HELPING YOUR PATIENTS ACCESS MEDICAID

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Tool Kit by

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Empire Justice Center

Empire Justice Center

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Empire Justice is a statewide, multi-issue, multi-strategy public interest law firm focused on changing the "systems" within which poor and low income families live. Empire Justice undertakes research and training, acts as an informational clearinghouse, and provides litigation backup to local legal services programs and community based organizations. As an advocacy organization, we engage in legislative and administrative advocacy on behalf of those impacted by poverty and discrimination. As a law firm, we provide legal assistance to those in need and undertake impact litigation in order to protect and defend the rights of disenfranchised New Yorkers.

INTRODUCTION

This toolkit is intended to help you help your patients get public health insurance or other help paying for medical care at your community health center.

The topics in this manual include:

1. Medicaid
2. Family Health Plus
3. Child Health Plus
4. Presumptive Eligibility for Children
5. Refugee Medical Assistance
6. Charity Care
7. Spend Down
8. Spousal Refusal
9. Pooled Trusts
10. Rights of Limited English Proficient Patients

How to Use this Toolkit:

You will find fact sheets of 3-4 pages on each topic with charts and/or sample forms following where applicable. Each fact sheet represents either one of New York's basic public health programs or an important tool you can use to help your patients qualify for a public health programs.

- Use the income chart that follows the fact sheet on Medicaid to get an idea about whether the patient you are helping is likely to be eligible for Medicaid. This chart also has the eligibility levels for the other major public health programs that are topics in this toolkit.

- If the patient you are helping has too much income for any of the major programs in this toolkit, read about spend down, pooled trusts and spousal refusal. One of these tools may help your patient qualify.

- If the patient you are helping cannot use these tools, or if he or she owes money to a hospital, read the section on Charity Care.

- If you are helping an immigrant, be sure to read the fact sheet the Rights of Limited English Proficient Patients. If the immigrant patient is a refugee, you should also read the fact sheet on Refugee Medical Assistance.

- In addition, the Community Health Center Association of New York State (CHCANYS) has developed a manual on immigrant eligibility that that will be helpful. Odds are this manual is on the shelf at your clinic. Look for:

  Community, Migrant and Homeless Health Center Handbook: Immigrant Eligibility for Publicly Funded Health Care Benefits, (January, 2009).

2009 NYS INCOME AND RESOURCE STANDARDS AND FEDERAL POVERTY LEVELS

Effective 04/01/09

GIS 08 MA / 35, **GIS** 09 MA / 001

Human Resources Administration
Department of Social Services

MAPDR-01.....Rev. 04/01/09

1. PCAP and Medicaid Monthly Income Levels (Pregnant Women and Children Under 19)

Family Size	1	2	3	4	5	6	Each Add'l Person
Children under 1 yr; Pregnant Women Perinatal Coverage Only **(200% FPL)**	$1805	$2429	$3052	$3675	$4299	$4922	$624
Children 1-5 **(133% FPL)**	$1201	$1615	$2030	$2444	$2859	$3273	$415
Children 6-18 **(100% FPL)**	$903	$1215	$1526	$1838	$2150	$2461	$312
Children 19-20 yrs; Parents/Disabled Individuals	$767	$1117	$1285	$1452	$1620	$1787	$168
Pregnant Women **(count as 2 people)** Full Coverage **(100% FPL)**		$1215	$1526	$1838	$2150	$2461	$312

2. Child Health Plus Premium Levels – Monthly Income (Effective 04/01/2009) Monthly Income by Family size (Children Under 19 NOT Medicaid Eligible)

Premium Categories	1	2	3	4	5	6	Each Add'l Person
Free Insurance **(160% FPL)**	$1443	$1942	$2441	$2939	$3438	$3937	$499
$9 per child per month (Max. $27 per family) **(222% FPL)**	$2004	$2696	$3388	$4080	$4772	$5464	$692
$15 per child per month (Max $45/Family) **(250% FPL)**	$2257	$3036	$3815	$4594	$5373	$6153	$780
$20 per child per month (Max. $60 per family) **(300% FPL)**	$2708	$3643	$4578	$5513	$6448	$7383	$935
$30 per child per month (Max. $90 per family) **(350% FPL)**	$3159	$4250	$5341	$6432	$7523	$8613	$1091
$40 per child per month (Max. $120 per family) **(400% FPL)**	$3610	$4857	$6104	$7350	$8597	$9844	$1247
Full Premium per child/month if **over** 400% FPL	$3610	$4857	$6104	$7350	$8597	$9844	$1247

3. **Regular Medicaid Levels (Parents, 19 and 20 year olds, 21-64 disabled or blind, 65 and over.)**

Family Size	1	2	3	4	5	6	7	8	9	10	E ach Add'l Person
Monthly Income	$767	$1117	$1285	$1452	$1620	$1787	$1955	$2122	$2290	$2458	$168
Resource Level	$13,800	$20,100	$23,115	$26,130	$29,145	$32,160	$35,175	$38,190	$41,205	$44,220	$3015

4. (a) FHP Income/Resource Levels (Parents Living with Children Under 21 in their Household; 19-20 year olds living with their parents)

Family Size	1	2	3	4	5	6	7	8	9	10	Each Add'l Person
FHP Limit 150% FPL	$1354	$1822	$2289	$2757	$3224	$3692	$4159	$4627	$5094	$5562	$468
Resource Level	$13,800	$20,100	$23,115	$26,130	$29,145	$32,160	$35,175	$38,190	$41,205	$44,220	$3015

4 (b) FHP Income/Resource Levels (Adults Without Children Under 21 in Household, and 19-20 Year Olds Living Alone)

INCOME LEVELS (100% FPL) →	Family of 1	$903	**RESOURCE LEVELS** →	Family of 1	$13,800
	Family of 2	$1215		Family of 2	$20,100

5. Family Planning Benefit Program Income Levels (No Resource Test)

Family Size	1	2	3	4	5	6	Each Add'l Person
FPBP 200% FPL (Child Bearing age)	$1805	$2429	$3052	$3675	$4299	$4922	$624

6. MBI-WPD (16-64)

Family Size	1	2	Resource
MBI-WPD 250% FPL	$2257	$3036	**(1)** $13,800
			(2) $20,100

If consumer (other than a single or childless couple) is ineligible because of excess income and or resources, consider Spenddown.

7. Monthly Medicaid Standards (Non-Disabled Adults ages 21-64 Without Children under 21 in the Household and Low Income Families)

Family Size	1	2	3	4	5	6	7	8	9	10	E ach Add'l Person
Monthly Income	$706	$881	$1048	$1217	$1391	$1519	$1653	$1825	$1924	$2023	$99
Resource Level	$13,800	$20,100	$23,115	$26,130	$29,145	$32,160	$35,175	$38,190	$41,205	$44,220	$3,015

8. Medicare Savings Program (Buy-In)

		Income	
		Family of 1	Family of 2
QMB 100% FPL **(Excludes $20 Disregard)**	Annual	$10,830	$14,570
	Monthly	$ 903	$ 1215
SLIMB 120% FPL	Annual	$12,996	$17,484
	Monthly	$ 1083	$ 1457
QI-1 135% FPL	Annual	$14,621	$19,670
	Monthly	$ 1219	$ 1640
NO RESOURCE TEST			

9. Other Important Figures

Medicare Part A Premium: $244.00 (30-39 Quarters)
$443.00 (Less than 30 Quarters)
Medicare Part B Premium: $96.40 for most recipients
Standard Allocation: From non-SSI-related parent to non-SSI-related child $350

PASS-THROUGH FACTORS: .965,174

Family Size	1	2
COBRA (100% FPL)	$ 903	$1215
AIDS Health Ins. Program (AHIP) (185% FPL)	$1670	$2247
QWDI (200% FPL)	$1805	$2429
COBRA, QWDI (Resource Level)	$4000	$6000

10. Spousal Support And Resource Level

INCOME (MMMNA) - $2739	**RESOURCES** – (Minimum) - $74,820 (Maximum) - $109,560	**FAMILY MEMBER ALLOWANCE USE** - $1822.00 $608 is the maximum family member allowance allowed.

