Representing the Elder Unmarried Couple

Attachments to PowerPoint

1) 2016 NYS Income and Resource Standards and Federal Poverty Levels (FPL) [Form MAPDR-01]
2) Excerpt from Medicaid Reference Guide: Categorical Factors – Legally Recognized Same Sex Marriages [page 5]
3) Spousal Refusal Forms: Applicant/Recipient Declaration Concerning the Legally Responsible Relative's Income/Resources [Form MAP-2161) and Declaration of Legally Responsible Relative [Form Map-2161(a)]
4) GIS 98 MA/024 – Retirement Funds owned by Medicaid Applicants/Recipients
5) GIS 06 MA/004 – Treatment of Community Spouses' Retirement Funds
6) GIS 16 MA/10 – 2015 Update to the Actuarial Life Expectancy Table
7) IRS Publication 590-B Appendix B Table III – Uniform Lifetime Table
8) Excerpt from Medicaid Reference Guide: Resources Transfer of Assets – Annuities [pages 452-454]
9) Consumer Intent to Return / Not to Return Home [Form MAP-259H] and Discharge Alert [Form MAP-259d]
10) Notice of Intent to Impose a Lien on Real Property (Institutionalized Individual)
11) Notice of Lien
12) Satisfaction of Mortgage/Lien
13) Sample Notice of Acceptance and Budget Explanation forms
14) Sample Spousal Contribution Letters and Attorney Response

2016 NYS INCOME AND RESOURCE STANDARDS AND FEDERAL POVERTY LEVELS (FPL)

Reference Documents: SA 2015-00031 -01, GIS 14 MA/029, GIS14 MA/08, GIS 15 MA/01, GIS 15 MA/03, GIS 15 MA/10 ,GIS 15 MA/21, MBL-Transmittal 14-5, WLM-2015-00344-00R1, OTDA 15-INF-10, WLM-2016-00055

NYC Human Resources Administration Department of Social Services

MAPDR-01 04/15/2016
(Obsoletes MAPDR-71)

Financial Levels for Medicaid and Related Program Eligibility

1. Non-MAGI Medicaid Levels (SSI and SSI-Related Consumers With or Without A Surplus)

Family Size	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Monthly Income	$825	$1,209	$1,390	$1,571	$1,753	$1,934	$2,115	$2,296	$2,478	$2,659	$182

2. Non-MAGI Resource Levels

Family Size	1	2	3	4	5	6	7	8	9	10	Each Additional Person
Resource Level	$14,850	$21,750	$25,013	$28,275	$31,538	$34,800	$38,063	$41,325	$44,588	$47,850	$3,263

3. Spousal Support and Resource Levels

Income (MMMNA) - $2,980.50 (Inst Spouse) - **$50**	**Resources** – (Minimum) - $74,820 (Maximum) - $119, 220 (Inst Spouse) - $14,850	**Family Member Allowance Formula:** Use - $1, 992 **$664** is the maximum family member allowance

4. Medicare Savings Program (Buy-In)

		Income	
		Family of 1	Family of 2
QMB 100% FPL	Annual	$11,880	$16,020
	Monthly	$990	$1,335
SLIMB 120% FPL	Annual	$14,256	$19,224
	Monthly	$1,188	$1,602
QI-1 135% FPL	Annual	$16,038	$21,627
	Monthly	$1,337	$1,803

NO RESOURCE TEST FOR ANY MSP PROGRAM

5. Other Important Figures

Medicare Part A Premium: $224.00 (30-39 Quarters)
$407.00 (Less than 30 Quarters)

Medicare Part B Premium: (Rates based upon 2014 income tax filings)

- **$104.90** for most Medicare Part B recipients in receipt of benefits on or before 12/31/2015. This includes individuals with an annual income of $85,000 or less and couples with joint annual incomes of $170,000 or less
- **$121.80** for persons in receipt of Medicare Part B benefits as of January 1, 2016, who are either individuals with an annual income of $85,000 or less and couples with joint annual incomes of $170,000 or less
- **$194.90** for persons in receipt of Medicare Part B benefits as of January 1, 2016, who are either individuals with an annual income of more than $160,000 but no more than $214,0000 and couples with joint annual incomes of more than $320,000 but no more than $428,000
- **$268.00** for persons in receipt of Medicare Part B benefits as of January 1, 2016, who are either individuals with an annual income of more than $214,0000 and couples with joint annual incomes of more than $428,000

Standard Allocation: From non-SSI-related parent to non-SSI- related child $384

PASS-THROUGH FACTORS: .968 and.160

Family Size	1	2
COBRA (100% FPL)	$990	$1,335
AIDS Health Ins. Program (AHIP) (185% FPL)	$1,832	$2,470
QWDI (200% FPL)	$1,980	$2,670
COBRA, QWDI (Resource Level)	$4,000	$6,000
Pickle/DAC/SSI (Resource Level)	$2,000	$3,000

6. MBI-WPD (Persons 16-64)		
Family Size	**1**	**2**
Monthly Income 250% FPL	$2,475	$3,338
Resources	$20,000	$30,000

7. Family Planning Benefit Program Income Levels (No Resource Test)							
Family Size	**1**	**2**	**3**	**4**	**5**	**6**	**Each Additional Person**
FPBP 223% FPL (Child Bearing Age)	$2,208	$2,978	$3,747	$4,516	$5,286	$6,055	$774

Note: FPBP eligibility is to be determined using only the applicant's income. The applicant's income is then compared to 223% of the federal poverty level for the appropriate family size. Family size continues to be determined using legal responsibility.

8. Monthly Regional Nursing Home Rates (Use the rate for the region in which the facility is located)	
NEW YORK CITY (All boroughs) - $12,029	**LONG ISLAND - $12,633** Nassau, Suffolk
NORTHEASTERN - $9,806 Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington	**NORTHERN METROPOLITAN - $11,768** Duchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester
WESTERN - $9,630 Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming	**ROCHESTER - $11,145** Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates
CENTRAL - $9,252 Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins	

9. Fair Market Regional Rates (Averages)	
NEW YORK CITY (All boroughs) (Shelter = 59) - $1094	**LONG ISLAND** (Shelter = 60) - **$1060**
NORTHEASTERN (Shelter = 54) - **$445**	**NORTHERN METROPOLITAN** (Shelter = 58) - **$837**
WESTERN (Shelter = 57) - **$341**	**ROCHESTER** (Shelter = 56) - **$400**
CENTRAL (Shelter = 55) - **$384**	
CONGREGATE CARE LEVEL III - (42+ Regional Rate for County) - **$1768 - $2487**	

In determining the community resource allowance on and after January 1, 2016, the community spouse is permitted to retain resources in an amount equal to the greater of the following: $74,820 or the amount of the spousal share up to $119,220. The spousal share is the amount equal to one-half of the total value of the countable resources of the couple as of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse. The look-back period is anchored in the month the A/R is both institutionalized and applying for MA.

