GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal No: 15-25**

TO: Medicaid Providers of Long Term Care Services

FROM: Claudia Schlosberg, JD
Senior Deputy Director/State Medicaid Director

DATE: JUL 13 2015

SUBJECT: Long Term Care Financial Eligibility Policy

Over the past several months the Department of Health Care Health conducted trainings for over 220 providers and their staff, sister agencies, and other stakeholders to explain new rules regarding Long Term Care Financial eligibility. These changes are effective July 1, 2015. The District adopted new Long Term Care Financial Eligibility rules on May 13, 2015 which were published in the D.C. Municipal Regulations on May 22, 2015. The rule can be found at http://dhcf.dc.gov/page/dhcf-medicaid-regulations .

The purpose of this transmittal is to advise providers of the Department of Health Care Finance (DHCF) policy on financial eligibility requirements for Medicaid long term care applicants and beneficiaries in the District of Columbia.

The District of Columbia is implementing financial eligibility requirements for Medicaid long term care applicants and beneficiaries found in the following federal authorities: The Deficit Reduction Act of 2005 (Pub. L. 109-171), Sections 1396a and 1396r-5 of Title 42 of the U.S. Code, and Sections 435.622, 435.726, 435.811, and 435.831 of Title 42 of the Code of Federal Regulations.

Overview

Long term care applicants and beneficiaries include those individuals applying for or receiving either institutional long term care services, or home and community based services (HCBS) provided under the Elderly and Persons with Physical Disabilities (EPD) or Persons with Intellectual and Developmental Disabilities (IDD) waiver programs.

The DHCF policy encompasses the establishment of financial eligibility for Medicaid long term care applicants, as well as the determination of beneficiaries' contribution to the cost of care following a determination of eligibility. Furthermore, the policy identifies requirements for the

allocation of income and resources to community spouses of long term care applicants and beneficiaries under spousal impoverishment protections.

Income and Resource Standards

Long term care applicants and beneficiaries must meet two (2) components of financial eligibility: income and resources.

Applicants and beneficiaries consist of the following three (3) populations:

1) Individuals who have been determined eligible for Social Security Income (SSI) by the Social Security Administration;
2) Individuals who meet the income and resource requirements under the Special Income Standard (SIS), which is equal to three hundred percent (300 %) of the SSI federal benefit rate ($2,199 for 2015); and
3) Individuals whose gross countable income exceeds the SIS and who elect to spend their excess income down to the Medically Needy Income Level (MNIL) in order to become financially eligible for Medicaid coverage of their long term care services.

Individuals who have been determined eligible for SSI are deemed automatically financially eligible for Medicaid long term care coverage and are exempt from the income and resource tests detailed in the policy.

Income from the following sources is used to determine an applicant's gross countable monthly income: taxable income received from employment, income received from sources other than employment, and self-employment income. Many types of income are not counted, including foster care payments, utility allowances, child nutrition payments, and housing assistance. A full list of excluded income types may be found in Appendix A of the attached policy.

Applicants and beneficiaries must not have gross countable resources in excess of four thousand dollars ($4,000). Similar to income, many types of resources are not counted, including an individual's primary residence (subject to certain conditions), one vehicle per household, retirement accounts, and household and personal goods. A full list of excluded resource types may be found in Appendix B of the attached policy.

Spousal Impoverishment Protections

As of January 1, 2014, spousal impoverishment protections were extended to HCBS waiver applicants and beneficiaries in addition to those receiving institutional long term care services. Spouses of long term care applicants and beneficiaries who remain in the community are entitled to retain a certain amount of income per month, as well as a certain share of the couple's total countable resources, in order to guard against impoverishment of the community spouse as a result of the high cost of care for the spouse receiving long term care services.

Improper Resource Transfers

When an individual applies for Medicaid coverage of long term care services, a review is conducted to determine whether the applicant, his or her spouse, or anyone authorized to act for the applicant or spouse by a power of attorney improperly transferred resources for less than fair market value within the sixty (60) month period prior to the date of application. If an improper resource transfer occurred during that period, a penalty period is assessed, during which the applicant is ineligible for Medicaid coverage of his or her long term care services.

The policy details several types of resource transfers which are not considered improper, even if made during the sixty (60) months prior to the date of application. Furthermore, if a penalty period is assessed as the result of an improper resource transfer, the applicant may request that the penalty period be waived. Such a waiver may be granted if the applicant can show that the imposition of the penalty period would create an undue hardship for him or her. The attached policy describes the circumstances considered to constitute an undue hardship.

Contribution to Cost of Care (Patient Pay Amount)

All Medicaid long term care beneficiaries who have income remaining after a series of post-eligibility income deductions are applied are required to contribute the remaining income to the cost of their long term care services. The monthly post-eligibility deductions detailed in the policy include the following:

1) A personal needs allowance (PNA) between seventy dollars ($70) and one hundred dollars ($100) for institutionalized beneficiaries and a community maintenance needs allowance (CMNA) equivalent to three hundred percent (300 %) of the SSI federal benefit rate ($2,199 in 2015) for HCBS beneficiaries;
2) A community spouse allowance (CSA) for beneficiaries with a community spouse;
3) A dependent family allowance, equal to the MNIL for each dependent, for beneficiaries with minor or disabled children, dependent parents and/or dependent siblings who reside in the beneficiary's personal home;
4) Incurred medical expenses;
5) Remedial care expenses;
6) A home maintenance deduction, equal to the MNIL, for institutionalized beneficiaries for whom a physician certifies that the beneficiary is likely to return home within six (6) months and who do not have a community spouse residing in the home; and
7) SSI or State Supplementary Payment benefits

The imposition of a patient pay amount for HCBS waiver beneficiaries will only affect those beneficiaries whose gross countable monthly income is above the income standard applied to determine eligibility, and who are required to spend down their excess income to become eligible for Medicaid coverage of their long term care services. This is because the primary deduction for all HCBS waiver beneficiaries, the community maintenance needs allowance, is equivalent to the Special Income Standard. As the income standard for eligibility and the post-eligibility deduction are equivalent, all HCBS waiver beneficiaries who are eligible under the special income standard will have no patient pay amount imposed.

Changes to the Application Submission Process

In order to file an application for D.C. Medicaid Long Term Care coverage, existing Medicaid beneficiaries must complete and submit a signed Long Term Care Program Medical Assistance Application to the DC Department of Human Services' Economic Security Administration. Applicants who do not have current Medicaid coverage must complete and submit a signed Combined Application for DC Medical Assistance in addition to the completed and signed Long Term Care Program Medical Assistance Application to the DC Department of Human Services' Economic Security Administration. Copies of both applications are included with this transmittal and will be posted on the DHCF website.

Questions regarding this transmittal should be directed to Danielle Lewis, Associate Director, Division of Eligibility Policy, Health Care Policy and Research Administration at (202) 442-9052 or via email at Danielle.Lewis@dc.gov.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Subject: REVISED - Financial Eligibility for Institutional Care and Home and Community Based Waiver Services

Policy Number: HCPRA-DEP-15-25

Policy Scope: Department-wide	**Number of Pages:** 35
Responsible Office or Division: Health Care Policy and Research Administration	**Number of Attachments:** 4
Effective Date: 7/1/2015	**Date Revised:** 7/1/2015
Cross References and Related Policies: N/A	**Expiration Date, if Any:** N/A

1. PURPOSE

To establish policies and procedures for determining financial eligibility for institutional care and participation in Home and Community Based Waiver programs for persons participating in these programs.

2. APPLICABILITY

This policy applies to the Department of Health Care Finance (DHCF), the Economic Security Administration (ESA), Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), and HCBS Waiver Service providers.

3. AUTHORITY

The authority and functions of the DHCF as set forth in the "DHCF Establishment Act of 2007", effective February 27, 2008 (D.C. Law 17-109).

The methods for determining financial eligibility for long-term care services are established in 42 USC §§ 1396a and 1396r-5; 42 CFR §§ 435.631, 435.726, 435.821, and 435.832.

4. DEFINITIONS

Community Maintenance Needs Allowance (CMNA): The Community Maintenance Needs Allowance (CMNA) is a standard income amount that a HCBS Waiver participant living in their home may retain to afford the costs associated with living in the community, such as expenses related to mortgage, rent, food, utilities, taxes, and home repairs. The District's CMNA is the Special Income Standard (SIS) of 300% of the SSI federal benefit rate. This rate is updated annually. The CMNA is the equivalent of the Personal Needs Allowance (PNA) that is available to institutionalized individuals.

Community Spouse: A community spouse is a spouse who is not institutionalized or enrolled in a Waiver program. The term community spouse includes any spouse recognized under District law, including same-sex couples whose marriages or civil unions are recognized under the D.C. Marriage Equality Act. The term does not include registered domestic partners.

Community Spouse Allowance (CSA): The CSA is the amount of the institutionalized spouse's income that can be maintained by or transferred to the community spouse. The CSA is the amount needed to maintain or raise the community spouse's income to the Minimum Monthly Maintenance Needs Allowance (MMMNA).

Community Spouse Resource Allowance (CSRA): A CSRA is an allowance of assets that the community spouse can keep without incurring penalties.

Contribution to Cost of Care (Patient Payability Amount): The contribution to cost of care (the "patient payability amount") is the amount of money that the institutionalized or HCBS Waiver individual is responsible for paying towards their care. The contribution to cost of care is calculated based on the individual's monthly income, after allowable deductions and community spousal impoverishment income protections have been applied.

Cost of Care: The cost of care is the amount of charged by the long-term care provider or HCBS Waiver services provider(s) for long-term care or Waiver services.

Disregards: Disregards are types of income that are not taken into consideration when calculating an applicant's total countable income to determine Medicaid eligibility.

Economic Security Administration (ESA): The Department of Human Services (DHS), Economic Security Administration (ESA) determines financial eligibility for institutional care and home and community-based waiver services based upon the policies and procedures established by the Department of Health Care Finance (DHCF).

EPD Waiver Application Package: The EPD Waiver application package is the set of forms that must be submitted by the EPD Waiver case management agency to determine an EPD Waiver individual's eligibility for Medicaid coverage of EPD Waiver services.

Exempt Assets: Exempt assets are assets that are not taken into consideration when calculating an applicant's total countable assets to determine Medicaid eligibility.

Exceptional Circumstances: Exceptional circumstances are circumstances that threaten the community spouse's ability to remain in the community due to severe financial duress.

Fair Hearing: A fair hearing is an administrative hearing where individuals can appeal Medicaid eligibility decisions.

Home and Community Based Waiver (HCBS Waiver) Programs: District of Columbia Medicaid Home and Community Based Waiver (HCBS Waiver) programs are programs authorized in Section 1915(c) of the Social Security Administration Act (the Act). HCBS Waiver programs provide home and community-based services that assist Medicaid-eligible individuals to live in the community and avoid institutionalization. The District operates two HCBS Waivers: the Home and Community-Based Waiver for the Elderly and Persons with Physical Disabilities (EPD), and the Home and Community-Based Waiver for Persons with Intellectual and/or Developmental Disabilities (IDD). IDD Waiver services are available to individuals residing in their own homes and through residential supports, including Supported Living, Residential Habilitation, and Host Home.

IDD Waiver Application Package: The IDD Waiver application package is the set of forms that must be submitted by the DDS/DDA Medicaid Waiver Unit to determine an IDD Waiver individual's eligibility for Medicaid coverage of IDD Waiver services.

Income/Countable Income: All references to income in this document, unless otherwise stated, refer to countable income. Countable income includes an individual's total gross earned and unearned income, excluding income from non-countable sources detailed in Attachment A of this document.

Institutionalized Individual: An individual is institutionalized if they are receiving an institutionalized level of care in an institutional setting (i.e., nursing facility or ICF/IID). An individual in an acute care facility is considered institutionalized if they are receiving an institutionalized level of care for more than thirty (30) days, or is likely to receive an institutional level of care for more than 30 days.

Long Term Care: Long term care is health-related care and services, above the level of room and board, not available in the community that is needed regularly due to a mental or physical condition.

Marriage: The term marriage refers to all marriages recognized under District law, including common-law and same-couples whose marriages or civil unions are recognized under the D.C. Marriage Equality Act. The term does not include registered domestic partners.

Medically Needy Income Level (MNIL): For a household of two or more individuals, the Medically Needy Income Level is 50% of the annual Federal Poverty Level (FPL). For a household of one, the MNIL is 95% of the MNIL for a household of two. The MNIL is calculated annually.[1]

Medicare Covered Stay: A Medicare covered stay is the period of time in which Medicare pays for Medicare-covered long term care services. During a Medicare covered stay, Medicaid may cover an individual's Medicare cost-sharing. The amount reimbursed by Medicaid will vary based on the facility in which the individual is receiving long term care services.

Medicare Dual Eligibles: Medicare Dual Eligibles are individuals entitled to Medicare and full Medicaid benefits.

Minimum Monthly Maintenance Needs Allowance (MMMNA): MMMNA is the minimum amount of monthly income that the community spouse is entitled to possess. This may consist solely of the community spouse's income or the sum total of the community spouse's income plus the Community Spouse Allowance.[2]

Personal Needs Allowance (PNA): The Personal Needs Allowance (PNA) is a standard income amount that an individual residing in an institution or receiving residential supports through the Department on Disability Services (DDS) may retain to pay for personal needs not provided by the institution. The District's PNA is $70.00 for an individual in a nursing facility not receiving a pension from the Department of Veterans Affairs (VA), $90.00 for an individual in a nursing facility receiving a pension from the VA, and $140.00 for a couple institutionalized in a nursing facility. The PNA for individuals who receive residential supports through the Department on Disability Services (DDS), such as Supported Living, Residential Habilitation, and Host Home, is $100.00. The PNA for individuals in an ICF/IID and receive Supplemental Security Income (SSI) is $70.00. The PNA for individuals in an ICF/IID and receive Social Security Disability Income (SSDI) is $100.00. The PNA is the equivalent of the Community Maintenance Needs Allowance (CMNA) that is available to HCBS Waiver participants who live in their home.

Skilled Care: Skilled care is direct care, management, observation, and evaluation of health care provided by skilled nursing or rehabilitation staff. Skilled care includes nursing, physical therapy, occupational therapy, and speech therapy. Skilled care does not include any service that can be safely administered by a non-medical person, including one's self, without the supervision of a nurse.[3]

Special Income Standard (SIS): The Special Income Standard is 300% of the Supplemental Security Income (SSI) federal benefit rate (FBR).

[1] DC Medicaid State Plan Attachment 2.6-A, page 14; 42 CFR §435.631 and 435.831.
[2] The yearly Minimum Monthly Maintenance Needs Allowance (MMMNA) is published at cms.gov annually.
[3] Medicare.gov, *Glossary.* Available at: http://www.medicare.gov/Homehealthcompare/Resources/Glossary.aspx

Spend Down: Spend down is the process by which an individual may use medical expenses to reduce countable income to the Medicaid income limit to meet financial eligibility requirements for Medicaid coverage.

Spousal Impoverishment Protections: Spousal impoverishment protections are allowances and deductions to a couple's income and assets, defined by the Social Security Act, that are designed to prevent the impoverishment of the community spouse.[4] Spousal impoverishment protections apply to HCBS Waiver individuals and institutionalized individuals who were institutionalized in a long-term care facility on or after October 1, 1989.

Start of Care Date: The start of care date is the date on which Medicaid coverage for long-term care services begins for an institutionalized or HCBS Waiver individual.

Start of Care Packet: The start of care packet is the set of forms that must be submitted by the institutional care provider to determine an institutionalized individual's eligibility for Medicaid coverage of long-term care services. For individuals enrolled in community Medicaid, the start of care packet consists of the Long Term Care Application and Start of Care Form 1346. For individuals who are not already enrolled in Medicaid, the start of care packet must also include the Combined Application for Benefits, proof of income, proof of assets, and the Level of Care form.