11. Monthly Regional Nursing Home Rates

NEW YORK CITY (All boroughs) **- $9,838**	**LONG ISLAND - $10,852** Nassau, Suffolk
NORTHEASTERN - $7,766 Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	**NORTHERN METROPOLITAN - $9,439** Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
WESTERN (Buffalo) - $7,418 Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**ROCHESTER - $8,720** Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates
CENTRAL (Syracuse) **- $6,938** Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	

In determining the community resource allowance on and after January 1, 2009, the community spouse is permitted to retain resources in an amount equal to the greater of the following: $74,820 or the amount of the spousal share up to $109,560. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the date of the first continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989. The look-back period anchored in the month the A/R is both institutionalized and applying for MA.

EMPIRE JUSTICE CENTER FACT SHEET ON MEDICAID

This four page fact sheet will explain New York's Medicaid program: services, eligibility and application processes.

What is Medicaid?

- New York's Medicaid program, also known as Medical Assistance, is actually a group of different programs for different types of people. The programs are different from each other either in the scope of services that are covered, or in the eligibility requirements.

- Regular Medicaid pays for all medically necessary care. This includes:
  - Hospital care
  - Lab tests and x-rays
  - Vision speech and hearing services
  - Rehab services (with some limitations)
  - Durable medical equipment
  - Emergency room and ambulance services
  - Behavioral health and chemical dependence services (with some limits)
  - Diabetic supplies and equipment
  - Hospice care
  - Radiation therapy, chemotherapy and hemodialysis
  - Dental services (but only if they are offered by the plan the patient selects)
  - Prescription drugs
  - Family planning and reproductive services
  - Home health care and nursing home care
  - For Children, Early & Periodic Screening, Diagnosis and Treatment

- Other Medicaid programs include
  - The Prenatal Care Assistance Program,
  - The AIDS Drug Assistance Program,
  - The Medicaid Buy-in Program for Working People with Disabilities,
  - The Medicaid Cancer Treatment Program,
  - The Family Planning Benefit Program, and
  - The Emergency Medicaid program for undocumented immigrants.

  For further information about these specialized programs, visit the NYSDOH website at http://www.health.state.ny.us/health_care/medicaid/index.htm

How does Medicaid Work?

- Most people in regular Medicaid must receive their health care through a managed care plan.

- If services are interrupted or denied, Medicaid patients have the right to request a fair hearing (and/or grieve the problem with the managed care plan).

- If the request for a fair hearing is made within 10 days of receiving notice of a reduction or denial of services, the patient should receive aid continuing while waiting for a fair hearing.

- There are no premiums for regular Medicaid and co-payments are minimal, with a cap of $200 annually.

Who is Eligible for Medicaid?

- Regular Medicaid is available to residents of New York who are qualified immigrants. Qualified immigrants include refugees, green card holders and immigrants who are permanently residing in the U.S. "under color of state law." This last group is sometimes referred to as PRUCOL.

- For a complete list of qualified immigrants, and further explanation of what PRUCOL means, see the CHANYS manual:

  Community, Migrant and Homeless Health Center Handbook: Immigrant Eligibility for Publicly Funded Health Care Benefits (January, 2009).

- Regular Medicaid is available to different groups at different income levels (check the eligibility chart following this fact sheet for specific levels):

  - Children have the most generous eligibility levels for Medicaid. Although income levels for children are currently on a sliding scale according to age, as of April 1, 2010, all children ages 1-19 will be eligible at either 133 or 160% of the federal poverty level (FPL), depending on federal approval.
  - Parents, caretakers, 19 & 20 year olds living at home, and aged and disabled persons qualify for regular Medicaid at just over 90% of the FPL.
  - Single adults and childless couples are subject to lower income limits, about 78% of the FPL.

- Parents, caretakers, 19 & 20 year olds living at home, and aged and disabled persons can qualify for Medicaid even if their income is above these levels, if they spend down their income on medical expenses (see fact sheet on "Spend Down").

- Children have no resource limit for regular Medicaid.

- The resource test is eliminated for most other Medicaid applicants effective October 1, 2009.

- The only applicants who will be subject to a resource test after October 1, 2009 are aged, blind and disabled applicants and recipients of Medicaid. The levels for this group can be found on the eligibility chart following this fact sheet.

How do patients apply for Medicaid?

- Applicants for Medicaid need to complete an application, provide proof of certain information, and, in most cases, select a health plan.

- Beginning on April 1, 2010, it will no longer be necessary to attend a personal interview at the Local Department of Social Services in order to apply for Medicaid.

- Facilitated enrollers can be a good resource for patients who want to apply for Medicaid. Facilitated enrollers are either employed by a community based agency or a managed care plan under contract with the NYS Department of Health.

- Facilitated enrollers will help people fill out applications for Medicaid, FHPlus and CHPlus, submit the complete application packet, and notify applicants when eligibility decisions are made.

- For a list of facilitated enrollers in your county, visit the New York State Department of Health website at http://nyhealth.gov/nysdoh/fhplus/where.htm

How long will it take for a patient to get a decision about Medicaid eligibility?

- Medicaid eligibility determinations should be made by the 45th day after you submit your completed application (30 days for children and pregnant women, 90 days for those needing a disability determination).

- Medicaid applicants who are waiting beyond the prescribed time period, or who are denied Medicaid eligibility can request a fair hearing.

- Once Medicaid is approved, it will pay for necessary medical services provided up to three months prior to the date of application, as long as the patient was eligible during the month the services were provided

Recertifying for Medicaid

- Providers should talk with low-income patients about the importance of completing the recertification process for Medicaid. Every year, an estimated 46% of those with public health insurance lose their coverage during recertification

- Patients will receive a recertification notice from the State Department of Health a year after their coverage began. They will need to complete the paperwork enclosed with the letter and return it, along with certain documents, by the date shown on the letter.

- If the local district does not receive the recertification information by the date shown in the letter, Medicaid coverage will end.

- Facilitated enrollers can help patients fill out recertification packets (see explanation of facilitated enrollers under "How do patients apply for Medicaid," above).

How do Patients Request Fair Hearings?

- Patients can request fair hearings by phone (1 800 342 3334), by fax (1 518 473 6735), on line (www.otda.state.ny.us/oah/forms.asap), or by mail:

  Fair Hearings Section
  NYS Office of Temporary and Disability Assistance
  P.O. Box 1930
  Albany, NY 12201

- Patients who have a fair hearing date may be able to get help from the legal services program in your area. For contact information for legal services program that help with Medicaid related problems, visit LawHelp at http://www.lawhelp.org/Ny/ and click on the Health link.

EMPIRE JUSTICE CENTER FACT SHEET ON FAMILY HEALTH PLUS

This three page fact sheet will explain New York's Family Health Plus insurance program.

What is Family Health Plus (FHPlus)?

- Family Health Plus is a public health insurance program for uninsured adults who are over age 19 and under age 65 with income too high to qualify for Medicaid.

- FHPlus provides comprehensive service, including:

    - Lab tests and x-rays
    - Vision speech and hearing services
    - Rehab services (with some limitations)
    - Durable medical equipment
    - Emergency room and ambulance services
    - Behavioral health and chemical dependence services (with some limits)
    - Diabetic supplies and equipment
    - Hospice care
    - Radiation therapy, chemotherapy and hemodialysis
    - Dental services (but only if they are offered by the plan the patient selects)
    - Family planning and reproductive services

- Prescription drug services are "carved out" of managed care in FHPlus, which means enrollees must use a state benefit card at the pharmacy, rather than their plan card, in order to get their prescriptions filled.

How does FHPlus work?

- All health care in FHPlus is delivered through managed care plans.

- FHPlus enrollees have 90 days after joining a plan to decide if the health plan meets your needs. If you do not switch to another plan, you must stay with the plan for the next nine months, unless you qualify for a special enrollment period.

- After the initial 12-month enrollment period, a FHPlus enrollee may change plans at any time and for any reason. Enrollees must call the local social services district to change FHPlus plans

- There are no premiums in FHPlus and co-payments are minimal, although slightly higher than Medicaid's co-payments.

