

SSI-RELATED MEDICAID PROGRAMS

FACT SHEET



The SSI-Related Medicaid Programs Fact Sheets provides only brief information. It is not a legally binding document and is not to be relied upon for specific information on recipient eligibility or service limitations. Specific policy is contained in statute or administrative rule. Policy staff in the Department of Children and Families prepares the fact sheet. The Department is responsible for eligibility policy for SSI-Related Programs (public assistance for the aged, blind or disabled). The fact sheets are located on the Internet at the following web address:
<https://www.myflfamilies.com/service-programs/access/docs/ssifactsheet.pdf>

Note: The financial Eligibility standards generally change during January and April of each year.

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CONTACT INFORMATION

Department of Children and Families (DCF)

The Department of Children and Families' main website may be accessed at: <http://www.myflfamilies.com/>

Individuals may apply for Medicaid:

- On-line at the DCF/Automated Community Connection to Economic Self Sufficiency (ACCESS) Florida website at: <https://www.myflorida.com/accessflorida/>
- On-site at a DCF/ESS Customer Service Center. To locate a service center, "Select a County" from the "Find Your Service Center" option at: <https://www.myflfamilies.com/service-programs/access/map.shtml>
- On-site through a member of the DCF Community Partner Network. Community partners are listed at: <https://access-web.dcf.state.fl.us/CPSLookup/search.aspx>
- By submitting a paper application, which may be requested by calling 1-850-300-4323, and submitting it in person, by mail or fax. Customer Service Center locations and fax numbers can be found at: <https://www.myflfamilies.com/service-programs/access/map.shtml>

Individuals may check their case status through the My ACCESS Account icon listed on the ACCESS Florida website at: <http://www.myflorida.com/accessflorida/>. The website is available 24 hours a day, 7 days a week. After registering, you can:

- Check on the status of an application or renewal
- View a list of items needed to process the application or renewal
- View when the next renewal is scheduled
- View the date and time of a scheduled appointment
- View the Share of Cost amount if enrolled in the Medically Needy program
- View the amount of the patient responsibility
- Print a temporary Medicaid card
- Upload and view documents

Information may also be accessed by calling the Interactive Voice Response (IVR) Phone System, which is an automated response system available by phone at 1-850-300-4323 or the website at: <https://www.myflorida.com/accessflorida/>

Community Partner Agencies

Community Partner Agencies work with the ACCESS Florida Program by providing a variety of services to individuals seeking or receiving Food, Cash, or Medical assistance. To find a local Community Partner Agency in your area, go to: <https://access-web.dcf.state.fl.us/CPSLookup/search.aspx>

Social Security Administration (SSA)

For more information about or to apply for benefits available through the Social Security Administration (retirement, disability insurance, Supplemental Security Income, Extra Help with Medicare Prescription Drug Plan costs), call the Social Security Administration at 1-800-772-1213, visit a local SSA Office or visit the SSA website at: <http://www.ssa.gov/>.

OVERVIEW OF PROGRAMS

Medicare

Medicare is a federal health insurance program that includes hospital insurance (Part A), medical insurance (Part B), Medicare HMO plans (Medicare Advantage), and Medicare prescription drug plans (Part D). For information about Medicare coverage, call 1-800-633-4227 or visit the Medicare website online at: <http://www.medicare.gov>.

Assistance Programs for Aged, Blind and Disabled

Public Assistance programs for aged, blind and disabled individuals include food assistance, Cash Assistance and Medicaid.

Food Assistance:

- The Food Assistance Program helps people with low-income buy healthy food. A food assistance household is normally a group of people who live together and buy food and cook meals together.
- The SUNCAP Program is a special Food Assistance Program for individuals who receive Supplemental Security Income (SSI). An individual may be eligible to receive food assistance benefits through the SUNCAP Program without any additional application, paperwork, or interview once they become SSI eligible.

Cash Assistance:

- Supplemental Security Income (SSI) provides cash assistance and Medicaid to eligible individuals and is administered by the Social Security Administration (SSA). For more information, visit: <https://www.ssa.gov/>.
- Optional State Supplementation (OSS) provides supplemental cash payments for eligible individuals living in specially licensed living arrangements such as Assisted Living Facilities and is administered by the Department of Children and Families.
- Home Care for the Disabled Adult (HCDA) provides case management services and a small financial subsidy to approved caregivers providing in-home care to disabled adults (ages 18 through 59) as an alternative to institutional or nursing home placement and is also administered by the Department of Children and Families.

Medical Assistance:

Medicaid is a federal and state program that is administered by the state. States are allowed options in the administration of the program. Eligibility requirements and available services may vary from state to state.