5. POLICY

This document identifies policies and procedures to establish financial eligibility for long-term care services and to determine the amount a beneficiary must contribute to the cost of care for long-term care services following a determination of eligibility.

This policy also identifies requirements for the allocation of income and assets from the institutionalized spouse to a community spouse under spousal impoverishment protections.

6. PROCEDURE

I. EFFECTIVE DATES

The financial eligibility policies and procedures for Institutional and HCBS Waiver services will become effective immediately for new applicants and for current beneficiaries at renewal.

The implementation of the Spousal Impoverishment Law is effective January 1, 2014 or, if earlier than January 1, 2014, the date when the District receives approval from the Centers for Medicare and Medicaid Services (CMS) after amending its 1915(c) home and community-based services (HCBS) waiver programs (Persons with Intellectual and Development Disabilities (IDD) Waiver and the Elderly and Persons with Physical Disabilities (EPD) Waiver) to include the spousal impoverishment protections.

[4] 42 U.S.C. §1396r-5.

II. MEDICAID COVERED GROUPS

An individual in long-term care services must meet Medicaid financial and non-financial eligibility requirements in order to be eligible for Medicaid coverage of long-term care services.

NOTE: An individual must be evaluated for non-financial eligibility to receive long-term care services prior to determining financial eligibility. The level of care (LOC) documentation must be submitted to the Economic Security Administration (ESA).

There are multiple ways to financially qualify for Medicaid for long-term care services. To determine financial eligibility, the ESA must follow a two-step process:

Step 1: Decide whether the individual is financially eligible for Medicaid long-term care services. The policies and procedures for determining financial eligibility are found in Sections 6.II, III, and IV.

Step 2: If the individual is financially eligible, determine how much the individual must contribute to his or her cost of care.

NOTE: A financial eligibility determination is not required for individuals who have been determined eligible for Supplemental Security Income (SSI).

NOTE: Medicaid does not pay for long-term care services during a Medicare-covered stay in a long-term care facility. The policies and procedures for Medicare beneficiaries are found in Section 6.II.D.

A. Supplemental Security Income (SSI)

1. Policy

Individuals who have been determined eligible by the Social Security Administration (SSA) for Social Security Income (SSI) payments are categorically eligible for Medicaid and automatically financially eligible for long-term care services. SSI-eligible individuals include individuals who may be eligible for SSI, but not receiving payments.

SSI-eligible individuals, *including SSI recipients who have additional income from other sources*, are not required to complete an income eligibility determination, since such income has already been reported to and verified by SSA. There is no asset limit for SSI recipients to be eligible for Medicaid.

NOTE: SSA will terminate or adjust an institutionalized individual's

SSI payment to $30 for any full month that the individual receives institutional long-term care services.

2. Process

Determine financial eligibility for SSI-eligible individuals:

a. Verify if the individual has been determined eligible for SSI payments. If the individual is eligible for SSI payments, the individual is categorically eligible for Medicaid.

B. Special Income Standard (SIS)

1. Policy

Individuals who are over the SSI income limit should be considered for eligibility for Medicaid coverage of long-term care services under the Special Income Standard (SIS).

To be eligible for long-term care services under the SIS, the individual must have:

a. Income that does not exceed the SIS, which is 300% of the SSI federal benefit rate (FBR); and
b. Countable assets that do not exceed $4,000.

2. Process

Determine financial eligibility for individuals who are not eligible for Medicare. The policies and procedures for Medicare beneficiaries are found in Section 6.II.D:

a. If the individual is ineligible for SSI payments, determine the individual's countable income and compare it to the Special Income Standard. Refer to Section 6.III, Evaluation of Income and Assets.
b. If the individual's income is less than the Special Income Standard, determine if the individual has countable assets exceeding $4,000.
    1. If the individual has countable assets exceeding $4,000, the individual is ineligible for long–term care services coverage. The individual may choose to reallocate assets and then submit a new application for coverage. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets.

c. If the individual's countable income exceeds the Special Income Standard, the individual is ineligible for long–term care services coverage. Determine if the individual is eligible for Spend Down. Refer to Section 6.II.C, Spend Down Eligibility.
d. If the individual's countable income is at or below the SIS, the individual is financially eligible for Medicaid. The next step is to calculate the amount of the individual's contribution to the cost of care. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

3. Examples

a. *(SSI Only)* Barbara is a single adult and has been admitted into a nursing care facility. She receives only $721 per month in SSI benefits. She is categorically eligible for Medicaid coverage and automatically financially for Medicaid coverage. Her SSI payments will be reduced to $30.
b. *(SSI Plus Other Income)* Ms. Henry is applying for long-term care services and her monthly income consists of SSI in the amount of $10.00 and a pension in the amount of $700.00 a month. She is categorically eligible for Medicaid coverage and automatically financially for Medicaid coverage. Once institutionalized, her SSI payments will terminate because her additional income is greater than $30.
c. Allen is a single adult and was recently admitted to a nursing care facility. He does not have Medicare or Medicaid and his only source of income is a pension in the amount of $1,500 per month. He also has $3,500 in a savings account. Allen applies for Medicaid coverage for his long-term care. Allen is ineligible for SSI payments because his income is higher than the SSI limit. However, his income and assets are within the income and asset limits for Special Income Standard eligibility. Allen is eligible for Medicaid coverage of his long-term care services.

C. Spend Down Eligibility

1. Policy

Spend Down is the process by which individuals with medical expenses qualify for Medicaid coverage of long term care services by deducting incurred or recurring medical expenses from the individual's countable income. Refer to Attachment C - Incurred and Recurring Medical Expenses. The individual's spend down obligation is the

amount of individual's countable income that exceeds the current Medically Needy Income Level (MNIL). Refer to Section 6.III, Evaluation of Income and Assets.

Spend down for long term care services is determined for a six-month budget period. Once the individual meets the spend down obligation, the individual will be automatically enrolled in Medicaid from the first day of the month in which the individual meets the spend down obligation through the remainder of the six–month budget period. At the end of the first six month budget period, another spend down obligation will be calculated for the second six month budget period within the twelve (12) month eligibility span.

To be eligible for Spend Down, the individual must have:

a. Income that exceeds the Special Income Standard, which is 300% of the federal benefit rate (FBR); and
b. Countable assets that do not exceed $4,000.

2. Process

Determine Spend Down eligibility for individuals:

a. Verify that the individual has countable income exceeding 300% of FBR. Refer to Section 6.III, Evaluation of Income and Assets.
b. Verify that the individual does not have countable assets exceeding $4,000. Refer to Section 6.III, Evaluation of Income and Assets.
c. Calculate the individual's spend down obligation by subtracting the Medically Needy Income Level from the individual's countable income. As the individual submits documentation of payment of eligible incurred or recurring medical expenses, deduct the amount from the individual's spend down obligation. Once the individual has met the spend down obligation, enroll the individual in Medicaid coverage from first day of the month in which the individual meets their spend down obligation through the remainder of the six-month spend down budget period. Refer to Attachment C - Incurred and Recurring Medical Expenses.
d. Calculate the amount of the individual's contribution to the cost of care. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.
e. At the end of the initial six–month spend down budget period, calculate a new spend down obligation for the second six-month budget period within the individual's twelve (12) month certification period.

3. Examples

a. Wallace applies for Medicaid to cover the costs of his HCBS Waiver services. He earns $2,000 per month from his rental properties, and has additional income of $1,500 per month from his retirement pension. He does not have any assets. He does not qualify for Medicaid coverage of his long term care services because he is over the income limit for Special Income Standard eligibility. To qualify for Medicaid, he must spend down his excess income to the Medically Needy Income Level. He is over income for Medicaid coverage under the Medically Needy Income Level (MNIL) by $2,877.36 ($3,500 - $622.64). He qualifies for Spend Down and will have a spend down obligation of $17,264.16 ($2,877.36 per month x 6 months) for his six-month spend down budget period.

b. Gerald is admitted to a nursing facility following a three-month stay in Howard University Hospital's acute care unit. He does not receive Medicare benefits. He has countable assets totaling $2,000 and monthly countable income totaling $3,000. He does not qualify for Medicaid coverage of his long term care services because he is over the income limit for Special Income Standard eligibility. To qualify for Medicaid, he must spend down his excess income to the Medically Needy Income Level of $622.64. His spend down obligation is $14,264.16 ($2,377.36 per month x 6 months) for the six-month spend down budget period. He can use his medical bills from his hospital stay, his projected institutional care expenses, and any incurred medical expenses to meet his spend down obligation.

D. Qualified Medicare Beneficiaries

1. Policy

The Qualified Medicare Beneficiary (QMB) Program provides cost sharing assistance to certain low-income Medicare beneficiaries. Medicare recipients entitled to Medicare cost sharing assistance are called "Qualified Medicare Beneficiaries." Medicare beneficiaries who are entitled to full Medicaid benefits are called QMB Plus Beneficiaries. They may also be referred to as dual eligible.

Medicare will cover skilled nursing facility care costs if all of the following conditions are met:

1. The individual is eligible for Medicare Part A and has had a qualifying hospital stay of at least three (3) consecutive days of inpatient care;
2. The individual enters a skilled nursing facility within thirty (30) days of the qualifying hospital stay; and
3. The individual requires skilled care, such as skilled nursing services or physical therapy.

Medicare provides coverage for skilled nursing facility care costs for up to one hundred (100) days per Medicare benefit period, as long as the individual continues to require Medicare nursing facility skilled care services.[5]

For the first twenty (20) covered days of the Medicare benefit period, Medicare pays 100% of the cost of skilled care. For days twenty-one (21) through 100, Medicare covers 80% of the Medicare skilled nursing facility payment rate. Medicaid covers the remaining 20% of the cost sharing for QMBs and QMB Plus individuals (dual eligibles) during Medicare covered days.

NOTE: For Medicare-covered services, QMB beneficiaries including dual eligibles cannot be billed for the difference in the Medicaid and Medicare payment levels. Further, cost of care contribution requirements do not apply during days covered in any part by Medicare. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

If an individual is receiving Medicare skilled nursing facility care and is not already enrolled in Medicaid, the individual must apply for Medicaid coverage of long-term care services to receive either Medicare cost sharing assistance or full Medicaid benefits. If an individual is not eligible for Medicaid, or is only eligible for Medicare cost sharing assistance as a QMB, the individual will become financially responsible for the cost of his or her care if they remain in the nursing facility after Medicare coverage ends. Refer to Section 7, Responsibilities of Long-Term Care Providers and the Economic Security Administration (ESA).

a. *Qualified Medicare Beneficiary (QMB)* – The Qualified Medicare Beneficiary program (QMB) provides Medicaid

[5]An individual's Medicare benefit period begins when the person enters the hospital or skilled nursing facility and ends when either: the individual has not been in either a skilled nursing facility or hospital for at least 60 days in a row; or the individual remains in a skilled nursing facility but has not received skilled care there for at least 60 days in a row. *See* Centers for Medicare and Medicaid Services. *Medicaid Coverage of Skilled Nursing Facility Care*, 14. http://www.medicare.gov/publications/pubs/pdf/10153.pdf.

coverage of the beneficiary's Medicare cost sharing, including the 20% of the cost of skilled care during Medicare covered days 21 through 100.

To be eligible for QMB, the individual must have:

i. Income at or below 300% of the Federal Poverty Level (FPL)
ii. There is no asset limit for the QMB program

b. *QMB Plus* – QMB Plus provides full Medicaid benefits and Medicaid coverage of the beneficiary's Medicare premiums and cost sharing. QMB Plus beneficiaries must meet financial eligibility for Medicaid.

To be eligible for QMB Plus, the individual must have:

i. Countable income below 100% of the FPL; and
ii. Countable assets below $4,000

c. *Spend Down Dual Eligible* – Spend down dual eligibles are eligible for coverage of the Medicare Part B premium and Medicare cost sharing.

Medicare recipients who have income exceeding the QMB income limit (300% of the FPL) may spend down to the Medicaid Medically Needy Income Level (MNIL) for Medicaid eligibility. Refer to Section 6.II.C, Spend Down Eligibility.

2. Process

To determine if an individual entitled to Medicare Part A is eligible for QMB assistance:

a. Determine the individual's countable income. Refer to Section 6.III, Evaluation of Income and Assets.
b. Compare the individual's countable income to the QMB level. If the individual has countable income under 300% of FPL, the individual is eligible for Medicaid coverage of the individual's Medicare cost-sharing under QMB.
c. Verify whether the individual is eligible for Medicare coverage for long–term care services. If the individual is not eligible for Medicare coverage, compare the individual's countable income to the QMB Plus and Special Income Standard levels. Refer to Section 6.II.B, Special Income Standard (SIS). Verify that the individual does not have countable assets exceeding $4,000. Refer to Section 6.III,

Evaluation of Income and Assets.

1. If the individual has countable assets exceeding $4,000, the individual is ineligible for long–term care services coverage. The individual may choose to reallocate assets and then submit a new application for coverage. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets.
2. If the individual has countable income under 100% of FPL, the individual is eligible for full Medicaid benefits under QMB Plus.
3. If the individual has countable income between 100% of FPL and 300% of FPL, the individual is eligible for Medicaid coverage of long–term care services only under the Special Income Standard.
4. If the individual's countable income exceeds 300% of FPL, the individual is ineligible for long–term care services coverage. Determine if the individual is eligible for Spend Down. Refer to Section 6.II.C, Spend Down Eligibility.

d. Calculate the amount of the individual's contribution to the cost of care during non-Medicare covered days. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

3. Examples

e. Devon receives $2,500 per month in SSDI benefits and is enrolled in Medicare Part A. She has $1,000 in a checking account. She is admitted into a nursing care facility. The nursing facility submits a QMB application on Devon's behalf to cover her Medicare cost-sharing. She is eligible for QMB cost-sharing because her income is under 300% of FPL. For the first twenty (20) she receives skilled care services, her Medicare Part A will cover 100% of her costs. Medicaid will cover her Medicare cost-sharing. After 23 days, she stops receiving skilled care services and her Medicare coverage ends. Her nursing facility submits a new application for Medicaid coverage of her long-term care services. She is over the Special Income Standard limit of 300% of SSI FBR. She has the option to spend down to the Medicaid Medically Needy Income Level (MNIL) for Medicaid eligibility.

f. Franz is a Medicare eligible individual who was admitted to a nursing care facility. Franz applies for Medicaid coverage for his long-term care. He has $900 per month in income. He is under the income limits for QMB and QMB Plus. He

is eligible for QMB coverage of his Medicare cost-sharing during his Medicare covered days and full Medicaid benefits when his Medicare coverage ends.

III. EVALUATION OF INCOME AND ASSETS

The Economic Security Administration (ESA) will evaluate the income and assets of the individual applying for or receiving institutional or Waiver services to determine whether the individual is financially eligible to receive Medicaid long-term care services. The income and asset evaluation will be used to establish initial financial eligibility and the individual's continuing contribution to the cost of his or her care.

ESA will count only the income and assets available to the individual at the time of the initial eligibility determination. If the individual has a community spouse, ESA will also evaluate the community spouse's income and assets to determine whether the institutionalized or Waiver spouse may lower his or her contribution to the cost of care to provide financial support to the community spouse. Refer to Section 6.V, Calculation of Beneficiary Contribution to the Cost of Care.

A. Policy

i. Income

Gross countable income is used to determine financial eligibility for long-term care coverage. Gross countable income includes any income from countable income sources. Income from non-countable income sources is excluded from the individual's gross countable income. Countable and non-countable income is defined in Attachment A - Income.

Income limits for specific coverage groups, if applicable, are defined in Section II.

