

January – March 2018 Summary of Changes

Chapter	Passage	Summary
0200	0240.0001, 0240.0102	Added Modified Project Aids Care (MPAC) to the list of SSI-Related Medicaid types
	0240.0111	Deleted references to Cystic Fibrosis (CF), Project AIDS CARE (PAC) and Traumatic Brain and Spinal Cord Injury (BSCIP)
	0240.0120	New passage - Modified Project Aids Care (MPAC)
1400	1440.0008, 1440.0507, 1440.1204, 1440.1302	Deleted references to Cystic Fibrosis (CF), Project AIDS CARE (PAC) and Traumatic Brain and Spinal Cord Injury (BSCIP)
1600	1610.0200	Updated Asset limit increase provided by Food and Nutrition Service for October 2017
	1640.0205, 1640.0315	Deleted Cystic Fibrosis
	1640.0514	Deleted the verbiage that a written statement is needed as verification that an asset is designated for burial to read that client's statement is acceptable that the asset is intended for burial.
	1640.0576.08	Under "Trusts for the disabled under 65" section, after bullet #3 added verbiage
	1660.0200	Asset limit updated to reflect \$2000 for refugees
2000	2040.0800	Deleted references to Cystic Fibrosis (CF), Project AIDS CARE (PAC) and Traumatic Brain and Spinal Cord Injury (BSCIP). Added Modified Project Aids Care (MPAC) to the list of SSI-Related Medicaid types
	2040.0815.02, 2040.0815.06, 2040.0815.08	Deleted passages: Cystic Fibrosis (CF), Project AIDS CARE (PAC), and Traumatic Brain/Spinal Cord Injury (BSCIP)
2200	2240.0612	Deleted references to Assisted Living, Long Term Care Community Diversion and Cystic Fibrosis waivers
2400	2410.0355	Changed the policy language to show that the

Technical changes and changes in non-substantive information may be excluded from this summary.

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		definition of a service animal not only applies to dogs, but to any animal that is trained to assist an individual with a disability. This is a result of a clarification from the Food and Nutrition Service.
2600	2620.0412	Strikethrough all; title changed to Contract Employment of Less Than One Year; passage discusses income calculations for contracted employees for less than one year
	2620.0412.01	New passage (Income from Contracted School Employees) – portion of passage removed from policy 2620.0412
	2630.0506.04, 2640.0506.04	Added language that cost associated with maintaining a certified service animal is a Recognized Medical Services expense.
	2640.0117	Deleted references to Cystic Fibrosis (CF)
	2640.0117.01	Deleted references to Project AIDS CARE (PAC) and Traumatic Brain and Spinal Cord Injury (BSCIP)
	2640.0118	Deleted references to Cystic Fibrosis (CF)
	2650.0412	Strikethrough all; Income received under an employment contract of less than one year will be prorated over the months it is intended to cover. The income is prorated to show the actual contracted time of employment for the individual.
	2650.0412.01	New passage (Income from School Employee Contract)

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Listing of Amended Passages

0240.0001 Caseload Distribution (MSSI, SFP)

Caseload assignments are frequently made according to the characteristics of a given assistance group and the type of assistance received. These breakdowns are called Temporary Cash Assistance cases, Family-Related Medicaid cases or SSI-Related Medicaid cases. Each type may include food stamps.

A Temporary Cash Assistance case or Family-Related Medicaid case may contain one or more of the following types of assistance: Temporary Cash Assistance (TCA), Refugee Assistance Program (RAP), food stamps, Family-Related Medicaid, MEDS or Medically Needy.

An SSI-Related Medicaid case may contain one or more of the following types of assistance: Institutional Care Program (ICP), MEDS-AD, Protected Medicaid (PM), Medically Needy, Emergency Medicaid for Aliens (EMA), Hospice, Home and Community Based Services (HCBS), [Modified Project Aids Care \(MPAC\)](#), Refugee Assistance Program (RAP), Qualified Medicare Beneficiaries (QMB), Working Disabled (WD), Special Low Income Medicare Beneficiary (SLMB), Optional State Supplementation (OSS), Qualifying Individual 1 (QI-1), Home Care for Disabled Adults (HCDA), or food stamps. All programs are Medicaid Programs except OSS, HCDA and food stamps. The Department of Elder Affairs currently handles Home Care for the Elderly (HCE).

A mixed caseload contains one or more Temporary Cash Assistance or Family-Related Medicaid and SSI-Related types of assistance, with or without food stamps.

Child in Care cases are frequently specialized due to the special confidentiality requirements and unique policy. Therefore, they are not considered part of the Temporary Cash Assistance or Family-Related Medicaid caseload and the information about the case is limited to eligibility specialists with special confidential security profiles. SSI Related cases may include a Child in Care individual.

0240.0102 Program Overview (MSSI, SFP)

SSI-Related Medicaid provides medical assistance as defined by policy (see below) to certain groups of individuals. Although Medicaid is run by the state, the state is given federal matching funds for the program and must follow certain federal requirements in order to receive these funds.

