The Department of Children and Families (DCF) determines eligibility for public assistance programs in Florida. Federal regulations, Florida Statute and Administrative Rule contain specific eligibility policy. The SSI-Related Medicaid Fact Sheet is intended to provide a general description and explanation of the SSI-Related Medicaid Programs. Note: Eligibility standards change during January and April of each year.
# TABLE OF CONTENTS

- **Contact Information**  
  Page 3
- **Overview: Assistance Programs for Aged and Disabled**  
  Page 4
- **Supplemental Security Income (SSI)**  
  Page 5
- **SSI-Related Programs Technical Requirements**  
  Page 6
- **SSI-Related Programs Income and Resource Limits**  
  Page 7
- **Medicaid Programs with Full Benefits**  
  - Medicaid for the Aged and Disabled (MEDS-AD)  
    Page 8
  - Institutional Care Program (ICP)  
    Page 8
  - Hospice  
    Page 8
  - Home and Community Based Services (HCBS) Waivers  
    Page 8
  - iBudget Waiver  
    Page 9
  - Cystic Fibrosis Waiver Program  
    Page 9
  - Familial Dysautonomia Waiver Program  
    Page 9
  - Model Waiver  
    Page 9
  - Program of All Inclusive Care for the Elderly  
    Page 10
  - Project AIDS CARE (PAC) Waiver  
    Page 10
  - Statewide Medicaid Managed Care Long–Term Care (SMMC LTC) Waiver  
    Page 10
  - Traumatic Brain and Spinal Cord Injury Waiver Program  
    Page 11
- **Medicaid Programs with Limited Benefits**  
  - Qualified Medicare Beneficiaries (QMB)  
    Page 12
  - Special Low-Income Medicare Beneficiaries (SLMB)  
    Page 12
  - Qualifying Individuals 1(QI-1)  
    Page 12
  - Medically Needy  
    Page 12
- **Non-Medicaid Programs**  
  - Optional State Supplementation (OSS)  
    Page 13
  - Home Care for the Disabled Adult (HCDA)  
    Page 13
  - Extra Help with Medicare Prescription Drug Plan Costs  
    Page 13
- **Additional Information for ICP, Hospice, HCBS and PACE Programs**  
  - Qualified Income Trust (QIT)  
    Page 14
  - Uncovered Medical Expense Deduction (UMED)  
    Page 16
  - Special Policies that Apply to Spouses  
    Page 17
- **Budgeting: Calculating Patient Responsibility**  
  Page 18
- **Long-Term Care (LTC) Insurance Partnership Program**  
  Page 19
- **Additional Resources for Assistance**  
  Page 20
Contact Information

DEPARTMENT OF CHILDREN AND FAMILIES
The Department of Children and Families’ main website may be accessed at: http://www.myflfamilies.com/

Individuals may apply for Medicaid:

- On-line at the DCF/ACCESS Florida website at: http://www.dcf.state.fl.us/ess/
- On-site at a DCF/ESS customer service center. To locate a service center, “Select a County” from the “Find an Office” option at: http://www.dcf.state.fl.us/ess
- On-site through a member of the DCF Community Partner Network. Our community partners are listed at: http://www.dcf.state.fl.us/access/CPSLookup/search.aspx
- By submitting a paper application, which may be requested by calling 1-866-762-2237 and submitting it in person, by mail or fax.

Individuals may check their case status through the MyACCESS Account icon listed on the ACCESS website at: http://www.myflorida.com/accessflorida/. This site is available 24 hours a day 7 days a week. After registering, you can:

- Check on the status of an application or review,
- View a list of items needed to process the application or review,
- View when the next renewal is scheduled,
- View the date and time of a scheduled appointment,
- View the Share of Cost amount if enrolled in the Medically Needy program,
- View the amount of the patient responsibility (if there is one), and
- Print a temporary Medicaid card.

Information may also be accessed by calling the ACCESS Response Unit (ARU), an automated response system available by phone at 1-866-762-2237.

SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) is responsible for specific benefits such as Social Security Retirement and Disability payments, Supplemental Security Income (SSI), Extra Help with Medicare Prescription Drug Plan costs, etc. For information, to apply, or report changes, call the Social Security Administration (SSA) at 1-800-772-1213 or visit the SSA website at: http://www.ssa.gov/

MEDICARE

Medicare is a federal health insurance program that includes hospital insurance (Part A), medical insurance (Part B), Medicare HMO plans (Medicare Advantage), and Medicare prescription drug plans (Part D). For information about Medicare coverage, call 1-800-633-4227 or visit the Medicare website on-line at: http://www.medicare.gov.
Overview: Assistance Programs for Aged, Blind and Disabled

Public Assistance programs for aged and disabled individuals include Food Assistance, Cash Assistance and Medicaid.