1. **Allocation of community spouse's income to institutionalized or Waiver spouse**

   If the payment of income is made solely in the name of the community spouse, no income of the community spouse shall be deemed available to the institutionalized or Waiver spouse during any month following the month of application in which the spouse receives institutional or Waiver long-term care services.

   NOTE: If payment of income is made in the names of both spouses, the income shall be allocated as follows:

   a. If the income does not come from a written legal document ("instrument") that establishes the ownership of the income, such as a trust, then one-half of the income shall be

considered available to each spouse.

b. If an instrument or trust document allocates the income, the income shall be considered available in accordance with the instrument allocation.[6]
   i. If payment of income is made solely in the name of one spouse, the income shall be considered available only to that spouse.[7]
   ii. If payment of income is made in the names of both spouses, one-half of the income shall be considered available to each.[8]
   iii. If payment of income is made in the names of (1) the institutionalized or Waiver spouse, the community spouse, and another person(s); (2) the institutionalized or Waiver spouse and another person(s); or (3) the community spouse and another person(s), the income shall be considered available to each spouse in the proportion to the spouse's interest.[9] If payment is made to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.[10]

2. **Rebuttal of income determination rules**

Income determination rules can be rebutted if the institutionalized or Waiver spouse can establish, by a preponderance of the evidence during a fair hearing, that the ownership interest in a source of income should not be assigned as described above.

3. **Periodic reconciliation of income**

At the end of each six-month period, or whenever any significant change in the institutionalized or Waiver individual's income or circumstances occurs, the District must reconcile projected income with the actual income that was received. The reconciliation may be made for a period up to six months prior to the month the reconciliation is done.

ii. **Assets**

[6] 42 U.S.C. 1396r-5(2) (A); 42 U.S.C. 1396r-5(b) (2) (B) (ii).
[7] 42 U.S.C. 1396r-5(b) (2) (A) (i); 42 U.S.C. 1396r-5(b) (2) (B) (I).
[8] 42 U.S.C. 1396r-5(b) (2) (A) (ii); 42 U.S.C. 1396r-5(b) (2) (B) (II).
[9] 42 U.S.C. 1396r-5(b) (2) (A) (iii); 42 U.S.C. 1396r-5(b) (2) (III).
[10] Id.

All countable assets are counted to determine financial eligibility for long–term care coverage. Exempt categories of assets, such as the individual's home or vehicle, are not included in the individual's countable assets. Exempt assets are defined in Attachment B – Assets.

Asset limits for specific coverage groups, if applicable, are defined in Section II. If an asset determination is required for financial eligibility, countable assets must be under $4,000 for individuals and $6,000 for couples on any day of the month for which eligibility is determined.

NOTE: Individuals institutionalized in a long-term care facility for longer than six (6) months will have a lien placed on their home, unless there is community spouse or dependent residing in the home. This rule does not apply to individuals receiving HCBS Waiver services.

1. **Spousal share for married couples**

   One-half of the couple's total countable assets are considered available to the institutionalized or Waiver spouse. Any assets held by either spouse at the time of long-term care placement in an institution or Waiver program are counted in the spousal share.

2. **Allocation of assets for married couples**

   All assets held by the institutionalized or Waiver spouse, the community spouse, or both, shall be considered available to the institutionalized or Waiver spouse, unless one of the following exceptions apply:

   a. The institutionalized or Waiver spouse has assigned to the District any rights to support from the community spouse;
   b. The institutionalized or Waiver spouse lacks the ability to execute an assignment due to physical or mental impairment, but the District has a right to bring a support proceeding against a community spouse without such assignment; or
   c. The District determines that the denial of eligibility would work an undue hardship. Refer to Section 6.III.E.iv, Undue Hardship Waiver of Penalty Period.

3. **Treatment of spousal assets during the continuing eligibility period**

   The community spouse's assets are only counted for the month of application.

4. **Reallocation of excess countable assets**

   If countable assets exceed the applicable asset limit, the individual may be able to reduce countable assets by reallocating them from countable to non-countable sources.

B. Process

Determine countable income for individuals and married couples:

i. Add all income from countable income sources. Do not include non-countable income. Refer to Attachment A – Income.
ii. If an institutionalized or Waiver spouse receives income pursuant to an instrument or trust document, add that income to the countable income pursuant to the terms of the instrument or Refer to Section 6.III.A.i.1, Allocation of community spouse's income to institutionalized or Waiver spouse.
iii. Reconcile the individual's countable income at the end of each six-month period or if the individual reports a change in income. Refer to Section 6.III.A.i.3, Periodic reconciliation of income.

Determine countable assets for individuals and married couples:

iv. Add all assets available to the individual. If the individual is married, include all assets available to the spouse, unless an exception applies. Refer to Section 6.III.A.ii.2, Allocation of assets for married couples. Do not include exempt assets. Refer to Attachment B – Assets.
v. If the individual is married, determine the spousal share. Reduce the total combined countable assets available to each spouse by one-half.
vi. If the individual is over the asset limit for the applicable coverage group, the individual is ineligible for long-term care services coverage. The individual may choose to reallocate assets and then submit a new application for coverage. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets.

C. Examples

i. Gerald applies for a HCBS Waiver program. He does not receive Medicare benefits. He has countable assets totaling $5,000 and monthly countable income totaling $3,000. He does not qualify for Medicaid coverage of his HCBS services because he is over the income limits for Special Income Standard eligibility. He is also over the asset limit for Medicaid. To be able to spend down his income to the Medically Needy Income Level, Gerald must first reduce his countable assets by reallocating them from countable to non-countable sources. Gerald

purchases a burial plot for $1,100, bringing his total countable assets down to $3,900. He can now submit a new application for coverage and will be determined to meet the asset limit and eligible to spend down his excess countable income to the Medically Needy Income Level.

ii. Paul is a married man residing in a nursing facility. He has countable assets totaling $3,000, monthly income in his name of $2,000, and an additional income source of $1,500, which is in the name of both him and his spouse. For the purposes of spend down, his total countable income is all of the income in his name, plus one half of all income he shares with his spouse. His total countable income is $2,750 per month.

iii. Roopa, an institutionalized spouse, and Anthony, her community spouse, each own a one-half interest in a trust that pays $200 per month. The income is attributed to them in proportion with their interest. Therefore, $100 is attributed to Roopa and $100 is attributed to Anthony.

iv. Robert, an institutionalized spouse, owns a trust that is entirely in his name. The trust provides $300 in income each month. The entire $300 is attributed to him. He and his spouse, Sally, were foster parents before entering the institution. As foster parents, they received $600 per month in foster care payments. While Robert is institutionalized, the foster care payments that Sally receives are not deemed available to him.

D. Right to Request a Resource Assessment

The institutionalized or Waiver individual or a community spouse has the right to request a resource assessment at the beginning of the first continuous period of institutionalization. If a resource assessment request is made, the District will calculate and document the total value of the individual's or couple's assets. The District must retain a copy of the resource assessment and also provide a copy to the individual or spouse. The District must also notify the individual or spouse of their right to a fair hearing on the resource assessment.[11]

E. Penalty Period for Improper Transfer of Assets

i. Policy

When an individual applies for Medicaid coverage for institutional or HCBS Waiver long-term care services, the individual will be subject to a review, or "look back," to determine whether the individual or his or her spouse transferred assets to another person or party for less than fair market value (FMV). The look back period consists of the sixty (60) months prior to the date the individual applied for Medicaid. When individuals transfer assets at less than FMV, they are subject to a penalty that delays the date they can qualify to receive Medicaid long term care services.[12] Refer to Attachment D – Treatment of Trusts, Annuities, and

[11] 42 U.S.C. 1396r-5(c)(1)(B).
[12] Deficit Reduction Act of 2005 §6011; DC Medicaid State Plan, Supplement 9(a) to Attachment 2.6-A.

Certain Financial Transactions.

NOTE: If an individual's right to receive income or assets is given or assigned in some manner to another person, such a gift or assignment is treated as a transfer of assets for less than fair market value.

NOTE: The transfer of lump sum payments before they can be counted as assets is treated as a transfer of assets for less than fair market value.

NOTE: For jointly owned assets, a withdrawal of funds or removal of the asset by the other owner that removes the funds or property from the control of the individual is treated as a transfer of assets for less than fair market value. The placement of another person's name on the account or asset that limits the individual's right to sell or dispose of the asset is treated as a transfer of assets for less than fair market value.

ii. Exceptions to Penalty Period for Improper Transfer of Assets

The following transfer of assets shall not be subject to a penalty:

1. The asset transferred is the individual's home, and title to the home is transferred to:
    a. The spouse of the individual;
    b. A child of the individual who is under age 21;
    c. A child who is blind or permanently and totally disabled;
    d. The sibling of the individual who has an equity interest in the home and who has been residing in the home for a period of at least one year immediately before the date the individual becomes institutionalized; or
    e. A son or daughter of the individual (other than a child as described above) who was residing in the home for at least two years immediately before the date the individual becomes institutionalized, and who provided care to the individual which permitted the individual to reside at home, rather than in an institution or facility.

2. The assets:
    a. Were transferred to the individual's spouse or to another for the sole benefit of the spouse;
    b. Were transferred from the individual's spouse to another for the sole benefit of the spouse;
    c. Were transferred to the individual's child who is blind or permanently and totally disabled, or to a trust established solely for the benefit of the individual's child;
    d. Were transferred to a trust established for the sole benefit of an individual under 65 years of age who is disabled as defined under SSI.

3. A satisfactory showing is made to the District that:
    a. The assets have been returned to the individual or the fair market equivalent has been returned;
    b. The assets were transferred only for a reason other than to qualify for Medicaid long term care services; or
    c. The individual intended to dispose of the assets for fair market value.

iii. Undue Hardship Waiver of Penalty Period

The penalty period may be waived if doing so could create an undue hardship. Undue hardship may exist if:

1. The individual has been threatened with eviction from a long-term care facility or medical institution and has exhausted all legal methods to prevent the eviction; or
2. The individual's HCBS Waiver provider has threatened to terminate HCBS Waiver services; and
    i. The transferee is no longer in possession of the transferred asset and the transferee has no other assets of comparable value with which to pay the cost of care; and
    ii. There is no family member or other individual or organization able and willing to provide care to the individual; or
3. The individual would be deprived of medical care that would endanger his or her life or health; or food, clothing, shelter, or other necessities of life; or
4. Any other undue hardship or good cause exemption exists, as may be defined by the Secretary for the Department of Health and Human Services or the Secretary for the Department of Agriculture. [13]

iv. Process

An asset is considered to be transferred for less than fair market value (FMV) if the asset was given away or if the amount received by the individual for the asset is less than its fair price in the local market.

To determine the penalty period, ESA will divide the total uncompensated value of the transferred asset by the average monthly cost of a private pay nursing facility patient in the District. The total uncompensated value is determined by subtracting the amount received by the individual from the FMV of the asset. If the calculation results in a partial month at the end of the penalty period, the individual is only eligible for long-term care services for the portion of the month after the penalty period ends.

[13] DC Medicaid State Plan, Supplement 9(a) to Attachment 2.6-A, page 5.

v. Examples

1. Elaine, an institutionalized spouse, transfers her $20,000 bank account to her community spouse, Jane. The transfer is legal because Jane is her community spouse. Elaine will not be penalized for making this transfer. If Elaine transferred her bank account to her daughter, Carla, instead of Jane, she would be subject to a penalty period because Carla is not her community spouse.
2. Bridget, an institutionalized spouse, transferred her $20,000 bank account to her daughter six years ago. This transfer will not subject Bridget to a penalty period because this transfer occurred outside of the look back period.
3. Sam sold his vacation home to his neighbor two months before he was admitted to a nursing care facility. The neighbor paid him $30,000 even though the value of the home was $100,000. The uncompensated value of the home is $70,000. Because the improper transfer occurred within the 60 month look back period, he will be assessed a penalty period. If the average monthly cost of nursing facility care in the District $7,000, he will not be eligible for Medicaid coverage of long-term care services for the first ten (10) months he is institutionalized ($70,000 divided by $7,000 equals 10).

IV. COMMUNITY SPOUSAL IMPOVERISHMENT PROTECTIONS

The Medicaid program creates financial protections for the spouses of individuals who require institutional or HCBS Waiver services. Spousal impoverishment protections are allowances and deductions to a couple's income and assets, defined by the Social Security Act, that are designed to prevent the impoverishment of the community spouse.[14] Currently, spousal impoverishment protections apply only to institutionalized spouses who were institutionalized in a long-term care facility on or after October 1, 1989. Under the 2010 Spousal Impoverishment Law, implemented under the Medicare Catastrophic Coverage Act of 1988 (MCCA), spousal impoverishment protections were extended to the spouses of HCBS Waiver individuals from January 1, 2014. Spousal impoverishment protections are not afforded to an individual who becomes eligible through the spend down process until the full amount of the spend down obligation is met.

A. Community Spouse Allowance (CSA)

[14] 42 U.S.C. §1924(d)(3), (6); Medicaid State Plan, Supplement 13 to Attachment 2.6-A.

i. Policy

The community spouse of an institutionalized or Waiver individual may retain a minimum monthly maintenance needs allowance (MMMNA), plus any excess shelter allowance, if applicable.[15] Excess shelter allowances may include rent or mortgage payments, electric, gas, heating oil, water, and a standard telephone deduction.

If the community spouse's countable income is less than the MMMNA, the institutionalized or Waiver spouse may provide the difference between the MMMNA and the community spouse's income. If the institutionalized spouse does not have income sufficient to bring the community spouse's monthly income allowance up to the MMMNA, the institutionalized or Waiver spouse may transfer any available assets that can produce income up to meet the MMMNA.[16] If the institutionalized or Waiver spouse does not have sufficient income or income producing assets to bring the community spouse's income up to the MMMNA, the community spouse will not receive the MMMNA.

The institutionalized or Waiver individual may deduct the amount provided as a spousal allowance from the institutionalized or Waiver spouse's countable income as long as the allowance is made available to the community spouse.

NOTE: The District shall verify that the individual has actually made available any spousal allowance to the community spouse at the first regularly scheduled renewal following the initial eligibility determination.

ii. Process

1. Determine the amount of countable income available to the community spouse. Refer to Section 6.III, Evaluation of Income and Assets.
2. Determine the total MMMNA the community spouse is entitled to receive by adding any excess shelter expenses to the MMMNA.
3. If the community spouse's countable income is less than the total MMMNA, verify the amount of the institutionalized or Waiver spouse's countable income. Refer to Section 6.III, Evaluation of Income and Assets.
    a. Deduct this amount from the institutionalized or Waiver spouse's countable income.
    b. If there is still an income deficit, verify the institutionalized or Waiver spouse's countable assets and the institutionalized or Waiver spouse to transfer to the

[15] This amount is published annually by CMS on cms.gov.
[16] 42 U.S.C. §1924(a).

community spouse the amount of assets needed to produce the amount of income to meet the MMMNA. Refer to Section 6.III, Evaluation of Income and Assets.

c. If there is still is an income deficit, the community spouse will not receive the MMMNA.

iii. **Exception: Allowance Greater than the MMMNA**

The community spouse may be entitled to a monthly amount higher than the MMMNA if he or she has a court order for spousal support or demonstrates "exceptional circumstances resulting in severe financial duress." Exceptional circumstances may include: recurring or extraordinary non-covered medical expenses; amounts to preserve, maintain, or make major repairs to a home; transportation costs; and amounts necessary to preserve an income-producing asset.

