TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Coverage and Enrollment

SUBJECT: Elimination of the Asset Test for the QMB and SLIMB Programs

EFFECTIVE DATE: Immediately
CONTACT PERSON: Local District Liaison:
Upstate: (518)474-8887 NYC: (212)417-4500

The purpose of this GIS is to inform local departments of social services that recent State legislation has eliminated the asset test for the Qualified Medicare Beneficiary Program (QMB) and the Specified Low Income Medicare Beneficiary Program (SLIMB), April 1, 2008. For applications that include a period of coverage prior to April 1, 2008, the resource test will apply to that period of coverage. The asset test for the Qualified Individual (QI) Program was eliminated in 2002 (see GIS 02 MA/009). The Medicaid Budget Logic system (MBL) has been changed to disregard resources in determining eligibility for all three of these Medicare Savings Programs (MSP).

In GIS 02 MA/009 and GIS 02 MA/025 districts were instructed that if an applicant that was income eligible as a QMB or a SLIMB, but had resources in excess of the QMB and SLIMB resource levels, such individuals could be eligible for the QI-1 Program. At the time, MBL automatically calculated QI eligibility for such individuals. Therefore, an individual would have been granted MSP eligibility if s/he met the income criteria for any of the three categories.

With elimination of the resource test for all MSP applicants, individuals who qualify for the MSP must be placed in the category that corresponds to their income.

No later than the next client contact or renewal (whichever is earlier), individuals who are enrolled as a QI-1, but meet the income criteria for either a SLIMB or a QMB **must** be changed to the correct MSP category based on income. The correct MSP code must be reflected both in WMS (on screen 3) and eMedNY. As a reminder, the appropriate code is "P" for QMBs, "L" for SLIMBs and "U" for QIs.

Since states are provided a limited allocation for the QI program every year, it is very important to use those funds only for cases that meet the income criteria for the QI program. Districts will receive a report which lists individuals with a budget stored on or after 4/1/08, up until the changes were made in MBL, for re-budgeting to reflect the correct MSP category.

As a reminder, eligibility for the QMB program also provides coverage for Medicare coinsurance and deductibles. Therefore, it is important for individuals who qualify for this benefit to be identified by the correct MSP category with a start date of April 1, 2008.

The DOH-4328, "Medicare Savings Program Application" (copy attached) has been revised to eliminate questions regarding resources. Also attached is a revised copy of the Medicare Savings Program Fact Sheet. Final versions and Spanish versions of these forms will soon be available on the intranet.

The renewal form for the SLIMB program and other automated client notices will be revised to reflect this new policy. For QMB cases, the regular Medicaid renewal form will continue to be used.

Districts are reminded that individuals may apply by mail for any of the Medicare Savings Programs; QMB, SLIMB or QI-1, using the one page DOH-4328 application. If applicants indicate that they wish to apply for Medicaid with or without a spenddown, or if they do not know which program they want, they must complete the common application (LDSS-2921) and appear for a face-to-face interview according to current procedures.

Individuals applying for Medicaid who are eligible for or in receipt of Medicare must have their eligibility for the MSP determined even if they do not indicate that they are applying for MSP on the LDSS-2921.

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Health Insurance Programs

MEDICARE SAVINGS PROGRAM
APPLICATION

(Please Print Clearly And Do Not Write In Dark Shaded Area)

APPLICANT	First Name		M.I.	Last Name			HOME PHONE	
HOME ADDRESS Is this a Shelter? Yes __ No__	Street		Apt.	City	State	Zip Code		County
MAILING ADDRESS *(If different from above)*	Street/P.O. Box		Apt.	City	State	Zip Code		County

NAMES (*List your name first. Include aliases and maiden name*)

	First	M.I.	Last	Date Of Birth	Sex	Social Security Number	Race/Ethnic Code
SELF							
SPOUSE							
CHILD*							

**If under 18 years of age. Attach extra sheet if necessary to list additional children.*

Race/Ethnic affiliation codes: **B -** Black, not of Hispanic origin **W -** White, not of Hispanic origin **H –** Hispanic **U -** Unknown **A -** Asian or Pacific Islander **I -** American Indian/Alaskan Native **O –** Other

