ADVOCACY FOR SENIORS

A How-To Manual

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ADVOCACY FOR SENIORS: A HOW-TO MANUAL

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ABOUT THE ORGANIZATIONS

Bet Tzedek Legal Services is a non-profit, public interest law center which provides free legal services to low-income residents of Los Angeles County. Bet Tzedek means “House of Justice” in Hebrew. Bet Tzedek serves persons of all racial, religious and ethnic backgrounds. Bet Tzedek is an agency of the United Way and of the Jewish Federation of Greater Los Angeles.

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The Los Angeles County Area Agency on Aging (AAA) is a State-designated agency responsible for identifying unmet needs of older adults and functionally-impaired adults as well as planning, coordinating, and implementing programs that promote the health, dignity, and well-being of the County’s residents. The AAA contracts with agencies county-wide to deliver human services that promote independent lifestyles for seniors.

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Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972 we’ve focused our efforts primarily on fighting for people who have been marginalized and excluded from justice, such as women, people of color, LGBTQ individuals, and people with limited English proficiency.

Justice in Aging assists attorneys and other advocates, publishes newsletters, issue briefs and reports that speak to the legal rights of low-income older adults. Justice in Aging does not represent individual clients.
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# CHAPTER ONE

## SOCIAL SECURITY

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CHAPTER ONE: SOCIAL SECURITY

Introduction

SOCIAL SECURITY VERSUS SUPPLEMENTAL SECURITY INCOME (SSI)

Both programs are administered by the Social Security Administration (SSA), an independent agency of the federal government.

Social Security is a social insurance program whose benefits are based on an individual’s work history or the work history of the individual’s spouse or parent(s). Social Security is funded by a payroll tax (FICA) paid on wages up to $142,800 per year in equal amounts by employer (6.2%) and employee (6.2%) for all persons working in a job covered by Social Security. Need is not a factor in making benefit determinations.

Social Security is also referred to as Title II and as OASDI (Old-Age, Survivors, and Disability Insurance). Social Security is linked to Medicare eligibility as is discussed in Chapter 4.

Supplemental Security Income (SSI), on the other hand, is based on need. Work history is not required, with a limited exception for some immigrants. SSI is also referred to as Title XVI.

In California, anyone receiving SSI is automatically eligible for Medi-Cal.

SOCIAL SECURITY IS THE MOST IMPORTANT INCOME SOURCE FOR OLDER AMERICANS

Over 64 million people in the U.S. receive Social Security benefits.

- Social Security is the single largest source of income for half of married couples and over 7 in 10 unmarried Americans over age 65. Most of the rest are still working.
- For about 1 in 4 people over age 65, Social Security provides at least 90% of their income.
- Among Asian-Americans receiving Social Security, 26% of married couples and 51% of unmarried beneficiaries over age 65 rely on Social Security for at least 90% of their income.
- Among African-Americans receiving Social Security, 35% of married couples and 58% of unmarried beneficiaries over age 65 rely on Social Security for at least 90% of their income.
- Among Hispanics receiving Social Security, 40% of married couples and 61% of unmarried beneficiaries over age 65 rely on Social Security for at least 90% of their income.
- Among unmarried women over age 65 receiving Social Security, 48% rely on Social Security for at least 90% of their income.
- Without Social Security, dire poverty would be the fate of most people in retirement.
SOCIAL SECURITY (OASDI) - AN INSURANCE PROGRAM SERVING SEVERAL PURPOSES

- Retirement benefits including spousal and child benefits
  - 49 million people
- Survivor benefits serving widow(er)s and children of deceased wage earners
  - 6 million people
- Disability Insurance
  - Over 9 million disabled workers
  - Over 1 million children of disabled workers

Proposal for Changes to Social Security

Under the latest (2020) projections, which do not include the impact of any proposed legislative change or the potential impact of the COVID-19 pandemic, the Social Security Trust Fund is expected to be depleted in 2035. After that, while benefits would still be paid, SSA would only be able to pay approximately three-fourths of a beneficiary’s scheduled benefit amount.

PROPOSED CUTS

Several different groups have seen the current political situation as an opportunity to make significant cuts to Social Security benefits.

One proposal would change the formula for calculating the annual cost of living adjustment (COLA) so that it would be slightly less each year. While this would have very little impact in the first years of retirement, it would have a major impact over time as retirees reach very advanced ages, since the reduction in the COLA would be compounded each year. An additional problem with this proposal is that it compounds the problems with the existing COLA, which does not adequately reflect the increase in cost of living for retirees and people with disabilities because they spend a much higher percentage of their income on health care, which is the sector of the economy with the highest rate of inflation.

There have also been a number of proposals to “increase the retirement age.” Advocates of increasing the retirement age often point to increases in longevity and assert the need for people to work longer. However, increasing the retirement age has no bearing on how long people actually work. The retirement age has already gradually increased from 65 to 66, and is continuing to increase to age 67. That increase has not caused people to work any longer, and it is unlikely that future increases would do so.

An increase in the retirement age is nothing more than a reduction in the amount of benefits that people will receive at whatever age they choose to start collecting benefits. People who begin receiving benefits today who are subject to the full retirement age of 66 will receive approximately 6% less than they would have received if the retirement age were still age 65. This is true whether they take early retirement and begin receiving benefits at age
62, or if they wait until age 70 or anywhere in between. If the retirement age is increased to age 70, as some propose, benefits will be almost one-third less than if the retirement age had remained at age 65.

