

LONG TERM CARE SERVICES

F-100 PERSONS INSTITUTIONALIZED AT LEAST 30 CONSECUTIVE DAYS

The term “institutionalized” refers to a person who is receiving long-term care services in a medical or nursing facility, or has been screened and approved to receive Medicaid-covered Long-Term Care (LTC) services in the person’s home or community setting. The individual must be in the institution at least 30 consecutive days. In determining the number of days in a medical institution for eligibility purposes, include the date of admission, but not the date of discharge/death. Applications can be processed under this category prior to the 30th day based on a licensed physician’s statement the client is likely to be in the institution at least 30 consecutive days.

The client must be an inpatient in a skilled nursing facility (SNF), intermediate care facility (ICF or ICF/MR), or hospital. Time spent in an institution for mental disease (IMD) is considered when determining institutionalization for 30 consecutive days when going to or from the IMD. If, when going from the IMD to a SNF, ICF or hospital, the client was only temporarily transferred and not actually discharged, the time in the IMD cannot be counted toward length of time institutionalized.

An "outpatient" stay is less than a 24-hour period regardless of the hour of admission, whether or not a bed is used or whether or not the patient remains in the facility past midnight.

Before determining a person’s financial eligibility for a long-term care coverage category, first determine that the person resides in an institution and that all non-financial requirements have been met. Institutionalized persons must meet the same non-financial requirements as non-institutionalized persons.

Special Medicaid eligibility rules, including a higher income limit, apply to institutionalized individuals.

Specific provisions, known as spousal impoverishment, are used to evaluate the income and resources of institutionalized persons who are married.

Eligibility begins the first day of the month in which the client entered the medical facility, provided an application is received, and all other eligibility requirements met.

F-100.1 Eligibility Exceptions

- Individuals under age 65 who are inpatients in an institution for mental diseases (IMD) i.e., freestanding psychiatric hospital, **are not** eligible for Institutional Medicaid. (See chapter Addendum listing IMD facilities.)

An institution for mental diseases (IMD) is a hospital, nursing facility or other institution of more than 16 beds **primarily** engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Individuals are considered severely psychotic, emotionally ill, suicidal and a danger to themselves, others or property. In Nevada, IMDs are commonly referred to as "psychiatric hospitals." **An institution for the mentally retarded IS NOT an institution for mental diseases.**

- An inmate of a public institution is ineligible for Medicaid UNLESS the institution is a medical institution. An inmate of a penal institution is NEVER eligible for Medicaid while in the custody of law enforcement officials, UNLESS admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. If determined Medicaid eligible, this individual is eligible for any Medicaid-covered services provided to them while an **inpatient** in these facilities. If this individual becomes an inpatient of a long-term care facility, they must meet level of care and plan of care assessments to become eligible.
- Individuals under age 22 receiving inpatient psychiatric services in a Residential Treatment Center (RTC) are considered to be in an acceptable living arrangement. (See chapter Addendum listing RTC facilities).
- RTCs specialize in treating children with conduct disorders, personality disorders, depression, hyperactivity, academic failure, and/or mild learning disabilities. Medicaid will pay for services provided in the RTC if the admission was prior authorized/certified by Medicaid's Peer Review Organization (PRO).

F-105 DEFINITIONS

Institutionalized Spouse – a married person residing in a medical facility at least 30 consecutive days who has a spouse in an independent living situation.

Community Spouse – a married person who is not in a medical facility whose spouse has been residing in a medical facility at least 30 consecutive days.

Spouse – a person legally married to another under state law. In Nevada, a person is married until divorced.

Medical Facility – a facility for skilled nursing or intermediate care, or a hospital.

Spousal Share – an amount equal to one-half of the total resources (separately and jointly held) at the time of the spouse's institutionalization.

Community Spouse Maintenance Allowance – an amount of income and/or resources allocated to the community spouse to allow them to maintain residence in the community.

Personal Needs Allowance – an amount of income institutionalized Medicaid recipients are allowed to keep to meet their own needs.

Continuous Period of Institutionalization – institutionalized at least 30 consecutive days. To determine whether Spousal impoverishment resource provisions apply, a continuous period ends when the client is absent from an institution for 30 consecutive days.

Designation of Resources through a Court Order – resources and/or portions of resources ordered to the community spouse by a court of competent jurisdiction.

