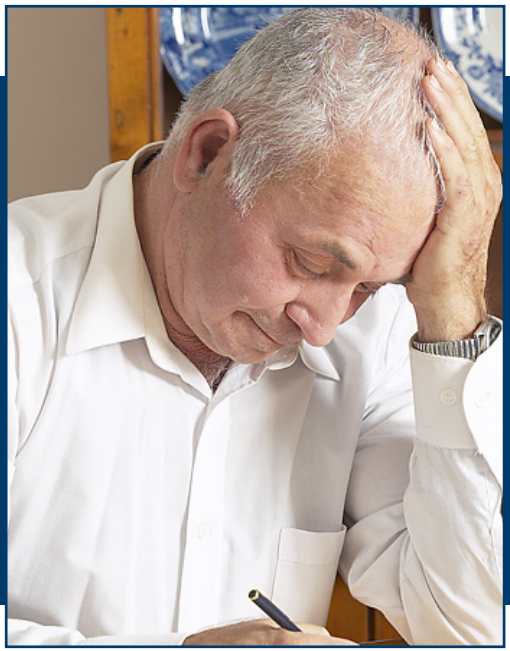
Guide to Applying for Medicaid Benefits



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Guide to The Medicaid Application Process

by

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Introduction and Overview

Someone in your life, maybe a spouse, parent or a sibling, needs long-term care or has been receiving long-term care and paying for it out of their personal funds. Now they are in need of help from Medicaid.

Medicaid is a complex program, with strict eligibility criteria and lengthy rules and regulations that change frequently. There are two different types of Medicaid benefits with various programs under each type.

Community Medicaid Benefits

Community based Medicaid applications are for elderly or disabled persons who wish to remain in the community, in the setting of their own home. This benefit requires three (3) months of financial documentation, current proof of income, along with "Common Documents" (e.g. birth certificate, health insurance card, veteran discharge papers) and the past year's income tax filings.

Currently, once benefits have been applied for and a Medicaid "pick-up" date has been established, the applicant can keep a total of $787 per month or, for a couple, $1,137, from their income. The remainder of the applicant's monthly income is then paid towards their medical costs before Medicaid will step in. When computing income, the formula is the gross monthly income (including, but not limited to, Social Security pensions, dividends, interest and annuity payments). The

only allowable deductions under Social Services regulations are health insurance premiums.

Resources, which are assets belonging to the applicant and/or their community spouse, must be reported. An individual is allowed to keep $13,800 or, a couple, $20,100.

For each individual, an assessment must be made by a home health agency, contracted with Medicaid, to determine the hours and care they will require. Should you feel that your loved one should be receiving more hours of care, or more benefits, you must file an appeal, called a Fair Hearing.

Chronic Care Medicaid Benefits

Perhaps your loved one can no longer stay at home because they have become a danger to themselves or others. In other cases, they need too much care or their caregiver can no longer manage their care. Since they may not qualify for 24/7 home care, you may want to apply for Chronic Care benefits. This type of application covers nursing home care and Long-Term Home Health Care (also known as Lombardi Program or Nursing Home Without Walls). Very few assisted living facilities are authorized to accept Medicaid.

The Chronic Care application requires a look-back of 36 months (3 years) at this time, gradually increasing to 60 months (5 years) by February 1, 2011. You must provide all financial statements of any open or closed accounts during this time period. Each county has different

requirements as to the type of documentation you must present. Some counties require copies of all checks with a value of $1,000 or more and an explanation of all deposits for this same amount while in the New York City area it is a value of $3,000 or more. Again, all "Common Documents" must be presented, three years of tax returns, proof of income, and the correct application.

The Department of Social Services will look for any gifts or transfers made during the look-back period. Each gift will incur a penalty period determined by the New York State Medicaid Regional Rates chart published each year. Should you apply before the penalty period has expired, you may be asked to provide additional documentation.

Once you have compiled the documentation and the completed application, you may have to call the Department of Social Services for an interview date or you may have to go to the department and wait until you are called. You must be prepared to answer any of the Case Examiner's questions and you may be issued a Missing Documentation List giving you ten days to provide the requested documents. Failure to provide the documentation may result in denial of the application.

On all applications, the county will investigate, requesting an IRS report for the past three years, a DMV report to see what vehicles are or were owned in the past 36 months, and a financial institution report under the applicant's and his/her spouse's Social Security numbers.