**PROPOSALS TO STRENGTHEN SOCIAL SECURITY**

While some people advocate reductions in benefit levels, still others note that benefit levels are already below the levels of a number of other developed countries and advocate for increases in benefits to more adequate levels. They note the reduction in savings and the disappearance of defined benefit pensions, as well as longer life expectancy for some populations and point out that, as a result, Americans in the future are going to rely on Social Security for a greater, not lesser, portion of their retirement income than they do now.

Advocates for strengthening Social Security also are seeking a change in the formula for calculating the COLA, but by moving to the CPI-E or Consumer Price Index for the Elderly, which is based on the living expenses of people age 62 and over. This formula includes out-of-pocket health care expenses, which are much higher for an older population, and would result in a higher annual increase than the current formula, which is based exclusively on the living expenses of the working age population.

Other benefit enhancements that have been proposed include:

- A 5% across-the-board benefit increase
- An increase in the replacement rate for the lowest paid workers
- Increased widow(er)’s benefits
- Creating a special additional monthly benefit for specific Social Security beneficiaries, including beneficiaries age 82 and older and SSI recipients who have reached full retirement age
- Giving credits for a certain number of years out of the paid workforce for family caregiving toward benefits
- Raising the cap on the payroll tax or eliminating the cap altogether, so more wages are taxed

**Sources of Law**

2. Social Security Regulations - Code of Federal Regulations, Title 20, Part 404 (Social Security) and Part 416 (SSI). Social Security regulations have the force of law. However, be careful, because regulations often do not reflect the most recent changes in the Social Security Act.
3. Social Security Rulings (SSRs) and Social Security Acquiescence Rulings (SSARs). SSRs are the Social Security Administration’s interpretations of regulations and policy statements on important issues, usually related to disability determinations. SSARs are SSA’s statements of how it will apply a Court of Appeals decision with which it disagrees. SSRs and SSARs are published in the Federal Register and are binding at all levels within SSA, although they do not have the force of law.
4. Program Operations Manual System (POMS). The POMS is unpublished, does not have the force of law, and is written in language which is often unintelligible to the uninitiated. One would think, therefore, that it is of little importance. WRONG! This is the go-to resource for the people who work in the local Social Security office. It is the only comprehensive formulation of SSA policy with which they are most likely to have ready access. Thus, it is important for an advocate to know what the POMS has to say on a client’s
issue.

5. Emergency Messages (EMs) are transmittals to SSA personnel explaining how to handle a particular issue. EMs have an expiration date.

6. Program Circulars are sometimes issued on subjects where SSA policy is thought to require clarification. Unlike the other documents previously mentioned, Program Circulars are often difficult to obtain, and an advocate often has no way of knowing of their existence. However, once you learn of them, SSA is usually willing to provide a copy.

**RESOURCES FOR ADVOCATES**

1. [www.ssa.gov](http://www.ssa.gov) - The Social Security Administration website is a wealth of useful information for advocates as well as for beneficiaries. It contains the Social Security Act, the regulations, SSRs, SSARs, POMS, and EMs.


3. **Understanding Supplemental Security Income** - This is a useful booklet published by the Social Security Administration, which provides a comprehensive explanation of the SSI program in question-and-answer format. It is available on the SSA website. [www.ssa.gov/ssi/text-understanding-ssi.htm](http://www.ssa.gov/ssi/text-understanding-ssi.htm)

**Language Assistance**

SSA policy is clear that it will provide an interpreter free of charge for anyone who prefers to do business with the agency in a language other than English. The same policy applies for deaf individuals as well. However, SSA field offices vary greatly in how well they apply that policy. The SSA policy on interpreters also applies to the state agencies that make disability determinations for SSA. SSA has a multilingual gateway to its website with a large quantity of useful informational material in 12 different languages and American Sign Language: [https://www.ssa.gov/site/languages/en/](https://www.ssa.gov/site/languages/en/). While SSA is a leader among federal agencies in its policy on oral interpretation services, its implementation on the ground varies greatly from one local office to another.

SSA staff should never ask someone to bring her own interpreter or bring a family member to interpret. Of course, if an individual prefers to have a family member or friend serve as the interpreter, that is her right as long as the friend or family member is an adult, is proficient in English as well as the other language and understands the obligations of an interpreter. If the individual is applying for disability benefits, it is also important that the interpreter be familiar with medical terms in both languages.

When it comes to written notices affecting an individual’s benefits, the agency is sadly lacking. SSA notices are consistently provided only in English, and often, but not always, in Spanish. Written notices are never provided in any other language.

*Caveat* - It is almost never appropriate for a bilingual advocate to serve as an interpreter while conducting business before the agency with a client, because of the inherent conflict in the two roles.
Accommodations for People with Visual Impairments

Approximately 3,000,000 people who receive Social Security and/or SSI benefits are blind or visually impaired. Most of them are over the age of 80. Some of them rely on a sighted spouse or other household member to read important communications for them. However, many of them live alone and are unable to read printed material in a standard font.

