

Public Initiatives That Help Elders and Individuals With Disabilities Remain at Home

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June, 2010**

Applicable Medicaid Coverage Groups

Categorically needy. Individuals who are “categorically needy” receive Medicaid services by reason of poverty and age or disability. Categorically needy individuals must be age 65 or older or must have a disability that meets Social Security criteria. Disability is defined by federal law as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months, or blindness.”¹ Income² and asset limits effective July 1, 2008 are as depicted (these change each July 1):

Region A	Monthly Income Limit	Asset Limit
Individual	\$610.61	\$1,600
Couple	\$777.92	\$2,400

Regions B & C	Monthly Income Limit	Asset Limit
Individual	\$506.22	\$1,600
Couple	\$672.10	\$2,400

Region A includes: Bethel, Bridgewater, Brookfield, Danbury, Darien, Greenwich, New Canaan, New Fairfield, New Milford, Newtown, Norwalk, Redding, Ridgefield, Roxbury, Sherman, Stamford, Washington, Weston, Westport and Wilton. **Regions B & C** comprise the rest of the state.

Categorically needy under special income level. Connecticut has extended categorical eligibility to residents of long-term care facilities and individuals who are receiving Medicaid benefits under a home and community-based waiver.

An individual living in the community is eligible under this category is eligible where he or she:

- would be eligible for Medicaid if residing in a long-term care facility;
- qualifies for home and community-based services under a Medicaid waiver; and
- would, without such service, require care in a long-term care facility.³

The community-based individual remains eligible as long as he or she meets all eligibility criteria and is receiving services under a waiver.⁴ To be eligible, the individual must have income below 300% of the SSI benefit (in 2010 for an individual, \$2,022 per month)⁵, and assets of \$1,600 or less.⁶ Working individuals with disabilities can qualify under more liberal income and asset limits⁷ (see below).

Medically needy. Medicaid benefits are also available to older adults and individuals with disabilities who are considered to be “medically needy”. While these individuals have incomes greater than those permitted for “categorically needy” eligibility, their out-of-pocket expenditures for medical services permit them to “spend-down” to eligibility.⁸

“Medically-needy” status emerged as a concession to the states by the federal government. Historically, Medicaid required participating States to provide medical assistance to persons who received cash

¹ 42 U.S.C. § 416(i)

² U.P.M. § 4530.05 B.2.; U.P.M. § 5520.15 A.2.a.

³ U.P.M. § 2540.92 A.

⁴ U.P.M. § 2540.92 B.

⁵ U.P.M. § 2540.92 C.1.; U.P.M. § 5520.15 A.3.b.

⁶ U.P.M. § 2540.92 C.2.

⁷ U.P.M. § 2540.92 C.3.

⁸ C.G.S.A. § 17b-282

payments under one of four welfare programs established by the Social Security Act: Old Age Assistance, Aid to Families with Dependent Children, Aid to the Blind, and Aid to Disabled. In 1972, the latter three programs were replaced by a new program: Supplemental Security Income for the Aged, Blind and Disabled. The SSI program continued to require that all recipients would also receive Medicaid services.

Given that eligibility standards for SSI were more lenient, however, the government responded to “woodwork” concerns of states by permitting them to opt out of automatically serving those eligible for SSI. Instead, such states could elect to serve only those who would have been eligible under the Medicaid state plan in effect on 1/1/72. A condition of electing this “209(b) option”⁹ was, however, that these states were subsequently required to offer a spend-down option.

Connecticut is a 209(b) state and permits individuals whose income exceeds the established income standards to spend-down to eligibility.¹⁰ Under spend-down, an individual must each six months show out-of-pocket medical expenses equal to or greater than the amount by which his or her income exceeds the income cap.¹¹ Described another way, Connecticut recognizes that individuals who have high out-of-pocket costs for medical care are effectively as poor as those who can meet the income requirements for categorically needy status.

Medicaid for Working Disabled.¹² Federal law establishes Medicaid coverage for certain working individuals with disabilities.¹³

Correspondingly, Connecticut covers three groups of employed individuals with medically certified disabilities or blindness under its MED-Connect Program:

- the Basic Insurance Group (authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999);¹⁴
- the Medically Improved Group (authorized by the federal Ticket to Work and Work Incentives Improvement Act of 1999);¹⁵ and
- the Balanced Budget Group (authorized by the Balanced Budget Act of 1997).¹⁶

The following income and asset criteria are applicable to all three coverage groups. An individual may qualify for the MED-Connect program if he or she has:

- gross income of no more than \$6,250 per month (\$75,000 per year)¹⁷; or
- applied income that is less than or equal to \$3,082.50 per month after reducing gross income by:
 - a \$20 general disregard;
 - a disregard of the first \$65 in earnings;
 - income that is needed for disability-related work expenses; and
 - half of the individual’s remaining earnings.¹⁸

Further, an individual must have assets of no more than \$10,000, or \$15,000 if he or she is part of a married couple that is living together.¹⁹ For purposes of asset eligibility limits, certain retirement

⁹ 42 U.S.C. § 1396a(f)

¹⁰ U.P.M. § 5520.20 B.5.a.

¹¹ U.P.M. § 5520.25 B.

¹² C.G.S.A. § 17b-597

¹³ 42 U.S.C. § 1396d(a)

¹⁴ U.P.M. § 2540.85 A.

¹⁵ U.P.M. § 2540.85 B.

¹⁶ U.P.M. § 2540.85 C.

¹⁷ U.P.M. § 2540.85 A.2.a.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.

¹⁸ U.P.M. § 2540.85 A.2.b.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.

¹⁹ U.P.M. § 2540.85 A.3.a.; U.P.M. § 4005.10 A.5.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.

accounts and accounts that are maintained for the purpose of increasing the individual's employability are excluded.²⁰

Generally, participants must pay a monthly premium equal to 10% of their income in excess of 200% of the FPL (effective April 1, 2010, \$1,734.00).²¹

As between the three coverage groups, the following additional criteria apply:

Coverage Group	Additional Criteria
Basic Insurance Group	<p>The individual must be between the ages of 18 and 64. Further, he or she must be engaged in substantial and reasonable work, as defined by:</p> <ul style="list-style-type: none"> • receiving cash remuneration and pay stubs; or • if self-employed, making regular FICA payments ; or • out of work through no fault of his/her own (e.g. by reason of a temporary health problem or involuntary termination), in which case coverage extends for up to one year from the date of loss of employment.²²
Medically Improved Group	<p>The individual must be between the ages of 18 and 64. Further, he or she must meet all of the criteria for coverage under the Basic Insurance Group, have lost eligibility because of a medical improvement that was determined at the time of a regularly scheduled continuing disability review²³; but continue to have a severe, medically determinable impairment.²⁴ For this group, substantial and reasonable work effort is defined as earning a monthly wage greater than or equal to forty (40) times the federal minimum hourly wage [in 2010, the minimum federal hourly wage = \$7.25]. Unlike individuals covered by the Basic Insurance Group, a Medically Improved Group participant must continue to be employed to receive coverage.²⁵</p>
Balanced Budget Act Group	<p>The individual must be age 65 or older. Further, he or she must meet all of the criteria for coverage under the Basic Insurance Group, and must have a medically certified disability or blindness.²⁶</p>

²⁰ U.P.M. § 2540.85 A.3.b.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.

