

## **Medicaid Fact Sheet:**

Medicaid is overseen by both State and Federal governments. Each state establishes its own eligibility standards, benefits package, payment rates, and program administration under broad federal guidelines. As a result, there are essentially 56 different Medicaid programs - one for each state, territory and the District of Columbia. You can apply for Medicaid through The Department of Social Services and NY State of Health.

### **How do I find my local Medicaid office?**

The Medicaid office is located in your local department of social services. A listing of offices can be located here:

[http://www.health.ny.gov/health\\_care/medicaid/ldss.htm](http://www.health.ny.gov/health_care/medicaid/ldss.htm)

If you need help understanding and filling out your application you can call or visit your [local department of social services](#) or <https://nystateofhealth.ny.gov/>

### **What do I need to apply for Medicaid?**

- If you are a U.S. citizen (born in the U.S. or one of its territories) and provide a valid Social Security Number (SSN), a match with Social Security Administration (SSA) will verify your SSN, date of birth/age and U.S citizenship. If SSA verifies this information no further proof is needed. The SSA match cannot verify birth information for a naturalized citizen. You will need proof of naturalization (e.g., Naturalization Certificate (N-550 or N-570) or a U.S. passport).
- Proof of age (if not verified by SSA) such as a birth certificate
- Proof of citizenship or immigration status\*
- Four weeks of recent paycheck stubs (if you are working)
- Proof of your income from sources like Social Security, Supplemental Security Income (SSI), Veteran's Benefits (VA), retirement, Unemployment Insurance Benefits (UIB), Child Support payments

- If you or anyone who lives with you is 65 years old or older, certified blind or disabled, you need to provide information on bank accounts, insurance policies and other resources.
- Proof of where you live, like a rent receipt, landlord statement, mortgage statement, or envelope from mail you received recently
- Insurance benefit card or the policy (if you have any other health insurance)
- Medicare Benefit Card (the red, white and blue card)

**\*NOTE:** Medicaid coverage is available, regardless of alien status, if you are pregnant or require treatment for an emergency medical condition. A doctor must certify that you are pregnant or had an emergency, and you must meet all other Medicaid eligibility requirements.

### **How do I know if my income and resources qualify me for Medicaid?**

The chart below shows the amount of income you may receive in a month and the amount of resources (if applicable) you can retain and still qualify for Medicaid. The income and resource (if applicable) levels depend on the number of your family members living with you.

Income and Resource Levels are subject to yearly adjustments. You may also own a home, a car, and personal property and still be eligible. The income and resources (if applicable) of legally responsible relatives in the household will also be counted. The Affordable Care Act of 2010 created a national Medicaid minimum eligibility level of 138% of the federal poverty level for nearly all Americans under age 65. This Medicaid eligibility expansion went into effect on January 1, 2014 and is reflected in the chart above.

Chart generated by: [www.health.ny.gov/health\\_care/medicaid/#long](http://www.health.ny.gov/health_care/medicaid/#long)

### **Can I be eligible for Medicaid even if I make more money than the chart shows?**

Yes, in some cases. Pregnant women, children, certified blind persons, certified disabled persons, and others may be eligible for Medicaid if their income is above these levels and they have medical bills. Ask your Medicaid worker if you fit into one of these groups. If you are hurt or sick and need a lot of care you might be able to get temporary help from Medicaid even if you make too much money to get

regular Medicaid. The amount your income is over the Medicaid level is called excess income. It is like a deductible. If you are eligible for Medicaid except for having excess income and **you can show that you have medical bills equal to your excess income in a particular month**, Medicaid will pay your additional medical bills beyond that for the rest of that month. This includes outpatient care, doctor and dental visits, lab tests, prescription drugs, and long-term care in the community such as home care and assisted living. You have to re-enroll in Medicaid Spend-Down every three months.

Go to [http://www.health.ny.gov/health\\_care/medicaid/excess\\_income.htm](http://www.health.ny.gov/health_care/medicaid/excess_income.htm) for more information on the **Medicaid Excess Income program** (also known as the **Spenddown program** or **Surplus Income program**).

