UTAH MEDICAL PROGRAMS SUMMARY

UTAH DEPARTMENT OF HEALTH

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www.health.utah.gov/Medicaid

Information in this document is provided as a public service to community agencies. The summary is designed to give a broad overview of the programs and should not be used to determine eligibility.

BUREAU OF ELIGIBILITY POLICY (BEP)
DEPARTMENT OF WORKFORCE SERVICES (DWS)
Medical Programs Summary

Medical assistance is available to U.S. citizens and resident aliens who meet Utah residency and specific non-financial and financial criteria. This booklet does not explain all of the eligibility criteria. Please contact a Medicaid Eligibility Worker if you have questions about qualifying for Medicaid or any medical assistance program.

☐**Assets:** Generally, any type of "property", such as cash, items easily turned into cash, and other non-cash property including bank accounts, cash on hand, vehicles or vacation homes. Each program has its own rules about counting assets. Some assets are not counted because a person would reasonably need them for normal living - for example, **Medicaid programs do not count the home a family lives in as an asset.**

☐**Deductions:** Amounts subtracted from gross income before comparing it to the applicable income limit.

☐**Disregard**: A disregard is either income or assets that we do not count to decide eligibility.

☐**Health Plan:** A medical provider network responsible for recruiting and paying the actual medical providers. Most Medicaid recipients must enroll in a Health Plan. Recipients can select a primary doctor from among the Health Plan's providers. The Health Plan must approve some types of services before the recipient receives it. Recipients must have a referral from the Health Plan to seek services from a provider who does not belong to the Health Plan.

☐**Income:** Any kind of money coming into the household such as wages, child support, interest from investments or bank accounts, Social Security.

☐**Liens:** The State has a right to recover from the recipient's estate all Medicaid funds spent on behalf of a recipient who is 55 years of age or older if all of the following conditions are met:

1. There is no surviving spouse.
2. There are no surviving children under age 21.
3. There are no surviving blind or disabled children.

ORS may waive estate recovery when the property is the sole income producing asset and source of support for the survivors. Anyone can apply for an undue hardship consideration for other circumstances. You are not required to sign a lien when you apply for Medicaid. A lien is placed on real property only after death. For more information see the pamphlet "Estate Recovery Information Bulletin", DWS 05-994.

☐**Medical bills as deductions:** Medically necessary services for a family member that the family must pay. The bill must either be unpaid, or the family must have received and paid for the service in the retroactive coverage period or application month. Bills may be used as a deduction from income only for certain Medicaid programs.

☐**MWI Premium**: The cost sharing responsibility of a disabled person who is eligible for the Medicaid Work Incentive Program. The MWI premium must be paid with a credit card, money order or check. DWS cannot accept payment of an MWI premium from a Medicaid provider. DWS will accept payment if the provider is your representative payee and the payment is made with your funds.

☐**Prior-authorization:** Medicaid requires some medical services to be approved by the Division of Medicaid and Health Financing or by the Health Plan provider before they are given. If the Medicaid client has the service without a prior authorization, neither the Division of Medicaid and Health Financing nor will the Health Plan pay the bill.

☐**Retroactive coverage:** Receiving medical coverage for a past period. Medicaid programs allow the person to request coverage for three months prior to the date of application. The Qualified Medicare Beneficiary program and the PCN program do not allow retroactive coverage.

☐**Spenddown:** A way for clients, who have income greater than the income limits for a Medicaid coverage group, to "buy" Medicaid coverage. The client either pays with a credit card, money order or check, or submits medical bills equal to the spenddown amount. The spenddown is the difference between the client's countable income and the medically needy income limit. Not all medical programs allow clients to spenddown to become eligible. DWS cannot accept payments of a spenddown from a Medicaid provider.

☐**Payments to Be Eligible:** If you owe a spenddown or other fee to receive medical assistance, you must pay such amount to DWS to be eligible. DWS cannot accept payments from Medicaid providers for your spenddown or other fee that you owe. DWS will accept payments if the provider is your representative payee and the payment is made with your funds.

