

SSI-RELATED MEDICAID

FACT SHEET



This Fact Sheet provides a general description and a brief overview of information about the coverage groups for individuals who are aged, blind, or disabled. The Department of Children and Families (DCF) determines eligibility. Federal regulations, Florida Statutes, and Florida Administrative Rule contain specific policies for eligibility.

Note: The income standards generally change effective January and April of each year.

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Table of Contents

Contact Information	3
Overview of Program	4
Eligibility Requirements	5
Coverage Groups with Full Benefits	6
Medicaid for Aged and Disabled (MEDS-AD)	6
Institutional Care Program (ICP)	6
Hospice	6
Program of All-Inclusive Care for the Elderly (PACE)	6
Modified Project AIDS Care (MPAC)	7
Home and Community Based Services (HCBS) Waivers	7
Familial Dysautonomia (FD) Waiver	7
iBudget Waiver	7
Model Waiver	8
Statewide Medicaid Managed Care, Long – Term Care (SMMC LTC) Waiver	8
Additional Information for ICP, Hospice, HCBS and PACE Coverage Groups	9
Qualified Income Trust (QIT)	9
Uncovered Medical Expense Deduction (UMED)	11
Special Policies that Apply to Spouses	11
Calculating Patient Responsibility (PR)	12
Long Term Care (LTC) Insurance Partnership Program.....	13
Coverage Groups with Limited Benefits	15
Medically Needy	15
Qualified Medicare Beneficiaries (QMB)	15
Specified Low-Income Medicare Beneficiaries (SLMB)	15
Qualifying Individuals 1 (QI-1)	15
Breast and Cervical Cancer Treatment (BCC)	15
Optional State Supplementation (OSS)	16
Home Care for the Disabled Adult (HCDA)	16
Extra Help with Medicare Prescription Drug Plan Costs	16
Additional Resources for Assistance	17
My ACCESS Account – Provider View Guide	19
Where to Find Customer’s Patient Responsibility Amount in Provider View	20

CONTACT INFORMATION

Department of Children and Families (DCF)

The Department of Children and Families main website is at: <http://www.myflfamilies.com/>

Individuals may apply for Medicaid:

- On-line at the DCF/Automated Community Connection to Economic Self Sufficiency (ACCESS) Florida website at: <https://www.myflorida.com/accessflorida/>
- On-site at a DCF/ESS Customer Service Center. To locate a service center, “Select a County” from the “Find Your Service Center” option at: <https://www.myflfamilies.com/service-programs/access/map.shtml>
- On-site through a member of the DCF Community Partner Network. Community partners are listed at: <https://access-web.dcf.state.fl.us/CPSLookup/search.aspx>
- By submitting a paper application or completing a telephonic application which may be done by calling 1-850-300-4323, submitting it in person, by mail or fax. Customer Service Center locations and fax numbers can be found at: <https://www.myflfamilies.com/service-programs/access/map.shtml>

Individuals may check their case status using their My ACCESS Account on the ACCESS Florida website at: <http://www.myflorida.com/accessflorida/>. The website is available 24 hours a day, 7 days a week. After registering, you can:

- Check on the status of an application or renewal
- View when the next renewal is scheduled
- Complete an annual renewal
- View a list of items needed to process the application or renewal
- View the date and time of a scheduled appointment
- View the Share of Cost amount if enrolled in Medically Needy
- View the amount of the patient responsibility
- Print a temporary Medicaid card
- Upload and view documents
- Report household changes

Information may also be accessed by calling the Interactive Voice Response (IVR) Phone System, which is an automated response system available by phone at 1-850-300-4323. Also available is the DCF’s Virtual Assistant chat assistant on the website at: <http://www.myflorida.com/accessflorida/>.

Community Partner Agencies

Community Partner Agencies work with the ACCESS Florida Program by providing a variety of services to individuals seeking or receiving Food, Cash, or Medical assistance. To find a local Community Partner Agency in your area, go to:

<https://access-web.dcf.state.fl.us/CPSLookup/search.aspx>

OVERVIEW OF PROGRAMS

Medical Assistance:

Medicaid is a federal and state program that is administered by the Agency for Health Care Administration (AHCA). States are allowed options in the administration of their Medicaid program. The eligibility requirements and available services may vary from state to state.

