# Medicaid Eligibility

State Name: Indiana

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**Eligibility Groups - Mandatory Coverage**
**Adult Group** **S32**

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

(•) Yes ( ) No

[■] **Adult Group** - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

[☑] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] Have attained age 19 but not age 65.

[■] Are not pregnant.

[■] Are not entitled to or enrolled for Part A or B Medicare benefits.

[■] Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

[■] Have household income at or below 133% FPL.

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

[■] There is no resource test for this eligibility group.

[■] Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

(•) Under age 19, or

( ) A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

[■] Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

(•) Yes ( ) No

[■] The presumptive period begins on the date the determination is made.

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■ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

■ Periods of presumptive eligibility are limited as follows:

○ No more than one period within a calendar year.

○ No more than one period within two calendar years.

◉ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

○ Other reasonable limitation:

The state requires that a written application be signed by the applicant or representative.

◉ Yes ○ No

○ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

◉ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

**An attachment is submitted.**

■ The presumptive eligibility determination is based on the following factors:

■ The individual must meet the categorical requirements of 42 CFR 435.119.

■ Household income must not exceed the applicable income standard described at 42 CFR 435.119.

☒ State residency.

☒ Citizenship, status as a national, or satisfactory immigration status.

■ The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

**List of Qualified Entities** **S17**

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual's household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

☐ Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan

☐ Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act

☐ Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990

- ☐ Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- ☐ Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- ☐ Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- ☐ Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- ☐ Is a state or Tribal child support enforcement agency under title IV-D of the Act
- ☐ Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- ☐ Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
- ☐ Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)
- ☐ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization
- ☒ Other entity the agency determines is capable of making presumptive eligibility determinations:

| | Name of entity | Description | |
|---|---|---|---|

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| | Name of entity | Description | |
|---|---|---|---|
| + | Qualified Provider | Provider types eligible to enroll as a presumptive eligibility Qualified Provider (PE QP) include: Acute Care Hospitals, Psychiatric Hospitals, community mental health centers (CMHCs), rural health clinics (RHCs), federally qualified health centers (FQHCs), and local health departments. To be eligible, an acute care hospital, psychiatric hospital, CMHC, RHC, local health department or FQHC must:<br><br>• Participate as a provider under the Indiana State Plan or under a demonstration program under Section 1115 of the Social Security Act. Local county health departments are not required to participate as a Medicaid provider.<br>• Notify the FSSA of the provider's intention to make presumptive eligibility determinations.<br>• Agree to make presumptive eligibility determinations consistent with state policies and procedures.<br>• Guide individuals in the process for completing and submitting the Indiana Application for Health Coverage paperwork to the FSSA.<br>• Complete and submit PE QP eligibility attestations through the PE enrollment process on Web interChange.<br><br>CMHCs, RHCs, FQHCs, and local health departments that wish to enroll as PE QPs are provided Web interChange training. During the Web interChange training session, the CMHC, RHC, FQHC, or local health department also receive a printed copy of the HPE/PE Process Guide. | X |

The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, ☑ and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

**An attachment is submitted.**