Medicaid eligibility is determined by DCF, except for SSI recipients. Individuals who receive SSI are automatically eligible for Medicaid in Florida. Medicaid services are managed by the Agency for Health Care Administration (AHCA). DCF determines eligibility for the following SSI-Related Medicaid Programs:

- **Medicaid programs that have full benefits include:**
 - Medicaid for aged and disabled individuals (MEDS-AD)
 - Institutional Care Program (ICP)
 - Hospice
 - Home and Community Based Services (HCBS) Waiver Program
- **Medicaid programs that have limited coverage include:**
 - Medically Needy (MN)
 - Medicare cost-sharing programs:
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individuals 1 (QI-1)

SSI-RELATED MEDICAID ELIGIBILITY REQUIREMENTS

Medicaid for low-income individuals who are either aged (65 or older) or disabled is referred to as SSI-Related Medicaid. The information below provides basic eligibility criteria. Some coverage groups require additional criteria that are specific to that program.

- **Aged, Blind or Disabled** – an individual must be aged (65 or older) or, if under age 65, blind or disabled. Note: The disability must prevent the individual from working and be expected to last for a period no less than 12 months or be expected to result in death. Individuals who receive a disability check from the Social Security Administration (SSA) based on their own disability automatically meet this requirement. A disability determination is completed by SSA or the state Division of Disability Determinations (DDD). DCF submits requests to DDD after the Medicaid application is received.
- **Citizenship Status** – an individual must be a U.S. citizen or a qualified non-citizen. Note: There may be a waiting period for non-citizens admitted to the U.S. with a qualified status on or after August 22, 1996.
- **Identity** – an individual must provide proof of identity. Exceptions: individuals receiving SSI, Medicare or Social Security Disability based on their own work history.
- **Residency** – an individual must be a Florida resident.
- **Social Security Number** – an individual must have a social security number or apply for one.
- **File for Other Benefits** – an individual must apply for other benefits for which they may be eligible (i.e. - pensions, retirement, disability benefits, etc.).
- **Report Third Party Liability** – examples include health insurance or payments by another party.
- **SSI-Related Income** – each program has a specific income limit, see link below.
- **SSI-Related Resources** – each program has a specific resource limit, see link below.

Note: Additional information and criteria are provided in this document by program.

The SSI-Related Medicaid Financial Eligibility Standards chart is located at:

https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf

SSI-RELATED MEDICAID PROGRAM WITH FULL BENEFITS

Medicaid for Aged and Disabled (MEDS-AD)

- Medicaid for low-income individuals who are either aged (65 or older) or disabled.
- This program does not cover blind individuals, unless they are considered disabled.
- Individuals cannot receive Medicare, unless the individual receives ICP, Hospice, or HCBS Waiver. Please refer to DCF Policy Passages 1440.1106 Receipt of Assistive Care Services and 2040.0813.03 Technical Requirements for MEDS-AD.

Note: If nursing facility care is required, the individual must meet the additional eligibility requirements for ICP.

Institutional Care Program (ICP)

- The Institutional Care Program (ICP) helps people in nursing facilities pay for the cost of their care and other medical services.
- Additional technical criteria include:
 - Determined to need nursing facility services and appropriate placement as determined by the Department of Elder Affairs (DOEA), Comprehensive Assessment and Review for Long-Term Care Services (CARES) process.
- Other important criteria for ICP eligibility include:
 - Transfer of Assets – assets transferred on or after January 1, 2010, may potentially affect eligibility. The “look-back” period for asset transfers is 60 months prior to the application month.
 - Spousal Allowance – assets and income are evaluated for married individuals when one spouse is institutionalized, and one spouse continues to live in the community (referred to as the “community spouse”). The community spouse may be eligible to receive a portion of the institutionalized spouse’s income.
- Please find additional information on forms and their instructions on AHCA’s website for [Medicaid Nursing Facility Provider Information](#).

Hospice

- The Hospice Program helps maintain care for terminally ill individuals. To receive Hospice services, the individual must enroll in a Hospice program.
- Additional technical criteria include:
 - A medical prognosis that life expectancy is six months or less (as long as the illness runs its normal course),
 - Election of hospice services, and
 - A certification of the individual’s terminal illness by a physician or medical director.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) provides home and community-based services for individuals in need of nursing facility care as assessed by DOEA CARES. Once enrolled in PACE, an individual may continue PACE services even if the individual moves to an assisted living facility or nursing home. More information can be found at: <http://www.ahca.myflorida.com/>

- An individual enrolled in PACE will have their medical needs managed regardless of their living situation (home, Assisted Living Facility (ALF), or nursing facility).
- Additional technical criteria include:
 - election of a PACE provider as the sole source of Medicare and/or Medicaid service delivery,
 - at least 55 or older (must meet disability criteria if under age 65), and
 - meet a nursing home LOC as determined by CARES.

Note: PACE is not a waiver but follows the same eligibility criteria as HCBS.