²¹ C.G.S.A. § 17b-597(b)(7); U.P.M. § 2540.85 A.4.a.; U.P.M. § 2540.85 B.2.; U.P.M. § 2540.85 C.1.

²² U.P.M. § 2540.85 A.1.

²³ U.P.M. § 2540.85 B.1.

²⁴ U.P.M. § 2540.85 B.3.a.

²⁵ U.P.M. § 2540.85 B.3.b.

²⁶ U.P.M. § 2540.85 C.

Decisional schema for matching clients with Connecticut's Medicaid waivers and other sources of support

The trend nationally is to move slowly but inexorably toward a less compartmentalized system of Medicaid waiver funding for home and community-based care. This is ultimately expected to result in coverage that is less specific to age or diagnosis, and instead focused on more universal criteria.

As Connecticut's current system remains reliant on each eligibility criteria, it may benefit the practitioner to employ a decisional schema to screen and match clients within the confines of existing approved waivers and other sources of support. There are two elements to this exercise:

- Does the applicant fit the eligibility criteria?
- Will the applicable program meet the applicant's needs?

Decisional schema: age. Historically, Connecticut's Medicaid waiver options required specific adherence to age criteria. Certain programs were limited to individuals age 18 to 64; others served only older adults. While the Connecticut Home Care Program for Elders retains a minimum age threshold (age 65), in recent sessions the Connecticut legislature has liberalized age limits for the Acquired Brain Injury (ABI), the Personal Care Assistant (PCA), and Medicaid for Employed Disabled by removing the upper age limit of 64. As a result, each of these waivers now serves individuals age 18 and older.

Decisional schema: citizenship. All of Connecticut's Medicaid waiver options require that an applicant be either a citizen or an eligible non-citizen.²⁷

Citizens are defined as:

- 1) an individual born in the continental United States, Alaska or Hawaii;
- 2) an individual born in an outlying United States territory including Guam, the Virgin Islands, or Puerto Rico;
- 3) an individual treated for administrative purposes as a citizen by the Immigration and Naturalization Service (INS), including, but not limited to, those born in American Samoa or the Northern Mariana Islands;
- 4) a naturalized citizen;
- 5) a child under the age of 18 whose parents are citizens or who have been naturalized; or
- 6) an individual who meets specific INS conditions for citizenship, including, but not limited to, an individual born in a foreign country with at least one parent who is a U.S. citizen, a foreign-born spouse of a citizen or a foreign-born child who has been adopted by a citizen.

Eligible non-citizens are defined as individuals who are:

- 1) lawfully admitted to the U.S. for permanent residence as an immigrant; or
- 2) permanently residing in the U.S. under color of law (PRUCOL), as determined by the INS, including, but not limited to:
 - a. non-citizens who entered prior to January 1, 1972 who have resided in the U.S. continuously since then;
 - b. non-citizens who have been granted political asylum by the U.S. Attorney General;
 - c. refugees;
 - d. parolees admitted at the discretion of the U.S. Attorney General for a definite period of time;
 - e. non-citizens residing in the U.S. pursuant to an indefinite stay of deportation;
 - f. non-citizens resident in the U.S. pursuant to an indefinite voluntary departure;

²⁷ U.P.M. § 3005.05

- g. non-citizens on whose behalf an immediate relative petition has been approved whose departure the INS does not intend to enforce;
 - h. non-citizens who have filed applications for adjustment of status whose departure the INS does not intend to enforce;
 - i. non-citizens who have been granted a stay of deportation by court order, statute or regulation, or by determination of the INS, whose departure the INS does not intend to enforce;
 - j. non-citizens granted voluntary departure whose departure the INS does not intend to enforce;
 - k. non-citizens granted deferred action status;
 - l. non-citizens residing in the U.S. under orders of supervision;
 - m. non-citizens granted suspension of deportation whose departure the INS does not intend to enforce;
 - n. non-citizens whose deportation has been withheld;
 - o. any other non-citizens living in the U.S. with the knowledge and permission of the INS whose departure the INS does not intend to enforce.
- 3) classified by the INS as a newly legalized non-citizen; or
- 4) a North American Indian born in Canada who has maintained residence in the U.S. since entry and is at least one-half American Indian.

◆ **Practitioners take note:** a non-citizen who does not fall into one of the above categories may qualify for Medicaid benefits if she/he has an emergency medical condition.

Decisional schema: residency. Connecticut residency is also an eligibility requirement of each of the waivers.²⁸ There is no durational requirement, but an applicant must “intend to remain”. This is satisfied where an individual 1) lives in the state not for a temporary purpose; and 2) indicates an intent to remain either permanently or indefinitely within the foreseeable future.

Decisional schema: income. To participate in a waiver, an applicant may have gross monthly income of no more than 300% of the Supplemental Security Income benefit. This amount is updated annually each January 1. In 2010, the monthly income limit is \$2,022. Income includes wages, pensions, Social Security benefits, Veterans’ benefits and Supplemental Security Income. Where an individual with a disability is over income, practitioners should consider use of a pooled trust.

Decisional schema: asset limit for an individual. The asset limit for an individual for the waivers is \$1,600. The protections and obligations of the Medicare Catastrophic Act Coverage Act of 1988 apply to the waivers.²⁹ Generally, assets are treated in the same manner as they would be with respect to an application for nursing home coverage. The applicant/recipient of HCBS services is referred to as the “institutionalized spouse” and his or her wife or husband is referred to as the “community spouse”.

Note that where a Connecticut Partnership-approved long-term care insurance policy has paid out benefits, assets equal to that figure may be excluded from the eligibility determination.