SSI-Related Medicaid Programs include:

1. SSI Eligible Individuals (SSI-DA),
2. Institutional Care Program (ICP),
3. Eligible Individuals under SOBRA - Aged or Disabled (MEDS-AD),
4. Protected Medicaid (PM),
5. Medically Needy (MN),
6. Emergency Medicaid for Noncitizens (EMN),
7. Hospice,
8. Home and Community Based Services (HCBS),
9. [Modified Project Aids Care \(MPAC\)](#),
10. SSI-Related Programs for Refugees (RAP),
11. Qualified Medicare Beneficiaries (QMB),
12. Working Disabled (WD),
13. Special Low Income Medicare Beneficiary (SLMB),
14. Qualifying Individuals I (QI1), and
15. Program of All Inclusive Care for the Elderly (PACE)

New language in passages appear **blue** in color and ~~strikethrough~~ is used for deleted language.
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Listing of Amended Passages

It should be noted that all SSI recipients are also entitled to Florida Medicaid but their eligibility is based on the determination for SSI, which is made by the Social Security Administration.

The eligibility specialist must not confuse Medicaid with Medicare. Medicaid is medical assistance based on need and the benefits may vary widely from state to state. Medicare is medical insurance which is not based on need, but on entitlement, as determined by SSA. Because Medicare is a federal program, the benefits do not vary from state to state.

Other SSI-Related Programs are considered state funded programs because the state receives no federal funds to help pay for them and all funding is from general revenue. However, the basic eligibility requirements for these programs are still based on SSI policy. These programs include Optional State Supplementation and Home Care for the Disabled.

0240.0111 Home and Community Based Services (MSSI)

The purpose of the Home and Community Based Services (HCBS) Programs is to prevent institutionalization of individuals by providing for care in the community. These programs are considered Medicaid waiver programs because they waive certain Medicaid eligibility criteria and allow individuals to be eligible who would not otherwise be eligible, and they allow additional services that are not usually available under Medicaid.

Following are HCBS waivers for which you must determine eligibility:

1. Familia Dysautonomia (FD), ~~Cystic Fibrosis (CF)~~,
2. iBudget Florida Developmental Disabilities (DD),
3. Model Waiver, ~~and~~
4. Statewide **Medicaid Managed Medical Care Long-Term Care (SMMC LTC) Project AIDS Care (PAC)**, ~~and~~
5. ~~Traumatic Brain and Spinal Cord Injury (BSCIP)~~.

The individual must meet all technical criteria, have income and assets within the limits for ICP or MEDS-AD, meet the level of care for the particular program involved and be enrolled in the waiver as documented by form CF-ES 2515. (Individuals cannot qualify for HCBS under the Medically Needy Program).

Note: With the exception of the ~~Long Term Care Community Diversion, Cystic Fibrosis, iBudget Florida and Statewide Medicaid Managed Care Long-Term Care Waivers Assisted Living Waiver Programs~~, spousal impoverishment policies do not apply to HCBS Programs. However, the transfer of assets policy does apply to all HCBS Programs.

0240.0120 MODIFIED PROJECT AIDS CARE (MPAC) (MSSI, SFP)

This is limited coverage for individuals who do not meet the criteria for enrollment in the Statewide Medicaid Managed Care Long Term Care Program. An individual who is diagnosed with the Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Deficiency Syndrome (AIDS) and meets the presumptive disability criteria as evidenced by AHCA Form 5000-0607, Acquired Immune Deficiency Syndrome (AIDS), Physician Referral for Individuals at Risk of Hospitalization. All other eligibility criteria must be met to qualify and the individual must not be eligible for another full Medicaid coverage group.

1440.0008 Additional Criteria - HCBS Waivers (MSSI)

The individual must also meet additional program specific criteria that vary according to the Home and Community Based Services (HCBS) Program waiver type.

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~~For the Cystic Fibrosis Waiver (CF/HCBS) individuals must:~~

- ~~1. be 18 years of age or older (must meet disability criteria if under age 65);~~
- ~~2. meet a level of care for being at risk of hospitalization as determined by CARES;~~
- ~~3. have a diagnosis of Cystic Fibrosis and a need for medically necessary services provided by the waiver as determined by Adult Services; and~~
- ~~4. be enrolled in the Cystic Fibrosis waiver as documented by form CF-ES 2515.~~

~~For Familial Dysautonomia Waiver (FD/HCBS) individuals must:~~

- ~~1. be age three or older (must meet disability criteria if under age 65);~~
- ~~2. meet a level of care of being at risk of hospitalization as determined by CARES;~~
- ~~3. have a diagnosis of Familial Dysautonomia and a need for medically necessary services provided by the waiver as determined by CARES, and~~
- ~~4. be enrolled in the Familial Dysautonomia waiver as documented by form CF-ES 2515.~~

~~For the iBudget Florida Waiver an individuals must:~~

- ~~1. be aged three or older (must meet disability criteria if under 65);~~
- ~~2. meet level of care requirements as determined by the Agency for Persons with Disabilities; and~~
- ~~3. be enrolled in the iBudget Florida waiver as documented by form CF-ES 2515~~

The iBudget Florida waiver is targeted to develop mentally disabled individuals and allows the customer more choice and control over his or her services.

