 (from a three-year average total of 394,000 children). Of those 169,000 children at or below 200% FPG, 30,000 are estimated to have no health insurance.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42CFR457.80(b))

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

The Idaho Department of Health and Welfare (DHW) strives to increase Idaho children's enrollment in public health insurance programs by coordinating enrollment efforts across DHW divisions, coordinating with other public agencies, and by coordinating with other stakeholders. These coordination efforts include:

- Idaho Health Plan Coverage Booklet—a brochure outlining the services available throughout DHW to families, including Title XIX and Title XXI child health programs.
- Idaho CareLine—an 800 number providing referral assistance to DHW customers throughout Idaho. The Idaho CareLine has a direct link to CHIP assistance. CHIP makes up the largest segment of callers on a regular basis. 888 KIDS NOW connects directly to the Idaho CareLine.
- Coordinated outreach and enrollment activities with the Idaho Department of Education and school lunch and child care food programs.
- Partnerships with stakeholder organizations that encourage posting of links to the State's CHIP website (www.chip.idaho.gov) on stakeholder web sites in order to provide current information to Idaho citizens.

In addition, DHW provides potential enrollees with several types of application assistance by:

- Providing mail-in/fax-in applications—the redesigned application allows potential CHIP enrollees to submit their application by mail or fax. Self-reliance specialists make CHIP eligibility determinations without a face-to-face visit. When information is missing, self-reliance specialists contact potentially eligible families by telephone.
- Using a simplified Application for Assistance for all benefit programs in the Self-Reliance Program (Health Coverage, Cash Assistance, Food Stamps, Child Care, Telephone Service and Nursing Home).
- Coordinating with Your Health Idaho, the Idaho health insurance exchange, to facilitate eligibility determination and enrollment of eligible participants in the Medicaid and CHIP programs.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

- IDHW conducts eligibility in coordination with Your Health Idaho, the Idaho health insurance exchange, to facilitate eligibility determination and enrollment of eligible participants in the Medicaid and CHIP programs.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5.)
(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))

The State of Idaho will use routine stakeholder meetings to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. (Section 2102)(a)(4) (42CFR 457.490(a))

The same method of assuring delivery of insurance products and delivery of health care services is used for Title XXI and Title XIX. Providers are required by contract to assure that services are delivered in accordance with state and federal regulations. CHIP utilizes the same provider panel as Idaho Medicaid. Providers are primarily reimbursed on a fee-for-service basis under a Primary Care Case Management (PCCM) model of managed care.

In addition, Idaho Medicaid will promote wellness by financing preventive services for children in schools. Idaho Medicaid will award grants to schools to facilitate delivery of preventive health services to low-income students. These grants will be issued as Title XXI non-primary expenditures and as an alternative to School-Based Administrative Claiming.

Existing Idaho and federal law obligates Idaho Medicaid to pay schools for covered rehabilitative and health-related services under the Individuals with Disabilities Act (IDEA). These services are listed in Individualized Education Plans (IEPs) for children identified as having special health needs. Idaho Medicaid pays schools on a fee-for- service basis by certifying school funds. In order to provide preventive services through schools, Idaho Medicaid proposes to fund services through Title XXI non- primary expenditures rather than develop an administrative claiming mechanism.

Title XXI non-primary expenditures are those program expenditures that are not medical services provided under the benefit package as described in the Title XXI state plan. Non-primary expenditures are reimbursable at the enhanced federal financial participation rate but are capped at 10 percent of the cost of benefits. Per 42 CFR 457.618, there are four categories of non-primary expenditures allowable under Title XXI, which include administrative expenditures, outreach, health initiatives and certain other child health assistance. Health Services Initiatives, defined in 42 CFR 457.10, means "activities that protect the public health, protect the health of

individuals, improve or promote a State's capacity to deliver public health services, or strengthen the human and material resources necessary to accomplish public health goals relating to improving the health of children (including targeted low-income children and other low-income children)."

Initially, Idaho Medicaid will issue grants to ten (10) school districts in state fiscal year 2007 to assist schools with the salary expenses of registered nurses (RNs) working in schools or with related resource needs. Idaho Medicaid has partnered with the Idaho Department of Education and the Division of Health, Idaho Department of Health and Welfare, to establish criteria for school nurse programs eligible for Medicaid grant funding and to distribute these grants. Currently, 33 out of 114 Idaho school districts maintain school nurse programs, and Idaho schools' current RN to student ratio in Idaho is 1:2,393 (the national standard is 1:750 for the general, non-special-needs student population.) Increasing the nurse to student ratio will result in increased health counseling and education, health screenings, prevention services, health coordination, referral to care outside of school, and applications to and enrollment in Title XIX and Title XXI health coverage programs.

Grant criteria will include the percentage of low-income students and need for increased access to health services. Idaho Medicaid will fund grant amounts proportionate to percentages of low-income students in each grantee district. Idaho Medicaid will require semi-annual reports from grantee schools on provision of preventive health services and achievement of health services objectives as outlined in the grant program scope of work. Grant agreements will stipulate that grantee districts may not expend grant funds on services that may be billed through existing school-based services under a child's Individualized Education Plan.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42CFR 457.490(b))

This State Plan uses utilization controls from the Title XIX program, including prior approval controls, peer reviews, claims processing edits, post-audit and review procedures. Primary care providers are charged with making referrals for medically necessary specialty services. Health services providers are provided a handbook describing the benefit package including limitations. Participants are issued an identification card which is used to determine covered services and service limitations.

Section 4. Eligibility Standards and Methodology. *(Section 2102(b))*

CS3 SUPERSEDED 4.0 – CURRENT MEDICAID EXPANSION 9SEE MAGI SECTION)

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low- income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))

SUPERSEDED BY CS18 FOR 4.1.0; 4.1-LR & 4.1.1LR (SEE MAGI SECTION)

4.1.1. ☒ Geographic area served by the Plan:

This State Plan applies to the entire State of Idaho.

4.1.2. ☒ Age: Children are eligible from birth through the month of the 19th birthday.

4.1.3. ☒ Income:

Children with family incomes over 133% through 185% FPL are eligible for Idaho's stand-alone SCHIP under Title XXI. Children who have family incomes over 100% through 133% FPL are eligible for Idaho's Medicaid-expansion SCHIP under Idaho's Title XIX State Plan from the month of their 6th birthday through the month of the 19th birthday.

4.1.1, 4.1.2 & 4.1.3 SUPERSEDED BY CS7 – GEOGRAPHICAL AREA & AGE AND INCOME (SEE MAGI SECTION)

4.1.4. ☐ Resources (including any standards relating to spend downs and disposition of resources):

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state): SUPERSEDED BY CS17 (SEE MAGI SECTION)

Children served are residents of the State of Idaho.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

4.1.7. ☒ Access to or coverage under other health coverage:

A child will be ineligible for coverage under this plan if they have access to or are enrolled in other health coverage, including the following scenarios.

- The child is covered by creditable health insurance at the time of application.
- The child has been voluntarily dropped from creditable coverage in the six months preceding application with the intention of qualifying for public coverage.
- The child is eligible under Idaho's Title XIX State Plan.
- The child is eligible to receive health insurance benefits under Idaho's state employee benefit plan.

4.1.8. ☒ Duration of eligibility:

The duration of eligibility is 12 months unless the child is terminated for one of the reasons described below.

- The child loses his or her Idaho residency.
- The child attains 19 years of age.
- The child becomes eligible for and is enrolled in Medicaid.
- The child's parent or adult who is legally responsible for the child's health care makes a written request to terminate coverage.
- The application is found to have inaccurate information which effected an incorrect eligibility determination.
- The child dies.

SUPERSEDED BY CS27 (SEE MAGI SECTION)

4.1.9. ☒ Other standards (identify and describe):

- At the time of application, a) the child must not be a patient in an institution for mental diseases, or b) an inmate of a public institution.
- The Social Security number, proof of application for a Social Security number or resident alien card number must be provided for applicants who are requesting coverage. Individuals on the application that are not requesting coverage are not required to provide Social Security numbers.
- The State does not exclude individuals based on citizenship or nationality, to the extent that the child is a U.S. citizen,

  U.S. national or qualified alien (as defined at section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, as amended by the BBA of 1997, except to the extent that section 403 of PRWORA precludes them from receiving Federal means- tested public benefits).

SUPERSEDED BY CS19 SECTION 4.1.9.1 (SEE MAGI SECTION)
ADDING CS14 AS SEPARATE SECTION UNDER 4.1 (SEE MAGI SECTION)

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B)) (42CFR 457.320(b))

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2)) (42CFR 457.350)

Methods of establishing eligibility and continuing enrollment include a combined application for all Idaho children's health insurance programs. The application can be mailed to DHW. Face-to-face interviews are not required. All eligibility determinations will be made within the 45 days following receipt of the application. All applicants are notified in writing regarding the outcome of their eligibility and enrollment status.

CS24 SUPERSEDES 4.3 SINGLE STREAMLINED APPLICATION SCREEN & ENROLL (SEE MAGI SECTION

An annualized gross income figure is used to determine eligibility. There are no earned income disregards. There is no resource limit. The number of persons in the family determines the applicable income standard.

The eligibility redetermination process entails checking all available interfaces and databases for current pertinent information prior to contacting the participant by phone. If the renewal is not completed at this point, a renewal form is sent to the family at least 45 days before their health coverage will end. The form instructs the family to review the information on the form, provide any updated information, sign and return the form or call and report that there are no changes.

ADDING CS13 TO 4.3 (SEE MAGI SECTION)
ADDING CS15 TO 4.3 (SEE MAGI SECTION)

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42CFR 457.305(b))

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

CS24 SUPERSEDES 4.4 RENEWALS SCREENING BY OTHER INSURANCE AFFORDABILITY PROGRAMS (SEE MAGI SECTION)

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) (42CFR 457.350(a)(1) and 457.80(c)(3))

The State of Idaho will ensure that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. The application for assistance requires information on when the child was last covered by health insurance. Creditable insurance determinations are made if

the applicant indicates current health insurance coverage. Place of employment is also required on the application which is used to determine if the applicant is a dependent of a State employee with access to coverage.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))

The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))

Through the single application process, all children are first reviewed for Title XIX eligibility. Those that are found eligible are enrolled in Title XIX. Those who are ineligible for Title XIX and meet the income standards for Title XXI are considered for Title XXI enrollment. Eligibility determinations for both Medicaid and SCHIP are handled by State employees.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))

SUPERSEDED BY CS20 (SEE MAGI SECTION)

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

The insurance provided under the state child health plan does not substitute for coverage under group health plans. A six month period of uninsurance is incorporated as an eligibility requirement for CHIP. The application requires information on when the child was last covered by health insurance. Exceptions to the period of uninsurance will be made if the applicant lost private insurance through no fault of their own (i.e., due to employer decisions) or due to hardship. The State monitors the number of eligibility denials of children that have creditable insurance who subsequently become eligible within six months.

4.4.4.2. ☐ Coverage provided to children in families over 200% and

up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution. The cost-

effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. (Section 2102)(b)(3)(D)) (42 CFR 457.125(a))

Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. Indian Health Service and tribal clinics are included as CHIP service providers. Idaho Medicaid and Tribal representatives formally meet on a routine basis. Tribal representatives can request that CHIP information be presented at any of these meetings. Additionally, regional Healthy Connections Representatives (primary care case management program coordinators) work with providers and enrollees (both Medicaid and SCHIP) to resolve issues and help ensure assistance is appropriately provided.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42CFR 457.90)

The State of Idaho places equal emphasis on outreach and education activities, which are those administrative procedures and program features that inform and recruit children and their families into potential enrollment. DHW directs outreach and education to the following groups.

- Health Care Providers
- Schools
- HeadStart/Child Care Providers
- Child Advocacy Groups

Idaho has developed a multi-dimensional approach to outreach including but not limited to the following.

- Support of stakeholder efforts to conduct targeted, grass-roots outreach.
- Supporting regional efforts by supplying professionally designed promotional materials.
- Provision of technical assistance to regional efforts through central office support staff.

In addition, regional outreach activities are conducted by regional Healthy Connections Representatives (primary care case management program coordinators). Healthy Connections Representatives are part of the Division of Medicaid but are located in regional offices, and coordinate outreach and education for CHIP throughout the state.

Section 6. Coverage Requirements for Children's Health Insurance

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan and proceed to Section 7 since children covered under a Medicaid expansion program will receive all Medicaid covered services including EPSDT.

6.1. The State elects to provide the following forms of coverage to children: (Check all that apply.) (Section 2103(c)); (42CFR 457.410(a))

6.1.1. ☐ Benchmark coverage; (Section 2103(a)(1) and 42 CFR 457.420)

6.1.1.1. ☐ FEHBP-equivalent coverage; (Section 2103(b)(1) (42 CFR 457.420(a)) (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; (Section 2103(a)(2) and 42 CFR 457.430) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431.

6.1.3. ☐ Existing Comprehensive State-Based Coverage; (Section 2103(a)(3) and 42 CFR 457.440) This option is only applicable to New York, Florida, and Pennsylvania. Attach a description of the benefits package, administration, and date of enactment. If existing comprehensive State-based coverage is modified, provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 State expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-approved Coverage**. (Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☐ Coverage the same as Medicaid State plan
6.1.4.2. ☐ Comprehensive coverage for children under a Medicaid Section 1115 demonstration waiver
6.1.4.3. ☒ Coverage that either includes the full EPSDT benefit or that the State has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage
6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage applicable only New York, Pennsylvania, or Florida

(under ☐457.440)

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The State elects to provide the following forms of coverage to children: (Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a)) (42CFR 457.490)

6.2.1. ☒ Inpatient services (Section 2110(a)(1))
6.2.2. ☒ Outpatient services (Section 2110(a)(2))
6.2.3. ☒ Physician services (Section 2110(a)(3))
6.2.4. ☒ Surgical services (Section 2110(a)(4))
6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
6.2.6. ☒ Prescription drugs (Section 2110(a)(6))
6.2.7. ☒ Over-the-counter medications (Section 2110(a)(7))
6.2.8. ☒ Laboratory and radiological services (Section 2110(a)(8))
6.2.9. ☒ Prenatal care and pre-pregnancy family services and supplies (Section 2110(a)(9))
6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11)
6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
6.2.13. ☒ Disposable medical supplies (Section 2110(a)(13))

6.2.14. ☐ Home and community-based health care services (See instructions) (Section 2110(a)(14))

6.2.15. ☒ Nursing care services (Section 2110(a)(15))
6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16)
6.2.17. ☒ Dental services (Section 2110(a)(17)) States updating their dental benefits must complete 6.2-DC (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)
6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
6.2.19. ☒ Outpatient substance abuse treatment services (Section 2110(a)(19))
6.2.20. ☒ Case management services (Section 2110(a)(20))

6.2.21. ☒ Care coordination services (Section 2110(a)(21))
6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
6.2.23. ☒ Hospice care (Section 2110(a)(23))

6.2.24. ☒ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
6.2.25. ☒ Premiums for private health care insurance coverage (Section 2110(a)(25))
6.2.26. ☒ Medical transportation (Section 2110(a)(26))
6.2.27. ☒ Enabling services (such as transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this Section (Section 2110(a)(28))

6.2-DC Dental Coverage (CHIPRA # 7, SHO # #09-012 issued October 7, 2009) The State will provide dental coverage to children through one of the following. Please update Sections 9.10 and 10.3-DC when electing this option. Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1-DC ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT[1]) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100-D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000-D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900-D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.1-DC ☒ Periodicity Schedule. The State has adopted the following periodicity schedule:
- ☒ State-developed Medicaid-specific
- ☐ American Academy of Pediatric Dentistry
- ☐ Other Nationally recognized periodicity schedule
- ☐ Other (description attached)

6.2.2-DC ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1-DC ☐ FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT[2] codes. If the State

chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2.2.2-DC ☐ State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)Page - 11 – State Health Official

6.2.2.3-DC ☐ HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, also attach a description of the services and applicable CDT codes)

6.2-DS ☐ **Supplemental Dental Coverage-** The State will provide dental coverage to children eligible for dental-only supplemental services. Children eligible for this option must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5). Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, and 9.10 when electing this option.