Many individuals, in attempting to file for Medicaid on their own, without the assistance of the elder law firm, complete the application incorrectly, do not provide the right documentation or give unnecessary information which causes the county to seek additional information or to deny the application. These types of errors often require a Fair Hearing to have them corrected.

An individual applying for chronic care benefits in a nursing home is allowed to keep $50 of their net monthly income after allowable deductions. The remaining income is paid to the nursing home each month before Medicaid will begin paying. The community spouse, if there is one, is currently allowed to keep $2,739 in income and, if they fall short, they may draw from the applicant's income to make up the shortfall before paying.

Resources are another concern. An individual in a nursing home is allowed to keep $13,800 in resources and the community spouse (if there is one) may keep between $74,820 and $109,560. There are additional techniques available to help the community spouse keep excess resources.

The Medicaid benefit application process can be confusing, time consuming and overwhelming. The New York State Legislature, as well as the counties, are constantly seeking ways to curb Medicaid spending, which can involve changing the rules as you go along. If you are not aware of the rules and regulations you may not even know what your current rights are.

Ettinger Law Firm has prepared thousands of Medicaid applications and can help you through these various programs and applications, especially concerning the many permissible ways to transfer and protect assets. We review the list of documentation you need to provide, compile accounting summaries for the open and closed accounts, advise you of ways to compile the documentation needed or where you may call to obtain some of the

"Common Documents". We will attend the interview with the Department of Social Services and handle all telephone calls and correspondence from them, following through until a Notice of Decision is issued. If a Fair Hearing is required, we will advise you accordingly and will represent you should you so choose.

Medicaid Eligibility Rules for Nursing Home Care

CAUTION! The rules for qualifying for Medicaid benefits change frequently and vary by state. The concepts and amounts mentioned here change on a regular basis. Before a family takes any action, a qualified elder law attorney knowledgeable in Medicaid law and the legal implications of asset transfers should be consulted.

Basic Eligibility Criteria

To be eligible for the New York State SSI-related Medicaid programs, including Chronic Care, the applicant must:

- Be a U.S. citizen or resident alien admitted for permanent residence;
- Be a resident of New York;
- Be over age 65, blind, or disabled;
- Be receiving skilled care in a Medicaid certified facility;
- Provide or file for a Social Security number;
- Assign to the State all rights to collect private health insurance benefits and long term care benefits;
- Meet the income test;
- Meet the asset test; and
- Apply for all eligibility benefits available elsewhere, such as the VA

Additional Requirement for Chronic Care Benefits: In addition to the basic criteria set forth above, Chronic Care applicants must also meet two requirements: (1) Level of Care (medical need), and (2) Asset Eligibility.

Income Criteria

Income Requirements for the Applicant: At the present time an individual is allocated $50 each month for a personal needs allowance. Gross income includes earned income as well as some unearned income and some payments that would not otherwise be deemed income by the Internal Revenue Service. For example, Social Security, including the amount deducted for the applicant's Medicare payment, is part of the gross income, as well as railroad retirement benefits, pensions, dividends, interest, rental payments, annuity payments (including the return of principal), and income from various other sources.

Income Requirements for the Community Spouse: Currently, the spouse at home, known as the "community spouse" may keep up to $2,739 per month of the couple's combined income. This portion is known as the "Minimum Monthly Maintenance Needs Allowance" or "MMNA" for short. There are some instances when the "institutionalized" spouse must contribute towards the needs of the community spouse. In order to raise the community spouse's monthly income to the $2,739 level, the institutionalized spouse's income is allocated to the community spouse. This spousal diversion of funds requires additional information as part of the application process. Under certain circumstances, the community spouse's income may exceed the $2,739 level. This is done after the institutionalized spouse receives his/her personal needs allowance of $50.

Asset Criteria

Types of Assets: Definitions

Exempt assets: Those assets that a person is allowed to own, the value of which is not counted when determining Medicaid eligibility.

Nonavailable assets: Assets not counted because the applicant, or the community spouse, has no means of accessing that particular asset and, therefore, it is not available.

Assets that produce monthly income: These assets are counted as income and not as assets, and are also considered nonavailable.