As the result of a lawsuit, the Social Security Administration has changed its previous policy of refusing to communicate with people who are blind in an accessible format. They now offer to send letters and notices to people with visual impairments in any one of a number of formats. In each case, the selected format will be accompanied by a standard print version. The alternative formats offered are:

- Microsoft Word compact disc
- Braille
- Large print (18 point font)
- Audio CD
- Standard print notice by certified mail
- Standard print notice by first class mail with follow-up phone call within 5 days (NOT RELIABLE)

An individual can choose a preferred format at www.ssa.gov/ notices.

Insured Status

Benefits Available - Old-Age, Survivors, and Disability Insurance (OASDI) benefits include retirement benefits, disability benefits, dependents benefits, and survivors benefits.

Fully Insured Status - In general, OASDI benefits require that the wage earner be “fully insured” at the time of retirement, disability, or death. Some survivors benefits are an exception to this rule.

As a general rule, an individual is “fully insured” if she has 40 “quarters” of credit in covered employment. Lesser amounts are required for those born before 1929 or who are under 31 years of age. There are some other minor exceptions as well.

“Quarters” - The use of this term is misleading. It has nothing to do with calendar quarters, as one might think. It simply refers to a dollar amount that one must earn in a calendar year to obtain a credit for that year, with four being the maximum number of credits one can earn in a given year. The amount required to earn a “quarter” is indexed and thus normally changes from year to year. In the year 2021, wages of $1,470 are required for one “quarter” of coverage. A chart for calculating quarters of coverage is included at the end of this chapter. (See page 20).
EXAMPLE

Q. George works only one month in covered employment in the year 2021 and earns $4,500 before taxes. How many quarters of coverage has he earned?
A. George has earned three quarters of coverage because he earned more than $4,410 ($1,470 x 3) for the year, but less than $5,880, the amount required for four quarters.

Q. Henrietta worked all year in covered employment at $4,000 per month for a total of $48,000 for the year before taxes. How many credits?
A. The answer is four because that is the maximum one can earn in a year.

AMOUNT OF BENEFITS

Social Security Statement - Until 2011, a Social Security Statement was mailed out to wage earners over age 25 about three months before their birthday. The Statement contained useful information as to potential benefits and also stated the amount of wages for which the wage earner was being given credit. In 2011, the mailing of the Statement was ceased as a cost-saving measure. It has been resumed, but only for people age 60 and over who are not yet receiving benefits and do not yet have a “my Social Security” online account. In May 2012, SSA announced the availability of the Social Security Statement online, https://www.ssa.gov/myaccount/statement.html. A sample statement is included at the end of this chapter. (See page 22).

Retirement Estimator - The SSA website has a retirement estimator (https://www.ssa.gov/benefits/retirement/estimator.html) that can be used to calculate projected benefits for individuals who have enough Social Security credits to qualify for benefits and do not have a pension for work not covered by Social Security; i.e., certain state and municipal workers. However, unlike the Social Security statement, it does not calculate disability or other benefits and does not display year by year covered wage history.

IMMIGRANT ELIGIBILITY

Undocumented immigrants are no longer eligible for Social Security benefits unless they filed an application before December 1, 1996. Immigrants filing on or after that date must show that they are “lawfully present” in the United States.

Retirement Benefits

A fully insured individual is entitled to collect full retirement benefits at age 66, whether still working or not. There is no longer an earnings test for receipt of retirement benefits for those over age 66.

EARLY RETIREMENT

An individual can begin to receive retirement benefits at age 62 if she is fully insured on that date. However, her benefit level is reduced permanently proportional to the number of months before her full retirement age.

The age for early retirement has not been increased. However, as full retirement age increases, the reduction for early retirement will be greater. For example, when full retirement was at age 65, retirement at age 62 meant a 20%
permanent reduction in the benefit level. However, for those whose full retirement age is age 66, retirement at age 62 means a 25% permanent reduction. And for those whose full retirement age is 67, retirement at age 62 means a 30% permanent reduction.

**Important** - The Social Security full retirement age has been 66, but is now increasing in two month annual increments beginning with people born in 1955, until it reaches age 67 for those born in 1960. The full retirement age is 66 and two months this year, with the retirement age increasing in two month increments until 2026 when it will be age 67. (See page 26).

What is the age at which one begins collecting benefits in order to maximize lifetime benefits?

**Earnings Test for Early Retirement** - It is important to remember that the earnings test remains in effect for those who choose early retirement. Benefits are reduced $1 for every $2 of gross earnings that exceed $18,960 per year until January 1 of the year in which the beneficiary reaches full retirement age. If the beneficiary reaches full retirement age in 2021, benefits are reduced $1 for every $3 of gross earnings that exceed $4,210 per month in the months prior to reaching full retirement age. These exempt amounts are indexed. The earnings test no longer applies beginning with the month in which the beneficiary reaches full retirement age.

What can be done to avoid the potentially disastrous reduction in benefits that comes with early retirement?

**SPOUSAL BENEFIT**

A spouse age 62 or older who is at least in their twelfth month of marriage can receive benefits on their retired spouse’s account in an amount equal to one-half the wage earner’s benefit, unless the benefit to which they are entitled on their own account is higher. A divorced spouse is also eligible for the spousal benefit if the following additional requirements can be met: 1) the marriage must have lasted for a minimum of ten years, 2) at least two years have elapsed since the divorce, and 3) the individual seeking spousal benefits has not remarried.

