# STATE OF NEW YORK
## DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
*Commissioner*

Dennis P. Whalen
*Executive Deputy Commissioner*


**ADMINISTRATIVE DIRECTIVE**

**TRANSMITTAL:** 04 OMM/ADM-6

**TO:** Commissioners of Social Services

**DIVISION:** Office of Medicaid Management

**DATE:** July 20, 2004

**SUBJECT:** Resource Documentation Requirements for Medicaid Applicants/Recipients (Attestation of Resources)

| | |
|---|---|
| **SUGGESTED DISTRIBUTION:** | Medicaid Staff<br>Fair Hearing Staff<br>Legal Staff<br>Staff Development Coordinators<br>Temporary Assistance Directors |
| **CONTACT PERSON:** | Bureau of Local District Support<br>Upstate: (518) 474-8216<br>NYC: (212) 268-6855 |
| **ATTACHMENTS:** | See Appendix I for listing of Attachments |

**FILING REFERENCES**

| Previous ADMs/INFs | Releases Cancelled | Dept. Regs. | Soc. Serv. Law & Other Legal Ref. | Manual Ref. | Misc. Ref. |
|---|---|---|---|---|---|
| 89 ADM-19<br>87 ADM-4<br>80 ADM-19<br>360-4.8 | 95 ADM-7 | 360-2.3<br>360-4.4<br>360-4.6(b) | 366-a(2)<br>366-c<br>Ch. 1 of Laws of 2002 | | |

## I. PURPOSE

This Administrative Directive (ADM) advises social services districts of the provisions of Chapter 1 of the Laws of 2002 regarding attestation of resources and Medicaid eligibility. Section 51 of Part A of Chapter 1 of the Laws of 2002 eliminated the resource documentation requirement for Medicaid-only applicants/recipients (A/Rs) who are NOT seeking coverage of long-term care services.

## II. BACKGROUND

Currently, in determining an individual's financial eligibility for Medicaid, the individual may be required to provide proof of the amount of his/her resources. Pregnant women and infants under the age of one do not have to provide proof of their resources. Children, age one up to the age of nineteen, do not have to provide proof of their resources unless electing to participate in the spenddown program or in instances when SSI-related budgeting is used to establish eligibility. Individuals eligible for Family Health Plus do not have to provide proof of resources. If an individual is seeking Medicaid coverage of nursing facility services, the individual must provide proof of the amount of his/her resources for the past 36 months (60 months for trust-related transfers) in order to ensure that there are no disqualifying resource transfer(s) that would affect the individual's eligibility for such care and services. If an individual does not require Medicaid coverage of nursing facility services, social services districts have had the option of offering a simplified resource review to establish community Medicaid coverage. Under the simplified resource review, the individual is required to provide documentation of current resources only and if otherwise eligible, is entitled to coverage of all Medicaid covered care and services except nursing facility services. This simplified resource review has enabled social services districts to re-deploy staff to other eligibility activities by reducing the number of full resource reviews required.

With the passage of Chapter 1 of the Laws of 2002, Medicaid-only A/Rs who are not seeking coverage of long-term care services will be allowed to attest to the amount of their resources rather than provide proof. This self-attestation of resources will further simplify the documentation requirements for determining eligibility for Medicaid.

Chapter 1 of the Laws of 2002 enacted the new provisions regarding attestation of resources, by adding a new Subdivision 2 to Section 366-a of the Social Services Law (SSL). An amendment to Section 360-2.3 of Title 18 of the New York Codes, Rules and Regulations has been filed on an emergency basis.

## III. PROGRAM IMPLICATIONS

Section 366-a(2) of the SSL, as enacted by Chapter 1 of the Laws of 2002, allows self-attestation of resources for certain Medicaid A/Rs. Effective August 23, 2004 retroactive to April 1, 2003, an individual may attest to the amount of his/her resources unless the individual is seeking Medicaid coverage of long-term care services. For purposes of attestation of resources, long-term care services include the following:

1. Nursing Facility Services

   - Alternate level of care provided in a hospital
   - Hospice in a nursing home
   - Nursing home care, except for short-term rehabilitation
   - Intermediate care facility
   - Home and community-based waiver services
   - Managed long-term care in a nursing home

   AND

2. Community-Based Long-Term Care Services

   - Adult day health care (medical model)
   - Limited licensed home care
   - Certified home health agency services, except for short-term rehabilitation
   - Hospice in the community
   - Hospice residence program
   - Personal care services
   - Personal emergency response services
   - Private duty nursing
   - Consumer directed personal assistance program
   - Assisted living program
   - Managed long-term care in the community
   - Residential treatment facility
   - Home and community-based services waiver programs, including:
     - Long-Term Home Health Care Program
     - Traumatic Brain Injury Waiver Program
     - Care at Home Waiver Program
     - Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program

With the release of this directive social services districts will no longer have the option to offer simplified resource reviews for individuals who are not seeking Medicaid coverage of nursing facility services. Instead, individuals will have the option of applying for:

1) Community Coverage Without Long-Term Care - requires a self-attestation to the amount of current resources;
2) Community Coverage With Community-Based Long-Term Care - requires proof of current resources; or
3) Medicaid coverage of all covered care and services (including nursing facility services)- requires a resource review for the past 36 months (60 months for trusts).

**Note:** These choices must be offered to all Medicaid-only A/Rs, including **Single Individuals and Childless Couples** (S/CCs). However, since S/CCs are subject to Public Assistance transfer rules, which include a 12-month look-back period and ineligibility for 12 months for a prohibited transfer, in order to determine eligibility for coverages #1 and #2 above, the district must ask at the interview whether the person has made a prohibited transfer within the past 12 months. If the individual states that no transfer has been made and there is no indication of a transfer, eligibility may be determined for the requested coverage. If an S/CC requests Medicaid coverage for all covered care and services (#3 above), resource documentation must be provided for the past 12 months.

Individuals who seek Medicaid coverage for short-term rehabilitation services may attest to the amount of their resources. Short-term rehabilitation services include one commencement/admission in a 12-month period, up to a maximum of 29 consecutive days of each of the following: certified home health care and nursing home care. In the event that the short-term rehabilitation services extend beyond 29 days, the individual will be required to provide proof of his/her resources in order to have Medicaid coverage for the rehabilitation services beyond the 29th day. Proof of resources includes resource documentation for the past 36 months (60 months from trusts) for nursing facility services and current resource documentation for certified home health care. Proof of resources also must be provided in order to have Medicaid coverage for a second commencement/admission of short-term rehabilitation within 12 months from the start of the first commencement/admission.

Medicaid A/Rs have the right to supply proof of their resources at any time. If an individual becomes in need of a service for which he/she does not have coverage, the individual must contact his/her social services district immediately for assistance in obtaining the Medicaid coverage required. Medicaid A/Rs who can reasonably expect to need long-term care services continue to be encouraged to provide proof of their resources in advance of the need for such services. This will help prevent any unnecessary delay in service delivery that may result from the absence of resource documentation. Social services districts may continue to independently verify the accuracy of the information provided by an A/R.

Pregnant women, children under one year of age and children between the ages of one and 19 who have incomes below the applicable federal poverty level are not affected by this change as there continues to be no resource test for these groups. In addition, applicants for the Family Planning Benefit Program, Breast and Cervical Cancer Treatment Program and Family Health Plus Program are not affected by this change since there is no resource test for these programs. Effective with this ADM, otherwise eligible individuals may be enrolled in a managed care plan

without providing proof of their resources, provided the individual is not being enrolled in a managed long-term care plan.

Specified Low Income Medicare Beneficiaries (SLIMBs) and Qualified Medicare Beneficiaries (QMBs) can attest to the amount of their resources for purposes of Medicaid payment of their Medicare Part B premium. There is no resource test for the Qualified Individual Program.

## IV. REQUIRED ACTION

### A. RESOURCE DOCUMENTATION REQUIREMENTS FOR MEDICAID-ONLY A/Rs

#### 1. Medicaid Applications

Effective August 23, 2004, applicants of any age who are not seeking Medicaid coverage of long term care services may apply using the DOH-4220, "Access New York Application." This application has been revised to require all individuals, other than pregnant women and children under the age of 19, to attest to the dollar amount of their resources. The DOH-4220 may also be used for the Medicaid Buy-In program for Working People with Disabilities (MBI-WPD), provided the individual is not seeking Medicaid coverage of long-term care services. As stated in GIS 04 MA/004, dated February 13, 2004, if the DOH-4220 form is used for the MBI-WPD program, the form must include a notation of the applicant's disabling diagnosis and job title.

