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Special Needs Trusts | Elder Law | Long Term Care Planning | Medicaid | Probate | Wills & Trusts
Incapacity Planning | Guardianship | Developmental Disabilities | Veteran's Benefits

BASIC RULES OF LONG TERM CARE MEDICAID NOW KNOWN AS: STATEWIDE MEDICAID MANAGED CARE (SMMC) LONG TERM CARE PROGRAM (LTC)

In Pinellas County and the surrounding area the average cost of nursing home care is approximately $8,000 - $10,000 per month not including medicines and supplies. The average cost of assisted living is approximately $2,500 - $5,500 per month. Memory care and secured assisted living care averages $4,000 - $7,000 per month. In-home care varies depending on the number of hours per day you need assistance and the level of expertise the home care provider must have to care for you appropriately. Generally, homemaker/companion services are approximately $18 - $21 per hour, they are not allowed to provide personal care but assist with daily household tasks, transportation and shopping. Home health aides and/or certified nursing assistants are approximately $20 - $24 per hour; they are allowed to provide personal care assistance with bathing and dressing, in addition to household tasks. If you need assistance with medication administration/management a Registered Nurse (RN) is required to dispense medicine or setup a weekly pill box reminder system.

There are many planning opportunities available that allow individuals and married couples to plan ahead and be in position to qualify for Medicaid. There are also crisis-planning strategies available if a person suddenly needs long term care. Each situation has its unique set of facts; the strategy to become eligible for Medicaid is determined on a case-by-case basis. This planning also provides peace of mind that assets are available to pay for services Medicaid does not cover, and protects assets for the family members. We can assist you with Medicaid planning if needed or wanted.

The State of Florida administers Medicaid Long Term Care programs through the Agency for Health Care Administration (AHCA). AHCA contracts with insurance companies, known as Managed Care Organizations (MCOs) throughout the state to contract and pay for Long Term Care needs.

In Pinellas/Pasco Counties the Long Term Care MCO Providers are:

- Humana Medical Plan www.humana.com
- Molina Healthcare www.molinahealthcare.com
- Sunshine Health Plan www.sunshinehealth.com
- United Healthcare www.uhccommunityplan.com

In Hillsborough County the Long Term Care MCO Providers are:

- Humana Medical Plan www.humana.com
- Coventry Health Care www.coventryhealthcare.com
- Molina Healthcare www.molinahealthcare.com
- Sunshine Health Plan www.sunshinehealth.com
- United Healthcare www.uhccommunityplan.com

There are many services identified to be provided for those with Long Term Care needs. The minimum requirements each of the companies listed above must provide are:

- Adult Companion Care
- Adult Day Health Care
- Assisted Living
- Assistive Care Services
- Attendant Care
- Behavioral Management
- Care Coordination/Case Management
- Caregiver Training
- Home Accessibility Adaptation
- Home Delivered Meals
- Homemaker Services
- Hospice Care
- Intermittent and Skilled nursing services
- Medical Equipment and Supplies
- Medication Administration
- Medication Management
- Nursing Facility care
- Nutritional Assessment and Risk Reduction
- Personal Care
- Personal Emergency Response System
- Respite Care
- Therapies, occupational physical, respiratory and speech therapy
- Non-emergency Transportation

The State under federal law must provide nursing home care if an individual requires that level of care. All other types of long term care are funded by the State as a Waiver Program and once the state spends their budget for the year all applicants are placed on a waiting list until state funds are available to assist with your long term care needs. ***You are required to pay privately for care while you are on the waiting list.*** This makes planning ahead very difficult, and often there is a shortfall of funds prior to approval. Planning ahead is essential.

To become eligible for Medicaid there are four primary requirements:

1) You must need the Level of Care (LOC) you are requesting.
2) Your income must be within the Medicaid limits.
3) Your assets must be within the Medicaid limits.
4) Other than for nursing home care as explained above, you must receive a "slot" from the waiting list to begin receiving Medicaid Long Term Care services.

What is a Level of Care? A Level of Care (LOC) is an assessment identifying long-term care needs and recommends the least restrictive, most appropriate services and/or placement.

If you are in the hospital and need to be transferred to a long term care facility for rehabilitation services or you are admitted to a nursing home from your home or a hospital the CARES unit of the Department of Elder Affairs (DOEA) may be contacted to conduct an assessment known as a 701B assessment to determine if you need the help that must be provided by a nursing home. If nursing home care is appropriate your physician must complete a 3008 form verifying the need. Prior to being discharged from the hospital and transferred to a nursing home a Pre-Admission Screening and Resident Review (PASRR) must be completed. The screening is for suspicion of mental illness and/or intellectual disability, to ensure appropriate placement in the least restrictive environment, and to identify the need to provide applicants with needed specialized services. PASRR screening applies to all new admissions into a Medicaid certified nursing facility, and includes private pay, Medicare, and Medicaid admissions regardless of payor source.

If you are at home and want to request home care, assisted living assistance, home delivered meals, medication management, etc… you must call the Area Agency on Aging, Aging and Disability Resource Center (ADRC), request services and complete a telephone assessment known as the 701S. This assessment acts as screening tool to determine your placement on the waiting list for services. The Pinellas/Pasco County ADRC telephone number is: 727.570.9696. The Hillsborough County ADRC telephone number is: 1.800.336.2226.

When you call the Area Agency on Aging for the determination of whether your loved one meets the level of care the interviewer will be utilizing a Form known as the 701S, you may obtain a copy at http://elderaffairs.state.fl.us/doea/forms/701S_Screening_Form.pdf for your review.

We encourage you to take the time to review the 701S Screening form prior to calling the ADRC. You will need to be prepared to answer each question, and your answer determines the person needing assistance placement on the waiting list. We recommend you respond to the questions honestly, however keep in the back of your mind the applicant's worst day and the help they require with their activities of daily living.