~~For the Model Waiver, individuals must:~~

- ~~1. be under 21 years of age;~~
- ~~2. be diagnosed as having a degenerative spinocerebellar disease; and~~
- ~~3. meet the appropriate level of care for inpatient hospital care as determined by Children's Medical services as documented by form CF-ES 2515.~~

Florida can only serve five children at any one time under this program. The Agency for Health Care Administration evaluates each case and authorizes slots.

~~For Project AIDS Care (PAC/HCBS), individuals must:~~

- ~~1. be disabled with AIDS (this also applies to an aged individual);~~
- ~~2. meet level of care requirements as determined by CARES, and~~
- ~~3. be enrolled in the PAC waiver as documented by form CF-ES 2515.~~

~~For the Statewide Managed Medical-Care Long Term Care Waiver (SMMC LTC) individuals must:~~

- ~~1. be enrolled in the SMMC-LTC waiver as documented by form CF-ES 2515;~~
- ~~2. meet the appropriate level of care requirement as determined by CARES; and~~
- ~~3. be 18 years of age or older (must meet disability criteria if under 65).~~

~~For Traumatic Brain and Spinal Cord Injury Waiver, individuals must:~~

- ~~1. be between the ages of 18 and 64;~~
- ~~2. be disabled due to Traumatic Brain Injury or Spinal Cord Injury;~~
- ~~3. meet a nursing facility level of care as determined by CARES; and~~
- ~~4. be enrolled in the waiver as documented by form CF-ES 2515.~~

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1440.0507 Age Requirements (MSSI, SFP)

For the ICP Program, there is no age requirement for individuals requiring skilled, intermediate, or intermediate care for the mentally retarded, institutional care benefits. However, an individual must be 65 years of age or older if care in a state mental hospital is required.

For Hospice care and the AIDS waiver Program, individuals may be eligible regardless of age.

For the OSS and HCDA Programs, the individual must be 18 or older. Refer to passage 1440.0008 for specific HCBS age requirements.

All individuals must also meet the aged, blind or disabled criteria to be determined eligible for Medicaid under SSI-Related Programs, which are discussed in passages 1440.1200 - 1440.1206.

1440.1204 Blindness/Disability Determinations (MSSI, SFP)

If the individual has not received a disability decision from SSA, a blindness/disability application must be submitted to the Division of Disability Determinations (DDD) for individuals under age 65 who are requesting Community Medicaid under community MEDS-AD, Medically Needy, and Emergency Medicaid for Alien Programs.

State disability determinations for disability-related Medicaid applications must be done for all applicants with pending Title II or Title XVI claims unless SSA has denied their disability within the past year. If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal.

When the individual files an application within 12 months after the last unfavorable disability determination by SSA and provides evidence of a new condition not previously considered by SSA, the state must conduct an independent disability determination. Request a copy of the SSA denial letter. The SSA denial letter contains an explanation of all the conditions considered and the reason for denial.

~~The Region or Circuit Medical Review Team (DMRT) handles all other necessary disability determinations (including ICP, OSS, HCBS, and PACE). In some regions or circuits, Children's Medical Services (CMS) and the Multi-Handicapped Assessment Team (CMAT) handle disability determinations for children under age 21.~~

The disability determination for the Home Care for Disabled Adults (HCDA) Program is determined by the Adult Services Counselor.

A medical prognosis with a life expectancy of six months or less satisfies the disability requirement for an individual who elects Hospice.

~~A level of care from CARES giving an appropriate level for Project AIDS Care (PAC) applicant/recipients satisfies the disability criteria for the PAC Waiver Program.~~

A level of care from the Agency for Persons with Disabilities giving an appropriate level for the iBudget Florida er DS Waivers satisfies the disability requirement for the DS Waiver Programs.

For individuals applying for dual programs such as OSS and MEDS-AD, the **Region or Circuit Medical Review Team (DMRT)** may be used to determine disability for both. When determining eligibility for ongoing ICP or HCBS and the individual is requesting MEDS-AD or Medically Needy for the prior months, use DMRT for both.

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Note: If Social Security determines an individual is not disabled, the decision generally replaces that which was made by the state. Refer to passages 1440.1205 and 1440.1206 for guidance.

1440.1302 Who Determines Need for Placement (MSSI)

The agency or office responsible for determining the need for care depends on the applicant's age and what kind of facility or program is needed. After the eligibility specialist requests a determination, the specialist must receive DOEA CARES Form 603 (Notification of Level of Care) for nursing home placement or the Certification of Enrollment Status for Home and Community Based Services (HCBS) Form (CF-ES 2515) for HCBS waivers from the responsible office to document the specific need in the case record.

Note: The eligibility specialist does not request level of care decisions for HCBS waivers but must receive documentation of decisions from case managers or CARES.

The determination will be obtained from one of the following offices:

CARES (Comprehensive Assessment and Review for Long Term Care Services), Department of Elder Affairs:

1. For ICP: determines Level of Care for applicant/recipients over age 21 in nursing facilities, swing beds or hospital based nursing facility beds.
2. For HCBS: determines if applicant/recipient meets waiver requirements for ~~the a~~ specific HCBS waiver, including ~~Channeling, Aged and Disabled Adult, Project AIDS Care, SMMC LTC, Traumatic Brain and Spinal Cord Injury, or Cystic Fibrosis.~~
3. For PACE: determines if the applicant/recipient meets the **Level** level of **Carecare**.

