# NEW YORK STATE OFFICE FOR THE AGING

2 Empire State Plaza, Albany, NY 12223-1251

Andrew M. Cuomo, Governor Greg Olsen, Acting Director

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| PROGRAM INSTRUCTION | Number: 20-PI-05 |
|---|---|
| | Supersedes: 19-PI-09 |
| | Expiration Date: |

**DATE:** **March 24, 2020**

**TO:** **Area Agency on Aging Directors**

**SUBJECT:** **2020 Financial Levels for EISEP and CSE Client Cost Share and Medicaid Eligibility Determination**

**ACTION REQUESTED:** Effective April 1, 2020 all Area Agencies on Aging (AAAs) and their contractors must:

Use the figures in this Program Instruction (PI) 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 individuals being assessed for services through these programs.

**PURPOSE:**

- To inform AAAs of the 2020 financial levels that must be used in determining client cost sharing and potential Community Medicaid eligibility for individuals being assessed to receive EISEP or CSE-funded EISEP-like services.
- To transmit the Client Cost Sharing Thresholds and Schedules – Effective April 1, 2020.
- To transmit an updated copy of the Financial Information Form (FIF) for use in determining client cost sharing and potential Community Medicaid eligibility. The financial information contained within this PI is used to update the FIF is available in the Statewide Client Data System.
- To reissue the English version of the approved EISEP and CSE Client Agreement form. This form is available in English, Spanish, Chinese, Russian, Korean, Haitian Creole, and Bengali in the Statewide Client Data System.

**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. As of 2018, (18-PI-09) NYSOFA changed the effective date for the EISEP and CSE-funded income thresholds and cost share schedules from January 1 to April 1 to align with the State Fiscal year and to reflect the most current rates.

A revised EISEP or CSE Client Agreement form was issued in 2019 as part of 19-PI-09. The EISEP and CSE Client Agreement form was distributed in English, Spanish, Chinese, Russian, Korean, Haitian Creole, and Bengali. Those forms are available in the Statewide Client Data System and remain the approved forms for statewide utilization. An English version of the EISEP or CSE Client Agreement form is contained within this Program Instruction.

**SUMMARY OF CHANGES:**

The FIF has been updated to reflect current income and housing adjustment thresholds. The following figures reflect the changes:

- Income Thresholds are $1,595.00 and $2,155.00 per month for an individual and couple, respectively;

- Housing Adjustment Thresholds are $638.00 and $862.00 per month for an individual and couple, respectively; and

- Maximum Housing Adjustment Thresholds are $638.00 and $862.00 per month for an individual and couple, respectively.

The income and resource levels provided in the Community Medicaid Pre-screen (Section 5) of this PI have been updated to reflect the amounts established by the New York State Department of Health (NYSDOH) for determining Community Medicaid eligibility. The 2020 levels are:

- Income levels are $875.00 and $1,284.00 per month for an individual and couple, respectively; and

- Resource levels are $15,750.00 and $23,100.00 for an individual and couple, respectively.