If assets do not fall into one of the above categories, they are considered countable. All countable assets are valued at their fair market value when determining Medicaid eligibility.

Asset Requirements

Applicant: The applicant cannot own countable assets in excess of $13,800, plus any exempt, nonavailable assets and income producing assets.

Community Spouse: The current asset requirements for Medicaid eligibility state that the community spouse can retain between $74,820 and $109,560 in assets, plus any exempt, nonavailable and income-producing assets.

When Both Spouses are Institutionalized: If both spouses are in a nursing home, they may each retain $13,800 in assets, plus any exempt, nonavailable and income producing assets.

Exempt Assets: Types

Homestead: Medicaid considers the homestead to be an exempt asset, as long as the community spouse is residing there; however, if the home has an equity interest above $750,000 it becomes an available asset but only to the extent of the excess. Home equity is calculated using the current market value of the home minus any debt. The current market value is the amount for which it can reasonably be expected to sell on the open market in its geographic area.

Motor Vehicles: One motor vehicle valued at less than $4,500 is exempt for an individual and a community spouse can own one motor vehicle, regardless of value.

Personal Property: Exempt if it does not include valuable art or jewelry.

Life Insurance: Exempt if the total combined face value of all policies is $1,500 or less. If the total combined face value of all policies exceeds $1,500, only the cash value of the policy is an available asset.

Burial Plan: A burial plan up to $1,500, or an irrevocable burial plan in any amount, are considered exempt.

Income Producing Assets: Assets that produce a fair market income are not counted as assets, but as income only.

Excess Assets: Planning Techniques

CAUTION! In the event the applicant and his/her spouse have excess assets, steps can be taken to become Medicaid eligible without spending all of the funds on the nursing home. Again, a note of caution: all of these rules and laws are changing on a regular basis.

Interspousal Transfers: A transfer of assets may take place between spouses without impacting upon any look-back period. Thus, regardless of when the applicant had assets, if the transfer was made to the spouse, that transfer will be deemed an exempt transfer and will not impact on Medicaid eligibility.

Asset Spend-Down: Asset spend-down focuses on the "best use of funds analysis". This strategy suggests a choice between paying the nursing home until all available assets are used up, or using funds to enhance asset value and add to the quality of life by purchasing exempt assets, reducing debt, or improving exempt property. Asset spend-down does not result in any disqualification from Medicaid and is a legal means of qualifying for Medicaid more quickly. Some examples of asset spend-down are as follows:

If there is a mortgage on the homestead property of the community spouse, the mortgage can be paid off in order to reduce the assets. Since homestead is an exempt asset for the community spouse, satisfying the mortgage is not a disqualifying transaction.

The community spouse may make improvements, repairs and replacements to the homestead, including repairing or replacing the roof, purchasing new furniture and appliances, carpeting, painting the house, etc.

Since the community spouse will be making many trips to the nursing home, he or she might consider purchasing a new motor vehicle. No disqualification will occur because a motor vehicle is considered an exempt asset.

If there are no funeral arrangements, it is imperative that they be made for both the applicant and the community spouse, and paid for as soon as possible. Contracts should be made irrevocable and the contract must clearly state this. These funds are protected by law so that they are guaranteed to be available when needed.

Personal Service Contracts: The Medicaid beneficiary and/or the beneficiary's spouse may enter into a personal service contract with someone who agrees to provide personal services to them for the rest of their actuarial life span. The contract must be entered into only if the party to whom services will be provided has not been declared terminally ill at that time. So long as there is a good faith contract, that contract may be for fair market value at reasonable hourly rates and may be prepaid in its entirety for the actuarial life span of the Medicaid applicant or his/her spouse. This prepayment will not be deemed a gift and will not affect Medicaid eligibility.

The party entering into the agreement may be a relative. However, whomever is entering into the agreement must in fact perform the services and keep time records to document it. It should be noted that the income derived from the personal service contract is subject to income tax (including self-employment tax), which can create negative consequences. Nevertheless, in many cases, the personal care contract is a viable planning device, especially when a child is providing care for a parent and is not working as a result.

Gifting

Transfers Prior to February 8, 2006

All transfers made prior to February 8, 2006, by either the applicant or applicant's spouse, to an individual, have a 36 month look-back period from the date of the transfer. Beginning February 2009 the look-back period increases by one month, each month, until it reaches a 60 month look-back period in 2011. All transfers made to a trust prior to February 8, 2006 have a five year look-back period from the date of the transfer.

