

NEW YORK STATE OFFICE FOR THE AGING

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Andrew M. Cuomo, Governor

Greg Olsen, Acting Director

An Equal Opportunity Employer

PROGRAM INSTRUCTION

Number: 12-PI-02

Supersedes: 10-PI-19

Expiration Date:

DATE: January 19, 2012

TO: Area Agency on Aging Directors

SUBJECT: 2012 Financial Levels for EISEP and CSE Client Cost Share and Medicaid Eligibility Determination

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ACTION REQUESTED: Effective January 1, 2012 all Area Agencies on Aging (AAAs) and their subcontractors must:

- Use the instructions and 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.

PURPOSE:

- To inform AAAs of the 2012 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.
- To transmit the “Client Cost Sharing Thresholds and Schedules – Effective January 1, 2012.”
- To transmit an updated copy of the optional financial assessment form for use in determining client cost sharing and potential Community Medicaid eligibility.
- To transmit a copy of the revised instructions for the Financial Information and Client Agreement. These instructions contain revised instructions for Section 4 Cost Share Calculation with a revised example for calculating the cost share for Ancillary Services.

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-19, 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 Information Assessment and Client Agreement” form has been updated.

The income thresholds and cost share schedules are revised each year to reflect the increase in the CPI-W (U.S., all items) between the third quarters of the current and previous calendar years. This year that is 3.6 percent. This increase is the same as the cost-of-living increase in social security benefits.

The EISEP income thresholds are an approximation of 150 percent of the 2012 federal poverty guidelines. They were calculated by applying the 3.6 percent cost of living increase to 150 percent of the 2011 poverty income guidelines. This method is the same method used in previous years.

The following figures reflect the changes:

- Income Thresholds are \$1,410 and \$1,905 per month for an individual and couple, respectively;
- Housing Adjustment Thresholds are \$564 and \$762 per month for an individual and couple, respectively; and
- Maximum Housing Adjustment Thresholds are \$564 and \$762 per month for an individual and couple, respectively.

Expanded In-home Services for the Elderly Program

CLIENT COST SHARING THRESHOLDS AND SCHEDULES

Effective January 1, 2012

Monthly Income Thresholds

INDIVIDUAL = \$1,410
 COUPLE = \$1,905

A. Housing Adjustment Thresholds

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

INDIVIDUAL = \$564
 COUPLE = \$762

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

INDIVIDUAL = \$564
 COUPLE = \$762

B. Cost Share Rate Schedule

INDIVIDUAL				COUPLE			
Adjusted Income		Fee Rate		Adjusted Income		Fee Rate	
\$0		0%		\$0		0%	
\$1	to \$49	5%		\$1	to \$67	5%	
\$50	to \$99	10%		\$68	to \$134	10%	
\$100	to \$148	15%		\$135	to \$201	15%	
\$149	to \$198	20%		\$202	to \$267	20%	
\$199	to \$247	25%		\$268	to \$334	25%	
\$248	to \$297	30%		\$335	to \$401	30%	
\$298	to \$346	35%		\$402	to \$468	35%	
\$347	to \$396	40%		\$469	to \$535	40%	
\$397	to \$445	45%		\$536	to \$602	45%	
\$446	to \$495	50%		\$603	to \$668	50%	
\$496	to \$544	55%		\$669	to \$735	55%	
\$545	to \$594	60%		\$736	to \$802	60%	
\$595	to \$643	65%		\$803	to \$869	65%	
\$644	to \$693	70%		\$870	to \$936	70%	
\$694	to \$742	75%		\$937	to \$1,003	75%	
\$743	to \$792	80%		\$1,004	to \$1,070	80%	
\$793	to \$841	85%		\$1,071	to \$1,136	85%	
\$842	to \$891	90%		\$1,137	to \$1,203	90%	
\$892	to \$940	95%		\$1,204	to \$1,270	95%	
* More than	\$940	100%		* More than	\$1,270	100%	

***Or eligible for Medicaid.**

Note: This year we are changing the cost calculation section of the FIF and the accompanying instructions. The section has been redesigned so that it is easier to complete for services that are provided on less than a weekly basis and for one time goods/items and services. While there are more items in the section, the additions are intended to reflect different types of frequency – services provided monthly, services provided less than monthly and services/goods/items that are provided once. We have used the experience of the AAA involved in the Community Living Program as the basis for this change.

