

NEW YORK STATE OFFICE FOR THE AGING

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David A. Paterson, Governor

Michael Burgess, Director

An Equal Opportunity Employer

PROGRAM INSTRUCTION

Number 10-PI-05

Supersedes 09-PI-18

Expiration Date

DATE: June 3, 2010

TO: Area Agency on Aging Directors

SUBJECT: Revised Maximum Housing Adjustment for 2010 Financial Levels for EISEP and CSE Client Cost Share Determination

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ACTION REQUESTED:

Effective May 26, 2010 all Area Agencies on Aging (AAAs) and their subcontractors must:

- Use the maximum housing adjustment figures in this Program Instruction in conducting client financial assessments and reassessments to determine cost sharing amounts for Expanded In-home Services for the Elderly Program (EISEP) services and Community Services for the Elderly (CSE) funded EISEP-like services, and
- Use the attached "Client Cost Sharing Thresholds and Schedules—Effective May 26, 2010."

For current clients, AAAs are permitted to implement the revised maximum housing adjustment at the next scheduled reassessment. However, AAAs may, and are encouraged to, implement this revision immediately for those clients who would benefit from this change.

PURPOSE:

- To inform AAAs of the revised maximum housing adjustment that must be used in determining client cost sharing for clients receiving EISEP or CSE-funded EISEP-like services.
- To transmit the “Client Cost Sharing Thresholds and Schedules—Effective May 26, 2010” that reflect the revised maximum housing adjustment.
- To transmit a copy of the optional financial assessment form for use in determining client cost sharing and potential Community Medicaid eligibility. This form incorporates the revised maximum housing adjustments used to determine cost sharing in EISEP and for CSE-funded EISEP-like services.
- To transmit the “Instructions – Financial Information and Client Agreement” that has been revised to reflect the change in the maximum housing adjustment.

BACKGROUND:

New York State Office for the Aging (NYSOFA) regulations governing EISEP and CSE-funded EISEP-like services require that income thresholds and cost share schedules be adjusted to reflect changes in the Consumer Price Index for all items between the third quarters of the preceding two calendar years. The regulations also prohibit AAAs from providing EISEP or CSE-funded services to individuals who can receive the same or similar services under other governmental funding sources, including Medicaid. Therefore, each year we provide AAAs with updated information on income and resource allowances under Medicaid, as well as the updated figures relevant for determining client cost sharing. The updated information for 2010 was provided in December, 2009.

However, since that time, there have been changes to regulations governing EISEP. One such change concerns the maximum housing adjustment that can be applied to an individual's or couple's income. It has increased from 20% of the income threshold to 40% of the income threshold. As a result, it is necessary to make the revisions as described in this Program Instruction.

SUMMARY OF CHANGES:

Effective May 26, 2010 the maximum housing adjustment for determining cost share for EISEP and CSE-funded EISEP-like services has been increased from \$275 and \$370 to \$550 and \$741 for an individual and couple, respectively in the attached documents as follows:

- The Financial Assessment and Client Agreement on page 2, Section 3;
- The Instructions - Financial Information and Client Agreement on page 4; and
- The Client Cost Sharing Thresholds and Schedules in section B.2.

Each AAA continues to have the choice of using the “Financial Information and Client Agreement” form or adapting it to collect additional local information or to better suit local needs.

AAAs using a client assessment tool that is part of their computer software but who continue to use a paper document to conduct the financial assessment, may want to contact their software vendor to determine if there is an electronic financial assessment tool available for their use. Where there is such a tool, the AAA will want to inform their software vendor of the changes described in this document.

If you have any questions or comments about this Program Instruction or its attachments please contact Sandra Abrams.

