



*Helping Older Persons With
Legal & Long-Term Care
Problems*

Community Medicaid

1. Who May Become A Community Medicaid Beneficiary (CMB)?

Individuals must meet general eligibility criteria such as citizenship, residency, and living arrangement status and certain income and resource requirements. The individual must be blind, disabled or age 65 or older. If eligible as a CMB some of the individual's medical expenses will be paid by Medicaid.

2. What Medical Expenses Does Medicaid Cover?

Medicaid coverage extends to these services:

- (a) inpatient and outpatient hospital care;
- (b) rural health and other clinic services;
- (c) physician, podiatrist, chiropractor and psychologist care;
- (d) prescription drugs;
- (e) nursing care;
- (f) hospice care;
- (g) medical transportation;
- (h) dental care and dentures;
- (i) optometrist services and eyeglasses;
- (j) physical therapy and related services;
- (k) community mental health services;
- (l) some prosthetic devices, including hearing aids; and
- (m) home health care services.

Limitations apply and some of these services must be authorized ahead of time. A Medicaid provider must provide these services. A Medicaid provider is one that has contracted with the Ohio Department of Job and Family Services to accept Medicaid payment for medical goods and/or services.

3. What Home Care Services Are Available?

Medicaid covered home health care services include nursing care, physical therapy and related services and homemaker aids. Medicaid provides these services either directly through the County Department of Job and Family Services (CDJFS) or by contracting with a private home health care agency.

4. What Are The Financial Requirements If I Live At Home?

Income: The countable monthly income must not exceed \$504 for an individual and \$869 for a couple. Countable income means gross earned and/or unearned income, minus \$20 from unearned income and the first \$65 of the earned income, plus one-half of the remainder of earned income. A married applicant living with an ineligible spouse will be credited with all of the ineligible spouse's income except \$163. Certain income is not counted, such as Supplemental Security Income (SSI), income tax refunds, Disability Assistance (DA), Residential State Supplement (RSS), and Ohio Works First (OWF).

Resources: An individual must have available resources at or below \$1,500, and \$2,250 for a couple. Available resources are assets that can be legally used and sold by the applicant(s). Some resources are not counted:

- (a) the home;
- (b) an irrevocable burial contract;
- (c) life insurance with a face value of \$1,500 or less;
- (d) a vehicle, if valued at \$4,500 or less, or if necessary for work or medical treatment, or if modified for the handicapped;
- (e) burial plot;
- (f) certain income-producing property; and
- (g) household goods and personal property.

5. Will I Be Eligible If I Give Assets (Resources) Away?

Yes, you will be eligible for Community Medicaid if you gift some or all of your assets to family or friends or sell them for less than fair market value. However, you will be ineligible for Medicaid payment of your nursing home care, if needed. The length of time you are ineligible depends on the total amount of the gift(s). If you have given some of your assets away or even sold them for less than fair market value consult an attorney before applying for Medicaid.

6. What Is Spend-down Medicaid?

If your monthly countable income exceeds \$504 you are not eligible for regular Medicaid. However, your monthly-incurred medical expenses may reduce your monthly countable income and make you eligible for spend-down Medicaid. Incurred medical expenses are those expenses that result from necessary medical and remedial services

and are not subject to payment by a third party, i.e., Medicare, private insurance, or Worker's Compensation. Depending on your income as compared to your medical expenses you may either qualify for ONGOING or DELAYED Medicaid.

7. What Is Ongoing Spend-Down Medicaid?

You may lower your countable income when you have medical expenses not covered by Medicaid, which occur on a regular basis, and these expenses reduce your countable income to \$504 or below. Examples of suitable monthly medical expenses are medical insurance premiums and past medical expenses (debt) the individual has a legal obligation to pay. After these expenses are verified and your countable income is reduced to \$504 or below you will be Medicaid eligible the first day of every month.

8. What Is Delayed Spend-down Medicaid?

When your countable income exceeds \$504 and you have medical expenses that may or may not occur on a regular monthly basis, you may be able to use the delayed spend-down method to become eligible for Medicaid. For example, if your **countable** monthly income is \$604 (compared to the need standard of \$504) you must incur or pay \$100 in verified medical expenses each month to be able to receive your Medicaid card. Your unpaid medical expenses that are four months old or older may be totaled and used to reduce your monthly spend-down amount.

9. When Do Delayed Spend-Down Recipients Receive Their Medicaid Card?

Monthly Medicaid eligibility does not begin until verification that medical expenses have been incurred is submitted to the CDJFS. Once verified the Medicaid card will be mailed to you and is valid for the remainder of the month. To avoid unnecessary delays in receiving your Medicaid Card you may pay the spend-down amount to your CDJFS no earlier than the 25th of the month to receive the card the following month.

10. Can Medicaid Pay Medical Bills I Received Before I Applied?

Yes. Medicaid will pay your unpaid bills for Medicaid-covered services but only for those services received during the three months prior to the month of application. You must be Medicaid-eligible in each of the three months. Your medical expenses must not be expenses covered by a third party, such as Medicare, an insurance company or workers' compensation. If you have past (four months or older) unpaid medical expenses the total amount will not be paid, but maybe used to reduce your monthly spend-down amount.

11. Once Found Eligible Do I Ever Have To Reapply?

Yes, except it is referred to as “re-certification”. Your initial Medicaid application is valid only for one year from date of application. Thereafter, every anniversary date your CDJFS will require re-certification that you still meet all Medicaid eligibility requirements.

12. What If I Disagree With A Decision Concerning My Medicaid Benefits?

Any Medicaid decision that affects your benefits or eligibility may be appealed by requesting a state hearing within 90 days after the mailing date of the written notice. If the Medicaid action being proposed is to terminate your benefits, you should request a state hearing within 10 days after you receive the written notice so your benefits will continue until the state hearing decision. You have the right to review your case file, present any relevant evidence and to be represented by an attorney or other representative. If you lose the state hearing, you must send a written administrative appeal to the Ohio Department of Human Service Office of Legal Services within 15 days after the mailing date of the state hearing decision. Whether the Administrative Appeal will continue to suspend the termination of benefits is optional at this stage. A negative Administrative Appeal decision may be appealed to the County Court Of Common Pleas within 30 days after you receive the appeal decision. You may contact the Ohio Department of Job and Family Services, Bureau of State Hearings, at 30 E. Broad Street, 32nd floor, Columbus, Ohio 43215, for more information.

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Pro Seniors provides free legal information and advice by toll-free telephone to all residents of Ohio age 60 or older. If a matter cannot be resolved over the phone, seniors are referred to other Pro Seniors' staff or community resources for more in-depth assistance.

In southwestern Ohio, Pro Seniors' staff attorneys handle matters that many private attorneys do not, such as Medicare, Medicaid, SSI, financial abuse and landlord/tenant problems. Pro Seniors' long-term care ombudsmen work with residents of southwestern Ohio to protect their rights and resolve complaints about nursing facilities and home care.

Pro Seniors may also refer seniors to a private attorney on our referral panel. Many of these attorneys have agreed to handle cases at a fee seniors can afford.

This pamphlet provides general information and not legal advice. The law is complex and changes frequently. Before you apply this information to a particular situation, call Pro Seniors' free Legal Hotline or consult an attorney in elder law.

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