Food Assistance:
- The Food Assistance Program helps people with low-income buy healthy food. A food assistance household is normally a group of people who live together and buy food and cook meals together.
- The SUNCAP Program is a special Food Assistance Program for individuals who receive Supplemental Security Income (SSI). An individual may be eligible to receive food assistance benefits through the SUNCAP Program without any additional application, paperwork, or interview once they become SSI eligible.

Cash Assistance:
- Supplemental Security Income (SSI) provides cash assistance and Medicaid to eligible individuals, and is administered by the Social Security Administration (SSA).
- Optional State Supplementation (OSS) provides supplemental cash payments for eligible individuals living in specially licensed living arrangements such as Assisted Living Facilities, and is administered by the Department of Children and Families.
- Home Care for the Disabled Adult (HCDA) provides case management services and a small financial subsidy to approved families or caregivers providing in-home care to disabled individuals residing in family type living arrangements in private homes as an alternative to institutional or nursing home placement, and is also administered by the Department of Children and Families.

Medical Assistance:
Medicaid is a federal program, administered by the state. States are allowed some flexibility in administration of the program, so eligibility requirements and services available may vary from state to state.

Medicaid eligibility is determined by the Department of Children and Families, except for SSI recipients that reside in the state of Florida, they are automatically eligible based on their SSI benefits determined by SSA. Medicaid services are managed by the Agency for Health Care Administration (AHCA).

- **Medicaid programs that have full benefits include:**
  - MEDS for certain aged and disabled individuals (MEDS-AD)
  - Institutional Care Program (ICP)
  - Hospice
  - Home and Community Based Services (HCBS) Waiver Programs
  Note: Individuals who receive SSI are automatically eligible for Medicaid in Florida

- **Medicaid Programs that have limited Medicaid benefits include:**
  - Medically Needy (MN)
  - Medicare cost-sharing programs:
    - Qualified Medicare Beneficiary (QMB)
    - Special Low-income Medicare Beneficiary (SLMB)
    - Qualifying Individuals 1 (QI-1)
| Purpose | The Social Security Administration (SSA) determines eligibility for SSI. It provides financial assistance to aged, blind, or disabled individuals who meet certain financial and technical requirements. |
| Requirements | To be eligible for SSI, an individual must:  
Be aged (65 or older), blind or disabled.  
Be a U.S. citizen (certain qualified non-citizens may be eligible).  
Meet other technical requirements as shown on page 6.  
Have countable resources that total no more than $2000.  
Have income less than $733 a month for individuals in a community living arrangement (home, assisted living facility, etc).  
(NOTE: If both husband and wife are applying for SSI; both must be aged, blind, or disabled. The income limit for couples is $1100; the resource limit is $3000.) |
| Amount of Payments | The payment is based upon how much income the individual/couple has and the amount of the maximum SSI payment standard. Currently, the maximum SSI payment is $733 for an individual and $1100 for a couple. |
| Medicaid | Florida residents who are eligible for a SSI check from Social Security automatically receive Medicaid from the State of Florida. SSI recipients who need Long-Term nursing facility care services must meet additional requirements for those benefits. (See Institutional Care Program on page 8 for more information.) |
SSI-Related Medicaid Programs: Technical Requirements

The Department of Children and Families determines eligibility for SSI-Related Medicaid Programs. The technical criteria are the same when determining eligibility for SSI-Related Medicaid Programs. Some programs require additional criteria that are specific to the program. Note: The information provided below is intended to provide basic requirements only.

SSI-Related Medicaid Technical Requirements:

- **Aged, Blind or Disabled** – an individual must be aged (65 or older) or, if under age 65, blind or disabled. Note: The disability must prevent the individual from working and be expected to last for a period of no less than 12 months, or be expected to result in death. Individuals who receive a disability check from the Social Security Administration (SSA) based on their own disability automatically meet this requirement.

- **Citizenship Status** – an individual must be a U.S. citizen or a qualified non-citizen. Note: There may be a waiting period for non-citizens admitted to the U.S. with a qualified status on or after August 22, 1996.

- **Identity** – an individual must provide proof of identity. Exception: individuals receiving SSI, Medicare or Social Security Disability based on their own work history.