Are you a U.S. Citizen? __Yes __No

If No, do you have satisfactory immigration status? Include Alien Number, Date of Status, and Date Entered Country, if applicable. __Yes __No
Alien Number _____
Date of Status (DOS) _____
Date Entered Country (DEC) _____

Is your spouse a U.S. Citizen? __Yes __No

If No, does your spouse have satisfactory immigration status? Include Alien Number, Date of Status, and Date Entered Country, if applicable. __Yes __No
Alien Number _____
Date of Status (DOS) _____
Date Entered Country (DEC) _____

APPLICANT'S MEDICARE INFORMATION Medicare # _____(*From red and blue Medicare card*)
Do you have Medicare Part A? __Yes __No Effective Date _____
Do you have Medicare Part B? __Yes __No Effective Date _____

SPOUSE'S MEDICARE INFORMATION, if applying Medicare # _____(F*rom red and blue Medicare card*)
Does spouse have Medicare Part A? __Yes __No Effective Date _____
Does spouse have Medicare Part B? __Yes __No Effective Date _____

Would you like us to consider providing retroactive reimbursement of your Medicare premium? __Yes __No

Do you or your spouse pay any health insurance premiums other than Medicare? __Yes __No Who? _____ Monthly Amount $_____

Do you or your spouse pay child/spousal support? __Yes __No Who? _____ Monthly Amount $_____

Do you or your spouse receive payments from or are named beneficiary of a trust? __Yes __No Who? _____ Value $_____

List below all available income such as: salary, wages, pension, social security, severance pay, rental or business income, etc.

Names of Applicant, Spouse, or Child under 18 (*Attach an extra sheet if necessary*)	**Who Provides the Money?** (*Name/source of Income*)	**What Amount?**	**How Often?** (*weekly, two weeks, monthly*)
		$	
		$	
		$	

Do you want to receive notices in: __ **English Only** __ **Spanish and English**

PAYMENT OF YOUR MEDICARE PREMIUM IS A MEDICAID BENEFIT

PENALTIES: I understand that my application may be investigated, and I agree to cooperate in such an investigation. Federal and State laws provide for penalties of fine, imprisonment or both if you do not tell the truth when you apply for Medicaid benefits or at any time when you are questioned about your eligibility, or cause someone else not to tell the truth regarding your application or your continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial and continuing eligibility for Medicaid or if you conceal or fail to disclose facts that would effect the right of someone for whom you have applied to obtain or continue to receive Medicaid benefits; and such benefits must be used by the other person and not for yourself.

CHANGES: I agree to inform the agency **promptly** of any change in my needs, income, property, living arrangements or address to the best of my knowledge or belief.

SOCIAL SECURITY NUMBER (SSN): If you are applying for the Medicare Savings Program, you must report your SSN, unless you are a pregnant woman. The laws requiring this are: 18NYCRR Sections 351.2, 360-1.2, and 360-3.2(j)(3); 42USC 1320b-7. SSNs are used in many ways, both within the local social services districts and also between local social services districts and federal, state, and local agencies, both in New York and in other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if absent parents can get health insurance for applicants, to see if applicants can get child support and to see if applicants can get money or other help.

CERTIFICATION OF CITIZENSHIP & IMMIGRATION STATUS: I certify, under the penalty of perjury, by signing my name on this application, that I, and/or any person for whom I am signing is a U.S. citizen or national of the United States or has satisfactory immigration status. I understand that information about me will be submitted to the United States Citizenship and Immigration Services (USCIS) for verification of my immigration status, if applicable. I further understand that the use or disclosure of information about me is restricted to persons and organizations directly connected with the verification of immigration status and the administration and enforcement of the provisions of the Medicaid program.

NON-DISCRIMINATION NOTICE: This application will be considered without regard to race, color, sex, disability, religious creed, national origin, or political belief.