Medicaid eligibility is determined by DCF, except for recipients of Supplemental Security Income (SSI). Individuals who receive SSI are automatically entitled to Medicaid in Florida. Medicaid services are managed by AHCA. DCF determines eligibility for the following SSI-Related Medicaid Coverage Groups:

- **Medicaid coverage groups that have full benefits include:**
 - Medicaid for aged and disabled individuals (MEDS-AD)
 - Modified Project Aids Care (MPAC)
 - Institutional Care Program (ICP)
 - Hospice
 - Home and Community Based Services (HCBS) Waiver
 - Program of All-Inclusive Care for the Elderly (PACE)

- **Medicaid coverage groups that have limited benefits include:**
 - Medically Needy (MN)
 - Medicare Savings Programs (MSP):
 - Qualified Medicare Beneficiary (QMB)
 - Specified Low-income Medicare Beneficiary (SLMB)
 - Qualifying Individuals 1 (QI-1)
 - Working Disabled (WD)
 - Low Income Subsidy (LIS)

Automatic Entitlement to Medicaid Coverage

An individual receiving cash benefits from the Social Security Administration's (SSA), SSI Program is automatically eligible for Medicaid. A separate application is not required when Medicaid coverage is through SSI. When the cash benefits terminate, the individual may be entitled to additional months of Medicaid coverage. If the SSI terminates, Medicaid coverage will continue for two months beyond the SSI payment end date to allow time for DCF to review eligibility under other coverage groups.

SSI-RELATED MEDICAID ELIGIBILITY REQUIREMENTS

Eligibility for individuals who are either aged (65 or older) or disabled is referred to as SSI- Related Medicaid. The information below provides basic eligibility criteria. Some coverage groups require additional technical criteria specifically for that coverage.

- **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 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. A disability determination is completed by SSA or the state Division of Disability Determinations (DDD). DCF submits requests to DDD after the Medicaid application is received.
- **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. Exceptions: individuals receiving SSI, Medicare or Social Security Disability based on their own work history.
- **Florida Resident** - residency exists when the intent of the individual is to remain in the state. Residency does not exist when the stay is for a temporary purpose such as a vacation and there is intent to return to a residence in another state.
- **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 (i.e. - pensions, retirement, disability benefits, etc.).
- **Report Third Party Liability** – examples include health insurance or payments by another party.
- **Income** – each coverage group has a specific income limit, see link below.
- **Resources** – each coverage group has a specific resource limit, see link below.

Note: Additional information and criteria are provided in this document by coverage group.

The SSI-Related Medicaid Financial Eligibility Standards chart is located at:

https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf

COVERAGE GROUPS WITH FULL BENEFITS

Medicaid for Aged and Disabled (MEDS-AD)

- Medicaid for low-income individuals who are either aged (65 or older) or disabled.
- This coverage group does not include blind individuals unless they are disabled.

Institutional Care Program (ICP)

- The Institutional Care Program (ICP) helps individuals in nursing facilities pay for the cost of their care and other medical services.
- Additional technical criteria include:
 - An evaluation to need 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) process to determine the level of care (LOC).
 - Other important criteria for ICP eligibility include:
 - Transfer of Assets – assets transferred on or after January 1, 2010, may potentially affect eligibility. The “look-back” period for asset transfers is 60 months prior to the application month.
 - Spousal Allowance – assets and income are evaluated for married individuals when one spouse is institutionalized, and one spouse continues to reside in the community (referred to as the “community spouse”). The community spouse (CS) may be eligible to receive a portion of the institutionalized spouse’s income.
- Additional information on forms and instructions is located on AHCA’s website for [Medicaid Nursing Facility Provider Information](#).

Hospice

- Hospice services help maintain care for terminally ill individuals. To receive Hospice care, the individual must enroll in Hospice.
- Additional technical criteria include:
 - A medical prognosis that life expectancy is six months or less,
 - Election of hospice services, and
 - A certification of the individual’s terminal illness by a physician or medical director.