10. MAGI Levels for Medicaid and Related Program Eligibility											
Family Size	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Each Add'l Person**
Pregnant Women and Infants Under Age 1 (223% FPL)	$2,208	$2,978	$3,747	$4,516	$5,286	$6,055	$6,826	$7,599	$8,373	$9,147	$774
Infants Under Age 1 223% FPL	$2,208	$2,978	$3,747	$4,516	$5,286	$6,055	$6,826	$7,599	$8,373	$9,147	$774
Children Age 1-5 154% FPL	$1,525	$2,056	$2,588	$3,119	$3,650	$4,182	$4,714	$5,248	$5,782	$6,316	$534
Children Age 6 -19 110% FPL	$1,089	$1,469	$1,848	$2,228	$2,607	$2,987	$3,367	$3,749	$4,131	$4,512	$382
Children Age 6-19 (Expanded - 154% FPL)	$1,525	$2,056	$2,588	$3,119	$3,650	$4,182	$4,714	$5,248	$5,782	$6,316	$534
Parents and Caretaker Relatives 138% FPL	$1,367	$1,843	$2,319	$2,795	$3,271	$3,747	$4,224	$4,703	$5,182	$5,661	$479
19 and 20 Year Olds Living With Parents 138% FPL	$1,367	$1,843	$2,319	$2,795	$3,271	$3,747	$4,224	$4,703	$5,182	$5,661	$479
19 and 20 Year Olds Living With Parents (Expanded - 155% FPL)	$1,535	$2,070	$2,604	$3,139	$3,674	$4,209	$4,745	$5,282	$5,820	$6,358	$538
S/CCs and 19 and 20 Year Olds Living Alone (100% FPL)	$990	$1,335	$1,680	$2,025	$2,370	$2,715	$3,061	$3,408	$3,755	$4,102	$347
S/CCs and 19 and 20 Year Olds Living Alone (Expanded 138% FPL)	$1,367	$1,843	$2,319	$2,795	$3,271	$3,747	$4,224	$4,703	$5,182	$5,661	$479

11. Children's Medicaid Income Eligibility Levels									
Family Size	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Each Additional Person**
Children Under 1 year; Pregnant Women*	$2,208	$2,978	$3,747	$4,516	$5,286	$6,055	$6,826	$7,599	$774
Children 1-18 Years	$1,525	$2,056	$2,588	$3,119	$3,650	$4,182	$4,714	$5,248	$534
Note: *Pregnant women household size calculation includes all expected children.									

12. Child Health Plus Premium Levels – Monthly Income by Family Size (Children Under 19 Not Medicaid Eligible)							
Premium Categories	**1**	**2**	**3**	**4**	**5**	**6**	**Each Add'l Person**
Free Insurance **(under 222% FPL)**	$1,583	$2,135	$2,687	$3,239	$3,791	$4,343	$554
$9 per child per month (Max. $27 per family) **(222% - 249% FPL)**	$2,198	$2,964	$3,730	$4,496	$5,262	$6,028	$770
$15 per child per month (Max $45/Family) **(250% - 299% FPL)**	$2,475	$3,338	$4,200	$5,063	$5,925	$6,788	$867
$30 per child per month (Max. $90 per family) **(300% - 349% FPL)**	$2,970	$4,005	$5,040	$6,075	$7,110	$8,145	$1,040
$45 per child per month (Max. $135 per family) **(350% - 399% FPL)**	$3,465	$4,673	$5,880	$7,088	$8,295	$9,503	$1,214
$60 per child per month (Max. $180 per family) **(400% FPL)**	$3,960	$5,340	$6,720	$8,100	$9,480	$10,860	$1,387
Full Premium per child/month if **over 400%** FPL (Premium amount varies from plan to plan)	Over $3,960	Over $5,340	Over $6,720	Over $8,100	Over $9,480	Over $10,860	

13. Disabled Adult Children (DAC) Levels		
Living Arrangements	**Shelter Types**	**Amount**
1	15	$999.48
1	28	$961.48
1	16	$1,168.00
1	29	$1,138.00
1	42	$1,427.00
1 or 5	Other than: 15, 16, 28, 29 or 42	$820.00
2	15	$1,998.96
2	28	$1,922.96
2	16	$2,336.00
2	29	$2,276.00
2	42	$2,854.00
2 or 6	Other than: 15, 16, 28, 29 or 42	$1,204.00
3	All	$961.48
4	All	$999.48

14. Congregate Care Level I, II and III Levels		
Shelter Codes	**PNA**	**Shelter Amount**
15 - (NYC, Nassau, Suffolk, Westchester, Rockland Counties) Level I	$141.00	$858.48
16 - (NYC, Nassau, Suffolk, Westchester, Rockland Counties) Level II	$163.00	$1,005.00
28 - (Rest of State) Level I	$141.00	$820.48
29 - (Rest of State) Level II	$163.00	$975.00
42 - (NYC, Nassau, Suffolk, Westchester, Rockland Counties) Level III	$193.00	$1,234.00
42 - (Rest of State) Level III	$193.00	$1,234.00

15.	SSI Levels			
SSI Consumer	**Amount**			
Allocation Amount (The difference between the regular Medicaid levels for a household of two [$1,209.00] and a household of one [$825.00])	$384.00			
Personal Needs Allowance (Certain waiver participants subject to spousal impoverishment budgeting)	$384.00			
Maximum Social Security Benefit at Full Retirement Age	$2,639			
State Supplement	Individual	$87.00	Couple	$104.00
Federal Benefit Rate	Individual	$733.00	Couple	$1,100.00
SSI Resource Levels	Individual	$2,000.00	Couple	$3,000.00
SSI Related Student Earned Income Disregard	Monthly	$1,780.00	Annual Max.	$7,180.00

16.	Substantial Gainful Activity (SGA) Levels	
Category	**Amount**	**Payment Occurrence**
Non-Blind	$1,130.00	Monthly
Blind	$1,820.00	Monthly
Month Trial Work Period	$810.00	Monthly

17.	Home Equity Maximum
Medicaid Coverage Limit (RVI 1 and 2 cases)	$828,000

CATEGORICAL FACTORS

LEGALLY RECOGNIZED SAME SEX MARRIAGES

Policy: Individuals who declare that they have been legally married in a jurisdiction that recognizes and performs same-sex unions must, regardless of gender, receive full faith, credit and comity as all other legally married persons when a district makes any Medicaid eligibility and case decision in New York State.

References: GIS 08 MA/023

Interpretation: Individuals of the same sex who have been married in a jurisdiction that recognizes and performs same-sex unions must receive equal treatment and recognition of such marriage. Equal treatment means that terms such as "husband", "wife" and "spouse" are construed in a manner that encompasses legal same-sex marriages. Factors including but not limited to the following must be evaluated in the same manner for all legally performed marriages:

- Required signatures on applications;
- Household composition and size;
- Budgeting methodology;
- Determination of Legally Responsible Relatives;
- Spousal and Child Support issues
- Health insurance premium payments;
- Chronic/long term care budgeting issues, including transfers of resources for SSI-related A/Rs;
- Income from trusts;
- Homestead and resource exemptions for SSI-related A/Rs
- Burial funds;
- Estates; and
- Liens and recoveries.

Disposition: Individuals who have been legally married in a same-sex union will have their eligibility for Medicaid and related programs determined in the same manner as individuals who are legally married that are not of the same sex.

Documentation: Documentation of a legally recognized same-sex marriage is only necessary in the same limited circumstances as documentation of any other marriage (for example, when an individual seeks spousal budgeting for long term care).