Several alternative sources of support are associated with more liberal asset guidelines. These include:

- the state-funded components of the Connecticut Home Care Program for Elders: the asset limit for an individual is 150% of the minimum Community Spouse Protected Amount (CSPA) (in 2010, \$32,868.00); the asset limit for a couple (one or both receiving services) is 200% of the minimum Community Spouse Protected Amount (CSPA) (in 2010, \$43,824.00);
- the Statewide Respite Program, which permits an individual to have up to \$109,000 in liquid assets; and
- the Veterans Administration Aid & Attendance Benefit, which permits an individual to have up to \$50,000 in assets, and a couple to have up to \$80,000 in assets.

²⁸ U.P.M. § 3010.05

²⁹ Pub. Law No. 100-360

Decisional schema: functional criteria. To qualify for the waivers and for certain state-funded supports, an individual must demonstrate not only that s/he meets financial eligibility criteria, but also that he or she has need for assistance. Different methods and descriptors are used to assess functional eligibility for services. Among these are:

- **specific diagnosis or condition**, examples of which include:
 - acquired brain injury (developmental or degenerative disorders do not apply) (ABI Waiver)
 - mental retardation as defined by statute or Prader-Willi Syndrome (DDS Waivers)
 - “severe disability” (Katie Beckett Waiver)
 - “chronic, severe, permanent disability” (those with mental illness, mental retardation, or dementia do not qualify on that basis) (PCA Waiver)
 - irreversible or deteriorating dementia (Statewide Respite Program)
- **“critical needs”** (CHCPE), which include bathing, dressing, toileting, transferring, eating/feeding, meal preparation, and medication administration;
- **“activities of daily living”** (PCA), which include bathing, dressing, eating, transferring, management of bowel and bladder; and
- **“level of care”** (DMR, Katie Beckett), which refers to the likelihood that the applicant is otherwise in need of care in nursing facility, chronic disease hospital or intermediate care facility.

Another important screening criteria is to assess the extent to which the level of care will adequately support the individual in the community.

Decisional schema: amount of coverage. The waivers cannot pay for 24-hour care. Each is associated with cost caps that reflect a certain percentage of what would otherwise be expended by Medicaid to support its participants in a nursing facility. In 2010, the monthly Medicaid nursing home reimbursement is \$5,598.00.

- ABI: up to 200% [\$11,196.00 per month]
- CHCPE Waiver: up to 100% [\$5,598.00 per month]
- CHCPE State-Funded: Level 1 up to 25%, Level 2 up to 50% [\$1,399.00 per month, \$2,799.00 per month]
- Katie Beckett: up to 100% [\$5,598.00 per month]
- PCA: percentage based on degree of impairment

The DDS waivers also impose cost caps on specific services such as specialized equipment, physical modifications to home. Further, the DDS Individual and Family Support Waiver permits expenditures of no more than \$50,000 per individual annually.

The VA Aid & Attendance benefit is calculated by deducting out-of-pocket medical expenses from income and then calculating the differential between that figure and the maximum income amount.

Generally, care provided under the waivers cannot replace care provided by family members.

Decisional schema: type of coverage. Each waiver specifies a list of covered services and generally cannot deviate from these to accommodate individual needs. The most limited waiver is PCA, which provides only personal care assistant services and emergency response systems; the most expansive, those associated with DDS.

Cost sharing. It is also critical to take note of any applicable cost sharing obligations that will be borne by recipient of service.

Under the waivers, a participant whose monthly income, adjusted for medical expenses (e.g. Medicare Part B premium of \$96.40 in 2010, Medigap premium), exceeds 200% of the Federal Poverty Level (FPL) (effective April 1, 2009, \$1,806), must pay “applied income” of the excess.

Further, “legally liable relatives” (spouses) may have an obligation to contribute toward the cost of care (the “Legally Liable Relative contribution”, LLR). This determination is made by the department that administers the involved waiver. Generally, an LLR contribution is determined by taking a percentage of the “community spouse’s” income that has been reduced by 1) an amount equal to 200% of the Federal Poverty Level (FPL)(effective April 1, 2009, \$1,806) and 2) the dollar value of any additional support (e.g. out-of-pocket costs of medical supplies, costs of special diet or transportation, home adaptation) that is provided by the community spouse to the applicant spouse. The resultant figure is compared with the community spouse’s monthly maintenance need allowance (MMNA). The minimum MMNA, effective July 1, 2009, is \$1,821.25. This amount is revised annually as of July 1. The required contribution is the amount by which the community spouse’s monthly income exceeds the MMNA, or the actual amount of the LLR, whichever is less.

Decisional schema: assignment/recovery. By applying for Medicaid benefits, an individual automatically assigns to the involved department any rights and claims to third-party reimbursement of services.³⁰ This includes claims against an insurer, a contract, other federal or state program and responsible third party. The department’s claim is the lesser of the amount of Medicaid benefits paid by the department or the amount owed under the right or claim.³¹

Regulations provide that recovery will be made in certain circumstances for individuals who were age 55 and older when they received home and community-based Medicaid services.³² Recovery from real or personal property is made only:

- after the death of the individual’s surviving spouse; and
- where the individual has no surviving child who is under the age of 21 or who is either blind or has a disability.³³

³⁰ U.P.M. § 7505.10 A; U.P.M. § 7520.10 A

³¹ U.P.M. § 7505.10 B

³² U.P.M. § 7525.10 A

³³ U.P.M. § 7525.10 B

Acquired Brain Injury Waiver

Waiver Information:

Waiver Type: 1915(c)
Enrollment Capacity: 369
Current Enrollment: 359
Year First Approved: 1997 (authorized in 1995 by C.G.S. Section 17b-260a)
Waitlist Status: waitlisted

Eligibility Criteria:

Age Range: 18 and older (2006 legislation removed upper age limit)

Functional status: must have acquired brain injury (developmental and degenerative disorders do not qualify) and meet the “level of care” requirement of otherwise needing care in a nursing facility, chronic disease hospital or ICF

Income limits effective January 1, 2010: **Asset limits effective January 1, 2010:**

Individual:	\$2,022 (300% SSI)	Individual:	\$1,600
Couple:	based on applicant’s income	Couple:	MCCA rules apply
Comments:	can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions	Exemptions:	MCCA rules apply (ex. primary residence, vehicle needed for employment or medical visits or modified for use of individual with disability)

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based		
Agency + Choice		
Self-Direct	X	Caregiver must be 18 or older, and may not be 1) spouse of client; 2) parent of client (if client is age 21 or younger); 3) the conservator of the client; or 4) related to a client’s conservator.
Other		

Covered Services: case management, personal care assistance, homemaker, chore services, companion, home-delivered meals, respite care, vocational supports, housing supports, home and/or vehicle modification, personal emergency response systems, transportation, supported employment, specialized medical equipment and supplies

Cost Caps/Cost Effectiveness Standards: Waiver pays up to 200% of average monthly Medicaid nursing facility cost (in 2010, \$11,196.00) depending on the level of institutional care the individual would otherwise require.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective April 1, 2010, 200% FPL = \$1,806 per month; amount is updated each April 1), adjusted for medical expenses; legally liable relative may have obligation to contribute.