Modified Project AIDS Care (MPAC) Program

- The Modified Project AIDS Care (MPAC) Program is a Managed Medical Assistance Program for individuals with AIDS who are not eligible for any other full Medicaid coverage group.
- Additional technical criteria include:
 - be at or below 300 percent of the Federal Benefit Rate
 - at least 18 or older (must meet disability criteria if under age 65),
 - meet presumptive disability criteria as evidenced by AHCA Form 5000-0607, Acquired Immune Deficiency Syndrome (AIDS), Physician Referral for Individuals at Risk of Hospitalization

Note: The Modified PAC Program is not a waiver but applicants who are potentially eligible under this program may apply directly with the Department of Children & Families. When submitting an application, the applicant should select “Medical Assistance for Individuals Seeking Medicaid Waiver Services”.

Home and Community Based Services (HCBS) Waivers

- The HCBS Waivers allow individuals to live in the community in an effort to avoid institutionalization.
- HCBS Waivers are:
 - Familial Dysautonomia (FD) Waiver
 - iBudget Waiver
 - Model Waiver
 - Statewide Medicaid Managed Care Long – Term Care (SMMC LTC) Waiver
- Additional information regarding ICP, Hospice, HCBS Waiver, and PACE Program eligibility can be found on pages 11 – 15.
- Please find additional information on forms and their instructions on AHCA’s website for [Medicaid Nursing Facility Provider Information](#).

HCBS WAIVER PROGRAMS

The Home and Community Based Services (HCBS) waiver programs allows the state to provide essential services that assist individuals to maintain an independent lifestyle while residing in the community to prevent institutionalization.

Familial Dysautonomia (FD) Waiver

- The Familial Dysautonomia (FD) Waiver provides HCBS for individuals diagnosed with the FD syndrome who would otherwise require hospitalization if not receiving special services.
- An individual may contact the Agency for Health Care Administration (AHCA) to initiate the waiver request. More information is available at: https://ahca.myflorida.com/Medicaid/hcbs_waivers/fd.shtml
- Additional technical criteria include:
 - enrollment in the FD Waiver,
 - age three or older (must meet disability criteria if under age 65), and
 - meet LOC for being at risk of hospitalization as determined by CARES.

iBudget Waiver

- The iBudget Waiver provides HCBS to individuals with a developmental disability to live in their home or the community as assessed by the Agency for Persons with Disabilities (APD). More information is available at: <http://www.apd.myflorida.com/>.
- Additional technical criteria include:
 - enrollment in the iBudget Waiver,
 - age three or older (must meet disability criteria if under age 65), and
 - meet LOC determination by APD.

Model Waiver

- The Model Waiver, formerly known as the Katie Beckett Waiver, provides HCBS to persons with degenerative spinocerebellar disease.
- These services are provided to eligible persons who require the level of care provided in an acute care hospital.
- An individual may contact the Agency for Health Care Administration (AHCA) to initiate the waiver request. More information is available at:
https://ahca.myflorida.com/Medicaid/hcbs_waivers/model.shtml.
- Additional technical criteria include:
 - enrollment in the Model Waiver,
 - a medical diagnosis of degenerative spinocerebellar disease,
 - under age 21 and disabled, and
 - meet a LOC for inpatient hospital care as determined by the Children's Medical Services (CMS).

Statewide Medicaid Managed Care, Long – Term Care (SMMC LTC) Waiver

- The Statewide Medicaid Managed Care, Long Term Care (SMMC LTC) Waiver provides HCBS to help prevent institutionalization by allowing an individual to live in their home or the community as assessed by DOEA CARES. More information can be found at:
https://ahca.myflorida.com/Medicaid/statewide_mc/.
- Additional technical criteria include:
 - enrollment in the SMMC LTC Waiver,
 - be 18 years of age or older (must meet disability criteria if under 65), and
 - meet a nursing home LOC as determined by CARES.
- Individuals needing home and community based services must contact their local Aging and Disability Resource Center (ADRC) to be screened for the SMMC LTC program.
- Beginning January 1, 2018, individuals with traumatic brain injury and spinal cord injury and HIV/AIDS needing HCBS must contact their local ADRC to be screened for the SMMC LTC program.
- The SMMC LTC program also provides services for adults with Cystic Fibrosis (CF). The Department of Elder Affairs (DOEA) is the new contact for entrance to the SMMC LTC program for adults with CF. Individuals, their caregivers and the provider community should contact DOEA for more information:
 - Email: Medwaiver@elderaffairs.org; Phone: (866) 232-3733, Fax: (850) 414-2310
- Individuals and their caregivers can also contact their local ADRC for referral. To find your local ADRC, call the Elder Helpline at 1-800-96-ELDER (800-963-5337) or go to the Department of Elder Affairs website at: <http://elderaffairs.state.fl.us/doea/arc.php>

SSI-RELATED MEDICAID PROGRAMS WITH LIMITED BENEFITS

Breast and Cervical Cancer Treatment (BCC)

- The Breast and Cervical Cancer Treatment Program is available for women needing treatment for breast and cervical cancer.
- A woman must be screened and diagnosed for breast or cervical cancer by the Department of Health (DOH).
- More information may be found online at:
<http://www.doh.state.fl.us/Family/cancer/bcc/index.html>
- Additional technical criteria include:
 - be uninsured or have health coverage that does not cover the necessary treatment,
 - be under age 65,
 - be a U.S. citizen or qualified noncitizen, and
 - have income below 200% of the federal poverty level.