PROGRAMS AFFECTED:

<input type="checkbox"/> Title III-B	<input type="checkbox"/> Title III-C-1	<input type="checkbox"/> Title III-C-2
<input type="checkbox"/> Title III-D	<input type="checkbox"/> Title III-E	<input checked="" type="checkbox"/> CSE
<input checked="" type="checkbox"/> EISEP	<input type="checkbox"/> NSIP	<input type="checkbox"/> Title V
<input type="checkbox"/> Other:	<input type="checkbox"/> SNAP	<input type="checkbox"/> Energy
	<input type="checkbox"/> HIICAP	<input type="checkbox"/> LTCOP

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Expanded In-home Services for the Elderly Program

CLIENT COST SHARING THRESHOLDS AND SCHEDULES

Effective May 26, 2010

A. Monthly Income Thresholds

INDIVIDUAL = \$1,375

COUPLE = \$1,852

B. Housing Adjustment Thresholds

1) To be eligible for a housing adjustment, average monthly housing expenses must be more than the following:

INDIVIDUAL = \$550

COUPLE = \$741

2) The amount of the housing adjustment cannot be more than the following maximum amounts:

INDIVIDUAL = \$550

COUPLE = \$741

C. Cost Share Rate Schedule

INDIVIDUAL				COUPLE			
Adjusted Income		Fee Rate		Adjusted Income		Fee Rate	
\$0		0%		\$0		0%	
\$1	to	\$48	5%	\$1	to	\$65	5%
\$49	to	\$97	10%	\$66	to	\$130	10%
\$98	to	\$145	15%	\$131	to	\$195	15%
\$146	to	\$193	20%	\$196	to	\$260	20%
\$194	to	\$241	25%	\$261	to	\$325	25%
\$242	to	\$290	30%	\$326	to	\$390	30%
\$291	to	\$338	35%	\$391	to	\$455	35%
\$339	to	\$386	40%	\$456	to	\$520	40%
\$387	to	\$434	45%	\$521	to	\$585	45%
\$435	to	\$483	50%	\$586	to	\$650	50%
\$484	to	\$531	55%	\$651	to	\$715	55%
\$532	to	\$579	60%	\$716	to	\$780	60%
\$580	to	\$627	65%	\$781	to	\$845	65%
\$628	to	\$676	70%	\$846	to	\$910	70%
\$677	to	\$724	75%	\$911	to	\$974	75%
\$725	to	\$772	80%	\$975	to	\$1,039	80%
\$773	to	\$820	85%	\$1,040	to	\$1,104	85%
\$821	to	\$869	90%	\$1,105	to	\$1,169	90%
\$870	to	\$917	95%	\$1,170	to	\$1,234	95%
* More than		\$917	100%	* More than		\$1,234	100%

***Or eligible for Medicaid.**

Instructions Form # 361 (Rev. May 26, 2010)

Financial Information and Client Agreement

This is an optional form that may be used:

- To collect information on income and housing expenses in order to determine the cost sharing responsibilities for clients receiving Expanded In-home Services for the Elderly Program (EISEP) or Community Services for the Elderly (CSE) EISEP-like services;
- To collect information in order to determine potential eligibility for Community Medicaid; and
- As the client's cost share agreement, affirmation of the accuracy of the financial information provided, acknowledgement of being informed of his/her rights under EISEP and CSE and acceptance of the Care Plan.

AAAs may choose to use this form, the alternative form, "Cost Share Determination and Client Agreement" or their own adaptation of either form to carry out these purposes.

The calculation of client cost share and completion of the client agreement usually take place in coordination with the client assessment or reassessment. As of July 14, 1999, the New York State Office for the Aging regulations provide that the reassessments take place at least every 12 months.

Throughout these instructions, the applicant or client is referred to as the "person." Line by line instructions are given only for those entries which are not self-explanatory.

Section 1: Case Information

1. If the person is married and living with a spouse who is also an applicant or client, enter the name of that person on the line provided. In this case, complete the remaining sections of this form for the couple. Only one form is required for the two people.

3. You should return to this item later in your assessment as you use additional sources of information. Review financial records and documents if you doubt the accuracy or validity of information provided by the person or representative.

Section 1: Case Information (Continued)

4. Persons who refuse to provide financial information may receive EISEP services if:

- They state that their income and/or resources make them ineligible for similar in-home services under Medicaid or any other government program; and
- They agree to pay the full cost of services.

With such persons, check the box on Line 4, and explain that the person may receive in-home, ancillary and/or non-institutional respite services (note only those services relevant to the person) if he/she agrees to pay their full cost. If the person is still interested, complete Section 4: Cost Share Calculation, fill in dollar amount in Section 6: EISEP or CSE Client Agreement, item D, discuss items F & G, and obtain person's signature. No other section of this form need be completed.