The transfers that Medicaid evaluates are transfers for less than fair market value, and uncompensated transfers. A transfer for fair market value (for example, selling a house for $100,000 when its fair market value is $100,000) is considered exempt so long as fair market value is substantiated. Any transfers for less than fair market value, and any uncompensated transfers made prior to February 8, 2006, have a penalty period beginning from the date of the transfer. Medicaid has conducted surveys to establish the average cost of nursing home care within the county the applicant resides and applies that figure to the amount transferred to determine the penalty period or length of time the applicant is ineligible for Medicaid benefits.

Example: Applicant transferred $90,000 to her son in January 2006. The average monthly cost of nursing home care in the area is $9,000, therefore the applicant is ineligible for Medicaid benefits for ten months from the date of the transfer.

Transfers Subsequent to February 8, 2006

If a Medicaid applicant or the applicant's spouse made or makes an uncompensated transfer, or a transfer for less than fair market value,

on or after February 8, 2006, then the penalty period resulting from the transfer begins on the later of the following dates:

The date the individual would otherwise meet all other eligibility requirements, except for the transfer. Eligibility requirements include being a resident of a nursing home, in receipt of Medicaid covered services and meeting the resource allowance.

The first day of the month in which the individual transferred the asset.

The first day following the end of an existing penalty period.

All uncompensated transfers, including those within the applicable look-back period, will be aggregated to determine the penalty period, which will only begin to run when the applicant is otherwise eligible for Chronic Care Medicaid benefits.

Example: Applicant transferred $90,000 to his son on January 1, 2008. He then applies for Medicaid in January 2011, at which time he meets all eligibility requirements except for the uncompensated transfer. The average cost of monthly nursing home care has been determined to be $9,000. The penalty period begins to run at that point. Medicaid would deem him ineligible for benefits for the next 10 months. He would be eligible, assuming the other criteria were still met, in November 2011.

As an aside, once the penalty period is imposed, the penalty period will continue even though the individual may no longer meet all of the criteria for eligibility for the entire penalty period, such as the receipt of new assets, being discharged from the nursing home and not in need of nursing home care.

Annuities: Balloon annuities are now considered an "available" asset and cease to be a viable planning tool if purchased or annuitized after February 8, 2006. Immediate, level payout annuities are not transfers for less than fair market value if they meet the following criteria:

Annuity Criteria - Medicaid Applicant
Irrevocable and non-assignable

- Actuarially sound using the life expectancy tables of the SSA, Office of the Chief Actuary. (In other words, it must be paid off in full within the life expectancy of the annuitant).
- Immediate pay with equal payments and no balloon or deferred payments
- Meet the beneficiary requirements below

Annuity Criteria - Community Spouse

- Actuarially sound using the life expectancy tables of the SSA
- Meet the beneficiary requirements

Annuity Beneficiary Requirements: Applicant and Community Spouse: Applicants and their spouses must disclose to the State of New York any interest they have in any annuities. If purchased after February 8, 2006, or if any beneficiary changes are made to any annuity purchased prior to this date, the State must be named as a remainder beneficiary either at the time of approval or upon recertification. The State must be named as remainder beneficiary in the first position for

the total amount of medical assistance paid by the State on the annuitant's behalf. If the applicant has a spouse, minor child or disabled child, the State must be named in the second position after the community spouse, minor child or disabled child.

Gift and Loan: "Gift and Loan" is based on the premise that saving half of the assets is a desirable planning opportunity. Half of the excess resources are gifted out of the applicant or applicant's spouse's name. The other half is loaned, through a promissory note, to someone, usually an adult child The amount gifted creates a penalty period, or length of time the applicant is ineligible for Medicaid and the promissory note is structured to be used, in additional to the monthly income, to pay the nursing home expenses during the penalty period.

Transfers to Disabled Child: If there is a disabled child who has obtained a disability determination from the Social Security Administration, or could obtain one if he/she has not yet done so, a transfer to that child will not be treated as an uncompensated transfer, and no penalty period will be imposed on the Medicaid applicant as a reuslt of that transfer. Of course, one must ensure that the transfer to the disabled child does not cause that child to lose any governmental benefits. In such a case, transfer may be made to a Supplemental Needs Trust for the benefit of the child. A transfer is also exempt if made to any other trust for the benefit of that child, as long as it is for the sole benefit of that child.