- If services are interrupted or denied, FHPlus enrollees have the right to request a fair hearing (and/or grieve the problem with the managed care plan) just like Medicaid managed care enrollees.

- If the request for a fair hearing is made within 10 days of receiving notice of a reduction or denial of services, the patient should receive aid continuing while waiting for a fair hearing.

Who is Eligible for FHPlus?

- FHPlus is available to uninsured single adults, childless couples and parents with limited income and resources, who are over age 19 and under age 65, residents of New York and either citizens of the U.S. or qualified aliens.

- The income limit for FHPlus is 150% of the FPL for parents, although that level will be increased to 160% of FPL as of April 1, 2010. See the eligibility chart following the Medicaid fact sheet for specific figures.

- The resource test is eliminated for FHPlus effective October 1, 2009.

- FHPlus is not available to persons who are eligible for Medicaid, unless they are eligible for Medicaid with a spend down, in which case the person can choose between Medicaid with a spend down and FHPlus.

How do patients apply for FHPlus?

- Applicants for FHPlus need to complete an application, provide proof of certain information, and select a health plan.

- Medicaid applicants whose income is too high for Medicaid should be automatically considered for FHPlus by the local social services district.

- Facilitated enrollers can be a good resource for patients who want to apply for FHPlus. Facilitated enrollers are either employed by a community based agency or a managed care plan that is under contract with the NYS Department of Health.

- Facilitated enrollers will help people fill out the applications for Medicaid, FHPlus and CHPlus, submit the complete application packet, and notify applicants when eligibility decisions are made.

- For a list of facilitated enrollers in your county, visit the New York State Department of Health website at http://nyhealth.gov/nysdoh/fhplus/where.htm

How long will it take to get a decision about my eligibility?

- Your FHPlus coverage should be in place 90 days from the day you signed your application.
- The local social services district has 45 days to make the eligibility determination and an additional 45 days to process enrollment with a managed care plan.
- If there is delay or error by the county during the application period, Medicaid should pay for necessary services that were provided after the 90 days runs.

Recertifying for FHPlus

- Providers should talk with low-income patients about the importance of completing the recertification process. Every year, an estimated 46% of those with public health insurance lose their coverage during recertification
- Patients who are enrolled in FHPlus will receive a recertification notice a year after their coverage began. They will need to complete the paperwork enclosed with the letter and return it along with certain documents, by the date shown on the letter.
- If the local district does not receive the recertification information by the date shown in the letter, FHPlus coverage will end.
- Facilitated enrollers can help patients fill out recertification packets (see explanation of facilitated enrollers, above).

How do Patients Request Fair Hearings?

- Patients can request fair hearings by phone (1 800 342 3334), by fax (1 518 473 6735), on line (www.otda.state.ny.us/oah/forms.asap), or by mail:

  Fair Hearings Section
  NYS Office of Temporary and Disability Assistance
  P.O. Box 1930
  Albany, NY 12201

- Patients who have a fair hearing date may be able to get help from the legal services program in your area. For contact information for legal services program that help with Medicaid related problems, visit LawHelp at www.lawhelp.org/ny and click on the Health link.

EMPIRE JUSTICE CENTER FACT SHEET ON CHILD HEALTH PLUS

This three page fact sheet will explain New York's Child Health Plus insurance program.

What is Child Health Plus (CHPlus)?

- Child Health Plus is a public health insurance program for children under the age of 19 who do not qualify for Medicaid.

- CHPlus provides comprehensive service, including:

    - Well-child care
    - Physical exams
    - Immunizations
    - Diagnosis and treatment of illness and injury
    - Lab tests and x-rays
    - Outpatient surgery
    - Emergency care
    - Prescription and non-prescription drugs if ordered
    - Inpatient hospital medical or surgical care
    - Short-term therapeutic outpatient services (chemotherapy, hemodialysis)
    - Limited inpatient and outpatient treatment for alcoholism, substance abuse and mental health
    - Dental care
    - Vision, speech and hearing services
    - Durable medical equipment
    - Emergency ambulance services
    - Hospice care

- CHPlus does not cover home care or other forms of long term care.

How does CHPlus work?

- All health care in CHPlus is delivered through managed care plans, which are also responsible for determining eligibility for the program.

- There are no premiums for those families under 160% of the federal poverty level (FPL). Monthly premiums apply above that level as follows:

    - $9 per child ($27 max.) for families with income above 160 and below 201% of FPL

  - $15 per child ($45 max.) for families with income above 200 and below 251% of FPL
  - $20 per child ($60 max.) for families with income above 250 and below 301% of FPL
  - $30 per child ($90 max.) for families with income above 300 and below 351% of FPL
  - $40 per child ($120 max.) for families with income above 350 and below 401% of FPL
  - Full premium for families with income above 400% of FPL. The amount of a full premium varies by plan, but remains considerably lower than anything available on the private market.

- CHPlus members can switch plans at any time and for any reason. Patients should first disenroll from the current plan and then enroll in the new plan.

Who is Eligible for CHPlus?

- New York's CHPlus program is available to uninsured children under age 19 who are not eligible for Medicaid.

- Premiums are free for those under 160% of FPL, subsidized for those under 400% of FPL, and full price for those over 400% of FPL (see premium levels above).

- CHPlus is one of the few public health insurance programs in New York available to undocumented immigrants, as long as they are income eligible and residents of New York.

- There is no resource limit for CHPlus.

How do I apply for CHPlus?

- Eligibility determinations for CHPlus are made by managed care plans rather than local social service districts.

- Families must apply for the program through a facilitated enroller, who will assist with the application and forward it to the managed care plan the family chooses.

- Facilitated enrollers can be community based organizations or employees of managed care plans.

- Facilitated enrollers are available to assist families in the evening as well as during the day. Some also have weekend hours.

Recertification for CHPlus

- CHPlus members do have to recertify their eligibility with their plan every year. Providers should stress the importance of recertification.

- Families will receive a recertification letter from their child's plan a year after joining the program. The family can then seek assistance from the plan or a facilitated enroller to complete the process.

Appeal Rights under CHPlus

- Unlike FHPlus and Medicaid, CHPlus members do not have the right to request a fair hearing or obtain aid continuing if services are reduced or denied.

- CHPlus members who are unable to get services they need should pursue grievances with their plan and contact the NYS Health Department's Bureau of CHPlus Enrollment at 1-518-474-6965.

EMPIRE JUSTICE CENTER FACT SHEET ON PRESUMPTIVE ELIGIBILITY FOR CHILDREN

This two page fact sheet will explain Medicaid's presumptive eligibility program for children in New York.

What is Presumptive Eligibility?

- Presumptive eligibility allows certain persons to enroll in Medicaid for a limited period of time before a final eligibility determination has been made.

- Presumptive eligibility is available only to certain types of Medicaid applicants: pregnant women and, now, children up to age 19.

- Pregnant Women can be presumptively enrolled in Medicaid's Prenatal Care Assistance Program, which provides prenatal care and 60 days of post-natal care for women with income below 200% of FPL.

- Starting in 2008, children up to age 19 can now be presumptively enrolled into regular Medicaid.

How does Presumptive Eligibility for Children work?

- Only qualified entities can use presumptive eligibility to enroll children into Medicaid. The New York State Department of Health has designated Federally Qualified Health Centers, such as Westside, as qualified entities for purposes of presumptive enrollment of children.

- Clinic staff conducting presumptive enrollment must be trained by the State Department of Health and confidentiality agreements must be maintained on site.

- Clinics must conduct presumptive eligibility screening using a state approved form (attached). Parents are allowed to self-attest to basic information, including citizenship, identity, residency, household size and income.

- After screening a child for presumptive eligibility, the clinic must call a designated toll free number at the State Department of Health (1-888-375-1912) in order to receive an authorization number.

- Clinics must notify the family of the presumptive eligibility determination and advise them of next steps, including the need to complete a regular Medicaid application for the child.

Does Presumptive Eligibility automatically convert into regular Medicaid?

- No, the family of a child that has been presumptively enrolled must complete a full Medicaid application and submit it to the clinic in order to continue Medicaid coverage.