If a district receives, or is working on, an older version of the DOH-4220, the district should continue to process the application and determine eligibility. If an applicant attested to having resources below the Medicaid resource limit and fails to submit the requested resource documentation, the application cannot be denied. Such individuals, if otherwise eligible, should be given Community Coverage Without Long-Term Care as discussed in the next section of this directive.

Applicants who want to apply for Medicaid coverage of long-term care services are required to apply using the LDSS-2921, "Application for Public Assistance/Medical Assistance/Food Stamps/Services." For applicants who elect to apply for Medicaid coverage of long-term care services, social services districts must offer the choice of applying for Community Coverage With Community-Based Long-Term Care or Medicaid coverage for all covered care and services including nursing facility services. Districts are encouraged to use the attached "Explanation of the Resource Documentation Requirements for Medicaid," (Attachment I) to discuss these coverage options with applicants.

#### 2. Resource Documentation Requirements

Resource documentation requirements will vary depending on the Medicaid coverage option selected.

a. Community Coverage Without Long-Term Care Services

If an applicant elects to apply for Community Coverage Without Long-Term Care, the applicant may attest to the accumulated amount of his/her resources. An applicant continues to be required to provide documentation of any trust agreement in which the applicant is named as the creator or beneficiary. This will enable the district to evaluate the trust and determine the availability, if any, of the trust income and/or principal. Additionally, if an applicant has an irrevocable pre-need funeral agreement, a copy of the agreement must be provided to the district for purposes of verifying the type of agreement.

Community Coverage Without Long-Term Care includes all Medicaid covered care and services except nursing facility services and community-based long-term care as defined on page 3 of this directive. A new Medicaid Coverage Code 20 defined as "Community Coverage without Long Term Care" is to be used for applicants with no spenddown requirement who attest to the amount of their resources. A new manual and CNS notice entitled, "Notice of Acceptance of Your Medical Assistance Application (Community Coverage Without Long-Term Care)", have been developed to inform individuals who attest to resources of the services for which they will not have coverage. See Section IV.D of the ADM for further information regarding notices.

Social services districts must ask S/CCs whether a prohibited transfer has been made in the past 12 months. If the individual or couple states that no transfer has been made, Community Coverage Without Long-Term Care shall be authorized. If an individual indicates that a transfer has been made, see Section IV.A.2.d of the ADM for further instructions.

(1) Short-term Rehabilitation

Individuals who attest to the amount of their resources will receive Medicaid coverage for short-term rehabilitation services (one commencement/admission in a 12-month period, up to a maximum of 29 consecutive days of each of the following: certified home health care and nursing home care). A recipient or nursing home administrator will need to alert the social services district of an admission to a nursing home in order for the district to make the necessary entries on the Principal Provider Subsystem for payment to the facility. Individuals who are authorized or denied coverage for short-term rehabilitative nursing home care must be sent a notice informing the individual of the decision. The nursing home must also receive a copy of the notice. See Attachment II of this directive for a copy of the notice that must be sent (Authorization for Short-Term Rehabilitative Nursing Home Care).

In the event that the short-term rehabilitation exceeds 29 days, the individual must provide proof of his/her resources in order for Medicaid coverage to be established for the rehabilitative services beyond the 29th day. Proof of resources includes resource documentation for the past 36 months (60 months for trusts) for nursing facility services and current resource documentation for certified home health care.

(2) Change in Need

If a recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of a new application for purposes of establishing the effective date and three-month retroactive period for the increased coverage. Districts must send the recipient a "Long-Term Care Change In Need Resource Checklist" (Attachment III to this directive). Districts may use the cover letter provided in this directive (Attachment IV) to inform the recipient that additional resource information is needed to determine eligibility for long-term care and that unless the recipient returns the information by a specified date, the request for Medicaid coverage for long-term care will be denied. The date of the recipient's request for Medicaid coverage of long-term care services should be clearly documented in the case record. The request date should also be specified on the resource checklist cover letter. Social services districts must complete the appropriate resource review and make an eligibility determination within 45 days of the request.

In cases where a recipient is requesting coverage for nursing facility services (Medicaid coverage for all covered care and services), the look-back period is determined from the date the recipient is requesting coverage to be established for nursing facility services. In instances where the initial days of nursing home care were covered as short-term rehabilitation, the look-back period is determined from the date the recipient started to receive the short-term rehabilitation coverage. For example, a recipient enters a nursing home on August 23, 2004 and receives Medicaid coverage for 29 days of short-term rehabilitation. The individual continues to need nursing home care. The look-back period is the 36-month period immediately preceding August 2004, the month the individual started to receive nursing home care as a short-term rehabilitation service.

If, when reviewing resource documentation, the district also reviews documentation of income, this review may be considered a renewal for purposes of extending the individual's Medicaid authorization/coverage period; otherwise, the case must be renewed as previously scheduled.

In instances where a recipient requests an increase in coverage but does not provide adequate proof of his/her resources, the social services district must either continue current Medicaid coverage or authorize coverage based on the resource information that has been provided. For example:

i. If a recipient needs Community Coverage With Community-Based Long-Term Care and does not provide documentation of his/her current resources, the social services district must deny the request and continue Medicaid coverage unchanged. The CNS Undercare notice, "Continue MA Unchanged (limited benefit package)," allows the worker to include the reason for the denial of the request for Community Coverage With Community-Based Long-Term Care.

ii. If a recipient requires Medicaid coverage for all covered care and services, including nursing facility services, and does not provide documentation of his/her resources for the past 36 months (or 60 months for trusts) but does provide documentation of his/her current resources, the social services district must deny the request for Medicaid coverage for all covered care and services and determine eligibility for Community Coverage With Community-Based Long-Term Care. If the recipient fails to provide documentation of his/her current resources, the social services district must deny the request for Medicaid coverage for all covered care and services and continue Medicaid coverage unchanged (Community Coverage Without Long-Term Care). The appropriate CNS Undercare notice allows the worker to include the reason for the denial of Medicaid coverage of all covered care and services when applicable.

iii. When a social services district determines that an individual in permanent absence status (with or without a community spouse) is not eligible for Medicaid coverage of nursing home care or alternate level of care in a hospital due to the failure or refusal of the individual to provide adequate resource documentation, the A/R's eligibility for Community Coverage With Community-Based Long-Term Care or Community Coverage Without Long-Term Care

must be determined under community budgeting rules, instead of chronic care budgeting. This means that the A/R's countable income is compared to the Medicaid income standard for a one-person household ($659 effective 2004). This includes institutionalized spouses who are subject to spousal impoverishment budgeting. In such cases, the institutionalized spouse's income is established as if it is the first partial month of institutionalization. If the otherwise eligible institutionalized person's income is at or below the Medicaid income standard for a one-person household, the case must be authorized with the appropriate coverage (Community Coverage With Community-Based Long-Term Care or Community Coverage Without Community-Based Long-Term Care). If the institutionalized person's income exceeds the Medicaid income standard for a one-person household, the case must be authorized as a spenddown with the appropriate coverage (Outpatient Coverage With Community-Based Long-Term Care or Outpatient Coverage Without Long-Term Care).

Medical expenses incurred for nursing home care or alternate level of care in a hospital can be used to meet the individual's spenddown requirement. When an individual incurs medical expenses that meet or exceed his/her monthly spenddown, the individual is eligible for ancillary services not included in the facility's Medicaid rate. New CNS notices for institutionalized persons have been developed to inform individuals of the availability of Medicaid coverage for ancillary services only.

**Note:** A person with a spouse who does not qualify for Medicaid coverage of a waiver service due to the failure or refusal to provide adequate resource documentation is not entitled to spousal impoverishment budgeting since there is no expectation that the individual will be in receipt of a waiver service for at least 30 days. Regular community budgeting rules apply.

(3) Excess Income/Optional Pay-In Program

Attestors who are eligible for Medicaid subject to a spenddown requirement may participate in the Excess Income/Optional Pay-In Program. As attestors, they are ineligible for coverage of nursing facility services and community-based long-term care services.

If the recipient becomes eligible for outpatient-only services by meeting his/her one-month excess income liability, the recipient will be covered for short-term

rehabilitative certified home health care and nursing home care. In a 12-month period, the recipient may qualify for one commencement/admission, up to a maximum of 29 consecutive days of certified home health care and rehabilitative nursing home care. A new Medicaid Coverage Code 22 "Outpatient Coverage without Long Term Care" has been developed for purposes of this benefit package. Persons who receive short-term rehabilitative nursing home care must have an appropriate entry on the Principal Provider Subsystem to authorize payment to the nursing home. Please note that attestors only need to meet a one-month spenddown requirement for Medicaid payment of nursing home care each month during a period of short-term rehabilitation. Changes have been made to the Principal Provider Subsystem to allow Coverage Code 22 to be entered for a short-term nursing home resident.