**Who Qualifies as a Spouse?** As a result of recent Supreme Court decisions, the same marital recognition rules apply for both same-sex and opposite-sex couples.

- **Domestic Partnership** - California Registered Domestic Partnerships, regardless of whether between same-sex or opposite-sex couples, are recognized as a marriage for purposes of the Social Security Act. However, this is not true of all domestic partnerships. It depends on the state of or nation in which the domestic partnership was entered into. For example, a New York domestic partnership is not recognized by Social Security.

- **Civil Unions** - Here too recognition of the relationship depends on the jurisdiction in which the civil union was entered into. For example, an Oregon civil union is recognized for Social Security, but a French civil union is not.

**OTHER DEPENDENTS**

The child of a Social Security beneficiary may also qualify for benefits on the retired parent’s account if they are unmarried and (1) under age 18, (2) age 18 to 19 years old and a full-time student (no higher than grade 12), or (3) an adult child with a disability that started before age 22. A spouse under age 62 can receive benefits when caring for
the wage earner’s child under age 16. Unmarried stepchildren and grandchildren also may qualify if they are able to demonstrate dependency as defined by Social Security regulations.

**Survivors Benefits**

**Spouse** - Survivors benefits are payable to a surviving spouse or divorced spouse over the age of 60 of a deceased wage earner, who is not entitled to a higher benefit on her own earnings record and was married for at least 9 months (10 consecutive years in the case of a divorced spouse). There are a few specific limited exceptions to the 9-month rule, and none to the 10-year rule for a divorced spouse. The age requirement is 50 for a spouse who is able to establish disability under the Social Security disability standard.

**Parents** - The parent of a deceased wage earner who was dependent on the wage earner for support may be entitled to benefits if the parent is over age 62.

**Children** - Unmarried children of the deceased wage earner are entitled to benefits until age 18 (or up to age 19 if they are attending elementary or secondary school full-time). A surviving spouse of any age is entitled to benefits while caring for the deceased wage earner’s children under age 16.

**Disabled Adult Children** - Unmarried, disabled adult children of the deceased wage earner are entitled to benefits if the onset of disability occurred before age 22.

**Currently Insured Status** - It is possible to receive children’s benefits or disabled adult child’s benefits even if the decedent was not fully insured at the time of death, if the decedent had credits for 6 of the 13 consecutive quarters ending with the quarter of death. This is referred to as “currently insured” status. Currently insured status also is sufficient for receipt of benefits as a spouse caring for a child under age 16.

**Social Security Disability Insurance**

Social Security Disability Insurance is also often referred to as SSDI or simply DI. While SSDI accounts for only about 15% of all Social Security Title II beneficiaries, it accounts for the overwhelming majority of contested claims because an individualized disability determination must be made in each case.

In addition to the disabled worker, others who can receive benefits on the disabled worker’s earnings records include:

- The disabled worker’s spouse or divorced spouse if over age 62,
- An unmarried child under age 18 (or between age 18-19 if child is a full-time student in a grade no higher than grade 12),
- An unmarried disabled adult child if the onset of disability was prior to age 22, and
- A spouse caring for a child, under age 16, who is entitled to benefits.

**Eligibility for SSDI** - In order to receive SSDI, the individual must be: (1) disabled; (2) fully insured; and (3) “disability insured.”

**“Disability Insured” Status** - A person has “disability insured” status if she has worked 20 of the last 40 quarters preceding onset of disability. A special rule exists for individuals under age 31. SSA has adopted a five step
sequential evaluation process that the state agencies must use to determine if someone meets the disability standard mandated by the Social Security Act.

**Increased Importance of SSDI for Older People** - SSDI has assumed increased importance as an alternative to early retirement because of the increase in the full retirement age and the resultant greater reduction in benefits for early retirement. It also increased in importance because of the large number of wage earners over age 60 who lost their jobs in the recession with little prospect of finding new employment. These older individuals must still meet SSA’s disability standard to receive SSDI benefits.

**SOCIAL SECURITY DISABILITY STANDARD**

The adult standards for determining disability for SSDI, SSI, and Medi-Cal are all the same. However, the Social Security disability definition is different from the definitions used in other programs, such as the Americans with Disabilities Act (ADA), state disability insurance, or Veterans benefits.

The Social Security Act defines disability as:

“inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.”

The combined effect of a person’s impairments must be “of such severity that he is not only unable to do his previous work but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy.”

**STATE AGENCIES MAKE DISABILITY DETERMINATIONS**

State agencies make all initial and reconsidered disability determinations, subject to appeal to SSA. In California, it is the California Department of Social Services Disability Determination Service Division (DDSD) that makes these disability determinations.

**SEQUENTIAL EVALUATION PROCESS**

SSA has adopted a five-step sequential evaluation process that the state agencies must use to determine if someone meets the disability standard mandated by the Social Security Act.

- **Step One** - Is the claimant currently working and, if so, are they engaging in “substantial gainful activity (SGA)?” If the answer is yes and the claimant is engaging in SGA, the evaluation process comes to an end and the claim is denied. If the answer is no, then the evaluation proceeds to Step Two.
  - SGA is determined by reference to gross wages unless there is a subsidy or special circumstance involved and the amount paid does not fully reflect the work performed by the claimant. In that case, the subsidy is subtracted from gross wages to determine whether the claimant is engaged in SGA.
  - Also, if the individual has Impairment Related Work Expenses (IRWE), then those expenses are subtracted from gross wages to determine if there is SGA.
• **What is SGA?** SSA uses an earnings test to determine if work activity constitutes SGA. For work done in 2021, earnings of $1,310 per month ($2,190 for blind people) indicate SGA. This amount is changed annually to reflect the change in average wages.