Exceptional circumstances must be determined at a fair hearing within thirty (30) days of the request for hearing.

iv. **Examples**

1. Ann is a community spouse whose income is $2,500 per month. Ann's income is $561.25 less than the MMMNA of $1,938.75. Her spouse, Ted, has income of $900 per month. Ted may transfer $561.25, the difference between the MMMNA and Ann's income, to her in order to bring her income up to $1,938.75. Ted may deduct the $561.25 from his countable income under the community spouse allowance. Ted's countable income is $338.75.
2. If Ann also pays $75 for gas, $120 for electric, $21 for telephone, and $50 for water each month, she will be entitled to retain the total amount, $266, in addition to the MMMNA under the excess shelter allowance. Ted may also deduct $266 from his countable income under the community spouse allowance. Ted's countable income is now $72.75.
3. Laura is a community spouse whose income is $500 per month. Her spouse, Mary, resides in a nursing facility. Her income is $1,438.75 less than the MMMNA of $1,938.75. The total amount that Mary is allowed to transfer to Laura is $1,438.75, the difference between Laura's income and the MMMNA. However, Mary only has $600 per month in income, which only brings Laura's income to $1,100. If Mary has assets in her own name, she can transfer the amount of assets necessary to produce the $838.75 each month to Laura to meet the MMMNA. In order to make such transfer, either Laura or Mary must establish at a fair hearing that the community spouse resource allowance is inadequate to raise he community spouse's income up to the

MMMNA. If so, Mary may transfer assets to Laura to generate $838.75 each month, bringing Laura's total income up to the MMMNA.

B. Community Spouse Resource Allowance (CSRA)

i. Policy

A community spouse may retain a portion of the couple's shared assets to meet current and future financial needs. The Centers for Medicaid and Medicare Services (CMS) sets the minimum and maximum amounts that may be claimed by a community spouse as a community spouse resource allowance (CSRA).

The CSRA is the spousal share of assets available to the community spouse during the initial eligibility determination, unless the spousal share is less than or greater than the resource standards set by CMS. If the spousal share is lower than the CMS minimum resource standard, the community spouse may claim the minimum resource standard. If the spousal share is greater than the CMS maximum resource standard, then the community spouse may only claim the maximum amount.[17]

1. Transfers of Assets to Community Spouse

An institutionalized or Waiver spouse may, without regard to penalties for transfers of assets for less than fair market value, transfer assets to the community spouse in an amount up to the community spouse resource allowance. This transfer shall be made as soon as possible after the determination of eligibility, taking into account the time needed to obtain a court order for support, if applicable.

If a court has ordered the institutionalized or Waiver spouse to support the community spouse, the penalty process shall not apply to assets transferred pursuant to such order for the support of the spouse or a family member.

NOTE: The District shall verify that the institutionalized spouse has completed any required asset transfers at the first regularly scheduled renewal following the initial eligibility determination.

2. Exception: Increased CSRA

If either the community spouse or the institutionalized or Waiver spouse is dissatisfied with the CSRA determination, that spouse is

[17] 42 U.S.C. §1924(f)(2).

entitled to a fair hearing within 30 days of the request for hearing. If either spouse establishes at the fair hearing that the CSRA does not generate enough income to raise the community spouse's income to the Minimum Monthly Maintenance Needs Allowance (MMMNA), the community spouse resource allowance shall be increased to an amount adequate to provide the MMMNA.

The amount of the CSRA may also be set by a court order or fair hearing, in such case the minimum and maximum amounts are not controlling.

ii. **Process**

1. Determine the couples' combined countable resources and the spousal share. Refer to Section 6.III.A.ii.1, Spousal share for married couples.
2. Compare the community spouse's spousal share to the CMS resource standards to determine the couple's protected asset amount. If there is a court order or amount set by fair hearing, then do not compare this amount to the CMS resource standards. If the spousal share is over the maximum standard, set the CSRA at the maximum amount. If the spousal share is under the minimum standard, set the CSRA at the minimum amount. Otherwise, set the CSRA at the spousal share.
3. If the community spouse's countable assets are lower than the CSRA, allow the institutionalized or Waiver spouse to transfer assets to the community spouse up to the CSRA.
4. If the CSRA does not generate enough income to raise the community spouse's income to the MMMNA, notify the individual that either spouse may request a fair hearing to increase the CSRA.
5. Compare institutionalized spouse's unprotected spousal share to the asset limit for one person ($4,000). If the unprotected spousal share exceeds the asset limit, the couple is not eligible for Medicaid long term care services. Allow the individual to reduce unprotected assets to the asset limit.

iii. **Examples**

1. Mary is a community spouse. Her spouse, James, is institutionalized. The couples' total countable assets are $110,000. The spousal share, which is one-half the couple's total countable assets in either or both Mary's and James's names at the time of institutionalization, is $55,000. The amount of the spousal share is greater than the minimum and less than the maximum, so the CSRA is the amount of the spousal share: $55,000. Mary may keep $55,000 in assets without incurring any penalties. The

remaining $55,000 is the unprotected asset amount used to determine James's eligibility. Because $55,000 is greater than the assets limit for one person ($4,000), Mary and James would need to reduce the unprotected assets of $55,000 down to $4,000 before Medicaid would begin to help pay for institutional care.

2. John is a community spouse. His spouse, Jerry, is institutionalized. The couples' total countable assets are $30,000. The spousal share, which is one-half of the couple's total countable assets held by either or both of them, is $15,000. The amount of the spousal share is less than the minimal CSRA of $23,448. Therefore, John may keep a CSRA of $23,448. Jerry's remaining assets are $6,552 ($30,000 minus $23,448) which is over the asset limit for one person ($4,000) by $2,552. John and Jerry would need to reduce Jerry's remaining assets to the asset limit before Medicaid would begin to help pay for Jerry's care.
3. Charles is a community spouse. His spouse, Julie, is institutionalized. The couple's total combined assets are $110,000. The spousal share, which is one-half of the couple's total countable assets held by either or both of them, is $55,000. This amount is greater than the minimum of $23,448, but less than the maximum CSRA of $117,240 so in this case, Charles may keep the CSRA of $55,000 without incurring any penalties. However, Charles is dissatisfied with the amount of the CSRA, so he requests a fair hearing. During the hearing, the Administrative Law Judge establishes $65,000 as a CSRA for Charles. Julie needs to transfer an additional $10,000 from her countable assets to Charles to bring his CSRA up to $65,000. Charles and Julie would then need to reduce Julie's remaining assets of $45,000 down to $4,000 before Medicaid would begin to help pay for her care.

C. Rights to a Fair Hearing under the Spousal Impoverishment Law for Assets and Income

When an institutionalized or Waiver spouse has applied for Medicaid coverage of long-term care services, either the community spouse or the institutionalized or Waiver spouse may request a fair hearing on any of the following:

1. The Community Spouse Allowance;
2. The amount of any other income otherwise determined available to the community spouse;
3. The Spousal Share;
4. The Community Spouse Resource Allowance; or
5. The attribution of assets.

Any such hearing respecting the determination of the community spouse allowance or community spouse resource allowance shall be held within 30 days of the request for the hearing.

V. CALCULATION OF BENEFICIARY CONTRIBUTION TO THE COST OF CARE (PATIENT PAYABILITY AMOUNT)

A. Policy

After an institutionalized or Waiver individual has been determined eligible for Medicaid coverage of long-term care services, the Economic Security Administration (ESA) will calculate the amount the institutionalized or Waiver individual is obligated to contribute to the cost of his or her care. The Medicaid program must reduce its payment for institutional care or HCBS Waiver services to the long-term care provider by the amount of the eligible individual's monthly income, after allowable deductions and community spousal impoverishment income protections have been applied. The amount left constitutes the beneficiary's contribution to cost of care.

The definition of income is the same as is used in the eligibility determination process. Refer to Section 6.III, Evaluation of Income and Assets.

i. Allowable Deductions from Income

1. **Personal Needs Allowance (for Institutionalized Individuals Only)** - The Personal Needs Allowance (PNA) is a standard income amount that an individual residing in an institution or receiving residential supports through the Department on Disability Services (DDS) may retain to pay for personal needs not provided by the institution. The District's PNA is $70.00 for an individual in a nursing facility and $140.00 for a couple institutionalized in a nursing facility. For an individual in a nursing facility who receives a VA pension, the PNA is $90.00. The PNA for individuals who receive residential supports through the Department on Disability Services (DDS), such as Supported Living, Residential Habilitation, and Host Home, is $100.00. The PNA for individuals in an ICF/IID who receive Supplemental Security Income (SSI) is $70.00. The PNA for individuals in an ICF/IID who receive Social Security Disability Income (SSDI) is $100.00. The PNA is the equivalent of the Community Maintenance Needs Allowance (CMNA) that is available to HCBS Waiver participants who live in their home.

2. **Community Maintenance Needs Allowance (CMNA):** the Community Maintenance Needs Allowance (CMNA) is a standard income amount that an HCBS Waiver participant living in their

home may retain to afford the costs associated with living in the community, such as expenses related to mortgage, rent, food, utilities, taxes, and home repairs. The District's CMNA is the equivalent of the Special Income Standard (SIS), or 300% of the SSI federal benefit rate. The CMNA is the equivalent of the Personal Needs Allowance (PNA), but applies to Home and Community-Based Waiver participants who live in their home.

3. **Community Spouse Allowance** - The institutionalized or HCBS Waiver individual may deduct the Community Spouse Allowance from the institutionalized or Waiver individual's countable income, as long as the allowance is made available to the community spouse. Refer to Section 6.III.A.ii.2, Allocation of assets for married couples.

4. **Dependent Family Allowance** - An institutionalized or HCBS Waiver individual may deduct an amount for the financial maintenance of other family members living in the home. The term "family member" includes only: minor or dependent children, including adult children with a disability, dependent parents, or dependent siblings of the institutionalized or community spouse who reside with the community spouse.

   The Dependent Family Allowance is the equivalent of the Medically Needy Income Level (MNIL) for each dependent family member.

5. **Other Incurred Medical or Remedial Care Expenses** - An institutionalized or HCBS Waiver individual may have medical expenses that are not covered by Medicaid or other third-party insurance, such as health insurance premiums, pre-eligibility medical expenses (PEME) which were incurred but not paid, deductibles, copays and guardianship/conservator costs. If medical expenses are used to meet a spend down amount, they may also be used as a medical expense in post eligibility.
   a. Guardianship/ Conservator Costs
      i. Remedial expenses can include fees paid to a guardian, conservator, or representative payee. A guardian or conservator is appointed when an individual lacks the capacity to care for him or herself or to manage his/her medical, legal, and financial affairs.
      ii. Guardianship or conservator fees include but are not limited to:
         1. Court filing fees;

2. Court-approved guardianship/conservatorship fees; and,
3. Court-approved legal fees.

iii. The individual must submit a copy of the court order or other legal agreement, and any supporting documentation, including an itemized bill for allowable guardianship/conservatorship expenses.

6. **Home Maintenance Deduction (for Institutionalized Individuals Only)** - If the individual has no community spouse living at home, and a physician has certified that the institutionalized individual is likely to return home within six (6) months, an amount may be deducted for the maintenance of the home.

   The home maintenance deduction is equal to the MNIL for one individual, and must not be deducted for more than a six (6) month period.

7. **Supplemental Security Income (SSI) or State Supplementary Payment (SSP) Benefits** - If the institutionalized or HCBS Waiver individual receives Supplemental Security Income (SSI) or State Supplementary Payment (SSP) benefits, the individual may deduct the full amount of these benefits.

ii. **Process**

Calculate the institutionalized or Waiver individual's contribution to his or her cost of long-term care services; after an individual has been determined eligible for Medicaid coverage of long-term care services:

1. Calculate the individual's countable income. Refer to Section 6.III, Evaluation of Income and Assets.
2. Subtract all applicable deductions from the individual's countable income. The remaining countable income is the patient payability amount.
3. Certify the patient payability amount for a one-year period. Notify the institutional or Waiver provider(s) and the individual of the patient payability amount.
4. At the end of each six-month period, or whenever any significant change in the individual's income or circumstances occurs, reconcile the projected income with the actual income that was received. Refer to Section 6.III.A.i.3, Periodic reconciliation of income. If a change in income is found at the time of reconciliation, recalculate the individual's patient pay amount and issue a new Form 1445. Any adjustments to the individual's patient pay amount will be applied prospectively.

iii. Examples

1. *(SSI Only)* - Ms. Jones resides in a long-term care facility and is applying for Medicaid coverage. Her monthly income is the amount she receives as an SSI beneficiary, which is $70.00 per month. Ms. Jones' SSI will reduce to $30.00 and the District would give her a state supplement in the amount of $40.00, to make her monthly income $70.00. Her personal need allowance in the long-term care facility would be $70.00. Her patient payability will be deducted from her monthly income (70 minus 70), which makes her patient payability equal zero.
2. *(SSI Plus Other Income)* - Ms. Henry resides in a long-term care facility and is applying for Medicaid. Her monthly income consists of SSI in the amount of $10.00 and a pension in the amount of $700.00 a month. Her SSI payments will terminate because her additional income is greater than $30. If Ms. Henry has incurred medical expenses of $30, her patient payability will be $600 ($700 minus $70 for her PNA and $30 for her incurred medical expenses deduction).
3. Mary received long term care services through an HCBS Waiver for the past two years. Mary has earned income from a part time job. She has worked three days a week during the past six months, earning $1,000 per month. In future months, Mary will work only two days a week, earning $700 per month. The District will treat Mary's average earnings ($1,000) as monthly income for the next six months. At the end of the six months, the District will determine Mary's actual income to reconcile any discrepancies between her projected income ($1,000) and actual income ($700). The District will use Mary's actual income as her projected income for the next prospective six month period.

7. TREATMENT OF INCOME AND ASSETS DURING ELIGIBILITY PERIOD AND AT ANNUAL RENEWAL

I. VERIFICATION OF ALLOWABLE TRANSFER OF ASSETS

Where an institutionalized individual is allowed to transfer excess countable assets following the initial eligibility determination to a community spouse, the individual must reallocate excess countable assets as soon as practicable before the first regularly scheduled renewal. No reallocation of assets to the community spouse may be made after the first annual renewal. Refer to Section 6.III, Evaluation of Income and Assets.

The District shall verify that the individual has transferred excess countable assets and/or

made available any amount of income under a spousal allowance to the community spouse at the first annual renewal following the initial eligibility determination. If excess countable assets have not been transferred and/or income has not been made available by the first annual renewal, the assets and/or income will be counted against the beneficiary spouse and may result in termination of long term care benefits.

Example:

1. Florence is a community spouse. Her spouse, Benjamin, is institutionalized. The couples' total countable assets are $24,000. The spousal share, which is one-half of the couple's total countable assets held by either or both of them, is $12,000. The amount of the spousal share is less than the minimum resource standard of $23,448. Therefore, Florence may keep a Community Spouse Resource Allowance (CSRA) of $23,448. At Benjamin's first annual renewal, the District will verify that any assets that were above the $4,000 asset limit were transferred from Benjamin's name into Florence's name.

II. CHANGES IN INCOME OR ASSETS DURING ELIGIBILITY PERIOD

A community spouse's income and assets are not deemed to be available to the institutionalized spouse for any month following the month of application. When there are changes in the amount of a community spouse's income or assets following the initial eligibility determination, no changes in the amount of the Community Spouse Allowance (CSA) or Community Spouse Resource Allowance (CSRA) will be made until the first annual renewal. When an institutionalized spouse receives an increase in countable income or assets, the District shall re-determine financial eligibility for the institutionalized spouse. Refer to Section 6.III.A.ii.4, Reallocation of excess countable assets and Section 6.IV.B.i.1, Transfer of Assets to Community Spouse.