Program of All-Inclusive Care for the Elderly (PACE)

- PACE provides home and community-based services for individuals in need of nursing facility care as assessed by DOEA CARES. Once enrolled in PACE, an individual may continue services even if the individual is admitted to an assisted living facility (ALF) or nursing home. More information can be found at: <http://www.ahca.myflorida.com/>
- Additional technical criteria include:
 - election of a PACE provider as the sole source of Medicare and/or Medicaid service delivery,
 - at least age 55 or older (must meet disability criteria if under age 65), and
 - meet a nursing home LOC as determined by CARES.

Note: PACE is not a waiver but individuals who are potentially eligible under this coverage group may apply directly with DCF. When applying, the applicant should select “Medical Assistance for Individuals Seeking Medicaid Waiver Services”.

Modified Project AIDS Care (MPAC)

- MPAC is a Managed Medical Assistance Program for individuals with Acquired Immune Deficiency Syndrome (AIDS) who are not eligible for any other full Medicaid coverage group.
- Additional technical criteria include:
 - be at or below 300 percent of the Federal Benefit Rate (FBR),
 - at least 18 or older (must meet disability criteria if under age 65), and
 - meet presumptive disability criteria as evidenced by AHCA Form 5000-0607, Acquired Immune Deficiency Syndrome (AIDS), Physician Referral for Individuals at Risk of Hospitalization

Note: MPAC is not a waiver but individuals who are potentially eligible under this coverage group may apply directly with DCF. When applying, the applicant should select “Medical Assistance for Individuals Seeking Medicaid Waiver Services”.

Home and Community Based Services (HCBS) Waivers/ Working People with Disabilities

- HCBS Waivers allow individuals at risk of institutionalization to receive the essential services necessary to maintain an independent lifestyle while residing in the community.
- HCBS Waivers are:
 - Familial Dysautonomia (FD) Waiver
 - iBudget Waiver
 - Model Waiver
 - Statewide Medicaid Managed Care Long – Term Care (SMMC LTC) Waiver
- The Working People with Disabilities (WPwD) eligibility criteria allow a higher income, and asset thresholds, when necessary, for individuals with earned income and enrolled in an HCBS waiver.

Familial Dysautonomia (FD)

- For individuals diagnosed with FD syndrome who would otherwise require hospitalization if not receiving special services.
- Contact AHCA to initiate the waiver request. More information is available at: https://ahca.myflorida.com/Medicaid/hcbs_waivers/fd.shtml
- Additional technical criteria include:
 - enrollment in the FD Waiver,
 - age three or older (must meet disability criteria if under age 65), and
 - meet LOC for being at risk of hospitalization as determined by CARES.

iBudget

- For individuals with a developmental disability to live in the community as assessed by the Agency for Persons with Disabilities (APD). More information is available at: <http://www.apd.myflorida.com/>.
- Additional technical criteria include:
 - enrollment in the iBudget,
 - age three or older (must meet disability criteria if under age 65), and
 - meet LOC determination by APD.

Model Waiver

- Formerly known as the Katie Beckett Waiver, provides services to individuals with degenerative spinocerebellar disease.
- Contact AHCA to initiate the waiver request. More information is available at: https://ahca.myflorida.com/Medicaid/hcbs_waivers/model.shtml.
- Additional technical criteria include:
 - enrollment in the Model,
 - a medical diagnosis of degenerative spinocerebellar disease,
 - under age 21 and disabled, and
 - meet a LOC for inpatient hospital care as determined by the Children's Medical Services (CMS).

Statewide Medicaid Managed Care, Long-Term Care (SMMC LTC) Waiver

- SMMC LTC provides services to help prevent institutionalization by allowing an individual to live in the community as assessed by DOEA CARES. More information can be found at: https://ahca.myflorida.com/Medicaid/statewide_mc/.
- Additional technical criteria include:
 - enrollment in the SMMC LTC Waiver,
 - be 18 years of age or older (must meet disability criteria if under 65), and
 - meet a nursing home LOC as determined by CARES.
- Contact their local Aging and Disability Resource Center (ADRC) to be screened for services. Provides services for adults with Cystic Fibrosis (CF), Traumatic Brain and Spinal Cord Injury (TBI) and HIV/AIDS. DOEA is the contact for SMMC LTC Waiver for adults. Individuals, their caregivers, and community providers should contact DOEA for more information:
 - Email: Medwaiver@elderaffairs.org; Phone: (866) 232-3733 or Fax: (850) 414-2310
 - To find your local ADRC, call the Elder Helpline at 1-800-96-ELDER (800-963-5337) or go to the Department of Elder Affairs website at: <http://elderaffairs.state.fl.us/doea/arc.php>

