

NEW YORK STATE OFFICE FOR THE AGING

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David A. Paterson, Governor

Greg Olsen, Acting Director

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PROGRAM INSTRUCTION

Number: 10-PI-19

Supersedes: 10-PI-05

Expiration Date:

DATE: December 29, 2010

TO: Area Agency on Aging Directors

SUBJECT: 2011 Financial Levels for EISEP and CSE Client Cost Share and Medicaid Eligibility Determination

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ACTION REQUESTED: Effective January 1, 2011 all Area Agencies on Aging (AAAs) and their subcontractors must:

- Use the figures in this Program Instruction in conducting client financial assessments to determine cost sharing amounts for Expanded In-home Services for the Elderly Program (EISEP) services and Community Services for the Elderly Program (CSE) funded EISEP-like services, and to determine potential Medicaid eligibility of clients in these programs, and
- Use the “Instructions -- Financial Information and Client Agreement” which was transmitted with 10-PI-05.

PURPOSE:

- To inform AAAs of the 2011 financial levels that must be used in determining client cost sharing and potential Community Medicaid eligibility for clients receiving EISEP or CSE-funded EISEP-like services. Please note -- these are the same as those used in 2010.
- To transmit the “Client Cost Sharing Thresholds and Schedules – Effective January 1, 2011.” Please note – these are the same as those used in 2010, as updated in 10-PI-05.
- To transmit a copy of the optional financial assessment form for use in determining client cost sharing and potential Community Medicaid eligibility. Please note -- the only change to this form is to reflect the year “2011.”

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 instructions for the “Financial Information and Client Agreement” form were revised in 2010 and included in 10-PI-05, the PI that transmitted the “Revised Maximum Housing Adjustment for 2010 Financial Levels for EISEP and CSE Client Cost Share Determination.” While this PI supersedes 10-PI-05, please continue to use the instructions that were attached to it.

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.

SUMMARY OF CHANGES: The “Financial Assessment and Client Agreement” form has been updated. The only change made this year is to the year in the upper right hand corner of the form to read “Calendar Year 2011.” The income thresholds, housing adjustments, and Medicaid income and resource levels are the same as they were for 2010.

The income thresholds and cost share schedules are revised each year to reflect changes in the CPI-W (U.S., all items) between the third quarters of the current and previous calendar years. However, there was no increase in the CPI-W (U.S., all items) between the third quarters of calendar years 2008 and 2010. (This is also the reason why there will be no cost-of-living increase in Social Security benefits as of January 1, 2011). Therefore, the income thresholds, housing adjustment thresholds and cost share schedules remain the same.

The following figures continue to be in effect as of January 1, 2011:

- Income Thresholds are \$1,375 and \$1,852 per month for an individual and couple, respectively;
- Housing Adjustment Thresholds are \$550 and \$741 per month for an individual and couple, respectively; and
- Maximum Housing Adjustments are \$550 and \$741 per month for an individual and couple, respectively.

The 2011 Medicaid income and resource levels established by the New York State Department of Health (SDOH) for determining Community Medicaid eligibility remain the same as they were in 2010. Therefore, the income and resource levels continue to be as follows:

- Income levels are \$767 and \$1,117 per month for an individual and couple, respectively; and
- Resource levels are \$13,800 and \$20,100 for an individual and couple, respectively.

Because the housing adjustment thresholds, income thresholds and the Community Medicaid allowable resource and income levels for 2011 are the same as for 2010, the only revision in the attached form is to reflect the year “2011.”

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 ask for instruction in using their product’s electronic financial form. When using any electronic forms provided by a vendor, always ensure that you are using the most recent version of that form and that it reflects the current year’s requirements.

If you have any question or comments about this Program Instruction or its attachments please contact Andrea Hoffman.

PROGRAMS AFFECTED:

- | | | | | |
|---|--------------------------------------|---|--|--|
| <input type="checkbox"/> Title III-D | <input type="checkbox"/> Title III-E | <input type="checkbox"/> Title III-B | <input type="checkbox"/> Title III-C-1 | <input type="checkbox"/> Title III-C-2 |
| <input checked="" type="checkbox"/> EISEP | <input type="checkbox"/> NSIP | <input checked="" type="checkbox"/> CSE | <input type="checkbox"/> SNAP | <input type="checkbox"/> Energy |
| <input type="checkbox"/> Other: | | <input type="checkbox"/> Title V | <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 January 1, 2011

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.**

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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) _____

3. Total allowable housing expense (Lines 1 + 2h)
4. Housing adjustment threshold
5. Excess housing expenses (Line 3 minus Line 4)
6. Maximum adjustment
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
11. Adjusted Income and Maximum Monthly Fee (Line 9 minus Line 10)

Amount	
A. Individual	B. Couple
-\$550.00	-\$741.00
\$550.00	\$741.00
\$1,375.00	\$1,852.00

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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)	\$

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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	2011 Allowable Resources 1 Person: \$13,800 2 Persons: \$20,100 <input type="checkbox"/> Line 3 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* Skip to Section 6. For all others, continue to Line 4.
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.				

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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.

