

Long-term Care Application Process

The application for Medicaid is the same whether the individual is applying for nursing home Medicaid or Home and Community Based Services.

APPLICATION

To obtain a copy of the **Medicaid application form** go to: www.cbms.state.co.us Click on:

- **Application for Assistance** to get the application form
- **Receipt** to get the receipt form that should be signed by the county Department of Human Services when the application and required documentation is delivered to them. Take it in person, do not mail. This is your proof that they received the documents and the date received which will be important as the start date for Medicaid when approved. **Keep this receipt with your copies.**
- **Information you Need to Know** to find out what documents you will need. It also lists the information for the County Departments of Human Services.

Information for Medicaid Long Term applicants: If you are applying for Medicaid Long-Term Care Nursing Home or Home and Community Based Services, including assisted living you need to secure your application start date. Copy pages 1 through 5, sign page 21, and submit them to your county Human Services office. You must submit the entire application within 10 business days from the date you submitted these pages.

After the Single Entry Point agency has been contacted and the ULTC-100.2 completed an eligibility technician at the county Department of Human Services will review the financial information. Some counties require a face-to-face interview with the technician, while other counties do not. The completed application and supporting documentation is reviewed and must be verified before Medicaid can be approved. This process should take 45 to 60 days or less, but may take as long as three months.

It is suggested that a copy of the application and the documentation papers be made and kept for the applicant's records, along with any correspondence from the county human service agency. This will help families complete the re-determination paperwork required every year.

NURSING HOME APPLICATION

Families should select a nursing home facility that accepts Medicaid payment. Even if the individual will not be eligible for Medicaid for several months or even a year, it is better to choose a Medicaid facility at the time of entry to avoid the trauma of moving and readjustment to a new facility at a later date.

Many facilities have a waiting list for a Medicaid bed, or require residents to pay privately for a certain number of months before they are accepted as Medicaid patients. This should be investigated and considered when looking for a nursing home (or assisted living facility, especially if resources are limited at the time of admission.

When is an application made for nursing home Medicaid?

An application for nursing home Medicaid can be made while the individual is at home, in the hospital, or already in a nursing home. For Medicaid to pay, the applicant must be either institutionalized for at least thirty days, or medical personnel presume that the applicant will be institutionalized for at least 30 days. This can be a combination of hospital days, days on Home and Community Based Service, and/or nursing home days.

If the applicant dies before thirty days have passed, Medicaid can still be approved for that brief period if the individual had met the financial requirements during that period. If the applicant leaves the nursing home, returning home, before 30 days of institutionalization, Medicaid will not pay any costs.

It is best to begin the application process when the individual meets the medical and income requirements and when resources are close (about a month before) to the allowed \$2,000 limit or the Community Spouse Resource Allowance limit for a married couple (\$109,560 in 2009). 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 located 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 facility 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 long-term Medicaid 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. This process should take 45 to 60 days or less, but may take as long as three months.

If the individual is already in a nursing home:

- The nursing home personnel must be notified at least one month before the applicant will be down to \$2,000 in resources. The Single Entry Point agency in the county where the nursing is located should be contacted to complete the ULTC –100.2. The application must be completed with documentation and sent into the county agency.
- When the applicant is down to \$2,000 or less in resources, he/she is considered "Medicaid Pending." If the applicant is single, all of the income is required to go to the nursing home each month, with \$50 allowed for personal needs. In a "Pending" situation for a married applicant, there is no patient payment during this time unless the community spouse's income is greater than the Maximum Monthly Maintenance Needs Allowance (\$2,541.50 in 2009). Once eligibility is approved there may be a payment by the community spouse which is decided by the technician who determines the Monthly Income Amount. See Qualifications for Married Individuals.

Timing of application for nursing home Medicaid

An application for a single individual should be started when the individual's resources are close to \$2,000, usually one to two months before reaching this limit. The application can be made while the individual is still at home or receiving Home and Community Based Services (HCBS).