**Note:** Effective with the release of this directive, Coverage Code 02 (Outpatient Only) is only to be used for individuals who provide resource documentation for the past 36 months (60 months for trusts) and who meet a one-month spenddown requirement. Coverage Code 02 will also be an allowable entry on the Principal Provider Subsystem for short-term nursing home stays where the person is not in permanent absence status (not subject to chronic care budgeting).

If an attestor becomes eligible for both outpatient and inpatient medical care by meeting his/her six-month excess income liability, the recipient will also be covered for short-term rehabilitative care. Such individuals are to be given Medicaid Coverage Code 20 "Community Coverage without Long Term Care".

Worker selected messages have been added to CNS spenddown notices to inform individuals who attest to resources of the services for which they will not have Medicaid coverage.

(4) Collateral Investigations

Social services districts may continue to verify the accuracy of the resource information provided by an A/R through collateral investigations. If there is an inconsistency between the information reported by the A/R and information obtained by the district, and the information obtained by the district is current, the district shall re-determine the recipient's eligibility based on the new information obtained through its investigation. If an individual is determined to be eligible for the Family Health Plus Program, Family Health Plus coverage should be authorized. If an individual is not eligible for Family Health Plus and/or the district requires further information about a particular resource in order to make an eligibility decision, the recipient must be notified to provide the necessary information. The district should request only

documentation that is necessary and relevant to the investigation. If the recipient fails or refuses to provide the requested information, Medicaid coverage shall be discontinued on the basis of the recipient's failure or refusal to provide information necessary to establish eligibility.

(5) Managed Care Implications

Recipients with Community Coverage Without Long-Term Care (Coverage Code 20) will be eligible to enroll in managed care, with the exception of managed long-term care. Once enrolled, the enrollee will be eligible for all care and services covered under the plan as well as any wraparound services that are covered under Medicaid fee-for-service. This includes the nursing home and home care benefits as defined in the benefit package of the managed care contract.

Upon disenrollment from managed care, such individuals' eligibility for Medicaid coverage of long-term care services will depend on whether the individual provided documentation of his/her resources.

b. Community Coverage With Community-Based Long-Term Care

Individuals electing to apply for Community Coverage With Community-Based Long-Term Care must provide documentation of current resources. Community Coverage With Community-Based Long-Term Care includes all Medicaid covered care and services except nursing facility services as defined on page 3 of this directive. The coverage does, however, include short-term rehabilitative nursing home care. A new Medicaid Coverage Code 19 defined as "Community Coverage with Community Based Long Term Care" has been developed for this benefit package. Coverage Code 19 is to be used for applicants/recipients with no spenddown requirement and those who meet a six-month excess income liability. See Section IV.D of the ADM for information regarding notices.

Individuals who meet a one-month excess income liability are to be given Coverage Code 21 (Outpatient Coverage with Community Based Long Term Care). Coverage Code 21 will cover all outpatient services except home and community-based waiver services. Coverage Code 21 will also include short-term rehabilitative nursing home care.

An otherwise eligible individual who fails or refuses to provide adequate resource documentation shall be denied Community Coverage With Community-Based Long-Term Care. Such individual shall be authorized with coverage for Community Coverage Without Long-Term Care if adequate information (not

documentation) regarding the individual's resources is provided.

If an S/CC indicates that no transfer has been made in the past 12 months, Community Coverage With Community-Based Long-Term Care shall be authorized. See Section IV.A.2.d of the ADM for further instructions if an S/CC indicates that a transfer has been made.

(1) Short-term Rehabilitative Nursing Home Care

Individuals who are eligible for Community Coverage With Community-Based Long-Term Care are eligible for certified home health care whether on a short-term or long-term basis. Individuals who have Community Coverage With Community-Based Long-Term Care are also eligible for one admission in a 12-month period of up to a maximum of 29 consecutive days of short-term rehabilitative nursing home care. Effective with the release of this directive, Coverage Codes 19 and 21 are an allowable entry on the Principal Provider Subsystem for short-term rehabilitative nursing home care.

(2) Change in Need

If a recipient who has documented current resources becomes in need of nursing facility services, the district must inform the recipient of the additional resource documentation that must be provided in order to determine eligibility for nursing facility services. Should a recipient fail or refuse to provide the requested resource documentation, the district shall deny Medicaid coverage for nursing facility services. In cases where the individual (with or without a community spouse) is in permanent absence status in a nursing home or on alternate level of care status in a hospital, the recipient's ongoing eligibility for Community Coverage With Community-Based Long-Term Care shall be determined under the community budgeting rules outlined in Section IV.A.2.a(2)(iii) of this directive.

**Note:** An individual who does not qualify for Medicaid coverage of a waiver service due to the failure or refusal to provide adequate resource documentation is not entitled to spousal impoverishment budgeting since there is no expectation that the individual will be in receipt of a waiver service for at least 30 days. Regular community budgeting rules apply.

(3) Managed Care Implications

Recipients with Community Coverage with Community-Based Long-Term Care (Coverage Code 19) will be eligible to enroll in managed care. Once enrolled, the enrollee will be eligible for all care and services covered under the plan as well as any wraparound services that are covered under Medicaid fee-for-service. This includes the nursing home and home care benefits as defined in the benefit package of the managed care contract.

Upon disenrollment from managed care, such individuals' eligibility for Medicaid coverage of long-term care services will depend on whether the individual provided documentation of his/her resources.

c. Medicaid Coverage for All Covered Care and Services

If an individual elects to apply for all Medicaid covered care and services, the social services district must follow current documentation requirements. To be eligible for all covered care and services (Coverage Code 01-Full Coverage), the applicant must provide documentation of his/her resources for the past 36-month period (or 60 months for trusts) immediately preceding the date the individual requests Medicaid coverage. Single Individuals and Childless Couples must provide resource documentation for the past 12 months.

Effective with the release of this directive, individuals who meet a monthly spenddown requirement are to be given Outpatient Only Coverage (Coverage Code 02) only if resource documentation has been provided for the past 36 months (60 months for trusts). Coverage Code 02 includes Medicaid coverage of home and community-based waiver services and with the release of this directive, temporary stays in a nursing home.

If an A/R who needs nursing facility services does not provide documentation of his/her resources for the past 36 months (60 months for trusts/12 months for SCCs) but does provide current resource documentation, the social services district must determine Medicaid eligibility for Community Coverage With Community-Based Long-Term Care. If the A/R provides information on the amount of his/her current resources but does not provide supporting documentation, the district must determine Medicaid eligibility for Community Coverage Without Long-Term Care. For individuals in permanent absence status in a nursing home or on alternate level of care status in a hospital, the individual's eligibility must be determined using the community budgeting rules outlined in Section IV.A.2.a(2)(iii) of this directive.

**Note:** An individual who does not qualify for Medicaid coverage of a waiver service due to the failure or refusal to provide adequate resource documentation is not entitled to spousal impoverishment budgeting since there is no expectation that the individual will be in receipt of a waiver service for at least 30 days. Regular community budgeting rules apply.

d. Transfer of Assets

For individuals who are determined to have made a prohibited transfer of assets, Coverage Code 10 (Limited Coverage) will continue to be used to limit Medicaid covered care and services to all Medicaid covered care and services except nursing facility services. An S/CC individual or couple is ineligible for Medicaid for a period of 12 months for a transfer of a non-exempt resource for the purpose of qualifying for Medicaid. The 12-month period of ineligibility begins with the month of transfer.

For individuals who meet a spenddown requirement who are found to have made a prohibited transfer of assets, a new Medicaid Coverage Code 23 (Outpatient Coverage with no Nursing Facility Services) must be used when the individual meets his or her one-month spenddown liability. Coverage Code 23 will prohibit payment of home and community-based waiver services and short-term rehabilitative nursing home care.

If an individual states that a transfer has been made but does not provide documentation of the transfer, one of the following coverage codes must be assigned based on the documentation that has been provided:

- Coverage Code 19 “Community Coverage with Community Based Long Term Care” for current resource documentation
- Coverage Code 20 “Community Coverage without Long Term Care” for attestation
- Coverage Code 21 “Outpatient Coverage with Community Based Long Term Care” for current resource documentation and a spenddown requirement
- Coverage Code 22 “Outpatient Coverage without Long Term Care” for attestation and a spenddown requirement

These individuals are not entitled to short-term rehabilitative nursing home care.