Spousal Refusal – Just Say No: Currently, under New York State Law, the community spouse may retain all of his or her assets and refuse to share these monies to assist with the spouse's long-term care needs. An institutionalized spouse may not be determined to be ineligible based upon a community spouse's resources, provided all of the following conditions are found to exist:

The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse's resources and the community spouse refuses to use the resources for the institutionalized spouse.

The institutionalized spouse assigns to the State any rights to support from the community spouse by submitting an Assignment of Support Rights form, signed by the institutionalized spouse or his or her representative. Currently, if the community spouse is the only person with the power of attorney, Social Services refuses to recognize that assignment. The institutionalized spouse would be eligible if only those resources to which the institutionalized spouse had access were counted and he or she had no other means to pay for the nursing home care. Additionally, the community spouse must provide all information and full disclosure to Medicaid of his or her assets and income. Failure to provide same will result in a denial of Medicaid for lack of cooperation and disclosure.

Excess Assets Planning Techniques: A Note About Tax Considerations

Some of the strategies mentioned thus far have tax implications that cannot be avoided. In fact, some may cause adverse income tax results. Thus, these strategies are considered asset protection planning, rather than financial planning in the general sense. We believe that it is critical that clients recognize this distinction. Families should seek tax advice from a qualified tax accountant, or an experienced elder law attorney, so they clearly understand the tax ramifications of these

Medicaid planning strategies.

Undue Hardships: In the event Medicaid would be denied because of uncompensated transfers or excess home equity, an application for an undue hardship can be made upon appeal. A claim would be made that imposing a period of ineligibility deprives the individual of medical care, endangering his or her life and health, because no alternative resources are available for the individual.

Estate Planning and Asset Protection: The irrevocable Medicaid trust is used to protect assets from nursing home costs. The applicant and/or the applicant's spouse are the grantor(s), or creator(s) of the irrevocable trust. Most people choose one or more of their adult children to act as trustee(s) or manager(s) of the irrevocable trust. Since principal is not available to the grantor(s), the client will not want to put all of their assets into such a trust. Assets that should be left out are IRA's, 401(k)'s, 403(b)'s, etc. The principal of these qualified assets are generally exempt from Medicaid and should not be placed into a trust, as this would create a taxable event requiring income taxes to be paid on all of the IRA, etc. If the institutionalized client has a community spouse, up to about $100,000 may also be exempted. Notwithstanding that the home is exempt if the community spouse is living there, it is generally a good idea to protect the home sooner rather than to wait until the first spouse has passed, due to the five year look-back period.

Estate Recovery: Pursuant to federal law, each state must set forth the manner of estate recovery for Medicaid recipients. Currently, under New York State Law, recovery can be made only from the recipient's probate estate upon the recipient's death, not from the spouse.

About the Author and Ettinger Law Firm

Principal attorney Michael Ettinger has been a member of the New York State Bar since 1980. He is an honors law graduate of McGill University in Montreal, Canada and obtained his Master of Laws from the London School of Economics in 1978. Ettinger Law Firm, dedicated exclusively to estate planning and elder law, was formed in 1991. Mr. Ettinger is a founding member of both the American Academy of Estate Planning Attorneys and the American Association of Trust, Estate and Elder Law Attorneys.

Ettinger Law Firm has prepared thousands of estate plans using trusts and has filed thousands of Medicaid applications. Our staff of attorneys and experienced Medicaid professionals provide you with over fifty years of combined experience in estate planning and elder law.

The law firm offers a free, one hour consultation to help you determine whether our services may be of benefit to you and your family. Please call us at 800-500-2525, ext. 10 to schedule your free consultation.

Please also visit our website, trustlaw.com, for office locations and directions and for more information about estate planning and elder law. Thank you for considering Ettinger Law Firm for your estate planning and elder law needs.

Testimonials

"We were very impressed with the knowledge, expertise and professionalism of your office. We've even recommended your firm to other attorneys. Thank you for making a confusing issue much clearer." — R.W.

"In our opinion your documents are excellent, and we receive many compliments from other professionals re: the thoroughness and clarity of our dox." — M. & C. W.

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