6.2.-D The State will provide dental coverage to children through one of the following.

Dental services provided to children eligible for dental-only supplemental services must receive the same dental services as provided to otherwise eligible CHIP children (Section 2103(a)(5)):

6.2.1.-D ☒ State Specific Dental Benefit Package. The State assures dental services represented by the following categories of common dental terminology (CDT) codes are included in the dental benefits:

1. Diagnostic (i.e., clinical exams, x-rays) (CDT codes: D0100- D0999) (must follow periodicity schedule)
2. Preventive (i.e., dental prophylaxis, topical fluoride treatments, sealants) (CDT codes: D1000-D1999) (must follow periodicity schedule)
3. Restorative (i.e., fillings, crowns) (CDT codes: D2000-D2999)
4. Endodontic (i.e., root canals) (CDT codes: D3000-D3999)
5. Periodontic (treatment of gum disease) (CDT codes: D4000- D4999)
6. Prosthodontic (dentures) (CDT codes: D5000-D5899, D5900- D5999, and D6200-D6999)
7. Oral and Maxillofacial Surgery (i.e., extractions of teeth and other oral surgical procedures) (CDT codes: D7000-D7999)
8. Orthodontics (i.e., braces) (CDT codes: D8000-D8999)
9. Emergency Dental Services

6.2.1.2-D ☒ Periodicity Schedule. The State has adopted the following periodicity schedule:

- ☒ State-developed Medicaid-specific
- ☐ American Academy of Pediatric Dentistry
- ☐ Other Nationally recognized periodicity schedule
- ☐ Other (description attached)

6.2.2-D ☐ Benchmark coverage; (Section 2103(c)(5), 42 CFR 457.410, and 42 CFR 457.420)

6.2.2.1.-D	☐	FEHBP-equivalent coverage; (Section 2103(c)(5)(C)(i)) (If checked, attach copy of the dental supplemental plan benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)
6.2.2.2-D	☐	State employee coverage; (Section 2103(c)(5)(C)(ii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)
6.2.2.3.-D	☐	HMO with largest insured commercial enrollment (Section 2103(c)(5)(C)(iii)) (If checked, identify the plan and attach a copy of the benefits description and the applicable CDT codes. If the State chooses to provide supplemental services, please also attach a description of the services and applicable CDT codes)

Inpatient Hospital Services

Inpatient Hospital Services include semi-private room, intensive and coronary care units, general nursing, drugs, oxygen, blood transfusions, laboratory, imaging service, physical, speech, occupational, heat and inhalation therapy; operating, recovery, birthing, and delivery rooms, routine and intensive care for newborns and other medically necessary benefits and prescribed supplies for treatment of injury or illness are covered.

No limitation is placed on the number of inpatient hospital days. However, such inpatient services must be medically necessary as determined by the Department or its authorized agent.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Inpatient hospital services do not include those services provided in an institution for mental diseases.

Inpatient services that are being furnished to infants and children described in 42 CFR 457.310 (targeted low income child) on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.

Limitations.
Payment is limited to semi-private room accommodations unless private accommodations are medically necessary and ordered by the physician.

Excluded Services. Elective medical and surgical treatments, except family planning services and non-medically necessary cosmetic surgery, are excluded from payment unless prior approved by the Department or its authorized agent. New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service and that are excluded by the Medicare program are excluded from payment.

Acupuncture, bio-feedback therapy, and laetrile therapy are excluded from Medicaid payment.

Procedures, counseling, and testing for the inducement of fertility are excluded from Medicaid payment.

Surgical procedures for the treatment of morbid obesity and panniculectomies are excluded unless prior approved by the Department or its authorized agent.

Organ Transplant Procedures.
Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described below.

Pursuant to the provisions of applicable Department rules, this benefit Package may include organ transplant services for cornea and bone marrow transplantation. Kidney, heart, intestinal, and liver transplants must be performed in Medicare certified transplant centers.

The treatment of complications, consequences or repair of any medical procedure in which the original procedure was not covered, unless the resulting condition is life threatening as determined by the Department or its authorized agent is excluded from payment.

Individuals may receive single or double lung, or combined heart-lung transplants from Medicare certified transplant centers. All other requirements regarding the pre-authorization of hospital stays and use of Medicare certified transplant facilities will continue to apply.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Outpatient Hospital Services

Outpatient Hospital Services include all benefits described in the inpatient hospital section which are provided on an outpatient basis in a hospital (including, but not limited to, observation beds and partial hospitalization benefits) or ambulatory surgical center; chemotherapy; emergency room benefits for surgery, injury or medical emergency; and other services for diagnostic or outpatient treatment of a medical condition, injury or illness.

Procedures generally accepted by the medical community and which are medically necessary may not require prior approval and may be eligible for payment.

Limitations.
Physical Therapy, Speech-Language Services & Occupational Therapy service limitations are described in the Therapy Services section of this table.

Psychotherapy services are limited to forty-five (45) hours per calendar year.

Other community based behavioral health services will be provided under the Idaho Behavioral Health Plans' PAHP contract.

Psychological evaluation, speech and hearing evaluations, physical therapy evaluation and, occupational therapy evaluation, and diagnostic services are limited to twelve (12) hours for each eligible recipient per calendar year.

Diabetic education and training services are limited to twenty-four (24) hours of group

counseling and twelve (12) hours of individual counseling through a diabetic education program or by a certified diabetic educator recognized by the American Diabetes Association.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Emergency Services

Emergency Hospital Services are covered when necessary to prevent death or serious impairment of health and when conditions dictate use of the most accessible hospital available, even if the hospital does not currently meet the conditions for participation under Medicare or the definitions of inpatient or outpatient hospital services included elsewhere in this State plan.

Limitations.
There is no limit on medically necessary emergency room services.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Ambulatory Surgical Centers Services (ASC)

Ambulatory surgical center services are outlined in applicable Department rules and must be provided in a facility certified by Medicare as an ASC, and are restricted to those procedures identified by the Medicare program in accordance with 42 CFR 416.65, or identified by the Department as meeting such requirements.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Physician Services

Medical Services:
These services include office, clinic, outpatient surgery center and hospital treatment by a physician for a medical condition, injury or illness. Physician services are covered whether furnished in the office, the patient's home, a hospital, or elsewhere.

Covered Services include treatment of medical and surgical conditions by doctors of medicine or osteopathy subject to the limitations of practice imposed by state law, and in accordance to the restrictions and exclusions of coverage contained in applicable Department rules. Medically appropriate second opinions are covered.

Limitations. Limits on psychiatric evaluations and psychotherapy in any twelve (12) month period for Outpatient Mental Health Services shall not apply when such services are provided as Physician Services.

Surgical Services:
Covered services include professional services rendered by a physician, surgeon or doctor of dental surgery.

Abortions Services:
A legal abortion is only covered to save the life of the mother or in cases of rape or incest as determined by the courts.

When a pregnancy is life threatening and abortion is provided to save the life of the mother, one licensed physician or osteopath must certify in writing that the woman may die if the fetus is carried to term.

Cases of rape or incest must be determined by a court or documented by a report to law enforcement, except that if the rape or incest was not reported to law enforcement, a licensed physician or osteopath must certify in writing that, in his/her professional opinion, the women was unable to report the rape or incest to law enforcement for reasons related to her health.

Excluded Services.
Hysterectomies that are not medically necessary and sterilization procedures are excluded from payment.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Other Practitioner Services

Other Practitioner Services include medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

Certified Pediatric or Family Nurse Practitioners' Services are those services provided by certified pediatric or family nurse practitioners as defined by state and federal law**.** This coverage has the same exclusions as Physician Services. This coverage specifically includes services by certified pediatric and family nurse practitioners. Services provided by nurse practitioners are limited to Section 54-1402(d) of Idaho Code.

Physician Assistant Services include those services provided by a physician assistant as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Services provided by physician assistants are limited to Section 54-1803(11) of the Idaho Code.

Chiropractor Services are limited to a total of six (6) office visits during any calendar year. The remedial treatment must involve the manipulation of the spine to correct a subluxation condition.

Podiatrist Services are limited to treatment of acute foot conditions.

Optometrist Services are limited to providing eye examination and eyeglasses unless the optometrist has been issued and maintains certification under the provisions of Idaho Code to diagnose and treat injury or diseases of the eye. In these circumstances, payment will be made for diagnosis and treatment services.

Nurse-Midwife Services are provided to the extent that nurse-midwives are authorized to practice under State law or regulation and without regard to whether the services are furnished in the area of management of the care of mothers and babies throughout the maternity cycle. Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid/CHIP agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

Certified nurse-midwife services are those services provided by certified nurse midwives as defined by state and federal law. This coverage has the same exclusions as Physician Services.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Primary Care Case Management (PCCM)

Primary Care Case Management Services are provided by a primary care case manager consistent with a program authorized under section 1937 of the Social Security Act. Most participants must enroll with a PCCM.

Certain covered individuals with selected chronic diseases may enroll with a PCCM provider who receives an enhanced PCCM fee for measured clinical best practices related to chronic disease management. Enhanced PCCM fees are performance-based incentive payments made for individuals with the following chronic conditions:

- Diabetes & a risk factor
- Asthma & a risk factor
- Serious & Persistent Mental Illness (SPMI) or
- Serious Emotional Disturbance (SED)

Risk factors include: obesity, dyslipidemia, tobacco use, hypertension, diseases of the respiratory system or Coronary Artery Disease (CAD)

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Prevention Services

Prevention Services include a Health Risk Assessment which consists of:

- An initial health questionnaire, and

- A well child screen.

The health questionnaire is designed to assess the general health status and health behaviors of a recipient. This information will be used to provide customized health education. The health questionnaire will be administered at initial program entry and periodic intervals thereafter.

A well child screen conducted at periodic or interperiodic intervals which constitutes a health risk assessment will consist of a comprehensive physical examination and health education.

Well Child Screens.
Periodic medical screens completed at intervals recommended by the American Academy of Pediatrics (AAP), Committee in Practice and Ambulatory Medicine are covered.

Periodic screens and Interperiodic screens should constitute a health risk assessment as specified in applicable Department rules. Interperiodic medical screens are screens that are done at intervals other than those identified in the AAP periodicity schedule referenced above and must be performed by physician or physician extender. Interperiodic screens will be performed when there are indications that it is medically necessary to determine whether a child has a physical or mental illness or condition that may require further assessment, diagnosis, or treatment. Interperiodic screening examinations may occur in children who have already been diagnosed with an illness or condition, and there is indication that the illness or condition may have become more severe or changed sufficiently, so that the further examination is medically necessary.

Developmental screening is considered part of every routine initial and periodic examination. If the screening identifies a developmental problem then a developmental assessment will be ordered by the physician and conducted by qualified professionals.

Diagnostic Screening Clinics. Services provided in a diagnostic screening clinic are outlined in applicable Department rules.

Limitations. Service limitations for Diagnostic Screening Clinics are as follows: five (5) hours of medical social services per eligible recipient per state fiscal year is the maximum allowable.

Prevention and Health Assistance (PHA) Benefits
Targets overweight individuals for enhanced Prevention and Health Assistance (PHA) benefits in accordance with applicable Department rules.

PHA benefits are individualized benefits targeted to address weight management. Authorizations will be managed by the state Medicaid agency.

PHA benefits will be available when individuals complete specified activities in preparation for addressing their weight. These activities include discussing the condition with their primary care provider, participating in an applicable support group, and completing basic educational material related to managing their weight.

PHA benefits may be used to purchase services related to weight reduction/management in accordance with applicable Department rules. These services may include weight-loss programs, and other health related benefits.

Nutrition Services
Include intensive nutritional education, counseling, and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/professional requirements in dietetics as approved by the American Dietetics Association to assure the patient's proper nutrition is allowed. Nutrition services must be discovered by the screening services and ordered by the physician; must be medically necessary; and, if over two (2) visits per year are needed, must be authorized by the Department prior to the delivery of additional visits.

Limitations. Nutrition services related to obesity, including dietary assessment and individualized nutrition education, shall not be subject to the above limitations when provided as PHA benefits.

Diabetes Education and Training Clinics
Provide diabetic education and training services as outlined in applicable Department rules. Outpatient diabetes education and training services will be covered under the following conditions.

The education and training services are provided through a diabetic management program recognized as meeting the program standards of the American Diabetes Association.

The education and training services are provided through a formal program conducted through a hospital outpatient department or a physician's office by a Certified Diabetic Educator certified by the American Diabetes Association.

Only training and education services which are reasonable and necessary for treatment of a current injury or illness will be covered. Covered professional and educational services will address each client's medical needs through scheduled outpatient group or individual training or counseling concerning diet and nutrition, medications, home glucose monitoring, insulin administration, foot care, or the effects of other current illnesses and complications.

To receive diabetic counseling, the following conditions apply to each patient:

- the patient must have a written order by his or her primary care physician or physician extender referring the patient to the program; and
- the physician may not use the formally structured program or a Certified Diabetes Educator as a substitute for basic diabetic care and instruction that the physician must furnish to the patient which includes the disease process/pathophysiology of diabetes mellitus and dosage administration of oral hypoglycemic agents.

The medical necessity for diabetic education and training are evidenced by the following:

- a recent diagnosis of diabetes within ninety (90) days of enrollment with no history of prior diabetic education; or,
- uncontrolled diabetes manifested by two or more fasting blood sugar of greater than one hundred forty milligrams per decaliter (140 mg/dL), hemoglobin greater than eight percent (8%), or random blood sugar greater than one hundred eighty

milligrams per decaliter (180 mg/dL), in addition to manifestations, or
- recent manifestations resulting from poor diabetes control including neuropathy, retinopathy, recurrent hypoglycemia, repeated infections, or non-healing wounds.

Diabetes education and training services will be limited to twenty-four (24) hours of group sessions and twelve (12) hours of individual counseling every five (5) calendar years

Limitations. Diabetes education related to obesity shall not be subject to the above limitations when provided as PHA benefits.

Tobacco Cessation Counseling
Services are covered in accordance with USPSTF Recommendations.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Laboratory and Radiological Services

Laboratory and Radiological Services include imaging and laboratory services for diagnostic and therapeutic purposes due to accident, illness or medical condition, as well as X-ray, radium or radioactive isotope therapy.

Laboratory and x-ray services are provided upon and under the direction of a physician or other licensed practitioner.

Excluded Services.
Laboratory and/or x-ray procedures which are associated with excluded Hospital Services and Physician Services are excluded from payment.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Prescribed Drugs

Prescribed Drugs are those prescribed by a practitioner acting within the scope of his practice, chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines and prenatal vitamins.

Prescribed drugs are provided for non-institutionalized persons as well as institutionalized patients. Prescriptions for oral contraceptives and diaphragms for women of child bearing age are also eligible for payment. All drug products requiring, by state or federal law, a licensed practitioner's order for dispensing or administration which are medically necessary are purchasable except for (1) those specifically excluded as ineffective or inappropriate by the Department of Health and Welfare policy, or (2) those drugs not eligible for federal participation. A prescription drug is considered medically necessary for a client if it is reasonably calculated to prevent or treat conditions in the client that endanger life, cause pain or functionally significant deformity or malfunction; and there is no other therapeutically interchangeable prescription drug available or suitable for the client requesting the service which is more conservative or substantially less costly; and the

prescription drug meets professionally recognized standards of health care and is substantiated by prescriber's records including evidence of such medical necessity. Those records shall be made available to the Department upon request. The criteria used to determine medical necessity is stated in applicable Department rules.