Liquid Resources - cash and other items that can reasonably be converted to cash within 20 workdays.

Non-Liquid Resources - items that are not cash and cannot be converted to cash within 20 workdays.

Monthly Maintenance Needs Allowance - an amount designated by a court order, or together the federal minimum maintenance need standard (150% of poverty for 2 persons), and an excess shelter allowance. This amount cannot exceed the federal maximum maintenance needs standard except as authorized by findings of an administrative review/hearing.

Housing Costs (principal place of residence) - the community spouse's expenses for rent or mortgage payment (including principal and interest), property taxes and mortgage/rental insurance. In situations where a maintenance charge is required, allow only that portion which does not include personal or individual utility expenses.

Standard Utility Allowance (SUA) – an amount established under SNAP which is the statewide average of total monthly utility costs.

- Do not allow SUA if utilities are included with the rent and cannot be separately identified.
- If the telephone service is the only utility, allow the telephone allowance instead of the full SUA.

Excess Shelter Allowance - An amount (if any) determined by subtracting the Federal Excess Shelter Deduction (30% of 150% poverty for two persons) from the community spouse's housing costs, plus the SUA.

F-110 BUDGETING PROCEDURES FOR FINANCIAL ELIGIBILITY-FORM 2203-EM

Perform the gross income test to determine if an individual is eligible as an institutional case.

Perform the net income test to determine which aid code is applicable.

F-110.1 Gross Countable Income Test (Side 1, Column 1) – Unearned Income, Earned Income and Division of Income.

- a. Enter the countable amount of all unearned income of the institutionalized individual.
- b. Enter the gross earned income of the institutionalized individual.
- c. Determine the **total gross countable income** by adding items a and b.
- d. Compare the total gross countable income to the income limit.

If the gross countable income is less than or equal to the income limit, the client is eligible as a state institutional case.

If gross countable income exceeds the income limit and the client is married, apply the equal division of income rules using column 1, item C. If one-half of the countable gross marital income exceeds the income limit, the client is ineligible for Medicaid.

Example 1: Mary is a single individual living in a skilled nursing facility and her only income is \$950 gross RSDI. Her total countable income (Side 1, Column 1, total of A and B) is \$950. The institutional income limit is \$2,313. Mary is income-eligible.

Example 2: Mary is a married individual living in a skilled nursing facility. Her income is \$2150 gross RSDI. Her spouse's income is \$750 gross RSDI. Using Side 1, Column 1, C - the gross community income is \$2900 ($\$2150 + \$750 = \2900). The institutional income limit is \$2,313. Mary is income-eligible.

F-110.2 Net Income Determination (Side 1, Column 2)

- a. Enter the countable amount of all unearned income (or one-half of marital unearned income) from Column 1.
- b. Subtract the \$20 general income exclusion from countable unearned income.

FORM 2203-EM

- c. Enter the gross amount of all earned income or one-half of the marital earned income (from Column 1) and subtract the following:
1. Any remaining general exclusion amount not offset by unearned income (example: unearned income is \$16, leaving \$4 left of the general exclusion); **and**
 2. The earnings exclusion of \$65; **and**
 3. Impairment-related work expenses (IRWE). This exclusion only applies to earned income of disabled (but not blind) individuals under age 65.
 - The expense must be reasonable; for items and/or services directly related to enabling an impaired individual to work, and are necessarily incurred by the individual because of a physical or mental impairment.
 - IRWE's are excludable if the cost is paid by the disabled individual and is not reimbursable from another source.
 4. One-half of the remaining earned income.
- d. Determine **total countable net income** by adding Column 2, A-2 and B-2.
- e. Aid Code Determination – See appendix D for current benefit levels.

SSI Institutional (SS) – These individuals are receiving the institutional \$30.00 SSI payment.

Would be SSI Eligible (WB) – These individuals have countable net income greater than \$30.00 but less than the SSI payment level, and would be receiving SSI or a state supplement if not residing in long-term care.

Special Income (SI) – These individuals have countable net income between the SSI payment level and 142% of the SSI payment level.

County Match (CM) – These individuals have countable net income exceeding the county match income limit (142% of the SSI payment level). The County pays the non-federal amount of assistance.