Section 2: Monthly Income

Section 2 gathers information essential to the cost share calculation and is used to screen for potential Medicaid eligibility.

Use Column A for a person who is (1) not married, or (2) married but not living with spouse, or (3) married and living with a spouse who is not an EISEP applicant.

Use Column B for information about the spouse of a person in case (3) above. (In this case, complete Column A for the person and Column B for the spouse.)

Use Column C for a married couple, when both are applicants or clients.

1. Enter the monthly amount received from each source of income by the person and spouse. Use net income, after expenses incurred in producing the income and federal, state and local income taxes are deducted. Net income cannot be less than \$0.00. Be sure to use the most up-to-date income information that is available.

1.a. This is the Social Security income after the Medicare Part A and B premiums have been deducted. Medicare Part D premiums are not deductible from the calculation of income available for cost sharing. Therefore, if a Part D premium has been deducted from the person's Social Security check, the amount of the premium must be added to the Social Security income.

1.b. Any person with Supplemental Security Income (SSI) is already certified for Medicaid - check asterisked box at the bottom of the page and refer the person to your local Department of Social Services (LDSS) for services. (If the person has not received a Medicaid card, contact LDSS). No other sections of this form need be completed.

Section 2: Monthly Income (Continued)

1.g. "Other" must include any:

- Net income from farm and non-farm self employment;
- Net income from buying and selling real or personal property which produces income, i.e., capital gains;
- Net income from roomers, boarders, or from the rental of property; and
- All other regular sources of income not listed in 1.a. through 1.f. or explicitly excluded below.

Exclude (do not count) income from the following sources:

- German War Reparations (or reparations from any other country);
- Earned income from wages, salary or stipends received under:
 - Title V, Older Americans Act;
 - Workforce Investment Act (Title II);
 - Foster Grandparents; or
 - Other programs established to foster employment of lower income elderly.
- Unearned income from:
 - One-time lump sum payments such as insurance benefits (however, interest or other regular income subsequently received from one-time lump sum payments will be counted as income);
 - Irregular gifts or contributions, IT-214 Property Tax Credits/ Rebate; and
 - Income from home equity conversion plans, i.e. "reverse mortgages" (funds received from such plans are debts that must be paid in the future).

Do not use the value of goods, services or benefits received in-kind when you calculate monthly income. The value of Food Stamps, Home Energy Assistance Program (HEAP) benefits and all other goods, services or benefits received in-kind are not considered income.

3. Add columns A and B for a married person living with a spouse who isn't an applicant or client.

Section 2: Monthly Income (Continued)

4 - 6. Complete lines 4 through 6 only for a married person living with a spouse who isn't an applicant or client. Ask if any part of the spouse's income is not available for the couple's mutual needs. Any reason provided is acceptable. Enter on Line 4 the monthly amount of the spouse's income not available.

Compare the computed monthly income to the income threshold noted on the form. The computed monthly income is found as follows:

Individual - Line 2, Column A

Couple/1 Client - Either Line 3 or Line 5

Couple/Both Clients - Line 2, Column C

If the income is at or below the threshold, the person(s) will pay no cost share. Check the last box at the bottom of the page and skip to Section 4, Line 1. Enter "0" as fee rate, and follow instructions for Section 4.

Look at the care plans of the person or couple. If the care plans include no EISEP or CSE-funded Personal Care Level I, Personal Care Level II, non-institutional respite, or ancillary services, this person will pay no cost share. Check the box at the bottom of the page and skip to Section 5.

For all other persons, proceed to Section 3.

Section 3: Housing Expenses and Income Adjustments

This section calculates adjusted income, and excludes portions of the person's income from the cost sharing calculation.

An Income Threshold, Housing Adjustment Threshold and Maximum Housing Adjustment help determine the amounts excluded. They are preprinted on the form. (This information is updated at the start of every year. Be sure you are using a form for the current year.)

Income Threshold - protected income for every person is equivalent to 150% of the previous year's poverty levels, updated annually for changes in the cost-of-living.