APPLICANT/RECIPIENT DECLARATION CONCERNING THE LEGALLY RESPONSIBLE RELATIVE'S INCOME/RESOURCES

NYC Human Resources Administration Department of Social Services

MAP-2161 (E) 03/13/2013

DATE: _____

CASE NAME: _____

CASE NUMBER: _____

_____

_____

_____

If you have any questions, call HRA Infoline at 718-557-1399

Dear _____

This form is to be completed by the applicant or recipient who is living with a Legally Responsible Relative (LRR) who has refused to make income and/or resources available for the cost of necessary medical care and services. Legally Responsible Relatives are: spouses (e.g. husband for wife, wife for husband) and parents for children under 21.

The Legally Responsible Relative is not absolved from providing financial resources for the care of his or her spouse or child. The Department of Social Services expects the legally responsible relative to cooperate with the process of substantiating the income and resources of the responsible relative in order to determine the amounts the Legally Responsible Relative will be required to pay. **Legally Responsible Relatives may be taken to court for failure to support their spouses or minor children**. Failure to provide requested financial information may also result in the legally responsible relative being taken to court.

Complete the table below, including your signature and the date, and return this entire form in the enclosed envelope within 10 days

I (Print name) _____ _____ declare that my
(First) (Last)

☐ Spouse ☐ Parent ☐ Other, specify: _____
has refused to make his/her income and/or resources available for the cost of necessary medical care and services. I have read the above and understand that the process of financial review and collection of my Medicaid debt from my legally responsible relative begins when I sign this form.

Name of Legally Responsible Relative: _____ _____
(First) (Last)

Social Security Number of Legally Responsible Relative: _____

In consideration of the determination of my eligibility for Medical Assistance, I hereby assign, to the Commissioner of the New York City Human Resources Administration (Department of Social Services), my right of support from the legally responsible relative named above.

Name of Legally Responsible Relative's Health Care Plan (if applicable)

Type of Health Care Coverage (i.e. Long-Term Care): _____

Policy Number (if applicable): _____

Contact Number: ( ) _____
(Area Code)

Signature of Applicant/ Recipient: _____ Date: _____

Worker's Name	Title	Section

Supervisor's Name (Print)	Supervisor's Name (Sign)

DECLARATION OF THE LEGALLY RESPONSIBLE RELATIVE

NYC Human Resources Administration Department of Social Services

MAP-2161a (E) 12/06/2011

_____

_____

_____

DATE: _____

CASE NAME: _____

CASE NUMBER: _____

HRA InfoLine: 718-557-1399

Dear _____:

An application/recertification for Medicaid has been submitted by or on behalf of the person named above. You have been identified as the Legally Responsible Relative (LRR).

If found eligible, Medicaid will cover that part of the consumer's care for which s/he is unable to pay because of the refusal of the Legally Responsible Relative to make available income and/or resources for the cost of necessary medical care and services.

Legally Responsible Relatives are: a husband for his wife, a wife for her husband, and parents for children under 21.

IMPORTANT NOTICE: Legally Responsible Relatives may be taken to court for failure to support their spouses or minor children.

Complete the table below, including your signature and the date, and return this entire form in the enclosed envelope within 10 days.

Name: _____ _____
(First) (Last)

Relationship to the Medicaid Applicant/Recipient (check box): ☐ Spouse ☐ Parent ☐ Other: _____
(specify)

Social Security Number: _____

Name of your Health Insurance Plan (if applicable):

_____

Type of Health Insurance Coverage (i.e. Long-Term Care): _____

Policy Number (if applicable):_____

Contact Number: (_____)_____
Area Code

I declare that I refuse to make my income and/or resources available for the cost of necessary medical care and services for the Medicaid applicant/recipient listed above.

Signature of the Legally Responsible Relative: _____ Date:_____

If you have any questions, contact:

SUPERVISOR	SECTION	TELEPHONE NUMBER

TO: Local District Commissioners, Medicaid Directors

FROM: Betty Rice, Director
Division of Consumer and Local District Relations

SUBJECT: Retirement Funds owned by Medicaid Applicants/Recipients

EFFECTIVE DATE: Immediately

CONTACT PERSON: Wendy Butz (518) 473-5500 or Dennis Boucher (518) 473-6111

This message is to clarify the Department's policy concerning the treatment of retirement funds for purposes of determining Medicaid eligibility. The clarification reflects the eligibility requirements of the Supplemental Security Income (SSI) program, however, the clarification applies to all Medicaid applicants/recipients.

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or other retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self employed individuals, sometimes referred to as Keogh plans.

Treatment as a Resource

A retirement fund owned by an individual is a countable resource if the individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. The value of the resource is the amount of money that the individual can currently withdraw. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Any income taxes due are not deductible in determining the resource's value.

As advised in 90 ADM-36, retirement funds owned by an ineligible or non-applying community spouse are countable for purposes of determining the total combined countable resources of the couple. However, the retirement funds are not considered available to the institutionalized spouse. The retirement fund owned by the community spouse is counted first toward the maximum community spouse resource allowance.

Periodic Payments

Medicaid A/Rs who are eligible for periodic retirement benefits must apply for such benefits as a condition of eligibility. If there are a variety of payment options, the individual must choose the maximum income payment that could be made available over the individual's life time. (By federal law, if the Medicaid A/R has a spouse, the maximum income payment option for a married individual will usually be less than the maximum income payment option that is available to a single individual.) Once an individual is receiving periodic payments, the payments are counted as unearned income on a monthly basis, regardless of the actual frequency of the payment. For example, if the periodic benefit is received once a year, the amount is to be divided by twelve to arrive at a monthly income amount.

Once an individual is in receipt of or has applied for periodic payments, the principal in the retirement fund is not a countable resource. This includes situations where a Medicaid applicant has already elected less than the maximum periodic payment amount and this election is irrevocable. In such situations, only the periodic payment amount received is counted as income and the principal is disregarded as a resource.

NOTE: Individuals who have met the minimum benefit duration requirement of a New York State Partnership for Long Term Care policy are not required to maximize income from a retirement fund. In addition, non-applying or ineligible spouses/parents cannot be required to maximize income from a retirement fund.

The above information will be contained in a forthcoming administrative directive.

TO: Local District Commissioners, Medicaid Directors

FROM: Betty Rice, Director
Division of Consumer & Local District Relations

SUBJECT: Treatment of Community Spouses' Retirement Funds

EFFECTIVE DATE: January 1, 2006

CONTACT PERSON: Local District Liaison
Upstate (518)474-8887 NYC (212)417-4500

This GIS informs districts of an amendment to Section 360-4.10(a)(9) of Department regulations, regarding the treatment of a community spouse's (CS's) retirement fund for purposes of determining an institutionalized spouse's Medicaid eligibility.

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or other retirement plans administered by an employer or union). Additional examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals (e.g., Keogh plans).

In accordance with recent federal notification regarding the Medicare Catastrophic Coverage Act of 1988, retirement funds are not excludable resources for purposes of determining an institutionalized spouse's Medicaid eligibility. Therefore, effective January 1, 2006, if a CS is NOT receiving periodic payments from his/her available retirement fund, the fund is considered a countable resource for purposes of determining the community spouse resource allowance (CSRA) and the institutionalized spouse's Medicaid eligibility. This includes situations where the retirement fund of the CS exceeds the CSRA. Prior to the regulation change, it had been the Department's policy to count the resource amount of any retirement fund belonging to the CS first toward the CSRA and to disregard any amount which exceeded the CSRA. The excess will no longer be disregarded.