If an S/CC individual or couple states that a transfer has been made but does not provide documentation of the transfer, Medicaid coverage shall be denied.

**3. Medicaid Renewals**

For renewals (non-chronic care) mailed on or after August 23, 2004, Medicaid-only recipients who are subject to a resource test will be instructed to itemize their resources and send in documentation if they are receiving Medicaid coverage for long-term care services. If a recipient provides the value of his/her resources, but fails to provide adequate resource documentation, the social services district must determine the recipient's on-going eligibility for Community Coverage Without Long-Term Care. Social services districts must provide adequate and timely notice if there is a reduction in a recipient's Medicaid coverage.

Recipients who are not receiving Medicaid coverage of long-term care services will be asked to itemize their current resources and attest to the value of the resources.

When renewing Medicaid coverage for a recipient in chronic care status, social services districts shall continue to use the LDSS-4411 "Recertification for Medical Assistance (Chronic Care)".

## B. RECIPIENTS WHO LOSE ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME

In accordance with 80 ADM-19, individuals who lose Supplemental Security Income (SSI) eligibility continue to remain eligible for Medicaid coverage of all covered care and services until a separate determination of eligibility is made. If the individual is determined eligible based on information on the State Data Exchange (SDX), social services districts must authorize Medicaid coverage for all covered care and services for up to one year. If eligibility cannot be determined due to insufficient information, social services districts must continue Medicaid coverage for all covered care and services and notify the individual to provide the additional information within 30 days. Unless the individual's SSI was discontinued due to a prohibited transfer, the individual is not required to provide documentation of his or her resources for purposes of the ex-parte eligibility determination. Provided the individual is otherwise eligible, the individual shall continue to qualify for Medicaid coverage of all covered care and services or, if eligible with a spenddown requirement, outpatient only coverage, until the first scheduled Medicaid renewal.

## C. APPLICATIONS/RENEWALS FOR TEMPORARY ASSISTANCE AND MEDICAID

Effective August 23, 2004, when an applicant for both Temporary Assistance (TA) and Medicaid provides information concerning his or her resources but fails to provide the requested proof, the request for TA may be denied but a separate Medicaid eligibility determination must be made for Community Coverage Without Long-Term Care or Family Health Plus. The individual's notice of this Medicaid determination will inform the individual of the care and services for which he or she does not have coverage and the reason for the decision.

Individuals who are closed on Temporary Assistance for failure to document resources are also to be referred to Medicaid for a separate eligibility determination. Temporary Assistance closing reason code V20 "Failure to Provide Verification (Closing or Recert Closing)" should be used to generate the appropriate Medicaid extension.

## D. NOTICES

### 1. CNS

Upstate, new CNS acceptance notices have been developed to inform individuals of the action taken on the Medicaid application. This includes informing individuals who have a resource test of the care and services for which there is no eligibility based on the resource documentation provided. Numerous changes have been made to upstate CNS undercare notices to accommodate the new policies contained in this directive. Details regarding CNS changes are contained in the August 2004 WMS/CNS Coordinator Letter associated with this migration. The WMS and CNS Code Cards will also be updated to reflect any new codes.

### 2. Manual

a. LDSS-3622 (Rev. 3/03): Notice of Decision on Your Medical Assistance Application

The LDSS-3622 may be used to inform an applicant that his/her Medicaid application has been accepted for all covered care and services, denied or no action taken. When using the acceptance portion of the notice, the notice must only be used for:

- pregnant women and children who are eligible for full Medicaid coverage; and
- Medicaid-only applicants who provided resource documentation for the past 36-months (60 months for trusts) and who are eligible for full Medicaid coverage including nursing facility services.

Administrative Directive 95 ADM-7 "Community Coverage Option" is cancelled with the release of this ADM. The mandated notices contained in a 95 ADM-7 have been either deleted or revised. The revised notices are contained in this directive. To ensure that usage of the new and revised notices begins immediately, districts are instructed to reproduce the attached copies until the notices are available.

b. Notice of Acceptance of Your Medical Assistance Application (Community Coverage Without Long-Term Care) (Rev. 6/04) (Attachment V)

This notice may be used to inform an applicant that his/her Medicaid application has been accepted for care and services except nursing facility services and community-based long-term care, with or without a spenddown requirement. The notice

advises the individual that he/she is not eligible for nursing facility services or community-based long-term care and the actions to be taken in the event coverage is needed for these services or for short-term rehabilitation services. The notice must be used for:

- applicants who attest to the amount of their resources;
- applicants who request community coverage for community-based long-term care but do not provide documentation of current resources; and
- applicants who request Medicaid coverage for all covered care and services but do not provide documentation of resources for the past 36 months (or 60 months for trusts) including current resource documentation.

For individuals who request Medicaid coverage for nursing facility services or community-based long-term care but do not provide adequate resource documentation, the worker must list the resource documentation that was not provided. If Medicaid coverage is authorized with a spenddown requirement, the box "Excess Income/Resources" must be checked and the LDSS-3973, "Notice of Decision on Your Medical Assistance Application (Excess Income/Resources)" must be completed.

**Note:** When completing an LDSS-3973 for an institutionalized spouse who has a community spouse (institutionalized spouse is expected to need nursing facility services for at least 30 consecutive days), the total monthly deduction amount must include any contribution to the community spouse. The allowable income standard is the Medicaid income level for a household of one since the institutionalized spouse is budgeted as if it is the first or partial month of institutionalization.

c. LDSS-4489 (Rev. 6/04): Notice of Acceptance of Your Medical Assistance Application (Community Coverage With Community-Based Long-Term Care) (Attachment VI)

The LDSS-4489 may be used to inform an applicant that his/her Medicaid application has been accepted for community coverage with community-based long-term care, with or without a spenddown requirement. The notice advises the individual that he/she is not eligible for nursing facility services and the actions to be taken in the event coverage is needed for nursing facility services or short-term rehabilitation. The notice must be used for:

- applicants who provide current resource documentation and are eligible for Medicaid coverage for community-based long-term care with or without a spenddown requirement; and
- applicants who request Medicaid coverage for all covered care and services but only provide current resource documentation.

For individuals who request Medicaid coverage for nursing facility services but do not provide adequate resource documentation, the worker must list the documentation that was

not provided. If Medicaid coverage is authorized with a spenddown requirement, the box "Excess Income/Resources)" must be checked and the LDSS-3973, "Notice of Decision on Your Medical Assistance Application (Excess Income/Resources)" must be completed. In addition, the "Note" in "b" above would apply to an institutionalized spouse who requests coverage for nursing facility services, is expected to receive such services for at least 30 consecutive days, but does not provide adequate resource documentation for the past 36 months (60 months for trusts).

d. LDSS-4038 (Rev. 6/04): Explanation of the Excess Income Program (Attachment VII)
The revised "Explanation of the Excess Income Program" must be used with the LDSS-3973, "Notice of Decision on Your Medical Assistance Application Excess Income/Resources." The informational notice has been revised to include information about resource documentation requirements for long-term care services

e. LDSS-4548 (Rev. 4/04): Optional Pay-In Program for Individuals with Excess Income (Attachment VIII)
The revised Optional Pay-In Program for Individuals with Excess Income" must be used with the LDSS-3973, "Notice of Decision on Your Medical Assistance Application (Excess Income/Resources)." The informational notice has been revised to include information about resource documentation requirements for long-term care services and the requirements for coverage of short-term rehabilitation.

f. Authorization for Short-Term Rehabilitative Nursing Home Care (Rev. 4/04) (Attachment II)
This notice is to be used to accept or deny an individual's request for Medicaid coverage of short-term rehabilitative nursing home care. A copy of the notice must be sent to the facility when authorizing coverage. When applicable, the notice will include information concerning any income that must be contributed toward the cost of care.

**Note:** See Section V.C. (Managed Care/Managed Long-Term Care) for additional manual managed care notice information.

## V. SYSTEMS IMPLICATIONS

Systems codes and edits have been modified to support attestation of resources. A detailed description of the items below can be found in the August 2004 WMS/CNS Coordinator Letter. The following is a summary of the changes.

