

NEW YORK STATE OFFICE FOR THE AGING
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Andrew M. Cuomo, Governor Corinda Crossdale, Acting Director
An Equal Opportunity Employer

PROGRAM INSTRUCTION	Number: 15 - PI - 10
	Supersedes: 14-PI-04
	Expiration Date:

DATE: June 18, 2015

TO: Area Agency on Aging Directors

SUBJECT: 2015 Financial Levels for EISEP and CSE Client Cost Share and Medicaid Eligibility Determination

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ACTION REQUESTED: Effective, 2015 all Area Agencies on Aging (AAAs) and their contractors 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 2015 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, 2015.
- 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.

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 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 1.7 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 2015 federal poverty guidelines. They were calculated by applying the 1.7 percent cost of living increase to 150 percent of the 2015 poverty income guidelines.

The following figures reflect the changes:

- Income Thresholds are \$1,471 and \$1,991 per month for an individual and couple, respectively;
- Housing Adjustment Thresholds are \$588 and \$796 per month for an individual and couple, respectively; and
- Maximum Housing Adjustment Thresholds are \$588 and \$796 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, 2015

Monthly Income Thresholds

INDIVIDUAL = \$1,471

COUPLE = \$1,991

A. Housing Adjustment Thresholds

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

INDIVIDUAL = \$ 588

COUPLE = \$ 796

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

INDIVIDUAL = \$ 588

COUPLE = \$ 796

B. Cost Share Rate Schedule

INDIVIDUAL				COUPLE			
Adjusted Income			Fee Rate	Adjusted Income			Fee Rate
\$0			0%	\$0			0%
\$1	to	\$52	5%	\$1	to	\$70	5%
\$53	to	\$103	10%	\$71	to	\$140	10%
\$104	to	\$155	15%	\$141	to	\$210	15%
\$156	to	\$207	20%	\$211	to	\$279	20%
\$208	to	\$258	25%	\$280	to	\$349	25%
\$259	to	\$310	30%	\$350	to	\$419	30%
\$311	to	\$361	35%	\$420	to	\$489	35%
\$362	to	\$413	40%	\$490	to	\$559	40%
\$414	to	\$465	45%	\$560	to	\$629	45%
\$466	to	\$516	50%	\$630	to	\$698	50%
\$517	to	\$568	55%	\$699	to	\$768	55%
\$569	to	\$620	60%	\$769	to	\$838	60%
\$621	to	\$671	65%	\$839	to	\$908	65%
\$672	to	\$723	70%	\$909	to	\$978	70%
\$724	to	\$774	75%	\$979	to	\$1,048	75%
\$775	to	\$826	80%	\$1,049	to	\$1,117	80%
\$827	to	\$878	85%	\$1,118	to	\$1,187	85%
\$879	to	\$929	90%	\$1,188	to	\$1,257	90%
\$930	To	\$981	95%	\$1,258	To	\$1,327	95%
*More than		\$981	100%	*More than		\$1,327	100%

The 2015 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 \$825 and \$1,209 per month for an individual and couple, respectively; and
- Resource levels are \$14,850 and \$21,750 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 Mike Gunn.

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"/> WIN | <input type="checkbox"/> Energy |
| | <input type="checkbox"/> HIICAP | <input type="checkbox"/> LTCOP |

CONTACT PERSON:

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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 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
-\$588.00	-\$796.00
\$588.00	\$796.00
\$1,471.00	\$1,991.00

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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. **Services(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.) \$ _____

<h1 style="font-size: 2em; margin: 0;">5</h1> <p>Community Medicaid Pre-Screen</p>	<input type="checkbox"/> Check if household includes one or more person in addition to the person and spouse		<input type="checkbox"/> Check if person is under age 65 and is not disabled	
	<p><i>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.</i></p>			
RESOURCES		Single Person Household	Two Person Household	2015 Allowable Resources 1 Person: \$14,850 2 Persons: \$21,750
1. Liquid Resources				
	a. Checking Accounts	\$	\$	<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.
	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 to 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.
8. Enter total amount from Section 2 Line 2 or 5 in appropriate column.				
Subtractions				*Note: Viable medical bills may reduce excess resources – see instructions.
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		\$825	\$1,209	
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)		\$	\$	
<p>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.</p>				

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.

B. Agreement – Cost Share

Check box if this section is part of the agreement.

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.

C. Agreement – Cost Share for Potential Medicaid Clients

Check box if this section is part of the agreement.

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 similar in-home services. I understand that I will be under no further financial obligation 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.

D. Agreement – Pay Full Cost, No Financial Information

Check box if this section is part of the agreement.

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-share 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 a re-determination of the amount of the fee(s) 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 arrangements, 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.

I have been informed of my rights to disagree with local Office for the Aging decisions as to my rights to services under EISEP or CSE, including the amount of my cost share. This includes my right to request a hearing and to request a settlement conference to resolve any disagreements informally and my right to appeal to the New York State Office for the Aging of a local Hearing Officer's decision.

G. Care Plan Acceptance

The Case Manager must review the Care Plan with each client and/or their authorized representative.

I accept the Care Plan

Yes No (Explain)

_____/_____
Client/Representative Signature **Date**

_____/_____
Client/Representative Signature **Date**

_____/_____
Case Manager **Date**