If you require Nursing Home care the Managed Care Organization (MCO) you select pays the nursing home the difference between the Medicaid approved rate for the facility and the amount the individual must pay the facility based on the individual's monthly income. Medicaid allows deductions from your income for supplemental insurance and other medical expenses when calculating your monthly patient responsibility. While in the nursing home the MCO determines the services and supplies to be paid on your behalf by having their caseworker complete an assessment of your needs.

You may apply for Long Term Care benefits retroactively up to three months; however, you must have met the eligibility criteria from the first month you are requesting benefits to begin. The time period you are requesting services until the date you receive approval for eligibility is called Medicaid Pending. In the event you are determined ineligible for Medicaid benefits you will need to pay the provider privately for services received.

For all other Long Term Care Services the MCO will assess your need and determine the amount of service they will pay for or provide to you. Typically for assisted living the MCO will contribute approximately $1,000 - $1,300 per month, and fees for services greater than the amount contributed by the MCO will need to be paid by the individual or their loved ones. If you intend to stay at home, the MCO caseworker will assess your home situation and authorize the number of hours of private duty home care assistance you need and any other assistance you require in the home. While at home you get to maintain your income and utilize towards your living expenses.

For those individuals hoping to remain in their own home Pinellas County offer The PACE program, the Program of All-inclusive Care for the Elderly offers a program that combines medical and long-term care services in a community setting. The PACE program is a division of Empath Health. If you decide to enroll in PACE, your medical needs will be managed by PACE regardless of your living situation. The program provides services for individuals in need of nursing home care who can remain at home with special services, and also individuals residing in assisted living facilities and nursing homes. The financial eligibility requirements are the same as the requirements for SMMC Long Term Care benefits.

Medicaid Application

A Medicaid application, known as a Request for Assistance (RFA) must be completed and all financial and personal information must be submitted to the Department of Children and Families (DCF) for any of the above programs. The Eligibility Specialist at DCF will require verification of all information provided and will determine whether or not the applicant is eligible. This process is not quick, usually taking 30-90 days. The Department of Children and Families has a website at http://www.myflorida.com/accessflorida/ where you may make an application for public benefits via the internet. Once you have filed the online application, your case is assigned to an eligibility specialist that will contact you through the mail with a list of all required documentation.

We can assist you through Medicaid planning and the application process. At our office we make the process as simple as possible for you, and complete all communication with the Department of Children and Families. This helps you avoid the stress of dealing with the Medicaid application process, allowing you to spend your time with your loved one.

BASIC REQUIREMENTS FOR SMMC LONG TERM CARE and PACE APPLICANT:

- Must be 65 years of age or blind or disabled (18 years of age or older) for SMMC long term care.
- Must be 55 years of age, disabled if under 65 and live in Pinellas County for the PACE program.
- U.S. Citizen or a qualified alien.
- Must have a Social Security number or file for a Social Security number.
- File for all benefits you may be entitled.
- Assign rights to State of Florida to collect private health insurance benefits.
- Florida resident, anyone residing in a nursing home or assisted living facility that is certified for Medicaid is considered to be a resident of Florida.
- Determined by the Department of Elder Affairs CARES office that you meet the level of care required. (Form 3008 must be completed). For assisted living care (ALF care) a form 1823 must be completed by the applicant's physician prior to admission. The requirements for assisted living are documented in the Florida Administrative Code at http://florida.eregulations.us/rule/58a-5.0181
- Asset Limit of $2,000 ($5,000 if the applicant's gross income is $885 per month or less).
- Monthly Gross Income Limit of less than $2,205. A Qualified Income Trust or Pooled Trust must be established to become eligible for Medicaid if the gross income exceeds this limit.

IF YOU ARE MARRIED:

- The applicant must meet the basic requirements listed above. The spouse, known as the community spouse if not living in a nursing home, must meet the Asset Limit of $120,900. Once the applicant is eligible for Medicaid and the assets of the community spouse are no longer available to the applicant within a 90-day period, the assets of the community spouse are no longer considered.
- If the married couple is in the same nursing home or assisted living facility, they may apply as single individuals or a married couple, whichever is to their advantage.
- If the application is made as a married couple, the income limit is $4,410 and the asset limit is $3,000 ($6,000 if combined monthly income is $1,191 or less).
- If the married couple lives in different nursing homes or assisted living facilities, they must apply as individuals.

ASSETS THAT ARE NOT INCLUDED IN THE $2,000 ASSET LIMIT:

- Homestead property, if the spouse or disabled child lives in the home.
- Homestead property, (equity value of $560,000 or less) if the applicant intends to return home.
- Rental property.
- Property listed for sale at fair market value.
- One vehicle regardless of age or value.
- An additional vehicle that is over seven years old (unless it is a luxury model, an antique or customized).
- Life Insurance with no cash value.
- Life Insurance, if the total face value of the policies equals or is less than $2,500.
- Irrevocable burial contracts.
- Up to $2,500 per person designated for burial expenses (revocable burial contracts, bank accounts designated for burial by notation in the title, or life insurance policies).
- Burial plot.
- Property used in trade or business.

- An Individual Retirement Account (IRA) paying an automatic, systematic, actuarially sound regular payment of principal and income to the beneficiary. (Payment is counted as income).
- Assets held in a Pooled trust, Under 65 Disabled Trust, Third party Special Needs Trust, or Qualifying Special Needs Trust if drafted correctly are not included as countable assets.

INCOME NOT INCLUDED IN THE $2,205 INCOME LIMIT:

- VA Aid and Attendance.
- VA Un-reimbursed Medical Expense payments.
- Life Insurance dividends.