Housing Adjustment Threshold - 40% of the Income Threshold.

Maximum Housing Adjustment - 40% of the Income Threshold.

The Housing Adjustment is income that is protected if a person's monthly housing expenses are more than the Housing Adjustment Threshold. This protected income cannot be more than the Maximum Housing Adjustment.

Section 3: Housing Expenses and Income Adjustments (Continued)

To ensure that the income protected by the Income Thresholds and Housing Adjustment is not used for required cost share fees, the dollar amount of fees cannot be more than the person's Maximum Monthly Fee. **The Maximum Monthly Fee an applicant/client can be required to pay is the amount of her/his Adjusted Income.**

1. Enter the monthly rent or mortgage payment made by the person or spouse. If housing is rent free, enter "0."
2. Costs that do not occur monthly must be averaged so that an average monthly cost can be entered on the appropriate line.

On line 2.g. enter any other housing expense that can be justified to maintain the home in a safe and habitable condition, e.g. homeowners insurance, snow removal, garbage removal, lawn care (only that needed to maintain safety and habitability). Do not include other household or personal expenses, as these are not allowable adjustments.

3. Add lines 1 and 2.h. and enter the total on line 3. Use the "Individual" column for a person who is (1) not married, or (2) married but not living with a spouse or (3) married and living with a spouse who is not an EISEP applicant or client and has income **all of which is declared unavailable to meet mutual needs.**

Use the "Couple" column when both are applicants or clients, or for a couple, when one is an applicant or client and the other has some income available to meet mutual needs, or for such a couple when the spouse has no income at all.

5. If Line 4 is more than Line 3, enter "0": the person is not eligible for a housing adjustment.
7. Enter the net monthly income available from Section 2. For an "Individual," use the amount on Line 2A of Section 2. For a "Couple," use the amount on Line 2C or Line 5 in Section 2.
8. Enter the amount of "excess housing expenses" from Line 5, but not more than the "maximum adjustment" on Line 6.
9. Subtract Line 8 from Line 7 and enter the amount.

11. The amount in Line 11 is the Adjusted Monthly Income and is the Maximum Monthly Fee that may be charged a client, regardless of the fee calculated in Section 4. 2.c.

Section 4: Cost Share Calculation

1. If you have not already completed Line 1 as a result of information in Section 2, complete it now. Consult the Cost Share Rate Schedule for the current year and determine the person's fee rate based on the amount of adjusted income in Section 3, Line 11 and cost share status (either individual, if you used column A in Section 3, or couple if you used column B in Section 3). The fee rate for a person who will provide no financial information is 100%. The fee rate for a potentially Medicaid eligible person is 100%. **If the fee rate is "0," check the box below Line 1 and skip to Section 5.**

2. Enter the number of units of service per week (Un/svc per wk.) from the Care Plan. Use the blank lines for any non-institutional respite services or ancillary services.

For a couple, both of whom are EISEP applicants or clients, services include the units of service from the care plans of both people. Multiply by 4.3 (weeks) to estimate units of service per month for each service. If these numbers are decimals, round them up to the next highest whole numbers.

Enter the "Unit Cost" from your local office for the aging schedule of unit costs. Multiply the unit cost by the number of units of service per month and enter the resulting cost per month for each service in the right hand column.

Add all of the service lines and enter the sum on Line 2.a. - "Total cost for one month."

No client may be required to pay more than the Maximum Monthly Fee (Section 3, Line 11). Therefore, enter the smaller amount, (either Line 2.c or 2.d) on Line 2.e. This is the estimated monthly cost share amount. **There is an exception for the potential Medicaid-eligible person -- the cost share is always 100% of the cost of the services.**

Section 5: Community Medicaid Pre-Screen

This section applies only to an individual or couple 65 or older or where the person or spouse is under 65, but disabled. If the person or the spouse is under 65 and not disabled, or if the household includes people other than the older person or couple, check the appropriate box(es) at the top of the page and **skip to Section 6**. If you believe the person may be eligible for Medicaid, consult your LDSS.

Allowable Resources (printed in the upper right-hand margin) are the maximum dollar amounts of resources that a Medicaid-eligible person and couple may possess. (Be sure you are using the current form.)

