Understanding SSI, CMH, and Medicaid Frequently-Asked Questions

Supplemental Security Income (SSI)

Q: I have a family that is only receiving $30 a month. Their daughter was in the NICU when they applied but have been home for months and still only receiving the minimum. How do they update their information to receive additional funds?
A: The family must notify the local Social Security office of the living arrangement change for the child. They can call 1-800-772-1213 to report, or they can reach their local office directly by looking up the number at www.ssa.gov/locator.

Note: Social Security will ask for proof of hospitalization dates, a letter or discharge papers showing inpatient dates can be faxed to the local office, also at www.ssa.gov/locator.

Q: Is payment back dated to application or based on date of determination?
A: The application date for SSI is the earliest date an applicant can be found eligible for SSI since there is no retroactivity, but the payment start date is ultimately based on the date they meet all eligibility requirements, including date of disability onset.

If there is potential eligibility for a child, the family should start the application process as soon as possible. Go to www.ssa/gov/benefits/ssi/ for a step-by-step guide on how to apply.

Note: Some EI agencies are helping families apply for benefits with our Social Security SSI VPAP Application Process. With VPAP, families don't have to wait for an appointment as our trained agency partners complete forms online and via fax. Contact Kelly.Draggoo@ssa.gov or Theresa.Busher@ssa.gov to set up training for your organization.

Q: How can we support families being asked to attend multiple outside appointments for additional evaluations of a child's disability? I have had a few families that have been asked to attend five plus additional evaluation appointments at a variety of locations. It feels as though our Early Intervention (EI) evaluation/assessment information isn't considered, or is not enough, even if it is very current.
A: Social Security must have evidence of an impairment(s) from an Acceptable Medical Source (AMS) such as a physician, psychologist, SLP, etc. see https://secure.ssa.gov/poms.nsf/lnx/0422505003. However, once we establish that the child has a medical impairment, we consider all evidence in the file including school information, social

service agencies, EI documentation, etc. Thus, all EI evaluations are most certainly considered in the determination, but if additional information is needed regarding the alleged impairments, we may need to schedule a Consultative Exam (CE) with an AMS – and we might need to look at various CE professionals if the child has multiple body systems involved. There is good information on the disability determination process at https://www.ssa.gov/disability/professionals/childhoodssi-pub048.htm.

Q: What happens if a child is deemed disabled by DDS but does not meet the income criteria? Does being determined disabled get any other benefits for the child/family?
A: When a child applies for SSI income and resource allegations for him/her as well as the parent(s) they live with are assessed.

If the income/resources are too high for SSI eligibility, no medical decision will be made-the application/claim will not be sent to DDS for a medical determination.

If there is a possibility of SSI payment based on alleged parental income and resource information, then a medical decision would be made at the DDS. But no payment would be made until parent income/resources and living situation are verified.

There is good information on SSI guidelines for parents at www.ssa.gov/ssi/text-understanding-ssi-htm.

Q: Can we hear a little bit on the differences between SSI and SSDI?
A: SSI and SSDI are both disability benefit programs administered by Social Security:

- SSI- Supplemental Security Income provides monthly payments who meet limited income/resource guidelines and living arrangement parameters AND meet Social Security disability criteria (or are age 65+). www.ssa.gov/benefits/ssi
- SSDI – Social Security Disability Insurance is based on a person's FICA earnings, so you must have worked under FICA a minimal amount in order to qualify (similar to retirement). The amount of SSDI varies depending on a person's earnings and amount of work. An SSDI recipient may also have family members eligible to draw benefits. See www.ssa.gov/benefits/disability

Q: I think I just heard if a family doesn't qualify for SSI based on income limits, they will be referred back to JFS to apply for Medicaid only? But doesn't JFS have lower income limits? Or is there a way to get Medicaid through them for a child with a disability?
A: As SSI is based on need, a child or adult qualifying for SSI is automatically Medicaid eligible in the state of Ohio. SSA provides data to Ohio JFS, so SSI recipients do not

have to make a separate Medicaid application.
However, many people receive Medicaid in Ohio who are not SSI recipients (or have a disabling medical decision) as JFS administers various types of Medicaid benefits which are not under Social Security's jurisdiction. If a family is unsure of Medicaid eligibility, SSA would always refer that family to their local JFS office for potential benefits. https://medicaid.ohio.gov/families-and-individuals/coverage/who-qualifies/who-qualifies

Children with Medical Handicaps (CMH)

Q: I have a family denied for formula, how do we reapply? She has a g-tube and WIC doesn't give enough. Also, cannot get the formula doctors recommended.
A: Children may be approved for CMH services but may not meet the CMH criteria for formula, and it also depends on the reason for the g-tube. For example, food aversions would not meet criteria, but medical reasons like cerebral palsy, severe reflux, or malformations of the esophagus or gut would be eligible. It also depends on who issued the denial and for what reason. If the family was denied medically by CMH, the reason will be listed on the denial letter. If the family was denied financially, they need to submit the requested forms noted in the denial letter. Instructions on how to appeal the decision are included on every CMH denial letter.

Families are having a lot of difficulty getting different kinds of formula. Please reach out to our nutritionist, Sarah Stargell, at sarah.stargell@odh.ohio.gov or call our customer service line at 614-466-1700 and ask to speak with her. If you want to discuss the specific case, please email me at sue.smith@odh.ohio.gov or call me at 614-466-2003.

