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WHAT IS MEDICAID?

Medicaid is a federal and state funded medical assistance program that pays for approved & needed medical care for persons who meet specific eligibility requirements.

WHO IS ELIGIBLE FOR MEDICAID IN THE LONG TERM CARE SETTING?

Medicaid reimbursement of intermediate and skilled nursing home care is available to individuals who are eligible for Medical Assistance (MA) under the following categories:

- Age sixty-five (65) or over; or
- Blind because of either central visual acuity of 20/200 or less in the better eye with the use of a corrective lens or a visual field restriction of 20 degrees or less; or
- Disabled - as determined by the Social Security Administration - because of a physical or mental impairment, disease or loss which appears reasonably certain to continue throughout his/her lifetime without significant improvement and which substantially impairs his/her ability to perform labor or services or to engage in a useful occupation.

In addition, the individual must:

- Be unable to pay for nursing facility care;
- Not have resources over the allowable limits
- Be a resident of Indiana
- Be a U.S. citizen or lawfully admitted alien with permanent resident status
- Not be a resident of a public institution (except one that is Medicaid certified)

TYPES OF MEDICAL CARE AND SERVICES COVERED BY MEDICAID

(Prior Approval Authorization is Required)

- Nursing Home Services
- Physician Services
- Inpatient Hospital and Clinic Services
- Prescriptions
- Medical Supplies and Equipment
- Eyeglasses and Prosthetic Devices
- Physical Therapy
- Occupational Therapy
- Respiratory Therapy
- Speech Therapy
- Optometry Services
- Podiatry Services
- Certain Inpatient Psychiatric Care
- Medically Related Transportation
- Personal Items
- Room and Board Services

HOW IS FINANCIAL ELIGIBILITY DETERMINED?

An aged, blind or disabled individual determined to be eligible for nursing home care under the Medical Assistance program is permitted to keep $52 per month ($30 per month for SSI recipients) +$22 from the state of Indiana of his income for personal needs (haircuts, magazines, etc.) and the remaining monthly income is to be paid to the nursing facility . In some cases, the income of the recipient will be applied toward the needs of his/her spouse and dependent child(ren) or to pay for health insurance before any income is applied tqward the cost of nursing facility care.

An applicant or recipient who is unmarried may have resources valued at $2,000 or less. An applicant or recipient who is married may have resource valued at $3,000 or less if both are at the facility. If a spouse remains in the home, the amount changes . The minimum amount is $24,720 with a maximum of $123,600. Resources mean cash on hand, deposits, checking, and savings in banks or other financial institutions, stocks or bonds, and cash surrender value of life insurance policies.

MEDICAID PRE-ADMISSION SCREENING

State law requires that every individual applying for admission to a nursing facility (SNF, ICF) is pre-screened to determine whether services are available in the community which would permit the individual to remain in the community. Failure to participate in the Pre-admission Screening Program will result in the individual's ineligibility for Medicaid reimbursement for per diem in any nursing facility (SNF, ICF) in Indiana.

ITEMS NEEDED FOR MEDICAID APPLICATION

- Record of marriage
- Social Security number, Medicare claim number, Railroad Retirement number, Veterans claim number, etc.
- Record of place of birth or, if foreign born, record of naturalization or alien status
- Bank books, record of stock, bonds
- Property deeds on owned property, but which you do not live
- Burial trusts of pre-paid funeral arrangements
- All life and medical insurance policies
- Documentation of all property transferred within the past 5 years
- Records showing age and ages of dependent children in the home, such as birth certificates, baptismal records, insurance p9Jicies
- Records of your income and the income of spouse and dependent children in the home

    a. SSI benefits: the letter of entitlement
    b. Social Security benefits: the check or letter of notification (if within 12 months)
    c. Veterans benefits: the check or letter of notification (if within 12 months)
    d. Railroad Retirement benefits: the check or letter of notification (if within 12 months)
    e. Unemployment Compensation
    f. Retirement or Union Benefits check
    g. Income from rental property
    h. Earnings: name(s) of employer(s), pay status covering the last three months, verification of work expenses

WHAT LENGTH OF STAY IN A NURSING FACILITY IS AVAILABLE UNDER MEDICAID?

A Physician must certify in writing the necessity for admission to a nursing facility and the level of care required. This certification must be completed prior to or at the time of admission.

A Medical Assistance recipient remains eligible for nursing facility care as long as the level of care is approved and he/she continues to meet all financial and other legally established eligibility requirements.

If an applicant is determined to be eligible for nursing facility care under the Medical Assistance program, Medicaid may be available to pay for medical bills incurred up to three months before the month in which the application is signed.

In order to receive Medicaid payment, the facility must be currently licensed by the Indiana State Department of Health, certified as a Medicaid provider by the Indiana Department of Public Welfare and hold a current Medicaid provider agreement.

SPOUSAL IMPOVERISHMENT PROTECTION LAW

The Spousal Impoverishment Protection Law applies for nursing home admissions occurring on or after September 30, 1989. The purpose of the law is to allow the community spouse to keep some of the couple's income and assets while still qualifying the nursing home spouse for Medicaid.

A snapshot of the couple's assets is taken in order to determine the community spouse's share. The snapshot reflects the couple 's assets at the time of the Medicaid applicant's FIRST date of continuous (minimum 30 days) institutionalization (nursing facility or hospital).

When a nursing home spouse is applying for Medicaid the couple will need to complete a resource assessment tool based upon the resources (assets) owned at the snapshot date AND an application for Medicaid (which asks for information about current resources) . The community spouse's share is calculated from the resource assessment tool. The nursing home spouse's eligibility is determined from the application. Assets of a married couple are generally considered to be jointly-owned no matter in whose name they have been placed.

Assets:

The community spouse is allowed to keep a maximum of half (1/2) of the non-exempt assets up to a total of $123 ,600 or at least a minimum of $24,720. The nursing home spouse is allowed only $2,000 in non-exempt assets to be eligible for Medicaid.

Income:

The community spouse is allowed to keep all income that is solely in his/her name, plus half (1/2) of all jointly owned income. If his/her income does not equal at least $2,030 per month, he/she may keep some of the nursing home spouse's income to get up to the minimum level of $2,030 each month. If the community spouse has high living expenses, he/she may appeal to keep more of the nursing home spouse's income - bringing his/her total maximum monthly income up to $3,023. The nursing home spouse must contribute all of his/her income towards the nursing home cost except for $52 per month for personal needs and any dollar amounts for health insurance, premiums, taxes, and medical expenses not covered by Medicaid. This contribution of income towards his/her care is called his/her "liability".