Example:

1. Betty, an institutionalized spouse, and Alfred, her community spouse, each own a one-half interest in a trust that pays $200 per month. The income is attributed to them in proportion with their interest. Therefore, $100 is attributed to Roopa and $100 is attributed to Alfred. During the eligibility period, Alfred begins receiving pension payments of $3,000 per month and a lump sum payment of $10,000. These amounts will not be considered available to Betty at any point during the eligibility period. At renewal, the amount of any Community Spouse Allowance (CSA) that Betty and Alfred are entitled to retain will be adjusted based on his new monthly income.

8. RESPONSIBILITIES OF LONG-TERM CARE PROVIDERS AND THE ECONOMIC SECURITY ADMINISTRATION (ESA)

The institutional care provider or case management agency, in the case of an HCBS Waiver participant, is responsible for helping the institutionalized or HCBS waiver individual or the

individual's family to apply for assistance under Medicaid to pay for the cost of care. The nursing facility or case management agency must assist the individual or the individual's family to obtain any necessary documentation to process their application for Medicaid assistance.

I. PROVIDERS OF INSTITUTIONAL CARE SERVICES

Start of Care Packet - Institutional care providers are required to submit a start of care packet to ESA within seven (7) days of when a long-term care recipient in a nursing facility or ICF/IID can qualify to receive Medicaid long-term care services. The long term care packet consists of the Long Term Care Application and Patient Start of Care Form 1346. For individuals who are not already enrolled in Medicaid, the institutional provider must also submit a Combined Application for Benefits and Level of Care form.

A. **Long Term Care Application -** The long-term care facility is responsible for submitting a completed Long Term Care Application within seven (7) days of when the facility admits an individual who is already enrolled in Medicaid or the individual can qualify to receive Medicaid long-term care services. The Long Term Care Application must be signed and dated by the individual or the individual's authorized representative with proof of D.C. residency. The individual may also be required to submit proof of income, assets, health insurance, and spousal/dependent information.

B. **Combined Application for Benefits -** If the individual is not already enrolled in Medicaid, the long-term care facility is required to submit a completed Combined Application for Benefits in addition to the Long Term Care Application within seven (7) days of when the facility admits the individual or the individual can qualify to receive Medicaid long-term care services. The Combined Application must be signed and dated by the individual or the individual's authorized representative with proof of D.C. residency. The individual may also be required to submit proof of income, assets, health insurance, and spousal/dependent information.

C. **Patient Start of Care Form 1346** - The long-term care facility is required to submit a Patient Start of Care Form 1346 within seven (7) days of when the facility admits an individual who is already enrolled in Medicaid or the individual can qualify to receive Medicaid long-term care services. The completed Patient Start of Care Form must be signed and dated by the long-term care facility Administrator to be processed for long-term care coverage.

All sections must be completed by the facility:

Section A- Patient

The following must be completed;

1. Name

2. Medicaid Number, if available
3. Birth Date
4. Sex: Male or Female
5. Date Admitted to Facility
6. Admitted From: Hospital or Nursing Facility or Residence/Home
7. Name and address from which Admitted

Section B- Medical Condition

The following must be completed;

1. Type of Care Required: Nursing Facility or Skilled Nursing Care
2. Is the Physician's Certificate for Skilled Nursing on file? If "Yes"; what is the period under which the individual is covered under skilled nursing care?
3. Is the Physician's Certificate for Nursing Facility Care on file? If "Yes"; what is the period under which the individual is covered under nursing facility care?
4. Name of Attending Physician, must print or type

Section C - Medicare Information

The following must be completed;

1. Was the Patient admitted into a hospital or skilled nursing facility in the past sixty (60) days? If "Yes"; Name of the Hospital or Skilled Nursing Facility and dates of admission and discharge
2. Is Patient a Medicare Part A Beneficiary? If "No"; Why not? If "Yes"; what are the dates of coverage by Medicare, 100% Medicare coverage and 80% Medicare coverage?
3. What is the Patient Payability Start Date (the date on or after the first day that Medicare Part A coverage ended)?

Section D - Guardian, Conservator, or Authorized Representative

The following must be completed;

1. Name
2. Telephone Number
3. Address
4. Relationship

Section E - Facility

The following must be completed;

1. Name
2. Address
3. Facility Provider Number
4. Administrator Telephone Number
5. Name of Administrator

6. Signature of Administrator and Date form signed

How to Submit Forms to ESA: Completed forms must be sent to:

The Economic Security Administration (ESA)
Long Term Care Unit
609 H St. NE, 5th Floor
Washington, DC 20002

II. PROVIDERS OF HCBS WAIVER SERVICES

A. **EPD Waiver Application Package -** The EPD Waiver case management agency is required to submit an EPD Waiver application package in the CaseNet system when the case manager receives a completed application package for Waiver services. If additional information is needed to complete the eligibility determination process, ESA will contact the individual to obtain the information.

The EPD Waiver application package consists of the following forms:

1. Long Term Care Application
2. 30-AW
3. Risk Assessment
4. Bill of Rights
5. Beneficiary Freedom of Choice
6. Referral for Medicaid Level of Care (this form must be signed by the physician and submitted to the Quality Improvement Organization (QIO) or DHCF designated agent. The Quality Improvement Organization (QIO) or DHCF designated agent will make a determination regarding the level care or functional limitations which places the recipient at risk for institutional care)
7. Health History
8. Individual Service Plan
9. Combined Application for Benefits, if the individual is not already enrolled in Medicaid. The Combined Application must be signed and dated by the individual or the individual's authorized representative with proof of D.C. residency. The individual may also be required to submit proof of income, assets, health insurance, and spousal/dependent information.

B. **IDD Waiver Application Package** – The DDS/DDA Medicaid Waiver Unit is required to submit an IDD Waiver application package to ESA when the DDS/DDA Medicaid Waiver Unit receives a completed application package for Waiver services. If additional information is needed to complete the eligibility determination process, ESA will contact the DDS/DDA Medicaid Waiver Unit to obtain the information.

III. ECONOMIC SECURITY ADMINISTRATION (ESA)

The ESA Long Term Care Eligibility Unit is responsible for processing community Medicaid applications, long term care applications, and HCBS Waiver applications.

An individual who is determined eligible for or is already enrolled in Medicaid must also have eligibility for long-term care services determined by the ESA Long Term Care Eligibility Unit at the time of institutionalization or start of HCBS Waiver services.

For institutionalized individuals, when the ESA Long Term Care Eligibility Unit determines that an individual is eligible for Medicaid long-term care services, it will calculate the beneficiary contribution to cost of care and issue an eligibility notice to the long-term care facility and the individual.

For EPD Waiver participants, ESA will process the Waiver application package after it is submitted in the CaseNet system and notify the DHCF Long Term Care Eligibility Unit of the eligibility determination.

For IDD Waiver participants, ESA will process the Waiver application package after it is submitted to ESA and notify the DDS/DDA Medicaid Waiver Unit of the eligibility determination. All notices and other information relating to an individual's Medicaid eligibility are mailed to the DDS/DDA Medicaid Waiver Unit.

8. RESPONSIBILITY

The Department of Human Services, Economic Security Administration (ESA) and Department of Health Care Finance (DHCF) are responsible for the implementation of this policy and procedure.

Claudia Schlosberg, J.D.
Acting Senior Deputy Director

4/27/15
Date

ATTACHMENT A – INCOME

Countable Income:[18]

- Earned Income-taxable income received from working (wages, salaries, tips, union strike benefits);
- Unearned Income- any income received from other sources other than employment (Social Security Income, VA, Private Pensions, SSI, Railroad Retirement, Civil Service Retirement, interest, dividends, investments, income from rental property)
- Self-Employment

Non-Countable Income:[19]

- Children's Earnings (earnings from an unmarried child who is living with a person who provides care or supervision);
- Adoption Subsidy;
- AmeriCorps/VISTA Income;
- Child Nutrition Payments;
- Domestic Volunteer Service Act Payments;
- Earned Income Taxes Credit;
- Educational Benefits (e.g., Department of Education (DOE) Bureau of Indian Affairs Benefits, DOE Title IV Benefits, DOE Perkins Vocational and Applied Technology Education Act, DOE work study wages and other Education benefits work study);
- Energy Assistance;
- Foster Care Payments;
- Housing Assistance provided by the federal or District of Columbia government or non-profit organizations;
- Incentive Payments for Prenatal & Well-Baby Care and from the Work Incentive programs for current or former TANF recipients;
- In-Kind Benefits- non-cash benefits in the form of voucher, commodity or service (food stamps, Section 8 voucher);
- Jury Duty Payments
- Money Received By a Third Party for a Group Member (not counted unless group member gains access to the funds);
- Money Received by Group Member on Behalf of Non-Group Member (not counted as income received if it does not reflect the needs of the person receiving the money);
- Nutrition Payments;
- Rehabilitation Service Administration Payments;
- Reimbursements;
- Roommates- Shared Living Arrangement;
- Senior Community Service Employment;
- TANF Underpayments;
- Training Income: Training Expense Allowances/Stipends; and
- Utility Allowances Received Through a Housing Program.

[18] Medicaid State Plan, Supplement 8a to Attachment 2.6-A.
[19] Id.

ATTACHMENT B – ASSETS

Exempt Assets:[20]

- Personal home (if the individual's home equity interest does not exceed the maximum home equity limit);[21]
- Accounts Receivable;
- Burial Funds (if the funds are in a separate; designated account);
- Promissory Notes (if the notes are not related to transfers of assets within the past 36 months);
- Earned Income Tax Credit (excluding for the first 12 months);
- Energy Assistance (if the payments are co-mingled with other countable assets, then the agency will apply SSI operational methodologies);
- Proceeds from Home Sale (if the customer purchases or intends to purchase new home within the next 12 months);
- Household/Personal Goods;
- Inaccessible Assets (assets that are not legally available that have a value that is not able to be sold for a reasonable return);
- Indian Lands;
- Jointly Owned Assets (if the owner is legally unable to liquidate asset);
- Land Contract;
- Life insurance (if the face value is under $1,500);
- Life Insurance Funded Funerals;
- Loan-Related Assets;
- Non-Saleable Assets (not fit to sell or capable of being sold);
- Property Pending Sale;
- HUD Reimbursements;
- Vehicles (limited to one per household);
- Higher Education Savings Plans (including 529 accounts, education IRAs, etc.);
- U.S. Savings Bonds (if penalties apply to early withdrawals/liquidations and they have not been renewed /reinvested during any immediately preceding period of Medicaid eligibility);
- Individual Retirement Accounts (IRAs, which include Roth and other non-educational IRAs);
- Keogh Accounts (a tax deferred trust saving account that allows self-employed individuals or those who own their own incorporated business to save for their retirement);
- Other Retirement Accounts (including 401(k), 403(b), and 457 accounts but excluding some types of annuities (if these payments are co-mingled with other countable assets, then the agency will apply SSI operational methodologies); and
- Funds or deposits with Continuing Care Retirement Communities (unless the funds can be used to pay for care under the terms of the contract should other resources of the individual be insufficient; the entrance fee, or remaining portion, is refundable when the individual dies or leaves the community; and the fee confers no ownership interest in the community).

[20] Medicaid State Plan, Supplement 8b to Attachment 2.6-A.

[21] The Centers for Medicaid and Medicare Services (CMS) sets the maximum home equity limit annually. The maximum home equity limit does not apply if the spouse of the individual or a child of the individual who is under age 21 or has a disability resides in the home.

ATTACHMENT C – INCURRED AND RECURRING MEDICAL EXPENSES

Incurred medical expenses are medical expenses incurred by an individual, family member, or financially responsible relative that are not subject to payment by a third party (e.g. insurance provider). This may include premiums, deductibles, copayments, enrollment fees, and expenses for necessary medical and remedial services.[22] Recurring medical expenses are expenses that an institutionalized individual is projected to incur within the spend down budget period. Only medical expenses related to institutional care may be projected. Recurring medical expenses that are not subject to payment by a third party may be counted at the Medicaid reimbursement rate. For individuals enrolled in an HCBS Waiver, only medical expenses for care that is equivalent to an institutional level of care may be counted as a projected institutional expense.

For the purposes of calculating an individual's initial spend down obligation, deduct all incurred expenses that an individual incurs before application, regardless of the date of the service, if the expense has not already been used in another budget period, if the individual is still liable for them, or if the individual has paid for them in the current budget period.[23]

[22] 42 CFR §435.831(d) and (e)
[23] 42 CFR §435.831(f)

ATTACHMENT D – TREATMENT OF TRUSTS, ANNUITIES, AND CERTAIN FINANCIAL TRANSACTIONS

A. Revocable Trust

In the case of a revocable trust:

- The entire corpus of the trust is counted as an available resource to the individual;
- Any payments from the trust made to or for the benefit of the individual are counted as income to the individual;
- Any payments from the trust which are not made to or for the benefit of the individual are considered assets disposed of for less than fair market value.

B. Irrevocable Trust

In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust, the following rules apply to that portion:

- Payments from income or from the corpus made to or for the benefit of the individual are treated as income to the individual;
- Income on the corpus of the trust which could be paid to or for the benefit of the individual is treated as a resource available to the individual;
- The portion of the corpus that could be paid to or for the benefit of the individual is treated as a resource available to the individual; and
- Payments from income or from the corpus that are made but not to or for the benefit of the individual are treated as a transfer of assets for less than fair market value.

When all or a portion of the corpus or income on the corpus of a trust cannot be paid to the individual, treat all or any such portion or income as a transfer of assets for less than fair market value. In treating these portions as a transfer of assets, the date of the transfer is considered to be:

- The date the trust was established; or,
- If later, the date on which payment to the individual was foreclosed.

In treating portions of a trust which cannot be paid to an individual, the value of the transferred amount is no less than its value on the date the trust is established or payment is foreclosed. When additional funds are added to this portion of the trust, those funds are treated as a new transfer of assets for less than fair market value.

C. Exceptions to Treatment of Trusts:

Establishment of the following trust types do not constitute a transfer of assets for less than fair market value:

- **Special Needs Trust** - a trust containing the assets of an individual under age 65 with a disability and which is established for the sole benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court. The trust must contain a provision stating that, upon the death of the individual, the District receives all amounts remaining in the trust, up to an amount

equal to the total amount of medical assistance paid on behalf of the individual under the Medicaid State Plan. In addition to the assets of the individual, the trust may also contain the assets of individuals other than the individual with a disability.

- **Pooled Trust** – containing the assets of an individual with a disability that meets the following conditions:
    - The trust is established and managed by a non-profit association;
    - A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;
    - Accounts in the trust are established solely for the benefit of individuals with a disability by the individual, by the parent, grandparent, legal guardian of the individual, or by a court; and
    - To the extent that any amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the District the amount remaining in the account up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the Medicaid State Plan. To meet this requirement, the trust must include a provision specifically providing for such payment.

D. Annuities

At the time of application, applicants must disclose any interest in an annuity. For annuities purchased on or after February 8, 2006, the annuity must name the District as the primary remainder beneficiary, or second remainder beneficiary after a community spouse or minor or child with a disability, for an amount equal to the total amount of medical assistance paid on behalf of the individual under the Medicaid State Plan. The annuity must be irrevocable, non-assignable, actuarially sound, and provide for payments in equal amounts during the term of the annuity, with no deferral or balloon payments; or meet the requirements pertaining to retirement plans identified in 42 U.S.C. 1396p(c)(1)(G)(i). If the annuity does not meet these requirements, the full purchase price of the annuity is the amount considered a transfer for less than fair market value.

For annuities purchased prior to February 8, 2006, actions taken by the individual that change the course of payments to be made by the annuity or treatment of the income or principle of the annuity subject the annuity to the requirements related to transfers of assets for less than fair market value. Routine changes and automatic events that do not require action by the individual do not subject the annuity to the requirements related to transfers of assets for less than fair market value.

