

Nursing Facility Eligibility

Introduction

This booklet is about getting Medicaid benefits for persons who expect to be in a nursing facility for at least 30 consecutive days.

If you are in a nursing facility for an extended period, Medicare and other insurance may not cover all the cost of your nursing facility care. Medicaid may be able to help with these costs.

Medicaid covers nursing facility care when it is medically necessary. There are limits on the amount of income and assets you may have and still get Medicaid health care coverage.

Medicare covers health care for people age 65 and over or who are disabled. No income or asset limitations apply. See Appendix II: "Programs to Help You" for your information.

You can have Medicaid and Medicare at the same time. Long-term care insurance, Medicare and other private insurance are sources of payment that may cover all or part of nursing facility costs. These other sources of payment may pay the beneficiary directly which must be passed on to the provider.

If you have a spouse, pay close attention to the sections of this booklet that explain how your spouse's income and assets can affect your Medicaid eligibility.

The rules about qualifying for Medicaid can change. Check with your local Michigan Department of Health and Human Services (MDHHS) office for more information before making any decision.

In this booklet "I", "you," "your" and "my" mean the person in the nursing facility. "We, "us" and "they" mean MDHHS.

Applying for Medicaid Coverage in a Nursing Facility

What should I do first?

You will need to work through your local MDHHS office. You may apply for Medicaid at any time.

To apply for Medicaid, contact the MDHHS office in your area. Ask for a Medicaid Application Patient of Nursing Home (DHS-4574). You can pick it up, your local MDHHS office can mail it to you or you can download it online at: www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Forms & Applications >> Medicaid Application Patient of Nursing Home (DHS-4574). You may have someone help you fill out the form. Tell MDHHS if you need help. Bring or mail the signed and dated form to your local MDHHS office.

If you have past medical bills, your Medicaid coverage may begin by going back up to three months before the month you apply.

You should apply for past coverage even if you have other insurance that might cover the cost. You will need to fill out an Asset Declaration form (DHS-4574-B).

You may not need to apply for Medicaid now. But be sure to contact us if you have been, or think you will be, in a hospital or nursing facility for 30 continuous days.

If you have a spouse, you must fill out an Asset Declaration form, DHS-4574-B. This will be used to help determine your eligibility.

After I apply for Medicaid, what happens?

Your local MDHHS office will decide if you are eligible for Medicaid. They will send you a letter with their decision:

- within 45 days, or
- within 90 days if you have a disability.

The nursing facility must be certified by Medicaid to provide the care you need. Medicaid only pays for services that are medically necessary. Medicaid only pays for nursing facility, MI Choice waiver and the Program of All Inclusive Care for the Elderly (PACE) services when you have been determined medically/functionally eligible via the Michigan Medicaid Nursing Facility Level of Care Determination.

If you are eligible, you will receive a **mihealth** identification card. You should also receive a notice from your caseworker advising you of the amount you are required to pay toward the cost of your care while in the nursing home. This is called a **Patient-Pay Amount**.

Your nursing facility will bill Medicaid for the portion of the bill you are not expected to pay.

If you have applied for Medicaid, you must inform your medical provider (doctor, hospital, pharmacy, nursing facility, etc.) that you have applied for Medicaid **prior to receiving medical service**.

You must give your medical provider a copy of your **mihealth** card as soon as it is received. Your medical provider needs this information to receive prompt payment for medical services provided to you. This information is also necessary in order to issue you a refund if you pay for the services between the date you file an administrative hearing request with MDHHS after they issued an incorrect Medicaid denial, and the date of an eligibility determination resulting from your hearing request.

It is the responsibility of the medical provider to submit any outstanding medical bills, using Medicaid billing procedures, to the Medicaid office within 12 months from the date of the Medicaid covered service.

Exceptions to the 12-month billing policy may be authorized if the delay in billing is caused by an agency error or as the result of a decision handed down by court order or administrative hearing decision.

What will MDHHS ask me?