- The completed application and required documentation must be compiled by the clinic and submitted to the local social services district within 21 days of the initial presumptive enrollment.

- The local social services district will then make a determination as to ongoing Medicaid eligibility for the child.

- Children can only be presumptively enrolled into regular Medicaid once in a twelve month period.

EMPIRE JUSTICE CENTER FACT SHEET ON REFUGEE MEDICAL ASSISTANCE

This two page fact sheet will explain New York's Refugee Medical Assistance program, which may help your patient gain access to Medicaid.

What is Refugee Medical Assistance (RMA)?

- RMA is a Medicaid program that is funded 100% by the federal government.
- RMA is designed to help refugees get medical services for the first eight months after they have arrived in the U.S.
- In New York, RMA blends into regular Medicaid and is not referred to as a separate program by most people.
- However, the income eligibility rules for RMA are more relaxed than regular Medicaid. Some refugees who have income above New York's income limits for regular Medicaid levels can qualify for RMA Medicaid for the first eight months after they enter this country.

Who is eligible for RMA?

- Single adults and childless couples who have income up to the level of New York's medically needy program can qualify for RMA. Without RMA, single adults and childless couples must meet lower income levels in order to get Medicaid.
- Also, single adults and childless couples can use spend down to qualify for RMA. Without RMA, single adults and childless couples cannot use spend down to qualify for Medicaid.

How does RMA work?

- RMA covers initial medical screenings for refugees. These initial screenings are arranged by local department of health rather than social service districts.
- Refugees then need to apply for Medicaid through their local department of social services. Single and childless couples whose income is too high for regular Medicaid should automatically be considered for RMA.

- In order to be sure that this happens, it is important to note on the first page of the Medicaid application, in red pen or some other highlighter, that the application is for a refugee. Some counties have worked out processes to expedite refugee applications.

- If a refugee is found eligible for RMA, he or she will be able to continue with the program for eight months, even if his or her income goes up during the eight month period.

- RMA will pay for the same services as Medicaid, but only for eight months following the refugee's entry to the U.S.

STRATEGY TIPS

- When you submit a Medicaid application for a refugee patient, be sure to indicate that the applicant is a refugee on the first page of the application in red pen or some other highlighter.

- You should also submit a cover letter with the application describing any immediate medical needs your patient may have and requesting that the social service agency consider alternatives to documents that can take time to produce, such as landlord statements. Some districts will accept statements from the social services agencies that are arranging housing for refugees rather than waiting for a landlord statement when there are immediate medical needs.

- If you find that Medicaid applications for refugees are not being processed quickly by your local social services department, convey your concerns to the social services agency that is working with the refugee populations in your area. The social service agency may be able to negotiate some special procedures with your local department of social services.

EMPIRE JUSTICE CENTER FACT SHEET ON CHARITY CARE

This two page fact sheet will explain New York's Charity Care system

What is Charity Care?

- In New York, charity care refers to financial assistance that hospitals make available to low-income, uninsured or under-insured patients to help them with their medical bills.

- New York law requires all hospitals to have financial assistance policies that help low-income patients with their bills.

- Hospitals with emergency rooms are required to notify patients that financial assistance is available during intake and on bills. They are also required to post information about financial assistance in languages their patients understand.

How much help can I get with my hospital bills?

- Financial assistance policies are different in each hospital but the law requires all hospitals to at least reduce charges for patients that are eligible for financial assistance according to these rules:

    - Patients with income below 100% of the Federal Poverty Level (FPL) cannot be charged anything more than a very small, token amount
    - Patients with income above 100% and below 150% of FPL cannot be charged more than 20% of their income
    - Patients with income between 150% and 250% of FPL are entitled to reductions on a sliding scale
    - Patients with income up to 300% of FPL are protected from charges that are any higher than what the hospital has negotiated with insurers

How do I apply for Financial Assistance from a hospital?

- You need to get an application from the hospital where you got the services. Examples of the applications from Rochester General and Via Health are in the appendix following this fact sheet.

- The application must be available in your language if 5% or more of the hospital's patients speak your language.

- You are entitled to help with the application if you ask for assistance.

- The application will ask you for information about your income and family size, and request copies of income stubs.

- Most applications will also ask whether you have applied for Medicaid to cover the bill you need help with and ask for proof of denials.

- Some applications will also ask for information about your savings. Hospitals are allowed to deny help for patients that have significant savings or assets, but they cannot consider your home, your retirement account, savings for children's college expenses, or cars that are in regular use by a family member.

- The hospital must give you at least 90 days after the date of your services to submit an application for financial assistance.

- The hospital must make a decision about your application within 30 days.

- If your application is denied, the notice must give you information about how to appeal the denial.

If the 90 day deadline for applying has passed, is there any protection against collection actions from the hospital?

- If the deadline has passed for applying for charity care, it is worth contacting the hospital anyway. Hospitals should allow late applications if a patient failed to receive notice of the hospital's financial assistance policy, or did not get notice in a language the patient could understand.

- New York law also requires hospitals to be fair and reasonable when they try to collect against patients with outstanding bills

    - Hospitals cannot force sales of patients' homes to collect debts
    - Hospitals cannot sue patients who were Medicaid eligible for the services they received
    - Hospitals cannot send accounts to collection if a patient has applied for financial assistance
    - Hospitals have to offer installment plans with monthly payments of no more than 10% of income
    - Interest rates on installment plans cannot be any higher than the 90-day security rate
    - Missed payments on installment plans cannot trigger higher interest rates

UNIVERSITY OF ROCHESTER MEDICAL CENTER
STRONG MEMORIAL HOSPITAL
Charity Care Application

Application Completed By:_____ Date: ____/____/____

*Please Mark Line **N/A** if non-applicable*

Patient Name: _____ Date of Birth: ___/___/___
Responsible Person:_____
Spouse/Parent Name: _____
Address: _____ Phone #: Home: ( )_____
_____ Work : ( )_____
Employer: _____ Gross Salary: $_____per_____
Spouse's Employer: _____ Gross Salary: $_____per_____
Number of people in the family_____
Other income including SSI/Social Security/Child Support payments:
Who receives income_____ Source_____ Gross amount $ _____per _____
Day Care Cost per child Amount paid $ per

Please list all household members including minor children under 21 who lives with you (even if they are not applying for Charity Care at this time. Use extra sheet if necessary.)

First and last name	Date of Birth	Relationship to you	Social Security Number	Medical insurance/ Cost

Medicaid Statement

[*Please check the appropriate statement boxes. Attach copies of DSS notice including attachments.]*

1. I/We (**[ ] have / [ ] have not)** applied for Medicaid to cover these services.
If not, please explain reason: _____
_____

2. I/We (**[ ] have** / **[ ] have not**) been rejected by Medicaid.
Reason for reject: Include a copy _____
_____

3. I/We **([ ] have/ [ ] have not**) been rejected by Child Health Plus or Family Health Plus_____
_____

4. I/We received an approval from Medicaid, but with a monthly spend down of $_____

The Strong Health Charity Care Program helps people who are unable to pay all of their medical bills. You may qualify for discounts on medical care through the Charity Care Program if:

- You do not have health insurance
- Your health insurance does not cover all of the medical care you need
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial criteria

I understand that this application for Charity Care is confidential and will be used to determine my eligibility for uncompensated services under the Charity Care guidelines established by Strong Memorial Hospital. If any information that has been given proves to be untrue, I understand that Strong Memorial Hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of responsible party:_____
Date:_____

Please turn this form over, complete the items on the back, and return it.

Return Form	**PLEASE PROVIDE COPIES OF THE FOLLOWING DOCUMENTS:** • **Wage/Income statements for the past 90 days** • **Complete previous year's tax return** • **Copy of insurance/Medicaid denial notices** **RETURN TO:** **Charity Care Officer** **Strong Memorial Hospital** **601 Elmwood Avenue – Box 888** **Rochester, NY 14642** If you have any questions about completing this form, I can be reached at (585) 784–8889 or (800) 257-7049

Thank you for your cooperation.

