HCS 495

OFFICE OF PUBLIC ASSISTANCE
PO BOX 202925
HELENA, MT 59620-2959

GREG GIANFORTE
GOVERNOR

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

CHARLIE BRERETON
DIRECTOR

Appendix B
Community Engagement Exclusions

Individuals who meet an approved exclusion are not required to meet the community engagement requirements to maintain Medicaid coverage. This form is required for each individual in the Medicaid household between the ages of 19 and 64 who is reporting a possible exclusion. Verification of exclusions may be required.

Verifications:

Based on the information provided on this form, the Department may attempt to verify your exclusion through data matching or require you to provide additional documentation. Additional details on what type(s) of verifications are allowed for each exclusion are summarized on Page 2 *Community Engagement Exclusions Summary Form*. Please visit medicaidchanges.mt.gov for a full list of exclusions and approved verifications.

Meeting Community Engagement Requirements:

You only meet the Community Engagement rules during the months when your exclusion applies. If your exclusion ends, you will need to either meet the Community Engagement requirements through approved activities or qualify for a different exclusion to keep your Medicaid coverage. For more information, please visit http://medicaidchanges.mt.gov

Reporting Compliance with Community Engagement Requirements:

Submit this form along with copies (do not send originals) of any documents to:

Mail:	Fax:	Drop Off:	Online:
HCSD PO Box 202925 Helena, MT 59620	1-877-418-4533	At your local OPA	www.apply.mt.gov

Visit our website for more information:

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Community Engagement Exclusions Summary Form

Please use this form to report all exclusion(s) that apply to each adult in your household and submit with your redetermination.

Name_____ Medicaid Case # (if known) _____ Date _____

Type of Exclusion	**Verification Provided**	**Months Applicable** (*write months*)
American Indian or Alaska Native ☐	***Enrollment Number, letter from IHS, or Self Declaration Form*** *(attached form– page 3)*	
Former foster child under 26 years of age ☐	***Self Declaration Form*** *(attached form– page 3)*	
Inmate of a public institution ☐	***Facility documentation (jail, prison, etc.)***	
Medical condition or health needs that impact ability to work or do other community engagement activities ☐	***Provider or facility documentation and attached form–*** *page 4****. For more information on what conditions are included, visit*** *medicaidchanges.mt.gov*	
Parent, Guardian, Caretaker Relative, or Family Caregiver of a Dependent Child Under age 14 or a Disabled Individual ☐	***Care of Dependent Child Under Age 14: Self Declaration Form*** ***Care for a Disabled Individual: Provider or facility documentation*** *(for both: attached form– pages 5-6)*	
Participant in an alcohol or drug addiction treatment program ☐	***Provider documentation: Enrollment or attendance letter***	
Pregnant or Entitled to Postpartum Coverage ☐	***Provider documentation or Self Declaration Form*** *(attached form– page 3)*	
Veteran with a disability rated as total *(Veteran Disability rating of 100%)* ☐	***Statement from the VA showing disability rating***	
Eligible for Medicare ☐	***Letter from SSA or Medicare card***	
Recently incarcerated in the last three months ☐	***Facility documentation (jail, prison, etc.)***	
Necessary travel for medical services not available in the community for a serious medical condition. ☐	***Provider documentation***	
Individual receiving inpatient or institutional services ☐	***Provider documentation***	

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General Exclusion Self-Declaration Form

Name_____ Medicaid Case # (if known) _____ Date _____

I, _____, confirm that (check one or more):

☐ I am American Indian, Alaska Native, California Indian
☐ I am eligible for services through Indian Health Services
☐ I am a former foster child under 26 years of age and I was in foster care when I turned 18
  ☐ *I was last served in the state of Montana as a foster child*
  ☐ *I was last served in a state other than Montana as a foster child*
☐ I am pregnant. Expected due date _____

Penalty of Perjury Statement

I declare under penalty of perjury, under the laws of the State of Montana and federal law, that the information on this form is true, correct, and complete.