Income Considerations:

- The applicant for Nursing Home care is allowed to keep $105 of their income for personal expenses; this is known as the Personal Needs Allowance. (Some individuals who receive VA Aid and Attendance Benefits are allowed to keep an additional $90).
- The amount of income the applicant is allowed to keep for personal needs for other Long Term Care fluctuates.
- If the applicant is paying for a supplemental insurance policy, the amount of the premium will be deducted from the patient responsibility calculation.
- If the applicant has a community spouse, he/she may be eligible for a community spouse income allowance. Medicaid will review the income and expenses of the community spouse (rent, mortgage payment, condominium maintenance fee, property taxes, homeowner's insurance, and a standard utility allowance of $347) and determine if any of the applicant's income can be paid to the community spouse.
- If the applicant has a minor or dependent adult child, dependent parent, or dependent sibling, a family allowance may be permitted. The family member must be living with the community spouse.
- If there is not a community spouse, there may be an income allowance for unmarried children under the age of 21 or disabled adult children.
- If the applicant or the applicant's deceased spouse is a Veteran, he/she must apply for Veteran benefits.

Medicare Part D

- If you have Medicare and full Medicaid coverage, Medicare covers your Part D prescription drugs. Medicaid may cover some drugs and other care Medicare does not provide.
- It is important to review your prescribed medications with the case manager or facility social worker and determine which Medicare Part D provider provides your medications under the Medicare D program.
- Prescription coverage must provide a 30-day supply of current medication when transitioning the patient from a medication not on their formulary.

Medicare Premium Assistance

- **Qualified Medicare Beneficiaries (QMB).** Individuals who qualify for the QMB program are eligible to have Medicaid pay for their Medicare Premiums (Part A and B), Medicare deductibles, and Medicare coinsurance within the prescribed limits. QMB recipients automatically qualify for the Extra Help Medicare Prescription Drug Plan Cost – through Social Security (see below). To qualify for QMB the individual must be a US citizen, a Florida resident and entitled to Medicare Part A. The income limit is

- $1,005 for an individual, $1,354 for a married couple. The asset limit is $7,390 for an individual and $11,090 for a married couple.
- **Special Low-Income Medicare Beneficiaries (SLMB).** Individuals who are eligible for SLMB are eligible to have Medicaid pay their Part B premiums. To qualify for SLMB the individual must be a US citizen, a Florida resident and enrolled in Medicare Part A. The income limit is $1,206 for an individual and $1,624 for a married couple. The asset limit is $7,390 for an individual and $11,090 for a married couple.
- **Extra Help with Medicare Prescription Drug Plan.** The applicant must have Medicare Part A and/or Part B insurance, live in the US and combined assets must be below $27,250 if married and living with spouse, or $13,640 if not married or not living with spouse. (The applicants home, personal possessions, burial plots, irrevocable burial contracts are not included as assets). The annual income limit is $18,096 for an individual or $24,360 for a married couple living together. This program may provide help to pay for the monthly premiums, annual deductibles, and co-payments related to the Medicare Prescription Drug program. However, you must be enrolled in a Medicare Prescription Drug plan to get this extra help.

STATEWIDE MEDICAID MANAGED CARE (SMMC) MANAGED MEDICAL ASSISTANCE PROGRAM (MMA)

The SMMC Long Term Care applicant may also need to select a SMMC Managed Medical Assistance Plan for Medicaid Assistance, which covers many health care services they may need. It is not required to select a Medicaid Assistance Managed Care Plan if you have creditable coverage already in place.

The State of Florida administers the Medicaid Assistance Managed Care Plan through the Agency for Health Care Administration (AHCA). AHCA contracts with insurance companies, known as Managed Care Organizations (MCOs) throughout the state to contract and pay for Medical Assistance needs.

In Pinellas/Pasco Counties the SMMC MMA MCO Providers are:

- Amerigroup www. www.amerigroup.com
- Prestige www.prestigehealthchoice.com
- Sunshine www.sunshinehealth.com
- Staywell www.staywell.com

In Hillsborough County the SMMC MMA MCO Providers are:

- Amerigroup www.amerigroup.com
- Better Health www.betterhealthflorida.com
- Humana www.humana.com
- Molina www.molinahealthcare.com
- Prestige www.prestigehealthchoice.com
- Sunshine www.sunshinehealth.com

- Staywell www.staywell.com
- United Health www.uhccommunityplan.com

The minimum requirements each of the companies listed above must provide are:

- Advanced registered nurse practitioner services
- Ambulatory surgical treatment center services
- Assistive Care services
- Birthing Care services
- Chiropractic services
- Dental services
- Early periodic screening diagnosis and treatment services for recipients under age 21
- Emergency services
- Family planning services and supplies
- Healthy Start Services
- Hearing services
- Home Health Agency services
- Hospice services
- Hospital inpatient services
- Hospital outpatient services
- Laboratory and imaging services
- Medical supply, equipment, prostheses and orthoses
- Mental health services
- Nursing care
- Optical services and supplies
- Optometrist services
- Physical, occupational, respiratory, and speech therapy
- Podiatric services
- Physician services, including physician assistant services
- Prescription drugs
- Renal dialysis services
- Respiratory equipment and supplies
- Rural health clinic services
- Substance abuse treatment services
- Transportation to access covered services

Each plan may choose to offer additional services. Each plan must have a sufficient provider network to serve the needs of their plan enrollees, as determined by the State.

If the applicant is currently enrolled in a Medicare Advantage plan, we recommend the applicant consider dis-enrolling from the Medicare Advantage plan and resume regular Medicare benefits. Regular Medicare A & B coverage typically provides a greater selection of providers than the Medicare Advantage Plans. The applicant will be required to select an MMA MCO provider in addition to Medicare A & B coverage.