E. Life Estates

The purchase of a life estate interest in another individual's home is treated as a transfer of assets for less than fair market value, unless the purchaser lives in the home for at least one year after the date of purchase. If the purchase the purchase amount of the life estate is greater than the computed value of the life estate's interest, the difference is considered a transfer for less than fair market value.

F. Promissory Notes and Loans

The purchase of a promissory note, loan, or mortgage is treated as a transfer of assets for less than fair market value unless the following conditions are met:

- The repayment terms are actuarially sound;
- Payments are made in equal amounts with no balloon payments; and
- The note, loan, or mortgage prohibits cancellation of the debt upon the death of the lender.

Long Term Care Program Medical Assistance Application

Instructions:

This is an application for Medical Assistance that will cover some or all of the costs of persons who stay in approved Long Term Care Facilities, or who want to receive services under the Home and Community Based (HCBS) Waiver Program. The HCBS Waiver Program includes: Persons Who Are Elderly or Physically Disabled (EPD), and
Persons with Intellectual and/or Developmental Disabilities (IDD).

You, or someone you have chosen to act for you, need to complete this application only if you are about to enter, or are staying in a Long Term Care Facility, or are applying for the Home and Community Based Waiver Program. If you want EPD services, you must first contact the DC Office of Aging's Aging and Disabilities Resource Center (ADRC). You can call the ADRC on (202) 724-5626 on weekdays from 8:00 a.m. to 5:00 p.m.

This is **NOT** an application for Cash Assistance, Food Stamps or other types of Medical Assistance.

You must be a resident of the District of Columbia or if you just started staying in a Long Term Facility in D.C., you must plan to remain in D.C. after your discharge from the facility.

You can mail this application to:

Long Term Care Unit
645 H Street N.E. 5th Floor
Washington, D.C. 20002

You can also bring in this application to the 645 H Street, N.E. Service Center. If you mail this application, please enclose a copy of the following documents:

- Proof of Residency- Mortgage/Rent Statement, utility bill etc., or
  Start Of Care Notice from the Long Term Care Facility if you currently stay in a Facility
- Proof of Income for the past 30 days for self and spouse
- Proof of any Assets that you (or spouse) own such as Bank Accounts,
  Stocks, Bonds, Life Insurance, Real Property, etc.
- Health Insurance Cards
- Copies of all paid or unpaid Medical expenses for applicant
- Documents of any assets you transferred in the last five (5) years

Upon your request, an assessment of assets can be completed when you provide proof of all of your assets. (Combined assets for yourself and spouse).

If you have any questions, you can call 202-698-4220. Revised May 2015

1. PERSONAL INFORMATION

Name:		Social Security Number:
Date of Birth:	Sex: O Male O Female	Marital Status: O Single O Married O Divorced O Widowed O Separated
Current Address or your address prior to entering the Long Term Care Facility:		Do you plan on returning to this residence upon discharge? O Yes O No
Name and Address of the Long Term Care Facility:		Date you entered Facility:

Do you plan to stay in the District of Columbia? O Yes O No

Have you ever received Medicaid in another state? O Yes O No

If yes, list the state and the date that your Medicaid was terminated.

State: Date Medicaid was terminated:

2. INFORMATION ON SPOUSE: Complete this information even if you are not applying for your spouse.

Name:	Date of Birth:
Address:	Social Security Number:

Under Long Term Care rules, you can transfer a portion of your income to your community spouse, if his/her income is below about $2000 a month, or more when he/she has high shelter costs. The income you can transfer is called a Spousal Allowance.

If your spouse qualifies for a Spousal Allowance, would you like to transfer a portion of your income to your spouse?
O Yes O No

If you agreed to transfer a portion of your income to your spouse, you need to tell us how much your income you want to keep and how much you would like to transfer. Please mark your choice below.

I want to transfer the maximum amount. O Yes O No If you answered no, tell us how much you want to keep.
I want to keep O $70 O $100 O $125 O $150 If you want to keep another amount, record the amount here. $_____

Are you responsible to pay Court Ordered Spousal Support (Alimony)? O Yes O No	If yes, the amount of monthly support:

3. INCOME: List below the types and amounts of unearned income and earnings you and/or your spouse receive. List the gross amount of income (before taxes and deductions are taken out).

Unearned Income - such as SSI, Social Security Benefits, Pensions and/or Annuities

Type of Unearned Income	Person Receiving Payment	Amount of Payment (before taxes and deductions)	How often is it received? (monthly, weekly, every two weeks, twice a month, etc.)

Earned Income

Person who is working	Employer's Name and Telephone Number	Amount of earnings before taxes and deductions	How often is it received? (monthly, weekly, every two weeks, twice a month, etc.)

4. Please list your spouse and any dependent children, dependent parents and dependent siblings that live in your home.

Last Name	First Name	Middle Initial	Sex	Date of Birth	Social Security Number	Relation to You	Do you claim this person as a dependent on your tax return?	Gross Monthly Income
1								
2								
3								
4								
5								

5. Legal Representation - Do you have one of the following acting on your behalf? Please answer here. O Yes O No

If you checked "yes" please provide the following information.

Conservator: O Yes O No	NAME:	ADDRESS:
	Do you pay a monthly Conservator fee? O Yes O No	
	If yes, the Fee Amount:	Telephone Number:
Representative Payee: O Yes O No	NAME:	ADDRESS:
	Do you pay a monthly Rep. Payee fee? O Yes O No	
	If yes, the Fee Amount:	Telephone Number:
Authorized Representative: O Yes O No	NAME:	ADDRESS:
	Do you pay a monthly fee? O Yes O No	
	If yes, the Fee Amount:	Telephone Number:

6A. Past Medical Expenses

If you have medical bills for services that you received before the month of this application, we may be able to help you pay some or all of those bills. If you don't want us to pay those bills, or Medicaid rules do not allow us to pay the bills, we may be able to reduce what you will need to pay for your long term care services.

You can ask for Medicaid to cover your medical bills for up to three months prior to the month of this application. We call this the **retroactive** period. For D.C. Medicaid to pay for those months, you must have lived in D.C., met income requirements, and met the resource limit for Medicaid of $4,000 for one person, or $6,000 for a couple. If you are eligible for the **retroactive** period, we will reimburse you for the bills you already paid for those months. **Retroactve** Medicaid may cover prior nursing home expenses, but may not cover other long term care services.

If you do not want **retroactive** benefits, you can ask us to use your unpaid medical bills to reduce the amount that you will need to pay for your long term care services for this month and future months. You can use any unpaid medical bills no matter how old they are. This includes unpaid bills for long term care services. If you want us to apply your past bills to your future long term care costs, then you will still be responsible for paying those past bills.

If your monthly income is more than $2,200, you may be over-income for LTC/HCBS services. Even if your income is over the limit, you may still be able to get LTC/HCBS Services by showing that you have high medical expenses. This is called Medicaid "Spend-Down." To get Medicaid under Spend-Down, you must have a certain amount of medical bills. The total amount of medical bills you need is your "deductible." When you have enough bills, including some past bills, you will meet your deductible and you may be eligible under Spend-Down. Medicaid will **not** pay the bills you count towards your deductible. After you meet your deductible, Medicaid may pay for your other medical bills. If you are over-income for LTC/HCBS services, you can use past medical bills to meet your Spend-Down deductible.

Under Spend-Down rules for LTC/HCBS services, you can also qualify based on the cost of the LTC/HCBS Services that you **expect** to pay during a six month Spend-Down period. If we approve LTC/HCBS services based on your **expected** costs, you are still responsible for paying these **projected** costs. If we use your projected LTC/HCBS costs to Spend Down to Medicaid, you can still use your past medical bills to reduce the amount you will need to pay for your LTC/HCBS services. You can use paid and unpaid bills from the current and past three months for Spend Down. You can also use unpaid bills that are more than three months old, and old bills that were just paid during the past three months. Since Medicaid cannot pay the bills that you use for Spend Down, it is usually best to use bills that you already paid. If you are found to be over-income and need to use Spend Down to get LTC services, we will send you a notice telling you the amount of your deductible. If you provide bills with your application that you ask us to use for Spend Down, we will send you an additioinal notice saying how much you still owe. In the over-income notice we send to you we will ask you if you want us to use your expected expenses. If you want us to use expected expenses, you will need to sign a statement saying you want to do that and return the signed statement to us. You can also provide any other bills you want to use.

If a third party insurance, like Medicare or other health insurance paid your medical bill, or if the bill was previously counted for Medicaid Spenddown eligibility, we cannot use the bill to reduce the amount you will need to pay for yout LTC/HCBS services.

In the boxes on the next page, please let us know if you want Medicaid coverage for the **retroactive** period, or if you want to use your past medical bills to reduce the amount you will need to pay for your future long term care services, or to determine your eligibility through Spend-Down, or if you want us to do a combination of these. For more information, ask your Medicaid worker.

6B. Listing of Past Medical Expenses

Do you need retroactive Medicaid coverage for paid or unpaid medical bills incurred during the past three months, including nursing home bills? O Yes O No	Do you have any past paid or unpaid medical bills, not being used to determine retroactive Medicaid coverage? (examples include Nursing Home expenses, Prescription drugs, Dental bills. Home Health Care costs, etc.) O Yes O No

If you answered "yes" to either, or both of the above questions, list the type and amount of these past medical bills that may be used to determine eligiblity for **retroactive** coverage, to qualify through Spend Down, and/or to calculate your share of the monthly costs for care in a Long Term Facility.

Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**
Type of Medical Service:	**Date of Medical Service:**	**Amount Billed for Medical Service:**

Attach another page if you have additional medical bills.

7. Health Insurance Information

Medicare Information (from your Medicare Card)

Do you have Medicare?	Type of Coverage:	Medicare Claim Number:	Effective Date
O Yes O No	O Part A O Part B		Part A:
			Part B:
Does your spouse have Medicare?	**Type of Coverage:**	**Medicare Claim Number:**	**Effective Date**
O Yes O No	O Part A O Part B		Part A:
			Part B:

Other Health Insurance

Do you have other health insurance?	O Yes O No	Amount of Monthly Premium: $
Does your spouse have other health insurance?	O Yes O No	Amount of Monthly Premium: $

If you or your spouse have other health insurance, including a Medicare supplement policy, please complete the boxes below and attach a copy (front and back) of the insurance cards.

	Health Insurance Company- Name and Address	Monthly Premium	Policy Number	Type of Coverage (Medigap, Retiree, RX, etc.)
Self				
Spouse				

8A. Current Assets

Do you or your spouse currently own any of the following assets? O Yes O No

If you answered "yes", please list the type and amount of assets you or your spouse currently own.

Asset Type	Value	Asset Type	Value
Bank or Credit Union Account	$	2nd Bank or Credit Union Account	$
Stocks/Bonds/Mutual Funds	$	Real Property including your Home	$
Certificates of Deposit	$	Boats/Recreational Vehicles/Motor Homes	$
Annuity/Trust Funds/Trust Accounts	$	Cash- Including Cash Surrender Value of any Life Insurance Policies	$

Do you or your spouse, own any other assets of value? O Yes O No

Description of Asset:	Asset Value:

8B. Assets when you entered the Long Term Care Facility

If you have a spouse who lived with you before you entered the Long Term Care Facility, you need to list below the amount of assets you or your spouse had when you entered the facility. You can skip this section if this situation does not apply to you.

Asset Type	Value	Asset Type	Value
Bank or Credit Union Account	$	2nd Bank or Credit Union Account	$
Stocks/Bonds/Mutual Funds	$	Real Property including your Home	$
Certificates of Deposit	$	Boats/Recreational Vehicles/Motor Homes	$
Annuity/Trust Funds/Trust Accounts	$	Cash- Including Cash Surrender Value of any Life Insurance Policies	$

Did you or your spouse own any other assets of value? O Yes O No

Description of Asset:	Asset Value:

8C. Transfer of Assets

Have you or your spouse given away or transferred anything of value in the last five years? This would include money in bank accounts, stocks, bonds, real estate or other possessions of value, or creation of an annuity. O Yes O No

If yes, complete the following:

Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:
Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:
Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:
Date of Transfer:	Who received the transferred asset?	Description of Asset:	Value of Asset at Transfer:	Amount received for Asset:

Attach another page if you transferred additional assets

9. Additional Questions to See How Much You May Need To Pay for Your Care

Do you own or rent a home? O Yes O No

Do you expect to return to this home within six (6) months? O Yes O No

If you expect to return, will your spouse or any of your dependents continue to stay in your home? O Yes O No

If your home will be unoccupied, you may qualify for a Home Maintenance Allowance that will reduce the amount you have to pay for your Long Term Care costs. If your home will be ocupied by your spouse, his/her Spousal Allowance may be increased becasue of high shelter expenses. Please list the amount you pay for the following:

Rent/Mortgage: _____	**Real Estate Taxes: _____**	**Home Insurance: _____**
Home Association Fees: _____	**Condo/Co-op Maintenance Fees: _____**	

10. Signature	
•	By signing below, I give my permission to DHS to get information about me and my spouse. DHS can get this information from those officials or institutions that have knowledge of my situation. I give all of these parties my permission to give information about me to DHS. I have reviewed the information in my application and I believe that all of the information on this entire application is true and correct. I know if I give false information, I may be breaking the law and I could be at risk of criminal prosecution and penalties. I know that state and federal officials will check this information. I agree to help and cooperate with their potential investigations.
•	I understand that the District of Columbia will seek recovery of the bills it pays for me when I am in a nursing home or other medical institution. This means that the District of Columbia may put a lien or claim on my property or estate.
•	I have received a copy of my rights and responsibilities. I understand my responsibilities and agree to cooperate as required.
•	I understand that if I, or my spouse, purchased an annuity on or after February 8, 2006, and I receive long term care services, the District of Columbia must be named a remainder beneficiary of the annuity.
•	Authorized Representative(s): If the applicant cannot sign this form, you may sign it for them. By signing, you certify that this person wants to apply for LTC benefits and agrees to the conditions above.

SIGNATURE: _____ **DATE:** _____

REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES
ECONOMIC SECURITY ADMINISTRATION

COMBINED APPLICATION FOR DC

MEDICAL ASSISTANCE
FOOD STAMPS
CASH ASSISTANCE*

* FOR THE DISABLED AND FAMILIES WITH CHILDREN

If you live in DC, you can use this form to apply for benefits. If you need help with this form, just ask your worker or another ESA employee. You can also call (202) 727-5355. Free interpreters are available.

Please bring this form to your area Service Center. To find out which Center is closest to you, call (202) 727-5355. You may also mail this form to 645 H St., NE, Washington, DC 20002.

❑ Sí, hablo ESPAÑOL (SPANISH)

Si usted vive en DC, puede usar este formulario para solicitar beneficios. Si necesita ayuda con este formulario, pídale ayuda a su trabajador u otro empleado de ESA. También puede llamar al (202) 727-5355. Intérpretes gratis están disponibles.

Por favor, lleve este formulario al Centro de Servicio de su área. Para saber cuál Centro le queda más cerca, llame al (202) 727-5355. También puede enviar este formulario por correo a 645 H St., NE, Washington, DC 20002.

Questions? ¿Preguntas? ጥያቄዎች?
有問題嗎？Có thắc mắc gì không?

