Medicaid for the Elderly and Disabled - July 2011

The Alabama Medicaid Agency has a number of programs for the elderly and disabled. Medicaid for Institutional care is for people in nursing homes, hospitals, and ICF-MR facilities. Home and Community Based Waivers are for people who are elderly, disabled, homebound, mentally retarded, or who have certain diagnoses and who live in the community. SSI Related Medicaid programs are for people who no longer receive Supplemental Security Income (SSI) payments, but have their Medicaid benefits protected under certain laws.

To be eligible for the Medicaid programs listed above, you must:

* Be living in Alabama,
* Be a U.S. citizen (You must provide proof of citizenship and identity unless you have been approved for Medicare or SSI.), or
  Be in satisfactory immigration status (You must provide proof of immigrant status.),
* Meet certain medical criteria,
* Have a monthly income below a certain limit, and
* Have resources below a certain limit.

NOTE: Eligibility for Home and Community Based Waivers (page 5) depends on the availability of slots from the administering agency.

Nursing Home, Hospital, and ICF-MR Medicaid for an Individual:

Medical Approval. An applicant must be medically approved by Medicaid or Medicare for the nursing facility to be paid. The nursing facility must submit the medical information to Medicaid. An applicant for Nursing Home, Hospital, or ICF-MR Medicaid must also be a resident of an approved medical institution for at least 30 continuous days to be eligible for Medicaid payments. (The exception is an SSI recipient.)

Income Limit. The income limit for Nursing Home, Hospital, or ICF-MR Medicaid is $2,022 per month for an individual. (This income limit changes each January.)

Some examples of income are:

Black Lung	Railroad Retirement
Social Security	Federal Civil Service

Examples of income (continued):

Veterans Benefits (less Aid and Attendant Care, and Continuing Medical Expenses)

Private Pensions or Retirements

SSI and welfare checks do not count as income.

Excess Income. If you are applying for Medicaid in a nursing home and have excess income, you have the option to establish a Qualifying Income Trust (QIT). The establishment of this trust, establishing the trust bank account, and the deposit of an income source to a corresponding trust account allows Medicaid to disregard that income in that month for the purpose of determining eligibility.

Medicaid has strict criteria for the establishment of an acceptable QIT. Contact the Medicaid District Office for a QIT packet or to download a packet, visit our website, www.medicaid.alabama.gov. If you feel you need legal advice on setting up a QIT, contact a private attorney or call the local Area Agency on Aging at 1-800-243-5463 for a referral. The trust document, proof of establishment of the trust bank account, and verification of the deposit of an income source to the trust account should be submitted with the nursing home application.

Resource limit. The resource limit for Nursing Home, Hospital, and ICF-MR Medicaid, as of the first day of each month, is $2,000. Special rules apply for an individual in a medical institution with a spouse at home. See Page 4 of this handout for information as to how Medicaid treats income and resources for a married couple.

Some examples of resources are:

Cash
Cash surrender value of life insurance when face value of all policies exceeds $5,000
Checking and Savings
Loans
Mineral and Timber Rights, etc.
Mortgages
Mutual Funds
Promissory Notes
Real Estate
Stocks and Bonds
Time Deposits (Certificates of Deposit, Annuities, etc.)

Some resources do not count toward the $2,000 resource limit, they are:

1. Household goods and personal effects.
2. Life insurance (or any insurance with a cash surrender value), if the total combined face value is $5,000 or less.

3. Burial fund or prepaid burial contract of up to $5,000. (The amount excluded is reduced by the face value of life insurance excluded in #2 above. The District Office will have to have copies of the fund or contract.)
4. Burial space items (casket, vault, burial plot, marker, opening and closing of grave).
5. One automobile per household, if used by the household member.
6. Property may not be counted as a resource in the following situations:
    a. Intent to return home from the medical institution,
    b. A bona fide effort is being made to sell the property,
    c. If a spouse, other dependent relative, or joint owner is living on the property,
    d. The property, valued less than $6,000, is income producing,
    e. If the property interest is a life estate.

NOTE: A lien may be required.

All property information such as deeds, wills, etc. will need to be submitted to the Medicaid District Office for review.

Excess Resources. The resource limit for Nursing Home, Hospital, and ICF-MR Medicaid is $2,000 **before** the first day of the month. This means that in order to be eligible for Medicaid you must not have more than $2,000 in resources on the first day of any given month.

