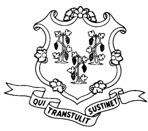

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

W-1659
(Rev 07/22)

QUESTIONS & ANSWERS: APPLYING FOR MEDICAID TO PAY FOR LONG TERM SERVICES AND SUPPORTS IN A NURSING FACILITY OR YOUR HOME

Medicaid rules are complicated and change often. This information describes some of the rules for applying for Medicaid for Long-Term Services & Supports (LTSS) while residing in a nursing facility or at home. The complete rules are in the Department of Social Services' Uniform Policy Manual found at https://portal.ct.gov/DSS/Lists/Uniform-Policy-Manual. Applications, along with directions on how and where to submit them, can be found at http://ct.gov/DSS/LTSS-Apply. If you have any questions about this information, please contact DSS at 1-855-626-6632.

We begin to review your eligibility for medical assistance on the date we get a signed and dated application. We try to make a decision on your application as quickly as possible, usually within 90 days after the date you apply and often more quickly. We can do this only if we have all the information that we need.

If you qualify for care in a nursing home, you may receive help up to three months before the date you applied, if you needed help and were eligible in those months.

If you qualify for home care services, you can only receive help from the date you are determined eligible.

1. WHAT IS MEDICAID?

   Medicaid, also called HUSKY Health in Connecticut, is a program that provides health coverage to eligible low-income individuals. DSS runs the program which is funded by both the state and federal government.

2. WHAT ARE LONG TERM SERVICES AND SUPPORTS?

   Health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with activities of daily living.

3. WHAT WILL I NEED TO DO WHEN I APPLY?

   To apply, you will need to submit a completed and signed application. The application requires complete and detailed information about your income and assets. You will need to give us proof of your income and asset information. We will tell you what we need to prove your income and assets and decide if you are eligible.

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4. IF I AM RECENTLY DIVORCED OR LEGALLY SEPARATED WILL DSS STILL NEED INFORMATION FROM MY EX-SPOUSE?

Yes, depending on how long ago you were legally separated or divorced we will need to collect information on the assets of your ex-spouse. If your marriage ended during the 60 months before you applied for help, we will need this information.

5. HOW DOES DSS DETERMINE IF MEDICAID CAN PAY FOR MY NURSING HOME CARE OR HOMECARE?

To be eligible you must:

- be a United States citizen or an eligible non-citizen,
- be a Connecticut resident,
- have a limited amount of income and assets, AND
- require the level of care provided in a nursing home, whether you are living at home or in a facility

6. WHAT ARE EXAMPLES OF INCOME AND ASSETS THAT DSS REVIEWS?

Examples of income: wages, Social Security benefits, pensions, veteran's benefits, dividends, and interest.

Examples of assets: bank accounts, stocks, bonds, trusts, annuities, crowdfunding accounts, property, and life insurance.

DSS follows federal and state laws about how much income and how many assets you can have and still be eligible.

7. HOW MANY ASSETS CAN I HAVE?

If you are widowed, divorced, or never married, your countable assets cannot be more than $1,600.00. If your assets exceed this limit, by even a penny, you will not be eligible. (see #14)

If you are married and your spouse is living at home, we call this a "community spouse" or "spouse in the community." The next question will explain how your assets are treated when you have a spouse in the community.

8. HOW ARE MY ASSETS TREATED IF I HAVE A SPOUSE IN THE COMMUNITY WHEN I APPLY?

If you have a spouse who lives in the community, you can protect part of your combined assets. We do not count the value of the protected assets when determining your

eligibility. First, we add your and your spouse's total countable assets, as of the initial date that you were admitted to a hospital or long-term care facility and had a continuous stay of 30 days or more. This is called the "date of institutionalization." If you have not yet been in the facility for 30 continuous days, DSS will review your medical records to determine the date of institutionalization.

We divide the total of your assets in half to determine the "spousal share." The spousal share is one-half of the total value of assets owned by you and your spouse. The amount you can protect is called the "Community Spouse Protected Amount" or "CSPA." The CSPA is equal to the spousal share from a minimum of 50,000 (effective 7/1/22) up to a maximum of $137,400 (effective 1/1/22). If the spousal share is less than the minimum, your spouse may be able to keep some or all of your share of the assets in order to bring him or her up closer to the minimum. The minimum and maximum amounts are set by federal law and the state is required to update the amounts yearly. The CSPA cannot exceed the maximum amount, except by a Fair Hearing decision or through a court order.

When you and your spouse have assets that are more than the CSPA plus the $1,600 Medicaid asset limit, the excess assets are considered available to you. This is true regardless of which spouse owns the assets. You are not eligible for Medicaid until you and your spouse's combined assets are reduced to the total of the $1,600 asset limit plus the CSPA. You and your spouse may reduce your asset total by paying your medical expenses. However, as long as fair market value is received, the excess assets may be spent on what either spouse needs.

9. WHAT ASSETS ARE NOT COUNTED?

The following assets do not count towards the $1,600 asset limit.

- The equity value of your home as long as one of the following is true:
    - You are living there;
    - Your spouse is living there;
    - Your child under the age of 21 is living there;
    - Your child with a disability is living there;
    - You are expected to return to the home;
    - Your brother or sister who jointly owns the home with you is living there and began living there at least 1 year before you entered the long-term care facility; or
    - The total equity value in your house is less than $955,000 (effective 1/1/22). Any amount over $955,000 will count as an asset.
- Term life insurance that has no cash surrender value.
- Ordinary household goods and personal effects.

- One car owned by either you or your spouse.

