LONG TERM CARE MEDICAID APPLICATION

Medicaid Assistance for Individuals

PACE

DDS Waiver

Elder Choices

Assisted Living

Nursing Facilities

Alternatives for Adults with Physical Disabilities

A growing number of Home and Community based programs are available as alternatives to Nursing Homes. While a Nursing Home is the right option for some people, others may find help is available to keep them at home. If you would like to talk to a counselor about your options, call toll free1-866-801-3435.

A brief description of each of these programs and their eligibility criteria, as well as the Medicaid application, can be found on the inside of this packet. If you are interested in one of these programs, please complete the attached application and return it to your local DHS county office or call for more information. The DHS county office will determine your eligibility and provide additional information on available assistance.

LONG TERM CARE MEDICAID APPLICATION KIT

LONG TERM CARE MEDICAID OPTIONS

The following programs are available for facility and non-facility care for individuals with long-term medical needs. These programs have common income and resource requirements.

Income Limit

The income limit for all of the following programs is three times the current SSI Standard Payment Amount (SPA) for an individual. The income limit for 2007 is $1,869. The income limit increases at the first of each calendar year. Only the income of the applicant is counted toward this limit. In some categories, if there is a non-institutionalized spouse, the spouse may be eligible to keep all or a portion of the institutionalized individual's income.

Resource Limit

The resource limit for the covered individual is $2,000. In some programs, if the covered individual has a spouse, the spouse may be eligible to keep all or a portion of the total spousal resources. See Resource Rule.*

Nursing Facilities

Institutions that provide medically necessary care 24 hours per day for residents who require skilled nursing care, rehabilitation services or health-related care and services above the level of room and board and not primarily for the care and treatment of mental diseases. Recipients receive the full range of Medicaid benefits. Medicaid also pays all or a portion of monthly facility vendor payment depending on the monthly income to be considered.

Individuals in Nursing Facilities with income over the current limit may become eligible for Medicaid by establishing an Income Trust. The DHS caseworkers have information about Income Trusts.

Non-institutionalized spouses of Nursing Facility recipients are eligible for the division of spousal resources and income.

In addition to being income and resource eligible, the Nursing Facility resident must be aged, blind or disabled and require medical care of a certain level, determined by the Office of Long Term Care.

Assisted Living Facilities Level II

Facilities that provide assistance with activities of daily living to individuals in a residential setting. Living units and common space are provided to address all activities of daily living on a 24-hour basis. Individuals in Level II Assisted Living Facilities are eligible for the full range of Medicaid benefits. Room and board cost are not included in the waiver coverage.

Individuals with income over the current limit may become Medicaid eligible by establishing an Income Trust. Non-institutionalized spouses of Assisted Living Facility recipients are eligible for the division of spousal income and resources.

Assisted Living Facilities Medicaid requires an Intermediate Level of Care as determined by the Office of Long Term Care. Individuals requiring Skilled Care are not eligible for this program.

ElderChoices (Alternative Community Services Program for the Aged)

Home-based care for individuals aged 65 and over. ElderChoices provides homemaker services, chore services, home delivered meals, Personal Emergency Response System, Adult Day Health Care, Adult Foster Care, Respite Care, Adult Day Care and Adult Companion Services. ElderChoices provides the full range of Medicaid benefits.
Applicants with spouses living in the community are eligible for the division of spousal resources, but not for spousal income as the recipient does not contribute income to his or her care.

Individuals eligible for ElderChoices require an Intermediate Level of Care as determined by the Office of Long Term Care. Individuals requiring Skilled Care are not eligible.

Alternatives for Adults with Physical Disabilities (AAPD)

Home and community based care for physically disabled individuals aged 21 to 64 as an alternative to institutionalization. AAPD provides Attendant Care and Environmental Accessibility Adaptation Services and the full range of Medicaid benefits.

Individuals eligible for AAPD require an Intermediate Level of Care as determined by the Office of Long Term Care. Individuals requiring Skilled Care are not eligible.

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

A comprehensive health and social services program that provides and coordinates primary, preventive, acute and long term care services for individuals 55 years of age or older who need nursing facility care. Services are provided in PACE Centers, in the home and in inpatient facilities. Individuals eligible for PACE must live in an area served by a PACE program and be able to live in a community setting without jeopardizing their health or safety.

PACE applicants with income over the income limit may become eligible for Medicaid by establishing an Income Trust. DHS caseworkers have additional information regarding Income Trusts. PACE participants with spouses living in the community are eligible for the division of spousal income and resources.

Individuals eligible for PACE require a nursing home Level of Care as determined by the Office of Long Term Care. The PACE program is expected to begin soon and will be available to individuals in the Jonesboro area.

