MLTC Consent Line Process Guide

Consent Line Usage:

The consent line provides an option to record verbal consent and/or signatures. The consent line saves the signatures for the length of time required for records retention purposes.

- Local Office staff that are on a call with a client and an application/renewal form is needed can complete the form and use the consent line to capture the signature.
- Local Office/CSC staff can use the consent line to acquire missing consent signatures.
- CSC staff that are not assigned to application queues or are working remotely and using a soft phone should use the consent line to capture signatures so that the appropriate records retention schedule is followed.

The process consists of reading the appropriate script and collecting the electronic signature. This process can be used when the applicant/spouse/POA or Authorized Representative (AR) needs to give consent or verbally sign documents. Examples might be:

1. Client, POA or Authorized Representative needs to complete a Medicaid application/renewal form.
2. The application on file does not include the consent information.
3. AVS consent is needed for the applicant or applicant's spouse.
4. Tax Household Information and/or Tax Permission is needed.
5. If you are in a CSC, and you are assigned to an application queue, you will not need to use the Consent Line. (If you are using a Soft Phone, you WILL need to use the Consent Line)

Calling the Consent Line

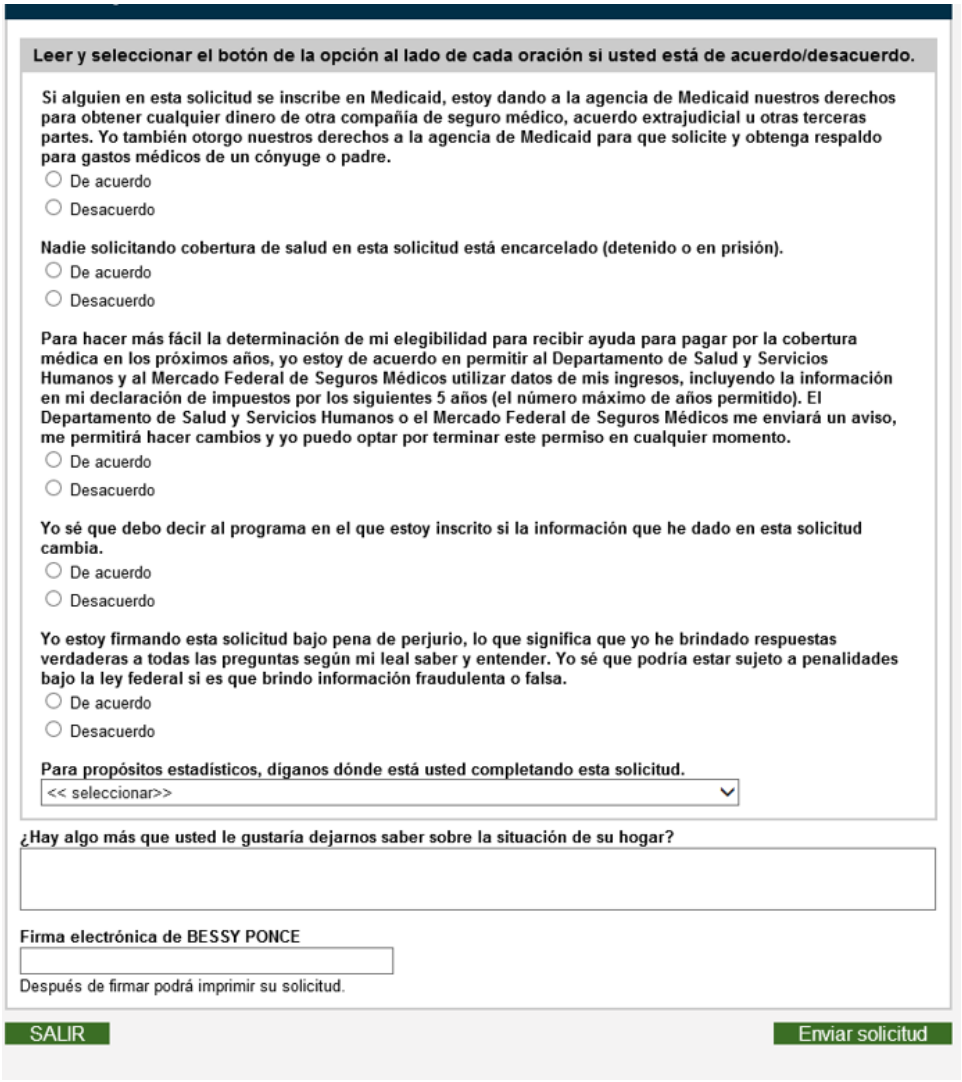
1. Office phone:
    a. Press Conference or Flash button on your phone or on the cisco app
    b. Dial consent line (402-473-8579)
    c. After the phone rings ONCE – press Conference/Flash button again and consent line is active.
        i. ONCE THE CONSENT LINE IS ANSWERED – THERE WILL BE SILENCE
    d. Start Consent Script
2. Cell Phone:
    a. Press the add call button on your phone
    b. Dial consent line (402-473-8579)
    c. After the phone rings ONCE – press the merge calls button.
        i. ONCE THE CONSENT LINE IS ANSWERED – THERE WILL BE SILENCE
    d. Start Consent Script
3. If the worker calls the consent line and it is busy, the worker will need to wait a few seconds and try it again (with the client still on the phone).
4. For both inbound and outbound calls, the consent line only records the consent script. All other questions or information gathering should occur before calling the consent line.