The 2012 Medicaid income and resource levels established by the New York State Department of Health (NYSDOH) for determining Community Medicaid eligibility income and resource levels have been updated as follows:

- Income levels are \$792 and \$1,159 per month for an individual and couple, respectively; and
- Resource levels are \$14,250 and \$20,850 for an individual and couple, respectively.

All changes in the housing adjustment thresholds, income thresholds and Community Medicaid allowable resource and income levels have been inserted in the revised form.

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 Bob Miller.

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 type="checkbox"/> SNAP | <input type="checkbox"/> Energy |
| <input checked="" type="checkbox"/> EISEP | <input type="checkbox"/> NSIP | <input type="checkbox"/> Title V | <input type="checkbox"/> HIICAP | <input type="checkbox"/> LTCOP |
| <input type="checkbox"/> Other: | | | | |

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2012 Instructions 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, Financial Information and Client Agreement Form 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.
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.

Section 1: Case Information (Continued)

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.

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;

Section 2: Monthly Income (Continued)

- 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.

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.

Section 2: Monthly Income (Continued)

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.

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.**

Section 3: Housing Expenses and Income Adjustments (Continued)

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 5.c.

Section 4: Cost Share Calculation

For a couple, both of whom are EISEP applicants or clients, include the units of services/goods/items from the care plans of both people.

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

Section 4: Cost Share Calculation (Continued)

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.

If the fee rate is NOT “0”, continue on to complete items 2-5 for those goods/services/items for which cost sharing applies.

2. Services Recurring Monthly: This section is to calculate the cost of services that are expected to recur each month. Refer to the care plan for the services to be delivered.

Column A: Services -- Identify the service

Column B: # of Units Each Time Service is Provided -- Enter the number of units each time the service is to be provided. If these numbers are decimals, round them up to the next highest whole numbers.

Column C: Frequency per Month -- Enter the number of times the service will be provided during the month. For example, for services that are delivered every other week, enter 2 as the frequency per month. For services provided weekly, use 4.3 as the frequency to estimate units of service on a monthly basis.

Column D: Unit Cost -- Enter the “Unit Cost” established by your local office for the aging.

Column E: Monthly Cost -- Enter the Monthly Cost (Multiply Column B X Column C X Column D)

For example: Transportation provided weekly and housekeeping provided twice a month:

A	B	C	D	E
Service	# of Units Each Time Service is Provided	Frequency per Month	Unit Cost	Monthly Cost
Transportation	2	4.3	\$ 25.00	\$ 215.00
Housekeeping	5	2	\$ 15.40	\$ 154.00

Section 4: Cost Share Calculation (Continued)

2. a.: Total all the amounts in Column E and enter 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 5.c or 2.d) on Line 5.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.**

3. Services Recurring Other Than Monthly: This section is to calculate the cost of services recurring other than monthly to be prorated on a monthly basis.

Column A: Identify the service

Column B: Enter the number of units each time the service is to be provided. [e.g., transportation to the doctor = 2 units (1 unit each way)]

Column C: Enter the "Unit Cost" established by your local office for the aging.

Column D: Enter the cost (Multiply Column B X Column C).

Column E: Enter the frequency in which the service is provided.

Column F: Enter the prorated monthly cost of the service (Divide Column D by Column E).

For example: Transportation provided every other month

A	B	C	D	E	F
Service	# of Units	Unit Cost	Cost	Frequency	Monthly Cost
transportation	2 Units	\$ 35	\$70	Every 2 months	\$35

3. a. Total all the amounts in Column F and enter on line 3.a.: "Total cost for one month".

NOTE: It will be necessary to carefully monitor when each service actually starts so that the inclusion of prorated monthly costs for services provided other than monthly begin in the appropriate months.

4. One Time Services, Goods and/or Items: This section is to calculate the prorated monthly cost(s) for one time services, goods and/or items spread out over the life of the care plan (for example for a 12 month care plan it would be from 12 months to 1 month- depending on when the good or item is expected to be received).