# Expanded In-home Services for the Elderly Program

CLIENT COST SHARING THRESHOLDS AND SCHEDULES

Effective April 1, 2020

A. Monthly Income Thresholds

INDIVIDUAL = $1,595.00

COUPLE = $2,155.00

B. Housing Adjustment Thresholds

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

INDIVIDUAL = $638.00

COUPLE = $862.00

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

INDIVIDUAL = $638.00

COUPLE = $862.00

C. Cost Share Rate Schedule

| **Individual** | | | | **Couple** | | | |
|---|---|---|---|---|---|---|---|
| **Adjusted Income and Maximum Monthly Fee (Section 3, Part 3, Question 11)** | | | Fee Rate | **Adjusted Income and Maximum Monthly Fee (Section 3, Part 3, Question 11)** | | | Fee Rate |
| $0 | | | 0% | $0 | | | 0% |
| $1 | to | $56 | 5% | $1 | to | $76 | 5% |
| $57 | to | $112 | 10% | $77 | to | $151 | 10% |
| $113 | to | $168 | 15% | $152 | to | $227 | 15% |
| $169 | to | $224 | 20% | $228 | to | $302 | 20% |
| $225 | to | $280 | 25% | $303 | to | $378 | 25% |
| $281 | to | $336 | 30% | $379 | to | $454 | 30% |
| $337 | to | $392 | 35% | $455 | to | $529 | 35% |
| $393 | to | $448 | 40% | $530 | to | $605 | 40% |
| $449 | to | $504 | 45% | $606 | to | $681 | 45% |
| $505 | to | $560 | 50% | $682 | to | $756 | 50% |
| $561 | to | $616 | 55% | $757 | to | $832 | 55% |
| $617 | to | $672 | 60% | $833 | to | $907 | 60% |
| $673 | to | $728 | 65% | $908 | to | $983 | 65% |
| $729 | to | $784 | 70% | $984 | to | $1,059 | 70% |
| $785 | to | $839 | 75% | $1,060 | to | $1,134 | 75% |
| $840 | to | $895 | 80% | $1,135 | to | $1,210 | 80% |
| $896 | to | $951 | 85% | $1,211 | to | $1,285 | 85% |
| $952 | to | $1,007 | 90% | $1,286 | to | $1,361 | 90% |
| $1,008 | to | $1,063 | 95% | $1,362 | to | $1,437 | 95% |
| *More than | | $1,063 | 100% | *More than | | $1,437 | 100% |

**PROGRAMS AFFECTED:** ☒ Title III-B ☐ Title III-C-1 ☐ Title III-C-2

☐ Title III-D ☐ Title III-E ☒ CSE ☐ WIN ☐ Energy

☒ EISEP ☐ NSIP ☐ Title V ☐ HIICAP ☐ LTCOP

☐ Other:

**CONTACT PERSON:**
Eileen Griffin

**TELEPHONE:**
(518) 408-1652

Email: EISEP@aging.ny.gov

## Expanded In-Home Services for the Elderly Program Financial Information

# 1

**Case Information**

1. Name: _____ _____ _____
   Last First M.I.
   *For a married couple when both are participating, enter name of second person:*

   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 Client Agreement Section-Agreement to Pay Full Cost, No Financial Information**

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

# 2

**Monthly Income**

1. Source

| | Amount of Monthly Income | | |
|---|---|---|---|
| **1.** | **A.** Person (Individual or Couple/1Client) | **B.** Person's Spouse | **C.** Couple/Both Clients |
| a. Social Security | | | |
| b. Supplemental Security Income: (SSI) | | | |
| c. Pension/Retirement Income: (Private/Gov't, veterans' benefits, annuities, IRAs, etc.) | | | |
| d. Interest: (Monthly Income) | | | |
| e. Dividends: (Monthly Average) | | | |
| f. Salary/Wages | | | |
| g. Other (Specify) | | | |
| h. Other (Specify) | | | |
| | | | |
| **2.** Total Monthly Income (total sum of lines a.-h.) | | | |
| **3.** Total Monthly Income of Couple/1 Client (*Sum of 2A 2B*) | | | |
| **4.** Amount of non-client spouse's income not available for mutual needs | | | |
| **5.** Net Monthly Income Available: (*Line 3 minus Line 4)* | | | |

☐ 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 $1,595.00 or less; for a couple, Line 2 Column C or Line 5, combined Columns A & B is $2,155.00or 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)*…… _____

| | Amount | |
|---|---|---|
| | **A.** Individual | **B.** Couple |
| 3. Total allowable housing expense *(Lines 1 + 2h)* | | |
| 4. Housing adjustment threshold | **-$638.00** | **-$862.00** |
| 5. Excess housing expenses *(Line 3 minus 4)* | | |
| 6. Maximum adjustment | **$638.00** | **$862.00** |
| 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 | **$1,595.00** | **$2,155.00** |
| 11. Adjusted Income and Maximum Monthly Fee *(Line 9 minus Line 10)* | | |

# 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. **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 | | | $ |

