# Your Florida Medicaid Information Guide

A Basic Primer on Florida Medicaid: What it is and How to Obtain it

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# Chapter 4:
# Basic Eligibility Guidelines for Florida Medicaid

Now that we have discussed the different methods of paying for long term care, let's take a closer look at the process involved in becoming eligible for the Florida Medicaid Program.

To be eligible for Florida Medicaid, an applicant must be:

*** 65 years of age or blind or disabled**

*** U.S. citizen or a qualified alien**

*** Florida Resident**

*** Asset Limit of $2,000** The community spouse may keep $113,640 of assets.

*** Monthly gross income** must not exceed the Florida State Income Standard (currently $2,094 as of January, 2012). Only the income of the applicant, not the applicant's spouse, is counted. If the individual's gross income exceeds this limit, we can assist you establish a Qualified Income Trust (QIT) to become eligible (see Income Requirements below).

*** Appropriate placement** – The individual must require assistance with activities of daily living as determined by the Florida Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services Team (aka, CARES Team) field office and they must work with a Medicaid certified agency or be placed in a Medicaid certified facility that provides the required level of care in order to receive benefits.

Probably the most important eligibility test for most Medicaid benefits is that the applicant must have a sufficient medical need to require custodial care in a nursing home (or equivalent services in a less restrictive setting). Only when this level of criteria

is met will the Florida Medicaid office consider whether the patient meets the Medicaid financial eligibility criteria.

There are programs available to seniors where the financial eligibility standards are almost the same but where the levels of care may be different. The medical condition of the Medicaid applicant must warrant either skilled, intermediate or custodial care to ensure a safe and humane environment for the applicant. Someone who meets a level of care for assistance at home may not meet the level of care for Institutionalized placement. However, someone who meets a level of care for Institutional care will always meet the level of care for in Home services.

The determination of a proper level of care is the responsibility of the CARES Team. The team consists of a registered nurse and/or a social worker. The CARES Team considers objective tests of capacity to determine the appropriateness of placement. The CARES Team looks at ACTIVITIES OF DAILY LIVING. The applicant is eligible if the applicant has substantial cognitive impairment or cannot perform a combination of activities of daily living without major assistance.

Activities of daily living (ADLs) are:

a. Walking and standing (transferring);
b. Dressing
c. Feeding
d. Bathing
e. Toileting

Incontinence, although an indication of a lack of toiletry performance, is not necessarily a key element.

For an individual who is looking for Medicaid to provide supervised care at home or in an assisted living facility (ALF) the nursing assessment is completed by the CARES Team only. If an individual is looking at Nursing Home placement a physician's statement and nursing assessment, together with an examination of all of the medical

records, and usually a personal interview with Medicaid applicant constitutes the basis for the CARES Teams determination of level of care. Once the medical need is determined then Florida Department of Children and Family Services (DCF) will review the applicant's finances (income and assets) for eligibility.

One other basic Medicaid eligibility rule states that an applicant may have only $2,000.00 or less in "countable" assets in applicant's name alone, jointly or in trust. If husband and wife both need long-term care simultaneously they are limited to $3,000.00 in countable assets between them. If only one spouse needs long-term care the community spouse may keep $113,640.00 (effective Jan. 1, 2012) in countable assets. "Countable" assets include all belongings except for the following EXEMPT assets:

(1) personal possessions, such as clothing, furniture, and jewelry

(2) one motor vehicle regardless of the vehicle's age or type. Medicaid also considers exempt a second vehicle over 7 years old, except for certain luxury and antique cars or customized vehicles (except for use by person with a physical disability).

(3) assets that are considered "inaccessible" by Medicaid standards for one reason or another; such as irrevocable funeral contracts or burial accounts.

(4) your homestead: Applicants with equity interest in their home in excess of $525,000 (effective Jan. 1, 2012) may only exclude up to $525,000 of the homes equity. Home equity is calculated using the current market value of the home, minus any debt. The current market value is the amount for which it can reasonably be expected to sell on the open market in its geographic area within a reasonable period of time.