Section 4: Cost Share Calculation (Continued)

Column A: Identify the one time service, good and/or item.

Column B: Enter the total cost of the service, good and/or item.

Column C: If it is a onetime service, enter the # of months remaining in the care plan beginning with the month the client is expected to receive the service. If it is a good or item, enter the # of months in the care plan the consumer will have the good or item

Column D: Enter the prorated monthly cost of the onetime service, good or item (Divide Column B by Column C).

For example: A ramp is expected to be provided in the 3rd month and 2 doorway thresholds removed in the 1st month of a 12-month care plan.

A	B	C	D
Service/Good/Item	Total Cost	Months Remaining in Care Plan*	Monthly Cost
Ramp	\$1,000.00	10	\$ 100.00
Remove 2 doorway thresholds	\$ 200.00	12	\$ 16.67

4. a. Total all the amounts in Column D and enter on line 4.a.: Total cost for one month.

NOTE: For consumers receiving one time services, goods and/or items it is important that they understand that their monthly cost share will, in part, be influenced by which month in their care plan they receive each one. The sooner they receive it the longer the period for prorating the costs and the lower the cost on a per month basis.

5. Monthly Cost Share: This section is to calculate the person's estimated monthly cost share.

5. a- 5.d Self Explanatory

5. e. No consumer may be required to pay more than the Maximum Monthly Fee (Section 3, Line 11). Therefore, enter the smaller amount of either Line 5.c. or 5.d. This is the estimated monthly cost share amount for all services, goods and items.

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,

Section 5: Community Medicaid Pre-Screen (Continued)

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 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.

Section 5: Community Medicaid Pre-Screen (Continued)

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.

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

Section 5: Community Medicaid Pre-Screen (Continued)

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.

Section 6: Client Agreement (Continued)

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.

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.

Section 6: Client Agreement (Continued)

- **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.

File: NYSOFA 361 Instructions **January 2012**

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) _____

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
		-\$564.00	-\$762.00
		\$564.00	\$762.00
		\$1,410.00	\$1,905.00

4

Cost Share Calculation

1. **Fee rate** for service(s) or items (from cost share rate schedule based on Section 3, line 11 or instructions at bottom of Section 2) _____%.

2. Service(s) Recurring Monthly

A	B	C	D	E
Service	# of Units Each Time Service is Provided	# of Times per Month	Unit Cost	Monthly Cost
2.a. Total cost for one month				\$

4

Cost Share Calculation Cont.

3. Service(s) Recurring Other than Monthly

A	B	C	D	E	F
Service	# of Units Each Time Service is Provided	Unit Cost	Cost	Frequency	Monthly Cost
	3.a. Total cost for one month				\$

4. One Time Services, Goods and/or Items

A	B	C	D
Service/Good/Item	Total Cost	Months Remaining in Care Plan*	Monthly Cost
	4.a. Total cost for one month		

*Based on when service/good/item is expected to be received.

5. Monthly Cost Share

- a. Total Monthly Cost (Sum of 2.a., 3.a., & 4.a.) \$ _____
- b. Fee Rate (Line 4.1, above) _____ %
- c. Fee for one month (Total cost X rate) \$ _____
- d. Maximum monthly fee (Section 3, Line 11) \$ _____
- e. Estimated monthly cost share (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	2012 Allowable Resources 1 Person: \$14,250 2 Persons: \$20,850 <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		\$792	\$1,159	
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, goods and/or items 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, goods and/or items 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 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.

I have been informed of my right to contest determinations made by the local office for the aging concerning my program eligibility for EISEP services based upon my functional condition (either a finding of no need for assistance or a finding that the needs are so great that it would not be possible for me to be maintained safely with EISEP services available to the local office for the aging), or the amount of the cost share. I also have been informed that I may contest an involuntary discharge from EISEP when the discharge arises due to failure to cost share, failure to cooperate with EISEP program requirements (such as refusal to meet with the case manager, or to agree to a care plan or to validate income information), or no expectation that I will need services for a period of the next 90 days. This includes my right to request from the local office for the aging a settlement conference to resolve any disagreement informally and/or a hearing. I also have been informed that I may appeal the local Hearing Officer's