The LTC SMMC recipient is not required to enroll in an SMMC MMA plan if they have creditable coverage. Medicaid considers creditable coverage to be any public or private health insurance or health benefit plan, whether insured or self-insured, including:

1. A group health benefit plan;
2. Individual or group health insurance coverage;

3. Medicare - Part A or Part B of Title XVIII of the Social Security Act;
4. Medicaid - Title XIX of the Social Security Act;
5. Medical and dental care for members and certain former members (and their dependents) of the armed forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration, and the Public Health Service under Chapter 55 of Title 10, United States Code;
6. A medical care program of the Indian Health Services or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under the Federal Employees Health Benefits Program (FEHBP) Chapter 89 of Title 5, United States Code (U.S.C.);
9. A public health plan established or maintained by a state, a foreign country, the U.S. government, or other political subdivision of a state, the U.S. government or foreign country that provides health insurance coverage;
10. A health benefit plan provided under the Peace Corps Act (22 U.S.C. 2504(e)).
11. A State Children's Health Insurance Program (CHIP) whether it is a stand-alone separate program, a CHIP Medicaid expansion program, or a combination program, and whether it is provided through a group health plan, health insurance, or any other mechanism.

Medicaid would not consider creditable coverage to include:

1. Accident-only or disability income insurance;
2. Coverage issued as a supplement to liability insurance.

Individuals with the following Medicare eligibility categories are excluded from participation in the SMMC MMA program:

- Qualified Individual (QI)
- Qualified Medicare beneficiary (QMB);
- Special low-income beneficiaries (SLMB).
- *In addition, the SMMC program contains a provision that allows recipients with access to employer sponsored insurance programs to opt out of all managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in their employer-sponsored coverage.

Considerations when choosing a SMMC MMA plan:

- What services do you think you need? Doctor’s Visits? Home Health Services? (Note: These are also known as direct service providers and must be in the plans’ network.)
- What plan do my doctors take?
- What kind of doctors do I need? Pediatrician? Family Doctor?
- What extra benefits meet my needs?
- http://www.flmedicaidmanagedcare.com/MMA/PlanInformation.aspx shows plans in your area with chart of the extra benefits offered
- Look at the Plan Information tab to see what extra services are offered by each plan.

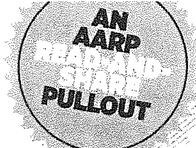
More information regarding SMMC is available at www.flmedicaidmanagedcare.com.

Please **contact our office at (727) 443-7898** with concerns regarding eligibility or choices, we can help. If you wish to file a complaint regarding SMMC with the State of Florida you may do so at http://ahca.myflorida.com/smmc.

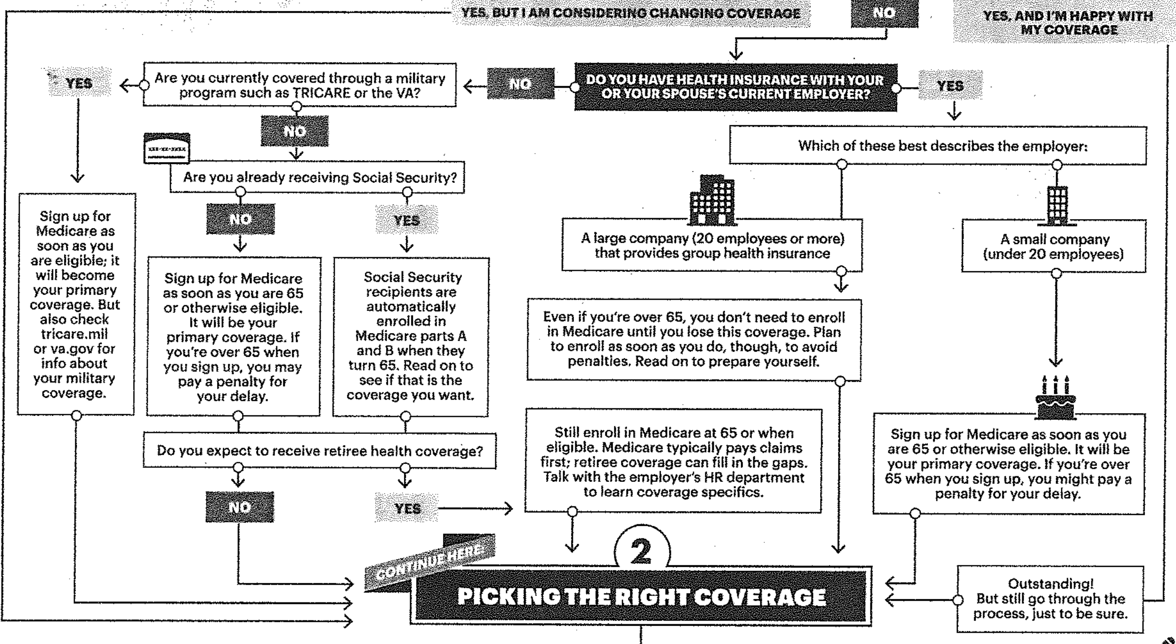
MEDICARE | HEALTH INSURANCE

NAVIGATING MEDICARE

Whether you are enrolling for the first time or contemplating changing your coverage, follow the paths below to help you make the best choices.



START HERE: **1** ARE YOU ALREADY ENROLLED?



Do you expect to receive retiree health coverage?

NO / YES

Still enroll in Medicare at 65 or when eligible. Medicare typically pays claims first; retiree coverage can fill in the gaps. Talk with the employer's HR department to learn coverage specifics.

Sign up for Medicare as soon as you are 65 or otherwise eligible. It will be your primary coverage. If you're over 65 when you sign up, you might pay a penalty for your delay.

Outstanding! But still go through the process, just to be sure.

CONTINUE HERE: **2** PICKING THE RIGHT COVERAGE

CHECK ALL THE STATEMENTS THAT APPLY TO YOU

- ☐ I prefer the broadest possible choice in doctors and medical providers.
- ☐ I spend a large amount of time traveling or residing in other states.
- ☐ I want to be able to see specialists without first getting approval from a primary care physician.
- ☐ I have employer-sponsored retiree health benefits or health coverage from the military.
- ☐ I'm OK with managing more than one insurance plan at once.