This change applies to Medicaid eligibility determinations with a budget "From Date" of January 1, 2006 or after. Undercare cases are not affected by this change.

NOTE: If the community spouse has elected to receive periodic payments from his/her retirement account, the retirement account is not a countable resource in determining the institutionalized spouse's eligibility. However, the periodic payments are countable income for the community spouse.

For purposes of determining Medicaid eligibility for SSI-related individuals who are not subject to spousal impoverishment budgeting, a retirement fund owned by a non-applying or ineligible spouse continues to be excluded as a resource.

TO: Local District Commissioners, Medicaid Directors

FROM: Judith Arnold, Director
Division of Eligibility and Marketplace Integration

SUBJECT: 2015 Update to the Actuarial Life Expectancy Table

EFFECTIVE DATE: Immediately

CONTACT PERSON: Local District Support Unit
Upstate (518) 474-8887 NYC (212) 417-4500

The purpose of this General Information System (GIS) message is to provide local departments of social services with the updated life expectancy table issued by the Office of the Chief Actuary of the Social Security Administration (SSA).

As advised in Administrative Directive 06 OMM/ADM-5, "Deficit Reduction Act of 2005 – Long-Term Care Medicaid Eligibility," the life expectancy table issued by SSA is required to be used in evaluating whether an annuity purchased by or on behalf of an applicant/recipient on or after February 8, 2006 is actuarially sound. The table is also used in determining whether the repayment term for a promissory note, loan or mortgage is actuarially sound.

The life expectancy table that was attached to 06 OMM/ADM-5 as Attachment VIII, is being updated to reflect the current information obtained from the Office of the Chief Actuary of the Social Security Administration. The revised life expectancy table is provided as an attachment to this GIS. Effective with the release of this GIS, districts must use the revised table.

Please direct any questions to your local district support liaison.

2015 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
0	76.18	80.95	30	47.76	51.92
1	75.69	80.39	31	46.83	50.95
2	74.72	79.42	32	45.90	49.99
3	73.74	78.44	33	44.96	49.02
4	72.76	77.45	34	44.03	48.06
5	71.77	76.47	35	43.10	47.10
6	70.78	75.48	36	42.17	46.15
7	69.79	74.48	37	41.24	45.19
8	68.80	73.49	38	40.31	44.23
9	67.81	72.50	39	39.39	43.28
10	66.82	71.51	40	38.46	42.33
11	65.82	70.51	41	37.54	41.39
12	64.83	69.52	42	36.62	40.45
13	63.84	68.52	43	35.71	39.51
14	62.85	67.53	44	34.81	38.57
15	61.87	66.54	45	33.91	37.65
16	60.90	65.56	46	33.02	36.72
17	59.93	64.57	47	32.13	35.81
18	58.97	63.59	48	31.26	34.89
19	58.02	62.61	49	30.39	33.99
20	57.07	61.63	50	29.53	33.09
21	56.13	60.66	51	28.68	32.19
22	55.20	59.68	52	27.84	31.30
23	54.27	58.71	53	27.01	30.42
24	53.35	57.74	54	26.19	29.54
25	52.42	56.76	55	25.38	28.67
26	51.49	55.79	56	24.57	27.80
27	50.56	54.82	57	23.78	26.93
28	49.63	53.85	58	22.99	26.07
29	48.69	52.88	59	22.21	25.22

2015 Life Expectancy Table

Age	Male Life Expectancy	Female Life Expectancy	Age	Male Life Expectancy	Female Life Expectancy
60	21.44	24.37	90	4.00	4.75
61	20.67	23.52	91	3.70	4.40
62	19.90	22.68	92	3.44	4.08
63	19.15	21.85	93	3.19	3.79
64	18.40	21.03	94	2.97	3.53
65	17.66	20.22	95	2.78	3.29
66	16.93	19.42	96	2.61	3.08
67	16.21	18.63	97	2.46	2.89
68	15.51	17.85	98	2.33	2.72
69	14.81	17.09	99	2.21	2.56
70	14.13	16.33	100	2.09	2.41
71	13.47	15.59	101	1.98	2.27
72	12.81	14.86	102	1.88	2.13
73	12.18	14.14	103	1.77	2.00
74	11.55	13.44	104	1.68	1.87
75	10.94	12.76	105	1.58	1.75
76	10.34	12.09	106	1.49	1.64
77	9.76	11.44	107	1.40	1.53
78	9.20	10.80	108	1.32	1.43
79	8.66	10.18	109	1.24	1.33
80	8.13	9.58	110	1.16	1.23
81	7.62	9.00	111	1.09	1.14
82	7.14	8.43	112	1.02	1.06
83	6.68	7.89	113	0.95	0.98
84	6.23	7.37	114	0.89	0.90
85	5.81	6.87	115	0.82	0.83
86	5.40	6.40	116	0.76	0.76
87	5.02	5.94	117	0.71	0.71
88	4.65	5.52	118	0.65	0.65
89	4.31	5.12	119	0.60	0.60

Appendix B. Uniform Lifetime Table

Table III

(Uniform Lifetime)

(For Use by:

- **Unmarried Owners,**
- **Married Owners Whose Spouses Are Not More Than 10 Years Younger, and**
- **Married Owners Whose Spouses Are Not the Sole Beneficiaries of Their IRAs)**

Age	Distribution Period	Age	Distribution Period
70	27.4	93	9.6
71	26.5	94	9.1
72	25.6	95	8.6
73	24.7	96	8.1
74	23.8	97	7.6
75	22.9	98	7.1
76	22.0	99	6.7
77	21.2	100	6.3
78	20.3	101	5.9
79	19.5	102	5.5
80	18.7	103	5.2
81	17.9	104	4.9
82	17.1	105	4.5
83	16.3	106	4.2
84	15.5	107	3.9
85	14.8	108	3.7
86	14.1	109	3.4
87	13.4	110	3.1
88	12.7	111	2.9
89	12.0	112	2.6
90	11.4	113	2.4
91	10.8	114	2.1
92	10.2	115 and over	1.9

RESOURCES
TRANSFER OF ASSETS

ANNUITIES

Description: An annuity is contract with a life insurance company, designed to provide payments on a regular basis either for life or a term of years.

Policy: As a condition of eligibility, all persons applying for Medicaid coverage of nursing facility services, including requests for an increase in coverage for nursing facility services, must disclose a description of any interest he/she, or his/her spouse, may have in an annuity. The disclosure of interest in an annuity is required regardless of whether the annuity is irrevocable or counted as a resource. Additionally, for annuities purchased by an SSI-related A/R or the A/R's spouse on or after February 8, 2006, the State must be named as a remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the institutionalized individual. In cases where there is a community spouse or minor or disabled child of any age, the State must be named the remainder beneficiary in the second position or named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

NOTE: In instances where the annuity has been determined to be a countable resource, the State is NOT named a remainder beneficiary.