To Apply: Download application from this link: <http://www.ct.gov/dss/lib/dss/pdfs/w1130ABIRquestForm.pdf>

CT Home Care Program for Elders Elder Waiver

Waiver Information:

Waiver Type: 1915(c)
Current Enrollment: 9,386
Year First Approved: 1987 (authorized by C.G.S. Section 17b-342)
Waitlist Status: no wait list for waiver or state-funded personal care assistance pilot; wait list exists for state-funded pilot that funds ALSA services in private MRC's

Eligibility Criteria:

Age Range: 65 and older
Functional status: must be in need of nursing facility care and evidence at least three "critical needs" (critical needs include bathing, dressing, toileting, transferring, eating/feeding, meal preparation, and medication administration)

Income limits effective January 1, 2010:	Asset limits effective January 1, 2010:
Individual: \$2,022 per month (300% SSI)	Individual: \$1,600
Couple: based on applicant's income	Couple: effective May, 2010, based on P.A. 10-73, \$111,160 (<u>maximum</u> CSPA of \$109,560 + applicant's \$1,600); MCCA rules apply
Comments: may use a pooled trust; VA "homebound" benefit to surviving spouses is excluded	Exemptions: MCCA rules apply

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Majority of clients receive services via agencies
Agency + Choice		
Self-Direct	X	Where client does not require care management
PCA	X	
Other	X	Services can also be provided to 1) residents of state-funded congregate housing; 2) residents of assisted living pilot projects; and 3) up to a statewide total of 75 residents of private managed residential communities who spend down to program limits and require assisted living services

Covered Services: adult day care, care management, chore, companion, home health aide, homemaker, home-delivered meals, laundry, mental health counseling, minor home modifications, respite, personal emergency response systems, skilled nursing visits, transportation and personal care assistants.

Cost Caps/Cost Effectiveness Standards: Waiver can pay no more than \$5,598.00 per month per individual (100% of the average monthly Medicaid cost). Within that cap, program can pay for no more than \$3,978.00 per month per individual for social services (all services other than skilled nursing visits and home health aide – the "medical services" covered by Medicaid).

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective April 1, 2010, 200% FPL = \$1,806 per month; amount is updated each April 1), adjusted for medical expenses (e.g. Medicare Part B premium of \$96.40, medical insurance premiums); legally liable relative may have obligation to contribute.

To Apply: Contact DSS Alternate Care Unit at 860-424-4904 and choose option #4 for initial screening and referral to regional Access Agency.

CT Home Care Program for Elders State-Funded Levels 1 & 2

Waiver Information:

Waiver Type: N/A
Current Enrollment: 5,342
Year First Approved: authorized by C.G.S. Section 17b-342
Waitlist Status: no wait list for Levels 1 or 2 or state-funded personal care assistance pilot; wait list exists for state-funded pilot that funds ALSA services in private MRC's

Eligibility Criteria:

Age Range: 65 and older
Functional status: **Level 1:** must be at risk of hospitalization or short-term nursing facility placement and evidence one or two "critical needs"; **Level 2:** must be in need of short or long-term nursing facility care and evidence three or more "critical needs" (critical needs include bathing, dressing, toileting, transferring, eating/feeding, meal prep, and med. admin.).

Income limits effective January 1, 2010:

Individual: none
Couple: none
Comments:

Asset limits for Levels 1 & 2 effective January 1, 2010:

Individual: \$32,868
Couple: \$43,824
Exemptions: UPM 8040.35 follows MCCA rules but does not require spousal assessment.
Comments: Note that as of April 1, 2007, the asset limit for an individual increased to 150% and for a couple to 200% of the minimum CSPA.

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Majority of clients receive services via agencies
Agency + Choice		
Self-Direct	X	Available where a client does not require care management
PCA	X	
Other	X	Services can also be provided to 1) residents of state-funded congregate housing; 2) residents of assisted living pilot projects; and 3) up to a statewide total of 75 residents of private managed residential communities who spend down to program limits and who require assisted living services

Covered Services: adult day care, care management, chore, companion, home health aide, homemaker, home-delivered meals, laundry, mental health counseling, minor home modifications, respite, personal emergency response systems, skilled nursing visits, transportation and personal care assistants.

Cost Caps/Cost Effectiveness Standards: Level 1 can pay no more than \$1,399.00 per month per individual (25% of average monthly Medicaid cost). Level 2 can pay no more than \$2,799.00 per month per individual (50% of average).

Cost Sharing Requirements: Except for individuals who reside in an affordable assisted living demonstration project, each participant whose income is at or below 200% of the FPL (effective April 1, 2010, \$1,806 per month; amount is updated each April 1) must make a 15% (**effective July 1, 2010 this will be reduced to 6%**) co-payment and each participant whose income exceeds 200% of the FPL must make a 15% (**effective July 1, 2010 this will be reduced to 6%**) co-payment over and above his/her applied income obligations, if any; legally liable relative may have obligation to contribute.

To Apply: Contact DSS Alternate Care Unit at 860-424-4904 and choose option #4 for initial screening and referral to Access Agency.

**DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT HOME CARE PROGRAM FOR ELDER (CHCPE)
Effective January 1, 2010**

<u>Service Level</u>	<u>Description</u>	<u>Functional Need</u>	<u>Financial Eligibility</u>	<u>Care Plan Limits</u>	<u>Funding Source</u>
Category 1	Limited home care for moderately frail elders	At risk of hospitalization or short term nursing home placement (1 critical need deficit)	Individual Income = no limit Assets: Individual = \$32,868 Couple = \$43,824	<25% NH Cost (\$1,399.00/mo)	STATE
Category 2A	Intermediate home care for very frail elders with some assets above the Medicaid limits	In need of short or long term nursing home care	Individual Income = no limit Assets: Individual = \$32,868 Couple = \$43,824	<50% NH cost (\$2,799.00/mo)	STATE
Category 2B	Same as 2A	Same as 2A	Same as 2A	<80% NH cost (\$4,544.30/mo)	STATE
Category 3	Extensive home care for very frail elders who would otherwise be in a nursing home on Medicaid	In need of long term nursing home care (deficits in 3 critical need areas or ADLs)	Individual Income = \$2,022/month Assets: Individual = \$1,600 Couple = (both as clients) = \$3,200 (one as client) = \$111,160	100% NH Cost (\$5,598.00/mo) (Social Services cap = \$3,978.00)	MEDICAID (state/federal)

