

**NEW YORK STATE OFFICE FOR THE AGING**

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Andrew M. Cuomo, Governor                      Greg Olsen, Acting Director  
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<b>PROGRAM INSTRUCTION</b>	<b>Number: 13-PI-09</b>
	<b>Supersedes: 10-PI-05</b>
	<b>Expiration Date:</b>

**DATE:** May 1, 2013

**TO:** Area Agency on Aging Directors

**SUBJECT: 2013 Financial Levels for EISEP and CSE-Like Client Cost Share and Medicaid Eligibility**

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**ACTION REQUESTED:** Effective May 1, 2013 all Area Agencies on Aging (AAAs) and their subcontractors must:

- Use the instructions and figures in this Program Instruction when conducting client financial assessments to determine cost sharing amounts for Expanded In-home Services for the Elderly Program (EISEP) and Community Services for the Elderly (CSE) funded EISEP-like services, and to determine potential Community Medicaid eligibility.

**PURPOSE:**

- To inform AAAs of the 2013 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, 2013.”
- To transmit a copy of the updated optional financial assessment form and instructions for use in determining client cost sharing and potential Community Medicaid eligibility.

**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 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.

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 NYSOFA provides AAAs with updated information on income and resource allowances under Medicaid, as well as the updated figures for determining client cost sharing.

Each AAA has the choice of using the “Financial Information and Client Agreement” form or adapting it to collect additional local information to better suit local needs, provided that all of the elements in the “Financial Information and Client Agreement” form are included.

### **2013 Financial Levels for EISEP and EISEP-Like CSE Client Cost Share and Community Medicaid Eligibility Levels**

**SUMMARY OF CHANGES TO EISEP AND EISEP-LIKE CSE CLIENT COST SHARE LEVELS:** The Client Cost Sharing Thresholds and Schedule have been updated to reflect the increase in the 2013 CPI-W and the federal poverty guidelines. The “Financial Information Assessment and Client Agreement” form (NYSOFA Form #361, revised March 2013) has been updated to reflect these changes and is attached. Instructions for Form # 361 are also included in this Program Instruction. Please note that no changes have been made to the Form #361 Instructions, which were last updated in 2010 and transmitted in 2010 via 2010-10-PI-05.

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, the increase is 1.7 percent, and is the same as the cost-of-living increase in Social Security benefits.

The EISEP income thresholds reflect 150 percent of the 2013 federal poverty guidelines. They were calculated by applying the 1.7 percent cost of living increase to 150 percent of the 2013 federal poverty income guidelines.

The following figures reflect the changes:

- Income Thresholds are \$1,436 per month for an individual and \$1,939 per month for an couple;
- Housing Adjustment Thresholds are \$574 per month for an individual and \$776 per month for couple; and
- Maximum Housing Adjustment Thresholds are \$574 per month for an individual and \$776 per month for a couple.
- The Client Cost Sharing Thresholds and Schedules for 2013 are attached.

## **Community Medicaid Income and Resource Eligibility Levels**

The 2013 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 \$800 per month for an individual and \$1,175 per month for a couple; and
- Resource levels are \$14,400 per month for an individual and \$21,150 for a couple.

All changes in the housing adjustment thresholds, income thresholds and Community Medicaid allowable resource and income levels are reflected in the revised “Financial Information Assessment and Client Agreement” 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, please make sure that they reflect the current year’s requirements.

If you have any questions or comments about this Program Instruction or its attachments, please contact Stacey Agnello.

### **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          |

### **CONTACT PERSON:**

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# Expanded In-home Services for the Elderly Program

## CLIENT COST SHARING THRESHOLDS AND SCHEDULES

Effective May 1, 2013

A. Monthly Income Thresholds

INDIVIDUAL = \$1,436  
COUPLE = \$1,939

B. Housing Adjustment Thresholds

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

INDIVIDUAL = \$ 574  
COUPLE = \$ 776

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

INDIVIDUAL = \$ 574  
COUPLE = \$ 776

C. Cost Share Rate Schedule

INDIVIDUAL				COUPLE			
Adjusted Income			Fee Rate	Adjusted Income			Fee Rate
\$0			0%	\$0			0%
\$1	to	\$50	5%	\$1	to	\$68	5%
\$51	to	\$101	10%	\$69	to	\$136	10%
\$102	to	\$151	15%	\$137	to	\$204	15%
\$152	to	\$202	20%	\$205	to	\$272	20%
\$203	to	\$252	25%	\$273	to	\$340	25%
\$253	to	\$302	30%	\$341	to	\$408	30%
\$303	to	\$353	35%	\$409	to	\$476	35%
\$354	to	\$403	40%	\$477	to	\$544	40%
\$404	to	\$453	45%	\$545	to	\$612	45%
\$454	to	\$504	50%	\$613	to	\$680	50%
\$505	to	\$554	55%	\$681	to	\$748	55%
\$555	to	\$605	60%	\$749	to	\$816	60%
\$606	to	\$655	65%	\$817	to	\$884	65%
\$656	to	\$705	70%	\$885	to	\$952	70%
\$706	to	\$756	75%	\$953	to	\$1,021	75%
\$757	to	\$806	80%	\$1,022	to	\$1,089	80%
\$807	to	\$857	85%	\$1,090	to	\$1,157	85%
\$858	to	\$907	90%	\$1,158	to	\$1,225	90%
\$908	to	\$957	95%	\$1,226	to	\$1,293	95%
* More than		\$957	100%	* More than		\$1,293	100%

\* Or eligible for Medicaid



# 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
<b>-\$574.00</b>	<b>-\$776.00</b>
<b>\$574.00</b>	<b>\$776.00</b>
<b>\$1,436.00</b>	<b>\$1,939.00</b>

# 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	<b>2013 Allowable Resources</b> <b>1 Person: \$14,400</b> <b>2 Persons: \$21,150</b>
<b>1. Liquid Resources</b>				
	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. <b>Real Property</b> : 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.* <b>Skip to Section 6.</b> For all others, continue with Line 6.
<b>6. Life Insurance</b>				
	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)				
<b>INCOME</b>				<input type="checkbox"/> Line 7 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* <b>Skip to Section 6.</b> 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				
<b>Subtractions</b>				
9. Health Insurance Premiums	\$			
10. Income Exclusion	\$ <b>20.00</b>			
11. Total Subtractions	\$	-	-	
12. Remaining net income (Line 8 minus Line 11)				
13. Net monthly Medicaid income level		<b>\$800</b>	<b>\$1,175</b>	
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 <b>Skip to Section 6.</b> For all others continue with Line 15.				
<b>MEDICAL EXPENSES</b>				
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. <b>Continue with Section 6.</b>				

# 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.