CMAT (Children's Multidisciplinary Assessment Team), Children's Medical Services in the Department of Health:

1. For ICP: determines Level of Care for children under age 21, unless they are applicants for Project AIDS Care or Developmental Disabilities iBudget Florida Waiver.
2. For HCBS: determines if applicants meet waiver requirements for the Model **Waiver** ~~waiver~~.

APD (Agency for Persons with Disabilities):

1. For Intermediate Care Facility for Developmental Disabilities: determines Level of Care for ICF/DD placement.
2. For HCBS: determines if applicant meets waiver requirements for the Developmental Disabilities, ~~Family and Supported Living~~ and iBudget Florida Waivers.

If the eligibility specialist is not sure who is handling this determination, or whether a determination has been requested, he should request assistance from his supervisor.

1610.0200 ASSET LIMITS (FS)

The asset limit is the maximum amount of liquid and/or nonliquid assets that an assistance group can retain and remain eligible for public assistance.

The total countable assets of the assistance group cannot exceed:

1. ~~\$3,250 for assistance groups that include a member(s) who is elderly or disabled. Elderly is defined as being age 60 or older. An individual may be considered elderly if they will~~

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- ~~be age 60 by the last day of the application month; or \$2,250 for assistance groups that do not include an elderly or disabled member; or~~
2. ~~\$2,250 for assistance groups that do not include an elderly or disabled member; or \$3,500 for assistance groups that include a member(s) who is elderly or disabled. Elderly is defined as being age 60 or older. An individual may be considered elderly if they will be age 60 by the last day of the application month.~~

For categorically eligible households, countable assets are assumed to be within the FS asset limits.

1640.0205 Asset Limits (MSSI, SFP)

Total countable assets for an individual or a couple must not exceed the following limits:

1. For MEDS-AD and Medically Needy, the asset limit is \$5,000 for an individual and \$6,000 for a couple.
2. For the Working Disabled (WD), the asset limit is ~~\$5,000~~ 4,000 for an individual and \$6,000 for a couple.
3. For ICP, PACE, all HCBS Waivers, [Modified PAC \(MPAC\)](#) and Hospice, the asset limit is \$2,000 for an individual (\$3,000 for eligible couple) or \$5,000 if the individual's income is within the MEDS-AD limit (\$6,000 for eligible couple).
4. For QMB, SLMB, and QI1 the asset limit is three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9.

Community spouse resource allowance policy applies to ICP, Institutional Hospice, ~~Cystic Fibrosis Waiver~~, iBudget, SMMC-LTC and PACE. Applicants who have spouses residing in the community or spouses who are not enrolled in HCBS, have a Community Spouse Resource Allowance (CSRA) subtracted from the couple's total countable assets before comparing the institutionalized spouse's countable assets to the \$2,000 or \$5,000 asset limit. The CSRA is an established amount that increases annually.

1640.0315 Assets Available to Spouse after Approval (MSSI)

The following policy applies to ICP, ICP/MEDS, PACE, Institutionalized Hospice Programs, iBudget and Statewide Medicaid Managed Care-Long Term Care and ~~Cystic Fibrosis~~ waivers.

Following approval, none of the assets solely owned by the community spouse are included as available to the institutional spouse. The amount of assets allocated to the community spouse which belong to the institutional spouse and are available to the institutional spouse must be transferred to the community spouse. The eligibility specialist must work with the individual to assure that the assets are transferred to the community spouse; however, the assets will not be counted as available to the institutional spouse until the first scheduled complete redetermination is conducted. In no instance should the failure to transfer the assets to the community spouse within the prescribed time limits result in overpayment.

Any assets received by the institutionalized spouse after approval, which cause the total assets to exceed the asset standard, will not affect the individual's eligibility if they are transferred to an allowable person (see Section 1640.0600) within the month of receipt or if the individual receives equitable value. If the assets are still available to the institutionalized spouse the month after receipt, the value of the new assets is considered a countable asset to the institutionalized spouse the month after the assets are received.

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If the individual returns home and the case is closed, the couple's assets must be reevaluated if the individual reappears after a 30-day absence from the institutional facility. This policy does not apply if the individual returns to the institutional facility within 30 days.

1640.0514 Burial Exclusion Policy (MSSI, SFP)

An individual and the individual's spouse may set aside funds of up to \$2,500 each for burial expenses. These funds are excluded as assets as long as the individual ~~states they are for burial~~shows that they are clearly designated as being set aside for burial. This is true even if the case has been closed as long as the funds continue to be designated for burial. The funds must be separately identifiable (not commingled with other funds ~~that are not set aside for burial~~) unless the asset cannot be separated or it is unreasonable to require it. ~~Accept the The~~The individual's (or deemed individual) must provide a written verbal statement of all the following:~~defining:~~

1. the amount of funds set aside,
2. for whose burial the funds are set aside, and
3. the form in which the funds are held.

The individual and the individual's spouse must be given the opportunity to designate funds for burial at the time of application and at review if the maximum amount is not already designated. These funds may be excluded regardless of whether the exclusion is needed to allow eligibility. Accept the individual statement that assets are intended for burial.

The \$2,500 limit is not reduced by the value of excluded life insurance policies or irrevocable burial contract.

