

NEW YORK STATE OFFICE FOR THE AGING

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Andrew M. Cuomo, Governor

Corinda Crossdale, Acting Director

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PROGRAM INSTRUCTION

Number: 14-PI-04

Supersedes: 13-PI-09

Expiration Date:

DATE: April 10, 2014

TO: Area Agency on Aging Directors

SUBJECT: Revised 2014 Financial Levels for EISEP and CSE Client Cost Share and Medicaid Eligibility Determination

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ACTION REQUESTED: Effective January 1, 2014 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 2014 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, 2014.”
- To transmit an updated copy of the optional Financial Information and Client Agreement Form (FIF) for use in determining client cost sharing and potential Community Medicaid eligibility.
- To transmit a copy of the revised instructions for the FIF.

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

Each AAA may either use the FIF or adapt it to collect additional local information or format to better suit local needs. A modified form must minimally include the information contained in the FIF.

SUMMARY OF CHANGES: The Financial Information Assessment and Client Agreement form (FIF) has been updated to reflect current income and housing adjustment thresholds. The form and instructions have been revised to include additional questions and instructions on determining poverty levels and identifying the need to refer for potential eligibility for Veteran's benefits.

The income thresholds and cost share schedules are revised each year to reflect the increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W)(U.S., all items) between the third quarters of the current and previous calendar years. This year that is 1.5 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 2013 federal poverty guidelines. They were calculated by applying the 1.5 percent cost of living increase to 150 percent of the 2014 poverty income guidelines. This method is the same method used in previous years.

The following figures reflect the changes:

- Income Thresholds are \$1,458 and \$1,966 per month for an individual and couple, respectively;
- Housing Adjustment Thresholds are \$583 and \$786 per month for an individual and couple, respectively; and
- Maximum Housing Adjustment Thresholds are \$583 and \$786 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, 2014

Monthly Income Thresholds

INDIVIDUAL = \$1,458

COUPLE = \$1,966

A. Housing Adjustment Thresholds

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

INDIVIDUAL = \$ 583

COUPLE = \$ 786

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

INDIVIDUAL = \$ 583

COUPLE = \$ 786

B. Cost Share Rate Schedule

INDIVIDUAL				COUPLE			
Adjusted Income		Fee Rate		Adjusted Income		Fee Rate	
\$0		0%		\$0		0%	
\$1	to \$51	5%		\$1	to \$69	5%	
\$52	to \$102	10%		\$70	to \$138	10%	
\$103	to \$153	15%		\$139	to \$207	15%	
\$154	to \$205	20%		\$208	to \$276	20%	
\$206	to \$256	25%		\$277	to \$345	25%	
\$257	to \$307	30%		\$346	to \$414	30%	
\$308	to \$358	35%		\$415	to \$483	35%	
\$359	to \$409	40%		\$484	to \$552	40%	
\$410	to \$460	45%		\$553	to \$621	45%	
\$461	to \$511	50%		\$622	to \$690	50%	
\$512	to \$563	55%		\$691	to \$759	55%	
\$564	to \$614	60%		\$760	to \$828	60%	
\$615	to \$665	65%		\$829	to \$897	65%	
\$666	to \$716	70%		\$898	to \$966	70%	
\$717	to \$767	75%		\$967	to \$1,035	75%	
\$768	to \$818	80%		\$1,036	to \$1,104	80%	
\$819	to \$869	85%		\$1,105	to \$1,173	85%	
\$870	to \$921	90%		\$1,174	to \$1,242	90%	
\$922	to \$972	95%		\$1,243	to \$1,311	95%	
* More than	\$972	100%		* More than	\$1,311	100%	

*Or eligible for Medicaid.

The 2014 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 \$809 and \$1,192 per month for an individual and couple, respectively; and
- Resource levels are \$14,550 and \$21,450 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.

Area Agencies on Aging (AAAs) that use a client assessment tool that is part of their computer software and 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, AAAs must use the most recent version of that form and ensure that it reflects the current year's requirements.

If you have any question 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:

Stacey Agnello

TELEPHONE:

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**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

Other *Specify* _____

4. Person(s) will provide no financial information **Skip to Sections 4, then 6D, F and G**

5. Financial Assessment Prepared by: _____ / _____
Name Date

2

Monthly Income

1. Source
- a. Social Security:
 - b. Supplemental Security Income: (SSI)*
 - c. Pension/retirement income: (Private/gov't, veteran's benefits, annuities, IRAs, etc.)
 - d. Interest: (Monthly income).
 - e. Dividends: (Monthly average).
 - f. Salary/Wages:
 - g. Other: (Specify)
 - Other: (Specify)

	Amount		
	A. Person <i>(Individual or Couple/1Client)</i>	B. Person's Spouse	C. Couple/ Both Clients
a. Social Security:			
b. Supplemental Security Income: (SSI)*			
c. Pension/retirement income: (Private/gov't, veteran's benefits, annuities, IRAs, etc.)			
d. Interest: (Monthly income).			
e. Dividends: (Monthly average).			
f. Salary/Wages:			
g. Other: (Specify)			
Other: (Specify)			
2. Total Monthly Income.			
3. Total Monthly Income of Couple/1 Client <i>(Sum of 2A + 2B)</i>			
4. Amount of non-client spouse's income not available for mutual needs			
5. Net Monthly Income available: <i>(Line 3 minus Line 4)</i>			

- * 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 **\$1,458** or less; for a couple, Line 2 Column C or Line 5, combined Columns A & B is **\$1,966** 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) _____

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
-\$583.00	-\$786.00
\$583.00	\$786.00
\$1,458.00	\$1,966.00

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/ Month	Unit Cost	Monthly Cost
2.a. Total cost for one month				\$

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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	2014 Allowable Resources 1 Person: \$14,550 2 Persons:\$21,450
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		\$809	\$1,192	
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.