DDS Waiver

Home and community based care for individuals with developmental disabilities who would otherwise require an ICF/MR Level of Care in an institution. DDS Waiver provides the full range of Medicaid benefits as well as other specialized services. Contact DDS at 501-682-8662 for information about this program.

*RESOURCE RULE FOR SPOUSAL RESOURCES

If total resources are under $20,328 – Community Spouse gets all.
If total resources are $20,328 to $40,656 – Community Spouse gets $20,328.
If total resources are $40,656 to $203,280 – Community Spouse gets one-half.
If total resources are over $203,280 – Community Spouse gets $101,640
(the maximum effective 1-1-07)

(These amounts increase annually.)

When completing an application for Long Term Care Assistance some of the items that you will need to provide are:

Verification of your bank accounts

Proof of your monthly income

Social Security card or number

Your Medicare card

Proof of Life and Health Insurance

If you have sold or transferred any property, please provide deeds.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
LONG TERM CARE APPLICATION FOR ASSISTANCE

What services are you requesting?

☐ Nursing Facility ☐ ALF ☐ EC ☐ AAPD Waiver ☐ PACE ☐ DDS Waiver

If you need this material in a different format, such as large print contact your DHS county office.

1. I am a resident of Arkansas: Yes ☐ No ☐

2. I am: 65 years of age or older ☐ Blind ☐ Disabled ☐

3. My full name is: _____ Race _____ Sex _____
Last First Middle

4. My current address is: _____
Street or Route No. City State Zip County

My former address was: _____
Street or Route No. City State Zip County

I have lived at my current address for: _____ years.

5. My telephone number is: _____ 6. I was born on: _____
Month Day Year

7. _____ _____ I was born in: _____
Social Security Number Medicare Number City or County

_____ _____ _____
Railroad Ret. Number VA Claim Number State or Country

8. I am a U.S. Citizen: Yes ☐ No ☐ 9. I am a lawfully admitted Alien: Yes ☐ No ☐

10. I am: Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐

Complete Questions 11 – 15 ONLY if you have a Spouse

11. My spouse's name is: _____
Last First Middle

12. My spouse's address is: _____
Street or Route No. City State Zip County

13. My spouse's telephone number is: _____ 14. My spouse was born on: _____
Month Day Year

15. _____ _____ _____ _____
Spouse's Soc. Sec. No Spouse's Medicare No. Spouse's Railroad Ret. No. Spouse's VA Claim No.

16. I and my spouse have income from the following: (Check (√) Yes or No. If yes enter the amount and how often the income is received).

	MYSELF				MY SPOUSE			
SOURCE OF INCOME	YES	NO	AMOUNT	HOW OFTEN	YES	NO	AMOUNT	HOW OFTEN
Retirement Benefits								
Social Security Benefits								
SSI								
Veteran's Benefits								
Railroad Retirement								
Civil Service Benefits								
Interest/Dividends								
Insurance								
Money From Trusts								
Mineral Rights/Oil Leases								
Rental								
Cash Contributions								
Unemployment Benefits								
Worker's Compensation								
Employment/Work								
Farming/Self Employment								
Deposits by Others for Me								
Other								

17. I or my spouse have received SSI in the past: Yes ☐ No ☐ If Yes, when _____

18. I or my spouse expect a change in income: Yes ☐ No ☐ If Yes, explain. _____

19. I or my spouse own a home. Yes ☐ No ☐
If yes, my home is occupied by my spouse and/or dependent relatives. Yes ☐ No ☐

Address of Home Equity Value

I or my spouse formerly owned homes in:

City, County and State

City, County and State

20. I or my spouse own real property, (land or buildings), other than my home. Yes ☐ No ☐
If yes, complete the following:

Address of Property Equity Value

Address of Property Equity Value

I or my spouse formerly owned real property other than my home in:

City, County and State

21. I or my spouse have sold/deeded/given away a home or other real property:

To Whom

22. I or my spouse retain life estate, dower, curtesy, inheritance or other interest in a home or other property

Location of Property (City, County, State) Type of Interest Value

23. I or my spouse own personal property such as cars, trucks, tractors or other farm machinery, trailers, boats, etc.: (If more than three, please list on a separate sheet)

Item (Make, Model, and Year) Equity Value

Item (Make, Model, and Year) Equity Value

Item (Make, Model, and Year) Equity Value

24. I or my spouse own livestock (cattle, poultry, catfish, minnows, crickets, worms, etc.)
Yes ☐ No ☐ If yes, complete the following:

Type of Livestock and Number Owned Value

25. I or my spouse have the following assets. (Check (√) Yes or No. If yes, enter the amount/value, location of the asset, and name of joint owner, if any.)