• **Step Two** - If the claimant is not engaging in SGA, the next question is whether they have a “severe” medically determinable impairment or combination of medically determinable impairments. If the answer is no, the claim is denied. If the answer is yes, then the evaluation proceeds to Step Three.

  - The severity test is a relatively minimal one. It requires that the impairment or combination of impairments “significantly” limits the “physical or mental ability to do basic work activities.” Where there is a combination of impairments, it is not necessary that any single one be “severe,” only that the combination of impairments be “severe.”

• **Claimants Age 72 or Over** - SSA has issued special instructions for claimants applying for SSI who are age 72 or over. For anyone age 72 or over with a medically determinable impairment, there will be no need to show that the impairment is severe. Severity will be presumed.

• **Step Three** - If the claimant has a severe impairment or combination of impairments, the next step is to see if the impairment meets or equals a listing in SSA’s Listing of Impairments. If the impairment meets or equals a listing, then the claimant is disabled. If not, the evaluation proceeds to Step Four.

  - **What is the Listing of Impairments?** The Listing of Impairments is a list of impairments with specific detailed medical criteria for each disease or impairment. If these criteria are met or equaled, it is assumed that there will be functional limitations to such a degree that a person will not be able to work regardless of age, education, or work experience.

• **Step Four** - The question at Step Four is whether the claimant retains the residual functional capacity to return to past relevant work. If the answer is yes, then the claim is denied regardless of whether the work is available or even exists in the national economy. This step can pose a particular problem for immigrants whose previous job in another country may not exist in the United States.

• **Step Five** - If the claimant cannot return to past work, the next and final step is to determine, taking into account the claimant’s age, education, and work experience, whether there are other jobs which exist in significant numbers in the economy that the claimant can perform. This is the step at which age is an advantage. SSA assumes that the older a person is, the more difficult it will be for them to adjust to a new job. Thus, it is far more likely that a claim will be allowed for a claimant of “advanced age” (55 or over) at this step than it is for a “younger individual” (under age 45).

**CONTINUING DISABILITY REVIEWS (CDRS)**

Anyone receiving SSDI or SSI Disability is likely to be subject to Continuing Disability Reviews (CDRs) to determine if she still is disabled and should continue to receive benefits. The frequency of CDRs depends on the nature of the impairment and whether improvement is expected. Unlike the initial application process where the burden is on the individual to show disability, in the CDR context the burden is on the agency to show that there has been medical improvement related to the ability to work since the initial determination was made, and that the individual no longer meets the disability standard.
CDRs are conducted by the state agency (DDSD in California). If DDSD determines that the individual is no longer disabled and that benefits should cease, a hearing can be requested before a disability hearing officer at the state agency. If the state disability hearing officer affirms the determination that the claimant is no longer disabled, the decision can be appealed to a Social Security Administration Administrative Law Judge (ALJ). In medical cessation cases the claimant has a right to continue receiving benefits through the ALJ decision, if the determination is appealed within ten days from receiving notice of the adverse determination. An additional five days are allowed for mailing.

**Return to Work** - If an SSDI beneficiary returns to work, earnings must be reported to SSA. However, full benefits are paid for a trial work period which continues until the beneficiary has completed nine (not necessarily consecutive) months with earnings of at least $940 per month, after deduction of impairment-related work expenses (IRWEs). After the Trial Work Period, there is a 36-month period of extended eligibility. During this period, the beneficiary can receive benefits for any month in which earnings fall below the SGA level ($1,310 in 2021).

**Note** - Medical cessation cases are the only Social Security Title II cases where the claimant has a right to continued benefits during a pending appeal from an adverse determination.

## SSA’s Administrative Appeals Process

SSA has a four-step administrative appeals process. It applies to both Social Security and SSI.

- **Step One: Initial Determination** - The initial determination is made in the SSA District Office, except disability determinations which are made in the state agency (DDSD in California). The individual should receive a written notice of that determination advising her that she has 60 days (SSA allows another five days for mailing) in which to appeal.

- **Step Two: Reconsideration** - This step also takes place at the District Office (or DDSD in the case of disability determinations) or a regional program center. For all Social Security cases, except appeal of an adverse decision on a continuing disability review (CDR) or on a request for waiver of recovery of an overpayment, reconsideration comes in the form of a “case review.” Different procedural options exist for some SSI cases.

  - A “case review” is a review of the paper record and does not involve a personal appearance or an opportunity to present witnesses. The percentage of claimants who win at this stage is quite low.

  - In the case of an appeal from a CDR decision, there is a right to an oral hearing at DDSD. Continued benefits are paid pending the hearing decision if the beneficiary requests the hearing within ten days (plus five days for mailing) of the notice of an adverse CDR determination.

- **Step Three: Administrative Law Judge (ALJ) Hearing** - If the claim is denied on reconsideration, the individual has 60 days (plus five days for mailing) to further appeal to the Social Security Administration’s Office of Hearings Operations (OHO). This time, it will be for an evidentiary hearing before an Administrative Law Judge (ALJ). At the ALJ hearing, the claimant can present witnesses and can request the
ALJ to subpoena witnesses and documents. This step is the same for all types of appeals. In medical cessation cases, benefits continue through the ALJ decision if the appeal from reconsideration is filed in time.