How many check marks? 3 OR MORE / 2 OR FEWER

CONSIDER ORIGINAL MEDICARE (Parts A and B)

PART A (HOSPITAL INSURANCE)
COVERS: Hospital, rehab, hospice
MONTHLY PREMIUM: None
OTHER COSTS: Copay of $1,316 for each hospital benefit period in 2017

PART B (MEDICAL INSURANCE)
COVERS: Doctor visits, lab tests, screenings, outpatient services
MONTHLY PREMIUM: standard amount is $134, less if getting Social Security (Average $109)
OTHER COSTS: Deductibles, plus 20 percent coinsurance. No annual limit on out-of-pocket costs

CHECK ALL THE STATEMENTS THAT APPLY TO YOU

- ☐ I can afford to spend $125 or more a month for more comprehensive health insurance coverage.
- ☐ I do not have supplemental insurance from a past employer, the military or my state.

Two check marks? NO / YES

CONSIDER MEDICARE ADVANTAGE (Part C)

COVERS: Comprehensive health coverage (combines parts A and B) provided by a private insurer, usually in the structure of an HMO or PPO
MONTHLY PREMIUM: Standard Part B premium plus another premium that can vary from $0 to $200
OTHER COSTS: Vary by plan. Most have an annual deductible for hospital, doctor, prescription drugs. Annual limit on out-of-pocket costs

SEE PLAN PROS AND CONS (PAGE 24)

Does your Medicare Advantage plan or the one you are considering cover prescription drugs? (Most do.) NO / YES

WARNING

All original Medicare enrollees should have some form of supplemental coverage. If you don't have retiree coverage and can't afford a Medigap plan, consider applying to a Medicare Savings Program or enrolling instead in Medicare Part C.

CONSIDER SUPPLEMENTAL INSURANCE OR MEDIGAP

COVERS: Pays for many of the coverage gaps that Medicare parts A and B don't cover
MONTHLY PREMIUM: Varies by plan and coverage—average about $180
OTHER COSTS: Does not cover prescription drugs—that requires a separate Part D policy

PRESCRIPTION DRUG COVERAGE (Part D)

If you have chosen original Medicare, sign up when eligible, even if you don't take prescription drugs now. If you wait, you face late enrollment penalties.
COVERS: Plans vary by state and by insurer but pick up most costs of prescription medicine.
MONTHLY PREMIUM: Average is $34.
OTHER COSTS: Copays vary by drug, especially generic versus brand-name medicines.
COVERAGE GAP: After reaching a government-set coverage limit, you pay full costs for your medicines until a government threshold. Then Medicare picks up most of the tab. This is the infamous "doughnut hole." This gap is scheduled to close in 2020.

DONE!

NICHOLAS RAPP

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SSI-Related Programs -- Financial Eligibility Standards: July 1, 2017

PROGRAMS & TYPES OF COVERAGE	INCOME		ASSETS	
	Individual	Couple	Individual	Couple
PROGRAMS MANAGED BY SOCIAL SECURITY				
***Supplemental Security Income (SSI)** Federal Benefit Rate (FBR) Cash payment of SSI from SSA; Includes Full Medicaid	**$735** (FBR)	**$1,103** (FBR)	**$2,000**	**$3,000**
***Low Income Subsidy (LIS) or Extra Help (150% FPL)** Helps with costs associated with Medicare Prescription Drug Plans Automatic with full Medicaid or Medicare Savings Programs (QMB, SLMB, QI1). Income limits change yearly	**$1,508**	**$2,030**	**$13,640**	**$27,250**
PROGRAMS FOR PEOPLE 65+ OR DISABLED (Community Medicaid Programs)				
***MEDS-AD (MM S) (88% FPL)** Full Community Medicaid	**$885**	**$1,191**	**$5,000**	**$6,000**
***Medically Needy (No Income Limit)** Medically Needy Income Level (MNIL) Full Community Medicaid when Share of Cost is met	**Subtract $180 from gross income**	**Subtract $241 from gross income**		
PROGRAMS FOR PEOPLE WITH MEDICARE (Medicare Savings Programs/Buy-In)				
***QMB (100% FPL)** Pays Medicare **A & B** premiums, coinsurance & deductibles **only**	**$1,005**	**$1,354**	**$7,390**	**$11,090**
***SLMB (120% FPL)** Pays for Medicare **Part B** premium **only** (PBMO)	**$1,206**	**$1,624**		
***QI1 (135% FPL)** PBMO	**$1,357**	**$1,827**		
***Working Disabled (200% FPL)** Qualified Disabled Working Individuals (QDWI) Program Pays for Medicare **Part A only. Must have lost SSDI due to employment**	**$2,010**	**$2,707**	**$4,000**	**$6,000**

MAINTENANCE NEEDS STANDARDS / OTHER

Disregards:
*Standard Disregard = **$20**
*Earned Income Disregard = **$65 + 1/2**
Student Earned Income Disregard = **$1,790** monthly, maximum **$7,200** for calendar year

Ineligible Spouse Deeming:
½ FBR = **$368**
Child Allocation = **$368/child** (Difference between the couple and single FBR)

Parent to Disabled Child Deeming:
Parent Allocation = **$735**

Disability Substantial Gainful Activity (SGA) = **$1,170** non-blind **$1,950** blind

Medicare Part B Premium = $134.00, Part A free for most **or $413**

** A $20 General Income Disregard applies to these programs. $20 will be subtracted from the total of all income not based on need before comparing the income to the income limit. In addition, $65 is subtracted from the total of all earned income, and ½ the remainder is subtracted before comparing the income to the income limit.*