A married couple with resources below \$111,560 (\$109,560 + \$2,000 in 2009) is resource eligible and an application can be started at any time, whether from home or directly on admittance to the nursing home. If a married couple has resources over the current CSRA amount an application should be started when the couple is one to two months away from having this amount.

Making an application too soon may result in a denial if the resources are more than the allowed amount when the eligibility technician at the department of Human Services processes the application.

After Medicaid Approval

When a recipient resides in a nursing home on Medicaid, all of his or her income (Social Security, pension, etc.) is required by law to go to the nursing home as patient payment, except for \$50 a month which may be retained for personal needs. Medicaid pays the difference between the resident's income contribution and the nursing home costs. An exception is made when there is a spouse living in the community, which may allow a payment of all or a portion of the recipient's income to the community spouse. If the individual has an Income Trust, the rules for trust distribution of income are followed. See Income Trusts.

PERSONAL NEEDS ALLOWANCE (PNA)

A nursing home resident is allowed to keep the first \$50 of income. This is a personal needs allowance (PNA) which can be used to pay for personal items, beauty shop expenses, non-prescription medications, clothes, etc. This money does not have to be spent each month. It can accumulate, but is counted toward the \$2,000 maximum resource amount allowed the individual. This money can be kept by the nursing home in an account for the resident, by a family member, or by the nursing home resident if appropriate. If kept by a family member, records should be kept of the expenses.

The PNA amount allowed to a recipient is determined by the facility, usually around \$100 if there is sufficient income to cover this amount.

POST-ELIGIBILITY TREATMENT OF INCOME (PETI)

After an individual has been approved for Medicaid, all of his or her income (minus \$50) must go to the nursing home for payment, unless there is a spouse at home. In some instances the applicant's income may be used to pay for a portion of medical services not covered by nursing home care, such as dental care, dentures, hearing aids, eye glasses, or for income tax deductions, and supplemental health insurance premiums. This is referred to as a PETI payment. Arrangements for payment of any of these services must be made with the nursing facility and the eligibility technician.

Once authorized, the medical expenses are deducted from the individual's gross income before the patient payment to the nursing home is paid. This may be a one-time payment for an item such as glasses, or ongoing as in the case of a monthly supplemental insurance payment. If the spouse at home receives all of the nursing home resident's income there will be no PETI offset funds available.

KEEPING A SUPPLEMENTAL INSURANCE POLICY

Part of the resident's income may be used to make payments on a Medicare supplemental insurance policy through the PETI fund once the resident has been approved for Medicaid. Even though Medicaid pays most medical expenses, a supplemental policy may be retained if approved by Medicaid. Payment is allowed for one year, with a review after that period to

determine if it cost effective to the State for the policy to be continued. If not approved as a PETI deduction, the cost of such insurance must be borne by the recipient or other family member.

The resident may want to keep a supplemental insurance policy in effect for several reasons. There may be a possibility that the nursing home resident may improve and not need institutionalization after several months. Or the individual's home may be sold in the near future, increasing the assets above the \$2,000 limit, making the resident ineligible for Medicaid. An institutionalized spouse may also need to keep insurance in order to have the community spouse covered under a retirement plan associated with prior employment.

KEEPING A HOME WHILE IN THE NURSING HOME

If a single individual enters a nursing home, and is expected to return home within six months, a deduction of approximately \$200 a month from the individual's income can be used to provide for the upkeep of the home. A request for this allowance must be made at the time of application. After six months, however, no income may be used for the upkeep and expenses on the home. The home can be rented to meet these costs, but any rental income over the allowable deductions will be considered income and must be paid to the nursing home.

HOME AND COMMUNITY BASED SERVICES (HCBS) APPLICATION

All applications for Home and Community Based Services are made through the Single Entry Point (SEP) in the county where the applicant resides.

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Spousal Protection

For married couples applying for HCBS. See Qualifications for Married Individuals.

A listing of the Department of Human Service agencies and Single Entry Point agencies in Colorado can be found in the Appendix 2 and 3.