- Unlike reconsideration, a high percentage of cases get reversed at this stage of the process. Most claimants are (and should be) represented by counsel at the ALJ hearing. It is extremely important that all relevant issues be raised at the ALJ hearing, as it may not be possible to raise additional issues later in the process.

- ALJs, although employed by SSA, have a great deal of independence from the agency. Unlike the people who make initial and reconsideration decisions, they are not bound by the POMS or other subregulatory statements of agency policy. They are, however, bound by SSA regulations. The overwhelming majority of cases that reach the ALJ stage of appeal and beyond are disability determination cases. As a result, this is the area in which ALJs have the greatest degree of expertise. Their knowledge may be comparatively lacking when it comes to other issues that may reach an ALJ.

- **Step Four: Appeals Council** - A claimant has 60 days (plus five days for mailing) to request the Appeals Council review of an adverse ALJ decision. Review by the Appeals Council is discretionary and in the overwhelming majority of cases they simply deny review. Although it does not happen often, the Appeals Council can also take a case on “own motion” review to review an ALJ decision that was favorable to the claimant. The Appeals Council is the last step within the SSA administrative appeal process.

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**Note** - U.S. District Court - A claimant has 60 days (plus five days for mailing) to appeal to federal court from an adverse Appeals Council decision or from a denial of review by the Appeals Council.

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**Good Cause for Late Appeal**

The Social Security regulations contain liberal good cause provisions for filing an appeal after the deadline has passed. These regulations apply at any stage, but most often come into play with respect to late requests for reconsideration, often because the beneficiary did not understand the notice or did not understand the importance of acting in a timely fashion.

Common reasons for good cause for a late appeal include limited facility in English and cognitive or mental impairments that prevented the individual from either understanding the content of the notice or appreciating the importance of a timely appeal. The regulation contains a useful list of possible reasons for good cause, but it should be remembered that the list is not exhaustive. While the regulation is a good one, it should never be regarded as a substitute for timely filing an appeal. A copy of the good cause regulation for Social Security is included at the end of the chapter. (See page 28). The SSI regulation on good cause for late filing is identical.

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**Overpayments**

An overpayment occurs when a beneficiary receives a greater amount of benefits than the amount to which she is entitled in a given month. Overpayments are relatively rare for Social Security beneficiaries, except for those who
are receiving SSDI. For SSDI beneficiaries, the most common source of overpayment results from the continued payment of benefits when a beneficiary has returned to work, has exhausted the Trial Work Period, and is engaged in Substantial Gainful Activity (SGA). Overpayments also result when a beneficiary dies and the spouse or other family member continues to receive their benefits. Similarly, excess earnings in early retirement can result in an overpayment.

If the beneficiary disputes either the existence or amount of the overpayment, the assessment of the overpayment can be appealed through SSA’s administrative appeals process. If, on the other hand, the beneficiary does not dispute the existence or amount of the overpayment and the amount of the overpayment is $1,000 or more, the best option for those who have the means to do so is simply to return the money. Unfortunately, most beneficiaries facing overpayments do not have the means to do that.

Another option is to request waiver of collection of the overpayment. There is a right to waiver if (1) the beneficiary was without fault, and (2) recovery would either (a) defeat the purpose of Title II or (b) be against equity and good conscience. Recovery is considered to defeat the purpose of Title II if the beneficiary uses substantially all of her income to meet “ordinary and necessary living expenses,” and if resources are less than $3,000 for an individual or $5,000 for a couple, plus $600 for each additional dependent.

Also, if the amount of the overpayment is less than $1,000 and a waiver is requested, SSA generally will grant the waiver as a matter of administrative convenience.

**Note** - SSA must wait at least 65 days from the date of the notice of overpayment before beginning efforts to recover the overpayment. If a waiver is requested, recovery efforts are further suspended until after the waiver request has been reviewed and, if not approved initially, until after a personal conference has been held to review the waiver request. If the waiver request is denied after the personal conference, the claimant can proceed with SSA’s administrative appeals process by requesting a reconsideration if they are an SSI recipient, or by requesting a hearing before an ALJ if they are a Title II beneficiary.

If it is ultimately determined that there is an overpayment and that the overpayment is not subject to the waiver, SSA will recover the overpayment through adjustment of future benefits if the individual is still receiving benefits. If the person is not receiving benefits, SSA can pursue other collection efforts including an offset of the individual’s income tax refund or administrative wage garnishment.
Supplemental Materials
If you need an interpreter

We provide free interpreter services on request to conduct your Social Security business. Please call us first so that someone who speaks your language will be available to help you.

Call 1-800-772-1213 Monday through Friday between 7 a.m. and 7 p.m.
# QUARTERS OF COVERAGE UNDER TITLE II OF THE SOCIAL SECURITY ACT

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<tr>
<th>Year</th>
<th>Required Wages for One Quarter of Coverage</th>
<th>Required Wages for Four Quarters of Coverage</th>
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<td>$470</td>
<td>$1,880</td>
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</table>
Beginning January 1, 1978, and continuing, quarters of coverage (earning credits) are granted on the total wages for the calendar year.