TYPE	YES	NO	AMT/VALUE	LOCATION OF ASSET	NAME OF JOINT OWNER
Cash					
Checking Account					
Savings Account					
Other Savings (Certificates, etc.)					
Promissory Notes					
Stocks					
Bonds					
Patient Fund Account					
Mortgage					
Burial Plot/Crypt					
Burial Funds/Insurance					
Life Insurance					
Trusts					
Other					

26. I or my spouse have additional income and/or property (real or personal) that I was unable to list under items 16 through 23.
Yes ☐ No ☐ If yes, record your answer(s) on a separate sheet.

27. I or my spouse have other resources (real or personal property) that are being held for me by another individual.
Yes ☐ No ☐ If yes, complete the following:

Type of Resource Location of Resource Amt/Value

Type of Resource Location of Resource Amt/Value

28. I or my spouse have hospital/medical insurance coverage. Yes ☐ No ☐ If yes, complete the following:

Name and Address of Insurance Company Policy No.

29. I have unpaid medical expenses from the past three (3) months. Yes ☐ No ☐

30. I, or someone in my household, would like to learn to read, or to read better. Yes ☐ No ☐

31. Do you have Long Term Care Insurance? Yes ☐ No ☐

- I understand that I must help establish my eligibility by providing as much of the requested information as I can.
- I authorize the Department of Human Services to make any investigation concerning me and/or my spouse necessary to establish my eligibility for assistance.
- I understand that no person may be denied long term care assistance or other Medicaid assistance on the grounds of race, color, sex, national origin or disability.
- I understand that I may request a hearing before the state agency representative if a decision is not reached on my case within the appropriate time limit or if I disagree with the decision reached.
- I agree to notify the Department of Human Services within 10 days if I or my spouse receive additional income, acquire or dispose of property or if any other changes occur in my circumstances.
- I understand that by applying for Medicaid I automatically assign my right to any settlement, judgment or award which may be obtained against any third party to the Arkansas Department of Human Services to the full extent of any amount which may be paid by Medicaid for my benefit. I also understand that this assignment is required by Act 463 of 1987.
- Assignment of Medical Support includes the rights to benefits from hospital/medical insurance, workers compensation, etc.
- I authorize the Department of Human Services to examine all records of mine, or records of those receiving or having received Medicaid benefits through me, for the purpose of investigating whether or not any person may have committed Medicaid fraud or for use in any legal, administrative or judicial proceeding.
- I understand that I must provide my Social Security Number as a condition of my eligibility; and I understand that this number may be used by the Agency without my express permission in a computer match to obtain information relative to my eligibility for assistance from the Social Security Administration, Department of Workforce Services, Internal Revenue Services, or other agencies.
- **I understand the requirement to disclose, in my application for Long Term Care services, information regarding any interest that I or my community spouse may have in an annuity.**
- **I understand the requirement to name the state as a remainder beneficiary in which I or my spouse is the annuitant.**
- If you have questions or problems regarding your application or care, please call your State Long Term Care Ombudsman at 501-682-8952.
- **IMPORTANT ESTATE RECOVERY NOTICE:**
  If you receive Medicaid in a nursing facility, ICF/MR facility, or under a home and community based waiver program, the total amount of the Medicaid benefits paid on your behalf will be a debt to DHS and may be recovered from your estate after your death. Your estate is the property you own at the time of your death. DHS will not make a claim against your estate while you are living. DHS will not make a claim against your estate after your death if your spouse is still living, or if you have dependent children under age 21 or blind or disabled children. DHS will collect the debt, if any, by filing a claim in your estate. Collection may not be made if it is not cost effective to DHS or if your heirs apply for a hardship waiver after your death. A hardship may exist if the estate property is the only source of income for your heirs, if that income is limited, or if there are other compelling circumstances.

CERTIFICATION: I HAVE READ THE ABOVE STATEMENTS; AND I AGREE TO THEIR PROVISIONS.

- **FOR LONG TERM CARE FACILITY RECIPIENTS/APPLICANTS ONLY**: After reviewing the alternatives to nursing facility placement available through the Department of Human Services, I understand that I am choosing to be served in a nursing facility.
- I understand that if I am admitted to a nursing facility based on conditional Medicaid approval and my Medicaid case is denied, I, or my family, will be responsible for any indebtedness while in the nursing facility.
- I understand that this form is signed subject to penalties for perjury, I understand that if I receive assistance to which I am not entitled as a result of withholding information or providing inaccurate information, such assistance will be subject to recovery by the Department of Human Services and I may be subject to prosecution for fraud and fined and/or imprisoned.

Witness (if signed by mark)/Date	Applicant, Guardian, or Authorized Rep's Signature
Address of Witness/Telephone Number	Date / Telephone Number
Name of Person Who Helped Complete Form/Date	Guardian or Authorized Rep.'s Address
Signature of County Office Worker/Date	