

Qualifying for Home and Community Based Services

Home and Community Based Services (HCBS) is a Medicaid program that pays for help in the home, adult day care, and assisted living, and respite care. It serves elderly and blind or disabled individuals who require long-term care services. The intent is to serve this population in a home or appropriate community setting that is more cost effective than a nursing home. The individual must have the same medical level of need as one who requires nursing home care.

Services are arranged by the Single Entry Point (SEP) agency which assigns a case manager to coordinate and monitor services. HCBS does not provide 24-hour help. The cost of all combined Home and Community Based services must be less than Medicaid's payment for nursing home care. There is a yearly cap on the amount the state spends on an individual, usually a third of comparable nursing home costs.

SERVICES AVAILABLE UNDER HCBS

Once accepted for HCBS, the following services are paid for by Medicaid to the extent they are part of the individual's care plan:

- Home health care as defined under the Medicaid Home Health Program, including services of medical personnel if needed.
- Personal care services such as hands-on assistance with activities of daily living (ADLs). This includes help with bathing, dressing, shampooing hair, ambulating, transfers, medication reminders, etc.
- Homemaker services, such as light housecleaning, meal preparation, laundry, grocery shopping, etc.
- Adult Day Care, offering protective oversight in a structured environment including activities, meals, and medication administration.
- Transportation to Adult Day services, grocery store, dental and vision appointments, support groups, and visits to a spouse in a nursing home.
- Respite care in a Medicaid-certified protective setting, such as a nursing home or assisted living facility, when the primary caregiver is unavailable. Maximum 30 days benefit per calendar year.
- Home modification such as a wheel chair ramp, widening doorways, bathroom grab bars, etc.
- Electronic monitoring or Lifeline emergency response system hookup, to signal a provider agency in an emergency.
- Prescription medications, not covered by Medicare, and certain over the counter medications.
- Assisted Living in an Alternate Care Facility (ACF), which is a licensed Medicaid facility.

NOTE: Assisted living costs are only covered by Medicaid if the recipient is in a Medicaid licensed Alternate Care Facility (ACF). This may be a small personal board and care home or a larger assisted living facility. Individuals who live in a non-Medicaid assisted living facility are not eligible for HCBS benefits. The recipient must move to a Medicaid assisted living facility in order to make an application for Medicaid.

An individual on Medicaid must pay a minimum monthly payment of \$618/month (2009) out of their own income each month to the assisted living facility.

Most Assisted Living facilities require a six-month or year of private pay before accepting Medicaid as the primary payor.

ELIGIBILITY REQUIREMENTS

Three requirements must be met for an individual to be eligible for Home and Community Based Services. The individual must be eligible in **all** three categories:

- *Medical need for care*
- *Income below a certain amount*
- *Resources (savings, stocks, life insurance) below a certain amount*

An individual applying for HCBS must be a citizen of the United States either by birth or naturalization or a legal alien living in the United States prior to August 22, 1996. Original documentation of citizenship is required. An applicant must be a resident of Colorado. There is no length of state residency requirement. The individual can apply for Medicaid the first day in Colorado, provided there is the intent to remain in Colorado. The application process cannot begin before the individual arrives in Colorado.

MEDICAL NEED

As for nursing home Medicaid, the Single Entry Point agency performs an assessment of the individual's activities of daily living using the UTLC-100.2 assessment tool. This is used to determine that the individual qualifies for nursing home care, which also entitles him/her to HCBS services. The assessment may be done in the hospital, nursing home, or in the individual's own home.

INCOME

The gross income of the applicant must be below \$2,022 a month (2009). If the income is over this amount, an Income Trust must be set up. The rules for an Income Trust for an individual on HCBS are different than those for an individual on nursing home Medicaid. See Income Trusts.

RESOURCES

The non-exempt resources of the applicant must be below \$2,000. After July 1, 1999 a couple is allowed the same Community Spouse Resource Allowance (CSRA) as that for nursing home applicants. That figure for 2009 is \$109,560. See Qualifications for Married Individuals.

WHERE TO APPLY

The application for Medicaid for long-term care services is made through the Single Entry Point agency (SEP) in the county where the applicant is physically at the time of application, whether this be in his/her own home, in the hospital, or in a nursing home. The SEP is a designated agency within a local area where persons seeking Medicaid long-term care services obtain screening and referral information, assessment of need, and case management services. This agency determines the need for long-term care in the appropriate program. The SEP agency may or may not be the local department of human services. If the applicant is at home and the home is in County A, but will be going into a nursing home in County B, an application is made through the SEP in County A. Upon approval, County A will transfer the application to County B.

A listing of SEP agencies is found in Appendix 3.

APPLICATION PROCESS

The application for Home and Community Based Services begins with the Single Entry Point Agency (SEP). The referral can be made to the SEP by a family member, social worker, hospital discharge planner, or anyone involved in the care of the applicant. Once the referral is made, the Medicaid application will need to be completed and turned into the county Department of Human Services, detailing income and asset information. When the application is received by the county agency, the ULTC-100.2 assessment is done using information obtained from the applicant, family members, or hospital personnel. A family member should be present at this appointment to supplement any information about the applicant's condition.

Once the applicant is approved by the SEP as needing nursing home level of care, the Medicaid application will be processed by the county Department of Human Services. An appointment may

be set up with an eligibility technician at the county department for financial eligibility. Not all counties require a face to face appointment. The application process can take two to three months before approval. Services for Home and Community Based Services cannot begin until the application is approved.

Many assisted living facilities require six months to a year of private pay before they will accept a resident on Medicaid. In many cases it is prudent to find an assisted living facility that accepts Medicaid and pay private pay while funds are available to obtain a Medicaid bed when funds run out.