**F-115 RESOURCES FOR PERSONS INSTITUTIONALIZED AT LEAST 30
CONSECUTIVE DAYS**

Resources are assets, both real and personal, which an individual owns and can apply, either directly or by sale, to meet basic needs of food, clothing, shelter, and medical costs.

Real property is land, including buildings or immovable objects attached permanently to the land.

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, mobile homes, automobiles, bank accounts, etc.

Any income retained the month following the month of receipt and later, is subject to resource evaluation.

Evaluate resources at market value, less encumbrances. When the combined value of all countable resources does not exceed the resource limit, verification of encumbrances is not necessary.

When the value of countable resources is under the resource limit on any day of the month, the client is eligible for that month.

All resources must be reported at the time of application, any time there is a change, and at redetermination.

F-115.1 Ownership/Availability (Non-Spousal Impoverishment)

If institutionalized prior to 09/30/1989, contact the Eligibility and Payments Unit for non-spousal impoverishment rules.

F-115.2 Resource Provisions for Spousal Impoverishment Cases

This section applies to ALL persons who begin a "continuous period of institutionalization" (medical/mental institution or a combination of both) on or after September 30, 1989 and who have a spouse in an independent living situation. These rules apply regardless of state laws relating to community property or to the division of marital property.

If the community spouse dies prior to an eligibility decision, spousal impoverishment rules do not apply. Treat the case as a non-spousal case and apply the treatment of resource rules accordingly for all requested months of coverage.

If the institutional spouse dies prior to an eligibility decision, **spousal impoverishment rules apply. Treat the case as a spousal case from the date of application through the date of death of the institutional spouse.**

F-115.2.1 Ownership/Availability

Sole Ownership - All of the resource evaluated at market value less encumbrances is available to the applicant/recipient or community spouse.

Shared Ownership - Shared ownership of real or personal property means two or more people own it simultaneously

- Resource Jointly Owned Between Spouses
 - a) Liquid resources (bank accounts, certificates of deposit, stocks, bonds, etc.)

Consider all liquid resources held jointly between spouses as available, in their entirety, to the institutionalized spouse only. Do not consider them as an "available resource" to the community spouse when determining the community spouse resource allowance.
 - b) Non-liquid resources (real property, vehicles, etc.)

When non-liquid resources are held jointly between spouses, consider only one-half as available to each spouse when determining the community spouse resource allowance.
- Resources Jointly Held With Someone Other Than a Spouse
 - a) If the client or community spouse is able to sell or dispose of a resource without another person's signature of approval, evaluate all of the resource at market value less encumbrances and considered available to the client or community spouse.
 - b) If the client or community spouse is able to sell or dispose of his/her share of a resource without another person's signature of approval, consider that portion evaluated at market value, less encumbrances as available to the client or community spouse.

- Exceptions

When a resource is owned jointly by more than one TANF/Medicaid applicant/recipient (other than a community spouse), divide the resource equally among those applicants/recipients to whom available.

When the client is representative payee or legal guardian for managing someone else's funds, these funds are not considered the client's resource when they are kept in an account separate and apart from the client's monies **and** can be identified as being received and designated for someone other than the client.

If the client has a court order dividing resources, send a copy of the order to the Chief of Eligibility and Payments for a decision on whether DWSS can recognize the order.

F-115.2.2 Spousal Impoverishment Resource Determination

An assessment of a couple's total resources completed at the time of institutionalization.

Effective 09/01/2019, Nevada automatically allows the community spouse the maximum federal spousal resource standard. This amount does not change from year to year; it is based upon the year the institutionalized spouse applies for Medicaid, or at the time a request is received by the Division, to determine the total value of a couple's resources.

Complete this determination only once at the beginning of the first continuous period of institutionalization (beginning on or after 9/30/89).

An institutionalized spouse, community spouse or their representative(s) may submit a written and signed request to the division at any time, to determine the total value of their resources. Make the determination whether or not the institutionalized spouse is applying for Medicaid. (See Task Guide - Case Initiation 03 for more information.)

Determine and verify the total value of all countable resources owned separately or jointly by the institutionalized spouse and the community spouse as of the beginning of a "continuous period of institutionalization."

If the request is not part of an application, make a determination within 45 days from the date of request unless delays are due to non-receipt of documentation/verification from the requesting party or third party. Make up a casefile for each assessment. The casefile shall contain the written request, the signed statement of resources owned by both spouses (Form 2794-EM), documentation and verification of the market value less encumbrances of all countable resources and Form 2793-EM "Assessment and Documentation of Resources." Keep these files alphabetically and retain them indefinitely.