The social services district must require a copy of the annuity contract owned by the SSI-related A/R or the A/R's spouse in order to verify that the State has been named the remainder beneficiary. If the SSI-related A/R or the A/R's spouse fails or refuses to provide the necessary documentation, the district must treat the purchase of the annuity as a transfer of assets for less than fair market value.

Individuals who are applying for or receiving care, services or supplies pursuant to a waiver under subsection (c) or (d) of Section 1915 of the Social Security Act (SSA) are **not** subject to these requirements regarding annuities. In New York, such waiver services are provided through the Long Term Home Health Care Program (LTHHCP), Traumatic Brain Injury Waiver Program (TBI), Care at Home Program (CAH), the Office for People with Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) Waiver, Home and Community- Based Services Waiver for Children with Serious Emotional Disturbance (Office of Mental Health [OMH]) and the Nursing Home Transition and Diversion Waiver (NHTD).

NOTE: Treatment of annuities for Partnership policy/certificate holders with Total Asset Protection OR Dollar for Dollar Asset Protection plans is discussed in **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE.

RESOURCES
TRANSFER OF ASSETS

ANNUITIES

References:

SSL Sect.	366-a (2) 366 366-c 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6
ADMs	10 OHIP/ADM-01 06 OMM/ADM-5 06 OMM/ADM-2 04 OMM/ADM-6 96 OMM/ADM-8
GISs	09 MA/027 07 MA/020 07 MA/018 07/MA/011 06 MA/016

Interpretation: The purchase of an annuity that does not name the State as a remainder beneficiary in the first position (or in the second position as explained above) will be treated as an uncompensated transfer of assets for SSI-related A/Rs. In addition, if an annuity is purchased by or on behalf of an SSI-related A/R, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity is:

- An annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986; or
- Purchased with the proceeds from an account or trust, described in subsection (a), (c), or (p) of Section 408 of such Code; a simplified employee pension (within the meaning of Section 408 (k) of such Code); or a Roth IRA described in Section 408A of such Code; or

RESOURCES
TRANSFER OF ASSETS

ANNUITIES

The annuity is:

- Irrevocable and non-assignable;
- Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); **AND**
- Provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

NOTE: These provisions apply to transactions, including purchases which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

NYC Human Resources Administration
Department of Social Services

MAP-259H (MLF).....Rev. 06/20/08

CONSUMER INTENT TO RETURN / NOT TO RETURN HOME

NAME OF RESIDENTIAL FACILITY:	CIN	SSN:

I, _____,hereby declare that I:

☐ Plan to return to my homestead upon completion of rehabilitation

☐ Do not plan to return to my homestead

Signature of Consumer: _____ Date:_____

Signature of Representative (if applicable)_____ Date:_____

أنا ، _____، أصرّح بموجبه أنني:

☐ أنوي العودة إلى منزلي عند الانتهاء من إعادة التأهيل.

☐ لا أنوي العودة إلى منزلي.

توقيع المستهلك / Signature of Consumer: _____ التاريخ/Date: _____

توقيع الممثل (إن كان ملائماً) / Signature of Representative (if applicable): _____ التاريخ/Date: _____

Yo, _____, por el presente declaro que:

☐ Tengo pensado regresar a mi lugar de residencia una vez termine la rehabilitación

☐ No tengo pensado regresar a mi lugar de residencia

Firma del consumidor / Signature of Consumer: _____ Fecha/Date:_____

Firma del representante (si corresponde) / Signature of Representative (if applicable)_____ Fecha/Date:_____

나, _____는 이로써 다음과 같이 선언합니다:

☐ 재활 프로그램 완료 후 나의 집으로 돌아갈 계획입니다

☐ 나의 집으로 돌아갈 계획이 없습니다

소비자 서명/Signature of Consumer: _____ 날짜/Date:_____

대표자 서명 (해당될 경우) /Signature of Representative: _____ 날짜/Date:_____

DISCHARGE ALERT
Non-Chronic Budget
Fee-for-Service and Managed Long Term Care Only

NYC Human Resources Administration Department of Social Services

MAP-259d (E) 10/20/2015

Date _____

TO:

Medical Assistance Program
NHED - Expedited Discharge Unit
P.O. Box 24210
Brooklyn, NY 11202-9810

FROM:

NAME OF FACILITY	
ADDRESS	
PROVIDER NUMBER	
CONTACT PERSON	TELEPHONE

Submit this form with the application or conversion packet.

LAST NAME	FIRST NAME	CIN

Upon completion of a rehabilitation program the above-named resident is planning to return to community living.

Diagnosis _____

_____

_____

Anticipated discharge date _____

PLANNED LIVING ARRANGEMENTS:

- ☐ Own Home/Apartment
- ☐ ALPS
- ☐ Adult Home
- ☐ Relative's Home
- ☐ Congregate Care

ATTESTATION

I, do certify that all the medical information contained within this form is both true and complete to the best of my knowledge and is supported by medical records on file at the facility. I may be contacted for further clarification.

PHYSICIAN'S NAME (Print)	SPECIALITY	PHYSICIAN'S SIGNATURE
DATE FORM SIGNED	LICENSE NO.	TELEPHONE NO.

DO NOT FAX THIS FORM. The original must be mailed. EDITS Nursing Home submitters must retain the original in the consumer's record.

Mwenmenm,_____, atravè dokiman sila a, map deklare ke mwen:

☐ Planifye pou m retounen nan pwopriyete familyal mwen dèke mwen fini avèk reyabilitasyon an

☐ Pa planifye pou m retounen nan pwopriyete familyal mwen an

Siyati kliyan an/Signature of Consumer: _____Dat la/Date:_____

Siyati reprezantan an (si l aplikab)
/Signature of Representative (if applicable):_____Dat la/Date:_____

本人 _____，謹此聲明我

☐ 打算在康復後返回我的老家

☐ 不打算返回我的老家

消費者簽名
/Signature of Consumer：_____ 日期 /Date：_____

代辦人簽名（假如適用）
/Signature of Representative
(if applicable)_____ 日期 /Date：_____

Я, _____,настоящим подтверждаю, что:

☐ по окончании реабилитационного периода я намерен (-а) вернуться к обычному месту своего проживания;

☐ я не намерен (-а) возвращаться к обычному месту своего проживания.

Подпись клиента / Signature of Consumer:_____ Дата / Date_____
Подпись официального представителя (если имеется)
/ Signature of Representative (if applicable)_____ Дата / Date_____

LDSS-4466(Rev.12/06/01) ATTACHMENT II

NOTICE OF INTENT TO IMPOSE A LIEN ON REAL PROPERTY
(INSTITUTIONALIZED INDIVIDUAL)

NOTICE DATE: August 4, 2014	NAME AND ADDRESS OF AGENCY/CENTER OR DISTICT OFFICE Division of Liens & Recovery Real Property & Asset Unit 250 Church Street - 7th floor New York, NY 10013
CASE NUMBER [redacted] / CIN/RID NUMBER	
CASE NAME (And C/O Name if Present) AND ADDRESS [redacted]	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP OR Agency Conference Fair Hearing Information and assistance Record Access Legal Assistance Information

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NO.	TELEPHONE NO.
				5505, 212-274-~~5092~~

We have determined that you are an inpatient in a medical institution who is not reasonably expected to be discharged and return home.