Q: How would a family learn about CMH services? Through their pediatrician?
A: Most of the children's hospitals in Ohio will inform families of the CMH program. Families can also contact their local public health nurse to apply for the program. Everyone attending the presentation was given a printable copy of our brochure that can be distributed widely to your families.

Q: Does the diagnostic program have financial eligibility?
A: No, it does not. It is available to all families birth to 21.

Q: Is CMH back dated/paid? If so, for how long?
A: Normally, CMH can pay claims up to a year old. There are some circumstances in which claims can be paid, but never more than two years old.

Q: Are places like Nationwide Children's Hospital always asking inpatient families if they would like a referral to CMH if there are medical concerns/potential dx?
A: Yes, with the caveat that not all departments automatically ask families, but most of them do. It also varies from hospital to hospital

Q: You mentioned the Diagnostic program is a nine-month program, so dx needs to be determined in that time? What happens if they haven't determined dx yet? What is the best way/process for a family to apply for the Diagnostic Program?
A: Hopefully, a diagnosis has been established within that time and many times during the evaluation process, a new diagnosis pops up. That physician can request another diagnostic period if a brand-new diagnosis is found during testing. CMH rules indicate that a child can have one diagnostic period approved per body system per life unless there has been a change in condition/diagnosis or a change of physician submitting the request. The family can ask if the physician their child seeing is a BCMH-approved provider. If so, they can submit the application. The family can also contact their local public health nurse (PHN) at their health department and the PHN can submit a referral to CMH to that physician.

Medicaid

Q: When you mentioned the waiver assessment, you said "current need or immediate need." What do you mean by needs, and what might that look like for children?
A: These are defined in our rule 5123-9-04 "Immediate need" means a situation that creates a risk of substantial harm to an individual, caregiver, or another person if action is not taken within thirty calendar days to reduce the risk. Situations that give rise to immediate need include:

a. A resident of an intermediate care facility for individuals with intellectual disabilities has received notice of termination of services in accordance with rule 5123:2-3-05 of the Administrative Code.
b. A resident of a nursing facility has received thirty-day notice of intent to discharge in accordance with Chapter 5160-3 of the Administrative Code 5123-9-04 3.
c. A resident of a nursing facility has received an adverse determination in accordance with rule 5123:2-14-01 of the Administrative Code.
d. An adult is losing his or her primary caregiver due to the primary caregiver's declining or chronic physical or psychiatric condition or due to other unforeseen circumstances (such as military deployment or incarceration) that significantly limit the primary caregiver's ability to care for the individual when: (i) Impending loss of the caregiver creates a risk of substantial harm to the individual; and (ii) There are no other caregivers available to provide necessary supports to the individual.

e. An adult or child is engaging in documented behavior that creates a risk of substantial harm to the individual, caregiver, or another person.
f. There is impending risk of substantial harm to the individual or caregiver as a result of: (i) The individual's significant care needs (i.e., bathing, lifting, high demand, or 24-hour care); or (ii) The individual's significant or life-threatening medical needs.
g. An adult has been subjected to abuse, neglect, or exploitation and requires additional supports to reduce a risk of substantial harm to the individual.

"Current need" means an unmet need for home and community-based services within twelve months, as determined by a county board based upon assessment of the individual using the waiting list assessment tool. Situations that give rise to current need include:

a. An individual is likely to be at risk of substantial harm due to: (i) The primary caregiver's declining or chronic physical or psychiatric condition that significantly limits his or her ability to care for the individual; (ii) Insufficient availability of caregivers to provide necessary supports to the individual; or (iii) The individual's declining skills resulting from a lack of supports.
b. An individual has an ongoing need for limited or intermittent supports to address behavioral, physical, or medical needs, in order to sustain existing caregivers and maintain the viability of the individual's current living arrangement.
c. An individual has an ongoing need for continuous supports to address significant behavioral, physical, or medical needs.
d. An individual is aging out of or being emancipated from children's services and has needs that cannot be addressed through community based alternative services.
e. An individual requires waiver funding for adult day services or employment related supports that are not otherwise available as vocational rehabilitation services funded under section 110 of the Rehabilitation Act of 1973, 29 U.S.C. 730, as in effect on the effective date of this rule, or as special education or related services as those terms are defined in section 602 of the Individuals with Disabilities Education Improvement Act of 2004, 20 U.S.C. 1401, as in effect on the effective date of this rule.
f. An individual is living in an intermediate care facility for individuals with intellectual disabilities or a nursing facility and has a viable discharge plan.

Q: Are parents allowed to enroll as a provider for their child?
A: Typically, in the Provider Certification 5123-2-09 rule parents of minor children are prohibited from providing services to their own minor children. This is currently temporarily waived under the Appendix K during the Federal Public Health Emergency with county board team approval via the ISP if the parent is employed by an Agency.

Q: Did the financial criteria change? I feel like it used to be higher.
A: This question would need to go to the County JFS Department. DODD does not do any part of the financial component of base Medicaid eligibility, however a person who has been assigned a waiver should be full Medicaid eligible.

Q: When a child has a Medicaid card, how do we find out the expiration date for eligibility since the date is no longer on the card?
A: If a child has a waiver, their Medicaid eligibility should be for the entire waiver span.

Q: Is that LOC also for children?
A: A child still must have an ICF LOC, the requirements change a bit after the child turns 10 years old, but it is still required that they have that Intermediate Care Facility LOC, because that is what they are waiving in order to have the HCBS community service.

Q: What would children use waivers for?
A: This varies by child, however for most children it is respite services, equipment, and home modifications.