



*Helping Older Persons With
Legal & Long-Term Care
Problems*

Medicaid Eligibility For Nursing Facilities

1. Who Is Eligible?

You must be a US citizen, lawful permanent resident whose date of entry is prior to August 22, 1996 or qualified alien and a resident of Ohio. In addition, you must be blind, disabled or 65 or older, and in need of nursing facility services. The financial requirements for eligibility include a monthly countable income at or below the private pay daily rate for nursing facility care and countable resources (assets) not to exceed \$1,500. You, or an authorized representative, may apply for Medicaid at the County Department of Job & Family Services in the county where the institutionalized individual lives. Medicaid eligibility may go back three months from the application date.

2. What Are Countable Income And Resources?

Countable income is your gross monthly income minus

- (a) \$20 (if your income is unearned);
- (b) Supplemental Security Income (SSI) and other needs-based income.

Countable resources are cash, checking and savings accounts, CDs, stocks, bonds, cars if not otherwise exempt and real property not otherwise exempt, certain property transferred or put in a trust; and any other property which you could sell to pay for your care and which, in general, is legally available for your use.

3. What Resources Are Exempt?

Resources not counted in reaching the \$1,500 limit are

- (a) your home during the first 13 months you are in an institution, or after the first 13 months, if your home is occupied by a spouse, dependent or disabled child, or sibling with an equity interest who has lived in the home for at least a year;

- (b) one car of any value if you have a spouse not in a nursing home and, if you have no spouse, one car not worth more than \$4,500;
- (c) the cash value of life insurance policies if the face values total \$1,500 or less (if the face value exceeds \$1,500, then the total cash value is counted);
- (d) an irrevocable pre-need burial contract and burial plots for you and your immediate family members;
- (e) certain trusts; and,
- (f) any other resource which is not legally available to you

4. Is The Community Spouse's Income Used To Pay For The Applicant Spouse's Care?

No. The community spouse's income is not used to pay for the Medicaid eligible spouse's nursing facility care.

5. Can The Community Spouse Keep Any Of The Institutionalized Spouse's Income To Meet Monthly Expenses?

Possibly. Once the institutionalized spouse becomes eligible, the community spouse may receive a Monthly Income Allowance (MIA). The MIA is based on the following formula:

- (1) the Minimum Monthly Maintenance Need Allowance (MMMNA), which is \$1,711, plus
- (2) the excess shelter allowance (ESA).

The ESA is the amount the community spouse's shelter costs exceed \$513. The only shelter costs counted are the mortgage/rent, home insurance, property taxes and utilities. The community spouse's gross monthly income is then subtracted from the total of the MMMNA and the ESA. The remainder is the amount the community spouse may keep from the institutionalized spouse's monthly income, i.e., the MIA. Exceptional circumstances, if proved at a hearing, will allow the community spouse to keep more money, up to a federal maximum of \$2,610 per month, unless a court orders a higher amount to be paid to support the community spouse.

6. Will The Institutionalized Spouse Pay Any Income To The Nursing Facility Each Month?

Probably. This depends partly on whether the community spouse will receive a MIA as described above and how much. To determine the institutionalized spouse's patient liability, begin with the individual's gross monthly income. Next, subtract a Personal Needs Allowance of \$40. Then subtract the MIA for the community spouse. Now deduct past medical expenses, monthly ongoing medical expenses not covered by Medicaid and health insurance premiums. The remainder is the patient liability and paid monthly to the nursing facility. Patient liability is prorated for the month of admission and the month of discharge to the community.

7. May The Community Spouse Keep Any Of The Resources?

Yes. The amount the community spouse may keep depends on the total value of all available resources owned by both spouses as of the date of the Medicaid resource assessment. The Medicaid resource assessment is completed based upon the beginning of the first continuous period of institutionalization, which is defined as an admission to a medical institution (or receipt of PASSPORT or other community-based waiver services) for a period of at least thirty consecutive days.

