

PUBLIC BENEFITS AND PROGRAMS*
that help elders and people with disabilities
stay in the community

current (hopefully) to 3/15/2018

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1. Introduction.

This outline addresses coverage for individuals in the community. While the rules that pertain to nursing home expenses have not changed significantly in 20+ years, there are many and varied rules for those in the community.

These programs may have their own rules when it comes to inheritance or other new sources of income, and when it comes to recovery from the estates of recipients at death. Other materials discuss in detail the "estate recovery" rules for the programs. Suffice to say that IT IS COMPLICATED. When advising clients whether or not to seek benefits, the practitioner should be sure to alert the client about the possibility of estate recovery. When advising clients whether or not to establish a "special needs trust," the practitioner must know whether or not the trust is actually *needed* in order to retain benefits, and should know whether or not the client's estate would escape recovery if no trust were in place.

These materials may become out-dated just as soon as they are written! Benefit rules change constantly, and unfortunately, it can be difficult or impossible to track down the details online. The State of CT DSS website has recently been changed, moving towards a consumer-oriented, mobile-friendly approach where the rules of the game are not spelled out and the consumer is invited to use online questionnaires to determine eligibility. The author will try to keep revising these materials and posting them on her webpage, <http://www.sharinglaw.net/elder/lawlinks.htm> when possible.

*IMPORTANT NOTE (3/2/18):

Significant portions of these materials are derived from materials created by Kate McEvoy, Esq. (now employed by the CT Department of Social Services) and included with much more comprehensive discussion, references and analysis by Attorney McEvoy in *A Practical Guide to Issues in Connecticut Elder Law* (CBA Elder Law Section, 2012). Any inaccuracies should be attributed to Lisa Davis, and any credit should redound to Kate McEvoy for having assembled this information in the first place. (The sections on AABD and the Medicare Savings Plans are strictly the work of Lisa Nachmias Davis, but the AABD article is also derived from materials published in *A Practical Guide*.) Both Kate McEvoy and Lisa Davis have published works in the field, McEvoy, *CT Elder Law* (West, updated annually, which should be considered the authoritative work on these programs) and Fleming & Davis, *Elder Law Answer Book* (Aspen, updated annually). Portions are also reprinted from the DSS website. Otherwise, copyright Lisa Nachmias Davis.

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Traditional Medicaid ("Husky C") (doctors, hospitals, dental, etc. -- see list)

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)

Traditional Medicaid has a \$1,600 asset limit for counted assets for individuals (\$2,400 for a couple living together), and income limits, but does not carry a penalty of ineligibility for transfers of assets. That is, a person who has Husky C because he/she also resides in a nursing home and meets the criteria for Medicaid nursing home coverage, who made a disqualifying transfer of assets, would not experience a penalty period for Husky C coverage of medical expenses even though he/she would experience the penalty of ineligibility for the nursing home care. For someone in the community, there would be no penalty, period.

Medicaid is available to those who are "categorically needy" (income less than a cap) or "medically needy," explained below. Because "medically needy" eligibility is available, for Husky C, "lump sums" are considered income for a six month period even if given away or spent or converted to assets in the first month.

Note that income is "deemed" to spouses living together. That is, for Traditional Medicaid, the income of both counts.

Recertification: for those who are "categorically needy" recertification is every twelve months; for those who are "medically needy" because income exceeds the categorically needy income limit, recertification is every six months.

Asset Rules. Chief among exempt assets are a home occupied by the individual or a spouse or disabled or minor child, and a vehicle needed to take the beneficiary to medical appointments, irrevocable funeral contract, burial plot or trust, term life insurance, assets in a 42 USC 1396p(d)(4) special needs trust. Counted assets cannot exceed \$1,600 for an individual, \$2,400 for a couple, except that if a person with a community spouse is on Husky C, asset rules are controlled by MCCA's spousal impoverishment rules.

Categorically Needy. Individuals who are "categorically needy" receive Medicaid by reason of poverty and age or disability. Categorically needy individuals must be age 65 or older or must have a disability (or blindness) 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." [42 U.S.C. sec. 416(i).] The first \$65 (\$85 for blind persons) of earned income, and half of any additional earned income, is disregarded. In addition, unearned income is disregarded in varying amounts based on living arrangements. Income and asset limits are generally updated each January 1st; see www.ctelderlaw.com. Those in effect **1/1/18** for individuals living in the community are:

Region A (most of Fairfield County)	Net Monthly Income Limit (after factoring in earned and unearned income disregards)	Asset Limit (excludes home, vehicle, irrev. funeral contract, burial trust, \$1,500 face value ins. etc.)
Individual	\$972.49 (633.49+339 disregard)	\$1,600.00 counted assets
Couple	\$ 1,483.09 (805.09 + 678 disregard)	\$2,400 counted assets

Regions B. and C (rest of the state)	Net Monthly Income Limit (after factoring in earned and unearned income disregards)	Asset Limit (excludes home, vehicle, irrev. funeral contract, burial trust, \$1500 face value ins., etc.)
Individual	\$862.38 (523.38 + 339)	\$1,600.00 counted assets
Couple	\$ 1,374.41 (696.41+678)	\$2,400 counted assets

(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 are the rest of the state.)

Categorically Needy (Institutional or Medicaid Waiver). Categorical eligibility for Husky C is also available to those in nursing homes or who qualify for the CHCPE Home Care services under the Medicaid waiver, that is, someone who would be eligible for Medicaid if residing in a long-term care facility, who qualifies for the services under a waiver, and who would otherwise require care in a long-term care facility. [UPM sec. 2540.92.A] The income limit for these institutional or waiver recipients is set as 300% of SSI (in 2018 for an individual, \$2,250 per month) and non-exempt assets of \$1,600 or less. In addition, different limits apply to working individuals with disabilities -- see "S 05," below. NOTE: *excess income, including "lump sum" income, "may be diverted into a "pooled trust account" or "d4a" trust if the person is under 65, to enable a person to qualify who would qualify but for the excess income; as a result the person becomes "categorically eligible."*

Medically Needy. Medicaid benefits are also available to those who are "aged, blind or disabled" and have income in excess of the categorical limits but who are "medically needy" because medical expenses generally exceed income. Income is averaged over six months and compared to the categorically needy income limit; the difference is considered the "spend down" amount, which may be thought of as a six-month deductible. Once out-of-pocket expenditures accrue to an amount in excess of six times the categorically needy income limit, the coverage kicks in.

Lump-Sum Income. Back payments of Social Security, wages, personal injury awards or settlements, and "windfalls" are considered "lump-sum" income in each six month period, rather than an asset, unless paid into a payback special needs trust or pooled trust described in 42 U.S.C. § 1936(p)(d)(4). Insurance proceeds for property damage are not considered lump-sum income. Inheritances are considered lump-sum income.

Other Income Rules. Receipt of cash for any reason is income. While the UPM does include payments of "in-kind support and maintenance" as income as described for SSI, this is not included for purposes of computing the "spenddown" to a medically needy income limit, and so, as a practical matter, in-kind income is not included. Gifts are included.

Applied Income. There is no "post-eligibility" requirement of contribution to the cost of traditional Medicaid benefits in the community. Either a person is categorically eligible (income under the cap) or medically needy (required to spend down excess income on costs of care in every six-month period). If, however, the person loses the minimal coverage for nursing home stays under traditional Medicaid and will be switched to the coverage group for long-term care, he or she will be required to contribute to the costs of care under the rules for LTCSS Medicaid.

Nursing Home Coverage - MCCA Rules. This outline does not deal with the rules that apply for nursing home coverage when one spouse is in the community; however, the treatment is similar to the treatment for the Medicaid waiver.

Estate Recovery. Under federal law, **there is no recovery *during lifetime* for Medicaid benefits properly paid.** Recovery of improperly paid benefits requires a court judgment. However, in Connecticut there is recovery from the probate estate for benefits received at age 55 and older and all benefits paid at any age for “institutional” (including waiver services) care. There is also recovery from annuities purchased by the beneficiary, either under state law or pursuant to rules required for annuities, and from the decedent's proportionate "share" of a jointly held bank account.

Effective Date. A person is eligible for coverage up to three months prior to application if (s)he was eligible during that time.

Medicaid for Low-Income Adults ("Husky D").