If the funds are not clearly designated for burial at the time of the application, the funds may be excluded if the individual:

1. ~~states provides a written statement~~ that the funds are intended for the individual's burial or completes CF-ES 2302, Designation of Resources for Burial Funds
2. submits evidence that the funds have been separately identified~~agrees to submit evidence that the funds are separately identifiable~~ and designated for burial within 10 days of signing the statement~~if the funds are currently commingled with non-burial funds.~~

Note: If the evidence is not provided in 10 days, the funds cannot be excluded until the information is provided.

Example: The applicant/recipient has a savings account with \$3500 in it and states it is a burial fund, we will exclude \$2500 and count \$1000. This meets the requirement of not being commingled. If the applicant/recipient states that only \$2500 is for burial and the other \$1000 is for emergencies, then the \$2500 is commingled with non-burial funds and the client would have to open a separate account to receive the \$2500 burial exclusion.

Assets may be designated as burial funds for any month, including the three months prior to the month of application. (Burial fund accounts for prior months may be commingled with non-burial funds.)

Any increase in the value of excluded burial funds which was left to accumulate is excluded from assets. Refer to passages **1640.0593** **1640.0596** and **1840.1000**.

Listing of Amended Passages

1640.0576.08 Exceptions for Trusts Set Up 10/1/93 or Later (MSSI, SFP)

The policies listed above in passage 1640.0576.07 do not apply to the following trusts:

1. Trusts established by a will (see passage 1640.0576.03).
2. Trusts for the disabled under age 65.
3. Pooled trusts for the disabled.
4. Qualified income trusts (see passage 1840.0110).

All special trusts must be forwarded to the Region or Circuit Program Office for review and Circuit Legal Counsel's written approval before the case can be approved, per guidelines in the Appendix-A-22.4, A-22.5 and A-22.6.

The following special trusts may be created on or after October 1, 1993, for disabled individuals if the trust meets the specific criteria indicated below:

Trusts for the disabled under 65: A trust containing the assets of a disabled individual under age 65, if:

1. it was established on or after 10/01/93; and
2. it was established for the benefit of the individual by, a parent, grandparent, **the disabled individual himself**, legal guardian or a court order (~~cannot be established by the disabled individual himself, must be by parent, grandparent, legal guardian or court order~~); and
3. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

Pooled trusts for the disabled: A trust containing the assets of an individual who is disabled, if:

1. it was established on or after 10/01/93;
2. the trust is established and managed by a nonprofit association;
3. a separate account is maintained for the beneficiary of the trust but, for purposes of investment and management, the trust pools the accounts;
4. the trust is established solely for the disabled individual by a parent, grandparent, legal guardian, court or the individual himself; and
5. to the extent that amounts remaining in the trust upon the individual's death are not retained by the trust, the trust pays to the state an amount equal to the total amount of medical assistance paid on behalf of the individual.

Both of the above special trusts can only be set up to benefit individuals who meet SSI disability criteria. Trusts for the disabled under 65 can be established only for individuals who are under 65. Pooled trusts for the disabled can be established for individuals of any age.

Disability must be determined for both of the above special trusts via regular policy; that is, the person must receive Social Security disability or SSI benefits or the Department must make an independent determination to show that the individual meets the disability requirement.

1660.0200 ASSET LIMITS (RAP)

The asset limit is the maximum amount of liquid and/or nonliquid assets that an assistance group can retain and remain eligible for public assistance.

The total countable assets for the Refugee Assistance Program cannot exceed \$1,000-**2,000**.

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Listing of Amended Passages

2040.0800 SSI-RELATED MEDICAID COVERAGE GROUPS (MSSI)

1. Aged, Blind and/or Disabled Medicaid for SSI eligible individuals (could be ICP, Hospice or HCBS);
2. Protected SSI Medicaid, including Regular COLA Protected Medicaid, ~~Disabled Widow(er) II Protected Medicaid, Disabled Widow(er) III Protected Medicaid, and~~ Disabled Adult Child Protected Medicaid;
3. SSI-Related MEDS for Aged or Disabled (Medicaid Expansion designated by SOBRA - Aged or Disabled);
4. Emergency Medical Assistance for Noncitizens, from an SSI-Related Medicaid category;
5. Medically Needy from an SSI-Related Medicaid category;
6. SSI Eligible ICP (includes Hospice);
7. SSI-EEI ICP (includes Hospice);
8. SSI-Related ICP except for transfer of assets (not eligible for ICP due solely to transfer of assets, cannot receive vendor payments for institutional services, but is eligible for all other services);
9. SSI MEDS ICP for Aged and Disabled;
10. SSI Medically Needy in a Long-Term Care Facility;
11. Hospice Services Medicaid, including SSI Eligible Hospice Services, SSI-EEI Hospice Services, SSI MEDS Hospice Services for Aged and Disabled, and SSI Medically Needy Hospice Services;
12. Home and Community Based Services (HCBS) Medicaid waivers, including ~~Project AIDS Care, Traumatic Brain and Spinal Cord Injury Waiver, Model Waiver, Familiar Dysautonomia, Cystic Fibrosis Waiver~~ and Individual budget (iBudget) program; and Statewide Medicaid Managed Care ~~-Long Term Care~~ Programs;
13. Qualified Medicare Beneficiaries Medicaid for all categorical Medicaid where the individual is Part A Medicare eligible;
14. Special Low Income Medicare Beneficiary Medicaid;
15. Qualified Individuals 1;
16. Working Disabled entitled to payment of Part A Medicare premium only (cannot receive other coverage);
17. Retroactive Medicaid;
18. Posthumous Medicaid;
19. Breast and Cervical Cancer Treatment; and
20. Program of All-Inclusive Care for the Elderly (PACE); ~~and~~
21. Modified Project Aids Care (MPAC).