PROGRAMS BASED ON INSTITUTIONAL POLICY – Patient Responsibility and Income Trusts may apply.	Income Individual	Income Couple	Assets Individual	Assets Couple	PERSONAL NEEDS ALLOWANCE Individual	PERSONAL NEEDS ALLOWANCE Couple
Institutional Care Program (ICP) Pays Nursing Home (NH) room, board & care Pays Medicare A & B premiums, coinsurance & deductibles	**$2,205** (MEDS-AD Institutional Income Limit $885)	**$4,410** (MEDS-AD Institutional Income Limit $1191)	**$2,000** ($5,000 if MEDS-AD eligible)	**$3,000** ($6,000 if MEDS-AD eligible)	**$105**	**$210**
Hospice Pays Hospice services related to terminal illness Pays Medicare A & B premiums, coinsurance & deductibles					**Community $1,005** **NH $105**	**Community $1,354** **NH $210**
Home and Community Based Services (HCBS) or Waivers Pays Medicare A & B premiums, coinsurance & deductibles	**$2,205**	**$4,410**	**$2,000**	**$3,000**	**PACE / SMMC-LTC in ALF: R&B+ $201 / $402** **PACE / SMMC-LTC at home: $2,205 / $4,410** **PACE in NH: $105 / $210** **iBudget / Cystic Fibrosis: $2,205 / $4,410** **References: 2640.0117.01 & 2640.0118**	
STATE FUNDED PROGRAMS						
OPTIONAL STATE SUPPLEMENT (OSS) REDESIGN **Maximum Payment = $78.40 single / $156.80 Couple** Assists with paying room & board at alternate living facilities	**$813.40**	**$1,626.80**	**$2,000**	**$3,000**	**$54** Provider rate $759.40	**$108** Provider rate $1,518.80
PROTECTED OSS **Maximum Payment = $239 single / $478 Couple** Assists with paying room & board at alternate living facilities	**$920**	**$1,840**			**$54** Provider rate $920	**$108** Provider rate $1,840
HOME CARE FOR DISABLED ADULTS (HCDA) Pays small stipend to caregivers of disabled	**$2,205**	**$4,410**				

SSI Individual $30 only in NH = $75 (SPS)
VA Individual $90 only in NH = $15 (SPS)

Transfer of Asset Divisor = $8,944 (eff 6/1/2017)

Community Hospice Allocations:
Spouse only = **FBR ($735)**
Spouse + Dependents or Dependents Only = **CNS Standard**

Spousal Impoverishment:
MMMNA = **$2,030**
Excess shelter = **$609**
Standard Utility Allowance = **$338**
Maximum Income Allowance = **$3,023**
Community Spouse Resource Allowance = **$120,900**
Family Members Allowance with Spouse = **(MMMNA-income) divided by 3**
Dependents with no Spouse = **CNS Standard**

Home Equity Interest Limit = $560,000

Special Needs Lawyers, PA

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Clearwater, Florida 33756

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SpecialNeedsLawyers.com

Travis D. Finchum, Esq.
Board Certified in Elder Law

Linda R. Chamberlain, Esq.
Board Certified in Elder Law

Charles F. Robinson, Esq.
Board Certified in Elder Law

Kole J. Long, Esq.
Elder Law Attorney

Special Needs Trusts | Elder Law | Long Term Care Planning | Medicaid | Probate | Wills & Trusts
Incapacity Planning | Guardianship | Developmental Disabilities | Veteran's Benefits

CONFIDENTIAL QUESTIONNAIRE

This information is extremely important. Please complete as much as possible.
Please use the back of each page to write additional information.

Date________________________________

Personal data of Client #1: (If Client #1 is deceased, please provide name, Social Security #, date of birth, date of death, and place of death.)

Client #1 name ____________________________

Home address ____________________________

City _______________State _______Zip_________

Telephone number__________________________

Fax number ______________________________

E-mail address ____________________________

Social Security #___________________________

Date of birth______________________________

Place of birth_____________________________

U.S. citizen: Yes _________ No ______________

Resided in Florida since _________

If deceased, date of death ___________________

If deceased, place of death __________________

Date of marriage __________________________

Place of marriage _________________________

Personal data of the Client #2: (If Client #2 is deceased, please provide name, Social Security #, date of birth, date of death, and place of death.)

Client #2 name ____________________________

Home address ____________________________

City _______________State _______Zip _________

Telephone number __________________________

Fax number ______________________________

E-mail address ____________________________

Social Security # ___________________________

Date of birth ______________________________

Place of birth_____________________________

U.S. citizen: Yes__________ No ______________

Resided in Florida since _________

If deceased, date of death ___________________

If deceased, place of death __________________

FAMILY MEMBERS AND OTHERS INTERESTED IN YOUR WELFARE
Please print all names as they would appear on legal documents.

Name ____
Address ____________________ City ______________ State _____ Zip___
Relationship __________________ Telephone number __________________
Spouse's name_____________________ Email:______________________

Name ____
Address ____________________ City ______________ State _____ Zip___
Relationship __________________ Telephone number __________________
Spouse's name_____________________ Email:______________________

Name ____
Address ____________________ City ______________ State _____ Zip___
Relationship __________________ Telephone number __________________
Spouse's name_____________________ Email:______________________

Name ____
Address ____________________ City ______________ State _____ Zip___
Relationship __________________ Telephone number __________________
Spouse's name_____________________ Email:______________________

Name ____
Address ____________________ City ______________ State _____ Zip___
Relationship __________________ Telephone number __________________
Spouse's name_____________________ Email:______________________

Name ____
Address ____________________ City ______________ State _____ Zip___
Relationship __________________ Telephone number __________________
Spouse's name_____________________ Email:______________________

Name ____
Address ____________________ City ______________ State _____ Zip___
Relationship __________________ Telephone number __________________
Spouse's name_____________________ Email:______________________

PERSONAL DATA

Please list any **Health Problems** for:

Client #1: ____

Client #2: ____

If Client #1 and/or Client #2 were in the hospital and unable to make decisions, with whom should the doctor consult regarding **health care and living arrangements**? (List in order of priority)

____

____

If Client #1 and/or Client #2 were unable to carry out **financial and business decisions**, who would pay the bills and make investment decisions?