You have an ownership interest in real property located at:

[redacted]

This real property is not counted as a resource to determine your Medical Assistance eligibility, since:

- [X] the property is your home and you have expressed your intent to return to the home;
- [ ] the property is your home, and although you do not intend to return home, the property continues to be occupied by your dependent
  - [ ] adult child who is not certified blind/disabled, stepchild, or grandchild
  - [ ] parent, stepparent, grandparent, aunt, uncle, niece, or nephew
  - [ ] sibling (who does not have equity interest in the property and has not resided in the home for at least one year), stepsibling, half brother/sister, cousin, or in-law;
- [ ] the property is used in a trade or business;
- [ ] there is a legal impediment which prevents you from selling the property. The property will be a countable resource as of the first of the month following the month that the legal impediment has been removed.

We intend to impose a lien (a secured legal claim) on the above-listed property for Medical Assistance paid or to be paid on your behalf. The lien does not affect your ownership of the property. If you are discharged from the medical institution and return home, we will remove the lien.

You are not required to sell the property. However, whenever the property is sold, we will recover the amount of Medical Assistance paid or to be paid on your behalf from the proceeds of the sale. If the proceeds of the sale are more than the amount of Medical Assistance paid or to be paid on your behalf, we will redetermine your Medical Assistance eligibility based on your income and resources at that time.

The LAWS and REGULATIONS which allow us to do this are Sections 369.1 and 369.2 of Social Services Law and 18 NYCRR 360-7.11.

REGULATIONS REQUIRE THAT YOU IMMEDIATELY NOTIFY THIS DEPARTMENT OF ANY CHANGE IN NEEDS, INCOME, RESOURCES, LIVING ARRANGEMENTS OR ADDRESS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

NOTICE OF LIEN

Pursuant to Section 369 of the New York State Social Services Law and Title 18 of the New York Codes Rules Regulations, Section 360-7.11

THE CITY OF NEW YORK - DEPARTMENT OF SOCIAL SERVICES

KINDLY RECORD AND RETURN TO:

HUMAN RESOURCES ADMINISTRATION
INVESTIGATION, REVENUE AND ENFORCEMENT ADMINISTRATION
LIENS AND RECOVERY DIVISION
250 CHURCH STREET, 7TH FLOOR
NEW YORK, NEW YORK 10013
TELEPHONE: (212) 274-4707

10/17/2014
DATE

TO: THE CLERK OF THE COUNTY OF KINGS, CITY OF NEW YORK:
CITY REGISTER, COUNTY OF KINGS, CITY OF NEW YORK:
STATE OF NEW YORK
AND ALL OTHERS TO WHOM IT MAY CONCERN:

PLEASE TAKE NOTICE THAT the Department of Social Services of the City of New York acting by and through the Commissioner of Social Services of the City of New York with offices located at 180 Water Street, New York, New York 10038 has claims a lien pursuant to Social Services Law Section 369 and 18 NYCRR 360-7.11, upon the house, building and appurtenances, and upon the lot, premises and parcel of land upon which the same may stand, hereinafter mentioned, for medical assistance paid or to be paid on behalf of the owner of said real property, pursuant to Title 11 of Article 5 of the Social Services Law of the State of New York, and hereby states:

1. OWNER OF PROPERTY [redacted] (First) — (Middle) — [redacted] (Last)

2. ADDRESS OF PROPERTY [redacted] CINN #

3. BLOCK AND LOT NUMBER OF PROPERTY
Tax Map of County of KINGS BLOCK # [redacted] LOT # [redacted]

4. LIENOR'S ATTORNEY

Martha A. Calhoun, General Counsel, 180 Water Street, New York, New York 10038.
This lien is for medicaid coverage in the nursing home commencing (date pending) through the present date, at the monthly regional rate of $9375.00, which sum continues to accrue.

5. NAME (S) AND ADDRESS (ES) FACILITY (IES)

The name and address of the nursing facility, intermediate care facility for the mentally retarded, or other medical institution in which said owner is an inpatient and from which said owner is not reasonably expected to be discharged and to return home are:

DITMAS PARK REHABILITATION
2107 DITMAS AVENUE
BROOKLYN , NY 11226

and or such facility at which the recipient is now or has resided.

6. Notwithstanding anything to the contrary stated herein, the whole of the principle amount due for Medicaid paid to or on behalf of the recipient for Medicaid services provided in in accordance with section 4 of this Notice of Lien, shall become due and payable upon any one of the following occurrences:

(a) the death of the recipient-owner of the property, if not survived by a spouse, and if survived by a spouse, then upon the death of that surviving spouse; or

(b) upon the death of the recipient or, upon the death of any care-giving child whichever occurs last; or

(c) upon the recipient, during his/her lifetime in title, or the recipient's care-giving child's lifetime in title, should either vacate or cease to reside at or convey or lease the premises to another, or create a life estate therein, or by any act by which the recipient or recipient's care-giving child transfers any of their interests in the premises, in whole or in part, or by any other act by which the recipient, or the recipient's care-giving child, hinders, liens and encumbers, pledges or assigns the title thereto, or any part thereof; or conveys or leases said described premises to another or others, or becomes tenant(s) of the said premises by reason of a conveyance, or any other acts by which the recipient, or the recipient's resident care-giving child, effects, hinders, liens pledges or assigns the title thereto, or any part thereof.

This lien may not be changed or terminated orally. The covariance contained herein shall run with the land and bind the the recipient, and/or the recipients resident care giving child, their heirs, personal representatives, successors and assigns or such recipient and/or resident care taking child, and upon all subsequent owners, encumbrancers, tenants and subtenants of the premises, and shall enure to the benefit of the Department, it successors and assigns.

Department of Social Services of the City of New York

By: _____

Martha A. Calhoun, GENERAL COUNSEL,
of the Department of Social Services of the City of New York

STATE OF NEW YORK:)
: S. S. :
COUNTY OF NEW YORK:)

On the 17th day of October, 2014 before me, the undersigned, personally appeared Martha A. Calhoun, General Counsel personally known to me or proved to me on the basis of satisfactory evidence to the individual whose name is subscribed to the within instrument and acknowledged to me that he executed same in his capacity, and that by his signature on person upon whose behalf the individual acted, executedthe instrument.

_____
NOTARY PUBLIC
Signature and Office of Individual taking acknowledgement

REBECCA A MANU
Notary Public, State of New York
No. 01MA6210228
Qualified in Bronx County
Commission Expires August 10, 2017

SEAL

HUMAN RESOURCES ADMINISTRATION
INVESTIGATION, REVENUE AND
ENFORCEMENT ADMINISTRATION
OFFICE OF REVENUE AND ADMINISTRATION
250 CHURCH STREET, 7TH FLOOR
NEW YORK, NY 10013

NYC Human Resources Administration Department of Social Services

[redacted]

07/15/2015

RE: [redacted]
Case # [redacted]
Property Address: [redacted]

Lien Date:	10/17/2014
Recorded:	11/07/2014
Amount:	$50,000.00
Commissioner:	steven banks
Reel:	Page:
Block: [redacted]	Lot: [redacted]
CRFN:	[redacted]

Dear [redacted]

The Department is currently in the process of preparing a "Satisfaction of Mortgage" which must be signed-off by the General Counsel Martha A. Calhoun.