Generally, the community spouse may keep 50% of the total resources. However, that 50% cannot be less than \$20,880, nor can it exceed \$104,400. The institutionalized spouse's half of the resources may be spent for the benefit of the institutionalized spouse, for the legal and/or financial obligations of either spouse, or for the purchase and maintenance of exempt resources, but no amount can be given away for less than fair market value. If 50% of the combined resources are more than the maximum of \$104,400, the community spouse keeps the maximum amount, which is \$101,640. When 50% of the combined resources are less than \$20,880, the community spouse keeps a minimum amount, which is \$20,880.

8. What Happens If I Give My Property Away?

As of 2/8/2006, the Federal Deficit Reduction Act of 2005 changed Medicaid gifting law as set forth below. Consult an attorney experienced in Medicaid before transferring assets for less than fair market value.

Medicaid looks back 60 months from the time you apply and enter a nursing facility to determine if you or your spouse transferred, gave away, disposed of or otherwise reduced your countable resources and income without receiving equal value in return and with the intent to give away resources in order to qualify for Medicaid. Certain transfers of available resources are permissible such as any property transferred to your spouse or to your disabled or dependent child. You may transfer the homestead property to your spouse.

Homestead property may also be gifted to your disabled or dependent child or your sibling who has an equity interest in your home and who has lived in your home during

the year before you entered the nursing facility. You may also gift your home to your adult non-disabled child if he or she lived in your home with you, took care of you for two years before you entered the nursing facility and you needed nursing facility care for those two years.

If either spouse gives away property or income, and the gift does not fit any of the above exceptions, Medicaid will presume that the gift was made to qualify for Medicaid and will not pay for your nursing facility care, hospital care or hospice care for a certain period of time, i.e., a penalty period. To avoid the penalty, you must prove with clear and convincing evidence that you made the gift either for fair value or you did not intend the gift to affect Medicaid.

The penalty period is determined by dividing the value of the gift by the average Ohio private pay rate for nursing facility services and, for gifts after 2/8/2006, runs from the time you are otherwise eligible for Medicaid. For example, a gift of \$52,470 means a penalty period of 10 months: \$52,470 divided by \$5,247 per month (average private pay rate). This penalty period also applies to PASSPORT services.

If you are denied Medicaid because of improper transfer of resources, the only exception is to provide evidence that ineligibility would cause an undue hardship. Also most asset transfers into trusts are not allowed.

9. What Happens If My Money Is In A Trust?

Most trusts are not allowed. However, there are some exceptions depending on when, why and by whom the trust is created. Some trusts that are allowed include:

- (a) special needs trusts;
- (b) pooled trusts;
- (c) qualifying income trusts (QITs); and
- (d) supplemental services trusts.

Trust rules are complicated and can have serious Medicaid consequences. You should consult an attorney experienced in Medicaid if you are thinking about setting up a trust.

10. How Do I Apply And Appeal A Medicaid Decision?

You or an authorized representative may apply in the county where the institutionalized individual lives. Financial eligibility should be decided within 45 days, and a notice of approval or denial must be mailed. Medicaid eligibility may go back three months from the application date. You may appeal any Medicaid decision that affects the amount, length or scope of coverage. Appeals are requested by writing or calling the Ohio Department of Job and Family Services within 90 days after the notice is mailed. If benefits are being terminated, a hearing must be requested within 10 days to continue the benefits during the hearing process. Administrative appeal and court review are also available.

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Pro Seniors' Legal Hotline for Older Ohioans provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If you have a concern that cannot be resolved over the phone, then the hotline will try to match you with an attorney who will handle your problem at a fee you can afford.

In southwest Ohio, Pro Seniors' staff attorneys and long-term care ombudsmen handle matters that private attorneys do not, such as nursing facility, adult care facility, home care, Medicare, Medicaid, Social Security, protective services, insurance and landlord/tenant problems.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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