(Caution: legislative initiatives have been proposed that would include a work or community service requirement with some exceptions)

Type of benefit program: FEDERAL (state pays, but high federal reimbursement)

This program is part of the Medicaid expansion portion of "Obamacare." There is no asset test for Husky D and thus no transfer penalties apply to transfers of assets. Eligibility is limited to those age 19-64 who are not eligible under any other coverage group and who are not eligible for Medicare, whose "modified adjusted gross income" or MAGI (adjusted gross income, plus otherwise untaxed Social Security income, plus foreign income) does not exceed 133% FPL with an additional 5% added to incorporate the income disregards, so effectively, with income at 138% FPL for the number of persons in the individual's tax household as reported on the individual's end of year tax return. Married individuals are treated as a common household, even if filing separately unless living apart (e.g. one in a nursing home, one at home). (Note that *SSI is not included in MAGI*.) The limits effective 1/1/18 are:

Statewide For...	Monthly Income Limit 138% FPL	Asset Limit
An individual without minor children	\$1,396 / monthly (comes to \$16,753/yr)	No Limit
A couple without minor children	\$1,893 monthly (comes to \$22,715/yr)	No Limit

(allowable income will increase depending on household size.) (see huskyhealthct.com)

Estate Recovery. Connecticut has opted to have *no* recovery during lifetime *or at death* for Husky D benefits paid on or after 1/1/14 *other than for institutional care*. Different results may apply for those living in other states that have adopted Medicaid expansion. For benefits paid prior to 1/1/14, there is recovery at death for benefits paid to persons age 55+ and for benefits for "institutional" care. Income limits were much lower prior to 1/1/14 but at that time there was a "medically needy" basis for eligibility that is no longer the case.

Applied Income / Contribution. There is no copay, spenddown, or other income contribution for Husky D benefits in the community; however, *for nursing home residents where Husky D is covering the nursing home costs, all but the personal needs allowance of \$60 must be contributed to the cost of care.*

Income Rules Income is based on "MAGI" and so income such as gifts does not count. There is no medically needy component to Husky D on/after 1/1/14, and so lump-sum income is either going to count – if included in MAGI—or not – if it doesn't, such as a lump sum back SSI benefits. By contrast, in-kind distributions from a trust that "carry out" taxable income to a trust beneficiary, would be counted as income to the extent included in the recipient's MAGI. "MAGI" is defined in USC 36B(d)(2)(B) -- adjusted gross income (USC 1001) increased by—(i) any amount excluded from gross income under section 911 [foreign-source income of those living abroad], (ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and (iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section

86 (d)) which is not included in gross income under section 86 for the taxable year. Gifts (§102), PI settlements (§104), discharge of indebtedness when the debtor is insolvent (§108) and SSI are also excluded. Alimony is included only if deductible to the paying spouse under §215.

Services. All the services provided under Husky C are available to those receiving Husky D, including drug coverage and dental coverage, but *in additional, nursing home care is fully covered. Waiver services are not, however, provided under Husky D.*

Effective Date. A person is eligible for coverage starting in the month in which application is made, assuming he or she was eligible that month. NOTE: eligibility is determined monthly and based on monthly income. In practice this means:

- 1) if typical/ provable / reportable income is within the annual limit, the person will be found eligible for HUSKY. Recertification may be automatic if income information is verified by the next year's income tax return.
- 2) if tax return is not an accurate reflection of CURRENT, MONTHLY income, applicant may prove otherwise and gain eligibility, despite tax returns showing higher income.
- 3) if in ONE MONTH income is received such as an IRA distribution, but the NEXT MONTH that income is not received, the person should only be ineligible in month of receipt and should regain eligibility the next month so practically speaking there should be no break
- 4) Access Health cannot backdate eligibility to the 3 months prior to application. Access Health will backdate to the first of the month of application assuming eligible that month. However, DSS can backdate eligibility to prior months if contacted.

How to Apply. Applicants apply through accesshealthct.gov. As noted, to have benefits backdated, must first have Access Health find eligibility and then contact DSS to get benefits backdated.

"S0-5" or Medicaid for Working Individuals with Disabilities a/k/a "MED-Connect."

[Conn. Gen. Stat. sec. 17b-597, UPM section 2540.85]

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)

Three groups: (1) Basic Group; (2) Medically Improved Group; (3) Balanced Budget Act Group (65+).

While other criteria apply, the core requirements are:

Disability

Basic Coverage Group: 18-64; found to meet SSA criteria for disability, which usually means having received SSI / SSDI although might have lost it by having too much income (although still unable to engage in "substantial gainful activity," the Social Security definition of disability.)

"Balanced Budget Act Group": 18+ (no age cap), same rules as "Basic" Group, except there is no requirement for receiving SSI/SSDI but only having a "medically certified disability or blindness"

Medically Improved Group" 18-64; someone who WAS covered under Basic Coverage Group but lost eligibility under Basic Coverage Group because of a medical improvement that was determined at the time of a disability review, but person continues to have a severe, medically determinable impairment and engages in a substantial and reasonable work effort, defined as earning a monthly wage greater than or equal to forty times the federal minimum hourly wage.

Working: EITHER paystub, OR self-employment of at least enough to require payment of self-employment tax (\$400), and to have actually paid in to the system -- "established an account" with Social Security. For Medically Improved Group, the "monthly wage of 40 x federal minimum hourly wage."

Note: work in a "sheltered workshop" does not qualify (Not in UPM but per Comptroller Opinion 94-9a (1994))

Note: EXCEPT FOR those eligible under Medically Improved Group: eligibility extends up to 1 year from loss of employment if unemployed through no fault of his/her own, such as temporary health problem, involuntary termination.

Financial Eligibility:

Gross income no more than \$75,000/year (\$6,250/mo) [**UPM § 2540.85**]

Net income of \$3,082.50 / month or less (computed by deducting \$20 + \$65 of earnings + income needed for employment expenses + half of remaining earnings.) SPOUSE'S INCOME IS NOT DEEMED TO THE APPLICANT for eligibility purposes. **UPM § 5020.75.A.1.a**

Assets no more than \$10,000 (or \$15,000 if married/living together). Retirement accounts and accounts to pay for employment expenses are excluded PERMANENTLY. **UPM § 2540.85.A.3.c.** Also "PASS" accounts.

(SO-5 Continued)

Applied Income / Contribution or "Premium":

Participants pay as premium an applied income: 10% of income in excess of 200% of Federal Poverty Level (eff 3/1/18, \$24,280/year or \$2,023/mo). For purposes of computing the premium, the spouse's income does count. UPM § 2540.85

Benefits: Basic coverage (Husky C, D), not waivers.

Effective Date. A person is eligible for coverage up to three months prior to application if (s)he was eligible during that time; however, application has to be made when a person is actually working. If the person was working, stops working temporarily and applies on the basis that he or she would still have been covered had he or she been approved for SO-5 when he or she was previously working, the application will be denied.

MO-3 (Breast / Cervical Cancer) - UPM § 2540.74

Income: DSS website says: under 250% of poverty although § 2540.74 says NO income limit.

No asset limit. UPM 4005.10 A.6

No creditable insurance coverage, not qualified under another category.

Under 65

"found to need treatment for breast or cervical cancer" -- and receive treatment.

Referred by health care institution -- must have been screened for breast and cervical cancer under the Breast and Cervical Cancer Early Detection Program

Husky A / Husky B

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)

HUSKY A -- for lower-income children and caregivers of children who are eligible for Husky A. www.huskyhealthct.com states: "Connecticut children and their parents or a relative caregiver; and pregnant women may be eligible for HUSKY A (also known as Medicaid), depending on family income. (**SEE STATE CHART IN APPENDIX**). This may cover grandparents or other individuals.

HUSKY B: Uninsured children under age 19 in higher-income households may be eligible for HUSKY B (also known as the Children's Health Insurance Program).

Note: for those caregiver/parents receiving Husky A who have increased income and so no longer qualify for Husky A, they are continued on Husky B (as an "FO3 or FO4" coverage group) until January 1st of the following year.

Financial Eligibility: Charts for eligibility criteria can be located at these links, and are attached. For example, for a family of three with combined income of \$41,04, parents AND children qualify for benefits with no copays. For a family of three with combined income up to \$51,867, the children under 19 will be covered, but there will be some copays. This benefit is through CHIP (Children's Health Insurance Program) and is not Medicaid.

<http://www.ct.gov/hh/lib/hh/pdf/HUSKYMonthlyIncomeChart.pdf>

<http://www.ct.gov/hh/lib/hh/pdf/HUSKYAnnualIncomeChart.pdf>

Income: The state uses "MAGI" to compute income. There is no asset test.