### A. UPSTATE WMS IMPLICATIONS

In order to systemically support attestation of resources, a new single character field, entitled "Resource Verification Indicator" (RVI is the field label), has been added to "WKUM01" and will be displayed on the LDSS 3209. An entry in this field will be required on MA Only cases (CT 20) for Opening (02), Re-Opening (10) and Recertification (06)

transactions as well as Undercare Maintenance Transactions (05) where the Case Type is being changed from 22 (MA-SSI) or 24 (FHP) to 20. An RVI will be required to be worker entered UNLESS all case members belong to one of the following categories:

- Pregnant Women (Categorical Codes 15, 42, 43, 48, 58, 59)
- Expanded Eligibility for Children and LIF Eligible Children (Categorical Codes 44, 45, 46, 47, 51, 60, 01-09)
- Unborns
- Family Planning Benefits Program (Categorical Codes 68 and 69)
- Breast and Cervical Cancer Treatment Program (Categorical Code 61, 62 or 63)

If an individual on a case has a Categorical Code which is other than one of those listed above, the RVI value entered on WKUM01 must be equal to "1", "2", "3" or "4". If all case members have one of the Categorical Codes listed above, the system will generate an RVI value of "9" if left blank or the worker will be able to enter a "9".

The RVI values are defined as follows:

"1" (Resources verified for 36 months) – A value of "1" is to be used for cases in which an applying household member has a resource test, resource documentation has been provided for the past 36 months (60 months for trusts) and there is no transfer of assets penalty. This value is to be used for cases with or without a spenddown of income requirement.

"2" (Resources verified only for current month) - For cases in which an applying household member has a resource test and documentation of current resources has been provided, the value "2" should be used. This value will provide coverage for community-based long-term care services and is to be used for cases with or without a spenddown of income requirement.

"3" (Resources not verified) - The value "3" is to be used for cases in which an applying household member has a resource test and has elected to attest to the amount of his/her resources. This value will prohibit coverage for long-term care services and is to be used for cases with or without a spenddown of income requirement.

"4" (Transfer of resources) – For those cases in which a district has determined that an individual has made a prohibited transfer and is not eligible for nursing facility services, the value "4" must be entered. This value will prohibit coverage of nursing facility services and will identify cases in which an actual transfer of assets has been made. The value "4" is to be used for cases with or without a spenddown of income requirement.

"9" (Exempt from resource verification) – A value of "9" will be required if all individuals on the case are one of the following: pregnant women, unborn, expanded child eligible under the federal poverty level, post-partum mother, participant in the Breast and Cervical Cancer Treatment Program

or a participant in the Family Planning Benefit Program. This value will provide coverage for all Medicaid covered care and services, unless otherwise restricted based on income or program participation.

For mixed households where there are household members who have no resource test, and members who have a resource test, the RVI value should be selected for the household members who have a resource test. The Categorical Code and eligibility outcome for the other family members will help the worker determine the correct Coverage Code to be data entered.

**Note:** Upstate, when a Case Type 20 is opened for a Case Type 22 closing based on the Auto-SDX, the system will store an RVI of "1".

**Conversion of Active Cases** – The weekend of the migration, the system will generate and store a value in the RVI field for all active Medicaid cases (Case Type 20) using the following logic:

a. If all individuals in the case are exempt from resource verification, as explained above, the RVI value will be set to "9".
b. If no one in the case has a Coverage Code of 10, the RVI value will be "1".
c. If at least one individual has a Coverage Code of 10, the RVI value will be "4".

**New Medicaid Coverage Codes** – Effective with this implementation, the following new Coverage Codes will be added:

Coverage Code 19 (Community Coverage with Community Based Long Term Care)

Coverage Code 20 (Community Coverage without Long Term Care)

Coverage Code 21 (Outpatient Coverage with Community Based Long Term Care)

Coverage Code 22 (Outpatient Coverage without Long Term Care)

Coverage Code 23 (Outpatient Coverage with no Nursing Facility Services)

Coverage Code 24 (Community Coverage without Long Term Care (legal alien during 5 year ban – NYC only)

The Principal Provider and Restriction/Exception subsystems and the Downgrade Matrix have been revised to accommodate the new Coverage Codes. Detailed information regarding these changes can be found in the August 2004 WMS/CNS Coordinator Letter.

**MBL Implications**

MBL Resource Code "98" defined as "Other Liquid Resources" should be used to identify an attestor's total countable resource amount. If the type of resource has been identified, the appropriate MBL Resource Type code should be used.

**B. NYC WMS IMPLICATIONS**

NYC WMS instructions will be provided under separate cover.

**C. MANAGED CARE/MANAGED LONG-TERM CARE**

Individuals with Coverage Codes 19, 20 or 24 (NYC only) can be enrolled in the regular Managed Care program. Individuals with Coverage Codes 19, 21 or 23 can be enrolled in Managed Long-term Care. It should be noted that if a managed long-term care participant requires nursing facility services, a determination of on-going eligibility is required. If an individual had previously not provided documentation of his/her resources for the past 36 months (60 months for trusts), such documentation must be provided as a condition of on-going eligibility.

**Note:** Coverage Code 19 will be accepted as a PCP enrollment for managed long-term care. For individuals with Coverage Code 21 or 23, the coverage code must first be changed to 19 or 01 coverage in order for a PCP enrollment to be accepted.

Upon disenrollment, the RVI field, State/Federal Charge Code and/or Categorical Code will be referenced in order to change to the appropriate Coverage Code. Timely and adequate notice is required for any decrease in coverage following disenrollment. Appropriate manual managed care disenrollment notice must be sent in addition to the eligibility notice. For purposes of timely and adequate notice, all of the new Coverage Codes are considered to be a decrease in coverage from managed care coverage.

For persons being disenrolled from managed care due to permanent placement in a medical facility, chronic care budgeting and the establishment of a contribution toward cost of care is effective the month following the month in which the person’s status changed to permanent absence status.

**Note:** For individuals who are disenrolled from managed long-term care, the system is not able to distinguish individuals with a spenddown requirement from individuals with no spenddown requirement. As a result, the cases are given either Coverage Code 01, 10 or 19 based on edits. Managed long-term care cases should be reviewed upon disenrollment for possible correction. Cases that require a change to a spenddown requirement must be given timely and adequate notice before the effective date of the change.

**D. EEDSS**

EEDSS will be revised to comply with the provisions of this directive.

## VI. EFFECTIVE DATE

The provisions of this directive are effective for all actions taken on a case or application on or after August 23, 2004. However, the provisions cannot be applied to any period prior to April 1, 2003.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management

# EXPLANATION OF THE RESOURCE DOCUMENTATION REQUIREMENTS FOR MEDICAID

If you want Medicaid coverage of certain care and services, you must submit proof of your resources. The following explains the resource information that must be submitted in order to be eligible for coverage of certain care and services.

When you apply for Medicaid, you will be asked to choose one of the following:

1. community coverage **without** long-term care;

2. community coverage **with** community-based long-term care; or

3. Medicaid coverage for **all** covered care and services.

Note: Pregnant women, children under age one, and children between the ages of one and 19, who have incomes at or below the applicable federal poverty level, do not need to provide proof of their resources in order to qualify for Medicaid coverage for all care and services.

## 1. Community Coverage Without Long-Term Care

Applicants/recipients who do **not** need nursing facility services or community-based long-term care may attest to the amount of their resources. If we find that you are eligible under this simplified review, you will get Medicaid coverage but **not** coverage for nursing facility services or community-based long-term care. If at some time you need nursing facility or community-based long-term care services, we will need to look at your resources before Medicaid can cover these services.

People who attest to the amount of their resources are eligible for short-term rehabilitation services. Short-term rehabilitation includes one commencement/admission in a 12-month period of up to 29 consecutive days of: nursing home care and certified home health care.

If we find the information you report is different from the information we get from investigating what you reported, you will be requested to give us proof of your resources.

## 2. Community Coverage With Community-Based Long-Term Care includes

- Adult day health care
- Limited licensed home care
- Certified home health agency services
- Hospice in the community
- Hospice residence program
- Personal care services
- Personal emergency response services
- Private duty nursing

- Residential treatment facility
- Consumer directed personal assistance program
- Assisted living program
- Managed long-term care in the community
- Home and community-based services waiver programs

To be eligible for community coverage **with** community-based long-term care services, you must give us proof of your current resources. If we find that you are eligible, you will get Medicaid covered care and services that include community-based long-term care services, but you will **not** get coverage for nursing facility services, except for short-term rehabilitation. If you later need nursing facility services, we will need to look at your resources for up to the past 36 months (60 months for trusts) before Medicaid can cover these services (see #3 below).