☐**Traditional Medicaid, Non-Traditional Medicaid & PCN:** Determines the benefits the eligible individual receives.
Card Colors: A purple card indicates Traditional Medicaid, a blue card indicates Non-Traditional Medicaid and a yellow card indicates eligibility for the PCN program.

MEDICAID PROGRAMS

Parent/Caretaker Relative Medicaid

Parent Caretaker Relative Medicaid provides coverage for low income parents and caretaker relatives with dependent children. Parents and caretaker relatives must meet a deprivation of support requirement. This means the children must be deprived of parental support due to the death, absence, incapacity, or underemployment of a parent or caretaker relative. Parents and caretaker relatives meet deprivation due to underemployment when the primary wage earner is unemployed or working less than 100 hours per month. Households receiving Parent/Caretaker Relative Medicaid may qualify for 12 Month Transitional Medicaid when they lose eligibility because the earned income of a parent or caretaker relative exceeds the income limit.).
Deductions: 5% income disregard and expenses from the front page the IRS 1040 form.
Spenddown: Not allowed.
Asset Limit: None
Retroactive coverage is allowed.

Family Medically Needy Medicaid

This program provides Medicaid coverage to low income families who do not qualify for Parent/Caretaker Relative Medicaid because of income or other household circumstances. This program has the same deprivation of support requirements as the Parent Caretaker Relative Medicaid program described above. The differences between the Parent Caretaker Relative Medicaid and the family medically needy program are that Parent Caretaker Relative Medicaid program uses tax law in the determination of income and doesn't have an asset test. With the Family Medically Needy Medicaid program, clients may spend down to the income limit to be eligible; and they may voluntarily choose to leave a child out of the coverage when they do not want to count the child's income or resources in determining eligibility. Families must include at least one eligible child in the coverage to qualify for the Medically Needy Family Program. Medically Needy Family households are not eligible for the 12 Month Transitional Medicaid program.

Deductions: $90.00 work allowance, a $30 and 1/3 disregard*****, child care ($200 maximum per child under age two, $175 over age two) from earned income; health insurance premiums; some medical bills.
*****Each individual with earned income must meet certain requirements to qualify for the $30 and 1/3 disregard.

Spend down: Allowed.

Asset Limit: 1 person - $2,000
2 people - $3,000
Each additional person add $25

Retroactive coverage is allowed.

12 Month Transitional Medicaid

Parents or caretaker relatives who become ineligible for Parent/Caretaker Relative Medicaid may receive additional months of Medicaid coverage for themselves and their children depending on the reason they became ineligible. Adults who are no longer eligible for Parent/Caretaker Relative Medicaid because of increased earnings can receive up to 12 months of continuous Medicaid coverage (12 Month Transitional Medicaid). A household must meet certain income and reporting requirements to qualify for 12 Month Transitional Medicaid.

Pregnant Woman

The Pregnant Woman program provides full Medicaid coverage to pregnant women. The program covers the mother from application through 60 days after the birth of her child. Once eligible, the woman remains eligible for the entire period. **Children born to women on Medicaid in Utah can receive Medicaid through the month of their first birthday under the Child Under Age 1 program.**

Income Limit: 139% of the Federal Poverty Level

Deductions: 5% income disregard and expenses from the front page the IRS 1040 form.

Spend down: Not allowed.

Asset Limit: None

Retroactive coverage is allowed.

Medically Needy Pregnant Woman

This program covers pregnant women who do not meet the income limits for the Pregnant Woman program. The advantage of the Medically Needy Pregnant Woman program is that a woman may pay a spenddown and receive the coverage. The woman may receive 60 day postpartum coverage if she applies for benefits before the birth of the child. Spenddowns are allowed and must be met for each month of coverage including the 60 day postpartum period. If the mother is on this program in the month of the child's birth, the child will qualify for Medicaid for the first year under the Child Under Age 1 program with no spenddown.

Child Under Age 1

This program covers children from birth to twelve months. Mothers who were not on Medicaid when the baby was born may apply after the birth. If the mother is determined eligible for Medicaid back to the date of the baby's birth, the baby will receive one year of coverage. The household must provide verification of information about any possible insurance coverage for the child. Application for a Social Security card will be requested, but isn't required.