**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. Total Monthly Cost**

a) (Sum of **Section 4**: 2.a., 3.a., & 4.a.) $_____

b) Fee Rate (**Section 4**: 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: (Use the lesser amount among c or d above) $_____

| **5** **Community Medicaid Pre-Screen** | ☐ Check if household includes one or more person in addition to the person and spouse ☐ Check if person is under age 65 and is not disabled<br><br>*If either or both of the above boxes are checked, there is no need to complete the following section. The next step is to complete client agreement form. Consult LDSS if you believe person or couple is Medicaid eligible.* |
|---|---|

| **RESOURCES** | | Single Person Household | Two Person Household | **2020 Allowable Resources** |
|---|---|---|---|---|
| 1. **Liquid Resources** | a. Checking Accounts | $ | $ | **1 Person: $15,750**<br>**2 Persons: $23,100**<br><br>☐ Line 3 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.* |
| | 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 | | -$1,500.00 | -$3,000.00 | |
| 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) | | | | ☐ Line 5 exceeds Allowable Resources. Person appears to be ineligible for Medicaid. |
| 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** | | | | ☐ Line 7 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.<br><br>***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 | | **$875.00** | **$1,284.00** | |
| 14. If Line 12 equals/exceeds Line 13 enter difference | | | | |
| ☐ Line 13 exceeds Line 12. Refer person to LDSS for Medicaid eligibility determination and, if appropriate, complete a client agreement form**.** 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.

**6**

# Expanded In-Home Services for the Elderly Program (EISEP) or Community Services for the Elderly (CSE)

## Client Agreement

**Name(s) of Client(s):**_____

**EISEP Provider Agency:** _____

**Area Agency on Aging:** _____

**Time Period Covered by this Agreement:**_____ **to** _____

### A. Agreement – No Cost Share

☐ Check box if this section is part of the agreement.

I understand that, based on the information I have provided, I am not required to pay a fee for services under the Expanded In-Home Services for the Elderly Program (EISEP) or EISEP-like services under the Community Services for the Elderly (CSE) program 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 and/or 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 and/or CSE. However, I will not be charged for any services I do not actually receive or for services received prior to my cost sharing determination.

It is my understanding that I will receive _____ units of in-home, _____ units of non-institutional respite and _____ units of ancillary services

### 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 and/or CSE services, as set in my care plan, be provided to me.

While Medicaid eligibility is determined, I understand that I am responsible for the cost of these services in the amount of $_____ per month during the period covered by this Agreement. However, I will not be charged for any services I do not actually receive or for services received prior to my cost sharing determination. I understand that if I am found Medicaid-eligible, Medicaid will pay for similar in-home services. At the point in time when I begin receiving in-home services under Medicaid, I understand that I will no longer be required to pay a cost share for my in-home services under EISEP/CSE and that this agreement will be ended. In the event I qualify for EISEP/CSE services and supports that fall outside the scope of Medicaid, I may reapply for EISEP/CSE 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 and/or 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 or for services received prior to my cost sharing determination.

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 my Case Manager. 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 any financial information I have provided in connection with EISEP and/or CSE services is true and correct to the best of my knowledge. I 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 the type or amount of services I receive, income, housing expenses, living arrangements, or medical expenses could affect this agreement. I agree to notify my Case Manager 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 Area Agency on 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 my cost share and understand that a willful failure to pay my cost share will result in my termination from the program and will make me ineligible to receive services under EISEP and/or CSE until payment of my past cost share is received.

**F. Payment Schedules, Billing Practices, and Payment Procedures**

I agree to the agency's payment schedules, billing practices, and payment procedures, and acknowledge that a copy of such has been provided to me along with this Agreement.

**G. Client Rights**

I have been informed in writing of my rights under EISEP and/or CSE. This includes any rights I may have to request a hearing and my right to dispute the amount of my cost share that was assessed by the Area Agency on Aging.

**H. Care Plan/Cost Share Determination Acceptance**

I have been informed of my Care Plan and Cost Share determination.

**I accept the Care Plan and Cost Share Determination**

☐ Yes ☐ No (Explain)

_____ / _____

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

_____ / _____

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

**Case Manager Affirmation**

I, _____, Case Manager for _____, affirm that the information contained in this document is consistent with the information provided by the client.

**Signature:** _____ **Date:** _____

**Name (Print):** _____

**Telephone:** _____

**Email:** _____