Please note that viable medical bills (including recurring medical expenses) and the total cost of EISEP in-home services may be used to reduce an applicant's excess resources. Therefore, it is important to determine if such bills exist before deciding that

Section 5: Community Medicaid Pre-Screen (Continued)

an individual does not appear to be Medicaid-eligible due to excess resources and before checking any boxes in the right hand margin.

1. Enter "0" if the household has none of the listed resources. For any type of resources owned by the person or spouse, enter the amount.

NOTE: Do not double-count income included in Section 2. Subtract from checking, savings or other accounts any income received during the current month and deposited in these accounts.

Add Lines 1 a through e, and enter in the appropriate column on Line 1.f.

3. If a person's or couple's adjusted total liquid assets (Line 3) are greater than the allowable resources, check the box next to Line 3 and **skip to Section 6.**

4. If the person and spouse own any real property other than an "exempt" home and an automobile, enter the value in the appropriate column. An exempt home is one the person is living in, or if not now living in, intends to return to. If the person does not intend to return to that home, it is counted as a resource. For a non-cash resource, enter the estimated market value. Do not include property, such as furnishings necessary for daily living.

5. After adding the value of real property to the adjusted liquid assets (Line 3), compare the total on Line 5 to the allowable resources. If the combined value of property and liquid assets is above the Medicaid eligibility limit, check the box next to Line 5 and **skip to Section 6.**

6. Determination if the person (or Spouse) has any life insurance policies. Enter the combined face value of the life insurance policies (the basic death benefit or maturity amount of the policy, specified on its face) on Line 6a if it is \$1,500 or less per person. If the face value is over \$1,500 per person, enter the cash surrender value (the amount the insurer will pay upon cancellation of the policy before death or maturity) on Line 6b.

Note: Term life insurance is excluded from this calculation and does not count as a resource.

7. After adding the countable value of life insurance (Line 6a or 6b) to other resources (Line 5), compare the total (Line 7) to the allowable reserve. If the combined value of insurance, property and liquid assets is above the Medicaid eligibility limit, check the box next to Line 7 and **skip to Section 6.**

8. If the person and/or spouse is earning a salary or wage, contact your LDSS to determine what portion of the salary or wage is disregarded as income for purposes of determining Medicaid eligibility. Subtract the disregarded earnings from the income in Section 2. Enter the result on Line 8.

Section 5: Community Medicaid Pre-Screen (Continued)

9. Health insurance means policies that pay for medical services that are provided to the person or spouse only. This includes union or employer-based health fund premiums; other hospital, medical, dental and long term care insurance; and prescription drug insurance. The latter includes EPIC and Medicare Part D premiums (whether deducted from Social Security check or bank account, or paid directly by the person or couple). Do not include Medicare Part A and B premiums because they were already deducted from the amount of the Social Security check listed in Section 2. Do not include policies that pay cash amounts directly to the beneficiary for each day of hospitalization. Divide annual premiums and enter the monthly amount.

10. Line 10 is an income disregard. An elderly couple is entitled to only one \$20 disregard. Do not double this amount for a couple.

11. Add Lines 9 and 10 and enter in the appropriate column.

14. If the amount on Line 12 is larger than that on Line 13, subtract Line 13 from Line 12 and enter the difference on Line 14, which is the Excess Income Program liability level for this person or couple (Excess Income Program was formerly referred to as the “spend down”). If Line 13 equals or exceeds Line 12, check the box below Line 14, refer the applicant/client to LDSS for complete eligibility determination, and **skip to Section 6**. For all other persons continue with Line 15.

Lines 15 and 16 estimate the person’s or couple’s medical expenses that may be applicable to “spending down” income and/or resources to qualify for Medicaid on the Excess Income Program.

15. Enter the estimated monthly cost of Medicaid reimbursable services from the COMPASS or assessment tool you use including the full cost that EISEP or CSE pays for Personal Care Level I and/or Level II services for the person or couple.

16. Enter recurring medical expenses, such as hospital, pharmacy, doctor and other health care bills including health insurance premiums listed on Line 9 above.