Child Age 0-5

This program provides Medicaid coverage for children from birth through the month the child turns age 6. A child does not have to reside with a relative to receive coverage.
Income Limit: 139% of the Federal Poverty Level (Same as Pregnant Woman program).
Deductions: 5% income disregard and expenses from the front page the IRS 1040 form.
Spend down: Not allowed.
Asset Limit: None
Retroactive coverage is allowed

Child Age 6-18

This program provides Medicaid coverage for children from age 6 through the month they turn 19. A child does not have to reside with a relative to receive coverage.
Income Test: 133% of the Federal Poverty Level
Deductions: 5% income disregard and expenses from the front page the IRS 1040 form.
Spend down: Not allowed.
Asset Limit: None
Retroactive coverage is allowed.

Child Medically Needy

Children in households that do not meet the income limits for the Child Age 0-5 or Child Age 6-18 Medicaid limit may be eligible for the Child Medically Needy program. Children must be under age 18 or between age 18 and 19, in school and expected to graduate before turning 19. Children do not have to be living with a relative. The income and assets of adult household members who are not the parents of the child are not counted. All other eligibility factors follow the guidelines under the Medically Needy Family program.
Spend down: Allowed.
Asset Limit: 1 person - $2,000
2 people - $3,000
Each additional person add $25
Retroactive coverage is allowed.

Refugee Medical Assistance

Refugees entering the United States are eligible to apply for and receive Medical Assistance for 8 months after their date of entry. The same income and resource standards apply as for Family Medically Needy Medicaid. Refugee Financial Assistance automatically provides eligibility for Refugee Medical.

Breast and Cervical Cancer Medicaid Program

The Medicaid Cancer program provides full Medicaid benefits to uninsured individuals under age 65 who have been screened for breast or cervical cancer under the CDC (Center for Disease Control) Breast and Cervical Cancer Early Detection Program and are found to need treatment for either breast or cervical cancer, including pre-cancerous conditions and early stage cancer. The Utah Cancer Control Program (UCCP) is the CDC provider that will complete the screening. If an individual has another type of cancer

but the primary cancer is breast or cervical cancer, they may still meet the requirement. An individual who is diagnosed with a precancerous condition can only receive Medicaid for three months under the Cancer program.
An individual must meet the general Medicaid requirements along with the following requirements:
• Screened by the UCCP
• Need treatment for breast or cervical cancer or a precancerous condition
• Cannot be eligible for any other Medicaid program unless a spenddown, premium or asset co-pay is required to qualify.
• Have no creditable health insurance coverage which covers treatment of breast or cervical cancer
• Must be under the age of 65
Income Test: There is no income limit after meeting the income test of the UCCP.
Asset limit: None
Retroactive coverage is allowed but not prior to the individual being screened by UCCP. The UCCP toll free referral number is 1-800-717-1811.

Foster Care Medicaid (Title IV-E)

The Foster Care Medicaid Program (Title IV-E) provides full Medicaid coverage to children: (1) who are in the custody of an agency within the Department of Human Services (DHS), (2) for whom a foster care maintenance payment is being made by DHS, and (3) who meet eligibility and reimbursement requirements for Title IV-E, as determined by DHS.
A child may continue to qualify for this program until age 18. A child between age 18 and 19 may qualify until the month of graduation if he is attending school full time and expecting to graduate before the child's 19th birthday.
Retroactive coverage is allowed to the date of the child's removal from the home when entering state custody.

Foster Care Medicaid (Non IV-E)

The Foster Care Medicaid program (Non IV-E) provides full Medicaid coverage to children: (1) who are in the custody of DHS, (2) for whom a foster care maintenance payment is being made by DHS, (3) who do not meet eligibility or reimbursement requirements for Title IV-E, as determined by DHS, and (4) who meet the requirement for another Medicaid program applicable for children.
Income, assets, and other eligibility factors are as defined for other existing Medicaid programs such as Child Age 0-5, Child Age 6-18, Disabled Medicaid, or Child Medically Needy. Continuing qualification is based on the criteria for the specific program each child qualifies under. Retroactive coverage is allowed to the date of the child's removal from home when entering state custody.