2040.0815.02 Additional Criteria – HCBS Cystic Fibrosis Waiver (MSSI)

For the Cystic Fibrosis Waiver, individuals must:

1. ~~be at least 18 years of age or older (must meet disability criteria if under age 65);~~
2. ~~meet a level of care for being at risk of hospitalization as determined by CARES;~~
3. ~~have a diagnosis of cystic fibrosis and a need for medically necessary services provided by the waiver as determined by Adult Services; and~~
4. ~~be enrolled in the Cystic Fibrosis waiver as documented by form CF-ES 2515.~~

2040.0815.06 Additional Criteria – HCBS Project AIDS Care (MSSI)

For Project AIDS Care (PAC), individuals must:

1. ~~be disabled with AIDS (this also applies to an aged individual);~~
2. ~~meet level of care requirement as determined by CARES, and~~
3. ~~be enrolled in the PAC waiver as documented by form CF-ES 2515.~~

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2040.0815.08 Add. Criteria - HCBS Traumatic Brain/Spinal Cord Injury Waiver (MSSI)

For the Traumatic Brain and Spinal Cord Injury Waiver, individuals must:

1. be between the ages of 18 and 64;
2. have one of the following medical conditions: traumatic brain injury or spinal cord injury;
3. meet a nursing facility level of care as determined by CARES; and
4. be enrolled in the waiver as documented by form CF-ES 2515.

2240.0612 Couple/One Requests Institutional Care Services (MSSI)

The following policy is applicable only to ICP, MEDS-ICP, PACE, and Institutional Hospice Programs and the Assisted Living, Long-Term Care Community Diversion and Cystic Fibrosis waivers.

If an individual has a community spouse and only one spouse is requesting institutional services, the income standard for one is used. Only the institutionalized individual's income is used to determine his income eligibility.

At the time of application, the total countable assets of both spouses are considered and an amount is allocated to the community spouse in accordance with policies in Chapter 1600.

After eligibility is established, income may be allocated to the legal spouse, family member, and dependents in accordance with policy in Chapter 2600.

2410.0355 Allowable Medical Expenses (FS)

Allowable medical expenses are:

1. Medical and dental care, including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by state law, or by other qualified health professional.
2. Hospitalization or outpatient treatment, nursing care, and nursing home care provided by a facility recognized by the state (an assistance group (AG) would continue to be eligible for an excess medical adjustment for the medical expenses of a former individual who is 60 or over or receives SSI or Social Security disability even after that individual becomes hospitalized, institutionalized or dies if the remaining AG individuals are legally responsible for payment of the expenses).
3. Prescription drugs when prescribed by a licensed practitioner authorized under state law, and other over-the-counter medication (including insulin), medical supplies, sickroom equipment (either rented or purchased), or other prescribed equipment when approved by a licensed practitioner or other qualified health professional.
4. Dentures, hearing aids, and prosthetics.
5. Eyeglasses or contact lenses prescribed by a physician skilled in eye disease or by the optometrist.
6. Health and hospitalization insurance policy premiums. If the insurance policy covers more than one AG individual, only that portion of the medical insurance premium assigned to the AG individual(s) eligible for the medical deduction may be allowed. In the absence of specific information on how much of the premium is for an AG individual eligible for a medical deduction, proration may be used to determine the amount to be allowed.

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Listing of Amended Passages

7. Medicare premiums related to coverage under Title XVIII of the Social Security Act, any cost sharing or spend down expenses incurred by Medicaid individuals.
8. Securing and maintaining a ~~Seeing Eye or hearing dog~~ certified service animal, including the cost of dog food and veterinarian bills.
9. Reasonable cost of transportation and lodging to obtain medical treatment or services. Count the actual costs of transportation to get medical treatment or services, including costs of travel to buy medicine. If the actual cost of transportation is unknown, use the current mileage allowance in effect for state employees.
10. Maintaining an attendant, homemaker, home health aide, or child care or housekeeper services if necessary due to age, infirmity, or illness. In addition, an amount equal to one individual benefit shall be considered a medical expense if the AG furnishes the majority of the attendant's meals. The benefit for this meal related expense shall be that in effect at the time of certification. The benefit amount for this deduction will be updated at the next certification. If an individual incurs attendant care costs that could qualify under both the medical deduction and dependent care deduction, the eligibility specialist shall treat the cost as a medical expense. If the expense is incurred for more than one individual, and only one of those individuals qualifies for a medical deduction, consider as a medical expense only that portion which can be identified as such. If the amount cannot be separately identified, the entire amount shall be prorated among those individuals for whom care is provided, and the portion considered as a medical expense shall be the prorated amount attributed to the individual(s) who qualifies for the expense as a medical adjustment.
11. Companion phone service may be allowed as a medical necessity if a doctor's statement is obtained to that effect. The fact that the individual receives SSD or SSI in itself does not mean that it is a medical necessity. The individual may be billed for this service (separate from his regular phone service) yearly or on a monthly basis. If the individual has other medical bills it may be to the overall advantage to include the monthly charge.