To keep from going over the $2,000 limit:

* If you owe money to the nursing home, pay it before the first of the month.
* Pay any of your bills that are due before the first of the month.
* Do not let anyone else deposit money into your bank account to help pay your bills. It may be counted as income in the month of the deposit and a countable resource the following month.
* If you get a Social Security check or other pension check and it is left in your bank account at the beginning of the next month, it is counted as a resource.
* If you have a life insurance or a burial contract for more than the limit, the amount over the limit will be counted as a resource.

Remember, if you have resources in excess of $2,000 on the first day of the month, you will NOT be eligible for Medicaid that month.

Disposal of Resources. You may not be eligible for Institutional Medicaid if you sold (for less than fair market value), gave away or transferred any resource(s) that you or your spouse owned.

Nursing Home, Hospital, and ICF-MR Medicaid for a married couple:

If a couple is legally married and one spouse is a patient in a medical institution (institutionalized spouse) while the other spouse remains in the community (community spouse), special rules apply for Nursing Home, Hospital, and ICF-MR Medicaid. Some or all of the assets of the couple may be protected for the community spouse. In addition, some of the income of the institutional spouse may be allocated to the community spouse.

Income Allocation for the Community Spouse. In order to receive a portion of the institutionalized spouse's income, the community spouse cannot have more than $1,839 per month. (This income allocation amount changes each July.)

If the community spouse has gross income at or above $1,839, no additional income can be allocated from the institutionalized spouse to the community spouse. If the community spouse has **gross** (before anything is taken out) monthly income that is less than $1,839 per month, the institutionalized spouse may allocate income to the community spouse.

Resource Assessment for the Community Spouse.
When someone enters the nursing home and their spouse remains in the community, an assessment of the combined assets (resources) is done by the Medicaid District Office. The Medicaid worker will ask for proof of all assets owned by the couple, either solely or jointly, as of the date the institutionalized spouse entered a medical institution. (Some of the same resource exclusions apply as mentioned earlier in this handout. The home will not be counted as long as the spouse lives in the home.) The value of all countable assets will be added together. The amount that can be protected for the community spouse will be determined by the Medicaid District Office.

If the total value of the couple's countable assets is $27,000 or less, spend down of the assets for the institutionalized spouse will not be required. If the combined countable assets are more than $27,000, some of the assets must be spent on the institutionalized spouse before he or she will be eligible for Medicaid assistance. (The Medicaid District Office will determine the amount of assets to be spent down.) If the value of the combined countable assets is more than $50,000, but less than $219,120, one half of the assets will be protected for the community spouse. The other half will be counted to the institutionalized spouse, who will not be eligible for Medicaid until his or her share of the assets is spent down to $2,000 before the first day of a month.

The maximum value of the countable assets that can be protected for the community spouse is $109,560. The couple must have $219,120 or more on hand as of the date the institutionalized spouse entered a medical institution in order to allow the maximum amount to be kept by the community spouse.

Home and Community Based Waivers:

The waivers under Home and Community Based Waiver Program are Elderly and Disabled, State of Alabama Independent Living (SAIL), Home and Community-Based Waiver for Persons with Intellectual Disabilities (ID), HIV/AIDS, Technology Assisted (TA) and Living at Home (LAH) Waiver for Persons with Intellectual Disabilities. For detailed information about the level of care requirements and the type of services that are provided in each waiver see the "Home and Community Based Waivers" handout.

Medical Approval. An applicant for Home and Community Based Waivers must be medically approved by Medicaid or Medicare.

Income limits.

Elderly and Disabled Waiver	- $2,022 per month
Independent Living Waiver	- $2,022 per month
Home and Community-Based Waiver for Persons with Intellectual Disabilities	- $2,022 per month
HIV/AIDS Waiver	- $2,022 per month
Technology Assisted Waiver	- $2,022 per month

(These income limits change each January.)

Resource limits. The resource limit for Home and Community Based Waivers is $2,000 for an individual. Spousal impoverishment rules do not apply to waivers. Income and resources of the spouse do not apply to waivers.