Former Foster Care Individuals (Non IV-E) and Foster Care Independent Living

The Former Foster Care Individuals Medicaid program (Non IV-E) provides full Medicaid coverage to individuals: (1) are age 18 to 26, (2) were concurrently enrolled in Medicaid and Foster Care in Utah at age 18 or higher, (3) where in the custody of DCFS, DHS, or an Indian tribe when Foster Care ended. There is no income or asset limit. Retroactive coverage is allowed.

An extension for Medicaid coverage, called Foster Care Independent Living, is available for youth through age 21 when they age out of foster care if they receive Independent Living Services through DCFS. This is an option for former foster care youth who do not qualify for the Former Foster Care Individuals program.

Custody Medical Care (MI-706)

The Custody Medical Care program enables children entering foster care to immediately access health care services. The program is for foster children who have not yet had Medicaid eligibility determined, who do not qualify for any Medicaid eligibility while in custody, or who need health care services not covered by Medicaid. The program is paid for with State general funds.
This program has no income, asset, or deprivation tests. The program can be authorized by a DHS or a DOH Fostering Healthy Children Program Nurse for each foster child. A child may qualify for this program until state custody is discontinued.

Subsidized Adoptions

A subsidized adoption refers to the adoption of a child with special needs where an adoption assistance agreement is established between the adoptive parents and a state or local government agency. The adopted child may qualify for either Title IV-E or State Adoption Assistance. A child who has an adoption assistance agreement in effect with a state or local government agency is eligible to receive Medicaid. It does not matter if the child is receiving a monthly cash subsidy. **There is no income or asset test for this type of Medicaid.**
The adoption assistance agreement usually ends the month that the child turns 18. However, the adoption assistance may extend through the month in which the child turns 21 if the child is determined to be physically, mentally or emotionally disabled by the agency originating the adoption assistance agreement. Subsidized Adoption Medicaid ends at the end of the month the adoption assistance agreement ends.

Baby Your Baby

Baby Your Baby is a type of temporary medical coverage for pregnant women who are determined presumptively eligible. Coverage begins the same day that a client is found eligible for the program by a qualified health care provider. This eligibility lasts only until the last day of the next month or until Medicaid makes a determination regarding the client's eligibility, whichever occurs first. The woman needs to apply for regular Medicaid before the presumptive period ends. Only one Baby Your Baby Presumptive Eligibility Card can be issued per pregnancy so it is important to apply for Medicaid as soon as possible. This card covers **outpatient pregnancy related services** while the Medicaid application is processed. If the applicant is determined eligible for Medicaid, the Medicaid card will cover the rest of the pregnancy along with other Medicaid covered services. The infant does not qualify for the one year of coverage if the mother is only eligible under the Baby Your Baby program and does not subsequently become eligible for Medicaid.
Income Limit: 139% of the Federal Poverty Level.
Deductions: None calculated for the Baby Your Baby Card
Asset Limit: None
Retroactive coverage is not allowed.

Children's Health Insurance Program (CHIP)

CHIP is a state health insurance plan for children who do not have other health insurance and do not qualify for Medicaid. Many children who qualify for CHIP come from working families. Depending on income and family size, uninsured Utah families may qualify. Once approved, CHIP covers well-child exams, immunizations, dental care, hearing and eye exams, and more. Depending on income, families may pay up to $75 every three months, as well as small co-pays for services like a visit to the doctor.
Enrollment is now always open. Families can call 1-877-KIDS-NOW (1-877-543-7669) for an application, apply online at www.health.utah.gov/chip, or apply in person at a local Department of Workforce Services office.
Age Requirement: Under age 19

Citizenship: Only the child needs to be a U.S. citizen or legal resident
Income limit: 200% of the Federal Poverty Limit for household size.
Deductions: 5% income disregard and expenses from the front page the IRS 1040 form.
Asset Limit: None
Retroactive coverage is not allowed.