ADDITIONAL INFORMATION FOR ICP, HOSPICE, HCBS AND PACE COVERAGE GROUPS

ICP, Hospice, HCBS, PACE, and Modified Project Aids Care (MPAC) coverage groups have additional income and resource (asset) criteria, which are evaluated during the eligibility determination process. The additional criteria are discussed on the next few pages.

Qualified Income Trust (QIT) What is a Qualified Income Trust?

If an individual's income is over the limit to qualify for Medicaid long-term care eligibility (including nursing home care), a QIT allows an individual to become eligible by depositing income into an account each month that the individual needs Medicaid. The QIT involves a written agreement, establishing a special account, and making deposits into the account.

Who needs a Qualified Income Trust?

An individual needs a QIT if their income **before any deductions** (such as taxes, Medicare or health insurance premiums) is over the income limit to qualify for eligibility for ICP, Hospice, HCBS, PACE coverage groups.

How do I set up a Qualified Income Trust agreement?

Professional help may be obtained to set up the QIT agreement but is not required. A QIT agreement must meet specific requirements and be approved by the Department of Children and Families Regional Legal Counsel. A copy of the QIT agreement must be submitted to an eligibility specialist who will forward these documents 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. When income is deposited into the QIT account in the month it is received, it will not be counted in an eligibility determination. Deposits cannot be made for a past or future month. If a deposit is not made in any given month, or enough income is not deposited, the individual will be ineligible for Medicaid.

Note: The income placed into a Qualified Income Trust is excluded as income in the eligibility determination but counted in the calculation of the patient responsibility.

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 coverage group limit(s). It is better to deposit more income than take the chance of depositing too little to qualify for Medicaid. For information about current income limits call (850) 300-4323 or visit:

https://www.myflfamilies.com/service-programs/access/docs/esspolicymanual/a_09.pdf

What happens to the income deposited in the Qualified Income Trust account?

The income deposited and withdrawn is used to calculate an individual's 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 Medicaid benefits 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" and send to:
Florida Medicaid TPL Recovery Program
PO Box 12188
Tallahassee, FL 32317-2188
Phone: 844-845-8352
Email: flsubro@conduent.com

The Qualified Income Trust Information Sheet can be found at:

https://www.myflfamilies.com/programs/access/docs/qualified_income_trust_factsheet.pdf

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 incurred when the individual is eligible for coverage in LTC. The amount of the deduction is the total of allowed medical expenses that is converted to a monthly figure.

The deduction reduces the amount the nursing facility or Medicaid services the 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 (iBudget and SMMC LTC only) or PACE that 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?

Medical expenses include:

- Health insurance costs (premiums, deductibles, and co-payments).
- 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, and
 - Certain medical supplies such as adult diapers, vitamins, and nutritional supplements.
- Nursing facilities care not covered by Medicare, Medicaid or another third party.
 - Nursing facility bills incurred no earlier than three months prior to the month of application (paid or unpaid), not 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?

- 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 renewal) are used to get an average of the expenses expected to occur over the next six months.
- The average cost is calculated and deducted 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, actual medical expenses incurred during the projection period are verified and compared to the projected expenses.
- If the projected amount differs from the actual expenses by more than \$120, the expenses are reconciled by averaging the balance over the next projection period together with an average of actual expenses.
- For some cases this process is repeated every six months while the individual receives Medicaid.

What must Medicaid recipients do?

Recipients must notify the Department of Children and Families of what medical expenses (paid or unpaid) they must pay. Proof of the type(s) 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. Upload proof of medical expenses and other documentation to the My ACCESS Account, or by fax at: 1-866-886-4342, or by mail to:

ACCESS Central Mail Center
P.O. Box 1770
Ocala, FL 34478-1770

Special Policies that Apply to Spouses

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

Resources at Application:

All resources of the couple must be counted together to determine the eligibility of the institutionalized individual. After deducting \$130,380 from their combined resources for the community spouse resource allowance, the institutional spouse’s remaining resources must not exceed \$2,000 to qualify (\$5,000 if the institutional spouse’s monthly income is \$945 or less).