Notes:

1. Clients with incomes of \$1,806.00 (this changes April 1 of each year) and above are required to contribute to the cost of their care.
2. There is no income limit for the State-Funded levels. The Medicaid Waiver income limit equals 300% of SSI.
3. Services in all categories include the full range of home health and community-based services.
4. Care plan limits in all categories are based on the total cost of all state-administered services.
5. Some individuals may be functionally eligible for either category 1 or 2 services and financially eligible for Medicaid. In such cases, home health services will be covered by Medicaid and other community-based services covered through state funds.
6. **Effective May, 2010, based on Public Act 10-73, the \$111,160 asset limit reflects an assumption of maximum CSPA of \$109,560 plus applicant's \$1,600.**
7. Functional need is a clinical determination by the Department concerning the applicant's critical need for assistance in the following areas: bathing, dressing, toileting, transferring, eating/feeding, meal preparation and medication administration.
8. Care plan cost limits are for CHCPE fee-for-service only.

Applied Income Methodology:

Applied income is calculated in a two-step process: the first step is completed by the Access Agency, and the second by the Alternate Care Unit of DSS.

Access Agency Initial Calculation: The formula for the first calculation follows below. Please note that the figures that are listed are effective for the calendar year 2010 and:

- that the Personal Needs Allowance (PNA), which equals 200% of the Federal Poverty Level (FPL), updates each April 1; and
- the Medicare Part B premium figure updates each January 1.

Applied Income Initial Calculation:

gross monthly income	\$
less Personal Needs Allowance	\$ 1,806.00
less Medicare Part B monthly premium	\$ 96.40
approximate Applied Income amount	\$
less any other monthly medical expenses	\$
= adjusted approximate Applied Income	\$

Alternate Care Unit Calculation:

adjusted approximate Applied Income (from above)	\$
less Community Spousal Allowance (CSA) (if applicable)	\$
less Community Family Allowance (CFA) (if applicable)	\$
final Applied Income	\$

“Legally Liable” Relative Methodology:

“Legally liable” relatives (spouses) may have an obligation to contribute toward the cost of care. This determination is made by DSS. First, DSS calculates the “community spouse’s” LLR contribution by:

- 1) reducing the community spouse’s adjusted net income from the previous tax year by 200% of the Federal Poverty Level (effective April 1, 2010, \$1,806);
- 2) multiplying the result by .25; and
- 3) further reducing the resultant sum by the dollar value of any additional support (e.g. out-of-pocket costs of medical supplies, costs of special diet or transportation, home adaptation) that is provided by the community spouse to the applicant spouse.

DSS then compares the resultant figure with the community spouse’s monthly maintenance needs allowance (MMNA). The minimum MMNA effective July 1, 2009 is \$1,821.25. This amount is revised each July 1. The required contribution is amount by which the community spouse’s monthly income exceeds the MMNA, or the actual amount of the LLR, whichever is less.

DSS Information Bulletin on the Use of Pooled Trusts:

◆ **Practitioners take note:** A bulletin issued by the Centers for Medicare and Medicaid Services (CMS) dated May 12, 2008 stated that transfers to (d)(4)(C) trusts by individuals age 65 and older may be subject to penalty for transfer of assets for less than fair market value.

In response, the Connecticut Department of Social Services issued an Information Bulletin, No. 09-02, on April 15, 2009 indicating:

- that it had interpreted the CMS bulletin to read that “exemption from the transfer of assets rules applies only to disabled individuals **under the age of 65** who transfer assets into a pooled trust”;
- that individuals with disabilities may, however, continue to make transfers of assets (defined by federal law as including income or assets or both) into pooled trusts without penalty if:
 - such transfers are made exclusively for reasons other than qualifying for Medicaid;
 - the individual receives, or is expected to receive, fair market value (FMV) for the transfer;
 - the individual transfers an amount that is less than one day’s stay in a long-term care facility at private pay rates [through June 30, 2008, \$311.14; this changes each July 1]; or

DSS example:

Mr. Jones, age 65 and disabled, is applying for Medicaid under the CHC [sic: Connecticut Home Care Program for Elders] program. He meets all eligibility criteria, except that his gross income is \$2,200 (the income [in 2009] for CHC is currently \$2,022 per month). However, he assigns \$179 of his monthly income into a pooled trust. We now compute his income to be \$2,021.00, which would make him eligible to the program.

- the individual transfers an amount equal to or greater than one day’s stay in a long-term care facility at private pay rates [through June 30, 2008, \$311.14; this amount changes each July 1] and DSS approves a plan for use of the funds.

DSS example:

Mrs. Smith, age 65 and disabled, is applying for Medicaid under the CHC program. She meets all eligibility criteria, except that her gross income is \$2,500 per month. She assigns \$590 of her monthly income into a pooled trust. The trust pays out \$290 per month on her behalf for additional waiver-type services that are not covered under Medicare or Medicaid. Mrs. Smith expends this \$290 in its entirety every month. The remaining amount, \$300, is less than the one-day penalty amount of \$311.14 described above. Mrs. Smith is eligible for the CHC program.

◆ **Practitioners take note:** A DSS comment in the Information Bulletin underscores that it is permissible to transfer up to \$311.14 in income to a pooled trust, even if a lesser amount would qualify an individual for income eligibility. As DSS notes, this will potentially reduce the individual’s applied income obligation (cost-sharing requirements of participation in the CHCPE).

◆ **Practitioners take note:** Another DSS comment suggests that it is potentially permissible to transfer a larger amount into a pooled trust in support of a financial obligation such as property taxes if DSS approves a plan for its expenditure.

CHCPE ALSA Options:

I. Moderate and Low-Income ALSA Demonstration Project – C.G.S. Section 17b-347e

First authorized through Public Act 98-239, and then expanded to 300 units by Public Act 99-279, the Moderate and Low-Income ALSA Demonstration Project has underwritten construction of new, stand-alone Managed Residential Communities (MRC's) through which residents who 1) are age 65 and older; 2) are at risk of nursing home placement; and 3) meet CHCPE financial eligibility criteria receive ALSA services. This project is a partnership involving the Department of Social Services (DSS), the Department of Economic and Community Development (DECD) and the Connecticut Housing Finance Authority (CHFA). Please see table for a listing of the involved sites.