### **What if I don't have bills that are equal to or exceed my excess income?**

If you do not have medical bills, but you need medical care there is another option called the **Pay-In Program**. You can pay your monthly excess income amount for any month to your [local department of social services](#). You should only do this if you need services in that month. Ask your local department of social services about this option.

If you do not choose the Pay-In option and you do not have any medical bills that are equal to or exceed your excess income, you will not have Medicaid coverage for that month.

### **What are resources?**

Resources are cash or those assets, which can be readily converted to cash, such as bank accounts, life insurance policies, stocks, bonds, mutual fund shares and promissory notes. Resources also include property not readily converted to cash (i.e., real property)

### **How often do I have to renew?**

Most renewals are on an annual basis. You will receive a renewal packet by mail prior to your renewal date. Your packet will let you know if there are other methods available to you for recertification such as phone or internet renewal.

Please note that Medicaid mail cannot be forwarded. This means that if you changed your address at the post office and not with the Medicaid office, you will

not receive your Medicaid mail. You must notify your Medicaid office of all address changes to ensure you receive any notices sent by them.

### **What do I have to do if I move from one county to another?**

It is important to notify your Medicaid office any time you move especially when you are moving to another county. Your original county needs to notify the new county and get your case transferred. If you are currently enrolled in a managed care plan that is not offered in the new county, your local department of social services will notify you so that you can choose a new plan.

### **What health services are covered by Medicaid?**

In general, the following services are paid for by Medicaid, but some may not be covered for you because of your age, financial circumstances, family situation, transfer of resource requirements, or living arrangements. Some services have small co-payments. These services may be provided using your Medicaid card or through your managed care plan if you are enrolled in managed care. You will not have a co-pay if you are in a managed care plan, except for pharmacy services, where a small co-pay will be applied.

- smoking cessation agents
- treatment and preventive health and dental care (doctors and dentists)
- hospital inpatient and outpatient services
- laboratory and X-ray services
- care in a nursing home
- care through home health agencies and personal care
- treatment in psychiatric hospitals (for persons under 21 or those 65 and older), mental health facilities, and facilities for people with mental retardation or developmental disabilities
- family planning services
- early periodic screening, diagnosis, and treatment for children under 21 years of age under the Child/Teen Health Program

- medicine, supplies, medical equipment, and appliances (wheelchairs, etc.)
- clinic services
- transportation to medical appointments, including public transportation and car mileage
- emergency ambulance transportation to a hospital
- prenatal care
- some insurance and Medicare premiums
- other health services

If you are eligible for Medicaid you will receive a Benefit Identification Card which must be used when you need medical services. There may be limitations on certain services.

For you to use your Benefit Identification Card for certain medical supplies, equipment, or services (e.g., wheelchair, orthopedic shoes, transportation) you or the person or facility that will provide the service must receive approval before the service can be provided (prior approval).

### **Can I get reimbursed for bills I paid for?**

Medicaid may be able to pay you for some bills you paid before you applied for Medicaid. You can be paid for bills you paid before you applied for Medicaid and for bills you pay until you get your Medicaid card. Bills you paid before you applied for Medicaid must be for services you received on or after the first day of the third month before the month that you applied for Medicaid. For example, if you apply for Medicaid on March 11th, Medicaid may be able to pay you for services you received and paid for from December 1st until you get your Medicaid card.

Medicaid can pay you for some bills even if the doctor or other provider you paid does not take Medicaid, even if you paid the bills before you applied for Medicaid. **After the day you apply for Medicaid, Medicaid can pay you only if the doctor or other provider accepts Medicaid.** Prior to your appointment, always ask the doctor or other provider if they take Medicaid.

More rules:

- The bills you paid must be for services that the Medicaid program pays for. These services include, but are not limited to, doctors, home care, hospitals and drugs.
- Medicaid may only be able to pay what Medicaid pays for the services. This may be less than the bill you paid.
- Medicaid can pay you only when Medicaid decides you can get Medicaid and only if you could have gotten Medicaid when you paid the bill.
- Medicaid can pay you only when the bills you paid were for services that you needed.
- You must give Medicaid the bills and prove that you paid them.