- **Residency** – an individual must be a Florida resident.

- **Social Security Number** – an individual must have a social security number or apply for one.

- **File for Other Benefits** – an individual must apply for other benefits for which they may be eligible for (i.e. pensions, retirement, disability benefits, etc.).

- **Report Third Party Liability** – examples include health insurance or payments by another party.

- Additional technical requirements for specific SSI-Related Programs are discussed later in this document.
SSI-Related Medicaid Programs: Income and Resource Limits

An individual’s or couple’s income and resources (assets) must be within certain levels, which vary by program, to be eligible.

<table>
<thead>
<tr>
<th>Coverage Group (Program)</th>
<th>Income Limit</th>
<th>Asset Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual*</td>
<td>$ 733</td>
<td>$ 2,000</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI)</td>
<td>$ 1,100</td>
<td>$ 3,000</td>
</tr>
<tr>
<td>Couple*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICP/HCBS/Hospice/HCDA Individual</td>
<td>$ 2,199</td>
<td>$ 2,000</td>
</tr>
<tr>
<td>ICP/HCBS/Hospice/HCDA Couple</td>
<td>$ 4,398</td>
<td>$ 3,000</td>
</tr>
<tr>
<td>MEDS-AD/ICP-MEDS/Individual (88% FPL)</td>
<td>$ 871</td>
<td>$ 5,000</td>
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<tr>
<td>MEDS-AD/ICP-MEDS/Couple</td>
<td>$ 1,175</td>
<td>$ 6,000</td>
</tr>
<tr>
<td>QMB Individual (100% FPL)</td>
<td>$ 990</td>
<td>$ 7,160</td>
</tr>
<tr>
<td>QMB Couple</td>
<td>$ 1,335</td>
<td>$ 10,750</td>
</tr>
<tr>
<td>SLMB Individual (100-120% FPL)</td>
<td>$ 1,187</td>
<td>$ 7,160</td>
</tr>
<tr>
<td>SLMB Couple</td>
<td>$ 1,602</td>
<td>$ 10,750</td>
</tr>
<tr>
<td>QI1 Individual (120-135% FPL)</td>
<td>$ 1,335</td>
<td>$ 7,160</td>
</tr>
<tr>
<td>QI1 Couple</td>
<td>$ 1,802</td>
<td>$ 10,750</td>
</tr>
<tr>
<td>Working Disabled Individual (200% FPL)</td>
<td>$ 1,978</td>
<td>$ 5,000</td>
</tr>
<tr>
<td>Working Disabled Couple</td>
<td>$ 2,669</td>
<td>$ 6,000</td>
</tr>
</tbody>
</table>

*SSI eligibility is determined by the Social Security Administration

Note: Figures are as of January 2015
SSI-Related Medicaid Programs with Full Benefits

Medicaid for Aged and Disabled (MEDS-AD)
- The MEDS-AD Program entitles a limited group of aged or disabled individuals to receive full Medicaid coverage.
- This program does not cover blind individuals unless they are considered disabled.
- Individuals cannot receive Medicare Part A or B unless the individual receives ICP, Hospice, or HCBS Waiver.
  Note: If nursing facility care is required, the individual must meet the additional eligibility requirements for ICP.

Institutional Care Program (ICP)
- The Institutional Care Program (ICP) helps people in nursing facilities pay for the cost of their care and provides general medical coverage.
- Additional technical criteria include:
  - Determined to be in need of nursing facility services and appropriate placement as determined by the Department of Elder Affairs (DOEA), Comprehensive Assessment and Review for Long-Term Care Services (CARES).
- Other important criteria of eligibility for ICP include:
  - Transfer of Assets – assets transferred on or after January 1, 2010 may potentially affect eligibility if they were not transferred for fair compensation.
  - Spousal Allowance – assets and income are considered differently for married individuals when one spouse is institutionalized and one spouse continues to live in the community (referred to as the “community spouse”).

Hospice
- The Hospice Program helps maintain a terminally ill individual at home as long as possible by providing at home care to prevent institutionalization whenever possible. However, hospice is also available to individuals residing in a nursing facility. For people living at home who already have Medicaid, hospice services are covered if the individual enrolls in the hospice program. For people who do not otherwise qualify for Medicaid, there is a special hospice coverage that allows higher income limits for the terminally ill.
- Additional technical criteria include:
  - A medical prognosis that life expectancy is 6 months or less (as long as the illness runs its normal course),
  - Election of hospice services, and
  - A certification of the individual’s terminal illness by the physician or medical director.