CERTIFICATION: In signing this application, I swear and affirm that the information I have given or will give to the Department of Social Services as a basis for Medicaid is correct. I also assign to the Department of Social Services any rights I have to pursue support from persons having legal responsibility for my support and to pursue other third-party resources. I understand that Medicaid paid on my behalf may be recovered from persons who had legal responsibility for my support at the time medical services were obtained.

CONSENT: I understand that by signing this application/certification form I agree to any investigation made by the Department of Social Services to verify or confirm the information I have given or any other investigation made by them in connection with my request for Medicaid. If additional information is requested, I will provide it.

Applicant/Representative
Signature X _____ Date _____

Spouse Signature X _____ Date _____

Representative Address, Phone Number and Relationship _____

If after reading and completing this form, you decide that you DO NOT want to apply for the Medicare Savings Program please sign on the following line.

I consent to withdraw my application _____ Date _____

SIGNATURE OF PERSON WHO OBTAINED ELIGIBILITY INFORMATION: **x**	DATE:	EMPLOYED BY:
Eligibility Determined By Worker: _____ (DATE)		Eligibility Approved By: _____ (DATE)

CENTRAL/OFFICE	APPLICATION DATE	UNIT ID	WORKER ID	CASE TYPE	CASE NO	REUSE IND.

CASE NAME	DISTRICT	REGISTRY NO.	VER.

Effective Date _____ MA Disp. Denial Withdrawal	REASON CODE	PROXY: Yes No

Medicaid and the Medicare Savings Programs

New York State Department of Health
Office of Health Insurance Programs
2008

THE FOLLOWING PROGRAMS ADMINISTERED BY LOCAL DEPARTMENTS OF SOCIAL SERVICES AND THE HUMAN RESOURCES ADMINISTRATION IN NEW YORK CITY CAN ASSIST INDIVIDUALS/COUPLES IN PAYING FOR THEIR MEDICARE PREMIUMS.

The income below, except for full Medicaid, includes a $20 exemption.

Full Medicaid for dual eligibles (Individuals eligible for both Medicare and Medicaid): This program pays for a wide range of medical care, services and supplies as well as premiums, coinsurance and deductible payments for Medicare beneficiaries. The 2008 income and resource requirements for those applicants who are aged or certified blind or disabled are:

	Income Below	Resources Below
Single:	$ 725 per month	$ 13,050
Couple	$1,067 per month	$ 19,200

Qualified Medicare Beneficiary Program (QMB): This program can pay for the Medicare Part A and/or Part B premiums, coinsurance and deductibles. An individual can be eligible for QMB only or for QMB and Medicaid. There is no resource test if applying for QMB only. The 2008 income requirements for this program are:

	Income Below
Single	$ 887 per month
Couple	$1,187 per month

Specified Low Income Medicare Beneficiary Program (SLIMB): This program pays for the Medicare Part B premium only. Individuals can be eligible for SLIMB only or for SLIMB and Medicaid (with a spenddown). The applicant must have Medicare Part A in order to be eligible for the program. There is no resource test if applying for SLIMB only. The 2008 income requirements for this program are:

	Income Below
Single	$1,060 per month
Couple	$1,420 per month

Qualified Individual-1 (QI-1): This program pays for the Medicare Part B premium only. Individuals cannot be eligible for QI-1 and Medicaid. The applicant must have Medicare Part A. States are allotted money for this program on a yearly basis. There is no resource test for this program. The 2008 income requirements for this program are:

	Income Below
Single	$1,190 per month
Couple	$1,595 per month

Qualified Disabled and Working Individual (QDWI): This program pays for the Medicare Part A premium **only,** not Part B. The applicant must be a disabled worker under age 65 who lost Part A benefits because of return to work. The 2008 income and resource requirements for this program are:

	Income Below	Resources Below
Single	$1,754 per month	$4,000
Couple	$2,354 per month	$6,000

Applications for all of these programs may be obtained from the Medicaid office at the local (county) department of social services. The phone number for the local department of social services may be found in the government pages of the Telephone book. Within New York City, the phone number to call for the Medicaid Helpline is 1-888-692-6116. Outside of New York City call 212-639-9675.