The following income guidelines may help determine if you are eligible for Strong Memorial Hospital's Charity Care program. The intent of providing this information is to enable you to determine if you or your household may be eligible for this program. If you are in doubt, or if extenuating circumstances have occurred, we encourage you to submit this application for consideration. Other payment options may be available, even if you do not feel that your household qualifies for Charity Care. After a completed application has been submitted, bills may be disregarded while that application is being reviewed. (<u>The following guidelines are effective 01/26/2009.</u>

2009 CC Schedule

CC% Allowance	Household Size	% of FPL	One Person	Two Person	Three Person	Four Person	Five Person	Six Person
	FPL -Annual		$10,830	$14,570	$18,310	$22,050	$25,790	$29,530
	Monthly		903	1,214	1,526	1,838	2,149	2,461
100%		up to 200%	21,660	29,140	36,620	44,100	51,580	59,060
			1,805	2,428	3,052	3,675	4,298	4,922
80%		201 – 250%	27,075	36,425	45,775	55,125	64,475	73,825
			2,256	3,035	3,815	4,594	5,373	6,152
60%		251 – 300%	32,490	43,710	54,930	66,150	77,370	88,590
			2,708	3,643	4,578	5,513	6,448	7,383
40%		301 -350%	37,905	50,995	64,085	77,175	90,265	103,355
			3,159	4,250	5,340	6,431	7,522	8,613
20%		351 - 400%	43,320	58,280	73,240	88,200	103,160	118,120
			3,610	4,857	6,103	7,350	8,597	9,843
0		over 401%						

For Office Use Only:

Date Received in PAO: ____/____/____ **By:** _____

Approved By: _____ **Rejected By:** _____

Reason: _____

_____

Applicant advised on ____/____/____ by [ ] *phone* [ ] *letter* [ ] *in person*.

An account for $_____ for _____ payments established.

Rev. 01/09ks

EMPIRE JUSTICE CENTER FACT SHEET ON SPEND DOWN

This three page fact sheet will explain Medicaid's spend down program and provide some strategy tips to help maximize the Medicaid revenue Westside can collect for services it provides to patients utilizing the spend down program.

What is spend down?

- Some patients who are not eligible for Medicaid because they have too much income or too many resources may be able to use current or even past medical expenses to bring their income or resources down to the Medicaid level.

How does the spend down program work?

- A patient who is determined to be eligible for Medicaid with a monthly spend down amount should receive a notice from the local social service district telling him or her the amount of the spend down or excess income.

- Spend down amounts must be satisfied each month, before the person's Medicaid card will be activated. There are two ways to satisfy spend down:

    - The patient can pay the excess amount in to the local district at the beginning of each month, or;
    - The patient can collect receipts totaling the excess amount (or more) each month and supply them to the district.

- Inpatient hospitalization bills are treated differently from other bills.

    - If a patient is hospitalized, Medicaid will only become active and pay for the costs after six months worth of spend down has been satisfied.

    - The patient will then have Medicaid activated going forward without needing to satisfy spend down again for six months.

    - ***Example***: Lisa is hospitalized for one night in September and is billed $2,000.00. She applies for Medicaid and is found eligible with a spend down of $50.00. Medicaid will pay the hospital bill amount above $300.00 (50 X 6) and Lisa won't need to satisfy her spend down amount again until March.

Who is eligible for the spend-down program?

- Only patients who are parents or caretakers of children under 21, or aged (65+) or disabled are eligible to use spend down to qualify for Medicaid.

- Technically, children and pregnant women are also eligible to use spend down, but they must spend down to the regular Medicaid levels, not the expanded levels they can other wise use, so spend down is rarely helpful to them.

Who is not eligible for spend-down?

- Adults ages 21-64 yrs old who are not disabled and who are not caring for a child under age 21 cannot use spend down.

- Also, no one can use spend down to qualify for FHPlus or CHPlus.

Whose bills can be used to meet a patient's spend-down?

- Patients can use bills for any member of their household who applied for Medicaid or any legally responsible relatives, even if they are not applying for Medicaid.

- Spouses are legally responsible for their spouses and parents are legally responsible for their children under age 21.

- A bill does not have to be paid to count toward the spend-down; it only has to be incurred. A bill is incurred on the date liability for the expense arises (usually date of service).

What kind of bills can be used to meet spend down?

- Costs of medical care or drugs paid for by a state or local program other than Medicaid, like ADAP or EPIC. This is the best way to help a patient meet spend down because nothing is actually billed to the patient!

- Health Insurance: Deductibles and co-pays for Medicare or private health insurance can be used to meet spend down.

- Medically necessary expenses not covered by Medicaid (ex. chiropractors and podiatrists, services by physicians who don't accept Medicaid, over the counter items, etc.).

- Medical expenses that are covered by Medicaid

How old can the bills be?

- Paid bills: Can only be used if the medical services where provided within 3 calendar months before month of application.

- Unpaid bills: Can be used as long as they are still “viable,” which means that the provider could still try to collect for the amount owed.

STRATEGY TIPS

- Medicaid will not pay the bill for a medical expense that was used to meet a patient’s spend down.

- The amount of expense occurred will be credited against the patient’s spend down, but whether or not the patient pays the bill is between the patient and the provider.

- Medicaid will pay the part of the bill that is over and above the spend down amount and other bills that were incurred that same month.

- Thus, in order to maximize Medicaid payment on services that are covered under the Medicaid program, it is always a good idea to first use expenses that Medicaid will *not* pay for, or expenses paid by a program like EPIC or ADAP.

- Remember, Medicaid will not pay bills incurred more than three months prior the date the patient applies for Medicaid.

- If a patient fails to satisfy his or her spend down for three consecutive months, most local districts will close the Medicaid case, in which case a new application must be filed.

EMPIRE JUSTICE CENTER FACT SHEET ON SPOUSAL REFUSAL

This two page fact sheet will explain how spousal refusal can help patients qualify for Medicaid.

What is Spousal Refusal?

- Spousal refusal is a legal term for the situation when one spouse refuses to make his or her income and resources available to pay for the medical needs of his or her spouse.

How does Spousal Refusal help for Medicaid purposes?

- Eligibility for New York's Medicaid program is determined by looking at an applicant's household income. All legally responsible relatives are considered to be part of the applicant's household, so the income of each legally responsible relative is counted.

- Spouses are legally responsible for each other in New York, so an applicant's spouse's income will be combined with the applicant's income when determining Medicaid eligibility.

- However, when a spouse's income is not available to a Medicaid applicant because the spouse has refused to provide assistance with medical care, New York's Medicaid program will not count the spouse's income

.

- Therefore, if one spouse needs medical care but cannot qualify for Medicaid because of the other spouse's income, spousal refusal can result in Medicaid eligibility for the spouse without income (or with lower income).

- The refusing spouse will need to submit documentation of his or her refusal. A sample spousal refusal document is attached.

What happens to the spouse who refuses to make income or resources available?

- The Medicaid applicant has an obligation to provide information about the refusing spouse's income and resources to the local district.

- The refusing spouse is then liable for the costs of providing care to the Medicaid applicant. The county can sue the refusing spouse for the amount Medicaid has spent caring for the non-refusing spouse. The circumstances under which counties will pursue recovery actions against refusing spouses varies by county.

- Also, the refusing spouse will not be able to apply for Medicaid him or herself as long as he or she is refusing to make income or resources available to a Medicaid recipient.

Can parents refuse to make their income available to children?

- Yes, a parent living with a child that needs Medicaid services can submit the same kind of refusal document that a refusing spouse submits.

- The local district will then evaluate the child's eligibility for Medicaid without considering the parent's income.

- The refusing parent will have to disclose income and asset information just as the refusing spouse does. And the parent will also be liable for the costs of the child's medical treatment, if the county sues the parent.

SPOUSAL REFUSAL FORM

I UNDERSTAND THAT BOTH MEDICAID POLICY AND NEW YORK STATE AND FEDERAL LAW PROVIDE THAT SPOUSES ARE FINANCIALLY RESPONSIBLE FOR EACH OTHER.

