NEW YORK STATE OFFICE FOR THE AGING

2 Empire State Plaza, Albany, NY 12223-1251

Kathy Hochul, Governor | Greg Olsen, Acting Director

An Equal Opportunity Employer

PROGRAM INSTRUCTION	Number: 23-PI-04 Supersedes: 22-PI-05 Expiration Date:

DATE: April 6, 2023

TO: Area Agency on Aging Directors

SUBJECT: 2023 Financial Levels for EISEP and CSE Client Cost Share and Potential Medicaid Eligibility Determination

....

ACTION REQUESTED: Effective April 1, 2023, 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 2023 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, 2023.
- 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 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.

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 are updated every year. 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.

The EISEP and CSE Client Agreement form in this PI is in English. Spanish, Chinese, Russian, Haitian Creole, Bengali, Korean, Italian, Yiddish, Arabic, Polish, French, and Urdu versions will be available in the Statewide Client Data System. NYSOFA will maintain compliance with Executive Law § 202-A regarding language translation services and will continue to update forms accordingly.

SUMMARY OF CHANGES:

Client Agreement Form

An amendment was made to wording within Section C, Cost Share for Potential Medicaid Clients of the EISEP and CSE Client Agreement.

The Financial Information Form

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

- Income Thresholds are $1,823.00 per month for an individual and $2,465.00 per month for a couple
- Housing Adjustment Thresholds are $729.00 per month for an individual and $986.00 per month for a couple
- Maximum Housing Adjustment Thresholds are $729.00 per month for an individual and $986.00 per month for a couple

The Community Medicaid Prescreen

The income and resource levels provided in the Community Medicaid Prescreen (Section 5) of this PI have been updated to reflect the amounts established by the New York State Department of Health for determining Community Medicaid eligibility. The 2023 levels are:

- Income levels are $1,677.00 for an individual and $2,268.00 per month for a couple
- Resource levels are $30,182.00 for an individual and $40,821.00 for a couple

Expanded In-Home Services for the Elderly Program

CLIENT COST SHARING THRESHOLDS AND SCHEDULES
Effective April 1, 2023

A. Monthly Income Thresholds

INDIVIDUAL = $1,823.00
COUPLE = $2,465.00

B. Housing Adjustment Thresholds

1) To be eligible for a housing adjustment, average monthly housing expenses must be more than the following:
   INDIVIDUAL = $729.00
   COUPLE = $986.00

2) The amount of the housing adjustment cannot be more than the following maximum amounts:
   INDIVIDUAL = $729.00
   COUPLE = $986.00

C. Cost Share Rate Schedule

Individual				**Couple**			
Adjusted Income and Maximum Monthly Fee (Section 3, Part 3, Question 11)				Adjusted Income and Maximum Monthly Fee (Section 3, Part 3, Question 11)			
Adjusted Income			Fee Rate	Adjusted Income			Fee Rate
$0			0%	$0			0%
$1	to	$64	5%	$1	to	$86	5%
$65	to	$128	10%	$87	to	$173	10%
$129	to	$192	15%	$174	to	$259	15%
$193	to	$256	20%	$260	to	$346	20%
$257	to	$320	25%	$347	to	$432	25%
$321	to	$384	30%	$433	to	$519	30%
$385	to	$448	35%	$520	to	$605	35%
$449	to	$512	40%	$606	to	$692	40%
$513	to	$576	45%	$693	to	$778	45%
$577	to	$639	50%	$779	to	$865	50%
$640	to	$703	55%	$866	to	$951	55%
$704	to	$767	60%	$952	to	$1,038	60%
$768	to	$831	65%	$1,039	to	$1,124	65%
$832	to	$895	70%	$1,125	to	$1,211	70%
$896	to	$959	75%	$1,212	to	$1,297	75%
$960	to	$1,023	80%	$1,298	to	$1,384	80%
$1,024	to	$1,087	85%	$1,385	to	$1,470	85%
$1,088	to	$1,151	90%	$1,471	to	$1,557	90%
$1,152	to	$1,215	95%	$1,558	to	$1,643	95%
*More than		$1,215	100%	*More than		$1,643	100%
*Or eligible for Medicaid							

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: (For staff use only)
Eileen Griffin

TELEPHONE:
(518) 408-1652

Email: EISEP@aging.ny.gov

For Case Manager Use Only

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 <u>**Skip to Sections 4, then Client Agreement Section-Agreement to Pay Full Cost, No Financial Information**</u>

5. Financial Assessment Prepared by:______________________/__________
   Name Date

2 Monthly Income

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

For Case Manager Use Only

.

☐ 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 $1,823.00 or less; for a couple, Line 2 Column C or Line 5, combined Columns A & B is $2,465.00 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)*…………………… ____________

		Amount	
		A. Individual	**B.** Couple
3. Total allowable housing expense *(Lines 1 + 2h)*	3.		
4. Housing adjustment threshold	4.	**-$729.00**	**-$986.00**
5. Excess housing expenses *(Line 3 minus 4)*	5.		
6. Maximum adjustment	6.	**$729.00**	**$986.00**
7. Net Monthly Income *(from Section 2, Line 2 or 5)*	7.		
8. Adjustment *(Enter either Line 5 or Line 6, whichever is less)*	8.		
9. Monthly income after deduction of excess housing costs *(Line 7 minus Line 8)*	9.		
10. Amount of income threshold	10.	**$1,823.00**	**$2,465.00**
11. Adjusted Income and Maximum Monthly Fee *(Line 9 minus Line 10)*	11.		

4

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)__________%

Cost Share Calculation

2. Services(s) Recurring Monthly

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

3. Service(s) Recurring Other than Monthly

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

4. One Time Services, Goods and/or Items

A Service/Good/Item	B Total Cost	C Months Remaining in Care Plan*	D 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) $____________

For Case Manager Use Only

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 *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	**2023 Allowable Resources** **1 Person: $30,182** **2 Persons: $40,821** ☐ Line 3 exceeds Allowable Resources. Person appears to be ineligible for Medicaid.*
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		-$1,500.00	-$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. ***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		**$1,677.00**	**$2,268.00**	
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 am applying for Medicaid and understand that 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: ______________________________