Home and Community Based Services (HCBS) Waivers
- The HCBS Program Waivers allow individuals to live in the community in an effort to avoid institutionalization.
- HCBS Waivers include:
  - iBudget Waiver
  - Cystic Fibrosis (CF) Waiver
  - Familial Dysautonomia (FD) Waiver
  - Model Waiver
  - Program for All-Inclusive Care for the Elderly (PACE)
  - Project AIDS Care (PAC) Waiver
  - Statewide Medicaid Managed Care – Long Term Care (SMMC – LTC) Waiver
  - Traumatic Brain and Spinal Cord Injury Waiver

Additional information regarding ICP, Hospice and HCBS Waiver eligibility can be found on pages 14 – 17.
HCBS Waiver Programs

iBudget Waiver
- The iBudget Waiver provides HCBS to help prevent institutionalization by allowing an individual with a developmental disability to live in their home or the community.
- An individual may contact the Agency for Persons with Disabilities (APD) to initiate the waiver request.
- Program funding is limited.
- Additional technical criteria include:
  - A level of care determination by APD,
  - Enrollment in the iBudget Waiver, and
  - To meet the aged, blind or disabled technical criteria an individual must be:
    - age 3 or older, and
    - disabled.

Cystic Fibrosis (CF) Waiver
- The Cystic Fibrosis (CF) Waiver provides HCBS for individuals diagnosed with cystic fibrosis, who require hospitalization, but could remain at home if provided special services.
- An individual may contact the Department of Health (DOH) to initiate the waiver request.
- Funding for this program is limited.
- Additional technical criteria include:
  - Meet a level of care for being at risk of hospitalization based on an assessment by DOEACARES
  - Enrollment in the CF Waiver.
  - To meet the aged, blind or disabled technical criteria an individual must be:
    - at least 18 years old and disabled, or
    - age 65 or older.

Familial Dysautonomia (FD) Waiver
- The Familial Dysautonomia (FD) Waiver provides HCBS for individuals diagnosed with the FD syndrome who would otherwise require hospitalization if not receiving special services.
- An individual may contact the Agency for Health Care Administration (AHCA) to initiate the waiver request.
- Funding for this program is limited.
- Additional technical criteria include:
  - Meet a level of care for inpatient hospital care based on an assessment by DOEACARES,
  - Enrollment in the FD Waiver, and
  - To meet the aged, blind or disabled technical criteria an individual must be:
    - age 3 or older, and
    - disabled.

Model Waiver
- The Model Waiver provides specified HCBS to persons with degenerative spinocerebellar disease.
- These services are provided to eligible persons who require the level of care provided in an acute care hospital.
- An individual may contact the Agency for Health Care Administration (AHCA) to initiate the waiver request.
- Additional technical criteria include:
  - A medical diagnosis of degenerative spinocerebellar disease,
• Meet a level of care for inpatient hospital care as determined by the Children’s Medical Services (CMS),
• Enrollment in the Model Waiver through CMS, and
• To meet the aged, blind or disabled technical criteria an individual must be:
  ▪ under age 21, and
  ▪ disabled.

Program of All-Inclusive Care for the Elderly (PACE)
• The Program of All-Inclusive Care for the Elderly (PACE) provides HCBS services for individuals in need of nursing facility care.
• An individual enrolled in PACE will have their medical needs managed regardless of their living situation (home, Assisted Living Facility (ALF) or nursing facility).
• An individual may contact DOEA CARES to initiate the request.
• Funding for this program is limited.
• Additional technical criteria include:
  ▪ Meet a nursing home level of care as determined by DOEA CARES,
  ▪ Election of a PACE provider as the sole source of Medicare and/or Medicaid service delivery, and
  ▪ To meet the aged, blind or disabled technical criteria an individual must be:
    ▪ at least 55 years old and disabled, or
    ▪ age 65 or older.
  ▪ Note: PACE is not a waiver but follows the same eligibility criteria as HCBS.

Project AIDS Care (PAC) Waiver
• The Project AIDS Care (PAC) Waiver provides HCBS for individuals with AIDS.
• A recipient must make an informed choice between hospital or nursing facility care to receive services as a part of the PAC Waiver.
• An individual may contact their local area Agency for Health Care Administration (AHCA) Medicaid Office or local AIDS case management organization to initiate the waiver request.
• Funding for this program is limited.
• Additional technical criteria include:
  ▪ Medical diagnosis of AIDS,
  ▪ Risk of institutionalization based on an assessment by DOEA CARES, and
  ▪ Enrollment in the PAC Waiver.