____

____

Names of those who **would inherit the estate** of Client #1 and/or Client #2 **Share** of Estate

____ ______

____ ______

____ ______

____ ______

Are there any **disabled extended family members (children, grandchildren etc.)**?

Yes ________ No _________

If yes, please complete the remainder of this page, if not please go to next page.

Disabled Individual information

Name: ______________________________ Relationship: ___________ Date of Birth ___________

Address: ____

____

Telephone: (day)________________________(evening)________________________

What is the Individual's disability? Also, if the Individual's condition has been medically diagnosed, what is the diagnosis?

____

____

What is the Individual's current Prognosis?

____

____

What governmental programs is the Individual currently receiving? (for example Social Security Disability, Medicare, Medicaid, Medicaid Wavier, Food Assistance, etc.)

____

____

WHO REFERRED YOU TO OUR OFFICE?

Name ____

Address ____

Telephone number ____

FINANCIAL ADVISORS

Stockbroker name ____

Address ____

Telephone number ____

Accountant or CPA name ____

Address ____

Telephone number ____

HEALTH/MEDICAL INSURANCE

Does Client #1 and/or Client #2 have health or medical insurance? Yes _______ No _________

Insured	Company name and address	Policy #	Premium amount

LONG TERM CARE POLICIES

Does Client #1 and/ or Client #2 have any long term care policies? Yes ________ No _________

If yes, name of insured, name of company, description of coverage ______________________________

____

____

VETERAN INFORMATION

Did either Client serve in the military? If yes, please complete the Veteran information. If no, please go to next page.

Please indicate which individual served in the military: Client #1 ____ Client #2 ____

What branch? _____________ Active service in which war? ____________

Dates of service? from___________________________ to ______________________________________

Does veteran have military discharge papers, i.e., DD214 or separation papers? Yes ____ No ____

Are they originals? Yes ____ No ____ What was discharge status? ____________________________

Have **VA benefits** (Aid and Attendance) for been applied for? Yes ____________ No _______________

ASSETS

MOTOR VEHICLES

Does Client #1 or Client #2 own vehicle? Yes ________________ No ______________

If yes, automobile _________ van ________ recreational vehicle _______ trailer __________________

truck ________ boat ________ other (if other, describe) ____

Make/Model/Year	**Value**	**Owner 's name(s)**
______________________________	__________________	______________________________
______________________________	__________________	______________________________

Does Client #1 have current driver's license? Yes ________ No ________

Does Client #2 have current driver's license? Yes ________ No ________

BANK or BROKERAGE ACCOUNTS

(Use the back of this page for additional bank accounts.)

Checking #1 Name of bank or firm ____

Branch/Address ____

Names on account ____

Account number ____

Direct deposits to this account ____

Current balance as of (date) __________________$ ____

Interest bearing? Yes _____ No ______ Interest rate ____

Checking #2 Name of bank or firm ____

Branch/Address ____

Names on account ____

Account number ____

Direct deposits to this account ____

Current balance as of (date) __________________$ ____

Interest bearing? Yes _____ No ______ Interest rate ____

Money Market Name of bank or firm ____

Branch/Address ____

Names on account ____

Account number ____

Direct deposits to this account ____

Current balance as of (date) __________________$ ____

Interest bearing? Yes _____ No ______ Interest rate ____

Savings Name of bank or firm ____________________

Branch/Address ____________________

Names on account ____________________

Account number ____________________

Direct deposits to this account ____________________

Current balance as of (date) __________ $ __________

Interest bearing? Yes _____ No _____ Interest rate __________

CERTIFICATES OF DEPOSIT

CD #1 Name of bank or firm ____________________

Branch/Address ____________________

Names on account ____________________

Account number ____________________

Face amount $ ____________________

Current balance as of (date) __________ $ __________

Maturity date __________ Interest rate __________

Interest paid by: Monthly check mailed to owner ________ Quarterly check mailed to owner ________

Reinvested in the CD ______ Credited to checking or savings account # __________

CD #2 Name of bank or firm ____________________

Branch/Address ____________________

Names on account ____________________

Account number ____________________

Face amount $ ____________________

Current balance as of (date) __________ $ __________

Maturity date __________ Interest rate __________

Interest paid by: Monthly check mailed to owner ________ Quarterly check mailed to owner ________

Reinvested in the CD ______ Credited to checking or savings account # __________

CD #3 Name of bank or firm ____________________

Branch/Address ____________________

Names on account ____________________

Account number ____________________

Face amount $ ____________________

Current balance as of (date) __________ $ __________

Maturity date __________ Interest rate __________

Interest paid by: Monthly check mailed to owner ________ Quarterly check mailed to owner ________

Reinvested in the CD ______ Credited to checking or savings account # __________

COMMON OR PREFERRED STOCKS AND MUTUAL FUNDS

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

CORPORATE BONDS

Name(s) of owner	Company	# of bonds	Current price per bond	Total value on / /	Date purchased	Purchase price

U. S. SAVINGS BONDS

Number of U.S. Savings Bonds: Series E _______________ Series EE ________________Series H____________

Total face value of all U. S. Savings bonds: $ _____ Total estimated current cash value of bonds: $___________

TAX-FREE MUNICIPALS

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

LIMITED PARTNERSHIPS, ETC.

