

Some Things You Need to Know When Submitting an Application

Submitting an Application:

Complete the application to the best of your ability. Make sure the applicant's name, social security number, and medicare number are correct. If you have ever been married, include the spouse's name, social security number, and if a veteran, the VA claim number.

Send the application to the appropriate District Office (see the back page of the application). A Medicaid caseworker will contact you for an interview after the application arrives in the District Office. It will be helpful if you include as many of the following items as possible when you submit the application:

1. Copies of Medicare and Social Security cards.
2. Verification of the gross (before anything is taken out) amount of Social Security, Veterans Administration, Railroad Retirement, Civil Service checks, private pension checks, rental income and annuities. (Verification should include claim and/or identification numbers.)
3. Verification of CDs, IRAs and Savings Bonds.
4. Verification of stocks, bonds and mutual funds.
5. Copies of deeds to property currently owned. (This includes heir property, life estate, etc.) Also, purchase and sale deeds to property which has been sold or transferred within the past 60 months.
6. Copies of trusts, mortgages, loans, and promissory notes.
7. Copies of all insurance policies, including:
 - a. Life, burial, funeral, vault, casket, cash, term and/or group.
 - b. Long Term Care policies.
 - c. Health, hospital, and/or cancer policies. (A copy of the card or premium notice and copy of payment method is needed.)
8. Copies of pre-need/prearranged burial contracts, including an itemized list of charges.
9. Verification of gross (before anything is taken out) wages.
10. Copy of power of attorney, guardianship papers, or curator papers.

Always keep a copy of the original application you submit to Medicaid. Send copies of all other documents, do not send your original documents except for proof of citizenship or identity, if required. Proof of citizenship and identity is not needed if you are currently receiving SSI benefits or are entitled to or enrolled in Medicare. If additional information is requested, make sure you supply the information as soon as possible. If you have questions about the information requested, call the Medicaid caseworker. If you need assistance in getting the information requested, see if the nursing home social service staff or business office worker is willing to assist.

Some things that can make a claimant ineligible:

- If someone else (a family member) deposits money (income) into the claimant's bank account, this is considered a "contribution" and must be budgeted as income to the claimant, which may make the claimant ineligible...
- If the claimant's countable resources exceed \$2,000 on the first day of the month, the claimant will be ineligible. (An example would be if the claimant receives their June check in May, Medicaid will not count the June check as a resource for May. Medicaid will count the June check as income for June.)

However, if the claimant's monthly income is allowed to accumulate and the countable resources exceed \$2,000, the claimant will be ineligible.)

- Transfers of assets/resources may affect eligibility. For the institutionalized claimant the transfer of assets/resources by claimant or claimant's spouse could cause the claimant to be ineligible for nursing home payment. For waiver Medicaid programs the transfer of assets/resources could cause the claimant to be ineligible for Medicaid.

If an application is denied, there may be some things that the claimant can do to become eligible:

1. Spend-Down of Money.

Medicaid looks at resources on the first moment of the first day of the month. The countable resource limit for an individual is \$2,000. If the total value of the couple's countable assets is \$27,000 or less, spend down of the assets for the institutionalized spouse will not be required. Monies can be spent down, however, the claimant's money is to be spent for the claimant's needs and/or expenses, not the community spouse.

2. Excess Income.

If the claimant has excess income, a "Qualified Income Trust" may need to be established. Qualifying Income Trust (QIT) packets are available at the Medicaid District Office or to download a packet, visit our website, www.medicaid.alabama.gov. QITs are necessary when a claimant's income exceeds the Medicaid income limit. (If you receive VA or State of Alabama retirement, talk with the Medicaid caseworker before establishing a QIT.)

3. Excess Resources.

If excess resources exist, you need to discuss burial exclusions and make sure that excess resources are spent for the needs of the claimant in a timely manner.

[Medicaid looks at countable resources as of the first moment of the first day of the month. It is the sponsor's responsibility to reapply in a timely manner. Make sure that you keep accurate records (bank statements, cancelled checks, receipts, etc.) to show how the money of the claimant has been spent.]

The Award Process:

When the application investigation has been completed, an award notice will be mailed indicating an eligibility date and a liability amount.

The liability amount is the amount that the claimant is to pay the nursing home each month for room and board. The nursing home will bill Medicaid for the difference. The "liability" is calculated by subtracting the following from the claimant's monthly gross income:

- Personal Needs (\$30.00) or VA (\$120.00, if VA check reduced to \$90.00),
- Allocation to Community Spouse (if the nursing home applicant has a spouse who resides in the community, we can allocate a certain amount of the claimant's monthly income to the spouse in the community),
- Allocation to family members,
- Health Insurance Premiums (verified as being paid with claimant's money).

The Annual Review Process:

Once a claimant has been approved for Medicaid, a review of the claimant's financial circumstances will be conducted annually. This means that one year from the date of the award notice, an annual review form will be mailed to the sponsor.

It is very important that the sponsor complete the form as soon as possible and return it, along with any requested information. Make sure the review form is signed, all the questions are answered and the requested information is enclosed.

You have ten (10) days to complete and return the form. If the form is not returned, along with the requested information, the active Medicaid case will be terminated.

Between Annual Reviews:

It is the responsibility of the claimant or sponsor to report any financial changes to their Medicaid caseworker within ten (10) days of the change. Examples of changes are: if claimant receives an increase in benefits or money from another source, if claimant returns home, if the sponsor changes his or her address, if the claimant stops paying premiums for health insurance. (If you are not sure if you should report a change, contact your Medicaid caseworker.)