I UNDERSTAND THAT IF MEDICAID IS PROVIDED TO MY SPOUSE, I MAY BE LIABLE FOR THE COST OF ASSISTANCE GIVEN TO MY SPOUSE, AND THAT RECOVERY FOR THE COST OF SUCH CARE PROVIDED MAY BE PURSUED THROUGH LEGAL CHANNELS.

I UNDERSTAND THAT BY SIGNING THIS REFUSAL, I AM IN NO WAY RELIEVED OF MY OBLIGATIONS TO MY SPOUSE, THE DEPARTMENT OF SOCIAL SERVICES, OR ANY OTHER PERSON OR AGENCY PROVIDING FOR OR ASSISTING WITH THE MAINTENANCE, CARE OR SUPPORT OF MY SPOUSE.

HOWEVER, I AM REFUSING TO MAKE (SELECT ONE OPTION):

- □ MY INCOME ONLY
- □ MY RESOURCES ONLY
- □ MY INCOME AND RESOURCES

AVAILABLE TO MY SPOUSE FOR THE COST OF NECESSARY MEDICAL CARE AND SERVICES.

_____

(REFUSING SPOUSE'S SIGNATURE)

_____

(PRINT SPOUS'S NAME)

Sworn to before me this_____day of

_____,20____

_____

Notary Public

EMPIRE JUSTICE CENTER FACT SHEET ON POOLED SUPPLEMENTAL NEEDS TRUSTS

This three page fact sheet will explain how pooled Supplemental Needs Trusts can be used to help patients qualify for Medicaid.

What is a pooled Supplemental Need Trust (SNT)?

- A Supplemental Needs Trust (SNT), sometimes referred to as a Special Needs Trust, is a legal document setting up an account for the benefit of a disabled person which allows the individual to retain income or assets and still qualify for governmental benefits such as Medicaid.

- A Pooled SNT is a Trust that many disabled persons have joined. Their contributions are pooled for administrative and investment purposes, but each member has a subaccount with a separate trust agreement.

- Generally, an attorney's help is necessary to establish or create an individual SNT, but disabled persons can join Pooled SNTs without the need of an attorney.

- Income or resources that are sent to a Pooled SNT are treated as invisible for Medicaid eligibility purposes, just as they would be in an individual SNT created by an attorney.

- Money in the Pooled SNT can then be used to pay expenses for the disabled beneficiary of the Trust. Pooled SNTs can be used to pay rent, utilities, mortgage, even credit card bills.

Who can use a pooled SNT to help qualify for Medicaid?

- Only persons with certified disabilities can use SNTs to help qualify for Medicaid.

- Only disabled persons under age 65 can use individual SNTs, but disabled persons of any age can join pooled SNTs to help qualify for Medicaid.

- Disabled people of any age can qualify for the pooled SNTs sponsored by NYSARC (the New York State Association for Retired Citizens) and CDR (the Center for Disability Rights).

- NYSARC's Pooled Trust is open to disabled individuals living anywhere in New York State. CDR's Pooled Trust is open to disabled individuals living in a ten county region around Rochester.

- Disabled persons who need Medicaid services other than nursing home care can use pooled SNTs to eliminate their spend downs. But this will *NOT* work for people needing nursing home (or equivalent waiver services like Lombardi) because the state uses different budgeting rules to determine spend down for these services.

How does a Pooled SNT work?

- Individuals certified as disabled can join a pooled Trust either before applying for Medicaid or after. Pooled Trusts work well for people who qualify for Medicaid with a spend down.

- After joining the Trust, the individual would deposits the amount of his or her spend down with the Trust each month, and submit bills for the Trust to pay each month.

- For people already enrolled in Medicaid with a spend down, once the Trust documents are signed and the local Medicaid program approves enrollment in the Trust, Medicaid will change the individual's Medicaid budget to eliminate any spend down.

- For those joining a Trust before applying for Medicaid, individuals can submit the Trust documents with the application, or wait for approval with spend down and then submit the Trust documents.

How do I join a Pooled Trust?

- The first step is to fill out a "Joinder Agreement," which is several pages long and requires a notarized signature. NYSARC's joinder agreement is attached as an example.

- Fees can be significant.

    - CDR operates the least expensive Pooled Trust at this time. CDR has a non-refundable, start-up fee of $200 and a monthly fee of $20.

    - NYSARC has the least expensive *statewide* Pooled Trust at this time. NYSARC has a $200 non-refundable start-up fee and monthly fees that range from $30 to $140, depending on the size of monthly deposits. In addition, NYSARC requires $100 plus 2 x the monthly deposit as an upfront deposit in the account.

- Once an applicant is approved, the organization sponsoring the Trust will sign the agreement and send it back along with a packet that instructs the new Trust member on how to make monthly deposits and submit monthly bills.

- NYSARC's Joinder Agreement is available on line at: http://onlineresources.wnylc.net/healthcare/docs/NYSARC_Joinder_Agreement.pdf

- CDR does not yet have forms available on line, but they do have staff who will assist people with the process of joining their Trust. Call Celia Brown, Independent Living Specialist at 585-546-7510 for help.

Terminating a Pooled Trust

- Technically, membership in a pooled Trust is not revocable unless a member dies or enters a nursing home.

- Money left in the Trust when a member dies or enters a nursing home stays in the Trust for the benefit of the other disabled members.

- If Trust members enter a nursing home or need equivalent care from a waiver program, their Medicaid budgets will no longer treat monthly deposits as invisible for spend down purposes (see "Who can use a Pooled SNT," above). People can submit bills to use up the remainder of any money in the Trust, but there is no longer any benefit to making deposits of excess income.

- Practically speaking, even people not needing nursing home care can leave Pooled Trusts by stopping their monthly deposits, but their spend down amounts will go up.

NYSARC, INC. COMMUNITY TRUST

(A Trust for Persons with Disabilities)

COMMUNITY TRUST II

BENEFICIARY PROFILE SHEET AND JOINDER AGREEMENT

NYSARC, Inc. Trust Services
318 Delaware Avenue
Delmar, NY 12054
Telephone: 518-439-8323
Toll Free: 800-735-8924
Facsimile: 518-439-2670
E-mail: trustdept@nysarc.org

Revised 2008

Beneficiary Profile Sheet

1. Name of Donor (Generally same as Beneficiary): _____

   Social Security No. of Donor: _____

   Address of Donor: _____

   _____

   Telephone Number of Donor: _____

2. Name of Disabled Beneficiary (In-Kind Beneficiary): _____
   (Please include middle initial)

   Please note that the Trustees in their discretion may require an intermediary to assist in the administration of the beneficiary's sub-trust account.

   Social Security No. of Disabled Beneficiary: _____
   Please return a copy of the Social Security Card with the Profile and Joinder Agreement.

   Address: _____

   _____

   Telephone (day): _____ (evening): _____

3. County of Residence: _____

   Place of Birth: _____

   Citizenship: _____

   Date of Birth: _____

   Gender: _____

   Please list qualifying disabilities: _____
   _____
   _____
   _____

4. Is the purpose of establishing this account to shelter monthly income? Yes___ No___

Indicate estimated monthly deposit. _____
(Note: This is supplemental information for NYSARC, Inc. purposes only. This amount may be changed at any time with no effect on the Joinder Agreement.)

5. Beneficiary Income:
If you receive any form of Social Security benefit, please submit a copy of your award letter. If you do not have this, please contact the Social Security office to obtain a copy.

Does the Beneficiary receive Supplemental Security Income (SSI)? Yes_____ No_____

Does the Beneficiary receive Social Security Disability Income (SSDI)? Yes_____ No_____

Does the Beneficiary receive Social Security Retirement Income (SSA)? Yes_____ No_____

Does the Beneficiary receive other income? Yes_____ No_____
If yes, please provide detail:

_____

_____

_____

Does the Beneficiary receive Medicaid? Yes _____ No _____ Pending_____

If yes, list Medicaid card number: _____

If the Beneficiary receives other benefits or entitlements, such as Food Stamps, HUD Sec. 8, etc. list these benefits and monthly amounts

_____

_____

6. Indicate the living arrangement of the Beneficiary:

Lives Independently ___ _	Lives with parents or other family _____
Family Care Program __ _	CR/IRA/ICF (supervised) __ __
CR/IRA (supportive) ___ _	Nursing Home __ __
Assisted Living Facility __ __	Other (explain) _____

Does the Beneficiary receive a clothing allowance as part of residential care?