PCN (Primary Care Network)

PCN is primary preventive health coverage for uninsured adults who do not qualify for Medicaid and do not have access to any other health insurance. PCN benefits include physician services, prescriptions, dental services, eye exams, emergency room visits, emergency medical transportation, birth control and general preventive services. Depending on income, adults may pay up to $50 per year for an annual enrollment fee, as well as low co-pays for services like a visit to the doctor. Applications are only accepted during open enrollment periods. For an application or more information visit www.health.utah.gov/pcn, call the PCN hotline at 1-888-222-2542 or apply in person at a local Department of Workforce Services office.
Age Requirement: 19 through 64
Citizenship: U.S. citizen or legal resident
Income limit: 150% of the Federal Poverty Level for household size.
Deductions: 5% income disregard and expenses from the front page the IRS 1040 form.
Additional Do not qualify for Medicaid or have access to student health insurance,
Requirements: Medicare or Veterans Benefits.
Asset Limit: None
Retroactive coverage is not allowed.

Utah's Premium Partnership for Health Insurance (UPP)

UPP (pronounced "up") helps uninsured, working individuals and families pay their monthly health insurance premiums. If an employee's company offers health insurance, qualified individuals and families will receive monthly reimbursements for the cost of their employer-sponsored health insurance coverage. If qualified, UPP will pay up to $150 per adult and up to $100 per child each month. UPP is for those that do not qualify for Medicaid, have access to health insurance through their employer and have not yet enrolled in their employer-sponsored health plan.
For an application or more information, call 1-888-222-2542, visit www.health.utah.gov/upp, or apply in person at a local Department of Workforce Services office.
Age requirement: Under age 65
Citizenship: U.S. citizen or legal resident
Income limit: 200% of the Federal Poverty Limit for household size.
Deductions: 5% income disregard and expenses from the front page the IRS 1040 form.
Additional Do not qualify for Medicaid and do not have access to Medicare or Veterans
Requirements: Benefits.
Asset Limit: None
Retroactive coverage is not allowed.

Aged, Blind, Disabled Medical

This program provides Medicaid for individuals who are Aged (65+), Blind, or Disabled. People under age 65 must meet the Social Security criteria for being blind or disabled. Receipt of SSI or SSA disability benefits meets the criteria for disability. If the individual is not on SSI or SSA disability benefits, the State Medicaid Medical Review Board may make a disability decision. If Social Security has not denied

disability based on medical evidence, the State Medicaid Medical Review Board can determine disability without considering substantial gainful employment.
If the person receives SSI, we do not count income of a spouse or parent; however, assets of a spouse or parent are counted. The SSI person's income doesn't count toward the income limit except for Nursing Home or Home and Community Based Waiver clients. Some individuals who lose their SSI payments may still qualify without a spenddown under one of the SSI protected groups.
Income: 100% of the Federal Poverty Level
Deductions: $20.00 general income exclusion, the first $65.00 and then ½ of earned income that remains, impairment related work expenses, health insurance premiums, and some medical bills.
Spend down: Allowed.
Asset limits: 1 person - $2,000
2 people - $3,000
Retroactive coverage is allowed.

Medicaid Work Incentive (MWI) Program

MWI is a Medicaid program for persons who meet the Social Security criteria for disability and have earned income. The household income limit is 250% of the Federal Poverty Level. If household net income does not exceed 100% of the Federal Poverty Level, the individual will not pay an MWI premium. If household net income is above 100% of the Federal Poverty Level, but below the 250% of the Federal Poverty Level, the individual will pay a MWI premium.
Income Test: Only the income of the client, a spouse living in the home and income of parents of a minor client will be counted and compared to the 250% of the Federal Poverty Level.
Deductions: $20 General income disregard; the first $65 of earned income and ½ of the remaining; impairment related work expenses. Allocations for children or parents are not allowed. A spouse's income does not have to exceed the allocation to be counted in the 250% test.
MWI Premium: Countable income is calculated the same way it is for the 100% Aged, Blind, and Disabled poverty group. **Only the countable income of the disabled wage earner is used to determine the premium amount**.
The MWI premium is calculated as follows:

Countable Income Is	**Multiply Income By**
More than 100% but not over 110% of FPL	5%
More than 110% but not over 120% of FPL	10%
Over 120% of FPL	15%

The MWI premium must be paid with a check, a money order or a credit/debit card.) DWS cannot accept payment of an MWI premium from any Medicaid provider.
Asset Limit: $15,000 for all household sizes. Certain retirement accounts are exempt.
Retroactive Coverage is allowed.