Statewide Medicaid Managed Care, Long Term Care (SMMC – LTC) Waiver
• The Statewide Medicaid Managed Care, Long Term Care (SMMC – LTC) Waiver provides HCBS to help prevent institutionalization by allowing an individual to live in their home or the community.
• Individuals will select a provider and receive long-term care services through a managed care plan.
• An individual may contact the Department of Elder Affairs (DOEA) Helpline at 1-800-963-5337 to initiate the waiver request.
• Program funding is limited.
• Additional technical criteria include:
  ▪ Meet a nursing home level of care as determined by DOEA, Comprehensive Assessment and Review for Long-Term Care Services (CARES),
  ▪ Enrollment in the SMMC-LTC Waiver, and
  ▪ To meet the aged, blind or disabled technical criteria an individual must be:
    ▪ between the ages of 18 and 64 and disabled, or
    ▪ aged 65 or older.
Traumatic Brain and Spinal Cord Injury Waiver Program

- The Traumatic Brain and Spinal Cord Injury Waiver provides HCBS to individuals who sustain the state definition of traumatic brain and spinal cord injury and require nursing home level of care with long-term community-based services and support to live safely and independently in their homes or in community-based settings rather than a nursing facility.
- An individual may contact the Department of Health (DOH) to initiate the waiver request.
- Funding for this program is limited.
- Additional technical criteria include:
  - Meet a nursing home level of care as determined by DOEA CARES,
  - Enrollment in the Traumatic Brain and Spinal Cord Injury Waiver, and
  - To meet the aged, blind or disabled technical criteria an individual must be:
    - between the ages of 18 and 64, and
    - disabled due to a traumatic brain injury or spinal cord injury.
SSI-Related Medicaid Programs with Limited Benefits

Qualified Medicare Beneficiaries (QMB)
- The Qualified Medicare Beneficiaries (QMB) Program allows qualified individuals to have Medicaid pay for their Medicare premiums (Part A and B), Medicare deductibles and Medicare coinsurance (within prescribed limits).
- QMB recipients automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program. See Page 12.
- Additional technical criteria:
  - Entitlement to Medicare Part A.

Special Low-Income Medicare Beneficiaries (SLMB)
- The Special Low-Income Medicare Beneficiaries (SLMB) Programs allows qualified individuals to have Medicaid pay Medicare directly for Medicare Part B premiums.
- SLMB recipients automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program. See Page 12.
- Additional technical criteria:
  - Enrolled in Medicare Part A.

Qualifying Individuals 1 (QI-1)
- The Qualifying Individuals I (QI-1) Program allows qualified individuals to have Medicaid pay Medicare Part B premiums.
- Funding for this program is limited.
- QI-1 recipients automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program. See Page 12.
- Additional technical criteria:
  - Enrolled in Medicare Part A.

Medically Needy Program
- The Medically Needy Program provides Medicaid to persons with high medical bills, but whose income is too high to qualify for traditional Medicaid programs.
- Individuals qualify for Medically Needy coverage on a month-to-month basis by meeting a monthly share of cost.
- More information may be found online at:
  [http://www.dcf.state.fl.us/programs/access/medicaid.shtml](http://www.dcf.state.fl.us/programs/access/medicaid.shtml)
Non-Medicaid Programs

Optional State Supplementation (OSS)
- The Optional State Supplementation (OSS) Program is a cash assistance program designed to supplement a person’s income to help pay for the room and board costs of an Assisted Living Facility (ALF), mental health residential treatment facility (MHRTF), or adult family care home (AFCH).
- The OSS payment is made directly to the client and the amount is based on the client’s income and the current OSS standard cost of care in the facility.
- Facilities that are enrolled Medicaid Assistive Care Service (ACS) providers may also bill Medicaid for the ACS services it provides to Medicaid eligible residents in their facility.
- Additional technical criteria include:
  - Certification by Adult Services, Developmental Disabilities or Adult Mental Health as needing placement in a licensed facility (ALF, MHRTF or AFCH).