5. After the consent is recorded, the worker should make sure the client ends the call first and leaves the consent line before ending the call.
6. Calls should not be transferred from the consent line to another queue. The client will need to call back. Make sure the client has the appropriate phone number before ending the call.

Application Consent Script:

1. The worker will read the following statements to the client:
    a. If anyone on this application enrolls in Medicaid, I'm giving the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I'm also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
        i. Please state either "I agree or I Disagree"
    b. I know I'll be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell the agency and I may not have to cooperate.
        i. Please state either "I agree or I Disagree"
    c. No one applying for health coverage on this application is incarcerated (detained or jailed).
        i. Please state either "I agree or I Disagree"
    d. To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the Department of Health and Human Services or the Federal Health Insurance Marketplace to use income data, including information form tax returns, for the next 5 years (the maximum number of years allowed). The Department of Health and Human Services or the Federal Health Insurance Marketplace will send me a notice, let me make any changes and I can opt out at any time.
        i. Please state either "I agree or I Disagree"
    e. I know that I must tell the program I'm enrolled in if information I listed on this application changes.
        i. Please state either "I agree or I Disagree"
    f. I'm signing this application under penalty of perjury, which means I'm provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to the penalties under federal law if I intentionally provide false or untrue information.
        i. Please state either "I agree or I Disagree"

2. Spanish:



3. Is there anything else you would like to tell us about your household's situation?
4. Please state and spell your full name as your electronic signature.
5. Narrate:
    a. Consent was obtained via phone with (name) on (date). The call was transferred to the consent line at approximately (enter time), from (phone number that the worker utilized). The script was read and the client agreed.

AVS Consent Script

1. The worker will read the following statements to the client:
    a. I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs. Such third parties shall include, but not be limited to: the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, a consumer reporting agency, and financial institutions. Any

third party shall also be authorized to provide any information or documents requested by the Nebraska Department of Health and Human Services concerning myself or, when required by law, any other person.

b. I further authorize the Nebraska Department of Health and Human Services to release such information or documents to cooperating State or Federal Agencies in accordance with any applicable law.

c. This authorization is given only to the Nebraska Department of Health and Human Services to be used in the administration of its programs and for no other purposes.

d. It shall continue in effect until the earliest of: the rendering of a final adverse decision on my spouse's application for medical assistance, the cessation of my spouse's eligibility for medical assistance, or such time as I state in writing that I rescind this authorization.

e. I release any third party from any and all liability to me and, when applicable, any other person, for supplying the aforementioned information or documents.

f. I hereby authorize the Nebraska Department of Health and Human Services and its agents to request from third parties any information or documents necessary for the administration of its programs, including financial information. I also authorize the release of my Social Security Number for this purpose.