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

G N M A 's

Name(s) of owner	Company	# of shares	Current price per share	Total value on / /	Date purchased	Purchase price

ANNUITIES

Client #1:

Company and Address	Salesman	Policy #	Owner	Beneficiary	Cash Value	Payments

Client #2:

Company and Address	Salesman	Policy #	Owner	Beneficiary	Cash Value	Payments

DEFERRED COMPENSATION /RETIREMENT ACCOUNTS

(IRA/SEP/401k/Profit sharing/Keogh)

Client #1:

Financial institution	Type (CD, stock, bonds etc.)	Value as of / /	Beneficiary	Date purchased	Purchase price	Payments

Client #2:

Financial institution	Type (CD, stock, bonds etc.)	Value as of / /	Beneficiary	Date purchased	Purchase price	Payments

BURIAL ASSETS

Location, description, and address of any **cemetery plots** Client #1 and/or Client #2 owns.

____

____

____

____

____

Burial contracts or pre-paid funeral agreements Client #1 and/or Client #2 has purchased.

Client #1's Contract Name of purchaser_________________________Date of purchase _______________

Name and address of funeral ____

Address____________________________ City _________________________ State ______Zip _________

Name of insurance company ____

Contract is: revocable ___________ irrevocable ________Contract amount $ _________________________

Client #2's Contract Name of purchaser_______________________________Date of purchase _________

Name and address of funeral ____

Address____________________________ City _________________________ State ______Zip _________

Name of insurance company ____

Contract is: revocable _____ irrevocable ________Contract amount $ ______________________________

Does Client #1/Client #2 have a **special bank account** set aside for burial funds? Yes _______ No ________

If yes, please provide name and location of bank, account number and current balance __________________

____

REAL PROPERTY

Homestead (your residence) address ____

This residence is: a house ________ a mobile home ___________ a condominium ___________

other (describe, if other) ____

Names exactly as they appear on the deed ____

Is there a mortgage? Yes ___ No ___ If yes, what is the mortgage balance? $ ____________________________

What is the tax assessor's value for this home? $ ____

If you were going to sell your home, what price would you expect to receive for it? $ ______________________

Date of purchase ____

Purchase price $ ____

All other real property:

Property #1 address ____

This property is: a house _________ a mobile home ___________ a condominium ___________

other (describe, if other) ____

Names exactly as they appear on the deed ____

Is there a mortgage? Yes ___ No ___ If yes, what is the mortgage balance? $ ____________________________

What is the tax assessor's value for this property? $ ____

If you were going to sell this property, what price would you expect to receive for it? $ ____________________

Date of purchase ____

Purchase price $ ____

Do you receive rental income? Yes ____ No______ If yes, monthly rental amount $ ______________________

If other real property is owned, please provide the information for the additional property on the back of this page.

LIFE INSURANCE

Client #1:

Company/ Policy #	Insured/Owner- if different, list both	Beneficiary	Date Issued	Face Value	Cash Value	Policy Loan Amount

Client #2:

Company/ Policy #	Insured/Owner if different, list both	Beneficiary	Date Issued	Face Value	Cash Value	Policy Loan Amount

LOANS (Mortgages and notes, money owed to you)

Does Client #1 or Client #2 **own a mortgage** and / or a promissory note? Yes ________ No ________

Names on the note or mortgage ____

Principal balance remaining due $ ____

Is the mortgage marketable (can it be sold?) Yes _______ No ________

If marketable, what could you sell it for? $ _______________________________________

Safety deposit box - Name of bank, name and address of branch, & box # _____________________

____

Who is authorized to enter box? ____

MONTHLY INCOME SUMMARY

List all income amounts - gross and net where applicable - that Client #1 or Client #2 receives per month:

Source	Client #1 Gross	Client #1 Net	Client #2 Gross	Client #2 Net	Name & Address of Company
Social Security					
Private Pension					
Railroad Retire.					
Veteran's Benefits					
Civil Service					
Interest Income					
Dividend Income					
Alimony					
Rental Income					
Distributions from IRA/retirement					
Wage from Job					
Self-Employment Income					
Total Income					

DOCUMENTS TO PROVIDE WITH QUESTIONNAIRE

Copy of current Will, Trust, Durable Power of Attorney, Health Care Surrogate, Living Will, or other estate planning documents for Client #1 and/or Client #2, and copies of driver's licenses for Client #1 and/or Client #2.

DOCUMENTS YOU MAY NEED TO PROVIDE LATER
It is a good idea to keep these documents handy.

1. Copy of long term care policy for Client #1 and/or Client #2. Please include benefit page.
2. Copies of most current statements from financial institutions:
   For all **open** accounts: checking, savings, Certificate of Deposits, brokerage, etc.
3. Copies of stock certificates, bonds, CDs, U.S. government bonds, municipals, annuities, Individual Retirement Accounts (IRAs), or any other deferred compensation plans for Client #1 and/or Client #2.
4. Copy of any prepaid burial or cremation contract for Client #1 and/or Client #2 and copy of deed to cemetery plot owned by Client #1 and/or Client #2. Copy of any special burial bank account for Client #1 and/or Client #2.
5. Copy of deed to residence, current real estate tax bill, homeowners insurance policy and premium statement. Copy of deed(s), tax bill, and proof of insurance for any other real property owned by Client #1 and/or Client #2.
6. Copy of life insurance policies for Client #1 and/or Client #2. Pages needed are the cover page, Declarations page which lists the information about the policy and the beneficiary information.
7. Copy of any mortgage and/or promissory note **owing to** Client #1 and/or Client #2.

After you have completed the Questionnaire, please sign the following statement:

I understand that it is my responsibility to disclose correct and complete information. I hereby attest that the information I have supplied is complete and accurate to the best of my knowledge. I realize that any changes must be reported as soon as possible.

Sign: ____Date ________________________________

ADDITIONAL INFORMATION PAGE