Covered Services (Husky A, C, D, S 05)

The HUSKY Health program offers a comprehensive health care benefit package. Basic benefits for HUSKY C and D members include:

- Preventive Care
- Doctor Visits
- Women's Health Care
- Family Planning Services
- Maternity Care
- Hospital Stays
- Physical Therapy/Occupational Therapy/Speech Therapy
- Audiology Services
- Physical Rehabilitation
- Dialysis
- Durable Medical Equipment
- Hearing Aids
- Orthotic and Prosthetic Devices
- Home Health Care
- Hospice Services
- Ambulatory Surgery
- Hospital Outpatient Care
- Laboratory Tests
- X-rays and other Radiology Services
- Vision Care (1 pr basic glasses per year or a partial payment for progressives)
- Emergency Care
- Dental Services (through CT Dental Health Partnership) (preapprovals)
- Behavioral Health Services (through CT Behavioral Health Partnership)
- Pharmacy (medications)
- Non-emergency transportation to health care appointments
- Smoking cessation services: counseling and medications
- Early and Periodic Screening, Diagnosis & Treatment (also known as EPSDT): children under 21 can receive medically necessary services even if they are not covered benefits
- Autism Spectrum Disorder (ASD) evaluation and treatment services for Medicaid enrolled members (HUSKY A, C, or D) under the age of 21 for whom ASD services are medically necessary.

IMPORTANT: Community First Choice is an option that can be selected by any person receiving Medicaid under any coverage group, and who is able to manage his or her care. This included personal care assistance. The person who elects Community First Choice would be given a budget based on various categories of need. This budget could be used to hire caregivers; if caregivers work more than 25 hours per week, to pay for the workers' compensation insurance that will be required; to pay for training on how to manage payroll, etc. DSS uses a Universal Assessment Tool to develop a "budget" for needed services, with 1-8 levels of care.etc. . This topic is beyond the scope of my outline but is addressed in general in the Appendix, containing a powerpoint on CFC from 2017.

Money Follows the Person.

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)

This program provides additional federal funds as a "match" to those residing in nursing homes for a specified period of time who need financial assistance to be transitioned to live "in the community." MFP has its own "waiver slots" so eligibility for MFP guarantees access to other waiver services despite waiting lists.

Enrollment: Capacity was originally set in 2012 at 5,000 over three years. As of December, 2015, Medicaid.gov reported 3,177 participants in Connecticut, considered one of the states with the greatest participation. Funded through 2020 - no waiting list.

Eligibility Criteria:

Age:	18+
Functional	individual must have resided in a nursing home or other health care facility for 90+ days, must wish to live in a community-based setting, and must meet functional/diagnostic criteria for the Medicaid waiver that will provide services ongoing (e.g., ABI, CHCPE, DDS, PCA)
Income:	\$2,250 (300% SSI) (can use special needs trust to reduce)
Assets:	\$1,600 individual (couples can use MCCA rules)

Special Services: MFP may provide up to \$10,000 in pre-approved home adaptations using state-selected contractors; may also provide rental assistance. MFP recipient does not have to pay nursing home applied income in final month before discharge so funds are available to pay for pooled trust, rent, etc.

To Apply: Call 1-888-99-CTMFP (1-888-992-8637) or apply online at <https://ctmfp.com>
The application itself is a simple online "walk-through" form, but of course, the person must ALSO qualify for LTSS Medicaid, with its full 5 years of records.
Project director is Dawn Lambert 860-424-4897.

Personal Care Assistance Waiver (PCA).

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)
Regs. Conn. State Agencies Secs. 17b-605-1a et seq.

NOTE: PCA services are now available to anyone qualifying for Medicaid under any other Medicaid coverage group; the PCA waiver is now largely available only to those being discharged from a nursing home under MFP.

Enrollment: Waitlisted 2015. Priority for those leaving nursing homes on Money Follows the Person.
However: Personal Care assistance services are now part of the traditional Medicaid services package and can be accessed in the community by someone opting for "community first choice" who can become eligible for Medicaid under another coverage group, including, for instance, an unmarried person who becomes eligible for Husky C by diverting excess income to a pooled or d4A trust . See Appendix.

Eligibility:

Age: 18+ (those 65+ must participate through CHCPE)
Functional 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 determinations or performs its own parallel review; must with to be able to self-direct care either directly or through POA or other agent
Income: \$2,250 (300% SSI) (can use special needs trust to reduce)
Assets: \$1,600 individual (couples can use MCCA rules)

Service Delivery: PCA (personal care assistant) must be 18+, may not be spouse, conservator, or related to conservator.

Covered Services Personal care assistance (bathing, dressing, companion), independent support, ERS

Cap in services: Waiver pays up to a percentage of the average *net* monthly Medicaid nursing facility cost to the state (in 2018, \$5,894.00) depending on level of impairment: 60% for those with at least 2 ADLs; 80% for those with 3 or 4; 100% for those with impairments in all areas.

Limits If hire PCA for more than 25.75 hours per week must purchase workers' compensation insurance and "self-employ."

Applied Income: Income over 200% of poverty (eff 1/1/18 \$2,023) after deducting medical expenses; however, possible to avoid this if income over \$2,023 is placed in pooled trust.

ABI Cost Caps

ABI (Community) - MFP ABI will go with Facility Cost Cap (Needs clinical justification)

1. ABI 2 - Level 1 NF (\$8,841/mo) (150% NH rate)
 - 2 ADLs (due to physical and/or cognitive deficit)
 - Impaired Cognition (in that case ADLs can just mean need cueing/supervision)

2. ABI 2 - Level 2 ABI/NF (\$19,452.00/mo) (150% subacute rate)
 - Impaired behavior (require daily supervision) or cueing
 - Impaired cognition
 - Mental illness (pre-morbid)
 - And/or currently in ABI-specific facility
(known to DHMAS prior to injury; impaired behavior)

3. ABI 2 - Level 3 ICF/MR (\$21,150/mo) (150% ICF/MR rate)
 - 2 ADLs (due to physical deficits)
 - Age of injury before 22
 - Impaired cognition
 - Impaired behavior (require daily supervision) or cueing

4. ABI 2 - Level 4 CDH (\$49,890/mo) (150% \$33,260)
 - 2 ADLs (due to physical and/or cognition deficits)
 - Impaired Behavior
 - Impaired Cognition

3 ICF/MR (\$21,150/mo) (150% ICF/MR rate)

ABI/NF (\$19,452.00/mo) (150% subacute rate)

Impaired Cognition (in that case ADLs can just mean need cueing/supervision)

DDS Waivers PAID THROUGH MEDICAID

1. Comprehensive Supports
2. Individual and Family Supports
3. Employment and Day Supports
4. Early Childhood Autism Waiver
5. Autism Waiver

www.ct.gov/dds/lib/dds/mir/master_file_march_2015_mir.pdf

DDS Comprehensive Supports Waiver (replaces prior DMR services).

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)

NOTE: DMR SERVICES WERE STATE FUNDED UNTIL APPROX 2005

Eligibility:

Age:	18+
Functional	Individual must have been assessed to have (1) mental retardation as defined in CGS 1-1g (IQ under 70) or (2) Prader-Willi Syndrome. Must have need for intermediate care facility / MR level of care and show need for at least one of the services.
Income:	\$2,250 (300% SSDI) (can use special needs trust to reduce)
Assets:	\$1,600 individual (couples can use MCCA rules)

Service Delivery:

- * Agency-based (must be qualified vendor)
- * Agency offers individual a choice of providers
- * Self-Direct: individual hires/manages caregiver
- * Blend

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 consultants and support)

Cap in services: Depends on service. e.g., specialized equipment cannot exceed \$750/year; physical modifications to home more than \$10,000 per three-year waiver term, etc. Cannot replace services already being provided by family members.

Applied Income: Income over 200% of poverty (eff 1/1/8 \$2,023) after deducting medical expenses; however, possible to avoid this if income over \$2,023 is placed in pooled trust.

DDS Individual and Family Support Waiver (replaces prior DMR services)
and
DDS Employment and Day Supports Waiver.