To apply for the Elderly & Disabled Waiver contact your local Area Agency on Aging at 1-800-243-5463 or your local Department of Public Health in your county of residence.
For the State of Alabama Independent Living Waiver contact your local Department of Rehabilitation Services or call 1-800-441-7607.
For the Home and Community-Based Waiver for Persons with Intellectual Disabilities contact your local Department of Mental Health or call 1-800-361-4491.
For the HIV/AIDS Waiver contact the local Department of Public Health in your county of residence or call 334-206-5341.
For the Technology Assisted Waiver contact the Department of Rehabilitation Services at 1-800-441-7607.
For the Living at Home Waiver for Persons with Intellectual Disabilities contact the Department of Mental Health at 1-800-361-4491. To qualify for these services you

have to be receiving SSI, Adoption Assistance Medicaid, Medicaid for Low Income Familieis, or SSI Related Medicaid Programs (listed below).

Limited funds and slots are available for these waivers.

SSI Related Medicaid:

Income limits. All SSI Related programs, such as Widow/Widower, Disabled Adult Child (DAC), Retroactive SSI, and Continuous (Pickle) Medicaid have an income limit that equals the Federal Benefit Rate (FBR) plus $20 per month.

The income limit for SSI Related Medicaid is $694 for an individual and $1,031 for a couple. (This income limit changes each January.)

NOTE: The couple income limit applies only if both are eligible, unless the ineligible spouse's income and resources are deemed (which means counting a portion of the income and resources) to the applicant. If only one person is eligible, the individual income limit applies.

In the Widow/Widower, DAC and Continuous cases, if the applicant otherwise qualifies, some income is not counted against the limit, such as Widow/Widower benefits, Child's benefits, or Social Security cost-of-living increases.

Resource limits. The resource limit for SSI Related Medicaid is $2,000.

Some resources do not count toward the $2,000 resource limit, they are:

1. Household goods and personal effects.
2. Life insurance (or any insurance with a cash surrender value), if the total combined face value is $1,500 or less.
3. Burial fund or prepaid burial contract of up to $1,500. (The amount excluded is reduced by life insurance. The District Office will have to have copies of the fund or contract.)
4. Burial space items (casket, vault, burial plot, marker, opening and closing of grave).
5. One automobile per household, if used by household member.

Please note: You must apply for and agree to accept any income from annuities, pensions, retirement, disability benefits, or other income to which you are entitled. Applying for these benefits is a condition of eligibility for Medicaid and failure to apply

could keep you from having Medicaid eligibility.

For Veterans or Veteran's Dependents:

If you receive or are eligible to receive VA benefits, you must apply for the maximum benefit available. The amount you receive varies depending on the type of benefit. Rather than increase, some VA benefits are dropped to $90 while you are in a nursing home. You should contact VA to determine how your benefit will be affected while you are in the nursing home.

Some Things You Need to Know When Submitting an Application

Submitting an Application:

Complete the application to the best of your ability. The application must be completed and signed in ink, not pencil. Make sure the applicant's Name, Social Security Number, and Medicare Number are correct. If you have ever been married, include the Spouse's Name, Social Security Number, and if a veteran, the VA Claim Number.

Send the application to the appropriate District Office (see the back page of the application). A Medicaid caseworker will contact you for an interview after the application arrives in the District Office. It will be helpful if you include as many of the following items as possible when you submit the application:

1. Copies of Medicare and Social Security cards.
2. Verification of the gross (before anything is taken out) amount of Social Security, Veterans Administration, Railroad Retirement, Civil Service checks, private pension checks, rental income and annuities. (Verification should include claim and/or identification numbers.)
3. Copies of bank statements (all accounts) going back five years. First of month account balances that exceed $2,000 will require copies of cancelled/ imaged checks.
4. Verification of CDs, IRAs and Savings Bonds.
5. Verification of stocks, bonds and mutual funds.
6. Copies of deeds to property currently owned. (This includes heir property, life estate, etc.) Also, purchase and sale deeds to property which has been sold or transferred within the past five (5) years.
7. Copies of trusts, mortgages, loans, and promissory notes.
8. Copies of all insurance policies, including:
    a. Life, burial, funeral, vault, casket, cash, term and/or group.
    b. Long Term Care policies.
    c. Health, hospital, and/or cancer policies. (A copy of the card or premium notice and copy of payment method is needed.)
9. Copies of pre-need/prearranged burial contracts, including an itemized list of charges.
10. Verification of gross (before anything is taken out) wages.
11. Copy of power of attorney, guardianship papers, or curator papers.