Additional Covered Drug Products. Additional drug products will be covered as follows:

- Therapeutic Vitamins;
- Injectable Vitamin B12 (cyanocobalamin and analogues);
- Vitamin K and analogues;
- Pediatric vitamin-fluoride preparations;
- Legend prenatal vitamins for pregnant or lactating women;
- Legend folic acid;
- Legend Vitamin D and analogues.

Prescriptions for non-legend products will be covered as follows:

- Disposable insulin syringes and needles;
- Permethrin; and
- OTC products as authorized by applicable Department rules.

Limitations.
Prior authorization will be required for certain drugs and classes of drugs. Prescribing physicians, pharmacists, and/or designated representatives may contact the Medicaid Pharmacy Unit for prior authorizations via 1-800 phone and fax lines, or by mail. Responses are issued within 24 hours of the request. Pharmacies are authorized to dispense a 72 hour supply of a prior authorized product in the event of an emergency. The program complies with requirements set forth in section 1927 (d) (5) of the Social Security Act pertaining to prior authorization programs. The following drugs require prior authorization:

- Amphetamines and related CNS stimulants;
- Growth hormones;
- Retinoids;
- Brand name drugs when acceptable generic form is available;
- Medications otherwise covered by the Department for which there is a less costly, therapeutically interchangeable medication covered by the Department;
- Medications prescribed in quantities which exceed the Food and Drug Administration (FDA) dosage guidelines;
- Medications prescribed outside of the FDA approved indications;
- Lipase inhibitors; and
- FDA, 1-A rated single source and innovator multi-source drugs manufactured by companies not participating in the National Rebate Agreement, which have been determined by the Department to be medically necessary.

Non-covered Drugs must be discovered as being medically necessary by the screening services for individuals qualifying under EPSDT; and must be ordered by the physician and must be authorized by the Department or its authorized agent prior to purchase of the drug.

Limitation of Quantities.
No more than a thirty-four (34) day supply of continuously required medication is to be purchased in a calendar month as a result of a single prescription. The following medications are the only exceptions to the 34 day supply limitation.

Up to one hundred (100) unit doses or a 100 day supply, whichever is less, of the following medications may be purchased:

- Cardiac glycosides;
- Thyroid replacement hormones;
- Prenatal vitamins;
- Nitroglycerin sublingual and dermal patch products;
- Fluoride and vitamin fluoride combination products; and

Oral contraceptive products may be purchased in a quantity sufficient for one (I), two (2), or three (3) cycles.

Excluded Drug Products.

- Legend drugs for which Federal Financial Participation is not available
- Nonprescription items (without the Federal Legend), except permethrin, oral iron salts, disposable insulin syringes and needles, and OTC products as authorized by applicable Department rules.
- Ovulation stimulants and fertility enhancing drugs.
- Medications used for cosmetic purposes.
- Prescription vitamins except injectable B12, vitamin K, legend vitamin D, legend pediatric vitamin and fluoride preparations, legend prenatal vitamins for pregnant or lactating women, and legend folic acid.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Family Planning Services

Family Planning Services include pre-pregnancy family planning services and prescribed supplies including birth control contraceptives.

Family planning services and supplies for individuals of child-bearing age include counseling and medical services prescribed by a licensed physician, qualified certified nurse practitioner, or physician's assistant. The Department will cover diagnosis, treatment, contraceptive supplies, and related counseling.

The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

All requirements of 42 CFR Part 441, Subpart F are met.

Limitations.
Contraceptive supplies include condoms, foams, creams and jellies, prescription diaphragms, intrauterine devices, or oral contraceptives, which are limited to purchase of a three-month supply.

Hysterectomies performed solely for sterilization are ineligible for payment.

Individuals under twenty-one (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medically necessary and prior authorized by the Department.

Behavioral Health Services

Inpatient Psychiatric Services
includes services for Certain Individuals in Institutions for Mental Diseases.

Inpatient psychiatric facility services include services provided which meet medical necessity criteria determined by the Department or its authorized agent and provided in a JCAHO accredited hospital.

Limitations. Inpatient mental health services, including Psychiatric Services covered under Inpatient Hospital Services, are limited to ten (10) days per calendar year.

Community-Based Outpatient Behavioral Health Services

Behavioral health services are medically necessary rehabilitation services that evaluate the need for and provide therapeutic and rehabilitative treatment to minimize symptoms of mental illness and substance use disorders and restore independent functioning. These services include:

- Behavioral Health Nursing
- Case Management
- Crisis Intervention
- Drug Screening
- Occupational Therapy
- Partial Care
- Pharmacological management
- Psychological and neuropsychological testing
- Psychotherapy (group, family and individual)
- Screening, Evaluation & Diagnostic Assessment
- Treatment Planning

All community based rehabilitation and substance use disorder treatment services will be provided through a Pre-paid Ambulatory Health Plan as the Idaho Behavioral Health Plan.

Limitations.
All community based outpatient behavioral health services are subject to limitations of practice imposed by state law, federal regulations and according to applicable Department rules, the PAHP contract as awarded or amended and approved by the Department or its authorized agent based upon medical necessity.

Excluded Services.
Experimental or Non-medically necessary services as determined by the Department or its authorized agent will be excluded.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if

determined to be medical necessary and prior authorized.

Home Health Care

Home Health Care Services include intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Services also include home health aide services provided by a home health agency.

Home health services are provided in accordance with the requirements of 42 CFR 441.15.

Limitations.
Services by a licensed nurse, when no home health agency exists in the area, must be prior approved by the Department as defined in 42 CFR 440.70(b)(l).

Home health visits are limited to one hundred (100) per recipient per calendar year provided by any combination of home health agency licensed nurse, home health aide, home health physical therapist, home health occupational therapist, licensed nurse.

Private Duty Nursing (PDN) are nursing services provided by a registered nurse or licensed practical nurse to a non-institutionalized child requiring care for conditions of such medical severity or complexity that skilled nursing care is necessary. The nursing needs must be of such a nature that the Idaho Nursing Practice Act, Rules, Regulations, or Policy require the service to be provided by an Idaho Licensed Professional Nurse (RN), or by an Idaho Licensed Practical Nurse (LPN), and require more individual and continuous care than is available from Home Health nursing services.

PDN Services must be ordered by a physician, and include:
1. A function which cannot be delegated to an Unlicensed Assistive Personnel (UAP) as defined by Idaho Code and Administrative Rules of the Idaho State Board of Nursing.
2. An assessment by a licensed professional nurse of a child's health status for unstable chronic conditions, which includes:

    - A medical status that is so complex or unstable, as determined by the attending physician, that licensed or professional nursing assessment is needed to determine the need for changes in medication or other interventions; or
    - A licensed or professional nursing assessment to evaluate the child's responses to interventions or medications.

Services delivered must be in a written plan of care, and the plan of care must be developed by a multi-disciplinary team.

The plan of care must be revised and updated as the child's needs change or upon significant change of the condition, but at least annually, and must be submitted to the Department or its authorized agent for review and prior authorization of service.

Limitations.
PDN services must be authorized by the Department or its authorized agent to delivery of service.

PDN Services may be provided only in the child's personal residence or when normal life

activities take the child outside of this setting. However, if service is requested only to attend school or other activities outside of the home, but does not need such services in the home, private duty nursing will not be authorized. The following are specifically excluded as personal residences:

- Licensed Nursing Facilities (NF);
- Licensed Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID);
- Licensed Residential Care Facilities;
- Licensed hospitals; and
- Public or private school

Individuals under (21) years of age pursuant to EPSDT, may receive additional services under this section if determined to be medical necessary and prior authorized.

Therapy Services

Therapy Services include physical therapy, occupational therapy, or speech-pathology and audiology services provided by a home health agency or medical rehabilitation facility.

Therapy services by an independent provider may be furnished by the following providers:

Physical therapist who in accordance with 42 CFR 440.110(a) is licensed by the PT Licensing Board within the Board of Occupational Licensing.

Occupational Therapist who in accordance with 42 CFR 440.110(b) is licensed by the Board of Medicine.

Speech-Language Pathologist who in accordance with 42 CFR 440.110(c), is licensed by the Speech and Hearing Services Licensure Board within the Board of Occupational Licensing.

All therapy services are provided according to a written physician order as a part of a plan of care, and be provided either in the patient's home or in the therapist's office. An office in a nursing home or hospital is not considered an independent therapist's office.

Respiratory care services may be furnished to individuals qualifying under EPSDT.

Limitations.
Home health agency visits by physical therapists and occupational therapists are limited to a total of one-hundred (100) visits per recipient per calendar year. Included in the total visit are all home health aides, nursing services, physical therapy services, and occupational therapy services in any combination. Speech pathology and audiology services are not provided for under home health services.

Physical Therapy and Speech-Language Services

Not limited but are subject to State review for appropriate coverage if the total amount billed for an individual exceeds a cap amount.

Occupational Therapy Services

Not limited but are subject to State review for appropriate coverage if the total amount billed for an individual exceeds a cap amount.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if determined to be medical necessary.

Audiology Services

Audiology Services include services for individuals with hearing disorders provided by an audiologist who is licensed by the Speech and Hearing Services Licensure Board in accordance with 42 CFR 440.110(c).

Audiology Services include audiometric services and supplies according to applicable Department rules. The Department will cover hearing screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate hearing screen. The guidelines coincide with certain scheduled medical screens; the hearing screen is considered part of the medical screening service.

Hearing Aids. Hearing aids and related services will be covered by the Department.

Augmentative Communication Devices. Augmentative communication devices are covered as specified in applicable Department rules.

Limitations.
The Department will pay for one audiometric examination and testing related to the exam each calendar year when ordered by a physician and provided by a certified audiologist and/or licensed physician. Any hearing test beyond the basic comprehensive audiometry and independent testing must be ordered in writing before the testing is done.

The Department will purchase one (1) hearing aid per recipient with prior approval by the Department. Follow up services are included in the purchase of the hearing aid for the first year. Necessary repairs resulting from normal use after the second year will be covered. Hearing aid batteries will be purchased on a monthly basis. Refitting of hearing aid or additional ear molds will be purchased no more often than forty-eight (48) months from the last fitting.

Individuals may receive audiology services and supplies ordered by a licensed physician and supplied by a physician or certified audiologist, with the following exceptions:

- When binaural aids are requested they will be authorized if documented to the Department's satisfaction, that the child's ability to learn would be severely restricted; or
- Replacement hearing aids may be authorized if the requirements in applicable Department rules are met.

The Department will purchase additional ear molds after the initial six (6) months to one (1) year period if medically necessary. Requests in excess of every six (6) months will require prior authorization and documentation of medical need from either the attending physician or audiologist.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if

determined to be medical necessary and prior authorized.

Medical Equipment, Supplies and Devices

Medical Equipment and Supplies
includes durable medical equipment and other medically-related or remedial devices. These also include medical supplies, equipment, and appliances suitable for use in the home.

Medical equipment and medical supplies must be ordered in writing by a physician. Medical equipment and supplies are provided only on a written order from a physician that includes the medical necessity documentation listed in the Medicare DMERC Supplier manual.

Limitations.
Items not specifically listed in applicable Department rules will require prior authorization by the Department or its authorized agent.

Specialized Medical Equipment and Supplies

Oxygen and related equipment is covered for individuals qualifying under EPSDT when the medical need is discovered during a screening service and is physician ordered. PRN oxygen, or oxygen as needed on less than a continual basis, will be authorized for six (6) months following receipt if medical documentation from the attending physician as to an acute or chronic medical condition which requires oxygen support to maintain respiratory status. Medical documentation will include a diagnosis, oxygen flow rate and concentration, and an estimate of the frequency and duration of use. Portable oxygen systems may be ordered to compliment a stationary system if the recipient is respirator dependent, or the attending physician documents the need for a portable oxygen system for use in transportation. Laboratory evidence for hypoxemia is not required under the age of six (6) months.

Prosthetic Devices
These services include prosthetic and orthotic devices and related services prescribed by a physician and fitted by an individual who is certified or registered by the American Board for Certification in orthotics and/or prosthetics.

The Department will purchase and/or repair medically necessary prosthetic and orthotic devices and related services which artificially replace a missing portion of the body or support a weak or deformed portion of the body.

Limitations.
Prosthetic and orthotic devices and services will be purchased only if pre-authorized by the Department or its authorized agent. Limit of one refitting, repair or additional parts in a calendar year.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if determined to be medical necessary and prior authorized.

Vision Services

Vision Services include eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

The Department will pay for vision services and supplies. One eye exam by physicians and/or optometrists is allowed during any twelve (12) month period. The Department will cover vision-screening services according to the recommended guidelines of the AAP. The screen administered will be an age-appropriate vision screen. The guidelines coincide with certain scheduled medical screens; the vision is considered part of the medical screening service, (i.e. eye chart). The Department will pay for one (1) eye examination by an ophthalmologist or optometrist during any twelve (12) month period for each eligible recipient to determine the need for glasses to correct or treat refractive error.

Eyeglasses. Each recipient, following a diagnosis of visual defects and a recommendation that eyeglasses are needed for correction of a refractive error, can receive one (1) pair of eyeglasses per year, except in the following circumstances: In the case of a major visual change, the Department can authorize purchase of a second pair of eyeglasses and can authorize a second eye examination to determine that visual change; or the Department may pay for replacement of lost glasses or replacement of broken frames or lenses. New frames will not be purchased if the broken frame can be repaired for less than the cost of new frames if the provider indicates one of these reasons on his claim. If repair costs are greater than the cost of new frames, new frames may be authorized.

Lenses will be provided when there is documentation that the correction needed is equal to or greater than plus or minus one-half (.50) diopters of correction.

Limitations.
Polycarbonate lenses will be purchased only when it is documented that the prescription is above plus or minus two (2.00) diopters of correction. Payment for tinted lenses will only be made when there is a diagnosis of albinism or in the case of extreme medical conditions as determined by the Department. Contact lenses will be covered only when documentation of an extreme myopic condition requiring a correction equal or greater than minus four (-4) ten diopters, cataract surgery, keratoconus, or other extreme medical condition preclude the use of conventional lenses. Replacement lenses will be purchased only when there is documentation of a major visual change of at least one-half (.50) diopter plus or minus.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if determined to be medical necessary and prior authorized.

Essential Providers

Clinic Services and Rehabilitative Services are preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician and which may include those services provided by community health centers.

Rural Health Clinic services and other ambulatory services furnished by a rural health clinic, which are otherwise included in the State plan.

Federally Qualified Health Center (FQHC) services and other ambulatory services that are furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Indian Health Service Facility services are provided in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

Independent School Districts which have entered into a provider agreement with the Department may bill for the following services when they are identified on the student's Individual Education Plan (IEP). All provider qualification and prior authorization requirements as specified in IDAPA 16.03.09 for these services apply.

Audiology Services Diagnostic, screening, preventive or corrective services provided by an audiologist licensed by the Speech and Hearing Services Board in the Idaho Board of Occupational Licensing.

Behavioral Consultation Consultation with the IEP team during the assessment process, performing advanced assessment, coordinating the implementation of the behavior implementation plan and providing ongoing training to the behavioral interventionist and other team members.

Behavioral Intervention Continuous intervention method focused on promoting the student's ability to participate in educational services through a consistent, assertive intervention process. It includes the development of replacement behaviors with the purpose to prevent or treat behavioral conditions of students who exhibit maladaptive behaviors.

Evaluation and Diagnostic Services Evaluation and diagnostic services are reimbursable if they are to determine eligibility or need for health related services. Evaluations must meet the criteria in IDAPA rule, section 852 School Based Services. Evaluations completed for education services only are not reimbursable.

Medical Equipment and Supplies Medical equipment and supplies that are covered by Medicaid and are needed for use at school but are too large or unsanitary to transport from home to school. They must be for the student's exclusive use and transfer with the student if the student changes schools.

Nursing Services Skilled nursing services that must be provided by a licensed nurse. Emergency, first aide or assistance with non- routine medications not identified on the IEP as health related services are not reimbursable.