When an applicant applies for assistance and provides a spousal resource assessment completed from another state, review the assessment. If the assessment is correct, use the assessment as provided; however, if there is an error(s) on the assessment, re-determine the resource assessment based on the error(s) only. Once the information is correct, the assessment is accepted. If more than one resource assessment, review all assessments to determine acceptability.

Form-2793 must notify the client/spouse/authorized representative of hearing rights. If this form is printed from NOMADS, ensure that the right to a hearing is included with the form prior to mailing.

F-115.2.3 Spousal Share of Resources at the Time of Institutionalization (Section I of Form 2797-EM)

Complete this determination only once at the beginning of the first continuous period of institutionalization (beginning on or after 9/30/89).

1. Enter the community spouse's separate resources.
2. Enter the institutionalized spouse's separate resources.
3. Enter joint resources between spouses.
4. Divide TOTAL resources equally. This one-half portion of total resources is the "spousal share."

F-115.2.4 Community Spouse Resource Allowance (Section II of Form 2797-EM)

1. Enter the state Medicaid maximum.
2. Enter the spousal share (one-half of resources at the time of the first continuous period of institutionalization) up to the federal maximum.
3. Enter the administrative hearing decision amount (if applicable).
4. Enter the court ordered amount (if applicable).
5. Enter the greatest of a, b, c, or d above.

The state Medicaid and spousal share maximums change annually. Use the annual amounts applicable to the year associated with the months of requested coverage.

The amount of resources (if any) determined from this computation is the community spouse resource allowance.

F-115.2.5 Assignment of Resources at the Time of Application for Medicaid (Section III Form 2797-EM)

Complete Section III for each month of requested Medicaid coverage.

1. Enter the community spouse's separate resources.
2. Enter the institutionalized spouse's separate resources.
3. Enter joint resources between spouses.
4. Total **all** resources.

Subtract the total amount of Section II, item "f" from the total countable resources of both spouses. The difference (if any) will be the amount of resources applied toward the institutionalized spouse's resource limit. If the value exceeds the resource limit, the client is ineligible. If the value is within the resource limit, the client is resource eligible.

CAUTION: There are situations in which the client has separate resources and/or joint resources with their spouse (Section III b & c) which exceed the \$2,000 resource limit (ineligible). This situation occurs even though the protected resource amount puts the countable resources for the client's eligibility (Section III f) within the \$2,000 resource limit.

A notice is sent to the community spouse which must advise them to place an amount of resources into their name, which will leave the client's resources under the \$2,000 resource limit. This notice is generated when the spousal resource assessment is completed in the system.

F-115.2.6 Permitting Transfer of Resources to the Community Spouse

The applicant must transfer an amount up to the community spouse resource allowance to the community spouse's name only within 30 days from the date of the approval notice.

In situations in which transferring the resource(s) cannot reasonably occur within the 30-day period, the client, spouse and/or their representative(s) must substantiate the circumstances and provide an expected date the transfer will take place. **The case manager must monitor, document and verify the situation until the transfer occurs.**

The client, spouse and/or their representative(s) must continue to make every effort and take all possible steps to transfer the resource(s) to the community spouse. Failure to comply will cause the resources to count towards the institutionalized spouse's resource limit.

State law regarding court orders giving state courts guidelines when protecting income and resources for the community spouse was amended effective October 1, 1993. The guidelines provide for an equal division of income and resources OR a protection of income not to exceed the federal maximum monthly maintenance needs allowance and a protection of resources which does not exceed the federal maximum spousal share.

The court may order a greater amount of income for the support of the community spouse upon finding exceptional circumstances resulting in significant financial duress. The court may also transfer a greater amount of resources, in relation to the amount of income generated by the resource, if resources up to the federal maximum are not enough to fund the amount of income ordered.

The transfer of resources policies DO NOT apply to transfers made under the provisions above.

F-115.2.7 Separate Treatment of Resources After Eligibility is Established

During the "continuous period" of institutionalization **and** after the client has been determined eligible, no resources of the community spouse are available to the client, unless actually made available to the client.