Emergency Medicaid

Emergency Medicaid is not a different Medicaid program. It refers to coverage for individuals who meet all of the other eligibility criteria for one of the Medicaid programs, but who are not U.S. citizens or qualified resident aliens. It only covers emergency medical services. Coverage is provided for the month the emergency occurs and is not provided ongoing. Pregnant women can apply one month before the expected date of delivery and receive coverage for the labor and delivery charges. Emergency Medicaid does not cover nursing home or other long-term care services, and is not available for Medicare Cost-

Sharing Programs, CHIP or PCN. An infant born to a woman eligible for emergency Medicaid is eligible for Medicaid through the month of the baby's first birthday.

MEDICARE COST-SHARING PROGRAMS

There are three Medicare cost-sharing programs for people with Part A Medicare. These programs help cover some of the recipient's costs for Medicare services. They are not Medicaid programs, but a Medicaid recipient who has Part A Medicare may be eligible for both Medicaid and either QMB or SLMB coverage. Qualifying Individuals (QI) benefits are only available to people who are not on Medicaid. About three months after becoming eligible for a Medicare cost-sharing program, the state begins paying the Medicare Part B premium and the Social Security check will increase. However, recipients will be reimbursed by Social Security for each month of eligibility during which a Medicare premium was deducted from the person's check.

Qualified Medicare Beneficiaries Program (QMB)

The QMB program pays Medicare premiums and copayments for low-income **Medicare** recipients. People who receive, or are eligible to receive, Part A Medicare may apply for QMB. QMB pays Medicare Part B premiums, deductibles, and Part A and Part B co-payments. It can also pay Part A premiums. Coverage begins the first of the month following the month the client is determined eligible. A card will be issued each month. If the individual does not receive Medicaid, the card will read "MEDICARE COST-SHARING ONLY." Otherwise, the card will look like a regular Medicaid card.
Income limits: 100% of the Federal Poverty Level
Deductions: $20.00; $65 of earned income and ½ of remaining earned income.
Spend down: Not allowed.
Asset limits: 1 person - $7,080.00
2 people - $10,620.00
Retroactive coverage is not allowed.

Specified Low-Income Medicare Beneficiaries (SLMB)

The SLMB program pays the Part B Medicare premium only. Part B Medicare covers a person's physician care, and a variety of out-patient services including out-patient hospital services. Applicants must pass all the QMB rules, except that they must be receiving Part A coverage and their income exceeds 100% of the Federal Poverty Level and does not exceed 120% of the Federal Poverty Level. No card is issued for the SLMB program. An individual may be eligible for both Medicaid and SLMB.
Income limits: 120% of the Federal Poverty Level
Deductions: $20.00 general income exclusion, the first $65.00 and then ½ of earned income that remains.
Asset limits: 1 person - $7,080.00
2 people - $10,620.00
Retroactive coverage is allowed.

Qualifying Individuals (QI)

The QI program pays the Part B Medicare premium. Applicants must pass all the QMB rules except that they must be receiving Part A Medicare and their income exceeds 120% of the Federal Poverty Level but not more than 135% of the Federal Poverty Level and the individual **cannot** be receiving Medicaid. This is not an entitlement program. States have been granted a set amount of federal money to cover the benefits paid by the QI program. When funds have been allocated for a calendar year, no new applicants will receive any benefits. Eligibility in future calendar years is not guaranteed. No card is issued for the QI program.
Income limits: 135% of the Federal Poverty Level
Asset limits: 1 person - $7,080.00

2 people - $10,620.00
Retroactive coverage is allowed.