Occupational Therapy, Physical Therapy or Speech Language Pathology Rehabilitation Services Services for the purpose of restoring certain functional losses due

to disease, illness or injury. Services for vocational assessment, training or vocational rehabilitation are not covered.

Personal Care Services School based personal care services include medically oriented tasks having to do with the student's physical or functional requirements while at school.

Psychological Evaluation Evaluations of cognitive abilities, mental health issues and issues related to brain injury.

Psychotherapy Rehabilitative therapeutic interventions to address alcohol or drug abuse and/or emotional, behavioral or cognitive problems.

Psychosocial Rehabilitation and Evaluation Services to assist the student in gaining and utilizing skills necessary to participate in school such as training in behavior control, social skills, and coping skills.

Social History and Evaluation Assessment of home and family environment, to determine suitability to meet the participant's medical needs.

Transportation Student must require special transportation that is ordered by a physician and included on the IEP, and receive another Medicaid reimbursable service on the same day.

Interpretive Services May only be billed when the student needs the services of an interpreter to receive a Medicaid reimbursable service. Not covered if the person providing the service is able to communicate in the student's primary language.

The amount of each service is determined by the interdisciplinary team through the Individualized Education Plan (IEP) Process.

Limitations.

Audiology Services These services do not include equipment.

Behavioral Consultation is limited to thirty-six (36) hours per student per year.

Occupational, Physical or Speech Therapy Services Claims exceeding $1870 for OT or $1870 for a combination of SLP and PT are subject to prepayment review for medical necessity.

Excluded Services. Vocational, Educational and Recreational services are not reimbursable

Individuals under (21) years of age pursuant to EPSDT, may receive additional services in this section, if determined to be medical necessary and prior authorized.

Medical Transportation Services

Medical Transportation Services include transportation services and assistance for eligible persons to medical facilities. Payment for meals and lodging may be authorized where appropriate.

Ambulance services will be covered in emergency situations or when prior authorized by the Department or its authorized agent.

Limitations.
Requests for transportation services will be reviewed and authorized by the Department or its authorized agent. Authorization is required prior to the use of transportation services except when the service is emergent in nature. Payment for transportation services will be made, for the least expensive mode available, which is most appropriate to the recipient's medical needs.

Excluded Services. Transportation to medical facilities for the performance of medical services or procedures which are excluded from payment are also excluded.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if determined to be medical necessary and prior authorized.

Long Term Care Services

Personal Care Services
are services furnished to a participant who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded intellectually disabled, or institution for mental disease that are:

- provided in accordance with a plan of care;
- provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and
- provided in the participant's home.

Providers who are expected to carry out training programs for intellectually disabled participants must be supervised at least every ninety (90) days by a Qualified Mental Retardation Intellectual Disability Professional (42 CFR 483.430(a)).

Limitations.
Services are limited to sixteen (16) hours per calendar week, per eligible client.

Individuals qualifying under EPSD, may receive personal care services in excess of sixteen hours of service per week.

Hospice Care

Hospice Care is provided only to terminally ill recipients. Services must be provided by a Medicare certified hospice and in accordance with Section 2302 of the Affordable Care Act, which requires hospice services to be provided to children concurrently with curative treatment.

Limitations.

A recipient is provided up to eight calendar months of hospice care. The benefit period starts on the first day of the month in which hospice was elected and hospice is automatically renewed each month until the date of the recipient's death, revocation, or failure to meet monthly eligibility requirements. The recipient will have at least 210 hospice days available.

Respite days are limited to five days per benefit period (calendar month).

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if determined to be medical necessary and prior authorized.

Special Services for Children/EPSDT

EPSDT Services include diagnosis and treatment involving medical care as well as such other necessary health care described in Section 1905(a) of the Social Security Act, and not included in this State Plan as required to correct or ameliorate defects and physical and mental illness discovered by the screening service. The Department will set amount, duration and scope for services provided under EPSDT. Needs for services discovered during a screening which are outside the coverage provided by applicable Department rules must be shown to be medically necessary and the least costly means of meeting the recipient's medical needs to correct or improve the physical or mental illness discovered by the screening and ordered by the physician, nurse practitioner or physician's assistant. The Department will not cover services for cosmetic, convenience or comfort reasons. Any service requested which is covered under Title XIX of the Social Security Act that is not identified in applicable Department rules specifically as a covered benefit or service will require preauthorization for medical necessity prior to payment for that service. The additional service must be documented by the attending physician as medically necessary and that the service requested is the least costly means of meeting the recipient's medical needs. Preauthorization from the Department or its authorized agent will be required prior to payment.

Case Management Services

Case Management Services are provided to targeted children who meet the requirements set forth in Department rules. A Service Plan must be completed and authorized prior to delivery of case management services. The case manager must review and update the approved service plan for service coordination at least annually. The Department or its authorized agent must approve the Service Plan for continued authorization.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if determined to be medical necessary and prior authorized.

Specific Pregnancy-Related Services

Risk Reduction Follow-up. Services to assist the client in obtaining medical, educational, social and other services necessary to assure a positive pregnancy outcome. Payment is available to licensed social workers, registered nurses and physician extenders either in independent practice or as employees of entities which have current provider agreements with the Department.

Individual and Family Medical Social Services. Services directed at helping a patient to overcome social or behavioral problems which may adversely affect the outcome. Payment is available for two (2) visits during the covered period to a licensed social worker qualified to provide individual counseling according to the provisions of the Idaho Code and the regulations of the Board of Social Work Examiners.

Nutrition Services. Intensive nutritional education, counseling and monitoring by a registered dietician or an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic/profession requirements in dietetics as approved by the American Dietetic Association to assure the patient's proper nutrition. Payment for two (2) visits per pregnancy is available.

Nursing Services. Home visits by a registered nurse to assess the client's living situation and provide appropriate education and referral during the covered period. A maximum of two (2) visits per pregnancy is provided.

Maternity Nursing Visit. Office visits by a registered nurse, acting within the limits of the Nurses Practices Art, for the purpose of checking the progress of the pregnancy. These services must be prior authorized by the Department's care coordinator and can be paid only for women unable to obtain a physician to provide prenatal care. This service is to end immediately when a primary physician is found. A maximum of nine (9) visits can be authorized.

Qualified Provider Risk Assessment and Plan of Care. When prior authorized by the Department care coordinator, payment is made for qualified provider services in completion of a standard risk assessment and plan of care for women unable to obtain a primary care physician, nurse practitioner, or nurse midwife for the provision of antepartum care.

Individuals under (21) years of age pursuant to EPSDT, may receive additional services if determined to be medical necessary and prior authorized.

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: (42CFR 457.480)

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2103(f)). Please describe: Previously 8.6

6.4. Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: (Section 2105(c)(2) and (3)) (42 CFR 457.1005 and 457.1010)

6.4.1. ☐ Cost Effective Coverage. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives

under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the incurred by the state to administer the plan, if it demonstrates the following (42CFR 457.1005(a)):

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28. (Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. Describe the community-based delivery system. (Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))

6.4.2. ☐ Purchase of Family Coverage. Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3)) (42CFR 457.1010)

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A)) (42CFR 457.1010(a))

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of

family coverage. (Section 2105(c)(3)(B)) (42CFR 457.1010(b))

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. (42CFR 457.1010(c))

6.4.3-PA: Additional State Options for Providing Premium Assistance (CHIPRA # 13, SHO # 10-002 issued February, 2, 2010)A State may elect to offer a premium assistance subsidy for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(B), to all targeted low-income children who are eligible for child health assistance under the plan and have access to such coverage. No subsidy shall be provided to a targeted low-income child (or the child's parent) unless the child voluntarily elects to receive such a subsidy. (Section 2105(c)(10)(A)). Please remember to update section 9.10 when electing this option. Does the State provide this option to targeted low-income children?

☐ Yes
☒ No

6.4.3.1-PA Qualified Employer-Sponsored Coverage and Premium Assistance Subsidy

6.4.3.1.1-PA Provide an assurance that the qualified employer-sponsored insurance meets the definition of qualified employer-sponsored coverage as defined in Section 2105(c)(10)(B), and that the premium assistance subsidy meets the definition of premium assistance subsidy as defined in 2105(c)(10)(C).

6.4.3.1.2-PA Describe whether the State is providing the premium assistance subsidy as reimbursement to an employee or for out-of-pocket expenditures or directly to the employee's employer.

6.4.3.2-PA: Supplemental Coverage for Benefits and Cost Sharing Protections Provided under the Child Health Plan**.**

6.4.3.2.1-PA If the State is providing premium assistance for qualified employer-sponsored coverage, as defined in Section 2105(c)(10)(E)(i), provide an assurance that the State is providing for each targeted low-income child enrolled in such coverage, supplemental coverage consisting of all items or services that are not covered or are only partially covered, under the qualified employer-sponsored coverage consistent with 2103(a) and cost sharing protections consistent with Section 2103(e).

6.4.3.2.2-PA Describe whether these benefits are being provided through the employer or by the State providing wraparound benefits.

6.4.3.2.3-PA If the State is providing premium assistance for benchmark or benchmark-equivalent coverage, the State ensures that such group health plans or health insurance coverage offered through an employer will be certified by an actuary as coverage that is equivalent to a benchmark benefit package described in Section 2103(b) or benchmark equivalent coverage that meets the requirements of Section 2103(a)(2).

6.4.3.3-PA: Application of Waiting Period Imposed Under State Plan: States are required to apply the same waiting period to premium assistance as is applied to direct coverage for children under their CHIP State plan, as specified in Section 2105(c)(10)(F).

6.4.3.3.1-PA Provide an assurance that the waiting period for children in premium assistance is the same as for those children in direct coverage (if State has a waiting period in place for children in direct CHIP coverage).

6.4.3.4-PA: Opt-Out and Outreach, Education, and Enrollment Assistance

6.4.3.4.1-PA Describe the State's process for ensuring parents are permitted to disenroll their child from qualified employer-sponsored coverage and to enroll in CHIP effective on the first day of any month for which the child is eligible for such assistance and in a manner that ensures continuity of coverage for the child (Section 2105(c)(10)(G)).

6.4.3.4.2-PA Describe the State's outreach, education, and enrollment efforts related to premium assistance programs, as required under Section 2102(c)(3). How does the State inform families of the availability of premium assistance, and assist them in obtaining such subsidies? What are the specific significant resources the State intends to apply to educate employers about the availability of premium assistance subsidies under the State child health plan? (Section 2102(c))

6.4.3.5-PA: Purchasing Pool- A State may establish an employer-family premium assistance purchasing pool and may provide a premium assistance subsidy for enrollment in coverage made available through this pool (Section 2105(c)(10)(I)). Does the State provide this option?

☐ Yes
☐ No

6.6.3.5.1-PA Describe the plan to establish an employer-family premium assistance purchasing pool.

6.6.3.5.2-PA Provide an assurance that employers who are eligible to participate: 1) have less than 250 employees; 2) have at least one employee who is a pregnant woman eligible for CHIP or a member of a family that has at least one child eligible under the State's CHIP plan.

6.6.3.5.3-PA Provide an assurance that the State will not claim for any administrative expenditures attributable to the establishment or operation of such a pool except to the extent such payment would otherwise be permitted under this title.

6.4.3.6-PA Notice of Availability of Premium Assistance- Describe the procedures that assure that if a State provides premium assistance subsidies under this Section, it must: 1) provide as part of the application and enrollment process, information describing the availability of premium assistance and how to elect to obtain a subsidy; and 2) establish other procedures to ensure that parents are fully informed of the choices for child health assistance or through the receipt of premium assistance subsidies (Section 2105(c)(10)(K)).

6.4.3.6.1-PA Provide an assurance that the State includes information about premium assistance on the CHIP application or enrollment form.

Section 7. Quality and Appropriateness of Care

☐ Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A)) (42CFR 457.495(a))

Claims data are collected and analyzed to assess performance using National Performance Measurements (see section 9.3.6). An annual participant survey monitors and assesses quality and appropriateness of care.

Will the state utilize any of the following tools to assure quality?

(Check all that apply and describe the activities for any categories utilized.)

7.1.1. ☐ Quality standards
7.1.2. ☐ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: (2102(a)(7)(B)) (42CFR 457.495)

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. (Section 2102(a)(7)) (42CFR 457.495(a))

Enrollment in Idaho's primary care case management program (Healthy Connections) is required in most areas of the state, which helps to ensure that enrollees have a usual source of care. Primary care providers are required by contract to provide primary care services to their enrollees. This includes wellness care and immunizations. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102(a)(7)) 42CFR 457.495(b))

The State of Idaho will ensure access to covered services, including emergency services as defined in 42 CFR 457.10. Referrals are not required to access emergency services. All provider types necessary to provide covered services are included in the provider panel.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102(a)(7)) (42CFR 457.495(c))

The State of Idaho will ensure access to appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition.

Contractually, primary care providers are required to make referrals for most medically necessary specialty services. All provider types necessary to provide covered services are included in the provider panel. In addition, Healthy Connections Representatives (primary care case management program coordinators) work with enrollees and providers to help ensure appropriate covered services are provided.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law or, in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. (Section 2102(a)(7)) (42CFR 457.495(d))

Decisions related to prior authorization of health services will be completed in accordance with State law and/or Administrative Rule and the medical needs of the patient.

Section 8. Cost-Sharing and Payment

☐ Check here if the State elects to use funds provided under Title XXI only to provide expanded eligibility under the State's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? (42CFR 457.505) Indicate if this also applies for pregnant women. (CHIPRA #2, SHO # 09-006, issued May 11, 2009)

8.1.1. ☒ Yes
8.1.2. ☐ No, skip to question 8.8.

8.1.1-PW ☐ Yes
8.1.2-PW ☒ No, skip to question 8.8.

Guidance: It is important to note that for families below 150% of poverty, the same limitations on cost sharing that are under the Medicaid program apply. (These cost-sharing limitations have been set forth in Section 1916 of the Social Security Act, as implemented by regulations at 42 CFR 447.50-.59). For families with incomes of 150% of poverty and above, cost sharing for all children in the family cannot exceed 5% of a family's income per year. Include a statement that no cost sharing will be charged for pregnancy-related services. (CHIPRA #2, SHO # 09-006, issued May 11, 2009) (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge by age and income (if applicable) and the service for which the charge is imposed or time period for the charge, as appropriate. (Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: Enrollees with family incomes at or above 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and an additional $5 per member per month for dental services. Premium amounts paid apply first to medical services in determining delinquency. Enrollees with family incomes above 142% FPL up to 150% FPL will be subject to a premium in the amount of $10 per member per month for medical services and are not subject to the dental premium.

Wellness Preventive Health Assistance (PHA): The state has established a mechanism to assist participants with their premium payment obligations. This mechanism is called Wellness PHA. Each participant who is required to make premium payments can earn 30 points every 3 months by receiving recommended wellness visits from their PCP and demonstrating up-to-date immunizations. These Wellness PHA points can be used to offset premium payments. Each point equals one dollar.

A child with family income below 150% FPG may have all his premium obligations met by

utilizing Wellness PHA. Children in families 150-185% FPG may offset up to two-thirds (two out of every three) of their payments.

8.2.2. Deductibles: Not applicable.

8.2.3. Coinsurance or copayments:

Co-payment amount: Beginning on November 1, 2011, the nominal fee amount required to be paid by the participant as a co-payment is three dollars and 65 cents ($3.65). The reimbursable amount of the services rendered during a visit must be at least ten times the amount of the co-pay. Visits where the provider is reimbursed $36.50 or less for their services are not subject to co-pay and providers are directed not to assess co-pays for services where reimbursement is less than or equal to $36.50. Well-baby and well-child care as defined in 42 CFR 457.520 are not subject to co-pay.

The State will submit a State Plan Amendment for any future changes to the co-pay amount.