To determine if you are eligible for Medicaid:

We will ask you about your:

- Income and assets
- Age
- Medical expenses
- Marital status
- Medical insurance

If you have a spouse, we will also ask about:

- Your spouse's assets
- Your spouse's income
- Income of other dependents at home

This is a two-step process. First we determine whether you are eligible on the basis of your assets. This is called asset eligibility. If you are asset-eligible, then we review your income. If you have too many assets to qualify for Medicaid benefits, your application may be denied.

What if I have other insurance?

Federal law and regulations require beneficiaries to use all other sources of payment available to them to pay for all or part of their medical care before Medicaid provides payment. The reporting of these other sources is required by the beneficiary and provider and can provide beneficial protection to the beneficiary's estate.

Reporting other sources of payment will not affect your Medicaid coverage.

If another source of payment is made directly to you, you may be held liable to reimburse Medicaid for these costs.

You can report other sources of payment to Medicaid by contacting the Beneficiary Help Line at 1-800-642-3195. Office hours are Monday through Friday 8 am to 7 pm. To report other sources of payment (such as long-term care insurance) to the nursing home, call the nursing home directly.

What will I need to verify?

- We will need proof of your income and assets. If you have a spouse, we will need proof of his or her income and assets, too.
- If you are under age 65, we may need proof of your disability.
- We will need proof that you are a U.S. citizen.

The documents we need include:

- Bank statements, including joint accounts

- Pension payment information
- Social Security benefit information
- Real estate value (including home)
- Recent medical bills

You must have a Social Security number. If you do not have one, we will help you apply for one.

Your Assets

What assets does MDHHS count?

The most common assets we count are:

Money in:

- Cash, savings accounts and checking accounts
- Credit union share and draft accounts
- Certificates of deposit
- U.S. Savings Bonds
- Individual Retirement Accounts (IRA) and Keogh plans
- Nursing facility trust funds
- Prepaid funeral contracts that can be canceled
- Trusts, depending on the terms of the trusts
- Annuities

Equity in:

- Real estate (other than your home)
- More than one car
- Boats or recreational vehicles
- Stocks, bonds and mutual funds
- Land contracts or mortgages held on real estate sold

See *Appendix II* for more help determining your assets.

What assets does MDHHS not count?

These are the most common assets we do not count:

- Your primary residence for Medicaid eligibility, but do count the equity when determining Medicaid payment for long-term care services.
- Personal belongings and household goods
- One car
- Burial spaces and certain related items for you and your immediate family.*
- Up to \$1,500 designated as a burial fund for you or your spouse, if you have one.*
- Irrevocable prepaid funeral contract.*
- Value of life insurance if total face value of all policies is \$1,500 or less per owner, or term insurance of any kind.*
- Assets that you do not have the legal right to use or dispose of. If you have a spouse, the same is true of assets your spouse does not have the legal right to use or dispose of.
- Assets you or your spouse have not been able to sell. You must have had the asset up for sale for at least three months prior to application and must continue until the property is sold. Your asking price must not have been more than the fair market value. You must not have turned down a reasonable offer. These assets must remain for sale as long as you receive Medicaid.

* For more information, see [page 5](#) - *What about funeral costs?*

What if I have a joint account with someone other than my spouse?

We count the entire amount as yours unless you prove some of the money belongs to another person. This rule applies to cash assets, such as:

- Savings and checking accounts
- Credit union share and draft accounts
- Certificates of deposit
- U.S. Savings Bonds

What about other assets I own with someone else?

We assume each person owns an equal share. Tell us if the ownership is different.

How does MDHHS determine my asset eligibility?

Your asset limit is \$2,000. You are asset-eligible if your countable assets for the month are \$2,000 or less. See page 2 for more information on countable assets. If you have questions, ask your MDHHS caseworker.

If you have a spouse, you should ask for an Initial Asset Assessment (IAA) when you are admitted to a nursing facility for the first 30-day continuous period. The IAA is the total amount of countable assets you have. The total is the assets you have on the day you first enter a nursing facility, including a hospital. We will use the IAA when you apply for Medicaid.