Site Name	Address	Telephone:	# of Units	ALSA
Herbert T. Clarke House	25 Risley Road Glastonbury	860-652-7623	45	Utopia
The Retreat	90 Retreat Avenue Hartford	860-560-2273	95	Community Outreach Program for Elders
Smithfield Gardens	32 Smith Street Seymour	203-888-4579	56	Utopia
Luther Ridge at Middletown	628 Congdon Street Middletown	860-347-7144	45	Employs own staff

II. ALSA in State-Funded Congregate Housing – C.G.S. Sections 8-119m & 17b-342(c)

In 2000, the Legislature extended the CHCPE to residents of state-funded congregate housing. This project also represents a partnership between DSS and DECD. The sites that are participating include: Augustana Homes Bishop Curtis (Bethel), Bacon Congregate (Hartford), D.J. Komanetsky Estates (Bristol), Ella B. Scantlebury Senior Residence (New Haven), Herbert T. Clark House (Glastonbury), Mount Carmel Congregate (Hamden), Luther Manor (Middletown), Mystic River Homes (Noank), Ludlow Commons (South Norwalk), Prospect Ridge (Ridgefield), Seeley Brown Village (Pomfret), Silverbrook Estates (Orange), Virginia Connolly Congregate (Simsbury), St. Jude Common (Norwich), The Marvin (Norwalk), and F.J. Pitkat Congregate Living (Rockville). Utopia is providing assisted living services at most of these sites.

III. State Assisted Living Demonstration in Federally Funded Elderly Housing – C.G.S. 8-206e(d)

Authorized by Public Act 00-2, then expanded in scope by Public Act 01-2, the Demonstration provides assisted living services to residents of certain designated buildings.

Site Name	Address	Telephone:	ALSA
Immanuel House	15 Woodland Street Hartford	(860) 525-4228	Utopia
Juniper Hill Village	1 Silo Circle Storrs/Mansfield	(860) 429-9933	Utopia
Tower One/Tower East	18 Tower Lane New Haven	(203) 772-1816	Utopia

IV. Private Assisted Living Pilot – C.G.S. Sections 17b-365 & 17b-366

This pilot is intended to assist a limited number of individuals who have spent down resources while living in private managed residential care (MRC's) with payment for assisted living services (this excludes payment for room & board). Initially authorized by Public Act 02-7 for 50 individuals eligible for the Medicaid Waiver, and 25 individuals eligible for the state-funded levels of the CHCPE, Public Act 04-258 made it available to 75 individuals without respect to level of care. There is currently a substantial wait list. DSS indicates that MRC participation is very changeable.

Department of Developmental Services Comprehensive Supports Waiver

Waiver Information:

Waiver Type: 1915(c) – for individuals who live in community living arrangements, community training homes, and managed residential communities

Enrollment Capacity: 6,700

Current Enrollment: approximately 4,450

Year First Approved: 2005

Waitlist Status: approximately 630 individuals are currently on the residential wait list (this includes applicants for both DDS waivers)

Eligibility Criteria:

Age Range: 18 and older

Functional status: Individual must have been assessed to have 1) mental retardation as defined in C.G.S. Section 1-1g; or 2) Prader-Willi Syndrome. Further, must have need for ICF/MR level of care and show need for at least one of the waiver services.

Income limits effective January 1, 2010: **Asset limits effective January 1, 2010:**

Individual:	\$2,022 (300% SSI)	Individual:	\$1,600
Couple:	based on applicant’s income	Couple:	
Comments:	can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions	Exemptions:	MCCA rules apply

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Services must be provided by “qualified vendors”
Agency + Choice	X	Agency offers the individual a choice of providers
Self-Direct	X	Individual hires and manages caregivers
Other		Waiver permits a blend of the above options

Covered Services: licensed residential services (community living arrangements, community training homes, assisted living), residential and family supports (supported living, personal support, adult companion, respite, personal emergency response systems, home and vehicle modifications), vocational and day services (supported employment, group day activities, individualized day activities), specialized and support services (behavior and nutritional consultation, specialized equipment and supplies, interpreters, transportation, family consultation and support)

Cost Caps/Cost Effectiveness Standards: Certain services come attached with specific, annual cost caps (e.g. specialized equipment has a cap of \$750 per year; physical modifications to home can cost no more than \$10,000 over three-year waiver term); cannot replace services already being provided by family members.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective April 1, 2010, 200% FPL = \$1,806 per month; amount is updated each April 1), adjusted for certain expenses.

To apply: Call DDS Eligibility Unit at 1-866-433-8192 to request eligibility determination documents.

Department of Developmental Services Individual and Family Support Waiver

Waiver Information:

Waiver Type: 1915(c) – for individuals who live in their own or family homes
Enrollment Capacity:
Current Enrollment: approximately 3,300
Year First Approved: 2005/three years
Waitlist Status: approximately 630 individuals are currently on the residential wait list (this includes applicants for both DDS waivers)

Eligibility Criteria:

Age Range: 18 and older
Functional status: Individual must have been assessed to have 1) mental retardation as defined in C.G.S. Section 1-1g; or 2) Prader-Willi Syndrome. Further, must have need for ICF/MR level of care and show need for at least one of the waiver services.

Income Limits effective January 1, 2010: **Asset Limits effective January 1, 2010:**

Individual:	\$2,022 (300% SSI)	Individual:	\$1,600
Couple:	based on applicant's income	Couple:	
Comments:	can use special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions	Exemptions:	MCCA rules apply

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	Services must be provided by "qualified vendors"
Agency + Choice	X	Agency offers the individual a choice of providers
Self-Direct	X	Individual hires and manages caregivers
Other		Waiver permits a blend of the above options

Covered Services: residential and family supports (supported living, personal support, adult companion, respite, personal emergency response systems, home and vehicle modifications), vocational and day services (supported employment, group day activities, individualized day activities), specialized and support services (behavior and nutritional consultation, specialized equipment and supplies, interpreters, transportation, family consultation and support)

Cost Caps/Cost Effectiveness Standards: Waiver generally will not spend more than \$50,000 per year per individual; certain services come attached with specific, annual cost caps (e.g. specialized equipment has a cap of \$750 per year; physical modifications to home can cost no more than \$10,000 over three-year waiver term); cannot replace services already being provided by family members.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective April 1, 2010, 200% FPL = \$1,806 per month; amount is updated each April 1), adjusted for certain expenses.

To Apply: Call DDS Eligibility Unit at 1-866-433-8192 to request eligibility determination documents.