Co-pays for use of emergency services for a non-emergent medical condition

- A participant who seeks care at a hospital emergency department for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider. The determination that the participant does not have an emergency medical condition is made by the emergency room physician conducting the medical screening and using the prudent layperson standard.
- A participant who accesses emergency transportation services for a condition that is not an emergency medical condition may be required to pay a co-payment to the provider of the service. The determination that the participant did not have an emergency medical condition is made by Idaho Medicaid.

Co-pays for other services

- Chiropractic services
- Occupational Therapy
- Optometric Services
- Physical Therapy
- Physician Office Visits
- Speech Therapy

The reimbursable amount of the services rendered during a visit must be at least ten times the amount of the co-pay. Otherwise, the visit is exempt from co-pay. The provider may provide the service and decline to collect the co-pay at the time of service, if the participant can't pay. The provider may also choose not to bill the participant for the co-pay.

Population: All children 142% - 185% of the federal poverty guidelines.

8.2.4. Other: Not applicable

8.2-DS ☐ **Supplemental Dental** (CHIPRA # 7, SHO # #09-012 issued October 7, 2009)For children enrolled in the dental-only supplemental coverage, describe the amount of cost-sharing, specifying any sliding scale based on income. Also describe how the State will track that the cost sharing does not exceed 5 percent of gross family income. The 5 percent of income calculation shall include all cost-sharing for health insurance and dental insurance (Section 2103(e)(1)(A)) (42 CFR 457.505(a), 457.510(b), and (c), 457.515(a) and (c), and 457.560(a)) Please update Sections 1.1-DS, 4.1-DS, 4.2-DS, 6.2-DS, and 9.10 when electing this option.

8.2.1-DS Premiums:
8.2.2-DS Deductibles:
8.2.3-DS Coinsurance or copayments:
8.2.4-DS Other:

8.3 Describe how the public will be notified, including the public schedule, of this cost sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. (Section 2103(e)((1)(A)) (42CFR 457.505(b))

8.4 The State assures that it has made the following findings with respect to the cost sharing in its plan: (Section 2103(e))

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42CFR 457.530)

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42CFR 457.520)

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103(e)(1)(A)) (42CFR 457.515(f))

8.5 Describe how the State will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the State for overpayment by an enrollee: (Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))

The State of Idaho will ensure that the annual aggregate cost-sharing for a family does not exceed five (5) percent of such family's income for the length of the child's eligibility period in the State. Upon enrollment participants are sent a notice advising them of their cost-sharing responsibilities. This includes notice of the five percent maximum.

Cost-sharing in the Idaho plan is set so low that very few families will reach their 5% limit.

The State informs families of the co-payment requirement and limitations in writing at the time of eligibility determination or re-determination. Idaho monitors co-payments and premiums on at least a monthly basis based on information from its systems that show the amount paid compared with family income. When the State identifies that co-pays and premiums assessed

have reached 95% or more of the maximum amount for the eligibility period, a letter is sent to the family informing them that they are approaching their limit and that they will be exempted for the remainder of the eligibility period. The status of the beneficiary is changed to co-pay exempt in the information system at that point for the remainder of the eligibility period.

Providers are instructed to check each participant's eligibility prior to rendering services. The co-pay field of the eligibility response indicates whether the participant is subject to co-pay or is exempt.

8.6 Describe the procedures the State will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. (Section 2103(b)(3)(D)) (42CFR 457.535)

The state will ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. Native American and Alaskan Native children will not be charged monthly premiums or co-payments. The family will be asked to declare Native American/Alaskan Native status so that the cost sharing exemption can be processed.

8.7 Provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42CFR 457.570 and 457.505(c))

Premiums Renewal: If premium payments are two or more months in arrears at the time of renewal, the child(ren) will lose eligibility for the program and be prohibited from participation until the delinquency is paid. Delinquent accounts will be sent a delinquency notice monthly. The notice includes the amount of the delinquency, their right to be considered for Medicaid eligibility and the consequence of not bringing their account current. The notice also includes a reminder that the family may receive help with their premium payments by participating in Wellness PHA.

Co-pays
If a participant is unable to make a co-pay the provider can bill the patient, waive the co-pay or refuse to provide services.

SUPERSEDED BY CS21 (SEE MAGI SECTION)

8.7.1 Provide an assurance that the following disenrollment protections are being applied:

Guidance: Provide a description below of the State's premium grace period process and how the State notifies families of their rights and responsibilities with respect to payment of premiums. (42CFR 457.570(a))

☒ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment.

☒ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42CFR 457.570(b))

☒ In the instance mentioned above, that the State will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42CFR 457.570(b))

☒ The State provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570(c))

8.8. The State assures that it has made the following findings with respect to the payment aspects of its plan: (Section 2103(e))

8.8.1. ☒ No Federal funds will be used toward State matching requirements. (Section 2105(c)(4)) (42CFR 457.220)

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copayments, coinsurance and all other types) will be used toward State matching requirements. (Section

2105(c)(5) (42CFR 457.224) (Previously 8.4.5)

8.8.3. ☒ **No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1)) (42CFR 457.622(b)(5))

8.8.5. ☒ **No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist **in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section** 2105)(c)(7)(A)) (42CFR 457.475)

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

The state of Idaho has developed a set of strategic objectives, performance goals, and performance measures to assess the success of implementing its Children's Health Insurance Program. Idaho will track enrollment, retention, access, comprehensiveness, and quality of care. All performance measures will be linked to performance standards and strategic objectives. These measures are designed to measure the effectiveness of both Title XIX and Title XXI Programs. The objectives, goals, and measures focus on standard indicators of success in enrollment and retention and in basic health outcomes. The measures have been developed based upon data that is readily available to the Department of Health and Welfare.

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2)) (42CFR 457.710(b))

Table 9.1

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)
Objectives related to Reducing the Number of Uninsured Children		
To increase the number of children participating in Title XIX and XXI health programs.	The targeted increase in enrollment is 8,000 children annually	New/Revised Continuig X Data Sources: Enrollment data from the Division of Medicaid claims payment system. • Methodology: Annual increase in enrollment of uninsured children in both programs compared to the previous federal fiscal year. • The total number of new uninsured children enrolled in both programs compared to the base number of enrollees as of 9/30/99 • Numerator: Number of enrollees on 9/30/03: 112,678 • Denominator: Number of enrollees on 9/30/99: 54,824

Table 9.1		
(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)**
		Progress Summary: Idaho achieved its annual target by increasing enrollment an additional 8001 children in FFY03. As of 9/30/03, Idaho has enrolled an additional 57,854 children, more than doubling the number of children covered by Title XIX & Title XXI in the past 4 years.
Objectives Related to SCHIP Enrollment		
To increase the number of children enrolled in the Title XXI. program	The targeted increase in enrollment is 2,000 children annually.	New/Revised Continuing X
		Data Sources: Enrollment data from the Division of Medicaid claims payment system
		• Methodology: Annual increase in enrollment of uninsured children compared to the previous federal fiscal year. • The total number of children enrolled each year. • Numerator: Number of enrollees on 9/30/03: 10,954 • Denominator: Number of enrollees on 9/30/99: 3,735
		Progress Summary: The number of Title XXI children decreased this year for the first time in 4 years. The number decreased by 1,022 in FFY03 resulting in an 8.5% decline. It is believed that with the downturn in the economy, children applying for assistance are qualifying for Title XIX instead of Title XXI. The statistics bear this out. As of 9/30/03, overall Idaho had increased enrollment since 1999 by 7,219 children, a 193% increase.
Objectives Related to Increasing Medicaid Enrollment		
To increase the number of children enrolled in Title XIX health	The targeted increase in enrollment is 6,000 children annually.	New/Revised Continuing X
		Data Sources: Enrollment data from the Division of Medicaid claims payment system.

Table 9.1		
(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (specify data sources, methodology, time period, etc.)**
programs		• Methodology: Annual increase in enrollment of uninsured children in Title XIX programs compared to the previous federal fiscal year. • The total number of new uninsured children enrolled in Title XIX programs compared to the base number of enrollees as of 9/30/99 • Numerator: Number of enrollees on 9/30/03: 101,724 • Denominator: Number of enrollees on 9/30/99: 51,089
		Progress Summary: The number of children enrolled in Title XIX increased by 9,023 or nearly 10% in FFY03. As of 9/30/03, Idaho had increased enrollment by 50,635 children, an increase of 99%.
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
To ensure that enrolled children have a medical home.	There will be a 10% annual increase in the number of children participating in Healthy Connections and having a primary care provider as a "medical home".	New/Revised Continuing X
		Data Sources: Division of Medicaid, Healthy Connections (PCCM) Program
		• Methodology: Baseline data on the number of children in the Healthy Connections is known. The data system will track new enrollees in the program • Numerator: Number of children enrolled in HC at the end of the FFY 9/30/03: 88,415 • Denominator: Number of children enrolled in HC at the beginning of the FFY 10/1/00: 25,661
		Progress Summary: Healthy Connections enrollment increased by 37,058 children in FFY 03, a 72% increase for the year and a 244% increase over the baseline. Percent of children participating rose from 49% to 80%.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		
To ensure that enrolled children receive	90% of enrolled children will have up-to-date, age-appropriate	New/Revised Continuing X
		Data Sources: Division of Medicaid information system, Division of Health Immunization Registry

appropriate and necessary medical care.	vaccinations. 80% of enrolled children age 12 months and younger will have received appropriate preventive care.	• Methodology: Claims data will be reviewed for immunization and preventive care visits. The immunization registry is being used to track immunization levels. • Numerator: Number of children with up-to-date immunizations and preventive care visits. • Denominator: Total number of Title XIX and XXI children.
		Progress Summary: No change- At this time, Idaho is examining the data collection criteria to report wellness visits. The FFY02 HCFA416 report indicates that the screening ratio for children <1 year of age has dropped to 25%. However this is believed to be currently underreported. FFY03 data is not available at the time of this report. Medicaid will be addressing the issue of correct coding for wellness visits in FFY04. Immunizations: No change. For the first three series of shots, Idaho's rate of immunizations is in the low 90s. By the time children are ready to go to school the rate is approximately 95%. Similar to other states, rates reflect a decline in the percentage for the 2 year old age group.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3)) (42CFR 457.710(c))

Performance goals are listed in Table 9.1.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.

9.3.4. ☒ The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

The State of Idaho uses a modified set of National Performance measures.

- Well child visits for children in the first 15 months of life.
- Well child visits in the 3rd, 4th, 5th, and 6th years of life.
- Use of appropriate medications for children with asthma.
- Comprehensive diabetes care (hemoglobin A1c tests).
- Children's access to primary care services.

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. ☐ Immunizations
9.3.7.2. ☐ Well childcare
9.3.7.3. ☐ Adolescent well visits
9.3.7.4. ☐ Satisfaction with care
9.3.7.5. ☐ Mental health
9.3.7.6. ☐ Dental care
9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1)) (42CFR 457.720)

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2)) (42CFR 457.750)

The assessments will be built upon the data obtained to monitor the achievement of the strategic objectives listed in Table 9.1.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3)) (42CFR 457.720)

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42CFR 457.710(e))

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR

457.135)

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

9.9.1 Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the State on the development and implementation of the procedures required in 42 CFR 457.125. States should provide notice and consultation with Tribes on proposed pregnant women expansions. (Section 2107(c)) (42CFR 457.120(c))

When the State determines the need to submit a SPA, a Tribal Solicitation notice is sent to Tribal contacts. The notice is mailed hard copy to Tribal Leaders, e-mailed to a distribution list of Tribal contacts and posted to the Idaho Medicaid-Tribes Teamsite (web-based). The State also meets quarterly with the Tribes. A standing agenda item for these meetings is discussion of SPAs.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR457.65(b) through (d).

Public hearings, advertised through prior public notice, are held in conjunction with Administrative Rules promulgation required to amend eligibility or benefits for the Children's Health Insurance Program. These hearings allow public comment on the entire program. Public notification of proposed changes to Administrative Rules is published the first Wednesday of each month in the Administrative Bulletin and also posted to the state's website.

SPA #15 changes: Public notice for eligibility changes and changes to tobacco cessation benefits was conducted on October 2, 2013, as part of the administrative rule making process. A public hearing regarding tobacco cessation benefits was conducted on October 15, 2013.

9.9.3 Describe the State's interaction, consultation, and coordination with any Indian tribes and organizations in the State regarding implementation of the Express Lane eligibility option. N/A

9.10 Provide a 1-year projected budget. A suggested financial form for the budget is below. The budget must describe: (Section 2107(d)) (42CFR 457.140)

- Planned use of funds, including:
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
  - Projected expenditures for the separate child health plan, including but not limited to expenditures for targeted low income children, the optional coverage of the unborn, lawfully residing eligibles, dental services, etc. All cost sharing, benefit, payment, eligibility need to be reflected in the budget.

- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.
- Include a separate budget line to indicate the cost of providing coverage to pregnant women.
- States must include a separate budget line item to indicate the cost of providing coverage to premium assistance children.
- Include a separate budget line to indicate the cost of providing dental-only supplemental coverage.
- Include a separate budget line to indicate the cost of implementing Express Lane Eligibility.
- Provide a 1-year projected budget for all targeted low-income children covered under the state plan using the attached form. Additionally, provide the following:
  a. Total 1-year cost of adding prenatal coverage
  b. Estimate of unborn children covered in year 1

Benefit Costs

	2013	2014	2015
Benefit Costs			
Insurance payments			
Managed care	$ 37,584,016.19	$ 35,653,756.83	$ 36,167,942.52
Weighted per member/per month rate @ # of eligibles	$143.82 PMPM * 24196	$133.57 PMPM * 24714	$135.06 PMPM * 24794
Fee for Service	$ 4,176,001.80	$ 3,961,528.54	$ 4,018,660.28
Drug Rebate	$ (1,229,373.26)	$ (1,290,841.93)	$ (1,355,384.02)
Total Benefit Costs	**$ 40,530,644.73**	**$ 38,324,443.44**	**$ 38,831,218.78**
(Offsetting beneficiary cost sharing payments)	$ (932,264.00)	$ (955,570.60)	$ (979,459.87)
Net Benefit Costs	$ 39,598,380.73	$ 37,368,872.84	$ 37,851,758.91

Administration Costs 1/ 3/			
Personnel	$0.00	$ -	$ -
General administration	$703,512.92	$ 738,688.56	$ 775,622.99
Contractors/Brokers (e.g., enrollment contractors)	$0.00	$ -	$ -
Claims Processing	$21,448.30	$ 22,520.72	$ 23,646.75
Outreach/marketing costs	$0.00	$ -	$ -
Healthy Schools	$0.00	$ -	$ -
Other 4/	$2,486,061.07	$ 2,610,364.12	$ 2,740,882.33
Total Administration Costs 4/	$3,211,022.29	$ 3,371,573.40	$ 3,540,152.07
10% Administrative Cap	$ 4,399,820.08	$ 4,152,096.98	$ 4,205,750.99
TOTAL COSTS OF APPROVED SCHIP PLAN	$ 43,998,200.81	$ 40,740,446.25	$ 41,391,910.98

Per Member Per Month

	2013		2014		2015	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	24,196	$14.38	24,714	$13.36	24,795	$13.51
Fee for Service	24,196	$129.44	24,714	$120.22	24,795	$121.56
Total	24,196	$143.83	24,714	$133.58	24,795	$135.06

	2013		2014		2015	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
SCHIP	10,558	60.05	10,680	59.08	10,412	59.08
MCHIP	13,638	60.05	14,034	59.08	14,382	59.08
Total	24,196	60.05	24,714	59.08	24,794	59.08

State match for CHIP participants with family incomes between 150% and 185% FPL is collected through a state-imposed premium tax on insurance policies sold within the State. A portion of these funds is dedicated to CHIP funding via Idaho statute. The premium tax that funds this portion of the program is imposed on all entities that sell insurance (not just health insurance) in Idaho. Less than 85 percent of the premium tax burden falls on health care providers. The premium tax collections from health insurance are treated the same as premium tax collections from other types of insurance. Therefore, this premium tax does not meet the definition of a "health-care related tax" as defined in 42 CFR §433.55.