If you have a spouse, you have a Protected Spousal Amount (PSA). This is the amount of assets set aside for use by your spouse. The PSA is half of the IAA. Maximum PSA amounts change every year.

We subtract the PSA from the countable assets for the month you apply for Medicaid.

You are asset-eligible if the result for that month is \$2,000 or less.

Example:

Mrs. Smith entered a nursing facility on January 1. Mr. Smith, her husband, lives at home. He asked for an IAA on January 3. The IAA amount for the day Mrs. Smith was admitted totaled \$50,000. The PSA is one-half of that amount, or \$25,000.

The Smiths applied for Medicaid on July 2. The MDHHS caseworker made a determination on July 25. The Smith's assets counted for July had decreased to \$26,500. Mrs. Smith's asset eligibility is shown below.

	\$26,500	countable assets for July
-	\$25,000	Protected Spousal Amount (PSA)
	<hr/>	
	\$ 1,500	countable assets for Mrs. Smith

Mrs. Smith's countable assets are less than \$2,000. She is asset-eligible for July.

She remains asset-eligible for 12 months. This period ends sooner if she leaves the nursing facility for 30 days or more. During this 12-month period, the Smiths can separate their jointly held assets. Mrs. Smith can transfer her assets to Mr. Smith. After the 12-month period, we determine Mrs. Smith's asset eligibility by counting only her assets. Her assets must be \$2,000 or less.

If you have any questions, ask your MDHHS caseworker.

What can I do if my assets are over the limit?

You can use your assets to pay medical expenses, living costs, and other bills. You can use your assets to buy things that are not countable assets. We may ask you to verify how you used your assets.

Can I give my assets or income away?

Giving away or transferring assets or income for less than fair market value (called divestment) may result in a penalty. This applies to you and your spouse.

Transfers include:

- Allowing another person to take your assets or income, or those of your spouse, by setting up a joint account or by other means, and
- Limiting the availability of your assets or income, or those of your spouse, through a trust, similar device or by other means.

The penalty is that Medicaid will not pay for your nursing facility care. The penalty lasts for the time the value of the assets or income you divested would have paid for the cost of nursing facility care.

We look at transfers that occurred up to 60 months before you request LTC, home help, home health, the MI Choice Waiver, or PACE and are eligible for Medicaid. We also look at transfers after you apply.

There is no penalty if you transfer assets to your spouse, or if you or your spouse transfer assets to your blind child or child with disabilities, regardless of your child's age or marital status. If you don't have a spouse, there is no penalty if you transfer assets to your blind child or child with disabilities, regardless of age or marital status.

You or your spouse may also transfer your home, without penalty, to:

- Your children under age 21
- Your children age 21 or older in your home who provided care that allowed you to stay at home for at least two years immediately before you entered the nursing facility
- Your brother or sister who is a part owner of the home and lived in it for at least one year immediately before you entered the nursing facility.

What about funeral costs?

You can prearrange your funeral and still get Medicaid. How much money you can protect, and for whom, depends on which arrangements you choose. Someone in the funeral or insurance business may be able to give you more information.

These are four commonly used arrangements:

Prepaid funeral contract

Irrevocable funeral contracts are not counted if the contract is for your expenses and the amount of the contract is less than the funeral maximum in BAM 805. You will need to contact your MDHHS caseworker since the allowable amount of the contract changes each year.

Life insurance

Michigan law allows you to assign money from your life insurance for your funeral costs. There is a limit to the amount you can assign. You can usually do this by transferring ownership to a trust when you buy the insurance. If you have a spouse, you may also protect funds to pay their funeral costs.

Buy burial space items

You can buy items for burial. Examples are a casket, a burial plot, a vault, a headstone, and opening and closing the gravesite.

These items do not count as assets when you buy them for yourself, your spouse, and are limited for members of your immediate family.