If the community spouse in an ongoing case dies, the only assets available to the institutionalized spouse are items received by a will after an order of the probate court, or anything held in joint tenancy.

F-115.2.8 Undue Hardship

An undue hardship determination may be requested at any time when applying spousal impoverishment rules, transfer of asset provisions, or when applying the home equity interest provision.

If undue hardship is claimed as a result of a denial of eligibility for excess resources under spousal impoverishment rules, the applicant may be determined eligible, despite having excess resources, if **all** of the following conditions exist:

1. The institutionalized spouse is otherwise eligible for Medicaid without applying spousal impoverishment rules; **and**
2. The community spouse is the sole owner of liquid resources **or** non-liquid joint resources valued in excess of the federal maximum; **and**
3. The community spouse has refused to make the resources available to the institutionalized spouse; **and**
4. The institutional spouse has insufficient funds to cover the cost of institutionalized care; **and**

5. Without Medicaid, the institutionalized spouse would go without life sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

NOTE: Undue hardship requests must address each point above. Send undue hardship requests to the Chief of Eligibility and Payments for evaluation and decision.

F-115.2.9 Additional Resources Following Initial Eligibility

If the institutionalized spouse acquires a new countable resource following the initial eligibility determination, his/her resource eligibility must be re-evaluated.

Determine how much of the spousal protected resources (Line II "e") was used to transfer resources in the community spouse's name only. If there is a balance remaining, more resources countable to the institutionalized spouse can be protected for the community spouse so the institutionalized spouse remains resource eligible.

Determine if the spousal protected resources has an unused balance in an amount equal to or more than the new resource. If not, and the excess of resources is over the resource limit, terminate Medicaid coverage allowing for adverse notice. If the balance of the spousal protected resources is enough to cover the new resource, apply the transfer to community spouse provisions as outlined in this section.

Example #1: Liquid Resources

The community spousal protected resources was determined to be \$12,000. After approval, the community spouse transferred \$8,600 of resources to his/her name only. This leaves a balance of \$3,400 in spousal protected resources. Later, the institutionalized spouse receives a retroactive VA benefit check for \$13,000; \$10,000 remains the month after receipt and is a countable resource.

Since the balance of the spousal protected resources is \$3,400, this is the maximum that can be protected. The difference of \$6,600 (\$10,000 – \$3,400) remains a countable resource to the institutionalized spouse and renders him/her ineligible for Medicaid.

Example #2: Non-Liquid Resources

The institutionalized and community spouse receive an inheritance of vacant land valued at \$5,000. One-half is available to each spouse (\$2,500). The spousal protected resources was determined to be \$12,000. Of this \$12,000, the community spouse used \$6,000 to transfer resources to his/her name after approval. Therefore, the community spouse has a \$6,000 balance in resource protection.

One-half of the vacant land (\$2,500) is available to the community spouse. Since there is a balance of \$6,000 in protected resources, the institutionalized spouse remains resource eligible by protecting his/her share of the vacant land. Transfer his/her share of the vacant land (\$2,500) to the community spouse. In this example, the new balance of the spousal protected resources would then be \$3,500.

F-115.3 Resource Exemptions

Exclude one vehicle without regard to use or value.

An individual who has received benefits under a qualified long-term care partnership insurance policy is eligible for a resource disregard equal to the amount of insurance benefits paid to or on behalf of the individual at the time of Medicaid application. Allow the resource disregard even if additional benefits remain available under the terms of the policy.

Only qualified long-term care partnership policies purchased after January 1, 2007 meet the resource exemption rules. Beneficiaries must provide a certificate indicating the amount of benefits issued and certifying the policy as a qualified partnership policy. The state will not seek adjustment or recovery from the individual's estate for assets or resources disregarded.

Note: LTC resource exclusion does apply to home equity in excess of \$ [REDACTED].

F-115.4 Resource Limits

The value of all countable resources of the client cannot be more than \$2,000. When the resource limit is exceeded the case is ineligible. Individuals with home equity interest exceeding \$ [REDACTED] are ineligible for long-term care services.

F-120 PATIENT LIABILITY

Patient liability is a post-eligibility calculation to determine the total amount of the institutionalized individual's income applied to the cost of institutional care. There is no patient liability for any portion of institutionalization (full or partial month stays) in a VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.