Qualified Medicare Beneficiaries (QMB)

- The Qualified Medicare Beneficiaries (QMB) Program allows qualified individuals to have Medicaid pay for their Medicare premiums (Part A and B), Medicare deductibles and Medicare coinsurance (within prescribed limits).
- QMB recipients automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program.
- Additional technical criteria include:
 - Entitlement to Medicare Part A.

Specified Low-Income Medicare Beneficiaries (SLMB)

- The Specified Low-Income Medicare Beneficiaries (SLMB) Programs allows qualified individuals to have Medicaid pay for their Medicare Part B premium.
- SLMB recipients automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program.
- Additional technical criteria include:
 - Enrolled in Medicare Part A.

Qualifying Individuals 1 (QI-1)

- The Qualifying Individuals I (QI-1) Program allows qualified individuals to have Medicaid pay for their Medicare Part B premium.
- Funding for this program is limited.
- QI-1 recipients automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program.
- Additional technical criteria include:
 - Enrolled in Medicare Part A.

Medically Needy

- The Medically Needy Program provides Medicaid to persons with medical bills, but whose income is too high to qualify for full Medicaid coverage.
- Individuals qualify for Medically Needy coverage on a month-to-month basis by meeting a monthly share of cost.
- More information may be found online at:
<https://www.myflfamilies.com/service-programs/access/medicaid.shtml>

NON-MEDICAID PROGRAMS

Optional State Supplementation (OSS)

- The Optional State Supplementation (OSS) Program provides cash assistance to individuals residing in an assisted living facility (ALF), mental health residential treatment facility (MHRTF), or adult family care home (AFCH).
- The OSS payment is made directly to the individual and the amount is based on the individual's income and the current OSS standard cost of care in the facility.
- Some facilities are licensed to provide Assistive Care Services to individuals who are Medicaid eligible.
- Additional technical criteria include:
 - Certification by an Adult Services Counselor, Developmental Disabilities Counselor, Mental Health Counselor, or the Aging and Disability Resource Centers (ADRCs) as needing placement in a licensed facility (ALF, MHRTF, or AFCH).

Home Care for the Disabled Adult (HCDA)

- The Home Care for the Disabled Adult (HCDA) Program provides case management services and a small subsidy to approved caregivers providing in-home care to adult persons with disabilities as an alternative to institutional or nursing home care.
- Payments are made directly to the provider/caregiver providing in-home care for the disabled adult.
- Eligibility for HCDA is based on the financial status of the person receiving care.
- Additional technical criteria include:
 - certification by a physician and an Adult Services case manager,
 - approval of the provider/caregiver, and
 - be between the ages of 18 and 59, and disabled.

Extra Help with Medicare Prescription Drug Plan Costs

- The Extra Help Program is also known as the Low-Income Subsidy (LIS).
- While prescriptions may be covered by Medicaid for certain people, Medicaid does not cover the costs of prescription drugs for Medicare beneficiaries.
- Medicare beneficiaries who qualify for QMB, SLMB, QI-1, and/or any full Medicaid program are automatically eligible for federal assistance with the costs of a Medicare prescription drug plan.
- All Medicare beneficiaries **MUST** enroll in a Medicare prescription drug plan to obtain prescription drug coverage even if they qualify for the Extra Help Program.
- With the Extra Help Program, individuals who enroll in a Medicare Prescription Drug Plan have the benefit of full prescription coverage similar to prescription coverage provided by Medicaid. Individuals are responsible for a small co-pay for each prescription.
- The LIS Program provides:
 - payment of all or most of the annual deductible,
 - coverage during the “doughnut hole” or gap period, and
 - payment of monthly plan premiums up to the base amount.
- More information may be found online at: <https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/find-your-level-of-extra-help-part-d>
- Additional technical criteria include:
 - Must be enrolled in Medicare Part A and B.

ADDITIONAL INFORMATION FOR ICP, HOSPICE, HCBS AND PACE PROGRAMS

The ICP, Hospice, HCBS, PACE, and Modified Project Aids Care (MPAC) Programs all have additional income and resource (asset) criteria, which are evaluated during the eligibility determination process. These additional criteria are discussed on the next few pages.

Qualified Income Trust (QIT)

What is a Qualified Income Trust?

If an individual's income is over the limit to qualify for Medicaid long-term care services (including nursing home care), a Qualified Income Trust (QIT) allows an individual to become eligible by placing income into an account each month that the individual needs Medicaid. The QIT involves a written agreement, establishing a special account, and making deposits into the account.