17. Enter the sum of Lines 15 and 16. If Line 17 equals or exceeds Line 14, and if the person has enough income above the amount needed for living expenses to pay the amount on Line 14, the person may be eligible for Medicaid on the Excess Income Program. **Refer the person to LDSS for a complete eligibility determination.** If the person will receive EISEP services while Medicaid eligibility is being determined, turn to Section 6.

NOTE: This concludes the information gathering and calculations necessary for cost sharing and screening for potential Medicaid eligibility. Return to Section 1 and re-check sources of information, if necessary. Then proceed with Section 6.

Section 6: Client Agreement

For the period covered by this assessment each person or couple, if both are clients or applicants, will sign the agreement.

Parts A – D of the agreement cover four different client cost sharing circumstances. For each person/couple only one part applies. The different circumstances are listed according to the frequency of use as follows:

Part A: No Cost Share

Part B: Cost Share

Part C: Cost Share for Potential Medicaid Clients

Part D: Pay Full Cost – No Financial Information

Your selection of the part to use is based on the results of information gathered in previous sections of this form as follows:

Section 1, Line 4: Person will provide no financial information – use Part D.

Section 2, box at bottom of page: Care Plan includes no EISEP or CSE-funded Personal Care Level I, Personal Care Level II, non-institutional respite or ancillary services – use Part A.

Section 4, Line 1: Fee rate is '0' – use Part A.

Section 5, below Line 14: Resources and income indicate potential Medicaid eligibility – use Part C

All other applicants required to cost share – Use Part B.

NOTE: Two copies of the signed agreement are needed: a copy is to be left with the person(s); and the original is to be maintained in the client file as evidence of agreement to cost share, affirmation of information accuracy and receipt of information on client rights, including Client's Right to Settlement Conference, Hearing and Appeal and a person's agreement with the Care Plan.

The copy placed in the client file (or another one if preferred) can also be used by appropriate staff for client billing and for fiscal monitoring on estimates of services expenditures and program income for the period.

Parts A – D: Check the box next to the Part that applies and complete the appropriate blanks.

Section 6: Client Agreement (Continued)

For Part B

Enter the fee rate from Section 4, Line 1.
Enter the maximum monthly fee from Section 3, Line 11.
Enter the estimated fee from Section 4, Line 2.e

For Parts C & D

Enter the full cost of services from Section 4, Line 2.a.

Parts E, F & G apply to all persons/couples.

Part E: complete all the blanks. If the agreement is being signed by a representative of the person(s), the first blank must be completed with the name of the representative followed by 'on behalf of' and the client's name(s). If the client is able, he/she should sign the agreement.

NOTE: As stated in Section 6654.6(f)(6) and the Standards for Cost Sharing, a redetermination is not required when the following changes have taken place:

- Schedule of unit costs;
- Cost Share Schedule;
- Income threshold; and/or
- The client's income resulting from cost of living adjustments in Social Security or other income subject to periodic adjustments based on the cost-of-living, consumer price index.

Part F: The person(s) must be informed of their Rights and the rights to a Settlement Conference, Hearing and Appeal. These must be explained and discussed in depth and in a manner such that it is reasonable to expect that they understood what was said.

Part G: The Case Manager must review the Care Plan with the person or their authorized representative.

- **Check Yes** if the client or representative has reviewed and accepted the Care Plan.
- **Check No** if the Case Manager reviews the Care Plan with the client or representative and they do not accept it. Services cannot begin if client/representative does not acknowledge acceptance of the Care Plan by signing it.

Expanded In-Home Services for the Elderly Program
Financial Information & Client Agreement

1 1. Name: Last First M.I.
For a married couple when both are participating, enter name of second person:

Case Information

Name: Last First M.I.

- 2. Initial Assessment Reassessment
3. Sources of Information Check all that are applicable Person(s) Spouse Financial Records
4. Person(s) will provide no financial information Skip to Sections 4, then 6D
5. Financial Assessment Prepared by: Name Date

2 Monthly Income

Table with 3 columns: Source, Amount (A. Person, B. Person's Spouse, C. Couple/Both Clients), and various income sources like Social Security, SSI, Pension, etc.