Resources after Approval:

Resources over the individual limit (\$2,000 or \$5,000) acquired after Medicaid is authorized must be transferred to the community spouse within twelve months after approval to maintain eligibility.

Income at Application:

The total gross monthly income received by the institutionalized spouse applying for Medicaid is considered in determining eligibility.

Allocation to the Community Spouse:

The allocation to the Community Spouse is referred to as the community spouse needs allowance (CSNA). To calculate the amount that is allocated for the community spouse a special budget is used to determine the personal needs allowance for the institutionalized spouse, the income needs for the community spouse and patient responsibility.

Determining the Community Spouse Needs Allowance:

The following steps are used to determine the community spouse’s excess shelter costs:

Step 1 - Obtain verification of the community spouse’s monthly assistance group expenses if questionable. Allowed expenses are limited to rent or mortgage payment (including principal and interest), taxes, insurance (homeowners or renters), maintenance charges if a condominium and mandatory homeowner’s association fees. Do not include expenses paid by someone other than the community spouse. Add all of these expenses.

Step 2 - To the total obtained above, add the current food stamp standard utility disregard (refer to [Appendix A-1](#)) if the community spouse pays utility bills. Allowed utilities are limited to water, sewage, gas, and electric.

Step 3 - To determine what portion of the total shelter costs is excess, subtract 30% of the state’s income allowance, from the total costs. The difference is the community spouse’s excess shelter costs.

Exception:

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.

Note: The state's MMMNA plus CS excess shelter cost cannot exceed the state's cap on CS income allowance (see [Appendix A-9](#)).

LONG-TERM CARE (LTC) INSURANCE PARTNERSHIP PROGRAM

What is the purpose of the Long-Term Care Insurance Partnership Program?

The Long-Term Care Insurance Partnership (LTCIP) 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 (LTCIP) policy?

The insurance policy must meet certain criteria and be certified by Florida's Office of Insurance Regulation (OIR) as a qualified LTCIP Program policy. Individuals purchasing or owning a standard long-term care policy may contact and ask their insurance carrier about purchasing or converting the current policy to a qualified LTCIP 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 LTCIP Program policy for the individual's cost of nursing home 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 ICP 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 LTCIP 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://training.floridashine.org/Website_Resources/Bene_FS/BLTCPartnership.pdf or <http://www.myfloridacfo.com/Division/Consumers/UnderstandingCoverage/LongTermCareOverview.htm>

BUDGETING: CALCULATING PATIENT RESPONSIBILITY

Medicaid coverage for ICP, Hospice, HCBS (SMMC LTC and iBudget) and PACE may have a patient responsibility based on the individual's gross monthly income and where the individual resides. The amount of the patient responsibility is determined by subtracting the personal needs allowance (PNA) and other allowable deductions from the individual's gross monthly income. Please refer to [DCF Policy Passage 2640.0118](#) Personal Needs Allowance for more details. The other allowances and deductions that may apply are spousal and/or family allowance, court ordered child support only, and uncovered medical expense deductions (UMEDS). The amount of the PNA is determined by the coverage group and placement type at home, in a nursing facility, or an ALF.

For SMMC LTC and PACE, the PNA is as follows:

- Residing in a nursing facility is \$130.
- Residing in an ALF is the ALF's basic monthly Room and Board rate plus 20% of the Federal Poverty Level (FPL).
- Residing in the community is 300% of the Federal Benefit Rate.
- For individuals residing in the community who are employed and receiving HCBS/WPwD is 550% of the FBR.

Example 1:

The applicant applies and is approved for ICP and reports a nursing home expense totaling \$8,000 (UMED) prior to the month of approval.

Budget:

$\$1,300$ monthly income - $\$130$ Personal Needs Allowance (PNA) = $\$1,170$

$\$1,170 \times 6$ months = $\$7,020$

$\$8,000$ nursing home bill - $\$7,020$ = $\$980$ remaining balance of bill

$\$8,000/6$ = $\$1,333.33$ = $\$0$ patient responsibility for each month

Since the nursing home bill exceeds the monthly income, use the remaining balance from the bill when determining the patient responsibility for the next six months.