Who needs a Qualified Income Trust?

An individual needs a QIT if their income **before any deductions** (such as taxes, Medicare or health insurance premiums) is over the income limit to qualify for the ICP, Institutional Hospice, PACE, or the HCBS Waivers.

How do I set up a Qualified Income Trust agreement?

Professional help may be obtained to set up the QIT agreement but is not required. A QIT agreement must meet specific requirements and be approved by the Department of Children and Families Regional Legal Counsel. A copy of the QIT agreement must be submitted to an eligibility specialist who will forward these documents for review.

What items must be included in the Qualified Income Trust agreement?

The QIT agreement must:

- Be irrevocable (cannot be canceled).
- Require that the State receive all funds remaining in the trust at the time of the individual's death (up to the amount of Medicaid benefits paid).
- Consist of the applicant's income only. (Do not include or add assets).
- Be signed and dated by the applicant, the applicant's spouse, or a person who has legal authority to act on the applicant's behalf.

How does the Qualified Income Trust account work?

After setting up the account, the individual must make deposits into the QIT account **every** month for as long as Medicaid is needed. This means deposits may be needed before a Medicaid application is approved. As long as income is deposited into the QIT account in the month it is received, it will not be counted. Deposits cannot be made for a past or future month. Any income received back from the trust will be counted as income. If a deposit is not made in any given month, or enough income is not deposited, the individual will be ineligible for Medicaid.

Note: The income placed into a Qualified Income Trust is excluded as income in the eligibility determination but counted in the calculation of the patient responsibility.

How much income must I deposit into the Qualified Income Trust account?

Enough income must be deposited into the QIT account each month so that remaining income is within program standards. It is better to deposit more income than take the chance of depositing too little to qualify for Medicaid. Call (850) 300-4323 or visit: https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf for information about current income standards.

What happens to the income deposited in the Qualified Income Trust account?

The income deposited and withdrawn is used to calculate an individual's patient responsibility. If an individual has a patient responsibility, they are responsible for paying that amount. If funds are left in the QIT upon death, it is paid to the State, up to an amount equal to the total Medicaid benefits the State paid on behalf of the individual.

How to pay funds remaining in the QIT to the State?

The QIT trustee or other individual acting on behalf of the individual should contact the long-term care facility to see if any refund for the month of death is due back to the trust. The balance of the QIT as of the date of death, plus any refund from the long-term care facility, must be paid to the State.

Mail a check payable to the "Agency for Health Care Administration" to
Xerox State Healthcare, LLC
PO Box 12188
Tallahassee, FL 32317-2188

A brief cover letter or note should state that the payment is for a QIT and include the Medicaid recipient's name, social security number, and/or Medicaid ID number. Enclose a copy of the QIT bank statement covering the date of death to confirm the check is for the balance. Also, include documentation of any refunds received from the long-term care facility. Contact Xerox State Healthcare, LLC at (877) 357-3268 if you have questions about payment of QIT funds to the State.

The Qualified Income Trust Information Sheet can be found at:

https://www.myflfamilies.com/programs/access/docs/qualified_income_trust_factsheet.pdf

Uncovered Medical Expense Deduction (UMED)

What is an Uncovered Medical Expense Deduction (UMED)?

An uncovered medical expense deduction (UMED) is a credit received for out-of-pocket medical expenses. The deduction reduces the amount the nursing facility or Medicaid services provider is paid each month and enables individuals to keep more money to pay for uncovered medical expenses.

Who can receive the deductions?

Individuals who receive Medicaid under ICP, Hospice, HCBS Waivers (iBudget and SMMC LTC only) or PACE Program and have a patient responsibility (share of the cost for care) to pay from their income may be entitled to the deduction.

What types of medical expenses can be deducted?

Deductible expenses include:

- Health insurance costs (premiums, deductibles and co-payments).
- The cost of medically necessary medical services or items, such as:
 - Dental services,
 - Hearing supplies and services,
 - Vision services and supplies,
 - Therapy services,
 - Over-the-counter medications, and
 - Certain medical supplies such as adult diapers, vitamins and nutritional supplements.
- Nursing facility care not covered by Medicare, Medicaid or another third party.
 - Nursing facility bills incurred no earlier than three months prior to the month of application (paid or unpaid), not paid by Medicaid or another third party, and were not incurred during a transfer of assets penalty period.

How we determine the deduction and apply it to monthly income?

- Medical expenses paid during a recent period (no earlier than three months prior to the month of application or the past six months prior to a renewal) are used to get an estimate of the expenses expected to occur over the next six months.
- The average cost is determined and is deducted from the income when calculating patient responsibility for the next six months. This is called a projection period. Near the end of a projection period, actual medical expenses incurred during the projection period are verified and compared to the projected expenses.
- If the projected amount is less than or more than the actual expenses by more than \$120, the expenses are reconciled by averaging the balance over the next projection period together with an average of actual expenses.
- This process repeats every six months while an individual receives Medicaid.