State match for CHIP participants with family incomes between 142% and 150% FPL is appropriated from the state General Fund.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. **Annual Reports.** The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2)) (42CFR 457.750)

10.1.1. ☒ The progress made in reducing the number of uncovered low- income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. (42CFR 457.710(e))

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 10.3-D ☒ Specify that the State agrees to submit yearly the approved dental benefit package and to submit quarterly the required information on dental providers in the State to the Health Resources and Services Administration for posting on the Insure Kids Now! Website. Expanded eligibility under the state's Medicaid plan, and continue to Section 12.

11.1. ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101(a)) (42CFR 457.940(b))

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: (Section 2107(e)) (42CFR 457.935(b)) The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)

11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)

11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)

11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)

11.2.4. ☒ Section 1128A (relating to civil monetary penalties)

11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)

11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program) expanded eligibility under the state's Medicaid plan.

12.1. Eligibility and Enrollment Matters

Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.

CHIP Eligibility

The State of Idaho uses a review process for eligibility and enrollment matters that complies with 42 CFR 457.1120. Idaho CHIP will use the same Fair Hearing rights and process for CHIP as for Idaho Medicaid. Families are informed of their rights and responsibilities upon application for coverage and via the "Notice of Decision" sent upon eligibility determination. A Fair Hearing can be requested to review any adverse decision made in determining eligibility or enrollment.

12.2. Health Services Matters

Please describe the review process for health services matters that comply with 42 CFR 457.1120.

The State of Idaho uses a review process for health services matters that complies with 42 CFR 457.1120. Upon enrollment, participants are provided instruction and contact information regarding how to file a grievance or make a complaint regarding service delivery. Idaho CHIP uses the same Fair Hearing rights and process for CHIP as for Idaho Medicaid.

12.3. Premium Assistance Programs

If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

Not applicable.

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Eligibility for Medicaid Expansion Program	CS3

42 CFR 457.320(a)(2) and (3)

Income eligibility for children under the Medicaid Expansion is determined in accordance with the following income standards:

There should be no overlaps or gaps for the ages entered.

Age and Household Income Ranges

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	6	19	107	133	X

PRA Disclosure Statement

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CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Eligibility - Targeted Low-Income Children **CS7**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.310, 315 and 320

☑ **Targeted Low-Income Children** - Uninsured children under age 19 whose household income is within standards established by the state.

☑ The CHIP Agency operates this covered group in accordance with the following provisions:

Age

Must be under age 19.

Income Standards

Income standards are applied statewide. Yes

Are there any exceptions, e.g. populations in a county which may qualify under either a statewide income standard or a county income standard? No

Statewide Income Standards

Begin with lowest age range first.

Please note that the lower bound for CHIP eligibility should be the highest standard used for Medicaid poverty-level children for the same age group or groups entered here.

	From Age	To Age	Above (% FPL)	Up to & including (% FPL)	
+	0	6	142	185	X
+	6	19	133	185	X

Age ranges may overlap. If there is an overlap, provide an explanation. Include the age ranges for each income standard that has overlapping ages and the reason for having different income standards.

Age ranges do not overlap.

Special Program for Children with Disabilities

Does the state have a special program for children with disabilities? No

CHIP Eligibility

PRA Disclosure Statement

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CHIP Eligibility

V.20130709

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program Eligibility - Deemed Newborns	**CS13**

Section 2112(e) of the SSA and 42 CFR 457.360

☑ **Deemed Newborns** - Children born to targeted low-income pregnant women are deemed to have applied for and be eligible for CHIP or Medicaid until the child turns one.

☑ The state operates this covered group in accordance with the following provisions:

☑ The child was born to an eligible targeted low-income pregnant woman under section 2112 of the SSA.

☑ The child is deemed to have applied for and been found eligible for CHIP or Medicaid, as appropriate, as of the date of the child's birth, and remains eligible without regard to changes in circumstances until the child's first birthday.

The state elects the following option(s):

☒ The state elects to cover as a deemed newborn a child born to a mother who is covered as a targeted low-income child under the state's separate CHIP on the date of the newborn's birth.

☐ The state elects to recognize a child's deemed newborn status from another state and provides benefits in accordance with the requirements of section 2112(e) of the SSA.

☐ The state elects to cover as a deemed newborn a child born to a mother who is covered under Medicaid or CHIP through the authority of the state's section 1115 demonstration on the date of the newborn's birth.

PRA Disclosure Statement

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CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Child Health Insurance Program
Eligibility - Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards **CS14**

Section 2101(f) of the ACA and 42 CFR 457.310(d)

☑ Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

The CHIP agency provides coverage for this group of children as follows:

○ The state has received approval from CMS to maintain Medicaid eligibility for children who would otherwise be subject to Section 2101(f) such that no child in the state will be subject to this provision.

◉ The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016).

Describe the methodology used by the state to identify and enroll children in a separate CHIP who are subject to the protection afforded by Section 2101(f) of the Affordable Care Act:

○ The state has demonstrated and CMS has agreed that all children qualifying for section 2101(f) protection will qualify for the state's existing separate CHIP.

◉ The state will enroll all children in a separate CHIP who lose Medicaid eligibility because of an increase in family income at their first renewal applying MAGI methods.

○ The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

[ ] % FPL

○ The state will enroll children in a separate CHIP who are found to be ineligible for Medicaid based on MAGI but whose family income has not increased since the child's last determination of Medicaid eligibility or who would have remained eligible for Medicaid (based on the 2013 Medicaid income standard) if the value of their 2013 disregards had been applied to the family income as determined by MAGI methodology.

○ Other.

Describe the benefits provided to this population:

◉ This population will be provided the same benefits as are provided to children in the state's Medicaid program.

This population will be provided the same benefits as are provided to children in the state's separate CHIP.

Other (consistent with Section 2103 of the SSA and 42 CFR 457 Subpart D).

Describe premiums and cost sharing required of this population:

Cost sharing is the same as for children in the Medicaid program.

CHIP Eligibility

- ◯ Premiums and cost sharing are the same as for targeted low-income children in the state's separate CHIP.
- ◯ No premiums, copayments, deductibles, coinsurance or other cost sharing is required.
- ◯ Other premiums and/or cost-sharing requirements (consistent with Section 2103(e) of the SSA and 42 CFR 457 Subpart E).

PRA Disclosure Statement

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CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
MAGI-Based Income Methodologies **CS15**

2102(b)(1)(B)(v) of the SSA and 42 CFR 457.315

☑ The CHIP Agency will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups, as described below, and consistent with 42 CFR 457.315 and 435.603(b) through (i).

In the case of determining ongoing eligibility for enrollees determined eligible for CHIP on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility, whichever is later.

If the state covers pregnant women, in determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- ○ The pregnant woman is counted just as herself.
- ○ The pregnant woman is counted just as herself, plus one.
- ◉ The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- ◉ Current monthly household income and family size.
- ○ Projected annual household income for the remaining months of the current calendar year and family size.

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- ☐ Include a prorated portion of the reasonably predictable increase in future income and/or family size.
- ☒ Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 457.315 and 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent. No

☑ The CHIP Agency certifies that it has submitted and received approval for the conversion for all separate CHIP covered group income standards to MAGI-equivalent standards.

An attachment is submitted.

PRA Disclosure Statement

CHIP Eligibility

CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Residency **CS17**

42 CFR 457.320

Residency

☑ The CHIP Agency provides CHIP to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

A child is considered to be a resident of the state under the following conditions:

☐ A non-institutionalized child, if capable of indicating intent and who is emancipated or married, if the child is living in the state and:

1. Intends to reside in the state, including without a fixed address, or
2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.

☐ A non-institutionalized child not described above and a child who is not a ward of the state:

1. Residing in the state, with or without a fixed address, or
2. The state of residency of the parent or caretaker, in accordance with 42 CFR.435.403(h)(1), with whom the individual resides.

☐ An institutionalized child, who is not a ward of the state, if the state is the state of residence of the child's custodial parent or caretaker at the time of placement, or

☐ A child who is a ward of the state regardless of where the child lives, or

☐ A child physically located in the state when there is a dispute with one or more states as to the child's actual state of residence.

If the state covers pregnant women, a pregnant woman is considered to be a resident under the following conditions:

☐ A non-institutionalized pregnant woman who is living in the state and:

1. Intends to reside in the state, including without a fixed address, or if incapable of indicating intent, is living in the state, or
2. Entered with a job commitment or seeking employment, whether or not currently employed.

☐ An institutionalized pregnant woman placed in an out-of-state-institution, as defined in 42 CFR 435.1010, including foster care homes, by an agency of the state, or

☐ An institutionalized pregnant woman residing in an in-state-institution, as defined in 42 CFR 435.1010, whether or not the individual established residency in the state prior to entering the institution, or

☐ A pregnant woman physically located in the state when there is a dispute with one or more states as to the pregnant woman's actual state of residence.

CHIP Eligibility

CHIP Eligibility

One or more interstate agreement(s). No

A policy related to individuals in the state only for educational purposes. No

PRA Disclosure Statement

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CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Citizenship **CS18**

Sections 2105(c)(9) and 2107(e)(1)(J) of the SSA and 42 CFR 457.320(b)(6), (c) and (d)

Citizenship

☑ The CHIP Agency provides CHIP eligibility to otherwise eligible citizens and nationals of the United States and certain non-citizens, including the time period during which they are provided with reasonable opportunity to submit verification of their citizenship, national status or satisfactory immigration status.

☑ The CHIP Agency provides eligibility under the Plan to otherwise eligible individuals:

Who are citizens or nationals of the United States; or

Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); or

Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality, or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), and 1902(ee) of the Act, and 42 CFR 435.406, 407, 956 and 457.380.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.	Yes
The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.	Yes

The date benefits are furnished is:

- (•) The date of application containing the declaration of citizenship or immigration status.
- ( ) The date the reasonable opportunity notice is sent.
- ( ) Other date, as described:

The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible children up to age 19, lawfully residing in the United States, as provided in Section 2107(e)(1)(J) of the SSA (Section 214 of CHIPRA 2009, P.L. 111-3).	No
The CHIP Agency elects the option to provide CHIP coverage to otherwise eligible pregnant women, lawfully residing in the United States, as provided in Section 214 of CHIPRA 2009, P.L. 111-3. The state may not select this option unless the state also elects to cover lawfully residing children. A state may not select this option unless the state also covers Targeted Low-Income Pregnant Women	No

CHIP Eligibility

PRA Disclosure Statement

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CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
Non-Financial Eligibility - Social Security Number **CS19**

42 CFR 457.340(b)

Social Security Number

As a condition of eligibility, the CHIP Agency must require individuals who have a social security number or are eligible for one as determined by the Social Security Administration, to furnish their social security number, or numbers if they have more than one number.

☑ The CHIP Agency requires individuals, as a condition of eligibility, to furnish their social security number(s), with the following exceptions:

Individuals refusing to obtain a social security number (SSN) because of well established religious objections, or

Individuals who are not eligible for an SSN, or

Individuals who are issued an SSN only for a valid non-work purpose.

☑ The CHIP Agency assists individuals, who are required to provide their SSN, to apply for or obtain an SSN from the Social Security Administration if the individual does not have or forgot their SSN.

☑ The CHIP Agency informs individuals required to provide their SSN:

By what statutory authority the number is solicited; and

How the state will use the SSN.

☑ The CHIP Agency provides assurance that it will verify each SSN furnished by an applicant or beneficiary with the Social Security Administration, not deny or delay services to an otherwise eligible applicant pending issuance or verification of the individual's SSN by the Social Security Administration and that the state's utilization of the SSNs is consistent with sections 205 and 1137 of the Social Security Act and the Privacy Act of 1974.

The state may request non-applicant household members to voluntarily provide their SSN, if the state meets the requirements below.

The state requests non-applicant household members to voluntarily provide their SSN. Yes

✓ When requesting an SSN for non-applicant household members, the state assures that:

- At the time such SSN is requested, the state informs the non-applicant that this information is voluntary and provides information regarding how the SSN will be used; and
- The state only uses the SSN for determination of eligibility for CHIP or other insurance affordability programs, or for a purpose directly connected with the administration of the state plan.

CHIP Eligibility

PRA Disclosure Statement

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CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program **Non-Financial Eligibility - Substitution of Coverage**	**CS20**

457.310(b)(2) and (b)(3), 457.320(a)(9) and 2110(b)(1)(C) of the SSA

Substitution of Coverage

☑ The CHIP Agency provides assurance that it has methods and policies in place to prevent the substitution of group health coverage or other commercial health insurance with public funded coverage. These policies include:

☐ Substitution of coverage prevention strategy:

CHIP Eligibility

CHIP Eligibility

	Name of policy	Description	
+	Monitoring for Substitution of Coverage	Insurance provided under CHIP does not substituted for coverage under group health plans. Prior to January 1, 2014, the State required that a child not have had creditable health insurance for the 6 months immediately preceding the application or to determine if the family lost insurance through no fault of the insured such as, financial hardship, unaffordable premiums, loss of employment, or the loss of eligibility for employer sponsored insurance. To monitor its substitution of coverage policy, the State requires applicants to list health coverage for all persons in the household who currently have health insurance, and to include the information on the policy for those that do. The application also contains a question on whether anyone has had health insurance end within the six months prior to application, and asks the applicant to provide a reason for the coverage ending. The trigger point for this policy is at initial application or at eligibility redetermination. Historically, very few applicants did not meet the no fault threshold. As of January 1, 2014, the Department will not require a 6 month period of un-insurance prior to receipt of CHIP. It has been found that the vast majority of applicants are able to meet the no-fault provisions and were provided coverage as of application date. The Department will continue to monitor the availability of private insurance through the application and eligibility redetermination process , the monitoring of coverage through our third party liability contractor, enforcement of child medical support orders and evaluating Medical billings that might indicate another party liable for an accident or injury. Applicants are informed of the requirement to pursue available coverage resources, including ESI, individual coverage, medical support or third party claims through the application process.	X

A waiting period during which an individual is ineligible due to having dropped group health coverage. ☐

☐ If the state covers pregnant women, the waiting period does not apply to pregnant women.

If the state elects to offer dental only supplemental coverage, the following assurances apply:

CHIP Eligibility

CHIP Eligibility

☐ The other coverage exclusion does not apply to children who are otherwise eligible for dental only supplemental coverage as provided in section 2110(b)(5) of the SSA.

☐ The waiting period does not apply to children eligible for dental only supplemental coverage.

PRA Disclosure Statement

V.20130718

CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program **Non-Financial Eligibility - Non-Payment of Premiums**	**CS21**
42 CFR 457.570	
Non-Payment of Premiums	
Does the state impose premiums or enrollment fees?	Yes
Can non-payment of premiums or enrollment fees result in loss of CHIP eligibility?	No

PRA Disclosure Statement

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V.20130709

CHIP Eligibility

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Eligibility Processing **CS24**

2102(b)(3) & 2107(e)(1)(O) of the SSA and 42 CFR 457, subpart C

☑ The CHIP Agency meets all of the requirements of 42 CFR 457, subpart C for application processing, eligibility screening and enrollment.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard:

☒ The single, streamlined application developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☐ An alternative single, streamlined application developed by the state and approved by the Secretary in accordance with section 1413(b)(1)(B) of the Affordable Care Act.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

☑ The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in CFR 457.340(a), by telephone, via mail, in person and other commonly available electronic means.

The agency accepts applications in the following other electronic means.