Type of benefit program: FEDERAL (state pays, federal partial reimbursement) NOTE: DMR SERVICES WERE STATE FUNDED UNTIL APPROX 2005

Eligibility:

Age:	18+
Functional	Individual must have been assessed to have (1) mental retardation as defined in CGS 1-1g (IQ under 70) or (2) Prader-Willi Syndrome. Must have need for intermediate care facility / MR level o care and show need for at least one of the services.
Income:	\$2,205 (300% SSI) (can use special needs trust to reduce)
Assets:	\$1,600 individual (couples can use MCCA rules)

Service Delivery:

- * Agency-based (must be qualified vendor)
- * Agency offers individual a chose of providers
- * Self-Direct: individual hires/manages caregiver
- * Blend

Covered Services, Individual and Family: 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 consultants and support)

Covered Services, Employment and Day Supports: targets young adults; provides adult day health, community-based day support options, respite, supported employment, independent support broker, behavioral support, goods and services, individualized day support, interpreter, specialized medical equipment and supplies, transportation.

Cap in services, Individual and Family: Waiver will not spend more than \$50,000 per year per individual; certain services come with specific annual cost caps, for instance, specialized equipment cannot exceed \$750/year; physical modifications to home more than \$10,000 per three-year waiver term, etc. Cannot replace services already being provided by family members.

Applied Income: Income over 200% of poverty (eff. 3/1/18 \$2,023) after deducting medical expenses

DDS Autism Waiver.

Serves age 3+, IQ of greater than 70. However, currently underfunded - long waiting list.

Note that eff 10/2015 Medicaid covers Autism Spectrum Disorder (ASD) evaluation and treatment services for Medicaid enrolled members (HUSKY A, C, or D) under the age of 21 for whom ASD services are medically necessary, without qualification under a waiver.

Katie Beckett Medicaid Waiver (Children).

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)
Conn. Agencies Regs. Secs. 17b-283-1 to 17b-283-18

Enrollment:

Capacity: 300
Waitlist: Waitlisted in 2015, current status unknown

Eligibility:

Age: 21 or younger
Functional: Institutionalized or at risk of institutionalization; have physical disabilities and may have co-occurring developmental disabilities

Income limits effective January 1, 2018

Applicant income (300% SSI) \$2,250 - parental income ***not deemed*** for severely disabled child
Individual Assets: \$1,600 of counted assets, parental assets ***not deemed***
Couple: Can use same methodology as for long-term care

Service Delivery Methods:

* Agency-based

Covered Services: case management and home health services

Cost Caps/Cost Effectiveness Standards: Waiver plan costs cannot exceed average *net* monthly Medicaid facility cost (in 2018, \$5,894/month).

Cost-Sharing Requirements: participants must pay as applied income 200% of Federal Poverty Level (\$2,023 eff. 1/1/18), adjusted for medical expenses; legally liable relative may also have to contribute. Note: excess income may be diverted to pooled trust.

Information/Application: 1-800-445-5394, Option #3

WISE Program Medicaid Waiver (Mental Health)

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)

Waitlist: Only 25 slots; waitlisted.

Eligibility Criteria:

Age: 22+

Functional: Must be:

- Medicaid-eligible
 - diagnosis of serious mental illness
 - either currently residing in a nursing facility
OR
living in community with active psychiatric disorder and under consideration for placement in nursing facility
OR already discharged from nursing facility under money follows the person
 - have 2 or more serious life problems due to mental illness
 - not be in need of emergency psychiatric hospitalization
 - need rehabilitation and professional assistance in developing and implementing a plan for recovery
- Meet level of care criteria: need assistance with 3 or more critical needs OR two critical needs and four or more cognitive deficits

Income limits effective January 1, 2018

Applicant income (300% SSI)	\$2,250
Individual Assets:	\$1,600 of counted assets
Couple:	Can use same methodology as for long-term care

Service Delivery Methods:

- * Agency-based
- Self-Direct

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 plan uses aggregated cap that requires total of each annual package cannot be more than 125% of *net* average that State spends on nursing home care or \$7,368/month) (net average is 7,105.64-1,211.47 or 5,894)

Cost-Sharing Requirements: participants must pay as applied income 200% of Federal Poverty Level (\$2,023 eff. 1/1/18), adjusted for medical expenses; legally liable relative may also have to contribute. Note: excess income may be diverted to pooled trust.

Process: pre-screening; then Medicaid eligibility determination; then a DMHAS Community Support Clinician will schedule a face to face interview to continue Level of Care determination.

Medicare Savings Programs (part of Medicaid).

Type of benefit program: FEDERAL (state pays, federal partial reimbursement)

Eligibility: Assets. No Asset Test (CONNECTICUT -- not the same in other states), so no transfer of assets penalty. **WARNING, LEGISLATION BEING PROPOSED MAY INCLUDE ASSET LIMITS.**

Eligibility - Income. Income is income in month of receipt only, no "lump-sum income" rule -- so effectively receipt of a lump sum in one month will not result in loss of benefits. A pooled trust can be used to divert excess income in order to gain eligibility.

CONNECTICUT 2018 income limits, factoring in "disregarded" income amounts that are higher in Connecticut than elsewhere:

QMB - \$2,134.62 for a single person and \$2,855.53 for a couple (211% FPL)
SLMB - \$ 2,336.95 for a single person and \$3,126.20 for a couple (231% FPL)
ALMB - \$2,488.70 for a single person and \$3,329.20 for a couple (246% FPL)

Limits slated to take effect July 1, 2018 per PA 17-1, January 2018 Special Session (HB 7601):

QMB - \$ 1,011.67 for a single person and \$1,353.33 for a couple (100% FPL)
SLMB - \$ 1,214.00 for a single person and \$1,624.00 for a couple (120% FPL)
ALMB - \$ 1,365.75 for a single person and \$1,827.00 for a couple (135% FPL)

Nature of Benefit:

QMB = Qualified Medicare beneficiary,
SLMB = Special Low Income Medicare Beneficiary
ALMB = Additional Low-Income Medicare Beneficiary

All three programs pay Medicare Part A and B premiums, including premiums that have been increased due to delayed enrollment past the initial or special enrollment period deadlines. QMB *also* pays Medicare co-pays and deductibles on Medicare-covered services.

Confers AUTOMATIC eligibility for "extra help" under Medicare Part D, a/k/a low-income subsidy or "LIS" -- low co-pays, "benchmark" premium is paid, and no doughnut hole. (see summary of LIS attached.) If enrolled before July 1 in any year, eligible for LIS entire following year. So anyone enrolled by 7/1/18 will be eligible all 2019.

Doctors are not allowed to balance bill QMB beneficiaries.
However, doctors are not required to treat QMB participants, and some will refuse.

Estate Recovery: No estate recovery for benefits post 1/1/2010; for benefits paid in prior years, estate recovery if recipient was 55+ or if payments were for institutional care (e.g. copays for nursing home stays).

Effective Date of Coverage: month after application is received; there is no retroactivity.

Medicare Home Care Benefit.

Type of benefit program: 100% FEDERAL

Functional Eligibility:

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 (if leaving home requires a "considerable and taxing effort" and absences are infrequent or of reasonably short duration." Note that "skilled nursing care" is needed even if "plateaued" if it would prevent deterioration; a recent law suit requires Centers for Medicare to make sure this is understood. Physician or "non-physician practitioner" must conduct and document a face-to-face encounter with beneficiary not more than 90 days prior to or within 30 days of the start of the home health care.

For coverage under Medicare Part A, the individual must have previously had a 3-day hospital admission or Medicare-covered nursing home stay, and the care must begin within 14 days of discharge.

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.

Caps:

An individual can receive more than 8 hours per day or 28 hours per week of nursing care and home health visits combined unless doctor indicates need for up to 35 hours and there is a "finite and predictable end" to need for additional hours.

Delivery: Services must be provide by a Medicare-certified home health agency

CHCPE Home Care Program: State-Funded and Medicaid Waiver
Conn. Gen. Stat. sec. 17b-342; state-funded portion under 17b-342(i).

Type of benefit program:

Category 1 and 2 (state-funded): STATE. (UPM § 8040)

Category 3 (Medicaid waiver): FEDERAL (state pays, federal partial reimbursement)
UPM § 2540.92.

Category 4 (CHCPD): STATE ONLY

Category 5 (Medicaid) -- same as Category 1 (1-2 critical needs) but income cap of \$1,508.

See attached chart for eligibility criteria for each portion of CHCPE.

Functional Eligibility: "NFLOC" or nursing facility level of care required in most cases (for new enrollees).

For CHCPE: age 65+.