If the community spouse dies prior to an eligibility decision, spousal impoverishment rules do not apply. Treat the case as a non-spousal case and apply patient liability rules accordingly for all requested months of coverage.

If the institutional spouse dies prior to an eligibility decision, spousal impoverishment rules do apply. Treat the case as a spousal case from the date of application through the date of death of the institutional spouse.

Obtain verification of the community spouse's gross income and housing costs.

- If income verifications are not received by the required date, the case will be completed without allowing a maintenance allowance.
- If verification of housing costs and/or utility expense is not received, compute the spousal income allowance without it.
- Notify the client on the Notice of Decision, that patient liability was determined without a maintenance allowance deduction.

If verifications are received after the patient liability has been determined, the maintenance allowance deduction will be allowed beginning the month the verification was received.

The community spouse monthly income allowance deduction will be discontinued if the agency receives information that the community spouse is not receiving the maintenance allowance.

F-120.1 Treatment of Income, Deductions and Expenses

The division of income policy DOES NOT APPLY when determining patient liability. Consider all income the payor designates as the institutionalized spouse's income when determining patient liability, unless otherwise excluded.

When determining patient liability for initial and ongoing cases, budget income for the month received and deductions/expenses for the month they are paid and/or incurred.

With receipt of unanticipated income, adjust patient liability for the month it is received, not to exceed the actual cost of care for the month.

If the payor designates payment to both the institutionalized and community spouse, consider one-half of the income available to each of them.

If the payor designated payment in the names of the institutionalized and community spouse, or both, and to another person(s), consider the income available to each person in proportion to the person's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.

If the client has a court order granting a spousal maintenance allowance, a copy of the order must be sent to the Chief of Eligibility and Payments for a decision on whether the Division of Welfare and Supportive Services (DWSS) can recognize the order. The response from the chief takes precedence.

F-120.2 Partial Month Proration

Prorate the amount of patient liability according to the number of days the client was in a facility when the person is institutionalized less than a full calendar month due to:

- a. Date of admission.
- b. Discharge to independent living, VA hospital, AGCF, FCH, freestanding psychiatric hospital or RTC.
- c. Partial month of eligibility due to transfer of asset penalty.
- d. Death.

Determine what the patient liability would be for a full month. Divide that full month amount by the number of days in the month of partial institutionalization to determine the daily amount of patient liability. Multiply this daily amount by the number of days the client was institutionalized in that month (include the day of admission but not the day of discharge/death). The result is the amount of patient liability due for the partially institutionalized month.

F-120.3 Effective Date of Patient Liability

- a. State Institutional
 - o Patient liability is effective the first month of eligibility (this includes requested months prior to the application month).
- b. State Institutional/QMB
 - o **Hospital Stay:** Establish patient liability effective the first day of institutionalization and send the appropriate notice(s). The Fiscal Intermediary will make the decision when patient liability will be collected and will advise the facility when they can begin collecting it.

c. Income Changes (ongoing cases)

- Applicants/recipients are required to report changes in circumstances by the 5th of the following month.
- When a change is reported timely, the agency is required to update the next administratively possible month, allowing 13 days advance notice if the action adversely impacts the client.
- If the change/information was not reported timely and results in a difference of \$25 or more, retroactively update the case back to the first month which should have been affected.

Example #1: The client or authorized representative fails to disclose at application that the client receives a pension each month. The case manager discovers the income at the regularly scheduled redetermination. The difference in monthly patient liability is greater than \$25. Because the *client* failed to disclose the income, patient liability is adjusted retroactively to the month that should have been affected. See FAME Task Guide Eligibility-04 for instructions on modifying P/L for a previously posted version.

Example #2: The case manager incorrectly allows a garnishment for back taxes as an income deduction, and calculates the patient liability using net income after the garnishment. The mistake is discovered during a supervisory case review. Because the *agency* incorrectly calculated patient liability by allowing the deduction, do not adjust patient liability retroactively; adjust patient liability the next administratively possible month, allowing for adverse notice.

d. Deceased clients

- Notify the facility of the patient liability amount due for the month of death. The facility will collect only for charges actually incurred. Deposit any unused patient liability in the patient trust fund account.

F-120.4 Notification of Patient Liability/Case Status

Upon approval or when patient liability changes, the client, authorized representative(s) and facility are notified on a Notice of Decision of the amount and effective date.