Katie Beckett Waiver

Waiver Information:

Waiver Type: 1915(c)
Enrollment Capacity: 200 (current funding only supports 180 slots)
Current Enrollment: 180
Year First Approved: 1983 (authorized by C.G.S. Section 17b-283)
Waitlist Status: over 100 individuals are currently wait listed

Eligibility Criteria:

Age Range: no limit, but most participants are children

Functional status: severe disability

Income limits effective January 1, 2010: **Asset limits effective January 1, 2010:**

Individual: \$2,022 (300% SSI) **Individual:** \$1,600
Couple: based on applicant's income **Couple:** MCCA rules apply
Comments: can use a special needs trust **Exemptions:**

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct		
Other		

Covered Services: case management, home health services

Cost Caps/Cost Effectiveness Standards: Waiver care plan costs cannot exceed average monthly Medicaid nursing facility cost (in 2010, \$5,598 per month)

Cost Sharing Requirements: not applicable unless applicant's income exceeds 200% FPL (effective April 1, 2010, \$1,806)

To apply: Contact DSS for application materials.

Medicare Home Care Benefit

Eligibility Criteria:

Age Range: N/A

Functional status: Physician must sign a plan of care for an individual who 1) has need for at least one skilled service (intermittent skilled nursing care, physical or occupational therapy, speech/language therapy); and 2) is homebound (an individual is considered homebound if leaving home requires a “considerable and taxing effort”, and if the absences are infrequent or of relatively short duration)

Service Delivery Method(s)

METHOD		COMMENTS
Agency-Based	X	Agency must be Medicare certified
Agency + Choice		
Self-Direct		
Other		

Covered Services: Part-time or intermittent skilled nursing care by RN or LPN; part-time or intermittent home health aide services (personal care) only where also receiving nursing care; physical, speech/language or occupational therapy; medical social work; durable medical equipment.

Cost Caps/Hour Limits/Cost Effectiveness Standards: An individual can receive no more than 8 hours per day or 28 hours per week of nursing care and home health visits, combined, unless the doctor indicates that there is need for up to 35 hours and there is a “finite and predictable end” to the need for the additional hours.

Cost Sharing Requirements: N/A (except for DME)

Practice Tips: For consult on eligibility or denials, call the Center for Medicare Advocacy at 1-860-456-7790

Money Follows the Person Program

Waiver Information:

Waiver Type:	N/A – this is a federal grant of enhanced Medicaid match funds
Enrollment Capacity:	5,000 over three years
Current Enrollment:	approximately 60 individuals have been transitioned to date
Year First Approved:	2008 (authorized in 2006 by Section 44 of Public Act 06-188; maximum participation expanded from 100 to 700 by Section 5 of Public Act 07-2; maximum participation expanded from 700 to 5,000 by Public Act 08-180)
Waitlist Status:	N/A

Eligibility Criteria:

Age Range:	18 and older
Other criteria:	individual must have resided in a nursing home or other health care facility for six months or more, must wish to live in a community-based setting, and must meet functional/diagnostic criteria for the Medicaid waiver (e.g. ABI, CHCPE, DDS, PCA) that will provide services ongoing (e.g. an individual age 65 who meets financial eligibility criteria must evidence three “critical needs” for services)

Income limits effective January 1, 2010:

Individual:	\$2,022 (300% SSI)
Couple:	based on applicant’s income
Comments:	can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions

Asset limits effective January 1, 2010:

Individual:	\$1,600
Couple:	MCCA rules apply
Exemptions:	MCAA rules apply

Service Delivery Method(s) (X indicates available): service delivery method depends on the Medicaid waiver for which the individual qualifies

Covered Services: The list of covered services is governed by the Medicaid waiver for which the individual qualifies. MFP can assist individuals with certain costs of transitioning from a nursing facility to a community-based living situation, including rental assistance and home adaptation.

Cost Caps/Cost Effectiveness Standards: The maximum dollar amount of services per month is governed by the Medicaid waiver for which the individual qualifies.

Cost Sharing Requirements: Participants must pay applied income and any other cost sharing that is required by the Medicaid waiver through which they receive services.

To apply: Call 1-888-99-CTMFP (1-888-992-8637) to apply.

Personal Care Assistance Waiver

Waiver Information:

Waiver Type: 1915(c)
Enrollment Capacity: 748
Current Enrollment: 748
Year First Approved: 1996 (authorized in 1995 by C.G.S. Section 17b-605a)
Waitlist Status: waitlisted

Eligibility Criteria:

Age Range: 18 and older (2006 legislation removed upper age limit)
Functional status: chronic, severe, permanent disability that results in limitations in at least two activities of daily living (bathing, dressing, eating, transferring, management of bowel and bladder); those with mental illness, mental retardation or dementia do not qualify on that basis; DSS either accepts Social Security disability determination or performs analogous review of disability status; must wish to and be able to self-direct care

Income limits effective January 1, 2010:

Individual: \$2,022 (300% SSI)
Couple: based on applicant's income
Comments: can use a special needs trust; those eligible for Medicaid for Working Disabled not subject to income and asset restrictions

Asset limits effective January 1, 2010:

Individual: \$1,600
Couple: MCCA rules apply
Exemptions: MCCA rules apply (ex. primary residence, vehicle needed for employment or medical visits or modified for use of individual with disability)

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based		
Agency + Choice		
Self-Direct	X	PCA must be 18 or older, and may not be either 1) the spouse of the client; 2) the conservator of the client; or 3) related to the conservator.
Other		

Covered Services: Personal care assistance (bathing, dressing, companion)

Cost Caps/Cost Effectiveness Standards: Waiver pays up to a percentage of the average monthly Medicaid nursing facility cost (in 2010, \$5,598), depending on level of ADL impairment: 1) 60% of cost for those with at least 2 ADL impairments; 2) 80% of cost for those with 3 or 4 ADL impairments; 3) 100% of cost for those with impairments in all ADL areas. Average monthly care plan cost per individual in 2005 was \$1,735. Currently cannot hire PCA for more than 25.75 hours per week.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective April 1, 2010, 200% FPL = \$1,806 per month; amount is updated each April 1), adjusted for medical expenses; legally liable relative may have obligation to contribute

To apply: Download application from this link: <http://www.ct.gov/dss/lib/dss/pdfs/W-982.pdf>

Kate McEvoy for the Agency on Aging of South Central Connecticut

June, 2010

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Statewide Respite Program

Eligibility Criteria:

Age Range: N/A

Functional status: diagnosed with an irreversible and deteriorating dementia (dementias may include, but are not limited to: Alzheimer's Disease, multi-infarct dementia, Parkinson's Disease with dementia, Lewy Body dementia, Huntington's Disease, normal pressure hydrocephalus and Pick's Disease)

Waitlist Status: program was re-opened to new applicants on May 1, 2010

Annual Income Limits effective July 1, 2009:

Individual: \$41,000
Couple: based on applicant's income

Asset Limits effective July 1, 2009:

Individual: \$109,000 (liquid assets)
Exemptions: home

Please note: Individuals who are eligible for the Connecticut Home Care Program for Elders are not eligible for services under this program. 2007 legislation removed the prior restriction on serving Medicaid-eligible individuals under the age of 65.