What must Medicaid recipients do?

Recipients must notify the Department of Children and Families of what medical expenses (paid or unpaid) they have to pay. Proof of the type(s) of expense, the cost, and proof that it was not paid by Medicare, Medicaid or a third party may be required. It is important that new expenses or changes in current expenses are reported within ten days after receiving a bill/receipt. Upload proof of medical expenses and other documentation to the My ACCESS Account, or by fax at: 1-866-886-4342, or by mail to: ACCESS Central Mail Center, P.O. Box 1770, Ocala, FL 34478-1770

Special Policies that Apply to Spouses

Resources and income are evaluated for married individuals when one spouse is institutionalized and one spouse continues to live in the community (referred to as the “community spouse”) when applying for the ICP, Institutional Hospice, HCBS Waiver (iBudget and SMMC LTC only) or PACE Programs.

Resources at Application:

All resources of the couple must be counted together to determine the eligibility of the institutionalized individual. After deducting \$123,600 from their combined resources for the community spouse resource allowance, the institutional spouse’s remaining resources must not exceed \$2,000 to qualify (\$5,000 if the institutional spouse’s monthly income is \$936 or less).

Resources after Approval:

Resources over the individual limit (\$2,000 or \$5,000) acquired after Medicaid is authorized must be transferred to the community spouse within twelve months after approval to maintain eligibility.

Income at Application:

Only the total gross monthly income received by the institutionalized spouse is considered in determining eligibility.

Allocation to the Community Spouse:

To calculate the amount of the institutional spouse’s income a special budget is used to determine the monthly patient responsibility amount once the personal needs allowance has been deducted. An additional amount of the institutional spouse’s income may be allocated to the community spouse. This is called the community spouse needs allowance.

Determining the Community Spouse Needs Allowance:

The community spouse needs allowance is computed as follows:

- $\$2,114$ (minimum monthly maintenance needs allowance) + excess shelter costs* - community spouse's monthly gross income = community spouse income allowance**

*Excess Shelter Cost is the amount by which the community spouse's shelter costs exceed \$634 per month. Shelter costs may include rent or mortgage payment, homeowner's insurance, condominium maintenance fees, and a monthly utility allowance of \$361 (effective 10/2019) based on the Food Assistance Program standard utility allowance.

**Total community spouse income allowance cannot exceed \$3,216.

Exception:

If there is a court order for support that is greater than the above allowance, the court ordered amount will be used as the community spouse allowance.

Other Dependents:

Under certain conditions, a dependent allowance may also be deducted from the institutionalized individual's income.

BUDGETING: CALCULATING PATIENT RESPONSIBILITY

Medicaid coverage for ICP, Hospice, HCBS (SMMC LTC and iBudget) and PACE programs may have a patient responsibility based on the individual's gross monthly income and their placement. The amount of the patient responsibility is determined by subtracting the personal needs allowance (PNA) and other allowable deductions from the individual's gross monthly income. Please refer to DCF Policy Passage 2640.0118 Personal Needs Allowance for more details. The other allowances and deductions that may apply are spousal and/or family allowance, court ordered child support only, and uncovered medical expense deductions (UMEDS). The amount of the PNA is determined by program and the placement type where the individual resides; at home, in a nursing facility, or an ALF.

For the Statewide Medicaid Managed Long-Term Care (SMMC LTC) program and the Program for All- Inclusive Care for the Elderly (PACE), the personal needs allowance is as follows:

- Residing in a nursing facility is \$130.
- Residing in an ALF is ALF basic monthly Room and Board rate plus 20% of the Federal Poverty Level (FPL).
- Residing in the community (at home) is 300% of the Federal Benefit Rate.

Example 1:

The applicant applies and is approved for ICP and reports a nursing home expense totaling \$8,000 (UMED) prior to the month of approval.

Budget:

\$1,300 monthly income - \$130 Personal Needs Allowance (PNA) = \$1,170

\$1,170 x 6 months = \$7,020

\$8,000 nursing home bill - \$7,020 = \$980 remaining balance of bill

\$8,000/6 = \$1,333.33 = \$0 patient responsibility for each month

Since the nursing home bill exceeds the monthly income, use the remaining balance from the bill when determining the patient responsibility for the next six months.

At the six-month review, the remaining balance of the nursing home bill of \$980 is used as an Uncovered Medical Expense Deduction (UMED).

Budget:

Remaining balance of bill \$980/6 = \$163.33

\$1,040 - \$163.33 = \$876.67 patient responsibility for each month

Example 2:

An individual is enrolled in the SMMC LTC program and resides in an ALF and has Social Security Income of \$1,750 each month. The ALF's basic monthly Room and Board rate is \$1,500.

Budget:

\$1,750 monthly income - \$1,500 *ALF basic monthly rate - \$202 (20% FPL) = \$48

patient responsibility for each month

*Note: This amount varies as it depends upon the facility's actual room and board charges.