☒ Other electronic means:

	Name of method	Description	
+	Fillable PDF	The State will have on line a fillable PDF application as an interim solution. The on line application is not yet completed but is in process. The PDF may be completed and printed or scanned or emailed, etc.	X
+	In person	Applicants may bring application into the office.	X
+	Telephonic	Applicants may complete an application in the course of a telephone interview and provide a telephonic signature.	X

CHIP Eligibility

CHIP Eligibility

+	E-Mail	The applicant may completed the fillable PDF and email to the local office.	X
+	Fax	A completed application may be faxed to the local office.	X
+	Postal mail	An applicant may mail a completed application to the Department.	X

Screen and Enroll Process

☑ The CHIP Agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low-income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

Procedures include:

■ Screening of application to identify all individuals eligible or potentially eligible for CHIP or other insurance affordability programs; and

■ Income eligibility test, with calculation of household income consistent with 42 CFR 457.315 for individuals identified as potentially eligible for Medicaid or other insurance affordability programs based on household income; and

■ Screening process for individuals who may qualify for Medicaid on a basis other than having household income at or below the applicable MAGI standard, based on information in the single streamlined application.

The CHIP agency has entered into an arrangement with the Exchange to make eligibility determinations for advanced premium tax credits in accordance with section 1943(b)(2) of the SSA. Yes

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 457.343:

■ Once every 12 months.

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

Screening by Other Insurance Affordability Programs

☑ The CHIP Agency provides assurance that it has adopted procedures to accept and process electronic accounts of individuals screened as potentially eligible for CHIP by other insurance affordability programs in accordance with the requirements of 42 CFR 457.348(b) and to determine eligibility in accordance with 42 CFR 457.340 in the same manner as if the application had been submitted directly to, and processed by the state.

☒ The CHIP Agency elects the option to accept CHIP eligibility decisions made by the Exchange or other agencies administering insurance affordability programs as provided in 42 CFR 457.348 and to furnish CHIP in accordance with requirements of 42 CFR 457.340 to the same extent and in the same manner as if the applicant had been determined by the state to be eligible for CHIP.

CHIP Eligibility

CHIP Eligibility

Check all types of agencies that apply:

☒ The Exchange

☒ Medicaid

☐ Other agency administering insurance affordability programs

☑ The CHIP Agency has entered into an agreement with agencies administering other insurance affordability programs to fulfill the requirements of 457.348(b) and will provide this agreement to the Secretary upon request.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CHIP Eligibility

CHIP Eligibility

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☐ Paper Application ☒ Online Application	
TRANSMITTAL NUMBER:	**STATE:**
ID-13-0023	Idaho

Through July 31, 2014, the state is using an interim online alternative single streamlined application. After July 31, 2014, the state will use a revised online single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

CHIP Eligibility

USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION	
☒Paper Application ☐Online Application	
TRANSMITTAL NUMBER: ID-13-0023	**STATE:** Idaho

Through January 31, 2014, the state is using an interim paper alternative single streamlined application. After January 31, 2014, the state will use revised paper application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state's application. The revised application will be incorporated by reference into the state plan.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Application for Assistance

Food Assistance

The Idaho Food Stamp Program is a supplemental nutrition assistance program that helps families buy food for good health. Eligible families get a debit like card to buy food items. You may be required to participate in work programs, and cooperate with Child Support Services.

Health Coverage Assistance

The Idaho Medicaid Program provides health coverage assistance according to individual needs. Eligible families may qualify for 1) free or low-cost coverage from Medicaid, 2) tax credits to help pay health coverage premiums, or 3) affordable private health insurance plans.

Cash Assistance

The Temporary Assistance for Families in Idaho Program provides cash assistance for: emergency situations, families with children, and the elderly, blind, or disabled. Eligible families receive a one-time or on-going payment, depending on the needs of the household.

Child Care Assistance

The Idaho Child Care Program helps parents and caretakers pay for a part of their child care costs while working, going to school, or participating in approved training activities. Eligible families receive a portion of child care costs paid to the provider.

Who can use this application

Anyone may use this application to:

- Apply for assistance for themselves and their household members
- Apply for just one type of assistance or for multiple types of assistance

What you may need to apply

Sending or bringing proof of the items below will help speed up your application:

- Identity
- Income
- Household expenses
- Resources

Why we ask for this information

We keep all information private and secure, as required by law. We ask for this information for a few reasons:

- To figure out what types of assistance you qualify for
- To figure out how much assistance you qualify for
- To make sure you get the right amount of assistance based on your situation.

Equal opportunity for applicants -

In accordance with federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, the Idaho Department of Health and Welfare is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited on the basis of religion or political beliefs.

To file a complaint of discrimination, contact USDA or HHS at:

- USDA, Director, Office of Civil Rights
  1400 Independence Avenue, SW
  Washington, D.C. 20250-9410
  (800) 795.3272 (voice)
  (202)720.6382 (TTY)
- U.S. Department of Health & Human Services
  Room 506F, 200 Independence Avenue, SW
  Washington, D.C. 20201
  ocrcomplain@hhs.gov
  (202) 619.0403 (Voice)
  (202) 619.3257 (TTY)

What happens next

Send your complete, signed application to the address below. We will tell you if you're eligible or not, or give you further instructions for completing your application.

Self Reliance Programs - Statewide Application Team
PO Box 83720
Boise, ID 83720-0026
Fax: 1-866-434-8278
E-mail: MyBenefits@dhw.idaho.gov

Get help with this application

- **Online:** healthandwelfare.idaho.gov
- **Phone:** 1-877-456-4233
- **E-mail:** MyBenefits@dhw.idaho.gov
- **In person:** Visit our website or call 1-877-456-1233 to find a local office.

- **Language Interpreter:**
Call 2-1-1 or 1-800-926-2588
or TDD 208-332-7205

Tell us about yourself (or another adult in the household who will be the primary contact for this application)

1. First Name	Middle Name	Last Name	Suffix	2. Date of birth	3. Former Names, if any

4. Physical Address	City	State	Zip Code	County

5. Mailing Address (if different)	City	State	Zip code	County

6. Daytime Phone	7. Phone type (choose one)	8. If none, where can we leave a message?	9. Email
	☐ Home ☐ Work ☐ Cell	Phone:	

10. Preferred language spoken (if not English):	11. Preferred language written/read (if not English):

12. Do you want an interpreter if you are interviewed (one will be provided at no cost to you)? ☐ No ☐ Yes

13. ¿Usted necesita a intérprete si usted tiene una entrevista (uno estará disponible en ningún costo para usted)? ☐ No ☐ Yes

14. Would you like to name someone as your authorized representative? ☐ No ☐ Yes. Complete Appendix A.

You may give a trusted friend, partner, or third party caseworker permission as an "authorized representative" to talk to the Department, see your information, and act on your behalf for all matters relating to your case.

15. Are you applying for Food Stamps? ☐ No. Skip this section. ☐ Yes. Complete this section.

If you are applying for Food Assistance only, you may start the application process immediately by filling out this page, signing it, and turning it in. You must complete the rest of the application and turn it in as soon as possible. If you qualify, emergency Food Stamp benefits can begin within 7 days.

a. Are any members of your household migrant or seasonal farm workers? ☐ No ☐ Yes

b. Is your income before taxes this month less than $150? ☐ No ☐ Yes

c. Are your monthly housing and utility costs more than your total monthly income and resources? ☐ No ☐ Yes

d. Are your resources (cash, checking, savings) less than $100? ☐ No ☐ Yes

Signature of applicant/authorized representative to request Food Stamps _____ Date _____

16. Do you want telephone assistance for your household? ☐ **No.** Go to the next section. ☐ **Yes.** Complete the questions below.

The Idaho Telecommunications Service Assistance Program (ITSAP) helps pay monthly telephone service costs.

a. Name of phone company	b. Phone number	c. Name on bill

Tell us who lives in your household

Who you need to include on this application

- We need information about ***everyone*** who lives at the physical address you wrote down in the "Tell Us About Yourself" section above.
- If applying for health coverage for anyone under 65 and not disabled, tell us about everyone included on your federal tax return (if you file taxes), even if they don't live at the same address. You don't need to file taxes to get health coverage.

Information that is optional or not required

Most fields in this section are required, but some are optional for certain household members.

- Social Security Number - optional for people not applying, and for people applying for emergency health coverage or child care assistance
- U.S. citizenship, and immigration status (questions 12 & 13) - not required for people not applying for assistance
- Race - optional for all types of assistance
- Hispanic or Latino - optional for all types of assistance

Tell us more about you (the primary contact person for this application)

You / Primary Contact Person 1. Type(s) of assistance requested for this person: ☐ Food ☐ Health ☐ Cash ☐ Child Care ☐ None

5. Social Security Number	7. Sex	8. Marital Status	9. Pregnant? If yes, due date / How many due?
	☐ M ☐ F	☐ Married ☐ Not Married	☐ No ☐ Yes

10. Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

11. Hispanic or Latino? (Optional) ☐ No ☐ Yes

12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

14. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a, b, c.

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Tell us about everyone else in your household

Tell us about each person who lives with you at the address you wrote down in the "Tell Us About Yourself" section on page 1. If applying for health coverage for anyone under 65 and not disabled, tell us about everyone included on your federal tax return. See page 1 for details.

Copy this page or attach another sheet if you need to provide more information than space allows.

Person 1

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health ☐ Cash ☐ Child Care ☐ None

2. First Name | Middle Name | Last Name | Suffix | 3. Former Names, if any | 4. Relationship to you

5. Social Security Number | 6. Date of birth | 7. Sex ☐ M ☐ F | 8. Marital Status ☐ Married ☐ Not Married | 9. Pregnant? ☐ No ☐ Yes If yes, due date How many due?

10. Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

11. Hispanic or Latino? (Optional) ☐ No ☐ Yes

12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

14. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a, b, c.

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Person 2

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health ☐ Cash ☐ Child Care ☐ None

2. First Name | Middle Name | Last Name | Suffix | 3. Former Names, if any | 4. Relationship to you

5. Social Security Number | 6. Date of birth | 7. Sex ☐ M ☐ F | 8. Marital Status ☐ Married ☐ Not Married | 9. Pregnant? ☐ No ☐ Yes If yes, due date How many due?

10. Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

11. Hispanic or Latino? (Optional) ☐ No ☐ Yes

12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

14. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a, b, c.

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Person 3

1. Type(s) of assistance requested for this person: ☐ Food ☐ Health ☐ Cash ☐ Child Care ☐ None

2. First Name | Middle Name | Last Name | Suffix | 3. Former Names, if any | 4. Relationship to you

5. Social Security Number | 6. Date of birth | 7. Sex ☐ M ☐ F | 8. Marital Status ☐ Married ☐ Not Married | 9. Pregnant? ☐ No ☐ Yes If yes, due date How many due?

10. Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

11. Hispanic or Latino? (Optional) ☐ No ☐ Yes

12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

14. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a, b, c.

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Continue telling us about each person who lives with you. See page 1 for details.

Person 4 1. Type(s) of assistance requested for this person: ☐ Food ☐ Health ☐ Cash ☐ Child Care ☐ None

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Sex	8. Marital Status	9. Pregnant? If yes, due date How many due?
		☐ M ☐ F	☐ Married ☐ Not Married	☐ No ☐ Yes

10. Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

11. Hispanic or Latino? (Optional) ☐ No ☐ Yes 12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

14. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a, b, c.

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Person 5 1. Type(s) of assistance requested for this person: ☐ Food ☐ Health ☐ Cash ☐ Child Care ☐ None

2. First Name	Middle Name	Last Name	Suffix	3. Former Names, if any	4. Relationship to you

5. Social Security Number	6. Date of birth	7. Sex	8. Marital Status	9. Pregnant? If yes, due date How many due?
		☐ M ☐ F	☐ Married ☐ Not Married	☐ No ☐ Yes

10. Race ☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Island

11. Hispanic or Latino? (Optional) ☐ No ☐ Yes 12. U.S. citizen or national? (Skip #12 & 13 if not applying for assistance) ☐ No ☐ Yes

13. If not a U.S. citizen or national, does this person have eligible immigration status? ☐ Yes. Complete questions a through d.

a. Immigration document type: _____ b. Document ID number: _____

c. Lived in the U.S. since 1996? ☐ No ☐ Yes d. A veteran or active-duty member of the U.S. military? ☐ No ☐ Yes

14. Does this person plan to file a federal tax return for the CURRENT YEAR? ☐ No. Skip to question c. ☐ Yes. Complete questions a, b, c.

a. Filing jointly with a spouse? ☐ No ☐ Yes If yes, name of spouse: _____

b. Claiming dependents? ☐ No ☐ Yes If yes, names of dependents: _____

c. Claimed as a dependent on someone's tax return who does not live at the address listed on page 1 of this application? ☐ No ☐ Yes

Tell us about your household situation

1. Is anyone in your household American Indian or Alaska Native? ☐ No ☐ Yes. If yes, complete Appendix B with the application.

2. Is anyone in your household applying for or already receiving Tribal Commodities? ☐ No ☐ Yes

3. Is anyone in your household applying for or already receiving Foster Care or Adoption Assistance? ☐ No ☐ Yes

4. Was anyone in foster care when they turned 18? ☐ No ☐ Yes a. If yes, who?

5. Is anyone in your home currently receiving assistance from another State? ☐ No ☐ Yes. If yes, tell us when, where, and the type.

a. Date	b. City	State	County

c. Type of assistance received

6. Is anyone who is applying for assistance disabled? ☐ No ☐ Yes a. If yes, who:

7. Does anyone who is applying have a pending application for Social Security disability? ☐ No ☐ Yes

a. If yes, tell us who:

8. Does anyone who is applying need medical services provided in the home? ☐ No ☐ Yes

a. If yes, who:

9. Does anyone who is applying live in a medical care facility? ☐ No ☐ Yes

a. If yes, who	b. Name of the facility	c. Phone

10. Is anyone listed on this application incarcerated? No Yes a. If yes, who: _____

☐ ☐

Attach another sheet if you need to provide more information than space allows.

Tell us about your household situation

Are you applying for health coverage only (no other assistance) for someone under 65 and not disabled?

☐ **No. Complete all questions on this page.** ☐ **Yes. Skip to page 5.**

If you are applying for health coverage for someone under 65 and not disabled along with other types of assistance, or you are applying for other types of assistance besides health coverage, complete the questions below.

If you are over 65 or disabled, complete the questions below.

1. Has anyone in your household been disqualified from public assistance due to an intentional program violation? ☐ No ☐ Yes

   a. If yes, who: b. When: c. State:

2. Has anyone in your household been convicted of a felony involving drugs? ☐ No ☐ Yes

   a. If yes, who: b. When:

3. Is anyone fleeing to avoid felony prosecution or jail time? ☐ No ☐ Yes

   a. If yes, who:

4. Is anyone currently violating conditions of probation or parole? ☐ No ☐ Yes

   a. If yes, who:

5. Is anyone applying for assistance age 16 to 19 and going to high school? ☐ No ☐ Yes. If yes, use the table below to tell us who.

Name of student	Name of high school	Expected graduation date

6. Is anyone applying for assistance age 18 to 49 and going to college? ☐ No ☐ Yes. If yes, use the table below to tell us who.

Name of student	Name of college	Student status	Work study
		☐ Full time ☐ Part time	☐ No ☐ Yes
		☐ Full time ☐ Part time	☐ No ☐ Yes
		☐ Full time ☐ Part time	☐ No ☐ Yes

7. If you have children in the home, are they immunized? ☐ No ☐ Yes

8. If you have children in your home, do any of them have a parent NOT living with them? ☐ No ☐ Yes. If yes, tell us who they are.

If you answered Yes, you will be required to give information about the absent parent(s) to Child Support Services and open a Child Support case unless you fear harm to yourself or your children.

Child name	Absent parent name	Absent parent Social Security Number	Absent parent Date of birth

Attach another sheet if you need to provide more information than space allows.

Tell us about your household income (required for all types of assistance)

Tell us about all income your household receives. We want to know about the last 30 days, as well as any money received quarterly or annually. Income is money earned (wages or salary) from a job or self-employment, or unearned from sources such as Social Security, child support, unemployment benefits, gifts, rental income, retirement income, etc.