Home Care for the Disabled Adult (HCDA)
- The Home Care for the Disabled Adult (HCDA) Program provides case management services and a small monthly subsidy to approved families or caregivers providing in-home care to disabled adults as an alternative to institutional or nursing home care.
- Payments are made directly to the provider/caregiver providing in-home care for the disabled adult.
- Eligibility for HCDA is based on the financial status of the person receiving care.
- Additional technical criteria include:
  - Certification by a physician and Adult Services staff that services are required as an alternative to nursing home placement,
  - Identification of an approved provider/caregiver, and
  - To meet the aged, blind or disabled technical criteria an individual must be:
    - between the ages of 18 and 59, and
    - disabled.

Extra Help with Medicare Prescription Drug Plan Costs
- The Extra Help Program is also known as the Low-Income Subsidy (LIS).
- While prescriptions may be covered by Medicaid for certain people, Medicaid does not cover the costs of prescription drugs for Medicare beneficiaries.
- Medicare beneficiaries who qualify for QMB, SLMB, QI-1, and/or any full Medicaid program are automatically eligible for federal assistance with the costs of a Medicare prescription drug plan.
- All Medicare beneficiaries MUST enroll in a Medicare prescription drug plan to obtain prescription drug coverage even if they qualify for the Extra Help Program.
- With the Extra Help Program, individuals who enroll in a Medicare Prescription Drug Plan have the benefit of full prescription coverage similar to prescription coverage provided by Medicaid. Individuals are responsible for a small co-pay for each prescription.
- The LIS Program provides:
  - Payment of all or most of the annual deductible,
  - Coverage during the “doughnut hole or gap period, and
  - Payment of monthly plan premiums up to the base amount
- Additional technical criteria:
  - Must be enrolled in Medicare Part A and B.
**Qualified Income Trust**

What is a Qualified Income Trust?

If income is over the limit to qualify for Medicaid long-term care services (including nursing home care), a Qualified Income Trust (QIT) allows an individual to become eligible by placing income into an account each month. The QIT involves a written agreement, establishing a special account, and making deposits into the account.

Who needs a Qualified Income Trust?

If income, before any deductions (such as taxes, Medicare or health insurance premiums), is over the income limit for the ICP, Institutional Hospice, HCBS Waiver or PACE Programs.

How do I set up a Qualified Income Trust agreement?

Professional help may be obtained to set up the QIT agreement, but it is not required. A QIT agreement must meet specific requirements and be approved by Department of Children and Families legal offices. A copy of the QIT agreement must be submitted to an eligibility specialist who will forward it for review.

What items must be included in the Qualified Income Trust agreement?

The QIT agreement must:
- Be irrevocable (cannot be canceled).
- Require that the State receive all funds remaining in the trust at the time of the individual’s death (up to the amount of Medicaid benefits paid).
- Consist of the applicant’s income only (do not include or add assets).
- Be signed and dated by the applicant, the applicant’s spouse, or a person who has legal authority to act on the applicant’s behalf.

How does the Qualified Income Trust account work?

After setting up the account, the individual must make deposits into the QIT account every month for as long as Medicaid is needed. This means deposits may be needed before a Medicaid application is approved. Deposits cannot be made for a past or future month. Any income received back from the trust will be counted as income. If a deposit is not made in any given month, or enough income is not deposited, the individual will be ineligible for Medicaid payment. As long as income is deposited into the QIT account in the month it is received, it will not be counted.

How much income must I deposit into the Qualified Income Trust account?

Enough income must be deposited into the QIT account each month so that remaining income is within program standards. Call (866) 762-2237 or visit: [http://eww.dcf.state.fl.us/~ess/policysearch/ssi_fin_elig_chart.pdf](http://eww.dcf.state.fl.us/~ess/policysearch/ssi_fin_elig_chart.pdf) for information about current income standards.
What happens to the income deposited in the Qualified Income Trust account?

The income deposited and withdrawn is used to calculate patient responsibility. If an individual has a patient responsibility, they are responsible for paying that amount. If funds are left in the QIT upon death, it is paid to the State, up to an amount equal to the total medical assistance the State paid on behalf of the individual.

How to pay funds remaining in the QIT to the State?

The QIT trustee or other individual acting on behalf of the individual should contact the Long-Term care facility to see if any refund for the month of death is due back to the trust. The balance of the QIT as of the date of death, plus any refund from the Long-Term care facility, must be paid to the State.

Mail a check payable to the “Agency for Health Care Administration” to:
Xerox State Healthcare, LLC
PO Box 12188
Tallahassee, FL 32317-2188

A brief cover letter or note should state that the payment is for a QIT and include the Medicaid recipient’s name, social security number and/or Medicaid ID number. Enclose a copy of the QIT bank statement covering the date of death to confirm the check is for the balance. Also, include documentation of any refunds received from the Long-Term care facility. Contact Xerox State Healthcare, LLC at (877) 357-3268 if you have questions about payment of QIT funds to the State.
Uncovered Medical Expense Deduction (UMED)

What is an Uncovered Medical Expense Deduction (UMED)?