**3. Medicaid Coverage for All Covered Care and Services includes**

- Nursing home care
- Nursing home care provided in a hospital
- Home and community-based waiver services
- Hospice in a nursing home
- Managed long-term care in a nursing home
- Intermediate care facility

To be eligible for these services, we must review your resources for up to 36 months (60 months for trusts/12 months for single individuals and childless couples) prior to your application. If we find that you are eligible, you will get **all** Medicaid covered care and services including the nursing facility services listed above and the community-based long-term care services listed under #2 above.

Applicants/recipients who do not need nursing facility services now may choose to apply only for Community Coverage with Community-Based Long-Term Care (#2 above) or Community-Coverage **without** Long-Term Care (#1 above).

**If you become in need of a service for which you have not received coverage, contact your worker immediately for assistance.**

# AUTHORIZATION FOR SHORT-TERM REHABILITATIVE NURSING HOME CARE

| NOTICE DATE: | | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN/RID NUMBER | |
| CASE NAME (and C/O Name if Present)AND ADDRESS | | |
| | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ |
| | | **OR** Agency Conference _____ |
| | | Fair Hearing Information and Assistance _____ |
| | | Record Access _____ |
| | | Legal Assistance Information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

This Department has made a decision concerning your request for Medical Assistance coverage of SHORT-TERM REHABILITATIVE NURSING HOME CARE. We are sending this notice to tell you that this Department will:

- ❑ APPROVE Medical Assistance coverage for short-term rehabilitative nursing home care from _____ to _____.

  We have calculated a monthly income contribution of $_____ to be paid toward the cost of care for _____ to _____ and $_____ to be paid toward the cost of care for _____ to _____.

  We have calculated the monthly contribution toward the cost of care for the period(s) indicated, as follows:

  Your net monthly income (gross income less Medical Assistance deductions) is $_____. The allowable income standard for a family household your size is $_____. The difference between your net monthly income and this standard is $_____ and is the monthly amount you must pay toward the cost of care.

- ❑ DENY Medical Assistance coverage for short-term rehabilitative nursing home care from _____ to _____ because:

  ____ You have already received one admission of short-term rehabilitative nursing home care within the past 12 months.

  ____ Other: _____

  _____

  This denial is only for coverage of short-term rehabilitative nursing home care. Your current Medical Assistance coverage will continue unchanged.

**If you need nursing home care beyond 29 days, notify your social services district immediately. We will then arrange to review your resources to find out if you are eligible for Medical Assistance coverage for these services.**

The Laws or Regulations which allow us to do this are: Social Services Law 366 and 366-a(2), and 18 NYCRR 360-2.3 and 360-4.8.

*REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS*

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

cc: _____
Name of Nursing Home

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**

3) **On-Line:** Complete and send the online request form at: **https://www.otda.state.ny.us/oah/forms.asp. OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

**ATTENTION:** Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

**Attachment III**

# Long-Term Care Change In Need Resource Checklist

| Resources | No | Yes | Amount | To Prove the Amount of this Resource, Mail In: |
|---|---|---|---|---|
| Checking accounts? | | | | ✓ Copy of Bank or Credit Union Statement |
| Savings accounts? | | | | ✓ Copy of Bank or Credit Union Statement |
| Retirement accounts (Deferred Compensation, IRA and/or Keogh)? | | | | ✓ Copy of Financial Statement |
| Life insurance policies? | | | | ✓ Copy of Life Insurance Policy **OR**<br>✓ Statement from Insurance Company Identifying Face Value and Cash Value |
| Stocks, bonds or certificates of deposit (CDs)? | | | | ✓ Copy of Stocks, Bonds, Certificates **OR**<br>✓ Copy of Financial Statement |
| Mutual funds? | | | | ✓ Copy of Bonds |
| Real estate other than homestead, including income producing and non-income-producing property? | | | | ✓ Copy of Deed and Statement from Real Estate Broker Verifying Current Value |
| Annuities? | | | | ✓ Copy of Annuity Agreement |
| "In trust" accounts? | | | | ✓ Copy of Bank Statement |
| Safe deposit box? | | | | ✓ Copy of Bank Record |
| Resources other than those listed above? | | | | |

Has anyone (including your spouse, even if not receiving Medicaid or living with you) given away any cash, or sold/transferred any real estate, income or personal property in the past 36 months? If yes, when? _____

Has anyone (including your spouse, even if not receiving Medicaid or living with you) created a trust since you last renewed or transferred any assets into a trust or become the beneficiary of a trust? If yes, when? _____

I swear and/or affirm under penalties of perjury that the information I have given or will give to the local social services district is correct.

_____ _____ _____ _____

**Recipient/Representative Signature** **Date Signed** **Spouse/Representative Signature** **Date Signed**

**LDSS NAME**
**MAILING ADDRESS**
**XXXX, NEW YORK XXXXX**

Date_____

# Long-Term Care Documentation Requirement Checklist

**Case Name:** _____ **Rep Name:** _____
**Address:** _____ **Due Date:** _____
_____ **Case Number:** _____

On _____, you requested Medical Assistance coverage of long-term care services. In order for us to determine your eligibility for long-term care services your worker must receive the following information checked below no later than the above due date. Failure to submit the information may result in the denial of Medical Assistance coverage for long-term care services. If you cannot obtain these items by the above date, you must contact your worker to request a brief extension. Verification of your attempt to obtain these documents may be required prior to granting an extension.

- ❑ Complete, sign and return the enclosed "Long-Term Care Change In Need Resource Checklist". Since you requested Medicaid coverage for community-based long-term care, you must provide proof of the current value of each resource checked "Yes".

- ❑ Complete, sign and return the enclosed "Long-Term Care Change In Need Resource Checklist". Since you requested Medicaid coverage for nursing facility services, you must provide proof of the value of each resource checked "Yes" for the period _____ to _____.

    - ❑ Document all checks and withdrawals over $_____.

    - ❑ Copies of your last three years tax returns (including 1099's and all schedules and forms).

_____ _____
Social Welfare Examiner Phone Number

Enclosure

**Attachment V**

**(Rev 06/04)**

# NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION
## (Community Coverage Without Long-Term Care)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME (and C/O Name if Present)AND ADDRESS | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ |
| | | **OR** Agency Conference _____ |
| | | Fair Hearing Information and Assistance _____ |
| | | Record Access _____ |
| | | Legal Assistance Information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

We are sending this notice to tell you that this Department will **ACCEPT** the Medical Assistance application dated _____ _____ for name(s) _____
for Community Medicaid Coverage Without Long-Term Care. The reason for this decision is as follows:

- ❑ Since you requested that we determine your Medicaid eligibility for Community Medicaid Coverage Without Long-Term Care Services, we did not review your resources and you will **NOT** be covered for the following long-term care services:

  **Nursing Facility Services**: Alternate level of care provided in a hospital, hospice in a nursing home, nursing home care other than short-term rehabilitation, intermediate care facility services, managed long-term care in a nursing home, home and community-based waiver services provided through the Long-Term Home Health Care Program, Traumatic Brain Injury Waiver Program, Care at Home Waiver Program, or Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program.

  **Community-Based Long-Term Care Services**: Adult day health care, certified home health care other than short-term rehabilitation, hospice in the community, residential treatment facility services, personal care services, assisted living program, managed long-term care in the community, home and community-based waiver services programs, limited licensed home care, private duty nursing, personal emergency response services and consumer directed personal assistance program.

- ❑ You requested that we determine your Medicaid eligibility for all covered care and services, including community-based long-term care, but you did not provide proof of your resources. You failed to verify:

  _____

  _____

  Since you did not provide proof of your resources, you will not be covered for the long-term care services listed above.

- ❑ **EXCESS INCOME/RESOURCES**
  See the enclosed LDSS-3973: Notice of Decision on Your Medical Assistance Application (Excess Income/Resources).

  **NOTE**: If there are other factors that affect your Medical Assistance Coverage, a separate notice is enclosed.

Please review the Medical Assistance Utilization Threshold information, found in the Medical Assistance section of the booklet, "LDSS-4148B: What You Should Know About Social Services Programs." The information explains any services limitations. The LDSS-4148B was given to you when you applied for assistance.

If you submitted paid medical bills for direct reimbursement, you will be notified separately of our decision.

If you need community-based long-term care or nursing facility services, notify the social services district immediately. We will then arrange to review proof of your resources to find out if you are eligible for Medicaid coverage of these services.

The Laws and/or Regulations which allow us to do this are: Social Services Law 366-a(2) and 18 NYCRR 360-2.3, 360-4.1, 360-4.4, 360-4.5, 360-4.7, 360-4.8.