At the six-month review, the remaining balance of the nursing home bill of $\$980$ is used as an Uncovered Medical Expense Deduction (UMED).

Budget:

Remaining balance of bill $\$980/6$ = $\$163.33$

$\$1,040 - \163.33 = $\$876.67$ patient responsibility for each month

Example 2:

An individual is enrolled in the SMMC LTC program and resides in an ALF and has Social Security Income of $\$1,750$ each month. The ALF's basic monthly Room and Board rate is $\$1,500$.

Budget:

$\$1,750$ monthly income - $\$1,500$ *ALF basic monthly rate - $\$202$ (20% FPL) = $\$48$ patient responsibility for each month

*Note: This amount varies as it depends upon the facility's actual room and board

SSI-RELATED MEDICAID COVERAGE GROUPS WITH LIMITED BENEFITS

Medically Needy

- Provides Medicaid to persons with medical bills, but whose income is too high to qualify for full Medicaid coverage.
- Individuals qualify for coverage on a month-to-month basis by meeting their monthly share of cost.
- More information may be found online at:
<https://www.myflfamilies.com/service-programs/access/medicaid.shtml>

Breast and Cervical Cancer Treatment (BCC)

- For women needing treatment for breast and cervical cancer.
- Must be screened and diagnosed for breast or cervical cancer by the Department of Health (DOH).
- Additional technical criteria include:
 - be uninsured or have health coverage that does not cover the necessary treatment,
 - be under age 65,
 - be a U.S. citizen or qualified noncitizen, and
- Have income below 200% of the federal poverty level.
- More information may be found online at:
<http://www.doh.state.fl.us/Family/cancer/bcc/index.html>

Qualified Medicare Beneficiaries (QMB)

- Allows qualified individuals to have Medicaid pay for their Medicare premiums (Part A and B), Medicare deductibles and Medicare coinsurance (within prescribed limits). Individuals enrolled only in Medicare Part B, may be conditionally enrolled in Medicare Part A after being determined eligible for the QMB Medicare Savings Program (MSP).
- An individual will automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program.
- Additional technical criteria include entitlement to Medicare Part A.
- Have income below 100% of the federal poverty level.

Specified Low-Income Medicare Beneficiaries (SLMB)

- Allows qualified individuals to have Medicaid pay for their Medicare Part B premium.
- an individual will automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program.
- Additional technical criteria include enrolled in Medicare Part A.
- Have income below 120% of the federal poverty level.

Qualifying Individuals 1 (QI-1)

- Allows qualified individuals to have Medicaid pay for their Medicare Part B premium.
- Funding for this program is limited.
- An individual will automatically qualify for assistance with Medicare Prescription Drug Plan costs through the Extra Help Program.
- Additional technical criteria include enrolled in Medicare Part A.

- Have income below 135% of the federal poverty level.

NON-MEDICAID PROGRAMS

Optional State Supplementation (OSS)

- Provides cash assistance to individuals residing in an assisted living facility (ALF), mental health residential treatment facility (MHRTF), or adult family care home (AFCH).
- The supplemental payment is made directly to the individual and the amount is based on the individual's income and the current OSS standard cost of care in the facility.
- Some facilities are licensed to provide Assistive Care Services to individuals who are Medicaid eligible.
- Additional technical criteria include Certification by an Adult Services Counselor, Developmental Disabilities Counselor, Mental Health Counselor or the Aging and Disability Resource Centers (ADRCs) as needing placement in a licensed facility (ALF, MHRTF, or AFCH).

Home Care for the Disabled Adult (HCDA)

- Provides case management services and a small subsidy to approved caregivers providing in-home care to adult persons with disabilities 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 is based on the financial status of the person receiving care.
- Additional technical criteria include:
 - certification by a physician and an Adult Services case manager,
 - approval of the provider/caregiver, and
 - be between the ages of 18 and 59 and disabled.