As soon as Ms.Calhoun signs-off on the "Satisfaction of Morgage",the department will forward the instrument to the City Register's ofice in the County of Kings for recording. In addition, upon receipt of the recorded instrument, the original will be forwarded to you.

Thank you for sharing your concerns and if there is any way I can assist you in the future please do not hesitate to telephone me at (212) 274-5508.

Sincerely,

Resources Consultant

NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION
(RVI)

NYC Human Resources Administration
Department of Social Services

MAP-2087n (E) 07/02/2013

[redacted]
Brooklyn, NY 11209

DATE: 3/15/17

CASE NUMBER: [redacted]

HOSPITAL/RHCF ADM. DATE: _____

If you have any questions, call the HRA InfoLine at 718-557-1399.

Dear Consumer:

I. We are sending you this notice to tell you that effective _____, **this Department will accept your Medicaid application** for the level of coverage indicated in **Section II** below. (Any member of your household approved for a different level of coverage will receive a separate notice.) We will provide:

☐ Medicaid coverage for the following persons: MC [redacted]

☐ Medicaid coverage for the period of _____ to _____ to pay for medical bills in excess of

☐ Your monthly **Spenddown** (Excess Income) of $_____

☐ Your monthly **NAMI** (Net Available Monthly Income) of $_____ should be paid to:

☐ The Medical Assistance Program ☐ The Residential Health Care Facility ☐ The Hospital

This: ☐ includes inpatient Medicaid coverage ☐ does not include inpatient Medicaid coverage.

See the enclosed MAP-2060c **Budget Explanation**, to see how we determined your eligibility for benefits and the enclosed MAP-931, **Explanation of the Excess Income Program** and MAP-931A, **Optional Pay-In Program for Individuals with Excess Income.**

II. **You** have been found **eligible** for the level of coverage checked below.

☐ **All Medicaid Covered Care and Services**

☐ **Community Coverage With Community-Based Long-Term Care**

☐ **Community Coverage Without Long-Term Care**

Please read the enclosed form, **MAP-2020H**, which explains the level of coverage. If you would like to be evaluated for a higher level of coverage, visit a Medicaid Office (See MAP-58d attached) and provide additional resource documentation.

III. The reason for this decision is as follows:

You requested that we determine your Medicaid eligibility for level of coverage checked above or you do not have a resource test;

☐ You requested that we determine your Medicaid eligibility for either All Covered Care and Services or Community-Based Long-Term Care, but you failed to provide proof/sufficient proof of your resources. You failed to document the following:

_____

for the ☐ current month (month of application) ☐ Look-back period of _____ to _____.

If you submitted paid medical bills for direct reimbursement, you will be notified separately of our decision.

This decision is based on Social Services Law: 366-a (2) and 18 NYCRR 360-2.3, 360-4.1, 360-4.4, 360-4.5, 360-4.7, 360-4.8.

WORKER (Print)	WORKER (Sign)	SECTION
Ms Hollings	Ms Hollings	MCTC 15115
SUPERVISOR (Print)	SUPERVISOR (Sign)	DATE

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE ENCLOSED FORM MAP-2086 FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION.

NOTICE OF ACCEPTANCE OF YOUR MEDICAL ASSISTANCE APPLICATION/RECERTIFICATION
(Home Care Services/Managed Long Term Care)

NYC Human Resources Administration
Department of Social Services
MAP-259p (E) 10/16/2012

[redacted]
Brooklyn, NY 11208

DATE: 4/17/17
CASE NUMBER: [redacted]

If you have any questions, call HRA Infoline at 718-557-1399

CHECK PROGRAM AREA
☐ Home Care Services Program
☐ Managed Long Term Care Program

Dear Consumer:

We are sending you this notice to tell you that the Medical Assistance Program will:

☒ **ACCEPT** your Medicaid application/recertification for **full** Medicaid coverage from: ____________

For the following person(s): [redacted]

☐ **ACCEPT** your Medicaid application/recertification with a **spenddown** (excess/ surplus income) from: ____________

For the following person(s): ____________

We have certified that you have a continuing need for Home Care/Managed Long Term Care Services.

WE HAVE DETERMINED YOUR SPENDDOWN AS FOLLOWS:

A. Total monthly income	$ 3166.19
B. Total monthly deductions	$ 2366.19
C. Net Medicaid income (line A minus line B)	$ 800.00
D. Medicaid level for your household size	$ 809.00
E. Monthly Excess Income (line C minus line D)	$ 0.00

THIS IS NOT A BILL. DO NOT SEND ANY MONEY TO MEDICAID. YOU WILL RECEIVE A BILL SHORTLY. FOLLOW INSTRUCTIONS ON THE BILL.

You are required to pay your full excess (surplus) income or spenddown in the amount of $__________ each month to the agency providing your Home Care/Managed Long Term Care services. You will receive your first bill shortly. This bill will be retroactive to the date indicated above and may be for more than one month's service.

This decision is based on Social Services Law or Regulation: 18NYCRR 360 4.3

WORKER	TITLE	SECTION
Ms. [signature]	ES-II	MLTC/5HS

YOU HAVE THE RIGHT TO APPEAL THIS DECISION

Regulations require that you immediately notify this department of any changes in needs, income, resources, living arrangements, or address.

BE SURE TO READ THE ENCLOSED FORM MAP-2086B FOR YOUR RIGHTS ON HOW TO APPEAL THIS DECISION

BUDGET EXPLANATION

NYC Human Resources Administration
Department of Social Services

MAP-2060 (E) 05/28/2013

CASE NAME: [redacted] **CIN:** [redacted]

We calculated your Medical budget for the period beginning _____ as follows:

MONTHLY GROSS INCOME	AMOUNT
Employment	$
Interest Income	$
Social Security	$ 1605.90
Child Support	$
Other (specify): Pension (IRA)	$ 1325.00
Other (specify): Pension (IRA).	$ 235.29
Other (specify):	$
TOTAL MONTHLY GROSS INCOME:	$ 3166.19

MONTHLY DEDUCTIONS	AMOUNT
Allowance for disabled, aged or blind persons	$ 20.00
Work Related Expenses	$
Family Care Expenses	$
Health Care Expenses Bny Mellon Med. Premium	$ 97.15
~~Child Support Exemption~~ Federal Trust	$ 2,144.14
Other (specify): Medicare	$ 104.90
TOTAL MONTHLY DEDUCTIONS:	$ 3366.19
TOTAL MONTHLY NET INCOME (gross income minus deductions)	$ 800.00

MONTHLY ALLOWANCES	AMOUNT
The monthly Medicaid allowance for your household is:	$ 800.00
The monthly Medicare Savings Program allowance for your household is:	$
The monthly Family Health Plus allowance for your household is:	$
The monthly Family Planning Benefit Program allowance for your household is:	$
The monthly Public Assistance Standard of Need for your household is:	$

After subtracting the appropriate monthly allowance from your monthly net income, we have determined that your income exceeds this allowance by: $ 0.00

(See back of page for resource details, if applicable)

RESOURCES (exempt resources such as money held in a burial fund are not shown below)	AMOUNT
Bank Accounts:	$ 376.03
Other (specify):	$ 5700.00
Other (specify):	$
Other (specify):	$
TOTAL RESOURCES:	$ 9476.53