- * Check if person receives SSI and is automatically Medicaid certified. Refer to LDSS
Check if person's care plan includes no EISEP or CSE-funded EISEP-like services, other than case management. Skip to Section 5
Check if Monthly Income is below the income threshold (for an individual, Line 2, Column A is \$1,375 or less; for a couple, Line 2 Column C or Line 5, combined Columns A & B is \$1,852 or less). Skip to Section 4, Line 1, and enter "0" as Fee Rate.

3

Housing Expenses & Income Adjustment

1. Monthly rent or mortgage payment _____
2. Other **monthly** expenses allowable as adjustment, paid from person's or spouse's income but not included in rent or mortgage payment:
 - a. Electricity _____
 - b. Other heating & cooking fuels _____
 - c. Telephone installation & local usage _____
 - d. Water & sewage _____
 - e. Property taxes _____
 - f. School taxes _____
 - g. Other (Specify) _____
 - h. **Total (Lines 2a through 2g)** _____

	Amount	
	A. Individual	B. Couple
3. Total allowable housing expense (Lines 1+2h)		
4. Housing adjustment threshold	-\$550.00	-\$741.00
5. Excess housing expenses (Line 3 minus Line 4)		
6. Maximum adjustment	\$550.00	\$741.00
7. Net monthly income (from Section 2, Line 2 or 5)		
8. Adjustment (enter either Line 5 or Line 6, whichever is less)		
9. Monthly income after deduction of excess housing costs (Line 7 minus Line 8)		
10. Amount of income threshold	\$1,375.00	\$1,852.00
11. Adjusted Income and Maximum Monthly Fee (Line 9 minus Line 10)		

4

Cost Sharing Calculation

1. Fee rate (from cost share rate schedule or instructions at bottom of Section 2) _____%

Fee rate is 0, no cost share is required. **Skip to Section 5 - Medicaid Pre-Screen**

2. Estimate of monthly cost share:

Service	Un/Svc. per week	Un/Svc. per month	Unit Cost	Cost per Month
Personal Care Level I	X 4.3 wks =	X	\$ =	\$
Personal Care Level II	X 4.3 wks =	X	\$ =	\$

- a. Total cost for one month \$
- b. Fee rate (Line 1, above) %
- c. Fee for one month (Total cost X rate) \$
- d. Maximum monthly fee (Enter from Section 3, Line 11) \$
- e. Estimated monthly cost share (Enter lesser of c or d) \$

5

Community Medicaid Pre-Screen

Check if household includes one or more people in addition to the person and spouse

Check if person or spouse is under age 65 and is not disabled

If either or both of the above boxes are checked, **Skip to Section 6.** Consult LDSS if you believe person or couple is Medicaid eligible.

RESOURCES		Single Person Household	Two Person Household	2010 Allowable Resources 1 Person: \$13,800 2 Persons: \$20,100
1. Liquid Resources				
	a. Checking accounts	\$	\$	
	b. Savings accounts	\$	\$	
	c. Other cash accounts	\$	\$	
	d. Stocks, bonds, mutual funds, etc.	\$	\$	
	e. Other liquid assets (IRAs, etc.)	\$	\$	
	f. Total liquid assets	\$	\$	
2. Subtract \$1,500 per person to be set aside as a burial fund		-\$1,500	-\$3,000	
3. Subtotal of Line 1.f minus Line 2				
4. Real Property : Net value of real property (other than exempt home and an automobile). Include second home, land, rental property, etc.				
5. Subtotal (Line 3 + Line 4)				<input type="checkbox"/> Line 5 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* Skip to Section 6. For all others, continue with Line 6.
6. Life Insurance				
	a. Face value of life insurance (\$1,500 or less per person)			
	b. Cash value of life insurance (if face value is over \$1,500 per person)			
7. Subtotal (Line 5 + Line 6a or 6b)				
INCOME				<input type="checkbox"/> Line 7 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* Skip to Section 6. For all others, continue with Line 8. *Note: Viable medical bills may reduce excess resources -see Instructions
8. Enter total amount from Section 2 Line 2 or 5 in appropriate column				
Subtractions				
9. Health Insurance Premiums	\$			
10. Income Exclusion	\$ 20.00			
11. Total Subtractions	\$	-	-	
12. Remaining net income (Line 8 minus Line 11)				
13. Net monthly Medicaid income level		\$767	\$1,117	
14. If Line 12 equals/exceeds Line 13 enter difference				
<input type="checkbox"/> Line 13 exceeds Line 12. Refer person to LDSS for Medicaid eligibility determination and Skip to Section 6. For all others continue with Line 15.				
MEDICAL EXPENSES				
15. Estimated monthly cost of Medicaid reimbursable services from the care plan.				
16. Estimated other medical expenses (list type and monthly amount)				
17. Total medical expenses (sum of Lines 15 and 16)		\$	\$	
If Line 17 equals or exceeds Line 14 and if the person or couple has enough income above the amount needed for living expenses to pay the Excess Income Program liability noted on Line 14 refer to LDSS for complete eligibility determination. Continue with Section 6.				