☎ (202) 727-5355

FOR AGENCY USE ONLY ❑ Application ❑ Recertification

Case Name _____ Case # _____
Date Rec'd _____ Prog. Approved _____
Date Disp. _____ Prog. Denied _____

ESA Combined Application: Revised June 2013

❑ 是，我說中文 (MANDARIN)

"如果您住在D.C.，您可以用這份表格來申請福利。如果您填寫這份表格時需要幫助，您可以向工作人員或其他IMA員工詢問。您還可以致電 (202) 727-5355 我們有免費翻譯服務。"

"請將這份表格送到您所在地區的服務中心。欲知離您處所最近的服務中心的地址，請致電 (202) 727-5355 5506。您也可以將這份表格寄至 645 H St., NE, Washington, DC 20002。"

❑ እም አማርኛ እናገራለሁ (AMHARIC)

"በዲሲ ውስጥ የሚኖሩ ከሆኑ የእርዳታ ጥቅሞችን ለማግኘት በዚህ ቅጽ ሊጠቀሙ ይችላሉ። ይህንን ቅጽ ለመሙላት እርዳታ ከፈለጉ ጉዳይዎን የያዙትን ሠራተኛ ወይም ሌላ የአይኤምኤ ሠራተኛን ይጠይቁ። እንዲሁም በ (202) 727-5355 ለመደወል ይችላሉ። ነፃ አስተርጓሚዎች ይኖራሉ።"

"ለባከዎ ይህንን ቅጽ ወደ አካባቢዎ የአገልግሎት ማዕከል ይዘውት ይሂዱ። የትኛው ማዕከል በእርስዎ አቅራቢያ እንደሚገኝ ለማወቅ ደግሞ በ (202) 727-5355 ይደውሉ። ይህንን ቅጽ በፖስታ ቤት በኩል ለ645 H St., NE, Washington, DC 20002. ለመላክም ይችላሉ።"

❑ Có, tôi nói VIỆT (VIETNAMESE)

"Nếu quý vị sống tại D.C., quý vị có thể dùng mẫu đơn này để xin quyền lợi. Nếu quý vị cần giúp đỡ điền đơn này, xin hỏi nhân viên xã hội của mình hoặc một nhân viên khác của IMA. Quý vị cũng có thể gọi số (202) 727-5355. Có thông dịch viên miễn phí.

"Xin đem mẫu này tới Trung Tâm Dịch Vụ khu vực của quý vị. Để tìm hiểu xem Trung Tâm nào gần quý vị nhất, gọi (202) 727-5355. Quý vị cũng có thể gửi mẫu đơn này tới 645 H St., NE, Washington, DC 20002."

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

ECONOMIC SECURITY ADMINISTRATION SERVICE CENTERS

Anacostia Service Center
2100 Martin Luther King Avenue, SE
Washington, DC 20020
Phone: (202) 645-4614
Fax: (202) 727-3527

Congress Heights Service Center
4001 South Capitol Street, SW
Washington, DC 20032
Phone: (202) 645-4525
Fax: (202) 645-4524

H Street Service Center
645 H Street, NE
Washington, DC 20002
Phone: (202) 698-4350
Fax: (202) 724-8964

Fort Davis Service Center
3851 Alabama Ave., SE
Washington, DC 20020
Phone: (202) 645-4500
Fax: (202) 645-6205

Taylor Street Service Center
1207 Taylor Street, NW
Washington, DC 20011
Phone: (202) 576-8000
Fax: (202) 576-8740

*Customers may call ESA at **(202) 727-5355***
to learn which Service Center serves their address.

Questions? ¿Preguntas? ጥያቄዎች?
[illegible] ? Có thắc mắc gì không?

☎ (202) 724-5506

0020030101

Your Information

Last Name	First Name	Middle Name	Date of Birth	Telephone

Current Address	Apt.	Mailing Address (if different)
City, State	ZIP	Are you Homeless? ❑ Yes ❑ No Do you plan to stay in DC? ❑ Yes ❑ No

I am applying for: ❑ **Medical Assistance/QMB** ❑ **Food Stamps** ❑ **IDA** (Interim Disability Assistance)

❑ **TANF/GC** (Temporary Assistance for Needy Families/General Assistance for Children)

Note: Your Food Stamp benefits start on the day that you apply. You can apply right away. Make sure to write down your name and address above and then sign at the bottom of this page.

Expedited Food Stamps

You might be able to get Food Stamps in less than a week! To see if you qualify, please tell us:

1. Will your household income be more than $150 this month? ❑ Yes ❑ No
2. Do you have more than $100 in cash or in the bank? ❑ Yes ❑ No
3. Is your income & ready cash this month more than your rent and utilities? ❑ Yes ❑ No

If you answered NO to the questions above, then you may be eligible. Please tell us:

(a) What will be your total income this month? $_____; (b) How much do you have in cash or the bank? $_____; and (c) What did you pay for housing (rent/ utilities) this month? $_____

4. Are you or anyone in your household a migrant or seasonal farm worker? ❑ Yes ❑ No

Authorized Representative

Do you want someone else to act for or represent you? ❑ Yes ❑ No If YES, please tell us:

Name of Your Authorized Representative:	Address of Rep.:	Telephone of Rep.:

What do you want them to do? ❑ Complete interviews ❑ Report changes ❑ Use EBT card

Signature

By signing below, I give my permission to DHS to get information about me. DHS can get this from my employer, landlord, bank, and utility company. I give all of these people my permission to give information about me to DHS. I believe that all of my information on this entire six-page form is correct. **I know that if I give any false information, I may be breaking the law. I know that state and federal officials will check this information. I agree to help with their investigations.**

I agree to follow the rules for DHS benefits. I have received a copy of these rules. I know that I will have to **recertify** for my benefits. I also understand that my child may get free health care through "HealthCheck."

Authorized Representatives: If the applicant cannot sign this form, you may sign it for them. By signing, you certify that this person wants to apply for benefits and agrees to the conditions above.

SIGNATURE: X _____ **DATE:** _____

Who Lives with You?

(Please list everyone in the household, even if you are not applying for them.)

Last Name	First Name	Middle Name	Applying for this Person? (Yes/No)	Sex (M/F)	Date of Birth	Age	Social Security Number*	Relation to you (child, aunt, friend, etc.)	Do you eat together? (Yes/No)	U.S. Citizen? (Yes/ No)**
1. (You)								(Self)	(n/a)	
2.										
3.										
4.										
5.										
6.***										

* You can leave this blank if this person does not have an SSN or does not want benefits. However, you may still have to report this person's income and assets.

** Many immigrants are eligible for benefits. To see if you may qualify, please fill out all of page 6. *** Attach another sheet if more than six people live in your house.

General Questions

1. Are you: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
(Not needed for Food Stamps)

2. Is anyone in the military or a U.S. Veteran? ❑ Yes ❑ No
If YES, who?

3. Is anyone **pregnant**? ❑ Yes ❑ No (Not needed for Food Stamps)
If YES, who? When is the baby due?

4. Are you in a long-term care facility (nursing home, ICF-MR, CRF, etc.)?
❑ Yes ❑ No If YES, where?

5. How much do you pay for **child-care** or **elder-care** (day care, babysitter, etc.)? $ How often do you pay this?

6. Are you or anyone in your household hiding or running from the law to avoid prosecution, being taken into custody, going to jail for a felony crime or attempted felony, or violating a condition of parole or probation? ❑ Yes ❑ No If YES, who?

7. Have you gotten benefits from another State in the last three (3) months? ❑ Yes ❑ No If YES, where?

8. Does anyone age 16 or older go to **school** or a **job-training** program? ❑ Yes ❑ No If YES, who?
Name of the school or program? How many hours per week?

9. In the last two (2) months, did anyone **stop working** or cut back on their hours? ❑ Yes ❑ No If YES, who?
Reason? _____ What was their last day at work ? _____ Date of final paycheck: _____

Income

Income from Work (**before** taxes or other deductions: gross, not net amount)

Are you or is anyone in your house working? ❑ Yes ❑ No

Person who is working	Employer's Name/Telephone	Start Date	How much is each paycheck? (**before** taxes)	How often do you get paid? (weekly, biweekly, monthly, etc.)
			$	
			$	

Other Income

Do you or anyone else get any other income? Please check all that apply and list each payment below.

- ❑ SSI
- ❑ Social Security (not SSI)
- ❑ Veterans benefits
- ❑ Unemployment/Workers Comp.
- ❑ Pensions and retirement
- ❑ Foster care/adoption subsidy
- ❑ Child support
- ❑ Help with expenses
- ❑ Other _____

Type of Payment	Who gets this?	How much is each payment? (**before** taxes and deductions)	How often do they get this? (weekly, biweekly, monthly, etc.)
		$	
		$	

Does anyone pay your family for meals or to rent a room (for example, a **roommate or boarder**)?

❑ Yes ❑ No If YES, who pays? _____ How much do they pay each month? $ _____

Assets

Cash	Does anyone have more than $1,000 in cash? If YES, how much $ _____	❑ Yes ❑ No
Bank Accounts	Does anyone have more than $1,000 in the bank? If YES, please attach your most recent bank statement(s).	❑ Yes ❑ No
Life Insurance	Does anyone have life insurance that they can cash in? If YES, how much money would you get if you cashed it in today? $ _____	❑ Yes ❑ No
Real Property	Does anyone own property besides the home you live in? (For example: boats, rental property, real estate)	❑ Yes* ❑ No
Car	Does anyone own a car, truck or van? If YES, list Make, Model and Year below. _____ Is it used by someone who's sick/disabled?	❑ Yes ❑ No ❑ Yes ❑ No
Other	Does anyone have any stock, bonds, etc.?	❑ Yes* ❑ No
Transfers	Did anyone sell, trade, or give away anything worth more than $1,000 during the last three (3) years?	❑ Yes* ❑ No

* If YES, please attach a description to this form.

For the Blind and Disabled
(Medical Assistance and IDA Only)

Is anyone in your house **blind** or severely **disabled**? ❑ Yes ❑ No If YES, who? _____

To get DC Disability Medicaid and Interim Disability Assistance (IDA), you may need to show that you are blind or disabled. Please get a Medical Form and have a doctor fill it out. If you do not have a doctor, call the DC Department of Healthcare Finance's Office of the Ombudsman on (202) 724-7491. They can help you find a doctor. The doctor will fill out the Medical Form for you. DHS will treat all of your information as confidential.

Note: You do **not** need to fill out a Medical Form (856) if **you are age 65 or older** or if a **child under 19 lives with you**. Also, you may not need to fill out the form if you get Social Security disability benefits. If you have questions, please ask your worker or call (202) 727-5355.

Housing, Utilities, & Other Bills
(Food Stamps Only)

Your Food Stamps amount may depend on your housing, utility, and medical bills. Please tell us the current amount of these bills. Do **not** include any past due amount. To qualify for more Food Stamps, you must provide proof of these bills. If you do not, we will assume that you do not want this deduction.

Rent or Mortgage

	Rent	Mortgage	Monthly Property Taxes*	Homeowners Insurance*	Condo Fee*	Other (describe below)
How much?	$	$	$	$	$	$
Who pays?						

* Leave this blank if it is part of your rent or mortgage.

Do you pay for heating or air-conditioning separately from your rent? ❑ Yes ❑ No

Utility Bills (if **separate** from rent/mortgage)

Do you pay any money for the following utilities (separate from your rent)?

❑ Electric Bill ❑ Gas Bill ❑ Fuel Oil ❑ Water Bill ❑ Phone Bill (including cell)

❑ Other _____

Other Bills

1. Is there anyone who is disabled or age 60 or older who pays medical bills?

   ❑ Yes ❑ No If YES, who pays? _____ How much do they pay each month? $ _____

2. Does anyone in your home **pay** child support?

   ❑ Yes ❑ No If YES, who pays? _____ How much do they pay each month? $ _____

Health Insurance and Medical Bills
(Medical Assistance Only)

ıu may still get Medical Assistance even if you have other health insurance. We can also pay your edicare premiums for you. Please tell us about your health insurance.

edicare	Does anyone have Medicare (a red, white and blue card)? If YES, who has Medicare? _____	❑ Yes ❑ No
ealth Insurance	Does anyone have any other insurance? If YES, please give us a copy of the insurance card.	❑ Yes ❑ No
etro Medicaid/ edical Bills	Did anyone have any medical bills in the last three months? If you get DC Medicaid, you can get paid back for some bills that you have paid. We can also pay some unpaid bills. Call **(202) 698-2009**.	❑ Yes ❑ No
	Were your address, income, and assets the same as now during the last three months? If no, describe the change.	❑ Yes ❑ No

Parents Not Living in the Home
(TANF and Medical Assistance Only)

Ve can help you get child support. Please tell us about any absent parents (any parents not living with ıeir child). However, you could have a good reason for not telling us about an absent parent. **If you ıre afraid that an absent parent might hurt you or someone in your family, then you have a good eason.** If you have a good reason, then you do not have to give any information now.

)o you have a good reason for not telling us about an absent parent? ❑ Yes ❑ No

f NO, then you need to fill in the information below. Please give as much information as you can.

Child's Name	Absent Parent's Name	Absent Parent's SSN	Monthly Support Received	Reason for Absence*
1.				
2.				
3.				
4.				

* Reasons for absence: never married, separated/divorced, in jail/prison, deceased, living somewhere else, etc.

Do you want to get this help with child support right away? ❑ Yes ❑ No

Voluntary Questions

Ethnicity: ❑ Hispanic/Latino ❑ Not Hispanic/Latino **Primary Language:** _____

Race: ❑ Black/African-American ❑ Asian ❑ American Indian or Alaskan Native
❑ White ❑ Native Hawaiian or Other Pacific Islander

Note: You may check more than one race. Also, you do not have to provide this information. None of this information will affect your benefits. We only ask for this information to make sure that we do not discriminate.

For Immigrants (Non-Citizens) Applying for Benefits

Many immigrants are eligible for benefits. For any non-citizen applying for benefits, please provide the immigration information below. **If your status is "OTHER," then we will not ask you for any more information about your immigration status.**

If you are only applying for your child, you do **not** have to give details about your immigration status. Instead, you can just give your child's immigration information. If you just want benefits for your child, you can mark "OTHER" for your own immigration status.

We may ask Immigration Services (USCIS) to verify the status of anyone who is NOT listed as "OTHER". This may affect your eligibility for benefits and the amount of your benefits

Please use these categories for "Current Status" in the table below:

- Lawful permanent resident (LPR)
- Refugee or Asylee
- Cuban or Haitian Entrant
- Person who has been granted withholding of deportation (removal)
- Parolee admitted for at least one year
- Alien who has been present before April 1, 1980, as a "Conditional Entrant"
- Person on active duty in U.S. Armed Forces (or veteran)
- Spouse, widow or dependent of American soldier or veteran
- A victim of domestic violence
- A victim of a severe form of trafficking in human persons
- Native American/Inuit born outside of the U.S.
- Hmong/Laotian
- Afghan/Iraqi Special Immigrant
- Amerasians who came to the U.S. due to the Vietnam War
- OTHER: status does NOT match one of those listed here.

Name	Alien ID # ("A" number)	Current Status	Date that You Moved to the U.S.	Was ever a Refugee/ Asylee?	Cuban/ Haitian?
1.				❑ Yes	❑ Yes
2.				❑ Yes	❑ Yes
3.				❑ Yes	❑ Yes
4.				❑ Yes	❑ Yes
5.				❑ Yes	❑ Yes

Important: Did anyone above move to the United States before August 22, 1996? ❑ Yes ❑ No

If YES, who? _____

Note: Some immigrants who moved to the U.S. after August 22, 1996 do not have to wait five years before getting benefits.

For Lawful Permanent Residents (LPRs) only:

1. Do you have a sponsor? ❑ Yes ❑ No
2. Have you, your parents, your spouse, and/or your sponsor ever worked in the U.S.? ❑ Yes ❑ No

This Is Your Receipt

The date stamp at the right shows that DHS got your application. If you have any questions, you can call your worker or (202) 727-5355.

Your worker will give you a "checklist." This checklist tells you which documents that you need to bring back to DHS. You can also mail copies to your Service Center or to DHS/ESA, 3rd Floor, 645 H St., NE, Washington, DC 20002. If you mail them, please write your name and your date of birth on each document. DHS must help you get the documents you need, when you are not able to get them.