For CHCPD: disabled, under age 65, not eligible for Medicaid. Additional slots were recently added, in addition to the original 50 filled slots.

Service Delivery:

- * Agency-based (must be qualified vendor)
- * Agency offers individual a chose of providers
- * Self-Direct: individual hires/manages caregiver (PCA)
- * Blend

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. *IN ADDITION, assisted living pilot can pay for "assisted" add-on to fees at assisted living facilities; pilot has a 1-year waiting list but one can apply before having spent down.* Currently, to avoid the copay for state-funded home care for the pilot, a person can use a pooled trust, which can be important for assisted living residents due to high cost.

Cap in services: Depends on state or waiver program - see attached chart. Caps are for fee-for-service only.

Applied Income: Income over 200% of poverty (\$2,023) after deducting medical expenses; however, currently possible to avoid this if income over \$2,023 is placed in pooled trust. The \$2,023 is called "the home care PNA." CMS has told DSS that all income, even income in a pooled trust, counts when computing post-eligibility applied income, but as of this writing (3/2018) DSS still has a moratorium in place on implementing this rule. DSS anticipates a compromise where a \$728 utility allowance will be added to the PNA, increasing it to \$2,751.

Counted Income: Conn. Gen. Stat. 17b-342 states that the "aid & attendance" VA benefit does not count towards income. However, DSS interprets this to exempt only \$733, the

difference between the VA pension with aid and attendance and the VA pension without it. See page 25.

Copay: For state-funded, 9% of state cost. For waiver services: no copay but applied income.

Application process: Referrals are made first to DSS Alternate Care Unit (Alternate Care Unit at 860-424-4904). If not eligible for Medicaid waiver, at that point access referral is made to access agency which does the intake for the program. If the person may be eligible for the Medicaid waiver, he/she must apply for Medicaid eligibility but may be qualified for state-funded program in the meantime. The DSS application is filed in the same way as a nursing home Medicaid application but sent to the Hartford region. Legally liable relative may have obligation to contribute and may be asked to complete a form, but this is rare.

Retroactivity: currently there is no retroactive coverage; eligibility starts only when the application has been approved.

CHCPE Assisted Living Options:

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

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	Assisted living service agency
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 St. Middletown	860-347-7144	45	Employs own staff

II. ALSA in State-Funded Congregate Housing - C.G.S. §§ 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)

The Demonstration provides assisted living services to residents of designated buildings.

Site Name	Address	Phone	Service agency
Immanuel House	15 Woodland Street Hartford	(860) 525-4288	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. §§ 17b-365 & 17b-366

This pilot assists a maximum of 75 individuals who have spent down resources while living in private assisted living facilities with payment for assisted living services. The pilot does not cover payment for room & board). There is currently a substantial wait list, and facility participation varies. As of this writing, call Barbara Wilson at DSS (860-424-5814) for a list of participating facilities or to get on the waiting list. Facilities report that application within a year of likely eligibility will permit placement on a waiting list.

Applied Income issue: Alternate Care Unit *will* permit use of a pooled trust to shield income over \$2,023 from being paid as applied income, even for individuals who are qualifying for the pilot under the state-funded categories 1 or 2. Individuals in assisted living usually need all income (which typically is over \$2,023) to pay for the basic assisted living costs that the pilot project does not cover. If, however, DSS responds to the CMS requirements for post-eligibility applied income, individuals will only be able to keep \$2,751 plus whatever they may need to pay for medical expenses. DSS has advised the author that the expenses of residency in a private assisted living facility will not be considered medical expenses.

**DEPARTMENT OF SOCIAL SERVICES CONNECTICUT
HOME CARE PROGRAM FOR ELDERS* Effective
March 1, 2018**

<u>Service Level</u>	<u>Description</u>	<u>Functional Need</u>	<u>Financial Eligibility</u>	<u>Care Plan Limits</u>	<u>Funding Source</u>	<u>Intake Status</u>
Category 1 CHCPE	Limited home care for moderately frail elders 65+	At risk of hospitalization or short term nursing home placement (1 OR 2 critical needs deficit)	Individual Income = No Limit* Assets: Individual = \$37,080 Couple = \$49,440	<25% NH Cost (\$1,474/mo)	STATE	No new enrollment (except for those grandfathered in)
Category 2 CHCPE	Intermediate home care for very frail elders 65+ with some assets above the Medicaid limits	In need of short or long term nursing home care ("nursing facility level of care")	Individual Income = No Limit* Assets: Individual = \$37,080 Couple = \$49,440	<50% NH cost (\$2,947/mo) (NOTE: 9% co-pay)	STATE	OPEN
Category 3 CHCPE	Extensive home care for very frail elders 65+ who would otherwise be in a nursing home on Medicaid	In need of long term nursing home care ("nursing facility level of care" or "NF LOC")	Individual Income = \$2,205/Month* (or if more, diverted to pooled trust) Assets: Individual = \$1,600 Couple = (both as clients) = \$1,600 each (one as client) = \$26,320 (MCCA rules apply to possibly increase assets allowed**	a) 100% NH Cost (\$5,894/mo) b) 115% NH Cost (\$6,778/mo) c) 100% Subacute*** (\$12,968/mo) d) 115% Subacute*** (\$14,913.20/mo)	MEDICAID WAIVER (state/federal)	OPEN
Category 4 CHCPD (DISABLED, NOT ELDERLY)	Intermediate home care for individuals UNDER 65 with a degenerative neurological condition, <u>not eligible for Medicaid</u>	In need of short or long term nursing home care ("nursing facility level of care")	No income limit Asset: \$37,080/individual Couple: \$49,440	<50% NH cost (\$2,947/mo)	STATE	Wait-list, limited to 100 slots
Category 5	Same as #1; also active on Husky C; must be age 65 or older	At risk of hospitalization or short term nursing home placement (1-2 critical needs)	Individual income: \$1,518 Assets: \$1,600		50% federal reimbursement	OPEN

CT Home Care Plan for Elderly / Disabled - Notes:

1. Clients in the higher income range (\$2,023+) are required to contribute the excess as "applied income" to the cost of their care.
- *2. There is no income limit for the State Funded portion. The Medicaid Waiver income limit remains at 300% of SSI.
3. CHCPE Services available at all categories include the full range of home health and community based services.
*1915(i) State Plan Option has limited PCA services to 14 hours weekly and homemaking services are limited to 6 hours weekly.
4. Care plan limits at all categories are based on the total cost of all state-administered services.
5. 1915(i) State Plan option covers individuals on Medicaid but who qualify for category 1 services. CT will claim 50% reimbursement from the federal government for home and community based services not reimbursable under Medicaid.
6. Some individuals under category 2 may become financially eligible for the Medicaid Waiver. In these cases, the client must apply for Medicaid and cooperate with the application process.
- ** 7. Married couples who are over this asset limit for category 3 may be eligible based on the special spousal asset protection rule.
8. Functional need is a clinical determination by the Department about the applicant's critical need for assistance in the following areas / Activities of Daily Living (ADLs): Bathing, Dressing, Toileting, Transferring, Eating/Feeding. Needs factors: 1. Behavioral Need - requires daily supervision to prevent harm. 2. Medication supports - Requires assistance for administration of physician-ordered daily medications, includes supports beyond set-up.
9. "Nursing facility level of care" or NF LOC is defined as:
 1. Supervision or cueing for 3 or more ADLS + a needs factor
 2. Hands-on assistance with 3 or more ADLS
 3. Hands-on assistance with 2 or more ADLS + a needs factor
 4. A cognitive impairment which requires daily supervision to prevent harm.
- ***10. Subacute LOC is defined as:
 1. Participant requires comprehensive medical monitoring but does not require intensive diagnostic and/or invasive procedures
 2. Participant requires intense medical supervision and therapy such as nursing intervention intermittently throughout the day and/or the need for ancillary or technological services (such as laboratory, pharmacy, nutrition, diagnostic)
 3. Participant may require services such as brain injury rehabilitation, high intensity stroke or orthopedic programs, ventilator programs, complex wound care or specialized infusion therapy.
11. Care Plan limits are for CHCP fee for service only.
12. For contracted Access Agencies use only.

Veteran's Benefits (Aid & Attendance [A&A] enhancement to VA Pension)

Type of benefit program: FEDERAL

Functional Eligibility: a veteran or the surviving spouse of a deceased veteran who served during a period of war 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 [although for nursing home residents, the benefit is limited to a \$90 addition to the personal needs allowance].