Extra Help with Medicare Prescription Drug Plan Costs

- Also known as the Low-Income Subsidy (LIS).
- Medicare beneficiaries who qualify for QMB, SLMB and QI-1 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.
- Individuals are responsible for a small co-pay for each prescription.
- LIS 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.
- More information may be found online at:

<https://www.medicare.gov/your-medicare-costs/get-help-paying-costs/find-your-level-of-extra-help-part-d>

Additional Assistance Programs for Aged, Blind and Disabled

Public Assistance programs for aged, blind, and disabled individuals include food assistance and Cash Assistance.

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). For more information, visit: <https://www.ssa.gov/>.
- 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 caregivers providing in-home care to disabled adults (ages 18 through 59) as an alternative to institutional or nursing home placement and is also administered by the Department of Children and Families.

ADDITIONAL RESOURCES

SSI recipients may contact 850-300-4DCF (4323) to request a lost or stolen Medicaid card. Individuals with a MyACCESS Account can request a replacement Medicaid card at: <http://www.myflorida.com/accessflorida/>

Social Security Administration (SSA)

For more information about or to apply for benefits available through the Social Security Administration (retirement, disability insurance, Supplemental Security Income, Extra Help with Medicare Prescription Drug Plan costs), call the Social Security Administration at 1-800-772-1213, visit a local SSA Office 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>.

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: [Elder Affairs Helpline](#)

A listing by [Area Agency on Aging](#) is also available.

My ACCESS Account – Provider View Guide

Provider View provides you with a secure gateway to the customers “account” information. The Provider View system allows you to view customer case information and interact with the Department of Children and Families through the Web at your convenience twenty-four hours a day seven days a week

Provider View (Check Information about Medicaid eligibility) allows you to:

- View current benefits for Medicaid
- View the date benefits will be available
- See when the next review is due
- See when an appointment is scheduled
- View Medicaid account history
- View Medicaid Patient Responsibility
- View a list of verifications needed
- View Personal Identification number (PIN)
- View a list of Applications that have been submitted
- View a list of Changes that have been submitted
- View a list of Requests for Additional Assistance
- View a list of Reviews that have been submitted

The information displayed in the customer’s account is updated nightly. Changes made during the day are available for you to view the following day. The date of the information is displayed at the top of the account status screens for reference.

Click here to go to the [My ACCESS Account – Provider View Guide](#).

Where to Find Customer’s Patient Responsibility Amount in Provider View

Log into ‘Provider View’ and complete ‘Customer Search’ to find the individual you want to review.

- To begin start at is the “My Benefits” screen – Refer to page 8 of Provider View Guide.
- Select ‘Click Here’ under Details section for Medical Assistance (see Figure 1.1 below).

Figure 1.1 Benefit Summary Page in Provider View

[Back to Benefit Summary](#)

My Benefits **My Applications**

If you are the payee for an EBT account, you are now able to request a replacement card here in your MyACCESS Account. Look for a link in the Case Information below under the blue box that says "Replace My EBT Card".

Benefit Summary

Case Information

This information is current as of July 19, 2017. If you made any changes to your case within the last 24 hours, please allow time for this information to be processed into the system. Please check back later.

Case Number	Head of the Household	Scheduled Appointments	Upload and View My Documents	My Notices	Verifications Needed	Replace My EBT Card
[REDACTED]	[REDACTED]	No appointments scheduled	click here	click here	No verifications needed	Not Authorized

My Benefits

Benefits	Details
Medical Assistance	click here

This will take you to the Medical Assistance page.

Medical Assistance Page

On this page you can view current month's patient responsibility amount by selecting 'click here' under 'Information' section or to view previous month's patient responsibility amount under 'History' section (see Figure 1.2 below). Note: The "Re-issue Medicaid Card" field is not available to Providers.

Figure 1.2 Medical Assistance Page in Provider View

Back to Benefit Summary

My Benefits **My Applications**

Medical Assistance

Case Information

Case Number [REDACTED] Head of the Household [REDACTED]

Medical Assistance

Individual	Pin No	Status	Coverage Type	Print Temporary Medicaid Card	Re-issue Medicaid Card	History	Information
[REDACTED]	[REDACTED]	OPEN	MEDICAID	click here	click here	click here	click here