Example 3:

The applicant applies for HCBS waiver and has Social Security income of \$1,900 each month and \$1,500 pension. He resides at home and has the \$1,500 pension is placed in a Qualified Income Trust allowing for Medicaid eligibility.

Budget:

$\$1,900 + \$1,500 = \$3,400$ total monthly income $-\$2,205$ PNA (300% FBR) = $\$1,195$ patient responsibility each month

My ACCESS Account – Provider View Guide

Provider View provides Medicaid Providers with a secure gateway to the customer's account information. The Provider View system allows providers to view customer case information and interact with the DCF through the web at their convenience twenty-four hours a day, seven days a week.

Provider View (Check Information about Medicaid Benefits) allows you to:

- View current benefits for Medicaid
- View the date benefits will be available
- See when the next review is due
- See when an appointment is scheduled
- View Medicaid account history
- View Medicaid Patient Responsibility
- View a list of verifications needed
- View Personal Identification number (PIN)
- View a list of Applications that have been submitted
- View a list of Changes that have been submitted
- View a list of Requests for Additional Assistance
- View a list of Reviews that have been submitted

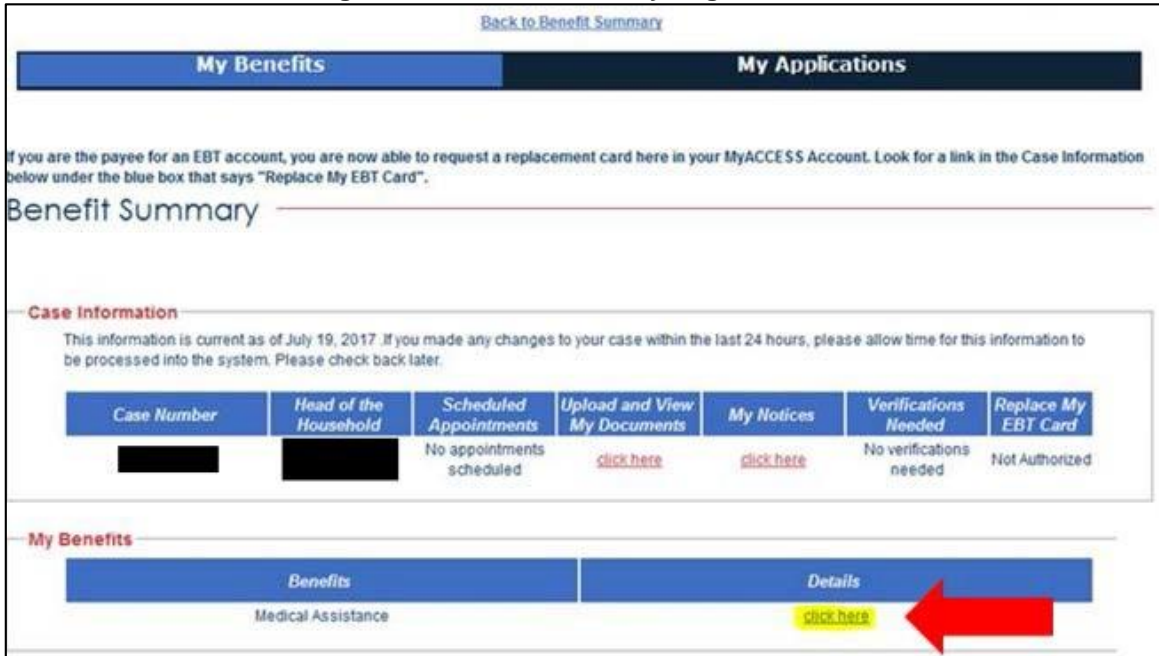
The information displayed in the customer's account is updated nightly. Changes made during the day are available for you to view the following day. The date of the information is displayed at the top of the account status screens for your reference.

Click here to go to the [My ACCESS Account – Provider View Guide](#).

Where to Find Customer’s Patient Responsibility Amount in Provider View

- Log into ‘Provider View’ and complete ‘Customer Search’ and find the individual you want to look up.
- The main screen you will start at is the “My Benefits” screen – Refer to page 8 of Provider View Guide.
- Select ‘Click Here’ under Details section for Medical Assistance (see Figure 1.1 below).