When the client moves from one facility to another, notify the facilities of the current case status and monthly patient liability if this information has not already been provided to them in or for that month.

F-120.5 Patient Liability Budgeting Procedures – Form 2220–EM/A

- a. Determine the client's **total** gross countable monthly income.
 - 1. Subtract income excluded in patient liability

b. Subtract the following items from **total monthly income** in the following order:

1. Personal Needs Allowance

- a) Deduct a \$35 personal needs allowance (PNA) for each month of institutionalization.
- b) Additional personal needs – Institutionalized individuals with **no** community spouse living in the home but with other dependent family members in the home are allowed an additional personal needs allowance based on household size. The additional personal needs amount is determined by subtracting the 1996 needs standard of \$459 from the current TANF need standard for the household size.
Note: this requires a NOMADS work around.

2. Community Spouse Monthly Income Allowance

Income allocated to the community spouse for maintenance. This amount (if any) is determined by subtracting any of the community spouse's income which is considered available (including need-based assistance like TANF, SSI, etc.), from the monthly maintenance allowance.

DO NOT count VA UME as income considered available to the community spouse.

Clients do not have to request the maintenance allowance for their spouse/dependents. The case manager will automatically request the information necessary to determine the maintenance allowance when there is a spouse or dependents at home.

3. Family Allowance (Spousal Impoverishment)

Family members must be a dependent child, dependent parent(s) or dependent sibling(s). The child, parent or sibling must be residing in the home of the community spouse **and** claimed by the community spouse or institutionalized spouse as dependent(s) for federal income tax purposes.

The amount determined to be the family allowance is deducted from the institutionalized spouse's countable income effective with the first month in which the continuous period of institutionalization is met, **or** if this deduction was not previously allowed, the deduction will be allowed effective the first month following the month in which the change is reported.

The family allowance deduction need not be determined **if** the \$35 personal needs allowance, in combination with the community spouse monthly income allowance, makes the patient liability zero.

Obtain verification of each family member's gross income.

- a) Subtract the family member's gross income from minimum needs allowance (150% of poverty).
- b) Divide the amount from above by three. This is one family member's allowance.

Repeat this calculation for each family member. If there is more than one family member, add each family member's allowance to determine the total family allowance deduction.

4. Dependent Allowance (Non-Spousal Impoverishment)

The dependent allowance is a monthly income allowance for each dependent family member living in the institutionalized individual's home with **no** community spouse living in the home.

Determine the dependent allowance by subtracting the dependent's total income from the Need Standard (100% Need Standard) for the household size.

5. Expenses Incurred For Health Insurance Premiums, Deductibles and Co-Insurance Charges

Deduct health insurance premiums, deductibles and co-insurance expenses incurred by the client. Clients/Representatives must advise the agency of medical insurance and provide proof of expenses. These expenses must not be paid or subject to payment by a third party.

NOTE: Medicare premiums are subject to payment by a third party.

For an institutional case in which the client is not an SSI recipient and will not receive a reimbursement for Medicare cost from any source, deduct the Medicare premium as an expense for months immediately preceding the second month after the month of approval.

Example #1 (Medicaid Only): Client applied June 2nd and requested 3 months prior medical. Case is approved July 10th. Deduct Medicare premiums from March through August. Beginning September, do not deduct the Medicare premium, as it is then subject to third-party payments.

Example #2 (Medicaid/QMB): Client applied for Medicaid/QMB on June 2nd and requested 3 months prior medical. In June, QMB eligibility is established and benefits begin effective July 1st. Then, on July 20th Medicaid eligibility is established back to March. Deduct Medicare premiums for March, April, May and June only. Effective July and ongoing, the premiums are subject to third-party payments as QMB coverage began in July.

6. Expenses Incurred For Medical Care

Deduct expenses incurred by the client for necessary medical care recognized under the state law but not covered under the Medicaid Program. This includes medical expenses incurred more than three months prior to the date of application. Client/Representatives must advise the agency and submit proof of the expenses.

The case manager must attach a copy of the medical bill plus all related medical records to Form-2536 and submit it to DHCFP for approval. These expenses must not be paid or subject to payment by a third party. DHCFP approval is required to assure the deduction is for necessary care payable to reasonable limits.

- c. The deficit, if any, is the client's share of facility cost (PATIENT LIABILITY).