Asset Limits: a "reasonable amount" which typically means \$50,000 for someone 80+, \$80,000 for a couple or a younger veteran. Note that the home is EXEMPT even if not occupied as a home. Thus, a person in an assisted living facility who owns a home, but does not sell the home, would qualify, whereas, if the home sells, the person may cease to qualify (see below). SNTs may count as assets.

Income: Proceeds of sale of the home count as income for a year; receipt of an inheritance counts as income for a year.

Benefit: VA deducts from "income" the applicant's medical expenses (if they exceed 5% of income) and provides a pension, enhance for someone needing aid and attendance, to bring the veteran up to the following:

Veterans: http://www.benefits.va.gov/pension/current_rates_veteran_pen.asp

No dependents: \$21,962/year or \$ 1830.17/mo

One dependent (i.e. married): \$26,036/year or \$2,169.67/mo

Two veterans married to each other, both need A&A: \$34,837/year or \$2,903.08/mo

Widow(er)s: http://www.benefits.va.gov/PENSION/current_rates_survivor_pen.asp

No dependents \$14,113/year or \$1,176.08/mo

One dependent \$16,837/year or \$1,403.08/mo

Medical expenses that may be deducted may include cost of a "personal service contract" with anyone, including a family member, except a person residing in the same household.

Transfers of Assets: No transfer penalties, although PUNITIVE proposed regulations have been issued and are subject to Notice and Comment in the Federal Register. However, a gift of property or a sale below the property's value to a relative residing in the same household does not reduce net worth; and a gift of property to someone other than a relative residing in the applicant's household does not reduce net worth unless it is clear that the applicant has relinquished all rights of ownership, including the right to control the property

Application Process: VA application process has significant delays and approval may take 6+ months. Only "VA approved" persons may assist, including attorneys who have passed certain requirements; no person may charge to assist with (unless an appeal).

Retroactivity: If awarded, benefits are retroactive to date of application, but may not be awarded posthumously.

Estate Recovery: None.

Supplemental Nutritional Assistance ("SNAP")

Elderly and disabled individuals may be eligible for SNAP and not realize it. Much of the following is reprinted from the DSS website at:

<http://www.ct.gov/dss/cwp/view.asp?a=2353&q=320232>

Households that include a disabled individual and those over 50 are *not* subject to time limits or work requirements which may apply to others. Also, households that include a "disabled" (SS criteria) or elderly (over 60) individual are not subject to the *gross* income requirements below. All households are subject to the net income requirements.

The income standards for SNAP are based on the federal poverty levels (FPL). All income standards listed in the following table below are monthly figures. There are gross and net income limits. The gross income limit is equal to 185% of the current Federal Poverty Level and is the amount of income the household has **before** taxes and deductions. The gross income limit applies to most households. The gross income limit does not apply to households in which at least one person is 60 years of age or older, or receives disability income. However, all households **are** subject to a monthly **net** income limit. The net income limit is equal to 100% of the current Federal Poverty Level and is the amount left over after certain deductions are allowed. These deductions are established by the USDA Food and Nutrition Service. Details can be found on their website at <http://www.fns.usda.gov/SNAP/>, currently:

- A 20 percent deduction from earned income;
- A standard deduction of \$160 for households sizes of 1 to 3 people and \$170 for a household size of 4 (higher for some larger households);
- A dependent care deduction when needed for work, training, or education;
- Medical expenses for elderly or disabled members that are more than \$35 for the month if they are not paid by insurance or someone else;
- Legally owed child support payments;
- Some States allow homeless households a set amount (\$143) for shelter costs; and
- Excess shelter costs that are more than half of the household's income after the other deductions. Allowable costs include the cost of fuel to heat and cook with, electricity, water, the basic fee for one telephone, rent or mortgage payments and taxes on the home. (Some States allow a set amount for utility costs instead of actual costs.) The amount of the shelter deduction cannot be more than \$517 unless one person in the household is elderly or disabled. (The limit is higher in Alaska, Hawaii and Guam.)

Effective October 1, 2017, the gross monthly income limits and net monthly income limits are as listed below.

Monthly Income Limits		
Household Size	Gross Income Limit (185% FPL) (applies to most households, except those in which at least one person is 60 years of age or older, or receives disability income)	Net Income Limit after deductions (100% of poverty) (applies to ALL households)
1	\$1,860 (2018)	\$1,012 (2018) plus standard deduction = \$1,172+ medical exp of elderly/disabled
2	\$2,504 (2018)	\$2,538 (2018) plus standard deduction = \$2,708 + medical exp of elderly/disabled
	(etc. depends on family size)	

A "household" is all the people who live together and buy and prepare food together. Once a household meets the eligibility requirements, DSS calculates the amount of the household's SNAP benefit based on the household's income and certain allowable deductions for shelter, dependent care expenses, medical costs and child support payments to others outside the household. Shelter costs are rent and mortgage payments, heating or cooling not included in rent, and utility and monthly telephone services charges.

Asset Limits

There is no asset limit EXCEPT for households whose gross income is more than 185% of the Federal Poverty Level. <https://www.cga.ct.gov/2016/rpt/pdf/2016-R-0106.pdf>

For those households subject to the asset limits, total assets including cash, savings accounts, stocks and bonds cannot be more than \$3500. Only certain special needs trusts are included -- there are special criteria, including an independent trustee. DSS does include the home the client lives in as an asset, nor does DSS lien the home, nor is there recovery from a decedent's estate (federal law). DSS does not count vehicles or retirement accounts, such as IRAs. Again, these asset limits only apply to households whose gross income is more than 185% of the Federal Poverty Level. This is a change: recently, the asset limits only applied to those with income over 300% of FPL. SNAP has strange rules when it comes to treatment of special needs trusts as exempt assets; these may or may not count as exempt. Benefits improperly paid may be recovered by reducing the SNAP benefit prospectively.

Transfer Rules: As a practical matter, "transfer of assets" rules only apply to individuals subject to asset limits.

Benefit Amounts

As of 2018, the **maximum** SNAP benefit amounts are listed in the table below.

For a household of:	the maximum SNAP benefit is:
1	\$192 monthly
2	\$352 monthly
3	\$504 monthly
4	\$640 monthly

SAGA Cash

For purposes of completeness, the following is reprinted from a 2017 DSS webpage -- no longer available -- with a few additional notes.

State Administered General Assistance (SAGA) Cash Assistance

Through the SAGA Cash Assistance program, the Department provides cash assistance to individuals who are unable to work for medical or other prescribed reasons, and to families that do not meet the blood-relationship requirements of the Temporary Family Assistance (TFA) program.

Employable individuals are not eligible for SAGA cash assistance. However, employable individuals who have substance abuse problems may be eligible to receive treatment and some financial support through the Department of Mental Health and Addiction Services' (DMHAS) Basic Needs Program. You can get information about the Basic Needs Program by calling toll-free 1-800-658-4472.

General application for SAGA Cash Assistance services is made at a local office of the Department of Social Services.

Qualifying for SAGA cash assistance benefits:

In order to qualify for SAGA cash assistance benefits, individuals must meet the following requirements:

- **Categorical Eligibility:** With limited exceptions related to abuse or neglect, unemancipated minors (under age 18) are not eligible for cash assistance. In addition, individuals must qualify as Unemployable, Short-Term Transitional or Long-Term Transitional.

Unemployable: Determined by the Department's disability examiners to have a physical and/or mental impairment (or combination of impairments) that will prevent employment for six months or more. The medical impairment criteria are identical to those used in the SSI and Medicaid programs, adjusted for duration and severity. Individuals may also qualify as unemployable for the following documentable non-medical reasons: under age 16; over age 65; over age 55 and no work history in the previous 5 years; full-time high school student; needed in the home to care for an incapacitated spouse or child; needed in the home to care for a child under age 2; or, pending receipt of a state or federal means-tested program, e.g., State Supplement or TFA.

Short-Term Transitional: Medical documentation of inability to work for 2 – 6 months. Must have a recent work history in order to qualify under this category (earned at least \$500 in each of 3 of the last 5 calendar quarters, or was eligible to collect Unemployment Compensation during the previous six months).

- **Long-Term Transitional:** Medical documentation of inability to work for six months or more. No work history required; however, all cases are referred to the Department's disability examiners for a review of unemployability.

Benefit Levels: Unemployables – up to \$212 per month. Short-Term and Long-Term Transitionals – up to \$212 per month if applicant has a rental obligation or \$53 if living rent-free.