If a home is held in any form of shared ownership, Medicaid considers only the fractional interest of the applicant requesting long-term care Medicaid benefits. In fact, even if you do not reside in the home because you have moved into an ALF or Nursing Home it will not count as an asset even if you rent it out provided that you have an intent to return there, however remote that possibility may be. Keep in mind that if the home is rented out, the income will be countable to you in the proportional share of your

ownership. If your home is not claimed as “homestead”, Florida Medicaid Estate Recovery may be able to recover any monies they have spent on your care by selling the house after you have passed on. Also note that if the time comes when you no longer wish to keep your home for any reason, you are free to sell it. But as soon as the sale closes the proceeds from the sale may wind up disqualifying you if you have not properly planned for this event.

In addition to the asset limits mentioned above, Medicaid eligibility rules impose a monthly income cap of $2094.00 (effective Jan. 1, 2012) on the ***gross income*** of the applicant. As you know, your monthly social security check is a net amount as Medicare premiums are deducted from the gross. The same may be true for pension income where deductions for your insurance or taxes may mislead you into believing that the applicant’s total income is below the income cap. For years, any amount of income in excess of income cap would have made the Medicaid applicant ineligible for benefits. This outcome was addressed in 1993 when the federal Medicaid law was last revised. The good news is that now if the Medicaid applicant has a gross income which exceeds $2,094 a month, there are methods for sheltering excess income in which the excess or all of the income can be placed into a specific type of trust known as the Qualified Income Trust. This technique will be discussed in greater detail a little further on in this e-book. And note, there is no limit on the well spouse's gross monthly income. Medicaid only looks at the applicant’s income to determine eligibility. However, If the well spouse's gross monthly income is below $1838.75 (effective Jan. 1, 2012), a portion of the applicant's income may be diverted to the well spouse. This portion is known as the Minimum Monthly Maintenance Needs Allowance (MMMNA). Under certain circumstances, this diversion can bring the spouse's income higher than $1838.75. *Note;* Effective July 1, 2012, the Minimum Monthly Maintenance Needs Allowance increased to $1891.25.

A major stumbling block to Medicaid eligibility involves the complex rules and penalties for transferring assets. If either the Medicaid applicant or spouse transfers assets within a certain period of time prior to filing the Medicaid application for less than fair market value to third parties (relatives or strangers) there will generally be an ineligibility period

imposed by Medicaid. This period of time is called the “Look Back Period”. The Look Back Period definition has changed over time and currently the maximum amount of months that a DCF worker can request information on to look for impermissible transfers for a Medicaid applicant and his or her spouse is 60 months or five years.

If such a transfer is made during the look back, Medicaid rules state that the penalty period starts as of the date of the application. The penalty period is computed by dividing the amount of the transfer for less than the full market value by $6,880 (the divisor), which is the current value Medicaid pays for a Medicaid nursing home placement per month. The resulting quotient, rounded up, is the number of months of ineligibility (penalties for less than (1) month are rounded up to a whole month). The calculation for transfers before November 1, 2007, are calculated based on the month they occur, unless the transfer occurs during an overlapping penalty period from a prior months transfer.

Please be aware that there are exceptions to the transfer penalty, but caution is needed about qualifying for the exceptions. These include, among others, inter-spousal transfers and transfers to a disabled child.

A Medicaid applicant is entitled to transfer assets, without penalty, to a child, even if that child is an adult, so long as that child as a bona fide disability. The disability must comply with the definition used by the Social Security Administration. If so, an unlimited amount of assets may be transferred penalty free. While this type of transfer strategy creates Medicaid eligibility with respect to the elder’s reduction of assets to allowable values it may jeopardize public benefits eligibility for the disabled child. If the Medicaid applicant’s child is under 65 years of age it is possible to transfer the parent’s assets into an Irrevocable Third Party Special Needs Trust. Such a trust holds the gifted assets as an exempt asset, with respect to that child’s eligibility for Medicaid and SSI. Any balance remaining may be distributed to whomever the elder wishes upon the passing of the disabled adult child.

NOTE: People don't know what they don't know. In the context of transfers, there are usually ways to rectify transfers made erroneously. According to Medicaid, such transfers are impermissible BUT NOT illegal. In many situations, with proper legal advice these situations can be reversed and eligibility can be obtained. This is where legal guidance can be invaluable.