Always keep a copy of the original application you submit to Medicaid. Send copies of all other documents, do not send your original documents except for proof of citizenship or identity, if required. Proof of citizenship and identity is not needed if you are currently receiving SSI benefits or are entitled to or enrolled in Medicare.

If additional information is requested, make sure you supply the information as soon as possible. If you have questions about the information requested, call the Medicaid caseworker. If you need assistance in getting the information requested, see if the nursing home social service staff or business office worker is willing to assist.

Some things that can make a claimant ineligible:
— If someone else (a family member) deposits money (income) into the claimant's bank account, this is considered a "contribution" and must be budgeted as income to the claimant, which may make the claimant ineligible..

— If the claimant's countable resources exceed $2,000 on the first day of the month, the claimant will be ineligible. (An example would be if the claimant receives their June check in May, Medicaid will not count the June check as a resource for May. Medicaid will count the June check as income for June. However, if the claimant's monthly income is allowed to accumulate and the countable resources exceed $2,000, the claimant will be ineligible.)

— Transfers of assets/resources may affect eligibility. For the institutionalized claimant the transfer of assets/resources by claimant or claimant's spouse could cause the claimant to be ineligible for nursing home payment. For waiver Medicaid programs the transfer of assets/resources could cause the claimant to be totally ineligible for Medicaid.

If an application is denied, there may be some things that the claimant can do to become eligible:

1. Spend-Down of Money.
Medicaid looks at resources on the first moment of the first day of the month. The countable resource limit for an individual is $2,000. If the total value of the couple's countable assets is $27,000 or less, spend down of the assets for the institutionalized spouse will not be required. Monies can be spent down, however, the claimant's money is to be spent for the claimant's needs and/or expenses, not the community spouse.

2. Excess Income.
If the claimant has excess income, a "Qualified Income Trust" may need to be established. [Qualifying Income Trust (QIT) packets are now available at the Medicaid District Office or to download a packet, visit our website, www.medicaid.alabama.gov. QITs are necessary when a claimant's income exceeds the Medicaid income limit. (If you receive VA or State of Alabama retirement, talk with the Medicaid caseworker before establishing a QIT.)]

3. Excess Resources.
If excess resources exist, you need to discuss burial exclusions and make sure that excess resources are spent for the needs of the claimant in a timely and efficient manner.

[Medicaid looks at countable resources as of the first moment of the first day of the month. It is the sponsor's responsibility to reapply in a timely manner. Make sure that you keep accurate records (bank statements, cancelled checks, receipts, etc.) to show how the money of the claimant has been spent.]

The Award Process:
When the application investigation has been completed, an award notice will be mailed indicating an eligibility date and a liability amount.

The **liability amount** is the amount that the claimant is to pay the nursing home each month for room and board. The nursing home will bill Medicaid for the difference. The "liability" is calculated by subtracting the following from the claimant's monthly gross income:

* Personal Needs ($30.00) or VA ($120.00, if VA check reduced to $90.00),
* Allocation to Community Spouse (if the nursing home applicant has a spouse who resides in the community, we can allocate a certain amount of the claimant's monthly income to the spouse in the community),
* Allocation to family members,
* Health Insurance Premiums (verified as being paid with claimant's money).

The Annual Review Process:
Once a claimant has been approved for Medicaid, a review of the claimant's financial circumstances will be conducted annually. This means that one year from the date of the award notice, an annual review form will be mailed to the sponsor.

It is very important that the sponsor complete the form as soon as possible and return it, along with any requested information. Make sure the review form is signed, all the questions are answered and the requested information is enclosed.

You have ten (10) days to complete and return the form. If the form is not returned, along with the requested information, the active Medicaid case will be terminated.

Between Annual Reviews:
It is the responsibility of the claimant or sponsor to report any financial changes to their Medicaid caseworker within ten (10) days of the change. Examples of changes are: if claimant receives an increase in benefits or money from another source, if claimant returns home, if the sponsor changes his or her address, if the claimant stops paying premiums for health insurance. (If you are not sure if you should report a change, contact your Medicaid caseworker.)