I understand that if I provide false incorrect, or incomplete information, it may result in:

- Denial or loss of benefits
- Repayment of benefits I was not eligible to receive
- Civil or criminal penalties

Printed Name: _____

Applicant Signature: _____ Date: _____

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Medical Condition or Health Needs that Impact Ability to Work or Do Other Community Engagement Activities

Name_____ Medicaid Case # (if known) _____ Date _____

I, _____, confirm that I meet one of the categories below and that the condition significantly impairs my ability to meet the community engagement requirement (*check one or multiple, complete information fields, and **attach documentation***):

☐ **Blind or disabled,** as determined under section 1614 of the Social Security Act

☐ A **substance use disorder (SUD)** where I have not been in stable recovery for 5 or more years — for example, alcohol, opioid, or stimulant use disorder

☐ A **disabling mental disorder** — for example, schizophrenia, moderate or severe bipolar disorder, major depressive disorder, or panic disorder

☐ A **physical, intellectual, or developmental disability** that significantly impairs my ability to perform one or more activities of daily living (ADLs) — for example, cerebral palsy, muscular dystrophy, spinal cord or brain injury, or Down syndrome

☐ A **serious or complex medical condition** — for example, cancer, end-stage renal disease, COPD, HIV/AIDS, heart disease, ALS, Parkinson's disease, or multiple sclerosis

*Please visit **medicaidchanges.mt.gov** for a full list of conditions that qualify for each category.*

Describe the health condition(s) that fit the descriptions above.

_____

_____

What health care provider(s) does the individual currently see for the condition(s) listed above and/or who provided the initial diagnosis?

Provider Name(s): _____

Address(es): _____

Telephone number(s): _____

Please attach provider and/or facility documentation to your redetermination.

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Caregiver Declaration Form (Page 1/2)

Name_____ Medicaid Case # (if known) _____ Date _____

This form should only be used if caregiving responsibilities total 80 hours or more per month. If caregiving responsibilities total less than 80 hours each month, these hours contribute to Community Engagement qualifying activity requirements and should be reported in *Appendix A: Community Engagement Requirements Reporting Form*.

1. Who You Care For and Your Relationship

The person I care for is (*check one*)**:**

☐ A dependent child ☐ An individual with a disability (***attach documentation of disability***)

2. Your Caregiving Situation

Check the statement that describes your caregiving situation.

☐ I live in the same household as the person I care for, and I provide assistance that is regular and not incidental. (*Sign only 3B below*)

☐ I am a relative of the person I care for, I do not live in the household with them, and I provide assistance that is regular and not incidental. (*Collect signatures for 3A and sign 3B below)*

☐ I am not a relative, I do not live with the person I care for, and I provide at least 80 hours of care to them per month. Estimated hours per month: _____ (*Collect signatures for 3A and sign 3B below)*

A relative is related by blood, adoption, or marriage — for example, a parent, grandparent, sibling, stepparent, stepsibling, aunt, uncle, cousin, niece, or nephew.

My relationship to the person I care for is (*check one*)**:**

☐ Parent ☐ Caretaker relative

☐ Legal guardian ☐ Other caregiver (not a relative)

3. Documentation and Verification

If you care for a dependent child in your household: No documentation of the child's status is required. Client completing redetermination's signed penalty of perjury statement in 3B below is sufficient.

If you care for a dependent child who is not in your household: Have a parent or guardian of the child complete 3A below, and client completing redetermination signs penalty of perjury statement in 3B.

If you care for an individual with a disability: *Attach provider or facility documentation of the disability*, the person receiving care (or their representative) completes 3A below, and the client completing redetermination signs penalty of perjury statement in 3B.

Form continues on next page

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Caregiver Declaration Form (Page 2/2)

Name_____ Medicaid Case # (if known) _____ Date _____

3A. Care Confirmation Statement *(not required if caring for dependent in household)*
I confirm that _____ (caregiver name) provides care for me, or for the person I represent. Care is provided for at least 80 hours per month. *Check one:*

☐ I am the person receiving care ☐ I am the legal guardian ☐ I have power of attorney

Printed Name: _____

Signature: _____ Date: _____

3B. Penalty of Perjury Statement *(to be signed by client completing redetermination)*
I declare under penalty of perjury, under the laws of the State of Montana and federal law, that the information on this form is true, correct, and complete.
I understand that if I provide false incorrect, or incomplete information, it may result in:

- Denial or loss of benefits
- Repayment of benefits I was not eligible to receive
- Civil or criminal penalties

Printed Name: _____

Applicant Signature: _____ Date: _____