<table>
<thead>
<tr>
<th>Year</th>
<th>Required Wages for One Quarter of Coverage</th>
<th>Required Wages for Four Quarters of Coverage</th>
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<td>1980</td>
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</table>

1. Wages had to be earned during the calendar year quarter of credit (the 3 month period ending 3/31, 6/30, 9/30, 12/31), except for farmworkers who could earn it anytime during the year.
Your Social Security Statement

Are you thinking about retirement? Are you ready for retirement?

We have tools that can help you!

• Estimate your future retirement benefits at socialsecurity.gov/estimator
• Apply for retirement, spouse’s, Medicare, or disability benefits at socialsecurity.gov/applyforbenefits
• And once you receive benefits, manage your benefits at myaccount.socialsecurity.gov

Your Social Security Statement tells you about how much you or your family would receive in disability, survivor, or retirement benefits. It also includes our record of your lifetime earnings. Check out your earnings history, and let us know right away if you find an error. This is important because we base your benefits on our record of your lifetime earnings.

Social Security benefits are not intended to be your only source of income when you retire.

On average, Social Security will replace about 40 percent of your annual pre-retirement earnings. You will need other savings, investments, pensions, or retirement accounts to live comfortably when you retire.

To see your Statement online anytime, create a my Social Security account at myaccount.socialsecurity.gov.

Social Security Administration
Your Estimated Benefits

*Retirement* You have earned enough credits to qualify for benefits. At your current earnings rate, if you continue working until...

- your full retirement age (67 years), your payment would be about $2,061 a month
- age 70, your payment would be about $2,561 a month
- age 62, your payment would be about $1,426 a month

*Disability* You have earned enough credits to qualify for benefits. If you became disabled right now, your payment would be about $2,027 a month

*Family* If you get retirement or disability benefits, your spouse and children also may qualify for benefits.

*Survivors* You have earned enough credits for your family to receive survivors benefits. If you die this year, certain members of your family may qualify for the following benefits:

- Your child.................................................................................................................. $1,520 a month
- Your spouse who is caring for your child................................................................. $1,520 a month
- Your spouse, if benefits start at full retirement age.................................................. $2,027 a month
- Total family benefits cannot be more than .................................................................. $3,700 a month
- Your spouse or minor child may be eligible for a special one-time death benefit of $255.

Medicare You have enough credits to qualify for Medicare at age 65. Even if you do not retire at age 65, be sure to contact Social Security three months before your 65th birthday to enroll in Medicare.

* Your estimated benefits are based on current law. Congress has made changes to the law in the past and can do so at any time. The law governing benefit amounts may change because, by 2035, the payroll taxes collected will be enough to pay only about 80 percent of scheduled benefits.

We based your benefit estimates on these facts:

- Your date of birth (please verify your name on page 1 and this date of birth)................. April 5, 1961
- Your estimated taxable earnings per year after 2018 .................................................. $52,769
- Your Social Security number (only the last four digits are shown to help prevent identity theft)..... XXX-XX-1234

How Your Benefits Are Estimated

To qualify for benefits, you earn “credits” through your work — up to four each year. This year, for example, you earn one credit for each $1,470 of wages or self-employment income. When you’ve earned $5,880, you’ve earned your four credits for the year. Most people need 40 credits, earned over their working lifetime, to receive retirement benefits. For disability and survivors benefits, young people need fewer credits to be eligible.

We checked your records to see whether you have earned enough credits to qualify for benefits. If you haven’t earned enough yet to qualify for any type of benefit, we can’t give you a benefit estimate now. If you continue to work, we’ll give you an estimate when you do qualify.

What we assumed — If you have enough work credits, we estimated your benefit amounts using your average earnings over your working lifetime. For 2021 and later (up to retirement age), we assumed you’ll continue to work and make about the same as you did in 2019 or 2020. We also included credits we assumed you earned last year and this year.

Generally, the older you are and the closer you are to retirement, the more accurate the retirement estimates will be because they are based on a longer work history with fewer uncertainties such as earnings fluctuations and future law changes. We encourage you to use our online Retirement Estimator at www.socialsecurity.gov/estimator to obtain immediate and personalized benefit estimates.

We can’t provide your actual benefit amount until you apply for benefits. And that amount may differ from the estimates stated above because:

1. Your earnings may increase or decrease in the future.
2. After you start receiving benefits, they will be adjusted for cost-of-living increases.

(3) Your estimated benefits are based on current law. The law governing benefit amounts may change.

(4) Your benefit amount may be affected by military service, railroad employment or pensions earned through work on which you did not pay Social Security tax.

Visit www.socialsecurity.gov to learn more.

Windfall Elimination Provision (WEP) — In the future, if you receive a pension from employment in which you do not pay Social Security taxes, such as some federal, state or local government work, some nonprofit organizations or foreign employment, and you also qualify for your own Social Security retirement or disability benefit, your Social Security benefit may be reduced, but not eliminated, by WEP. The amount of the reduction, if any, depends on your earnings and number of years in jobs in which you paid Social Security taxes, and the year you are age 62 or become disabled. For more information, please see Windfall Elimination Provision (Publication No. 05-10004) at www.socialsecurity.gov/WEP.