We have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

**ATTENTION: Persons accepted for Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE call Verizon, toll free at 1-800-555-5000**

*REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS*

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**

3) **On-Line:** Complete and send the online request form at: **https://www.otda.state.ny.us/oah/forms.asp. OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

**ATTENTION:** Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

# NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION
## (Community Coverage With Community Based Long-Term Care)

| NOTICE DATE: | EFFECTIVE DATE: | NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE |
|---|---|---|
| CASE NUMBER | CIN NUMBER | |
| CASE NAME (and C/O Name if Present)AND ADDRESS | | GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____<br>**OR** Agency Conference _____<br>Fair Hearing Information and Assistance _____<br>Record Access _____<br>Legal Assistance Information _____ |

| OFFICE NO. | UNIT NO. | WORKER NO. | UNIT OR WORKER NAME | TELEPHONE NO. |
|---|---|---|---|---|
| | | | | |

We are sending this notice to tell you that this Department will **ACCEPT** your Medical Assistance application dated _____ _____ for name(s) _____ for Community Medicaid Coverage With Community-Based Long-Term Care. The reason for this decision follows:

- ❑ Since you requested that we determine your Medicaid eligibility for all covered care and services including community-based long-term care but not nursing facility services, we did not review proof of your resources for the past 36 months (60 months for trusts) and you will **NOT** be covered for the following nursing facility services:
  - nursing home care other than short term rehabilitation
  - nursing home care provided in a hospital
  - home and community-based waiver services
  - hospice in a nursing home
  - managed long-term care in a nursing home
  - intermediate care facility services
- ❑ You requested that we determine your Medicaid eligibility for all covered care and services including nursing facility services but you did not provide proof of your resources for the past 36 months (60 months for trusts). You failed to verify:
  _____
  _____.
  Since you did not provide proof of your resources for the past 36 months (60 months for trusts), you will not be covered for the nursing facility services listed above.
- ❑ **EXCESS INCOME/RESOURCES**
  See the enclosed LDSS-3973: Notice of Decision on Your Medical Assistance Application (Excess Income/Resources).

  **NOTE**: If there are other factors that affect your Medical Assistance Coverage, a separate notice is enclosed.

Please review the Medical Assistance Utilization Threshold information, found in the Medical Assistance section of the booklet, "LDSS-4148B: What You Should Know About Social Services Programs." The information explains any services limitations. The LDSS-4148B was given to you when you applied for assistance.

If you submitted paid medical bills for direct reimbursement, you will be notified separately of our decision.

If you need Medicaid coverage of nursing facility services, contact your worker immediately. We will then arrange to review your resources for up to the past 36 months (60 months for trusts) to find out if you are eligible for Medicaid coverage for these services.

The Laws and/or Regulations which allow us to do this are: Social Services Law 366-a(2) and 18 NYCRR 360-2.3, 360-4.1, 360-4.4, 360-4.5, 360-4.7, 360-4.8.

We have enclosed a budget worksheet(s) so that you can see how we determined eligibility for benefits.

**ATTENTION: Persons accepted for Medical Assistance may be eligible for a discount on their telephone service. For information on LIFELINE call Verizon, toll free at 1-800-555-5000**

*REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGES IN NEEDS, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS*

**YOU HAVE THE RIGHT TO APPEAL THIS DECISION**
**BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION**

**RIGHT TO A CONFERENCE:** You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the front page of this notice. This number is used only for asking for a conference. ***It is not the way you request a fair hearing.*** If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

**RIGHT TO A FAIR HEARING:** If you believe that the above action is wrong, you may request a State fair hearing by:

1) **Telephone:** You may call the state wide toll free number: 800-342-3334 (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL) **OR**

2) **Fax:** Send a copy of this notice to fax no. (518) 473-6735. **OR**

3) **On-Line:** Complete and send the online request form at: **https://www.otda.state.ny.us/oah/forms.asp. OR**

4) **Write:** Send a copy of this notice **completed**, to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

☐ I want a fair hearing. The Agency's action is wrong because:_____

_____

_____

Print Name: _____ Case Number_____

Address: _____Telephone: _____

Signature of Client: _____ Date: _____

**YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING**

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, pay stubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

**LEGAL ASSISTANCE:** If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the front of this notice.

**ACCESS TO YOUR FILE AND COPIES OF DOCUMENTS:** To help you get ready for the hearing, you have a right to look at your case file. If you call or write to us, we will provide you with free copies of the documents from your file which we will give to the hearing officer at the fair hearing. Also, if you call or write to us, we will provide you with free copies of other documents from your file which you think you may need to prepare for your fair hearing. To ask for documents or to find out how to look at your file, call us at the Record Access telephone number listed at the top of the front of this notice or write us at the address printed at the top of the front of this notice.

If you want copies of documents from your case file, you should ask for them ahead of time. They will be provided to you within a reasonable time before the date of the hearing. Documents will be mailed to you only if you specifically ask that they be mailed.

**INFORMATION:** If you want more information about your case, how to ask for a fair hearing, how to see your file, or how to get additional copies of documents, call us at the telephone numbers listed at the top of the front of this notice or write to us at the address printed at the top of the front of this notice.

**ATTENTION:** Children under 19 years of age who are not eligible for Child Health Plus A or other health insurance may be eligible for the Child Health Plus B Insurance Plan (Child Health Plus B). The plan provides health care insurance for children. Call 1-800-522-5006 for information.

## EXPLANATION OF THE EXCESS INCOME PROGRAM

The following is an explanation of how you may become eligible for Medical Assistance and receive help with your medical bills even though you may be over the limit. Please contact your social services worker if you need help understanding this letter.

If you have applied for Medical Assistance, our written notice to you will tell you if you have income over the Medical Assistance income level and the amount by which your income is over. This amount is also called excess income. If your net income is over (in excess of) the Medical Assistance level for your family size for a period in which you want help with your medical bills, you may receive Medical Assistance coverage only if either A or B is met:

### A) Outpatient Care and Service (One-Month Eligibility)

You can become eligible for Medical Assistance for outpatient care and services if in any month you have medical bills that are equal to or more than the amount of your excess income.

This is possible under the Excess Income Program which provides outpatient coverage on a month-to-month basis for people who become eligible by bringing us their paid or unpaid medical bills which add up to at least the amount of their monthly excess income. You must present these medical bills to the agency when they add up to at least the amount of your excess income.

When you incur (owe) or have paid the amount of your monthly excess income and have submitted these bills and/or receipts to the agency, you may receive Medical Assistance coverage for all other eligible outpatient services for that month.

You can also become eligible for Medical Assistance coverage of long-term care services such as adult day health care, personal care services, and the Assisted Living Program. In order to be determined eligible for such services, you must supply proof of your current resources.

### B) Outpatient and Inpatient/Hospital Care and Services (Six-Month Eligibility)

You can become eligible for Medical Assistance for all appropriate medical care and services (inpatient and outpatient) if you become hospitalized and/or are seeking help with your inpatient hospital bills, and if you incur (owe) or have paid an amount of medical bills equal to your monthly excess income for six months. Once you have medical bills (paid or unpaid), including any other medical bills besides your hospital bill that equal this six months' figure and present them to the agency, you will then receive Medical Assistance coverage each month for these six months for all other covered medical expenses (whether in-hospital or not).

You can also become eligible for Medical Assistance coverage of long-term care services such as adult day health care, personal care services, and the Assisted Living Program. In order to be determined eligible for such services, you must supply proof of your current resources.

### C) Medicare, Private Insurance and Use of Bill

If a bill or service is covered in full by Medicare or private insurance, it cannot count as a medical expense to meet your monthly excess. If only part of a bill is covered by Medicare or private insurance, then that portion which remains (not covered by Medicare or private insurance) can count toward reducing or eliminating your monthly excess.

Bills for your care, your spouse's care or the care of your children who are under the age of 21 may be counted toward your monthly excess within the following guidelines. Medical bills of a child living with you will be considered. Medical bills of a child who is not part of your household may also be considered as long as you are providing medical support for the child. Bills for your parent's care, if you are under 21 and live with your parents, may also be counted toward meeting your monthly excess. Medical bills from prior months may be counted toward meeting your monthly excess. Once medical bills, whether old or current, are credited toward meeting your monthly excess, they cannot be counted again.

After you have enrolled in the Excess Income Program, you must arrange to either bring in or mail in your bills and receipts each month once you have accumulated medical expenses equal to or greater than your excess income.