An uncovered medical expense deduction (UMED) is a credit received for out-of-pocket medical expenses. The deduction reduces the amount the nursing facility or Medicaid services provider is paid each month and enables individuals to keep more money to pay for uncovered medical expenses.

Who can receive the deductions?

Individuals who receive Medicaid under ICP, Hospice, HCBS Waivers (Cystic Fibrosis, iBudget, SMMC-LTC only) or PACE Program and have a patient responsibility (share of the cost for care) to pay from their income may be entitled to the deduction.

What types of medical expenses can be deducted?

Deductible expenses are health insurance costs (premiums, deductibles and co-payments) and the cost of medically necessary medical services or items, such as dental services, hearing supplies and services, vision services and supplies, therapy services, over-the-counter medications, certain medical supplies such as adult diapers, vitamins and nutritional supplements, and nursing facility care not covered by Medicare, Medicaid or another third party.
Note: Nursing facility bills must be incurred no earlier than three months prior to the month of application (paid or unpaid), will not be paid by Medicaid or another third party, and were not incurred during a transfer of assets penalty period.

How we determine the deduction and apply it to monthly income?

We use the medical expenses paid during a recent period (no earlier than three months prior to the month of application or the past six months prior to a review) to get an estimate of the expenses expected to occur over the next six months. We determine the average cost and deduct it from the income when calculating patient responsibility for the next six months. This is called a projection period. Near the end of a projection period, we ask for verification of actual medical expenses incurred during the projection period. We compare the estimate we projected with actual expenses. If the projected amount was less than or more than the actual expenses by more than $120, we reconcile by averaging the balance over the next projection period together with an average of actual expenses. This process repeats every six months while an individual receives Medicaid.

What Medicaid recipients must do:

Notify the Department of Children and Families of what medical expenses they have to pay. Proof of the types of expense, the cost, and proof that it was not paid by Medicare, Medicaid or a third party may be required. It is important that new expenses or changes in current expenses are reported within ten days after receiving a bill/receipt. Also, it is important to respond to requests from the Department for documentation of actual expenses.
Special Policies that Apply to Spouses

Resources and income are considered differently for married individuals when one spouse is institutionalized and one spouse continues to live in the community (referred to as the “community spouse”) when applying for the ICP, Institutional Hospice, HCBS Waiver (Cystic Fibrosis, iBudget, SMMC-LTC only) or PACE Programs.

Resources at Application:

All resources of the husband and wife must be counted together to determine the eligibility of the institutionalized individual. After deducting $119,220 from their combined resources for the community spouse resource allowance, the institutional spouse’s remaining resources must not exceed $2000 to qualify ($5000 if the institutional spouse’s monthly income is $871 or less).

Resources after Approval:

Resources over the individual limit ($2000 or $5000) acquired after Medicaid is authorized must be transferred to the community spouse within twelve months after approval to maintain eligibility.

Income at Application:

Only the total gross monthly income that belongs to the institutionalized spouse is considered in determining eligibility.

Income After Approval:

After the individual is determined eligible, a special budget is used to determine the monthly patient responsibility amount. After deducting the personal needs allowance, an additional amount of the institutional spouse’s income may be allocated to the community spouse. This is called the community spouse needs allowance.

Determining the Community Spouse Needs Allowance

The community spouse needs allowance is computed as follows:

- $1,966 (minimum monthly maintenance needs allowance) + excess shelter costs* - community spouse's monthly gross income = community spouse income allowance**

*Excess Shelter Cost is the amount by which the community spouse's shelter costs exceeds $590 per month. Shelter costs may include rent or mortgage payment, homeowner's insurance, condo maintenance fees, and a monthly utility allowance of $337 (effective 10/2014) based on the Food Assistance Program standard utility allowance.

**Total community spouse income allowance cannot exceed $2,981.

Exception to Spouse Allowance:

Court-ordered support. If there is a court order for support that is greater than the above allowance, the court ordered amount will be used as the community spouse allowance.