Note: The cost of health and accident policies such as those payable in lump sum settlements for death or reimbursement, or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled, are not deductible.

2620.0412 Seasonal/Contractual Earned Income Contract Employment of Less Than One Year (TCA)

~~Income received by individuals on a contractual basis can, at the option of the individual, be:~~

1. ~~prorated over the period of the contract; or~~

Note: ~~The standard earned income disregard is allowed for each month of the contract.~~

2. ~~counted as received.~~

~~If the school employee receives income other than on an hourly or piece rate basis, they are considered under contract whether it is written or implied.~~

~~Annual income received by assistance group members from the contractual school employment must be averaged over 12 months.~~

New language in passages appear blue in color and strikethrough is used for deleted language.
The Introduction and Appendices are excluded.

Listing of Amended Passages

Income received under an employment contract of less than one year will be prorated over the month it is intended to cover. The income is prorated to show the actual contracted time of employment for the individual.

2620.0412.01 Income from School Employee Contract (TCA)

If the school employee receives income other than on an hourly or piece rate basis, they are considered under contract whether it is written or implied.

Annual income received by assistance group member from the contractual school employment must be averaged over 12 months.

2630.0506.04 Recognized Medical Services (MFAM)

Recognized medical services are:

1. cost of public transportation to obtain recognized medical services;
2. medical services provided or prescribed by a member of the medical community; **or** and
3. personal care services in a person's home, prescribed by a member of the medical community.

Note: This includes the portion of the payment for personal care made by an ALF resident to the ALF provider. The provider must separate out the portion of the payment which is for room and board. The balance is for personal care, and can be considered an allowable medical expense for bill tracking purposes.

Examples of recognized services include:

1. ambulance, bus, or taxi (to receive medical services);
2. prosthetic devices, orthopedic shoes, wheelchairs, walkers, crutches, and equipment to administer;
3. oxygen;
4. prescription drugs;
5. insulin;
6. needles;
7. syringes;
8. drugs for family planning;
9. oxygen;
10. surgical supplies;
11. medicine chest supplies or other over-the-counter purchases that are prescribed by a member of the medical community as medically necessary; and
12. services related to activities of daily living or essential to the ill person's health and comfort, such as:
 - a. eating,
 - b. bathing,
 - c. grooming,
 - d. taking medication,
 - e. personal laundry,
 - f. meal preparation,
 - g. shopping, **and**
 - h. ~~light~~-housekeeping; **or**
 - i. Cost associated with maintaining a certified service animal, including the cost of food and veterinarian bills

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The Introduction and Appendices are excluded.

Listing of Amended Passages

Examples of expenses or items which are not recognized include:

1. medicine chest supplies, such as:
 - a. nonprescription cold remedies,
 - b. nonprescription ointments,
 - c. thermometers,
 - d. handrails,
 - e. **rubbing** alcohol, **or and**
 - f. cotton swabs.
2. household repairs; **or heavy housekeeping and**
3. 4-yard work.

2640.0117 Patient Responsibility Computation (MSSI)

The following policy applies to ICP, Institutionalized MEDS, Institutionalized Hospice, Community Hospice, PACE and the following HCBS Waiver Programs:

1. iBudget Florida, **Cystic Fibrosis**,
2. Statewide Medicaid Managed Care Long-Term Care (SMMC LTC)

After the individual is determined eligible, the amount of monthly income to be applied to the cost of care (patient responsibility) is computed as follows:

Step 1 - Deduct the personal needs allowance and one half of the gross therapeutic wages up to the maximum of \$111 for institutionalized individual only, if applicable. Refer to 2640.0118 for information regarding the personal needs allowance.

Step 2 - Deduct the community spouse income allowance, family member allowance, or the dependent's allowance, if applicable.

Step 3 - Consider protection of income policies for the month of admission or the month of discharge, if appropriate (refer to 2640.0123) for the following programs:

1. Institutional Care Programs, (including Institutionalized MEDS and Institutionalized Hospice) - the month of admission to and discharge from a nursing facility,
2. PACE and SMMC LTC - the month of admission or discharge from a nursing facility or from an assisted living facility.

Step 4 - Deduct uncovered medical expenses as discussed in passages 2640.0125.01 through 2640.0125.04.

The balance is the amount of the patient responsibility.

Note: The following individuals have no patient responsibility:

1. ICP children (aged 3-17 years) in ICF/DDs.
2. QMB individuals (with income 100% or less of the federal poverty level) while in a nursing home under Medicare coinsurance period, and
3. SSI recipients who have no other source of income and are only entitled to a \$30 SSI payment.