10. CAN THE STATE PLACE A LIEN ON MY HOUSE OR FORCE ME TO SELL IT?

    We will not place a lien on your house.

    If any of the individuals mentioned in #9 above live in your house, we will not force you to sell it. If none of these people live in your house and you are not expected to return home, you must sell your house for fair market value.

11. WHAT IF MY HOUSE DOES NOT SELL?

    As long as you are doing your best to sell the house, DSS will not count it as an asset.

12. WHO GETS THE MONEY IF I SELL MY HOUSE?

    All funds received from the sale of your house must be used solely for your needs. You will not get Medicaid until you spend the rest of your money from the sale of your house. Once you have $1,600 or less in total assets, you can receive Medicaid. If it takes more than 90 days to spend your money down to $1,600 or less, you will need to submit a new application.

13. DOES THE VALUE OF A WHOLE LIFE INSURANCE POLICY OR A PRE-PAID BURIAL CONTRACT COUNT TOWARDS THE ASSET LIMIT?

    - We may or may not count whole life insurance policies as an asset. We look at the face value of your policies to decide if we must count them. We add the face value of your policies together and if the total of your policies is $1,500 or less, we do not count them as an asset. If the total is more than $1,500, you must verify the cash surrender values of each policy and we will count the cash surrender values of the policies as an asset.
    - We exclude any life insurance policies that have a cash value of $10,000 or less if you have requested the cash surrender value and provide proof that you have done so.
    - You can have an irrevocable funeral contract with a Connecticut funeral home that is valued up to $10,000 effective 1/1/2020 or with a funeral home outside of Connecticut, subject to the laws of that state. Any such contract issued in Connecticut on or after 1/1/2020 must state that any unused funds will be turned over to the State of Connecticut to repay certain public assistance you received, including Medicaid LTSS. You can have a separate contract for burial space items that includes the purchase of a burial plot, opening and closing of a grave site, cremation urn, casket, outer burial container and a headstone or marker. Burial space contracts have no limit and must be paid in full.

- We will exclude any life insurance policy when the beneficiary of the policy is assigned to a funeral home and you receive fair market value in the form of a valid burial contract.

14. WHAT CAN I DO IF MY ASSETS ARE MORE THAN $1,600?

Assets over the $1,600 limit may be used in several ways, as long as they are not given away or exchanged for something of lesser value. For example, you may use your assets to pay for the cost of your care in the nursing home or at home, pay other bills that you have, make repairs to your home, or prepay your funeral expenses.

15. HOW ARE JOINT ACCOUNTS TREATED?

The full value of any accounts with your name on them is presumed to belong to you, unless the other owner(s) can document that some or all of the funds are his or hers.

16. WHAT IF I TRANSFER ASSETS TO A PERSON OTHER THAN MY SPOUSE?

If you apply for LTSS Medicaid, we look to see if you or your spouse gave away any assets in the 60 months before you apply for help. We call this the “look-back period.” There is no penalty if you sell your assets for fair market value. However, if you transfer assets for less than fair market value to someone other than your spouse, a blind or disabled child, or certain others described in DSS regulations, there will be a penalty period during which you will be ineligible for payment of nursing home or home care services. Currently, the penalty period is one month of ineligibility for every $14,060 (effective 7/1/22) transferred for less than fair market value.

17. DO I HAVE TO USE MY MONTHLY INCOME TO PAY FOR THE NURSING HOME OR HOME CARE SERVICES?

If you are on Medicaid, you may need to contribute to the cost of your care. Your contribution begins once you are in the nursing facility for 30 days. If you are receiving home care it will start the month that your eligibility for services begins. This contribution is called your patient liability amount (PLA). Your PLA is determined using your total gross income minus your total allowable deductions.

You can keep some money each month. We deduct these amounts from your total gross income:

- If you are living in a nursing home, $75 as a personal needs allowance (this amount changes occasionally);
- An amount we calculate or a court orders for support for your spouse or other dependent living at home;

- Health care costs that Medicaid does not pay;
- $90 each month for a single war veteran or spouse of a deceased war veteran with reduced VA Improved pensions;
- Some expenses for your home, if you are expected to return within 6 months; and
- If living at home and receiving home and community based services, $2,265 as a personal needs allowance (this amount is updated yearly).

18. SHOULD I PAY THE NURSING HOME WHILE MY APPLICATION IS PENDING?

Yes, you should pay the nursing home while your application is pending. This payment can be from your excess assets or your PLA for the months Medicaid is being requested. If you keep this money in a savings, checking or patient account, we will count it as an asset. If counting it causes you to have more than $1,600, we will not be able to help you for that month.

19. ONCE MY APPLICATION IS GRANTED DO I HAVE TO STAY WITHIN THE $1,600 ASSET LIMIT?

Yes, once your application is granted, you need to carefully watch the interest that builds up in your bank accounts and be sure to spend this and the personal needs allowance so that your assets stay below the limit. We will request proof and review your assets at each annual renewal of your eligibility.

20. WHAT DO I DO IF I THINK DSS MADE A MISTAKE WITH MY APPLICATION?

If you think that we made a mistake with your application, call your assigned worker to review the results. If you still do not agree, you may ask for a hearing. You or your representative must ask for a hearing in writing within 60 days of the action taken by the department. Send your hearing request to the Department of Social Services, Office of Legal Counsel Regulations and Administrative Hearings, 55 Farmington Ave, 11th Floor, Hartford, CT 06105. For information about how hearings work, or to get a hearing request form, you can call: (860) 424-5760 or toll free 1-800-462-0134.