MEDICAID FOR LONG-TERM CARE

To get Medicaid to pay for long term care, people must be financially and medically eligible. The individual may enter a medical facility such as a nursing home, or may be able to receive care in his or her own home under one of the home and community based waivers. Space is limited in home and community based waivers and may not be available in all areas. Home and community based waivers allow Medicaid to pay for some specialized services that would not otherwise be covered by Medicaid in community settings.

Nursing Home (NH)

Nursing home Medicaid will pay for nursing home and other medical costs. Some different income and asset rules apply for married couples. An individual must meet medical criteria for nursing home level of care to be 14 eligible for Medicaid in a nursing facility.
Income limits: Complicated. For single people, income deductions are different if they will be there less than six months. A long-term nursing home resident is able to keep $45 of monthly income for their personal needs. The rest of the money, in most cases, must be paid to the nursing home.
Supplemental income: SSI recipients in nursing homes receive an SSI payment of $30 a month plus a state supplemental payment of $15.
Deductions: Complex. Under Spousal Impoverishment, a spouse at home may be allowed to keep a portion of the income of the nursing home resident for living expenses. Medical insurance premiums are an allowable deduction.
Spend down: Allowed. It is considered a contribution to care and is paid to the nursing home.
Asset limits: Complex. Under Spousal Impoverishment law, the nursing home resident is allowed $2,000.00. Subject to certain limits, the spouse at home may keep ½ the total amount of countable assets that the couple owned when the patient entered the nursing home. These limits go up January 1st of each year. Clients must report all annuities in which the client or spouse have an interest. Annuities must name the state as the beneficiary upon the death of the client.
Transfer of Assets: Transfers of assets for less than the fair market value can result in the person being ineligible for nursing home Medicaid services for a period of time. When an application for Medicaid is made, the eligibility worker will ask for information from the prior 60 months about what the person has done with assets. This is called the look-back period.
Substantial Home Equity: If a person has equity value in his or her home of $536,000 or more, the person is ineligible for Medicaid coverage of the nursing home charges.
Retroactive coverage is allowed for nursing home charges only from the date the patient is determined medically eligible. Ancillary (non nursing home) charges are allowed.
For more information request the pamphlet “Nursing Home Information, May we be of service to you?” DWS 05- 969. For Married couples also request, “Assessment of Assets” DWS 05-992.

Aging Home and Community Based Waiver

This waiver is a special program for clients who would be medically appropriate for institutional care. These clients are eligible for medical services that are not generally available to Medicaid recipients in community settings such as day treatment programs, lifeline, and in-home respite care. To be eligible for this program, recipients must be at least 65 years old. The referral process begins with the Area Agency on Aging (AAA). A case manager from AAA must complete an evaluation of the individual’s appropriateness for the waiver.
Income limits: 100% of the Federal Poverty Level (adjusted annually). Only the waiver client's income counts.

Deductions: $125 earned income deduction; spousal and family allowance; health insurance premiums; medical expenses; some shelter costs.
Spend Down: Allowed
Asset Limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.
Transfer of Assets: Same as Nursing Home. Waiver services will not be paid during a penalty period.
Retroactive coverage is allowed. However, Waiver services received prior to the date the person met the medical criteria, as certified by the AAA worker, cannot be paid.
Substantial Home Equity: If a person has equity value in his or her home of $536,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Utah Community Supports Waiver

This waiver is a special program that helps severely disabled people of any age remain in their homes rather than be institutionalized. Applications are taken through the Division of Services for People with Disabilities (DSPD). Parent's income and assets are not counted in determining a minor child's eligibility. Also, an intensive service plan is drawn up for the client. To be eligible for this program, clients must have been disabled before age twenty-two.
Income limits: 100% of the Federal Poverty Level (adjusted annually)
Deductions: Earned income deduction equal to SSA's substantial gainful activity level; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.
Spend down: Allowed.
Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home
Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.
Substantial Home Equity: If a person has equity value in his or her home of $506,000 or more, the person is ineligible for Medicaid coverage of waiver services.
Retroactive coverage is allowed. However, Waiver services received prior to the date the client met the medical criteria, as certified by DSPD, cannot be paid.