Designate a burial fund

A burial fund pays for funeral costs not covered by allowable burial space items. A separate savings account for a burial fund for you or your spouse does not count as an asset. The limit is \$1,500. The limit includes:

- The face value of life insurance that was not counted.
- The amount paid for an irrevocable funeral contract.
- The amount of insurance for burial costs.

Your Income

Is there a limit on income?

Yes. You may get help when your income is not enough to pay your medical expenses. Usually, you pay part of your medical expenses and Medicaid pays the rest.

What income does MDHHS count?

Examples of the income MDHHS counts include:

- Social Security benefits
- Pension benefits
- Veterans' benefits

How much of my income can I keep?

We will deduct the following from your monthly income:

- \$60 for your personal needs
- Health insurance premiums, including Medicare, you pay for yourself and other members of your fiscal group
- Up to \$60 per month for guardian or conservator fees and costs
- An allowance for your spouse (the basic shelter allowance, plus certain shelter costs, less your spouse's income).
- An allowance for your dependents or your spouse's dependents living at home. They must be living with your spouse. The allowance for both amounts changes every year on July 1.

If I have a spouse, is there a limit on my spouse's income?

No, but if your spouse gives you money regularly, we count that money as your income.

Administration

Do I have to repay Medicaid?

You may have to repay if you get more benefits than you should have.

Upon your death MDHHS has the legal right to seek recovery from your estate for services paid by Medicaid. This means that some or all of your estate may be recovered. MDHHS will not recover from your estate while there is a legal surviving spouse or a legal surviving child who is under the age of 21, blind, or disabled. An estate consists of real and personal property. If you have received an asset disregard due to a long-term care partnership policy, the amount disregarded will be subtracted from the amount sought under Estate Recovery. If you have received an asset disregard due to a long-term care partnership policy, Estate Recovery applies to all assets whether they are subject to probate administration or not. Estate Recovery only applies to certain Medicaid and Healthy Michigan Plan recipients who received Medicaid services after the effective date of the

estate recovery statute. MDHHS may agree not to pursue recovery if an undue hardship exists. An application must be submitted to determine if the applicant qualifies for an undue hardship waiver. Undue hardship waivers are temporary. For further information regarding Estate Recovery or to request an undue hardship application, call 1-800-642-3195.

What if I think MDHHS's actions are wrong?

First, talk with your MDHHS caseworker or his or her manager. If you still believe the action was wrong, you may ask for a hearing. You must file a written hearing request within 90 days of notice of a MDHHS action. You, your spouse, or an authorized person must sign the hearing request. Take or send it to your local MDHHS office.

MDHHS does not provide or pay for estate planning.

Appendix I: Federal Rules

The rules in this booklet are based on Section 1924 of the Social Security Act (42 U.S.C. 1396r-5)

This booklet explains the income and asset rules that apply to persons:

- Who were admitted to a nursing facility, and
- Who are expected to remain in a medical facility for at least 30 consecutive days.

The income rules apply to all persons who expect to remain in a nursing facility for at least 30 days, regardless of admission date.

Rules about trusts and transfers are in Section 1917 (c), (d), and (e) of the Social Security Act (42 U.S.C. 1396p (c), (d) and (e)).

Appendix II: Programs to Help You

Call one of these programs if you need help:

Medicare: **1-800-Medicare (1-800-633-4227)**

The Medicare/Medicaid Assistance Program: **1-800-803-7174**

For help understanding Medicaid rules that apply to paying for nursing facility care, call the State Long Term Care Ombudsman: **1-866-485-9393**

For information about Medicaid, see: www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid.

If you have questions about your eligibility, call your local MDHHS caseworker. Look under Government, Michigan Department of Health and Human Services, in your local telephone directory.

To find your local MDHHS office, see: www.michigan.gov/mdhhs >> **Inside MDHHS >>County Offices.**

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أي سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

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10,000 printed at \$0.XXX cents each with a total cost of \$XXX.