THE OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

Getting Long-Term Care

Providing Long-Term Care Coverage to People with Limited Income and Resources

ohio medicaid

Getting Care

Those who cannot care for themselves at home may need care in a long-term care setting. In Ohio, long-term care can be provided in the home, community or in a nursing home setting. **Because this type of care can be costly, Ohio's Medicaid program helps eligible Ohioans pay for long-term care.**

Who is Eligible?

To be eligible for long-term care services paid by Medicaid, an applicant must:

- be an Ohio resident,
- have (or get) a Social Security Number,
- meet citizenship requirements,
- need an institutional level of care (care in a nursing home or other long-term care setting for at least 30 days), and
- meet certain financial and non-financial requirements.

What is an institutional level of care?

Level of care refers to the amount of help a person needs to live in a healthy and safe way. A person must have an intermediate or skilled level of care to require care in a long-term care setting. For example: an individual with care needs that require help with getting dressed, cooking meals, eating, and rehabilitation.

A level of care determination is completed when a person enters a nursing home or other long-term care setting.

Financial Requirements

Ohio Medicaid requirements are based on both gross income (before taxes) and resources. The resource limit for anyone applying for Medicaid coverage for long-term care is $1,500 ($2,250 for a couple).

Examples of income include Social Security benefits, pensions, cash-assistance, earnings from rental property, etc. Examples of resources include trusts, annuities, stocks, bonds, checking and savings account, CDs (certificates of deposit), etc.

Generally, an individual is not eligible for Medicaid long-term care if he or she owns a home with an equity valued at more than $500,000 (some exceptions apply).

Some resources may not be counted when determining Medicaid eligibility. These resources may include:

- home - up to 13 months after approval of Medicaid if its equity is valued at less than $500,000
- home - if a spouse or dependent children younger than age 21 live in the home, then these individuals can continue to live in the home
- one vehicle
- fixed, pre-paid funeral costs and cemetery plots

Transfer of Resources

After income and resource amounts are established, the caseworker will review resources and look for any resources that were transferred to another party up to five years prior to the date of the application (in most circumstances). There are certain resource transfers which are proper and others which are improper.

Improper Transfers

An improper transfer is a transfer of real and personal property that is less than the fair market value (or true value) of the item(s) and was transferred to avoid using it to pay for the applicant's medical care.

If it is determined an applicant has improperly transferred resources, Medicaid will not pay for care in an institutional setting for a specified period of time. This is called a Restricted Medicaid Coverage Period (RMCP).

The RMCP will not affect whether or not someone can live in a nursing home; it only affects Medicaid's payment for their care. The caseworker will determine the date the RMCP begins for the applicant. The length of the RMCP varies depending on the amount of the improper transfer(s). If all other eligibility criteria are met, Medicaid will begin paying for nursing home care once the RMCP is over.

If the applicant thinks the RMCP causes a hardship, he or she may ask the caseworker to review the case for undue hardship. If a review finds there is an undue hardship, the RMCP is eliminated and Medicaid coverage begins immediately.

See *Transfers of Resources* (JFS 08028) for more information.

Spousal Impoverishment

If the applicant is married, the community spouse (the spouse who lives at home) is allowed to keep some resources and still get Medicaid coverage for his or her spouse's long-term care. This is done to protect the spouse from becoming impoverished or living in poverty.

The community spouse can keep his or her monthly income and may be able to keep some of the institutionalized spouse's income too. **The community spouse does not have to use his or her income to pay for the institutionalized spouse's nursing home care.**

Resource limits are updated every January. In 2007 the minimum spousal impoverishment is $20,328 and the maximum is $101,640.

Patient Liability

A patient's liability is the amount of the nursing home cost the Medicaid consumer must pay directly to the nursing home. Deductions for health insurance premiums, past unpaid medical bills and monthly personal needs (usually $40) are made before the patient liability is determined.

Application Process

Step One: Get an application (form JFS 07200) from the local county department of job and family services (CDJFS) or online at **www.jfs.ohio.gov/ohp/consumers/Application.stm**. Applications are available in English, Spanish and Somali. Also, complete form JFS 02399 if interested in home care services.