Technology Dependent Children Waiver

A special program which helps medically fragile children remain in their home rather than be institutionalized. Children can qualify for this waiver through the month in which they turn 21. Recipients 21 and older who are admitted to the waiver prior to their 21st birthday may receive ongoing benefits. Applications are taken through the Division of Family Health Services. Parent's income or assets are not counted towards the child's eligibility. An intensive service plan is drawn up for the client and parents receive specialized training in how to provide some of the care the child needs. Families usually receive private-duty nursing services due to the complex medical condition of these children. To be eligible for this program, clients must meet specific medical criteria.
Income limits: 100% of the Federal Poverty Level (adjusted annually)
Deductions: $125 earned income deduction; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.
Spend down: Allowed.
Asset limits: Complex. $2000; same spousal impoverishment rules as nursing home.
Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.
Substantial Home Equity: If a person has equity value in his or her home of $536,000 or more, the person is ineligible for Medicaid coverage of waiver services.
Retroactive coverage is allowed. However, Waiver services received prior to the date the client met the medical criteria, as certified by the Division of Family Health Services cannot be paid.

Brain Injury Waiver

This waiver is a special program for clients who have a brain injury and would be medically appropriate for institutional care. These clients are eligible for medical services that are not generally available to Medicaid recipients in community settings such as supported employment, day treatment programs, behavioral training and in-home respite care. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits: 100% of the Federal Poverty Level (adjusted annually) Only the waiver client's income is counted.

Deductions: $125 earned income deduction; some shelter expenses; health insurance premiums; medical bills; and a deduction for a dependent spouse or children.

Spend down: Allowed.

Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.

Substantial Home Equity: If a person has equity value in his or her home of $536,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed but not prior to the date the client met the medical criteria.

Physical Disabilities Waiver

Clients who are eligible for this waiver would be medically appropriate for institutional care. Additional services the waiver may provide include: personal care assistance, consumer training and personal emergency response services. Policy follows the institutional policy except that the client is allowed higher income deductions. Applications are taken through the Division of Services for People with Disabilities (DSPD).

Income limits: 300% of the SSI rate. If income exceeds the 300% of SSI rate, the person must spend down to the BMS and follow DM income policy. Only the waiver client's income is counted.

Deductions: If income is below 300% of the SSI rate, all income is deducted.

If over 300%, deduct; 100% of the Federal Poverty Limit, some shelter expenses, health insurance premiums, medical bills, and a deduction for a dependent spouse or children.

Spend down: Allowed when income is over 300% of SSI.

Asset limits: Complex. $2000; same spousal impoverishment rules as Nursing Home.

Transfer of Assets: Same as Nursing Home Medicaid. Waiver services will not be paid during a penalty period.

Substantial Home Equity: If a person has equity value in his or her home of $536,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed. However, waiver services received prior to the date the client met the medical criteria, as certified by the DSPD worker, cannot be covered.

New Choices Waiver

The New Choices Waiver provides home and community based services in community settings for eligible clients who require the level of care provided in a nursing facility. The primary goal of the NCW is to move people out of institutional care to a less restrictive community care setting.

To be eligible for the NCW, an individual must be age 65 or older, or must be age 21 through 64 and meet SSA disability criteria. Individuals must then meet the criteria for one of the eligibility coverage groups listed below.

• SSI recipients

• SSI Protected Group individuals: 1619(a) and (b); Adult Disabled Child; Disabled Widows/Widowers; Pickle Amendment

• 100% FPL Aged and Disabled (not spenddown clients)
• Medicaid Work Incentive
• Special Income Group (income not over 300% of the SSI Rate. Income is not deemed from a spouse; resources follow institutional resource rules)
• Spenddown Waiver Group - for individuals who cannot qualify under any other group (income is not deemed from a spouse; resources follow institutional resource rules)

Transfer of Assets: Same as Nursing Home Medicaid and apply to individuals eligible under the Special Income Group. Waiver services will not be paid during a penalty period.

Substantial Home Equity: If a person has equity value in his or her home of $536,000 or more, the person is ineligible for Medicaid coverage of waiver services.

Retroactive coverage is allowed.