ESA Contact: _____ Tel: _____

Service Center address: _____

Case Name _____

Documents That You May Need to Bring to DHS

Proof of:	Examples
Income	Recent paystubs; statement showing retirement income, disability income, or Workers Compensation; pension statement; etc.
Assets	Recent bank and checking account statements, etc.
DC Residency	DC driver's license, lease, rent receipt, written statement from your landlord, utility or telephone bill, etc.
Social Security Number	Social Security card; tax or payroll documents with your SSN on it; DC driver's license with your SSN on it; etc. (Not required for Food Stamp-only applicants.)
Medical Exam Report/Disability	Recent medical report (or Form 856) and any supporting materials from your doctor.
Immigration Information	Employment Authorization card, I-94, visa, passport, or other documents from the INS.
Rent/Mortgage (Food Stamps only)	Lease, rent receipt, cancelled check, mortgage statement, etc.
Utility Bills (Food Stamps only)	Recent bills for electric, gas, fuel, phone, water, telephone, etc. (if you pay these separately from your rent).
Relationship (TANF only)	Birth certificate (full copy) for your child(ren) or official records from a school, court, hospital, etc.
"Living with" (TANF only)	Statements from two non-relatives or school records.

Also bring your **Medicare card** or other health insurance card, if you have one.

Referrals

- HealthCheck provides **free check-ups** for children on Medicaid. It also pays for other services that a child needs. HealthCheck can also get you **free rides to the doctor**. To find out more, call (202) 639-4030.
- WIC is a program for children under five. With WIC, you can **save up to $140** each month on food. Also, WIC staff can talk with you about breast-feeding. To find out more, call (202) 645-5663.
- If you are eligible for DC Medicaid, you can get money back for **recent medical bills** that you have paid. To find out more, call (202) 698-2009.
- The District has a special program for seniors and the disabled who need **in-home nursing** and other **home care**. This program has a higher income limit than regular Medical Assistance. To find out more, call (202) 204-3540.

HIV/AIDS testing and services	(202) 671-4900	Medicare	1-800-633-4227
Alcohol and drugs	1-888-7WE-HELP	Social Security Administration	1-800-772-1213
Depression and mental health	1-888-7WE-HELP	Energy Assistance	(202) 673-6700
Breast/cervical cancer screening	(202) 442-5900	Public Housing and Section 8	(202) 535-1000

Free Legal Help

Neighborhood Legal Services
3101 Martin Luther King Jr. Ave., SE, 3rd Fl
(202) 832-6577

Legal Clinic for the Homeless
1200 U St., NW
Washington, DC 20009
(202) 328-5500

Bread for the City Legal Clinic
1640 Good Hope Rd., SE
(202) 561-8587

Legal Aid Society
Suite 800
666 11th St., NW
(202) 628-1161

Bread for the City Legal Clinic
1525 Seventh St., NW
(202) 265-2400

Legal Counsel for the Elderly
(for people age 60 and older)
601 E St., NW
(202) 434-2120

Your Rights and the Program Rules

Recertification

We will send you a recertification notice in the mail. If you get Medical Assistance, just complete the form and send it back to DHS. If you get Food Stamps or cash assistance (TANF, GC or IDA), then you will need to come to DHS for an interview. If you do not recertify, then you will lose your benefits. Also, please let us know if you move. Just call **(202) 727-5355** to report your new address

General Rules

You must give true and complete information. If you lie or give false information, you may lose your benefits. You could also be fined and go to prison. We may verify your information to make sure it is correct. We may check on your income, your Social Security information, and your immigration information. We verify this information through computer matching programs. We may also interview you and do a home visit.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include personal interviews and a review of your medical records. By applying, you agree to cooperate with the state or federal reviewers. If you refuse to cooperate, you may lose all or part of your benefits. If you are under investigation or are fleeing to avoid the law, we may share your information with federal and local agencies. If a food stamp claim arises against you, the information on this form, including SSNs, may be sent to Federal and State offices, or private claims collection agencies for claims collection action against all adults in the household.

Under federal and District law, you must provide your Social Security Number (if you have one) if you are in the assistance unit. (See 42 CFR 435.910, 7 CFR 273.6, DC Code §4-204.07, §4-205.05a, and §4-217.07) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The DHS computer system uses your SSN to verify your income by using records from the Internal Revenue Service, the Social Security Administration, and the DC Child Support Services Division (CSSD).

Unless you receive a notice of simplified reporting, you must report changes in your income, assets, shelter and childcare costs, and who lives with you. To report a change, call **(202) 727-5355**. You must call us before the 10th day of the month after the change.

Fair Hearings

If you think that DHS has made a mistake, then you can get a Fair Hearing. Call **(202) 698-4650** to find out more. You can also call (202) 727-8280. At a Fair Hearing, you can ask someone else to speak for you. This could be an attorney, a friend, a relative, or someone else. You can also bring witnesses. We will pay for transportation to the Fair Hearing for you and your witnesses. We may also pay for some of your other costs. You can also get free legal help for a Fair Hearing. Call one of the agencies above to talk to a lawyer or counselor.

Medical Assistance Rules

After you apply, you will get a decision about your Medical Assistance within 45 days (or 90 days if DHS must determine if you are disabled). If you do not get a notice within this period, please call your ESA worker or (202) 727-5355. To get free legal help with Medicaid, call Terris, Pravlik, and Millian on (202) 682-0578 or write to them at 1121 12th Street, NW, Washington, DC 20005.

If you get Medical Assistance, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance. Also, if you lose TANF, you may still get Medical Assistance.

Child Support: You agree to cooperate fully with the DC Child Support Services Division (CSSD) in establishing paternity and getting child and medical support as required by law. You can apply for an exception to this if you have a good reason. However, you can lose your benefits if you do not cooperate without a good reason.

Estate Recovery: The District will seek recovery for the bills we pay if you are in a nursing home or other medical institution. Also, if you are age 55 or older, the District will seek recovery for services that you get. This means that we may put a lien or claim on your property or estate. If you have questions, call (202) 442-9075.

Lawsuits: If you sue or enter into settlement negotiations with a third party for a medical claim or injury, you must provide written notice of the action (either by personal service or certified mail) within 20 calendar days to the Medical Assistance Administration, Third Party Liability Section, 825 N. Capitol St., NE, 4th Floor, Washington, DC 20002. If you have questions, call (202) 442-9075.

TANF Rules

After you apply, you will get a decision about your TANF within 45 days. If you do not get a notice within 45 days, you can get a Fair Hearing. Also, if you think your benefit amount is incorrect, then you can get a Fair Hearing.

If you do not follow all of the program rules, then you may lose part or all of your benefits. You would lose these benefits until you comply (or longer). Also, if you fail to cooperate with CSSD, then you would lose 25% of your TANF benefit.

Food Stamp Rules

You may file an application for Food Stamps separately from other benefits. You will get Expedited Food Stamps within seven (7) days if you are eligible. After you apply, you will get a decision about your Food Stamps within 30 days. If you do not get a notice within this period you can get a Fair Hearing. Also, if you do not think your benefit amount is correct, then you can get a Fair Hearing.

You must have an interview with DHS to get Food Stamps. If you need to do an interview by telephone, please let your worker know. We can do phone interviews if you cannot come to DHS because of work. We can also do phone interviews if you are sick or have a sick relative for whom you are caring.

You will have to come to DHS to recertify when we send you a notice. Note: some elderly and disabled customers only have to recertify every two years. However, there is no time limit for getting Food Stamps. In fact, even if you lose TANF, you may still get Food Stamps.

If you get Food Stamps, you must follow these rules.

- **Do not lie or hide information to get Food Stamps.**
- **Do not trade or sell your Food Stamps;**
- **Do not use someone else's Food Stamps; and**
- **Do not buy alcohol or tobacco with Food Stamps.**

If you break the rules, then you could be fined and go to prison for up to 20 years. You may also lose your benefits for one year for the first violation, two years for the second violation, and permanently for the third violation. If you lie about living in the District or your identity, then you cannot get Food Stamps for 10 years. If you sell or trade your Food Stamps for any purpose (e.g., to get drugs, firearms, ammunition, or explosives) or traffic in $500 or more in benefits, then you may lose your benefits permanently.

IDA Rules

After you apply, you will get a decision about your IDA within 60 days. If you do not get a notice within 60 days, you can get a Fair Hearing. Also, if you do not think your benefit amount is correct, then you can get a Fair Hearing.

If you get IDA, then you must cooperate with your IDA case manager. This means:

- Give us medical reports and other materials;
- Keep your appointments with the doctor and with the Social Security Administration;
- Keep your appointments with your case manager; and
- Go to treatment programs, as required.

If you do not follow these rules, then you may lose part or all of your IDA benefits. Also, DHS will take out the amount of IDA that you got from your first "lump sum" SSI check; DHS will send the rest of your first SSI check to you.

Rights of Support

You must turn over to the District Government any payments that you get from an insurance company for medical care. You must turn over part or all of your child support to the DC Child Support Services Division (CSSD) after you get your first TANF payment. If you do not agree to these conditions, then you cannot get Medicaid or TANF. Once you are off TANF, then you can keep any current child support payments. If you use a Medicaid card or the TANF benefit, then you are telling us that you agree to these conditions.

Confidentiality

By applying, you give DHS permission to talk with your employer, your landlord, your bank, your doctor, and other people who have information about you. You also give these people your permission to give information about you to DHS. In addition, you also give DHS permission to look at your motor vehicle records, wage data, tax information, and other government records. Of course, DHS keeps all of your information confidential. DHS does not release your records without your permission (except when required by law).

Equality and Non-Discrimination

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (202) 720-5964 (voice and TDD). Write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Ave., SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). USDA and HHS are equal opportunity providers and employers.

In accordance with the DC Human Rights Act of 1977, as amended, DC Official Code § 2-1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex, age, marital status, gender identity or expression, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an intra-family offense, and place of residence or business. Sexual harassment is a form of sex discrimination, which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action.

Notice of Rights and Responsibilities

General Rules

You must give true and complete information. If you lie or give false information, you may lose your benefits. You could also be fined and go to prison. We may verify your information to make sure it is correct. We may check on your income, your Social Security information, and your immigration information. We verify this information through computer matching programs. We may also interview you and do a home visit.

Your case may be chosen for a Quality Control review. This is a detailed review of all of your information. It may include some personal interviews and a review of your medical records. By applying, you agree to cooperate with the state or federal reviewers. If you refuse to cooperate, you may lose all or part of your benefits. If you are under investigation or are fleeing to avoid the law, we may share your information with federal and local agencies.

Under federal and District law, you must provide your Social Security Number (if you have one) if you are in the assistance unit. (See 42 CFR 435.910, 7 CFR 273.6, DC Code §4-204.07, §4-205.05a, and §4-217.07) Your SSN will be used to verify your identity, prevent receipt of duplicate benefits, and make required program changes. The DHS computer system uses your SSN to verify your income by using records from the Internal Revenue Service, the Social Security Administration, and the DC Child Support Services Division (CSSD).

Medical Assistance Rules

After you apply, you will get a decision about your Medical Assistance within 45 days (or 60 days if DHS must determine if you are disabled). If you do not get a notice within this period, please call the DC Medicaid Branch on (202) 698-4220 or the Change Center on (202) 727-5355. To get free legal help with Medicaid, call Terris, Pravlik, and Millian on (202) 682-0578 or write to them at 1121 12th Street, NW, Washington, DC 20005. If you get Medical Assistance, then you must recertify each year when we send you a recertification notice. There is no time limit for getting Medical Assistance.

Estate Recovery: The District will seek recovery for the bills we pay for you if you are in a nursing home or other medical institution. Also, if you are age 55 or older, the District will seek recovery for services that you get. This means that we may put a lien or claim on your property or estate. This does not apply to any Qualified Medicare Beneficiary (QMB) benefits you get. Effective January 1, 2010, Section 115 of the Medicare Improvement for Patients and Provider Act (MIPPA) prohibits states from recovering Medicaid payments for Medicare cost sharing expenses made on behalf of Qualified Medicare Beneficiaries. The District cannot seek recovery of payments for Medicare cost sharing.If you have questions, call (202) 698-2000.

Lawsuits: If you sue or enter into settlement negotiations with a third party for a medical claim or injury, you must provide written notice of the action (either by personal service or certified mail) within 20 calendar days to the Medical Assistance Administration, Third Party Liability Section, 441 4th Street, NW, Suite 1000-South, Washington, DC 20001. If you have questions, call (202) 698-2000.

Recertification

We will send you a recertification notice in the mail. You will need to work with your Waiver services case manager, or nursing facility, to get the information you need to give us to continue getting your Medical Assistance. Please contact them right away to make sure that you can complete your recertification on time. If you do not recertify, then you will lose your benefits. Also, please let us know if you move. Just call **(202) 727-5355** to report your new address.

Reporting Changes

You must report changes in your income, Medicare status, marital or institutional status, who lives with you, or if you move from D.C. You may want to report a change of District address, changes in your shelter costs and changes in medical expenses. To report a change, call **(202) 727-5355**. You must call us by the 10th day of the month after the change. You may also call the LTC unit at **(202) 698-4220** to report changes that will affect what you need to pay for your Long Term Care services.

Confidentiality

By applying, you give DHS permission to talk with your employer, your landlord, your nursing facility, your bank, your doctor, and other people who have information about you. You also give these people your permission to give information about you to DHS. In addition, you also give DHS permission to look at your motor vehicle records, wage data, tax information, and other government records. Of course, DHS keeps all of your information confidential. DHS does not release your records without your permission (except when required by law).

Equality and Non-Discrimination

In accordance with Federal law and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write HHS, Director, Office for Civil Rights, Room 506-F, 200 Independence Ave., SW, Washington, DC 20201 or call (202) 619-0403 (voice) or (202) 619-3257 (TDD). HHS is an equal opportunity provider and employer.

In accordance with the DC Human Rights Act of 1977, as amended, DC Official Code § 2-1401.01 et seq., (Act) the District of Columbia does not discriminate on the basis of actual or perceived: race, color, religion, national origin, sex (gender or sexual harassment), age, marital status, personal appearance, sexual orientation, gender identity or expression, familial status, family responsibilities, matriculation, political affiliation, genetic information, disability, source of income, status as a victim of an intra-family offense, and place of residence or business. Sexual harassment is a form of sex discrimination, which is prohibited by the Act. In addition, harassment based on any of the above protected categories is prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action. Complaints of possible violations of this law may be filed with the Government of the District of Columbia, Office of Human Rights, 441 4th Street NW, Suite 570-North, Washington, DC 20001. Telephone: (202) 727-4559. Fax: (202) 727-9589.

Fair Hearings

If you think that DHS has made a mistake, then you can get a Fair Hearing. Call 202-698-4650 to find out more. You can also call (202) 727-8280. At a Fair Hearing, you can ask someone else to speak for you. This could be an attorney, a friend, a relative, or someone else. You can also bring witnesses. We will pay for transportation to the Fair Hearing for you and your witnesses. We may also pay for some of your other costs. You can also get free legal help for a Fair Hearing. Call one of the agencies above to talk to a lawyer or counselor.

Free Legal Help

Neighborhood Legal Services
4609 Polk St., NE
(for Ward 7 only)
680 Rhode Island Ave., NE
2811 Pennsylvania Ave, SE
(for Ward 8 only)
(202) 832-6577

Legal Counsel for the Elderly
(for persons age 60 or older)
601 E Street, NW
(202)434-2120

University Legal Services
220 I Street, NE, Suite 130
(202) 547-0198

Legal Aid Society
666 11th Street, NW, Suite 800
(202) 628-1161