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct		
Other		

Covered Services: adult day care, home health aide support, homemaker, companion, skilled nursing visits and/or short-term stays in a nursing or assisted living facility

Cost Caps/Cost Effectiveness Standards: Total grant may not exceed \$7,500 per calendar year.

Cost Sharing Requirements: Eligible individuals must pay a 20% co-payment of the cost of each service received under the program. Where a hardship can be demonstrated, this co-pay can be waived.

To apply: Contact the Area Agencies on Aging at 1-800-994-9422 for application materials. This number automatically directs the caller to the AAA in greatest geographic proximity. AAA staff review and approve applications, and conduct in-home visits to assess the needs of both the caregiver and care recipient.

Practice Tip: Advocates should also explore whether clients are eligible for the \$500 per family annual benefit from the Alzheimer's Association Connecticut Chapter's Respite Fund. The fund, originally established by a \$50,000 bequest, makes grants for purchase of respite services including adult day programs, home health aides, homemaker/companion, skilled nursing care or short-term nursing home care. There is no age limit with respect to the diseased person or caregiver. Applications are available by calling 1-800-356-5502. A doctor's certificate and medical release are required.

Veterans Administration Aid & Attendance Benefit

Eligibility Criteria:

Age Range: N/A

Functional status: a veteran or the surviving spouse of a veteran who meets certain service requirements and 1) is determined by a physician to need “aid and attendance” with activities of daily living (eating, dressing, toileting); 2) is blind; or 3) is, by reason of having a physical or mental disability, a resident of a nursing facility

Income Limits effective January 1, 2010:

Asset Limits effective January 1, 2010:

Individual veteran: \$1,644 per month

Individual: \$50,000

Surviving spouse: \$1,056 per month

Couple: \$80,000

Couple: \$1,949 per month

Exemptions: home

Comments: benefit is determined by deducting out-of-pocket medical expenses from income and then calculating the difference between that figure and the maximum income amount

VA does not review or penalize on basis of transfers of assets

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct		
Other		

Covered Services: Individuals can use benefit to pay for home care as well as assisted living services in a managed residential community.

Cost Caps/Cost Effectiveness Standards: Capped by amount of benefit; must prove expenditures at each annual re-evaluation.

Cost Sharing Requirements: N/A

Practice Tip: Contact the CT Department of Veteran’s Affairs at 860-594-6604 with questions.

WISE program (*Working for Integration, Support and Empowerment*)

Waiver Information:

Waiver Type: 1915(c)
Year First Approved: 2009
Waitlist Status: no wait list

Eligibility Criteria:

Age Range: 22 and older
Functional status: individual must require nursing home level of care and:
 1) reside in a nursing home;
 2) participate in Money Follows the Person; or
 3) have had:
 a) two or more inpatient psychiatric hospitalizations within two years prior to applying;
 b) a single inpatient psychiatric hospitalization of 30 or more days within two years prior to applying; or
 c) three crisis episodes within the year prior to applying; and
 4) must meet two of these additional criteria:
 a) require medication;
 b) be unable to work full-time;
 c) require supervision and support;
 d) be homeless or at risk of homelessness;
 e) have had or be likely to have an acute episode;
 5) must not currently require inpatient care; and
 6) must need one-on-one psychiatric rehabilitation and support coordination.

Income limits effective January 1, 2010:	Asset limits effective January 1, 2010:
Individual: \$2,022 (300% SSI)	Individual: \$1,600
Couple: based on applicant's income	Couple: MCCA rules apply
Comments: those eligible for Medicaid for Working Disabled subject to different eligibility rules	Exemptions: MCCA rules apply

Service Delivery Method(s) (X indicates available):

METHOD		COMMENTS
Agency-Based	X	
Agency + Choice		
Self-Direct	X	

Covered Services: assertive community treatment (ACT), community support program (CSP), peer support, recovery assistant, short-term crisis stabilization, supported employment, transitional case management, non-medical transportation, specialized medical equipment, and home accessibility adaptations

Cost Caps/Cost Effectiveness Standards: Waiver uses an aggregated cap analysis that requires that the total of each client's annual service package must be no greater than the amount that the State would otherwise spend on nursing home care.

Cost Sharing Requirements: Participants must pay applied income over 200% FPL (effective April 1, 2010, 200% FPL = \$1,806 per month; amount is updated each April 1), adjusted for medical expenses; legally liable relative may have obligation to contribute.

To Apply: Call DMHAS at 1-866-548-0265.

Links to Brochures and Applications:

Acquired Brain Injury Waiver

Brochure

http://www.ct.gov/dss/lib/dss/pdfs/abi_brochure.pdf

Application

<http://www.ct.gov/dss/lib/dss/pdfs/w1130ABIRequestForm.pdf>

Connecticut Home Care Program for Elders:

Brochure

http://www.ct.gov/dss/LIB/dss/pdfs/chcpe_052002.pdf

Application

<http://www.ct.gov/dss/LIB/dss/pdfs/w-1487.pdf>

DDS Waivers:

Fact Sheet

<http://www.ct.gov/dds/cwp/view.asp?a=2050&q=382310>

Guidebook for Consumers and Families

http://www.ct.gov/dds/lib/dds/waiver/hcbs_guidebook.pdf

Medicaid for the Employed Disabled

Brochure

<http://www.ct.gov/dss/lib/dss/pdfs/whatismedicaidfortheemployeddisabled.pdf>

Medicare Home Health Benefit

Summary by the Center for Medicare Advocacy, Inc.

http://www.medicareadvocacy.org/FAQ_HomeHealth.htm

Personal Care Assistant Waiver:

Brochure

<http://www.ct.gov/dss/lib/dss/pdfs/pcapam06.pdf>

Application

<http://www.ct.gov/dss/lib/dss/pdfs/W-982.pdf>

Statewide Respite Program:

Brochure

<http://www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313026>

Veterans Administration Aid & Attendance Benefit

Summary of Eligibility Requirements and Application Process

<http://www.veteranaid.org/apply.php>

DMHAS WISE Program:

<http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=425724>