Yes_____ No_____

If yes, how much is it and how often received? _____

7. List other Services that the Beneficiary receives (include day services, service coordination, employment programs, etc.):

Service	Name of Provider

8. a. Is there a court appointed Guardian for the Beneficiary? Yes____ No____

If yes, attach copy of Decree or Letters of Guardianship and complete the following:

Guardian of the Person _____, Property _____, Both _____

If specific powers/authority is granted please list:
(Include dental and medical)_____

_____

If specific powers/authority is exempted please list:
(Include dental and medical)_____

_____

Please list name(s) and addresses of Guardian(s).

_____

_____

b. Are Standby Guardian(s) appointed? Yes_ _ No____

If yes, for the Person_____, Property_____, Both _____

Please list name(s) and addresses of Standby Guardian(s).

_____

_____

_____

c. Are Alternate Standby Guardian(s) appointed? Yes____ No____

If yes, for the Person_____, Property_____, Both _____

Please list name(s) and addresses of Alternate Standby Guardian(s).

_____

_____

_____

9. Relationship of Donor to Beneficiary? _____

10. ***Please note that NYSARC, Inc., requires the beneficiary to have an authorized contact to speak to us on your behalf.***

Who is authorized to speak with us regarding your sub-trust account? (Please include address and phone number)

Agency/Individual	Address/Phone #	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact: _____
(Please include name, address, and phone number)

If you would like monthly statements and tax information sent to above person(s), rather than yourself, check here ____. (Indicate who if more than one contact is listed).
_____

Is this person authorized to make disbursement requests on your behalf? Yes___ No___

11. Who will be submitting the Trust documents to Medicaid, Social Security Administration, or other government agency on your behalf?

Name: _____ Phone #: _____
Agency/Firm, etc. _____

12. Does the Beneficiary have funeral provisions in place (pre-paid funeral, burial plot, etc.?)

Yes _____ No _____

If yes, briefly describe and list contact information: _____

_____

_____

13. Is there a life insurance policy in place for the Beneficiary? Yes___ No___

If yes, provide the name and address of the insurance company and the policy number:

_____

_____

I certify that the above information is accurate and complete to the best of my knowledge.

_____ _____

Donor/Beneficiary Signature Date

THE NYSARC, INC. COMMUNITY TRUST
(A TRUST FOR PERSONS WITH DISABILITIES)

Joinder Agreement

NOTE: THIS IS A LEGAL DOCUMENT. IT IS AN AGREEMENT PERTAINING TO A SUPPLEMENTAL NEEDS TRUST CREATED PURSUANT TO 42 UNITED STATES CODE §1396. YOU ARE ENCOURAGED TO SEEK INDEPENDENT, PROFESSIONAL ADVICE BEFORE SIGNING THIS AGREEMENT. ADDITIONALLY, THE NYSARC, INC. TRUST SERVICES DEPARTMENT MAY NOT ACCEPT THIS JOINDER AGREEMENT UNLESS YOU HAVE A LEGAL REPRESENTATIVE.

The undersigned hereby adopts, enrolls in and establishes a sub-trust account under the **NYSARC, INC. COMMUNITY TRUST II ("CT II")** dated, October 17, 2002 and as amended, this Trust being incorporated herein by reference. **THIS TRUST IS IRREVOCABLE.**

1. Name of Donor (Generally same as Beneficiary): _____

   Social Security No. of Donor: _____

   Date of Birth: _____

   Address of Donor: _____

   _____

   Telephone Number of Donor: _____

2. Name of Disabled Beneficiary (In-Kind Beneficiary): _____

   Disabled Beneficiary's Social Security Number: _____

   Date of Birth: _____

   Address: _____

   _____

   Telephone (day): _____ (evening): _____

3. Fees shall be paid in accordance with the published fee schedule.

4. Death of Beneficiary

a. **The Beneficiary's sub-trust account terminates upon his or her death**. If, upon the death of the Beneficiary, funds remain in his or her sub-trust account, such funds shall be deemed to be property of the Trust and all funds that are remaining in the Beneficiary's separate sub-trust account shall be retained by the **NYSARC, INC. COMMUNITY TRUST II** to further the purposes of the Trust.

b. All final disbursement requests must be submitted within ninety (90) days of the Beneficiary's death and upon submission of the death certificate. Only expenses incurred prior to the Beneficiary's death will be considered.

c. Funeral expenses will only be paid pursuant to a Medicaid eligible pre-need funeral agreement established prior to the Beneficiary's death. **Funeral Expenses will not be paid after the beneficiary's death.**

5. Contributions/Deposits:

a. All contributions made to the Trust Account will be held and administered pursuant to the provisions of the **NYSARC, INC. COMMUNITY TRUST II** dated October 17, 2002 and as amended. The provisions of the **NYSARC, INC COMMUNITY TRUST II** are incorporated herein by reference.

b. The Trustees shall have the sole and absolute right to accept or refuse additional deposits to the Sub-Trust Account.

c. In the event that a Beneficiary has a zero ($0) sub-trust account balance for sixty (60) or more consecutive days, the Trustee shall retain the right to close the Beneficiary's sub-trust account. Please be advised that the Trustee may continue to charge administrative fees for the management of the sub-trust account prior to its closure. In the event that a Beneficiary wishes to re-open a sub-trust account, the Beneficiary may be required to pay any outstanding administrative fees stemming from the prior sub-trust account. Additionally, the Beneficiary shall be required to pay a new enrollment fee when re-opening a sub-trust account.

6. Disbursements:

a. All disbursement requests shall be reviewed and approved on an individual basis.

b. Disbursements for expenses incurred prior to 90 days of a submission of a disbursement request form shall not be paid.

c. The Trustees, in their discretion, have determined that disbursements for the following items shall not be paid: purchases of firearms, alcohol, tobacco, items relating to illegal activity, bail, or restitution.

d. All disbursements shall be made at the sole and absolute discretion of the Trustees.

7. Disability Determination:

In the event that a disability determination is required for Medicaid purposes, please be advised that administrative fees shall be incurred while the determination of disability is being made.

8. Miscellaneous:

Amendments:
Provisions of this Joinder Agreement may be amended by the parties hereto in writing, so long as any such amendment is consistent with the Master Trust.

Taxes:

a. The Donor acknowledges that contributions to the **NYSARC, INC. COMMUNITY TRUST II** are not tax deductible as charitable gifts, or otherwise.

b. Sub-trust account income, whether paid in cash or distributed in other property, may be taxable to the Beneficiary subject to applicable exemptions and deductions. Professional tax advice may be needed.

9. Disclosure of Potential Conflict of Interest:

There may be a potential conflict of interest in the administration of the Trust since the Trust retains those funds remaining in the sub-trust account at the time of death of the Beneficiary. Funds remaining in the Trust may be used to pay for ancillary and/or supplemental services for Beneficiaries and potential Beneficiaries for which services may be rendered by a **Chapter of NYSARC, Inc.** or by **NYSARC, Inc.** itself.

The Donor(s) executing this Joinder Agreement is/are aware of the potential conflicts of interest that exist in the Trustee's administration of the Trust. The Trustee shall not be liable to the Donor or to any party for any act of self-dealing or conflict of interest resulting from their affiliations with **NYSARC, Inc.** or with any Beneficiary or constituent agencies and/or Chapters.

10. Situs: The sub-trust account created by this Agreement has been accepted by the Trustee in the State of New York and will be initially administered by **NYSARC, Inc.** and a financial institution in the State of New York. The validity, construction, and all rights under this Agreement shall be governed by the laws of the State of New York. The situs of this Trust for administrative, accounting and legal purposes shall be in the County of Albany, the County where the majority of meetings concerning establishment of the Trust have occurred.

11. Invalidity of any Provision: Should any provision of this Agreement be or become invalid or unenforceable, the remaining provisions of this Agreement shall be and continue to be fully effective.