Other Dependents:

Under certain conditions, a dependent allowance may also be deducted from the institutionalized individual’s income.
Calculation of Patient Responsibility

Medicaid Coverage for ICP, Hospice, HCBS (SMMC LTC, iBudget and Cystic Fibrosis) and PACE Programs may have a patient responsibility based on the individual’s gross monthly income and where they reside. The amount of the patient responsibility is determined by subtracting the personal needs allowance and other allowable deductions from the individual’s gross monthly income. Other allowances and deductions that may apply are spousal and/or family allowance, court ordered child support (ICP), and uncovered medical expense deductions (UMEDs). The amount of the personal need allowance is determined by the placement type where the individual resides; at home, in a nursing facility or an Assisted Living Facility (ALF).

The PNA is as follows:
- Placed in a nursing facility is $105.00 or,
- an Assisted Living Facility (ALF) receiving HCBS is the provider rate plus 20% of the Federal Poverty Level, and
- Residing in the community (at home) receiving HCBS is 300% of the Federal Benefit Rate.

Examples of how the patient responsibility is calculated for the different placement types are listed below:

**Nursing Facility:**
- Social Security Benefits (gross income) $2,000.00
- Personal Need Allowance $-105.00
- PATIENT RESPONSIBILITY $1,895.00

**ALF (HCBS):**
- Social Security Benefits (gross income) $1,750.00
- ALF Basic Monthly Rate $-1,500.00
  (Usual Charge for room and board)
- 20% of the Federal Poverty Level $-198.00
- PATIENT RESPONSIBILITY $52.00

**Community (HCBS/Hospice/PACE):**
- Social Security Benefits (gross income) $1,750.00
- Personal Need Allowance $2,199.00
- PATIENT RESPONSIBILITY $0.00
What is the purpose of the Long-Term Care Insurance Partnership Program?

The Long-Term Care Insurance Partnership Program is a federal and state initiative intended to encourage individuals to plan for their future long-term care needs by purchasing long-term care insurance policies.

How do I know if my policy is a qualified Long-Term Care Insurance Partnership Program policy?

The insurance policy must meet certain criteria and be certified by Florida’s Office of Insurance Regulation (OIR) as a qualified Long-Term Care Insurance Partnership Program policy. Individuals owning a standard long-term care policy may ask their insurance carrier to convert the current policy to a qualified Long-Term Care Insurance Partnership Program policy.

Contact your insurance company for information about converting a standard long-term care policy or purchasing a qualified Long-Term Care Insurance Partnership Program policy.

What is the benefit of a qualified Long-Term Care Insurance Partnership Program policy?

The Department of Children and Families will not count a portion of an individual’s assets if they apply for Medicaid to cover their nursing home care. The amount not counted is equal to the actual amount of benefits paid out, or paid on their behalf, by the qualified Long-Term Care Insurance Partnership Program policy for the individual’s cost of care.

For example, if the insurance company paid out $60,000 in benefits for John Doe’s care, the State would not count $60,000 of his assets when Mr. Doe applies for Medicaid to cover his ongoing care. In other words, Mr. Doe can keep $60,000 of his countable assets above the Institutional Care Program asset limit and still qualify for Medicaid if he meets all other eligibility standards.

What information do I need to provide to the Department when I apply?

Individuals with a qualified Long-Term Care Insurance Partnership Program Policy must provide documentation of the insurance benefits paid out, or paid on their behalf, for the cost of their care. Contact your insurance agency for assistance.

For more information regarding the Long-Term Care Insurance Partnership Program visit: [http://ahca.myflorida.com/Medicaid/ltc_partnership_program/index.shtml](http://ahca.myflorida.com/Medicaid/ltc_partnership_program/index.shtml) [http://elderaffairs.state.fl.us/shine/docs/LTCPartnershipFAQ.pdf](http://elderaffairs.state.fl.us/shine/docs/LTCPartnershipFAQ.pdf)
Additional Resources for Assistance

Florida Discount Drug Card
Individuals who are not eligible for full Medicaid may receive help with the cost of prescription drugs through the Florida Discount Drug Card at: http://www.floridadiscountdrugcard.com/.

Florida Elder Helpline and Referral
Information regarding elder services and activities is available through the Elder Helpline Information and Referral Service within each Florida county at: 1-800-96-ELDER (1-800-963-5337).

All elder help lines may be accessed through the Florida Telecommunication Relay System (1-800-955-8771 for TDD, or 1-800-955-8770 for Voice), which allows telephone calls to be placed between TDD users and nonusers with the help of specially trained operators translating the calls.

Information is also available on the Internet at: http://elderaffairs.state.fl.us/.