EXPLANATION OF THE RESOURCE DOCUMENTATION REQUIREMENTS FOR MEDICAID

If you want Medicaid coverage of certain care and services, you must submit proof of your resources. The following explains the resource information that must be submitted in order to be eligible for coverage of certain care and services.

When you apply for Medicaid, you will be asked to choose one of the following:

1. community coverage **without** long-term care;

2. community coverage **with** community-based long-term care; or

3. Medicaid coverage for **all** covered care and services.

Note: Pregnant women, children under age one, and children between the ages of one and 19, who have incomes at or below the applicable federal poverty level, do not need to provide proof of their resources in order to qualify for Medicaid coverage for all care and services.

1. Community Coverage Without Long-Term Care

Applicants/recipients who do **not** need nursing facility services or community-based long-term care may attest to the amount of their resources. If we find that you are eligible under this simplified review, you will get Medicaid coverage but **not** coverage for nursing facility services or community-based long-term care. If at some time you need nursing facility or community-based long-term care services, we will need to look at your resources before Medicaid can cover these services.

People who attest to the amount of their resources are eligible for short-term rehabilitation services. Short-term rehabilitation includes one commencement/admission in a 12-month period of up to 29 consecutive days of: nursing home care and certified home health care.

If we find the information you report is different from the information we get from investigating what you reported, you will be requested to give us proof of your resources.

2. Community Coverage With Community-Based Long-Term Care includes

- Adult day health care
- Limited licensed home care
- Certified home health agency services
- Hospice in the community
- Hospice residence program
- Personal care services
- Personal emergency response services
- Private duty nursing

- Residential treatment facility
- Consumer directed personal assistance program
- Assisted living program
- Managed long-term care in the community
- Home and community-based services waiver programs

To be eligible for community coverage **with** community-based long-term care services, you must give us proof of your current resources. If we find that you are eligible, you will get Medicaid covered care and services that include community-based long-term care services, but you will **not** get coverage for nursing facility services, except for short-term rehabilitation. If you later need nursing facility services, we will need to look at your resources for up to the past 36 months (60 months for trusts) before Medicaid can cover these services (see #3 below).

3. Medicaid Coverage for All Covered Care and Services includes

- Nursing home care
- Nursing home care provided in a hospital
- Home and community-based waiver services
- Hospice in a nursing home
- Managed long-term care in a nursing home
- Intermediate care facility

To be eligible for these services, we must review your resources for up to 36 months (60 months for trusts/12 months for single individuals and childless couples) prior to your application. If we find that you are eligible, you will get **all** Medicaid covered care and services including the nursing facility services listed above and the community-based long-term care services listed under #2 above.

Applicants/recipients who do not need nursing facility services now may choose to apply only for Community Coverage with Community-Based Long-Term Care (#2 above) or Community-Coverage **without** Long-Term Care (#1 above).

If you become in need of a service for which you have not received coverage, contact your worker immediately for assistance.