Step Two: Complete, sign and date the application. If an individual cannot complete the application, an authorized representative can do so on their behalf. Anyone age 18 or older can be an authorized representative, including a family member, friend, business or non-profit organization. The county office may appoint an authorized representative, if necessary.

Step Three: Return the application by fax, mail or by taking it to the local county office.

If available, attach copies of income, resources, disability and other health insurance information (e.g., Medicare).

Incomplete applications will be accepted if they contain contact information, a date, name and signature. (Please note: proof of U.S. citizenship or alien status may be requested.)

Step Four: Within five days, the caseworker will schedule a face-to-face interview to get more information about the applicant and his or her resources. If the applicant does not speak English, an interpreter will be provided by the county office at no cost.

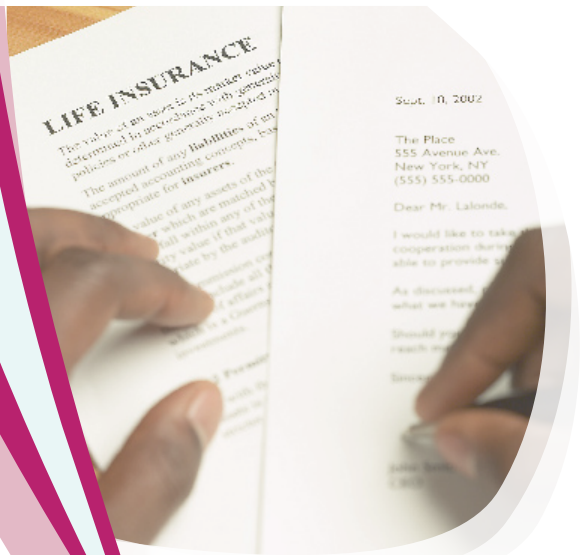
In addition, Medicaid applicants can have their eligibility explored for the three months prior to the date of application. If eligible, Medicaid will pay for Medicaid-covered services provided within that time period that were not covered by Medicare or other insurance.

The application process is usually complete within 30-45 days.

What should applicants bring to the interview?

If not already provided, caseworkers ask applicants to bring documents to the interview to confirm the information on the application is accurate. The caseworker can assist applicants in obtaining the necessary documents.

The following chart shows a list of requirements the caseworker may ask applicants to prove. (This is not a complete list.)



General Requirements	Proof of Financial Status*
• Social Security Number • Must be an Ohio resident • Provide proof of citizenship, other medical insurance (e.g., Medicare), age and/or disability	• Savings and/or checking account statements • Value of trusts, annuities, stocks and bonds • Benefits check or letter • Income from property • Motor vehicle title • Insurance policies • Written statement of cash on hand
*** Many documents are accepted and/or requested to verify financial status; caseworkers can provide more detailed information.**	

Frequently Asked Questions

Can I keep my home?

For the first 13 months of your stay in a nursing home after you become eligible for Medicaid, your home is not counted as a resource. After 13 months in a nursing home, your home may be counted as a resource unless certain conditions exist.

Can I transfer my home to my children?

Homes may only be transferred to your child who resided in the home and provided two years of care, at no cost to you, immediately prior to your entrance into a nursing home.

What if my financial status changes?

You are required to notify caseworkers within 10 days of all changes because some changes affect Medicaid eligibility and Patient Liability. Unreported changes may make you ineligible for Medicaid coverage or result in overpayment.

What should an out-of-state resident who wants to move to an Ohio nursing home and apply for Medicaid do?

Visit www.ltcohio.org/consumer for a list of nursing homes in Ohio, or call the Medicaid Consumer Hotline 1-800-324-8680 for further assistance.

Once you move to Ohio, you should contact the local county department of job and family services to apply for Medicaid.

What if I am unable to find documents that verify my U.S. citizenship?

If you make a reasonable attempt to obtain the documents, but cannot, ask your casework to help you.

Will my annuity or trust be counted when determining eligibility?

The caseworker will review all annuity and trust documents to decide if they count or not.

Can I get long-term care services outside a nursing home?

Yes. Other options like home care are available; ask your caseworker for other options when you apply for Medicaid.

For more information and answers to your questions, please call:

Medicaid Consumer Hotline:

1-800-324-8680

TTY/TDD for hearing impaired:

1-800-292-3572

Ted Strickland, *Governor*
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JFS 08072 (5/2007)