6

EISEP or CSE Client Agreement

Name(s) of Client(s): _____

Time Period Covered by this Agreement: _____ to _____

Check box if this section is part of the agreement

A. Agreement – No Cost Share

I understand that, based on the information I have provided, I am not required to pay a fee for my EISEP or CSE EISEP-like services for the period covered by this agreement.

Check box if this section is part of the agreement

B. Agreement – Cost Share

I agree to pay a fee for the services I receive under EISEP/CSE for the period covered by this agreement. This fee will not exceed _____% of the cost of services I receive in a month or \$_____, whichever is less. This does not include the cost of case management, which is free.

The estimated fee I will pay each month is \$_____, based on the services I expect to receive from EISEP/CSE. However, I will not be charged for any services I do not actually receive.

Check box if this section is part of the agreement

C. Agreement – Cost Share for Potential Medicaid Clients

I understand that I appear to be eligible for Medicaid and I understand that I must apply for Medicaid. During the Medicaid application and determination process, I request that the EISEP/CSE services, as set in my care plan, be provided to me.

I understand that I am responsible for the cost of these services in the amount of \$ _____ per month for the period covered by this Agreement. However, I will not be charged for any services I do not actually receive. I understand that if I am found Medicaid-eligible, Medicaid will pay for these services as authorized by Medicaid. I understand that I will be under no further financial obligation to EISEP/CSE when I am determined eligible for Medicaid. If I am ineligible for Medicaid, this agreement will be ended, and a new agreement will be drawn based on my income, housing costs and living arrangements. This new agreement may, if necessary, include a cost share for the period of this agreement.

Check box if this section is part of the agreement

D. Agreement – Pay Full Cost, No Financial Information

I decline to provide the information required for this form. I believe my income and resources make me ineligible to receive similar in-home or case management services under Medicaid or any other government program. I understand that by refusing, I am ineligible to receive cost-sharing assistance under EISEP/CSE. I elect to receive the services for which I am eligible by this agreement and to pay the full cost of the services, \$_____ per month, for the period covered by this agreement. However, I will not be charged for any services I do not receive.

I understand that should I decide to provide all of the information requested on this form, I have the opportunity to request and receive re-determination of the amount of the fee I am required to pay. To request this, I will contact _____ at _____. A re-determination under this section shall take effect no earlier than the date of the new agreement.

E. Affirmation of Financial Information

I, _____, affirm that the financial information given here is true and correct to the best of my knowledge and agree that this information may be checked as necessary. I realize that any false statements or misrepresentation knowingly made by me in connection with this financial assessment may result in my being ineligible for services.

I understand that future changes in income, housing expenses, living arrangement, or medical expenses could affect this agreement. I agree to notify _____ at _____ of any changes if they occur. I understand that if changes occur, my cost share may be recomputed from the time of the change. If I have overpaid, I will be reimbursed in full by the local office for the aging. If I have underpaid, I will pay the amount owed. If a mistake is found, I understand that my cost share may be recomputed from the time services began.

I have been fully informed of the policy and procedure for paying fees and understand that failure to pay may make me ineligible to receive services under EISEP or CSE.

F. Rights

I have been informed of my rights under EISEP and CSE and have received a copy of these rights. My case manager has explained them to me, answered my questions, and assured me that any other questions will be answered at any time I wish.