### **How long does it take to get Medicaid?**

Generally, local districts must determine if you are eligible and send a letter notifying you if your application has been accepted or denied within 45 days of the date of your application. If you are pregnant or applying on behalf of children, the local district has 30 days from the date of your application to determine if you are eligible for Medicaid. If you are applying and have a disability which must be evaluated, it can take up to 90 days to determine if you are eligible.

### **What are my rights?**

The Medicaid application, Access NY Health Care, tells you what your rights are when you apply for Medicaid. See the pages titled "Terms, Rights and Responsibilities." People who receive Medicaid have privacy rights. Medicaid keeps your health information private and shares it only when they need to.

If you are not satisfied with a decision made by the local social services district, you may request a conference with the agency. You may also appeal to the New York State Office of Temporary and Disability Assistance and request a Fair Hearing.

### **How do I request a State fair hearing?**

You can ask for a fair hearing by:

**1) Telephone:** You may call the state wide toll free number: 1-800-342-3334; **OR**

**2) Fax Number:** (518) 473-6735; **OR**

**3) On-Line:** Complete and send the online request form at:

<http://otda.ny.gov/programs/applications/>; **OR**

**4) Write:** to the Fair Hearing Section, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, New York 12201.

### **What is a Medicaid managed care program?**

Enrollment in a [Medicaid managed care program](#) through a Health Maintenance Organization (HMO), clinic, hospital, or physician group is available at any [local department of social services](#). You may be required to join a managed care plan. When you join a managed care program, you will choose a personal doctor who will be responsible for making sure all your health care needs are met. The doctor will send you to someone else if you need more help than the doctor can provide.

### **What does managed care cover?**

Managed care covers most of the benefits recipients will use, including all preventive and primary care, inpatient care, and eye care. People in managed care plans use their Medicaid benefit card to get those services that the plan does not cover.

### **Medicaid for those living in an institution or nursing home:**

#### **If I am in a nursing home (Residential Health Care Facility) or in an intermediate care facility (ICF) for the developmentally disabled can I still keep part of my income?**

Yes. Under Medicaid you are allowed to keep a small amount for your personal needs. You can also keep some of your income for your family if they are dependent on you. A spouse who remains in the community may also keep resources and income above the levels shown.

### **What is a Community Spouse?**

A community spouse is someone whose husband/wife is currently institutionalized or living in a nursing home. The community spouse is not currently living in a nursing home and usually resides at the couple's home.

## **If I am a community spouse will I be allowed to keep any income or resources?**

If your spouse is institutionalized or living in a nursing home, you will be permitted to keep some income known as a minimum monthly maintenance needs allowance (MMMNA). If you are currently receiving income in excess of the minimum monthly maintenance needs allowance, you may be asked to contribute twenty-five percent (25%) of the excess income to the cost of care for the institution.

## **What is a "lookback" period?**

When applying for Medicaid for nursing facility services (Nursing Home), the local department of social services will look at financial transactions to determine whether any assets have been transferred or given away for less than fair market value during a certain time period prior to your application in order to determine if a transfer of assets penalty period needs to be applied. This is known as the "lookback" period. Currently the "lookback" period is 60 months (5 years) prior to the month you are applying for coverage of nursing home care.

A penalty period may be imposed for the transfer of non-exempt assets for less than fair market value. The penalty period results in a period of ineligibility for Medicaid coverage of nursing facility services.

A penalty period is not applied for the transfer of your home to the following individuals:

- Spouse
- Child under the age of 21
- Sibling who has an equity interest in the home and has resided in the home for at least one year immediately prior to you entering the Nursing Home.
- Adult child who resided in the home for at least two years, immediately prior to you entering the Nursing Home and who provided care to you which permitted you to reside at home rather than in a medical facility.

For more information regarding the transfer of assets and penalty periods, please contact your [local department of social services](#).

\*\*The information in this document is subject to change. Please visit [http://www.health.ny.gov/health\\_care/medicaid/](http://www.health.ny.gov/health_care/medicaid/) and the Department of Social Services for updates. Materials prepared by Elizabeth Berka, Health Information Specialist, Southern Tier Independence Center, 135 E. Frederick St., Binghamton, NY 13904, phone: (607) 724-2111