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2640.0117.01 Home and Community Based Services Waiver Programs with no Patient Responsibility (MSSI)

The following HCBS programs have no patient responsibility:

1. Familial Dysautonomia, **and**
2. Model.,
3. ~~Project Aids Care (PAC)~~, and
4. ~~Traumatic Brain and Spinal Cord Injury.~~

2640.0118 Personal Needs Allowance (MSSI)

The amount of the individual's income which is designated as a personal needs allowance (PNA) varies by program.

For ICP and Institutionalized MEDS-AD, the personal needs allowance is \$105 as follows:

1. If the individual has less than \$105 total countable income, a supplemental payment must be authorized through the Supplemental Payment System (SPS). The personal needs allowance supplement (PNAS) cannot exceed \$75 a month.
2. Single veterans (and surviving spouses) in nursing homes who receive a VA \$90 pension (disregarded as income in both eligibility and patient responsibility computations) are also entitled to the \$105 PNA.
3. Single veterans (and surviving spouses) with no dependents who reside in state Veterans Administration nursing homes may keep \$90 of their veterans payments, including payments received for aid and attendance and unreimbursed medical expenses, for their personal needs. Any amount exceeding \$90 will be part of their patient responsibility to the facility. These individuals are also entitled to the \$105 PNA.

For Community Hospice, the PNA is equal to the Federal Poverty Level.

For Institutionalized Hospice, the PNA is \$105. If the individual has less than \$105 total countable income, a supplemental payment must be authorized through the SPS. The PNAS cannot exceed \$75 per month.

For the ~~Cystic Fibrosis~~, and iBudget Florida **W**waivers, the PNA is equal to 300% of the federal benefit rate. Because the PNA is the same as the HCBS income limit, only those individuals who become eligible using an income trust will have a patient responsibility.

For the Statewide Medicaid Managed Long-Term Care (SMMC LTC) program and the Program for All-Inclusive Care for the Elderly (PACE), the personal needs allowance is as follows:

1. For an individual residing in the community (not an ALF), the PNA is 300% of the Federal Benefit Rate.
2. For an individual residing in an ALF, the PNA is computed using the ALF basic monthly rate (three meals per day and a semi-private room), plus 20% of the Federal Poverty Level. The ALF basic monthly rate will vary depending on the facility's actual room and board charges.
3. For an individual residing in a nursing home, the PNA is \$105.

For the Familial Dysautonomia Waiver the personal needs allowance is equal to the individual's gross income, including amounts that may be placed in an income trust.

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For individuals in institutional care who earn therapeutic wages, an additional amount equal to one half of the therapeutic wages, up to \$111, can be deducted or protected for personal needs. The total amount of income to be protected as therapeutic wages cannot exceed \$111. (This is in addition to the \$105 personal needs allowance).

For individuals in institutional care who have a court order to pay child support, an additional PNA equal to the court-ordered child support amount **can** be deducted for personal needs. (This is in addition to the \$105 personal needs allowance).

2640.0506.04 Recognized Medical Services (MSSI)

Recognized medical services are:

1. cost of public transportation to obtain recognized medical services;
2. medical services provided or prescribed by a member of the medical community; **or** and
3. personal care services in a person's home, prescribed by a member of the medical community.

Note: This includes the portion of the payment for personal care made by an ALF resident to the ALF provider. The provider must separate out the portion of the payment which is for room and board. The balance is for personal care, and can be considered an allowable medical expense for bill tracking purposes.

Examples of recognized services include:

1. ambulance, bus, or taxi (to receive medical services);
2. prosthetic devices, orthopedic shoes, wheelchairs, walkers, crutches, and equipment to administer oxygen;
3. prescription drugs;
4. insulin;
5. needles;
6. syringes;
7. drugs for family planning;
8. oxygen;
9. surgical supplies;
10. medicine chest supplies or other over-the-counter purchases that are prescribed by a member of the medical community as medically necessary;
11. services related to activities of daily living or essential to the ill person's health and comfort, such as:
 - a. eating,
 - b. bathing,
 - c. grooming,
 - d. taking medication,
 - e. personal laundry,
 - f. meal preparation,
 - g. shopping, **and**
 - h. light housekeeping; **or**
 - i. **cost associated with maintaining a certified service animal, including the cost of food and veterinarian bills.**

Examples of expenses or items which are not recognized include:

1. medicine chest supplies, such as:
 - a. nonprescription cold remedies,

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- b. nonprescription ointments,
 - c. thermometers,
 - d. handrails,
 - e. rubbing alcohol, or
 - f. cotton swabs.;
- 2. household repairs; heavy housekeeping or and
 - 3. yard work.

2650.0412 Seasonal/Contractual Earned Income (CIC)

Income received under an employment contract of less than one year will be prorated over the months it is intended to cover. The income is prorated to show the actual contracted time of employment for the individual.

~~Income received by individuals on a contractual basis can, at the option of the individual, be:~~

- 1. ~~prorated over the period of the contract; or~~

Note: ~~The standard earned income disregard is allowed for each month of the contract. A disregard for a child or an incapacitated adult day care cost is allowed only in the months the individual actually worked and incurred such cost during the contract period.~~

- 2. ~~counted as received.~~

2650.0412.01 Income from School Employee Contract (CIC)

If the school employee receives income other than on an hourly or piece rate basis, they are considered under contract whether it is written or implied.

Annual income received by assistance group members from the contractual school employment must be averaged over 12 months.