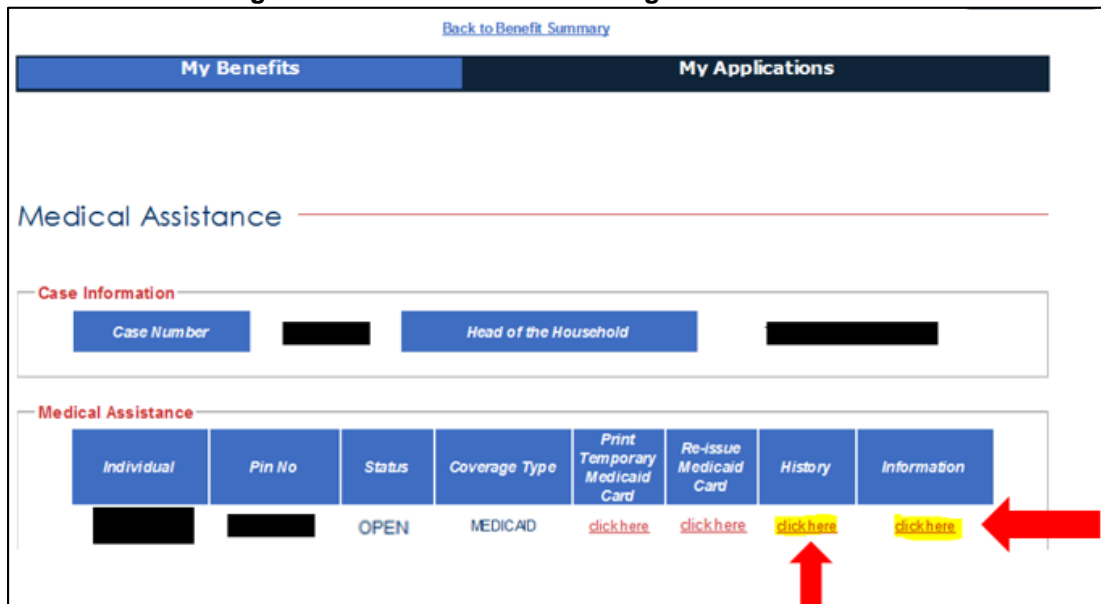
Figure 1.1 Benefit Summary Page in Provider View



This will take you to the Medical Assistance page.

On this page you can view current month’s patient responsibility amount by selecting ‘click here’ under ‘Information’ section or to view previous month’s patient responsibility amount under ‘History’ section (see Figure 1.2 below). Note: The “Re-issue Medicaid Card” field is not available to Providers.

Figure 1.2 Medical Assistance Page in Provider View



When you select “History” the provider will see the historical patient responsibility (PR) amounts.

LONG-TERM CARE (LTC) INSURANCE PARTNERSHIP PROGRAM

What is the purpose of the Long-Term Care Insurance Partnership Program?

The Long-Term Care Insurance Partnership (LTCIP) Program is a federal and state initiative intended to encourage individuals to plan for their future long-term care needs by purchasing long-term care insurance policies.

How do I know if my policy is a qualified Long-Term Care Insurance Partnership Program policy?

The insurance policy must meet certain criteria and be certified by Florida's Office of Insurance Regulation (OIR) as a qualified LTCIP Program policy. Individuals purchasing or owning a standard long-term care policy may contact and ask their insurance carrier about purchasing or converting the current policy to a qualified LTCIP Program policy.

What is the benefit of a qualified Long-Term Care Insurance Partnership Program policy?

The Department of Children and Families will not count a portion of an individual's assets if they apply for Medicaid to cover their nursing home care. The amount not counted is equal to the actual amount of benefits paid out, or paid on their behalf, by the qualified LTCIP Program policy for the individual's cost of nursing home care.

For example, if the insurance company paid out \$60,000 in benefits for John Doe's care, the State would not count \$60,000 of his assets when Mr. Doe applies for Medicaid to cover his ongoing care. In other words, Mr. Doe can keep \$60,000 of his countable assets above the Institutional Care Program asset limit and still qualify for Medicaid if he meets all other eligibility standards.

What information do I need to provide to the Department when I apply?

Individuals with a qualified LTCIP Program Policy must provide documentation of the insurance benefits paid out, or paid on their behalf, for the cost of their care. Contact your insurance agency for assistance.

For more information regarding the Long-Term Care Insurance Partnership Program visit:

http://ahca.myflorida.com/Medicaid/ltc_partnership_program/index.shtml,

http://training.floridashine.org/Website_Resources/Bene_FS/BLTCPartnership.pdf or

<http://www.myfloridacfo.com/Division/Consumers/UnderstandingCoverage/LongTermCareOverview.htm>

ADDITIONAL RESOURCES FOR ASSISTANCE

Florida Discount Drug Card

Individuals who are not eligible for full Medicaid may receive help with the cost of prescription drugs through the Florida Discount Drug Card at: <http://www.floridadiscountdrugcard.com/> .

Florida Elder Helpline and Referral

Information regarding elder services and activities is available through the Elder Helpline Information and Referral Service within each Florida County at: 1-800-96-ELDER (1-800-963-5337).

All elder help lines may be accessed through the Florida Telecommunication Relay System (1-800-955-8771 for TDD, or 1-800-955-8770 for Voice), which allows telephone calls to be placed between TDD users and nonusers with the help of specially trained operators translating the calls.

Information is also available on the internet at: <http://elderaffairs.state.fl.us/> .