RESOURCE ALLOWANCE	AMOUNT
Medicaid Resource Allowance	$ 14,400.00
Public Assistance Resource Allowance	$

After subtracting the appropriate resource allowance from your non-exempt resources, we have determined that your resources exceed this allowance by: $ 0

WORKER (Print)	WORKER (Sign)	SECTION
M Hollings	M Hollings	M4-RC/5119
SUPERVISOR (Print)	SUPERVISOR (Sign)	DATE
L Smith	L Smith	3/10/14

CC-116 (E) 09/19/2012

HUMAN RESOURCES ADMINISTRATION
INVESTIGATION, REVENUE AND
ENFORCEMENT ADMINISTRATION
DIVISION OF CLAIMS AND COLLECTIONS
250 CHURCH STREET - 12TH FLOOR
NEW YORK, NY 10013

Human Resources Administration
Department of Social Services

[redacted]

May 21, 2014

CASE: [redacted]

Dear [redacted]:

This letter will inform you that pursuant to New York State Law, you are required to contribute towards the medical support of your spouse, to the extent that your income and resources exceed the maximum amounts set by New York State regulations, by repaying the Human Resources Administration for Medicaid provided on behalf of your spouse who is a current resident of a nursing facility.

We are conducting a review of the income and resources information that was submitted to the Medical Insurance and Community Services Administration (MICSA) with your spouse's Medicaid application. In order to determine a fair contribution amount, we need to review other pertinent factors, such as your personal living expenses, which may affect your required level of contribution.

Please contact me to schedule an office appointment. If you would like, you may schedule a home visit to discuss this matter.

Please respond within twenty days of receipt of this notice.

Thank you for your cooperation.

Yours truly,

[redacted]

Fraud Investigator
(212) [redacted]

HUMAN RESOURCES ADMINISTRATION
INVESTIGATION, REVENUE AND
ENFORCEMENT ADMINISTRATION
DIVISION OF CLAIMS AND COLLECTIONS
250 CHURCH STREET - 12TH FLOOR
NEW YORK, NY 10013

NYC an Resources inistration tment of Services

[redacted]

June 11, 2014

Dear [redacted]

CASE [redacted]

You were previously contacted by this office by letter dated, May 21, 2014. You were informed of your potential obligation to provide medical support for your spouse and asked to contact our office to discuss your financial circumstances. You have failed to respond to that letter. Accordingly we have prepared a claim for repayment based on the information that was provided to the Medical Insurance and Community Services Administration (MICSA) as part of your spouse's Medicaid application.

Medicaid was furnished to your spouse effective November 16, 2013. Medicaid benefits expended through May 26, 2014 total $123,821.80. The Human Resources Administration is authorized by law to seek recovery of medical expenses and an ongoing contribution from a Community spouse whose resources and/or income exceed the amounts set by State Regulation. According to our information, your resources total $203,637.96 and your monthly income totals $1,632.90. Under current provisions, a community spouse (the spouse of a Medicaid recipient who resides in a nursing home) is permitted to retain $117,240.00 in resources and $2,931.00 in monthly income. If you own a home and it is your primary residence, as an exempt resource, its value has not been included in the calculation of your resources.

We have determined that:

1. 25% of your monthly income totals $0.00.
2. Your resources are in excess of the allowable limit by $86,397.96.

Please find attached a remittance notice and business reply envelope. If applicable, you will receive a statement each month. Follow the instructions on your monthly statement in making future payments. Please contact us if your circumstances change. Our mailing address is:

New York City Human Resources Administration
Division of Claims and Collections
P.O. Box 414312
Boston, MA 02241-4312

If you dispute the information listed in this document, we invite you to contact the undersigned to discuss this matter. However, if you fail to respond to this letter, or contact the undersigned within fifteen (15) days of the date of this letter; this office will have no alternative but to refer the matter for immediate legal action to recover the amount of Medicaid issued on behalf of your spouse, as provided by the New York State Social Services Law.

Yours truly,

[redacted]

[redacted]
Fraud Investigator
(212) [redacted]

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HUMAN RESOURCES ADMINISTRATION
INVESTIGATION, REVENUE AND
ENFORCEMENT ADMINISTRATION
DIVISION OF CLAIMS AND COLLECTIONS
250 CHURCH STREET - 12TH FLOOR
NEW YORK, NY 10013

NYC
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[redacted]

June 11, 2014

CASE: [redacted]

Dear [redacted]

Make check payable to the **Department of Social Services** for the following amounts:

- $123,821.80 representing your excess resources towards the cost of care paid to date for your spouse.
- $0.00 per month, representing 25% of your excess income.

Please return this notice along with payment within 15 days of the date indicated above, using the enclosed envelope. Write your spouse's name and case number on the check and mail to:

New York City Human Resources Administration
Division of Claims and Collections
P.O. Box 414312
Boston, MA 02241-4312

Thank you for your cooperation. If you have any questions, please contact the fraud investigator listed below.

Yours truly,

[redacted]

[redacted]
Fraud Investigator
(212) [redacted]

GRIMALDI & YEUNG LLP

ELDER LAW
SPECIAL NEEDS PLANNING
ESTATE PLANNING
BUSINESS SUCCESSION PLANNING

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June 17, 2014

VIA FIRST CLASS MAIL RETURN RECEIPT REQUESTED
Human Resources Administration
Investigation, Revenue and
Enforcement Administration
Division of Claims and Collections
250 Church Street, 12th Floor
New York, NY 10013
Attn: [redacted]

Re: [redacted]
Case #: [redacted]

Dear [redacted]

Please be advised that this office represents [redacted] and his wife, [redacted]. We are responding in regards to HRA's letter to [redacted] dated June 11, 2014. After reviewing [redacted] financial records, we contend that your office miscalculated [redacted] resources. According to your letter, you calculated [redacted] resources to be $203,637.96.

Your calculations [redacted] resources included the Chase Bank Acct [redacted], which belonged to the Applicant. In addition, [redacted] IRA and 401(K) are both in payout status. These two (2) accounts are not to be included in the calculation towards her resources. Therefore, [redacted] resources should have been $143,123.28 (see copy attached of IRA and 401(K) statements.)

[redacted] resources are further reduced as she had purchased two (2) pre-need funeral agreements for both herself and her husband for a total of $28,000 (see copy attached). As a result, [redacted] total resources of $115,123.28 did not exceed the $117,240 community spouse resource level.

Please see below for a breakdown of [redacted] 's resources:

Resources:		**$203,637.96**
Chase Bank Acct [redacted] (Checking)	[redacted]	($5,441.73)
Chase Bank Acct [redacted] (IRA)	[redacted]	($6,000.80)
Wells Fargo (401(K)	[redacted]	($49,072.15)
Pre-need Funeral Agreement	[redacted]	($14,821.00)
Pre-need Funeral Agreement	[redacted]	($13,179.00)
Total Resources:		**$115,123.28**

We kindly ask that you close your agency's claims against [redacted] as her resources did not exceed the amount set by State Regulations. Thank you.

Very truly yours,

GRIMALDI & YEUNG LLP

Pauline Yeung-Ha

PHY/ac
Enclosures
cc: [redacted]