2. Ask the individual if they agree and if they state, "yes", have the individual state and spell their first and last name.
3. Narrate the following:
    a. **Client:** AVS consent was obtained via phone with (client name) on (date). The client was transferred to the consent line at approximately (enter time), from (phone number that the worker utilized, this is needed because the worker will initiate the call to the consent line). The script was read and the client agreed.
    b. **Non-Applicant Spousal consent:** AVS Spousal consent was obtained via phone with (spouse name) on (today's date). The client was transferred to Consent Line at approximately (enter time), from (phone number the worker called from). The consent script was read and the non-applicant spouse agreed.

Tax Information Form Script

1. Complete the form with the client prior to dialing the consent line.
2. The worker will read the following statements to the client

English:

a. To make it easier to determine my eligibility for help paying for health coverage today and in the future, I agree to allow the Department of Health and Human Services (DHHS) to use income data, including information from tax returns. DHHS will send me a notice, let me make any changes, and I can opt out at any time.

b. I am signing this form under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and/or untrue information.

c. I know that I must tell Nebraska Medicaid if anything changes (and is different than) what I wrote on this application. I can go to iServe.nebraska.gov or call 1-855-632-7633, (402)473- 7000 in Lincoln, (402)595-1178 in Omaha.

d. I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.

e. I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

f. If not, then please state who is incarcerated.

g. We need information to check your eligibility for Medicaid. We'll check your information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security Administration (SSA), The Department of Homeland Security, and or a consumer reporting agency. If the information doesn't match, we may ask you to send us verification.

Spanish:

a. Para hacer más fácil la determinación de mi elegibilidad para recibir ayuda para pagar por la cobertura médica en los próximos años, yo estoy de acuerdo en permitir al Departamento de Salud y Servicios Humanos (DHHS) utilizar datos de mis ingresos, incluyendo la información en mi declaración de impuestos. El Departamento de Salud y Servicios Humanos me enviará un aviso, me permitirá hacer cambios y yo puedo optar por terminar este permiso en cualquier momento.

b. Yo estoy firmando este formulario de renovación bajo pena de perjurio, lo que significa que yo he dado respuestas verdaderas a todas las preguntas de este formulario según mi leal saber y entender. Yo sé que podría estar sujeto a penalidades bajo la ley Federal si doy información fraudulenta y/o falsa.

c. Yo sé que debo comunicar a Medicaid de Nebraska si algo cambia y es diferente a lo escrito en este formulario de renovación.

d. Yo sé que bajo la ley Federal está prohibido discriminar por motivos de raza, color, origen nacional, sexo, edad, orientación sexual, o discapacidad. Yo puedo presentar una queja por discriminación yendo al sitio web www.hhs.gov/ocr/office/file.

e. Yo confirmo que ninguna persona que está solicitando seguro médico en este formulario de renovación está encarcelado (detenido o preso).

f. Si no es así, _____está encarcelado/a.

g. Necesitamos información para verificar su elegibilidad para Medicaid. Nosotros verificaremos su información en nuestra base de datos y las bases de datos del Servicio de Recaudación de Impuestos (IRS), la Administración de Seguridad Social (SSA), el Departamento de Seguridad Nacional y/o las agencias de reportes al consumidor. Si la información no concuerda, le podríamos pedir que nos envíe verificaciones adicionales.

2. Please state and spell your full name as your electronic signature.
3. Narrate:
    a. Tax Permission was obtained via phone with (name) on (date). The call was transferred to the consent line at approximately (enter time), from (phone number that the worker utilized). The script was read and the client agreed.
4. Tax Information Form, if completed, should be uploaded to DI, or information narrated.