I have received and reviewed a copy of the Community Trust II Master Trust prior to the signing of this ***Joinder Agreement***. I have also read the Information and Procedures and Questions and Answers and acknowledge that I understand the contents of all of the trust documents. I also understand that said documents may be amended from time to time.

By signing below, the Donor acknowledges that the Beneficiary is disabled as defined in Social Security Law Section 1614 (a) (3) [42 USC 13822c(a) (3)]

Under penalty of perjury, all statements made in this document are true and accurate to the best of my knowledge.

By signing below, you agree to the following:

The NYSARC, Inc. Community Trust II is a trust authorized to be used by individuals with disabilities pursuant to federal and state law. By agreeing to accept a donor's property pursuant to this Joinder Agreement, NYSARC, Inc., agrees only to manage the trust funds in accordance with the terms of the Master Trust Agreement and in compliance with applicable federal and state law and regulation. It is the sole responsibility of the donor and/or the donor's representative to determine whether the donor is "disabled" as that term is defined under federal law, and to determine the impact that a transfer of property to the NYSARC, Inc. Community Trust II will have on the donor's continuing eligibility for government benefit programs.

NYSARC, Inc. is not assuming any responsibility as counsel for the donor or Beneficiary, or providing any legal advice as it relates to the consequences of a transfer of property to the NYSARC, Inc. Community Trust II.

The Trustees in their discretion may require an intermediary to assist in the administration of the Beneficiary's sub-trust account.

The party authorized to speak with us on your behalf or the intermediary must notify NYSARC, Inc., immediately upon your death and will be required to provide us with a certified death certificate.

An individual requesting and/or receiving disbursements in contravention of the Master Trust Agreement and the Joinder Agreement will be required to repay the amount disbursed.

_____ _____ _____

SIGNATURE OF DONOR/GUARDIAN RELATIONSHIP TO BENEFICIARY DATE

State of New York)s
County of _____)

On this _____ day of _____, 200____, before me, the undersigned, a Notary Public in and for said State, personally appeared, _____ Personally known to me or proved to me on the basis of satisfactory evidence to be the individual whose name is subscribed to within the instrument and acknowledged to me that he/she executed the same in his/her capacity and that by his/her signature on the instrument, the individual or the person upon behalf of which the individual acted, executed the instrument.

_____

Notary Public

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FOR OFFICE USE ONLY

_____ _____

NYSARC, INC., as Trustee DATE

Date Received: _____
Date Accepted _____
Initial Funding: _____

EMPIRE JUSTICE CENTER FACT SHEET ON THE RIGHTS OF LIMITED ENGLISH PROFICIENT (LEP) PATIENTS

This three page fact sheet will explain the rights of limited English proficient (LEP) patients who are applying for or receiving Medicaid services.

All entities that receive federal Medicaid money, including Federally Qualified Health Centers, Local Departments of Social Services, hospitals, and other care providers, are required to provide language assistance to limited English proficient persons they serve.

What Language Assistance Services Must the Local Departments of Social Services (LDSS) Provide?

- LEP Medicaid applicants and recipients are entitled to an interpreter free of charge and should be advised of that right.

- Vital documents, such as applications, notices, consent and complaint forms must be translated into languages spoken by groups that represent five percent or 1,000, which ever is less, of the total population of persons eligible to be served. Other documents can be translated orally.

- The LDSS must post the "Interpreter Services Poster" (PUB-4842) in waiting areas.

What should happen when an LEP patient calls or visits the LDSS to apply for Medicaid?

- The LDSS worker should ask the LEP person what language he/she speaks.

- If the person is unable to answer the question, the worker should attempt to identify the applicant's/recipient's language by using the Interpreter Services Desk Guide, PUB-4842 Language Poster /PUB-4843 Interpreter Services Desk Guide.

- Once the language is identified, the worker should seek the aid of an on-site bilingual staff person to assist as an interpreter, if available.

- If no qualified interpreter is available on site, the worker should refer to the district's specific procedure for providing access to LEP persons (LEP Medicaid applicants and recipients cannot be required to bring their own interpreter -- the LDSS is responsible for obtaining a qualified interpreter);

- The worker should address any emergency/immediate needs prior to scheduling a return appointment;

- The worker should document in the case record the language of the LEP person, whether the LEP person chose to use his/her own interpreter, and/or whether a

request for an interpreter was made, so that an interpreter can be scheduled, if necessary, for any future appointments;

- The worker must be sure that the applicant/recipient understands the date, time and location of the new appointment if a return appointment is required;

- When an appointment is rescheduled because no interpreter is available on the date the application is filed, the delay should not affect the application filing date or any other deadline.

What Language Assistance Services Must Hospitals Provide?

- All hospitals in New York must develop a written language access plan.

- Hospitals must provide interpreters in inpatient and outpatient settings within 20 minutes; and to LEP patients in the emergency service within 10 minutes of a request from the LEP patient or their family.

- Family members, friends, or non-hospital personnel may not act as interpreters except when the patient agrees or the offered hospital interpreter services are refused.

- Children under 16 can only be used to interpret in emergency circumstances.

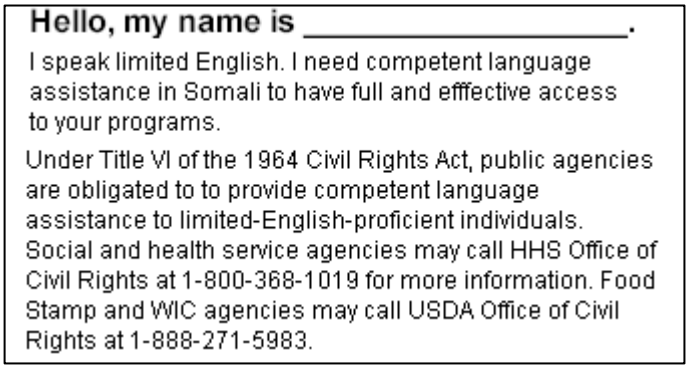
- Hospitals must translate significant documents into frequently encountered LEP languages.

- See http://tinyurl.com/DOH-405-7 or http://tinyurl.com/Interprerer-Regulations

How to Ensure LEP Medicaid Recipients are Provided Language Assistance Services

Many Local Social Services Districts and hospitals fail to provide adequate assistance with language barriers. Unfortunately, enforcing the rights that LEP Medicaid applicants and recipients is very difficult. Here are some suggestions:

- Provide the LEP Medicaid recipient with an "I Speak" card to bring to medical appointments or when they are applying for Medicaid benefits at the local department of social services. This card would be handed to a staff person at the office and explains the person is limited English proficient and has a right to receive language assistance services. Other examples may be found on this website: http://www.palsforhealth.org/


Hello, my name is _____.

I speak limited English. I need competent language assistance in Somali to have full and efffective access to your programs.

Under Title VI of the 1964 Civil Rights Act, public agencies are obligated to to provide competent language assistance to limited-English-proficient individuals. Social and health service agencies may call HHS Office of Civil Rights at 1-800-368-1019 for more information. Food Stamp and WIC agencies may call USDA Office of Civil Rights at 1-888-271-5983.

- Call the Empire Justice Center at 585-454-4060 and ask for attorney Michael Mulé or New York Lawyers for the Public Interest at 212-244-4664 and ask for attorney Nisha Agarwal. If we find a pattern of complaints, we may be able to use advocacy resources in our offices to bring pressure to bear on your county or local hospital.

- LEP individuals who are denied access to programs that receive Medicaid or other forms of federal assistance have the right to file a national origin discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights, To file this complaint, patients can go online to http://www.hhs.gov/ocr/civilrights/complaints/index.html and file in English, Chinese, Korean, Polish, Russian, Spanish, Tagalog or Vietnamese.

CONCLUSION

We hope this toolkit proves helpful to you in your efforts to maximize public health insurance or other financial assistance for patients at your health center.

Please feel free to contact us with comments about this toolkit. We welcome ideas for improvement. You can email Trilby de Jung at tdejung@empirejustice.org with your suggestions or questions.