Income Rules: Adjusted income (gross minus certain exclusions and deductions) may not exceed \$53 or \$212 per month, depending upon the individual's Unemployable or Transitional status.

Asset Rules: The asset limit is \$250 per person, or up to \$1,000 for a family of four or more. The department does not count the equity of an automobile as long as it is no more than \$4,500. The department counts any amount over \$4,500 towards the asset limit. Real property is subject to a lien or security mortgage.

Citizenship: Applicants must be citizens or qualified aliens. Rules are identical to those of the TFA program. Sponsor's income is deemed for entrants following December 1997.

Third Party Benefits: Applicants and recipients must pursue all third party benefits (including SSI and TFA) in order to qualify.

Substance Abuse: Active substance abusers (drug and/or alcohol) are required to participate in treatment.

Funeral Allowance: The Department pays for funeral and burial expenses of SAGA, TFA, State Supplement recipients and indigent persons who die without sufficient estate or legally-liable relatives able to pay for the cost of a proper funeral and burial. The Department's maximum payment is \$1,200. This amount is reduced by any liquid assets in the estate (such as money in a bank account), life insurance policies, the amount in any funeral fund, any prepaid funeral contract, and (eff 7/1/16) the amount of contributions (regardless of source) that exceed \$3,400.

Application must be made within one year of the date of death and may be filed by the funeral director, a family member, or any individual who made the funeral arrangements. Payment for the funerals can only be made to the funeral director, cemetery or crematory. Family members and individuals cannot be reimbursed or receive payment from the Department.

Recovery: SAGA benefits may be recovered during lifetime, subject only to the 50% limitation on recoveries from inheritances and proceeds of a cause of action; SAGA benefits will also be recovered from the beneficiary's decedent estate (probate estate) at death.

State Supplement a/k/a Aid to the Aged, Blind and Disabled or

AABD: Conn. Gen. Stat. § 17b-600 (et seq)

Type of benefit program: STATE FUNDED ONLY.

Estate recovery: YES, during lifetime (from inheritances and PI settlements/awards, although state may try other means) and at death (from probate estate). (See more below)

Liens: State WILL lien recipient's home even if occupied. State has sometimes liened after-acquired property. (See more below)

Nature of Benefit:

Community residents: "cash assistance," accessed through a grey "Connect" Card that is also used for food stamps, QMB, and Medicaid. Usually not more than \$200.

Residents of "rated housing," residential care facilities: a much higher rental subsidy that is sometimes paid directly to the institution as a credit towards the state rate -- in effect, the institution is the "representative payee" for the State Supp. that is payable to the resident

-- with the individual responsible for the difference. In other residential facilities, the State Supp. is paid directly to the resident or resident's representative, such as the conservator. In either case, the benefit is not a direct payment for the person's care, but a cash subsidy based on rental expenses. The RCH will refer to the benefit as "Medicaid" and say they "take

Medicaid" when it is really AABD. This is probably because a person eligible for State Supp. benefits is automatically, or "categorically," eligible for Medicaid coverage of health care expenses .

Eligibility: As with other benefits, AABD has functional and financial eligibility requirements. State Supp. is available to those who qualify as "aged" (65+), blind, or disabled (in other words, would meet SSI's functional eligibility requirements), who have income, and who meet other requirements.

Functional Eligibility. The Department of Social Services can determine whether a person is "disabled" even if not receiving SSI or Social Security Disability, but if an application is pending with SSA, DSS may choose to wait, or to make its finding provisional only. As for other limitations: residents of "public institutions" (e.g., prisons, state mental institutions) are ineligible for both SSI and State Supp., with some exceptions. Also: At a technical level, to receive AABD an individual must either receive SSI or be eligible to receive it except for the fact that he or she has income in excess of the SSI standard. In practical terms, to be eligible for AABD, a person must either be receiving SSI, or receive (or be deemed to receive) some other source of income in excess of the SSI amount for which the person would qualify, but which is below the standard of need. The benefit is "supplemental," so it must be "supplemental" to other income. The income need not be SSI

Financial eligibility: INCOME

Gross income may not exceed 300% of SSI, currently (2018) \$2,250 per month. (Whether or not a benefit is awarded will depend upon a formula that takes into account

living expenses, as described below.) Income of spouses is "deemed" to the other spouse only if living together. Excess income of resident in a residential care home can be transferred to a "pooled trust account" described in 42 USC sec. 1396p(d)(4)(C) to the extent necessary to obtain eligibility. Income, but not assets, can be transferred; a transfer of an assets to a pooled trust will disqualify the individual.

Financial Eligibility: ASSETS. \$1,600 asset limit. (Usual exclusions.)

Special Rules:

- assets of a spouse who is not living with the applicant are not "deemed" or otherwise considered available to the applicant.
- no spousal protections
- assets in a self-settled "special needs trust" described in 42 U.S.C. § 1396p(d)(4)(A) are not exempt.
- assets of a parent are generally "deemed" available to a minor child, there are exceptions where the child is residing in an institution or is blind.
- home is exempt BUT STATE WILL LIEN as condition of eligibility

Transfer Penalties: 24-month look-back period; non-exempt transfer during that period incurs penalty at the rate of \$500 = 1 month of ineligibility, no cap. However, the penalty starts to "run" in the month it is made, as the rules of DRA have not been applied to State Supp. transfer penalties.

Other important differences from Medicaid penalties:

- Transfers are only subject to penalty if made "for the purpose of qualifying," which is shown only if three factors apply: (1) fair market value not received; (2) no convincing evidence that the transfer is for another purpose; and (3) transferor does not retain sufficient funds for foreseeable needs (i.e., sufficient to pay for twenty-four months in a nursing home); arguably, this imposes a greater burden on the State to show that a transfer should give rise to a penalty than under the Medicaid program.

- Transfers between spouses may be subject to penalty. An exception will be making a spouse a joint owner of property, or division of property pursuant to a written agreement when the spouses begin to live separately (because one is in a licensed boarding facility).

- A transfer of the home by an applicant residing in the community is not subject to a transfer penalty (following SSI rules that take the same approach).

Retroactivity: NONE. Eligibility for AABD begins the first day on which both are true: (i) the individual has applied; and (ii) all other eligibility requirements are met, including reduction of assets to the permitted limit.

Applied Income: Because of the formula used to compute the amount of rental subsidy there is no "applied income" as such, but the formula does not provide for payment of a the Medicare Part B premium or supplemental insurance. The typical AABD recipient will usually have such low income that he or she will be eligible for the QMB benefit which pays the Medicare Part B premium, but this can be a problem if the person is a higher-

income person residing in a boarding facility,

Legally Liable Relative Contributions: A contribution may be required, but this is unusual. The contribution will be limited to 12% of the difference between the LLR's prior year's taxable income, and the Connecticut median income of the applicable family size. In 2017, the median family income in Connecticut for a family of one was \$57,277.48, for a family of two, \$74,901.32. (Source: <http://uwc.211ct.org/connecticut-state-median-income-2013/>) (No, it is definitely for 2017, not 2013.)

Liens: State Supp. is not limited by Medicaid law limiting liens; in fact, federal regulation specifically authorizes them. Anyone living in a home in the community will have a lien placed on the home as a condition of receiving State Supp. In addition, a lien may be placed on in-state real property owned by a legally liable relative (which might be a spouse) even if not living with the assistance unit. Thus, if one spouse is in a residential care home on AABD, and the other is at home, the home might be liened -- quite different from Medicaid rules that protect spouses against liens.

Estate Recovery: State Supp. is also not limited by Medicaid restrictions on estate recovery. A current or former recipient of State Supp. who receives anything of value during lifetime is liable for repayment during lifetime, limited only by state law limitations on recovery from inheritances and personal injury settlements up to 50% of the amount received or recovered. The State also has a claim against the estate of any decedent who received these benefits at any time during life. The only limitation on the state's claim is when the probate court rules that the estate is needed to provide for the support of the deceased beneficiary's surviving spouse, parent, or dependent child under twenty-one; no other spousal or other protections against estate recovery exist.

Computing Benefit Amount under State Supp.