Copy this page or attach another sheet if you need to provide more information than space allows.

Income Source 1

1. Name of person with income:

☐ **Income from a job -** Tell us about any income this person gets from working a job.

2. Employer name | 3. Employer phone | 4. Average hours worked each week

5. Wages/tips (before taxes) $ ____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

☐ **Income from your own business -** Tell us about any income this person gets from a business they own.

7. Name of business | a. Type of work | b. Years in business | c. Estimated net income this month

☐ **Income from other sources -** Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	b. Amount	c. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income Source 2

1. Name of person with income:

☐ **Income from a job -** Tell us about any income this person gets from working a job.

2. Employer name | 3. Employer phone | 4. Average hours worked each week

5. Wages/tips (before taxes) $ ____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

☐ **Income from your own business -** Tell us about any income this person gets from a business they own.

7. Name of business | a. Type of work | b. Years in business | c. Estimated net income this month

☐ **Income from other sources -** Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	b. Amount	c. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Income Source 3

1. Name of person with income:

☐ **Income from a job -** Tell us about any income this person gets from working a job.

2. Employer name | 3. Employer phone | 4. Average hours worked each week

5. Wages/tips (before taxes) $ ____ paid ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

6. Income expected to change (raise, hours changed, etc.) ☐ No ☐ Yes Why?

☐ **Income from your own business -** Tell us about any income this person gets from a business they own.

7. Name of business | a. Type of work | b. Years in business | c. Estimated net income this month

☐ **Income from other sources -** Tell us about any other income sources for this person, such as Social Security, child support, etc.

8. Source of income	b. Amount	c. How often paid
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly
		☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

Are you applying for health coverage only (no other assistance) for someone under 65 and not disabled?

☐ **No. Complete all questions on this page.** ☐ **Yes. Skip to page 8.**

If you are applying for health coverage for someone under 65 and not disabled along with other types of assistance, or you are applying for other types of assistance besides health coverage, complete the questions below.

If you are over 65 or disabled, complete the questions below.

Tell us about your vehicles, resources, and property

1. Motor Vehicles - Tell us about all vehicles, including cars, trucks, motorcycles, trailers, boats, snowmobiles, and other recreational vehicles that your household owns.

Owner	Year, make, and model	Current value	Primary use for this vehicle (choose one)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Income producing ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Income producing ☐ Personal (other)
			☐ Business ☐ Get to work ☐ Work search ☐ Medical ☐ Recreational ☐ Residence ☐ Income producing ☐ Personal (other)

2. Resources - Tell us about all resources your household owns, including cash on-hand, checking and savings accounts, stocks, bonds, mutual funds, 401Ks, IRAs, trusts, CDs, life insurance policies, burial funds, etc.

Name / owner of resource	Resource type	Name of financial institution	Account number	Current value

3. Property - Tell us about all other property (including your home) owned by anyone living in your home.

Name / owner of property	Property type	Property Address	Value	Primary use for this property (choose one)
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:
				☐ Home ☐ Rental income ☐ Business/Self-employment ☐ Other:

4. Sale or transfer of resources and property - Tell us about everyone in your home who has sold, transferred or given away cash, property, or other assets within the last five years.

Name	Date of Transaction	What Assets	Amount Received	Fair Market Value

Are you applying for health coverage only (no other assistance) for someone under 65 and not disabled?

Attach another sheet if you need to provide additional information that this space allows.

☐ **No. Complete all questions on this page.** ☐ **Yes. Skip to page 8.**

If you are applying for health coverage for someone under 65 and not disabled along with other types of assistance, or you are applying for other types of assistance besides health coverage, complete the questions below.

If you are over 65 or disabled, complete the questions below.

Are you applying for health coverage only (no other assistance) for someone under 65 and not disabled?

☐ **No. Complete all questions on this page.** ☐ **Yes. Skip to page 8.**

If you are applying for health coverage for someone under 65 and not disabled along with other types of assistance, or you are applying for other types of assistance besides health coverage, complete the questions below.

If you are over 65 or disabled, complete the questions below.

Tell us about your household expenses

1. Shelter Expenses - Tell us about your recurring expenses. When telling us the amount of each expense, include only the amount ***you*** pay. If your mortgage payments include other payments such as irrigation, property taxes, HOA fees, etc., break them out and record them separately below.

Rent per month	Mortgage per month	2nd Mortgage per month	Space rent per month
$	$	$	$
Irrigation	**Property tax**	**HOA fees**	**Homeowners Insurance**
$ per	$ per	$ per	$ per

Check the boxes below for each utility you pay that is NOT included in your rent or mortgage:

☐ Heating ☐ Cooling ☐ Water ☐ Sewer ☐ Trash ☐ Telephone

Landlord's name Landlord's contact number

2. Dependent Care Expenses - Use the space below to tell us about any child care, adult disabled care, or elderly care.

Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address		Provider phone
Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address		Provider phone
Dependent name	Total charge for care	Amount you pay	How often you pay
Provider name	Provider address		Provider phone

3. Individual Expenses - Use the space below to tell us about any individual expenses. Allowable expenses include child support paid and some medical expenses for household members who are disabled or over the age of 60. When telling us the amount of each expense, include only the amount ***you*** pay.

Name of person with expense	Expense type	Amount	How often paid?
		$	
		$	
		$	
		$	
		$	

Attach another sheet if you need to provide more information than space allows.

Tell us about your health coverage situation

1. Does anyone who is applying for health coverage want help paying for medical costs from the last 3 months?

☐ **No.** Skip to #2. ☐ **Yes.** Complete questions the two questions below.

a. If yes, tell us who

b. If yes, tell us your gross household income (income before taxes) received by your family in each of the last three months:

Last month	Two months ago	Three months ago

2. Is anyone on this application insured by any of the following?

☐ Medicaid ☐ No ☐ Yes Who? _____

☐ CHIP ☐ No ☐ Yes Who? _____

☐ Medicare ☐ No ☐ Yes Who? _____

☐ TRICARE ☐ No ☐ Yes Who? _____

☐ VA Health Care ☐ No ☐ Yes Who? _____

☐ Peace Corps ☐ No ☐ Yes Who? _____

☐ Employer Insurance ☐ No ☐ Yes Who? _____

Name of insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ No ☐ Yes

Is this a retiree health plan? ☐ No ☐ Yes

What services are covered? Check all that apply. ☐ Inpatient/outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical services ☐ X-ray services

☐ Other Insurance ☐ No ☐ Yes Who? _____

Name of insurance: _____

Policy number: _____

Monthly premium: _____

Is this a limited-benefit plan? ☐ No ☐ Yes

What services are covered? Check all that apply. ☐ Inpatient/outpatient hospital services ☐ Lab services ☐ Physicians medical/surgical services ☐ X-ray services

3. If not currently receiving coverage, does anyone have access to health insurance from a job? Check "yes" even if the coverage is from someone else's job such as a parent or a spouse.

☐ **No** ☐ **Yes.** Complete Appendix C.

Rights and Responsibilities

I understand that...

_____ My signature certifies that the information on this application is true and accurate. I could be sanctioned and required to return any benefit I receive if my information is not true. Sanctions may include administrative, civil or criminal actions against me, including prosecution.

_____ I consent to the gathering, use and disclosure of my amount. information by the Idaho Department of Health and Welfare or its designees. I understand the information is needed for the purpose of providing benefits or services, obtaining payment for my benefits or services, and for normal business operations of the Department.

_____ I consent to the gathering and use of income data, including information from tax returns for determining eligibility for help paying for health coverage in future years (up to 5 years). I will receive notice when this occurs, be able to make changes, and may opt out at any time.

_____ I have the right to revoke this consent, in writing, at any time except to the extent the Department has already used and disclosed my information in reliance on this consent. If I revoke this consent, the Department may not provide further benefits or services.

_____ I will be notified of the right to appeal Department decisions and I can contact the Department for information on the appeal process.

_____ My signature indicates I have received a copy of the Department Privacy Practices.

_____ By applying for benefits for a minor child, a medical support case must be opened, when applicable. If I am receiving benefits for myself, failure to cooperate with Child Support Services may result in a loss or decrease of my benefits.

_____ If I receive a Child Support payment in error, Child Support Services will withhold future payments to recover the amount unless I submit written instructions to the contrary.

_____ By applying for heating and energy assistance, I authorize the Department to request information from and/or disclose necessary information to my utility companies for the purpose of determining my eligibility and providing benefits or services until I become ineligible or I request to end the benefits or services.

_____ If I am determined eligible for Medicaid, I choose the plan that is based on my health needs, unless I tell the Self Reliance worker otherwise.

_____ If I am determined eligible for Medicaid, I may be responsible for paying part of the cost of my child's health coverage, and I will be notified of my co-pay

_____ My signature or the signature of my representative authorizes State offices to communicate with insurance companies related to my/my child's medical assistance.

_____ I have the right to choose a Healthy Connections Primary Care Doctor, to request referrals for services, and to change the doctor/clinic if my circumstances change.

_____ If I receive Medicaid after age 55, my estate may be subject to recovery of medical expenses paid on my behalf, and that any transfer of assets may be set aside by a court if I do not receive adequate value.

_____ If a third party is responsible for my child's disease or injury, I give to Medicaid any rights I may have, or may acquire in the future, to be compensated by the responsible party for any medical benefits I receive for myself/my children.

_____ If I receive Medicaid/Cash Assistance, I am required to report changes in my circumstance, including income, assets, and living situation within ten (10) days of the change.

_____ I may be required to cooperate with state or federal reviewers who are making sure my benefits are correct. I may not be eligible to receive benefits if I do not cooperate.

_____ To receive Food Assistance, I may be required to participate in work programs. Failure to do so may result in a loss or decrease in benefits.

_____ It is illegal to give my Quest EBT card away or to trade the benefits on my card for cash, firearms, drugs, or other goods and services. Penalties include fines, imprisonment, and disqualification from future benefits.

_____ If I receive cash assistance (TAFI), I may not withdraw cash benefits, or use cash benefit funds to purchase products and services, in gambling establishments, liquor and tobacco stores, adult entertainment venues, other establishments prohibiting persons under the age of 18, or tattoo, body piercing, or other branding parlors.

Signature (must be completed)

Under penalty of perjury, I swear or affirm the information I have provided is true and complete. My signature confirms that I have read and understand the Rights and Responsibilities listed on this page.

_____ _____

Signature of applicant/authorized representative — Date

_____ _____

Signature of applicant/authorized representative — Date

Reset Form | Print Form | Submit Form

Appendix A

IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

You can name someone as an authorized representative.

You may give a trusted person, such as a friend, partner, or third party caseworker permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative, contact the Department to complete a new Authorized Representative Form.

If you're a legally appointed representative for someone on this application, submit proof with the application.

Tell us who you want to name as your authorized representative

First Name	Middle Name	Last Name

Address	Apartment or suite number

City	State	Zip Code	County

Phone	Phone type (choose one)	Email
	☐ Home ☐ Work ☐ Cell	

Organization Name (if third party caseworker)	Organization ID (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with the Department.

Signature of Authorized Representative _____ Date _____

Appendix B

IDAHO DEPARTMENT OF HEALTH & WELFARE

American Indian or Alaska Native Family Member

Complete this appendix if you or a family member are American Indian or Alaska Native. Submit this with your Application for Assistance.

Tell us about your American Indian or Alaska Native family member(s).

American Indians (AI) and Alaska Natives (AN) can get services from the Indian Health Services, tribal health programs, or urban Indian health programs. They also may not have to pay cost sharing and may get special monthly enrollment periods. Answer the following questions to make sure your family gets the most help possible.

NOTE: If you have more than three people to include, make a copy of this page and attach with your Application for Assistance.

Person 1

1. First Name | Middle Name | Last Name

2. Is this person a member of a federally recognized tribe? ☐ No ☐ Yes b. **If yes**, name of tribe:

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ No ☐ Yes

   b. **If no**, is this person eligible to receive these services? ☐ No ☐ Yes

4. List any income (amount and how often) reported on the application that includes money from:

   - Per capita payments from a tribe that come from natural resources, usage rights, or royalties
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

   Amount: $ _____

   Frequency: _____

Person 2

1. First Name | Middle Name | Last Name

2. Is this person a member of a federally recognized tribe? ☐ No ☐ Yes b. **If yes**, name of tribe:

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ No ☐ Yes

   b. **If no**, is this person eligible to receive these services? ☐ No ☐ Yes

4. List any income (amount and how often) reported on the application that includes money from:

   - Per capita payments from a tribe that come from natural resources, usage rights, or royalties
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

   Amount: $ _____

   Frequency: _____

Person 3

1. First Name | Middle Name | Last Name

2. Is this person a member of a federally recognized tribe? ☐ No ☐ Yes b. **If yes**, name of tribe:

3. Has this person ever received services from the Indian Health Service, a tribal health program, or urban Indian health program, or through a referral from one of these programs? ☐ No ☐ Yes

   b. **If no**, is this person eligible to receive these services? ☐ No ☐ Yes

4. List any income (amount and how often) reported on the application that includes money from:

   - Per capita payments from a tribe that come from natural resources, usage rights, or royalties
   - Payments from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
   - Money from selling things that have cultural significance

Amount: $ _____

Frequency: _____

Appendix C

IDAHO DEPARTMENT OF HEALTH & WELFARE

Health Coverage from Jobs

Complete this appendix if someone in the household is eligible for health coverage from a job. Attach a copy of this page for each job that offers coverage.

Tell us about the job that offers coverage

Take the Employer Coverage Tool on the next page to the employer who offers coverage to help you answer these questions. You only need to include this page when you send in your application, not the Employer Coverage Tool.

Employee Information

1. First Name	Middle Name	Last Name	2. Social Security Number

Employer Information

3. Name			4. Identification Number (EIN)
5. Address			6. Phone
7. City		8. State	9. Zip Code

10. Who can we contact about employee health coverage at this job?

11. Phone	12. Email

13. Are you currently eligible for coverage offered by this employer, or will you become eligible in the next 3 months?

☐ **No.** Stop here and submit this form with your application. ☐ **Yes.** Complete the rest of this form.

a. If you're in a waiting or probationary period, when can you enroll in coverage? _____

b. List everyone who is eligible for coverage from this job:

Tell us about the **health plan** offered by this employer.

14. Does the employer offer a health plan that meets the minimum value standard?* ☐ Yes ☐ No

15. For the lowest-cost plan that meets the minimum value standard* offered **only to the employee** (don't include family plans):
If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

16. What change will the employer make for the new plan year (if known)?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. Seequestion 15.)

a. How much would the employee have to pay in premiums for that plan? $ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Quarterly ☐ Yearly

c. Date of change:

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is

no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

CHIP Eligibility

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Separate Child Health Insurance Program
General Eligibility - Continuous Eligibility **CS27**

2105(a)(4)(A) of the SSA and 42 CFR 457.342 and 435.926

The CHIP Agency may provide that children who have been determined eligible under the state plan shall remain eligible, regardless of any changes in the family's circumstances, during a continuous eligibility period up to 12 months, or until the time the child reaches an age specified by the state (not to exceed age 19), whichever is earlier.

The CHIP Agency elects to provide continuous eligibility to children under this provision. Yes

- (●) For children up to age 19
- ( ) For children up to age

The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends:

- [■] At the end of the 12 months continuous eligibility period.

Exceptions to the continuous eligibility period:

- [■] The child attains the age specified by the state Agency or age 19.
- [■] The child or child's representative requests voluntary disenrollment.
- [■] The child is no longer a resident of the state.
- [■] The Agency determines that eligibility was erroneously granted at the most recent determination or renewal of eligibility because of Agency error or fraud, abuse, or perjury attributed to child or child's representative.
- [■] The child dies.
- [■] There is a failure to pay required premiums or enrollment fees on behalf of a child, as provided for in the state plan.
- [ ] Other

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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