**- Continued On Other Side -**

We suggest that you make any necessary doctors appointments or fill prescriptions in the early part of each month so that, after you have met your excess amount, you can have the benefit of a Medical Assistance card to use for the payment of other medical expenses for that month. Medical Assistance may also be available for unpaid and certain paid bills for services and supplies received in the three calendar months prior to the month you applied.

**D) Payment of Medical Bills**

It is important to check to see if your doctor or other medical person accepts Medical Assistance payments. Medical Assistance will only **pay** bills from a doctor, druggist or other provider who accepts payments under New York's Medical Assistance Program. However, even if the doctor or other medical person does not accept Medical Assistance payments, you may still use bills from that person, whether paid or unpaid, to meet your excess income amount to qualify under the **Excess Income Program** (see below).

E) **Allowable Medical Expenses**

You should note that when meeting your excess amount, you could use doctor bills as well as medical expenses such as:

- Transportation expenses to obtain necessary medical services (in most cases).
- Medical expenses or payment made to therapists, nurses, personal care attendants and home health aides (as required by a physician).
- Prescription drug bills.
- Payments made toward surgical supplies, medical equipment, prosthetic devices, hearing aids and eyeglasses (as ordered by a doctor).

You can also use medical expenses that are not covered by the Medical Assistance Program such as:

- Chiropractor's services (and other non-covered services).
- Co-payments you are charged when you receive certain Medical Assistance services.
- Services from non-participating providers (people who provide medical services but do not accept Medical Assistance payments).
- Some over-the-counter drugs and medical supplies such as bandages and dressings may be applied toward reduction of your excess income if they have been ordered by a doctor or are medically necessary. Bills for cosmetics and other non-medical items are not acceptable.

Certain of these bills can be counted only if required by a physician. Some of these services and supplies can also be paid for with your Medical Assistance card, but may have some restrictions.

**F) Excess Income Amount**

You may also pay your excess income amount directly to the social services agency to obtain Medical Assistance coverage. Ask your Medical Assistance examiner for information.

Should there be a change in your circumstances (financial, household size, etc.), your eligibility in the Excess Income Program could be affected. All changes must be reported to your local social services office.

**IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR MEDICAL ASSISTANCE ELIGIBILITY EXAMINER FOR DETAILS**

**DSS-4548** (06/04) Attachment VIII

## OPTIONAL PAY-IN PROGRAM FOR INDIVIDUALS WITH EXCESS INCOME

Individuals whose income exceeds the Medical Assistance income limits may still receive help with medical bills. The form DSS-4038, "EXPLANATION OF THE EXCESS INCOME PROGRAM" explains that if you bring in or send us your medical bills each month which are equal to or more than the amount of your excess income, you may receive coverage for any other **outpatient** medical expenses you incur from a Medical Assistance provider in that month. Explained below is another way you can get Medical Assistance coverage.

Instead of bringing or mailing in your medical bills each month, you can pay to this agency the amount of your income that is over the limit. If you decide to pay this money to us, you will be given outpatient coverage for the month you are paying for, and will not have to wait until you incur a medical bill. If you pay a total of six months of excess income, you will be given outpatient and inpatient coverage for that six-month period. Once you are given coverage, you can use your medical Assistance card to obtain services from your doctor or other medical provider. You must be sure the provider accepts payments from the Medical Assistance program before you receive the service.

If you pay your excess income to this agency, and then get or pay a bill for medical services that Medical Assistance does not cover (for example, chiropractor's service), we will give you a refund or we will give you a credit toward the next available uncovered month. You must bring in or send to us the paid or unpaid bill in order to get a credit or refund.

*Remember, we will not pay for or give credit for any bill or portion of a bill that is covered by **Medicare** or other health insurance that you have.

If you decide to pay your excess income to the agency, from time to time we will review the amount of all the claims we have paid for you, and compare this amount to the amount you have paid. If you have paid more than you should have, we will decide to give you a refund or give you credit for coverage in another month. We will make this decision based on your circumstances.

You should consider the following before deciding to take part in the PAY-IN PROGRAM:

1. Unless you know that you will need medical services during a month, it is NOT to your benefit to pay us your excess income that month.

2. If you pay your excess income for a period and then do not use your Medical Assistance card, it may take at least a year for us to give you a refund or credit. This is because we must wait to see if any claims have been paid for you for that period.

3. If you decide you want to pay your excess income to this agency, you may do so every month, or only in those months that you know you will need medical services. If you want, you may pay us for more than one month at a time, up to six consecutive months. However, if you decide to pay your excess income and then do not make a payment to us for three consecutive months, you MAY receive a notice of our intent to close your case. You may reapply for Medical Assistance if you incur or expect to incur medical expenses at least equal to your excess income and wish to make a payment or submit bills to receive coverage.

**If you did not provide proof of your resources when we determined your eligibility for Medical Assistance, you will not be eligible for coverage of long-term care services.**

**YOUR MEDICAL ASSISTANCE EXAMINER CAN ANSWER ANY QUESTIONS YOU HAVE AND HELP YOU DECIDE IF PAY-IN IS RIGHT FOR YOU.**

NON-SPENDDOWN

| Coverage Code | Resource Documentation | Benefit Package | RVI Code |
|---|---|---|---|
| 01<br>(Full Coverage) | Current Resources and previous 36/60 months (unless exempt) | All Medicaid covered services | 1 (documenters)<br>or<br>9 (exempt) |
| 10<br>(All services except Nursing Facility Services) | Current Resources and previous 36/60 months | All Medicaid covered services except nursing facility services | 4 |
| 11<br>(Legal/Alien – Full Coverage) | Current Resources and previous 36/60 months | All Medicaid covered services | 1 |
| 19<br>(Community Coverage with Community-Based Long-Term Care) | Current Resources | Coverage Code 10 **plus** up to 29 days nursing home care/12 months | 2 |
| 20<br>(Community Coverage without Long-Term Care) | Attest to value of current resources | Coverage Code 10 **plus** up to 29 days nursing home care/12 months<br>**but:** - No community-based LTC except up to 29 days CHHA/12 months | 3 |
| 24-(NYC Only)<br>(Community Coverage without Long-Term Care (legal alien during 5 year ban) | Attest to value of current resources | Same as 20 | 3 |

SPENDDOWN

| Coverage Code | Resource Documentation | Benefit Package | RVI Code |
|---|---|---|---|
| 02<br>(Outpatient Coverage) | Current Resources and previous 36/60 months | Outpatient services only (including waivered services) | 1 |
| 21<br>(Outpatient Coverage with Community-Based Long-Term Care) | Current Resources | Outpatient services **plus** up to 29 days of nursing home care/12 months<br>**but:**<br>No waiver services | 2 |
| 22<br>(Outpatient Coverage without Long-Term Care) | Attest to value of current resources | Outpatient services **plus** up to 29 days of nursing home care/12 months<br>**but:**<br>No community-based LTC except up to 29 days of CHHA/12 months<br><br>No waiver services | 3 |
| 23<br>(Outpatient Coverage with no Nursing Facility Services) | Current Resources and previous 36/60 months | Outpatient services **but** no waivered services | 4 |

# LONG-TERM CARE SERVICES

| LONG-TERM CARE | | |
|---|---|---|
| **Community-Based Long-Term Care Services** | **Nursing Facility Services** | **Short-Term Rehabilitation Services** |
| - Adult day health care<br>- Assisted living program (ALP)<br>- Certified home health agency (CHHA)<br>- Hospice in the community<br>- Hospice residence program<br>- Residential treatment facility<br>- Managed long-term care in the community<br>- Personal care services<br>- Non-waiver services in the following programs:<br>a) Long-Term Home Health Care Program<br>b) Traumatic Brain Injury Waiver Program<br>c) Care at Home Waiver Program<br>d) Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program<br>- Consumer directed personal assistance program<br>- Limited licensed home care services<br>- Personal emergency response services<br>- Private duty nursing | - Alternate level of care provided in a hospital<br>- Hospice in a nursing home<br>- Nursing home care<br>- Intermediate care facility<br>- Managed long-term care in a nursing home<br>- Home and community-based waiver services provided through the following programs:<br>a) Long-Term Home Health Care Program<br>b) Traumatic Brain Injury Waiver Program<br>c) Care at Home Waiver Program<br>d) Office of Mental Retardation and Developmental Disabilities Home and Community-Based Waiver Program | One commencement/admission in a 12-month period of up to 29 consecutive days of :<br><br>- Nursing home care<br>- Certified home health care |