(a) **Licensed Facility.** The AABD budget for a person residing in a licensed board facility is calculated by adding the monthly state rate of the particular facility to a personal needs allowance of \$ 29.51 to reach the applicant's "basic needs." This is compared to the applicant's income, disregarding \$246.70 (2018 figure). The balance is deducted from the total needs and the facility receives a check for the difference. The applicant's award letter will not say "Medicaid has been granted eff. (date); your obligation to pay applied income is \$2,000 in June, \$2,000 in July, \$2,000 in August (etc.)." Rather, the award letter may say "we will pay \$3,500 per month to the facility." The facility and the individual must then agree about what is left over. The upshot, however, is that the applicant keeps \$ 29.51 + \$246.70 or \$276.21 and the rest goes to the facility. Note: there is no ability to deduct for supplemental insurance premiums. These must either be paid by the individual out of the \$246.70, or the insurance must be dropped. However, eligibility for State Supp. makes a person "categorically" eligible for Medicaid.

(b) **State Supp. in the Community.** For the person in the community, a/k/a not in "rated housing," the "basic need" is actual rent up to a maximum of \$400 (if living alone) or \$200 (if sharing); DSS then computes "total need," consisting of the basic needs amount, plus a personal needs allowance of \$167.55 (\$168.57 for a married individual), plus any "special needs." (Personal needs allowance figures have remained constant for some time.) "Total need" is then compared to income (net of any disregard), and AABD makes up

the difference. In 2018, the unearned income disregard for an individual in the community, living as a roomer in someone else's home, or in a skilled nursing facility, is \$339; for someone sharing with a non-relative the disregard was \$406.90 (increasing each year to reflect Social Security Administration adjustments, although the increase is at perpetual risk of elimination under repeated gubernatorial budget proposals). There are also "earned income" disregards. As with SSI, these will be the first \$65 of earned income plus 1/2 the remainder for a disabled person; the first \$85 plus 1/2 the remainder for a blind person (who was blind prior to age 65). Work-related expenses are also added to the disregard, usually when the individual is on a Social Security Administration-approved plan to return to employment.

(c) Examples of How to Compute the Benefit.

Example#1: Single individual in the community with SSI of \$750, rent of \$600.

"Basic need" is $\$400 + \167.55 (no special needs) or $\$567.55$.

"Income" is $\$750 - \$339 = \$411$.

$\$567.55 - \$411 = \$156.55$.

Individual gets \$750 from SSI (which doesn't reduce to reflect the supplement) plus \$156.55 from the State of Connecticut. (Individual probably also gets Food Stamps)

Example#2: Single individual living at Jerome Home (hypothetical state rate: \$117.62/day, \$3,577.60/mo), SSI of \$750.

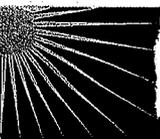
"Basic need" is $\$3,577.60 + \$29.51 = \$3,607.11$.

Counted "Income" is $\$750 - \$246.70 = \$503.30$.

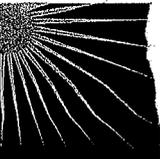
$\$3,607.11 - \$503.30 = \$3,103.81$.

State pays facility \$3,103.81. Resident pays $\$3,577.60 - \$3,103.81 = \$473.79$, keeps \$276.21 (which coincidentally = $\$246.70 + \29.51). This is the technical way to compute it but easier (if not technically correct) is that resident keeps \$276.21 and gives the rest of his income of \$750 as applied income: $\$750 - \$276.21 = \$473.79$. Or put another way, counted income $503.30 - 246.70 - 29.51 = 473.79$; $\$473.503.30 - \$29.51 = \$473.79$.

Additional Benefits: Recipients of AABD, both in the community and in licensed boarding facilities, are entitled to assistance with moving expenses in certain circumstances, special clothing assistance, help with purchase or repair of essential household items, and telephone installation, therapeutic diets prescribed by a physician, and meals on wheels for those in the community. A person eligible for AABD residing in a nursing home, where SSI reduces to \$30/month, will also get an extra \$30 to make up the \$60 personal needs allowance permitted under Medicaid for individuals residing in skilled nursing facilities.

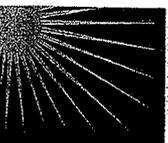


- Participants must be:
 - At institutional level of care
 - Nursing home, Chronic Disease Hospital, ICF/MR (eligible for services from Department of Developmental Services)
 - Living in a 'community setting'
 - Choosing to self-direct and manage an individual budget
 - Financially eligible for Medicaid under a HUSKY coverage group



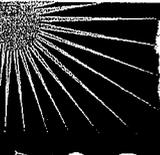
Community First Choice Budgets

Need Grouping	Approximate PCA Hours 7 days per week	Budget Maximum - No ADLs
Level 1	Not Eligible for CFC	\$1445
Level 2	4	\$2104
Level 3	6	\$3156
Level 4	8	\$4207
Level 5	10	\$5259
Level 6	11	\$5818
Level 7		Subacute level of care
Level 8		Chronic disease level of care

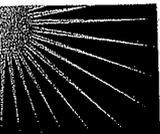


**Budget Based on Need
Activities of Daily Living (ADLs)**

ADLs	Monthly Budget
2	\$3490
3 or 4	\$4654
5	5818 (increase attributed to wage increases 6690)



Service	Limits
Self-hired personal care attendant <ul style="list-style-type: none"> • 12 Hour • Shared PCA • Live-in 	Budget (IB) determined by level of need
Workman's Compensation Insurance	Within IB
Home delivered meals	No more than 2 meals per day (within IB)
Emergency response system	Individual's choice (within IB)
Support and Planning Coach	Not to exceed \$500 per year without prior authorization (within IB)



Service	Limits
Health Coach - Nurse, Occupational Therapy, Speech Therapy, Physical Therapy	Not to exceed 25 hours within 3 months without prior authorization (within IB)
Participant education	At discretion of participant (within IB)
Personal attendant education	At discretion of participant (within IB)
Assistive Technology	Maximum \$5,000 per year (within IB)
Environmental Adaptations	In addition to budget - not to exceed \$15,000 over a 5 year period
Transitional Services	In addition to budget - not to exceed \$2,000 over a 2 year period

Connecticut HUSKY Health Program Monthly Income Guidelines – effective January 1, 2018

Family of 2	Family of 3	Family of 4	Family of 5	Family of 6	Overview
under \$1,867	under \$2,349	under \$2,830	under \$3,309	under \$3,791	HUSKY A (parents/caregivers) <ul style="list-style-type: none"> • Medicaid health care coverage for parents and caregiver relatives. • No cost. • Enrolled parents/relative caregivers no longer have HUSKY A eligibility when the youngest child turns 18 if the child is not going to graduate high school by 19th birthday (federal rule)
under \$2,720	under \$3,421	under \$4,121	under \$4,820	under \$5,521	HUSKY A (children) <ul style="list-style-type: none"> • Medicaid health care coverage for children and youths under 19th birthday. • No cost.
under \$3,558	under \$4,476	under \$5,391	under \$6,307	under \$7,225	HUSKY A (pregnant women) <ul style="list-style-type: none"> • Medicaid health care coverage for pregnant women. • No cost. • For eligibility of pregnant women, unborn child is also counted as a family member.
under \$1,867 (single-person household under \$1,387)	under \$2,349	under \$2,830	under \$3,309	under \$3,791	HUSKY D (adults without minor children) <ul style="list-style-type: none"> • Medicaid health care coverage for adults from age 19 to under 65th birthday • No cost. • For those who do not qualify for HUSKY A; who do not receive federal Supplemental Security Income or Medicare; who are not pregnant; and who do not have dependent child(ren) under 19 in household.
from \$2,720 to \$3,437	from \$3,421 to \$4,323	from \$4,121 to \$5,207	from \$4,820 to \$6,091	from \$5,521 to \$6,977	HUSKY B (level 1): health care coverage for children under 19th birthday. <ul style="list-style-type: none"> • Children’s Health Insurance Program (non-Medicaid) • No monthly premiums; some co-payments. • Eligible for HUSKY Plus Physical

from \$3,438 to \$4,370	from \$4,324 to \$5,497	from \$5,208 to \$6,622	from \$6,092 to \$7,746	from \$6,978 to \$8,873	<p>HUSKY B (level 2): health care coverage for children under 19th birthday.</p> <ul style="list-style-type: none"> • Children's Health Insurance Program (non-Medicaid) • Monthly premium of \$30 for first child; maximum monthly premium of \$50, regardless of number of children; some co-payments. • Eligible for HUSKY Plus Physical
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CT DSS/updated 11/17/17 Income levels are approximate; application and eligibility determination necessary for qualification

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