Government Pension Offset (GPO) — If you receive a pension based on federal, state or local government work in which you did not pay Social Security taxes and you qualify, now or in the future, for Social Security benefits as a current or former spouse, widow or widower, you are likely to be affected by GPO. If GPO applies, your Social Security benefit will be reduced by an amount equal to two-thirds of your government pension, and could be reduced to zero. Even if your benefit is reduced to zero, you will be eligible for Medicare at age 65 on your spouse’s record. To learn more, please see Government Pension Offset (Publication No. 05-10007) at www.socialsecurity.gov/GPO.
### Your Earnings Record

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<thead>
<tr>
<th>Years You Worked</th>
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**Total Social Security and Medicare taxes paid over your working career through the last year reported on the chart above:**

- **Estimated taxes paid for Social Security:**  
  - You paid: $73,110  
  - Your employers paid: $75,047
- **Estimated taxes paid for Medicare:**  
  - You paid: $17,585  
  - Your employers paid: $17,585

**Note:** Currently, you and your employer each pay a 6.2 percent Social Security tax on up to $142,800 of your earnings and a 1.45 percent Medicare tax on all your earnings. If you are self-employed, you pay the combined employee and employer amount, which is a 12.4 percent Social Security tax on up to $142,800 of your net earnings and a 2.9 percent Medicare tax on your entire net earnings.  
*If you have earned income of more than $200,000 ($250,000 for married couples filing jointly), you must pay 0.9 percent more in Medicare taxes.

### Help Us Keep Your Earnings Record Accurate

You, your employer and Social Security share responsibility for the accuracy of your earnings record. Since you began working, we recorded your reported earnings under your name and Social Security number. We have updated your record each time your employer (or you, if you’re self-employed) reported your earnings.

Remember, it’s your earnings, not the amount of taxes you paid or the number of credits you’ve earned, that determine your benefit amount. When we figure that amount, we base it on your average earnings over your lifetime. If our records are wrong, you may not receive all the benefits to which you’re entitled. **Review this chart carefully** using your own records to make sure our information is correct and that we’ve recorded each year you worked. You’re the only person who can look at the earnings chart and know whether it is complete and correct.

Some or all of your earnings from last year may not be shown on your Statement. It could be that we still were processing last year’s earnings reports when your *Statement* was prepared. Your complete earnings for last year will be shown on next year’s *Statement*. **Note:** If you worked for more than one employer during any year, or if you had both earnings and self-employment income, we combined your earnings for the year.

There’s a limit on the amount of earnings on which you pay Social Security taxes each year. The limit increases yearly. Earnings above the limit will not appear on your earnings chart as Social Security earnings. (For Medicare taxes, the maximum earnings amount began rising in 1991. Since 1994, all of your earnings are taxed for Medicare.) **Call us right away at 1-800-772-1213** (7 a.m.–7 p.m. your local time) if any earnings for years before last year are shown incorrectly. Please have your W-2 or tax return for those years available. (If you live outside the U.S., follow the directions at the bottom of page 4.)
Some Facts About Social Security

About Social Security and Medicare…
Social Security pays retirement, disability, family and survivors benefits. Medicare, a separate program run by the Centers for Medicare & Medicaid Services, helps pay for inpatient hospital care, nursing care, doctors’ fees, drugs, and other medical services and supplies to people age 65 and older, as well as to people who have been receiving Social Security disability benefits for two years or more. Medicare does not pay for long-term care, so you may want to consider options for private insurance. Your Social Security covered earnings qualify you for both programs. For more information about Medicare, visit www.medicare.gov or call 1-800-633-4227 (TTY 1-877-486-2048 if you are deaf or hard of hearing).

Retirement — If you were born before 1938, your full retirement age is 65. Because of a 1983 change in the law, the full retirement age will increase gradually to 67 for people born in 1960 and later.

Some people retire before their full retirement age. You can retire as early as 62 and take benefits at a reduced rate. If you work after your full retirement age, you can receive higher benefits because of additional earnings and credits for delayed retirement.

Disability — If you become disabled before full retirement age, you can receive disability benefits after six months if you have:
— enough credits from earnings (depending on your age, you must have earned six to 20 of your credits in the three to 10 years before you became disabled); and
— a physical or mental impairment that’s expected to prevent you from doing “substantial” work for a year or more or result in death.

If you are filing for disability benefits, please let us know if you are on active military duty or are a recently discharged veteran, so that we can handle your claim more quickly.

Family — If you’re eligible for disability or retirement benefits, your current or divorced spouse, minor children or adult children disabled before age 22 also may receive benefits. Each may qualify for up to about 50 percent of your benefit amount.

Survivors — When you die, certain members of your family may be eligible for benefits:
— your spouse age 60 or older (50 or older if disabled, or any age if caring for your children younger than age 16); and
— your children if unmarried and younger than age 18, still in school and younger than 19 years old, or adult children disabled before age 22.

If you are divorced, your ex-spouse could be eligible for a widow’s or widower’s benefit on your record when you die.

Extra Help with Medicare — If you know someone who is on Medicare and has limited resources and income, Extra Help is available for prescription drug costs. The Extra Help can help pay the monthly premiums, annual deductibles and prescription co-payments. To learn more or to apply, visit www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Receive benefits and still work...
You can work and still get retirement or survivors benefits. If you’re younger than your full retirement age, there are limits on how much you can earn without affecting your benefit amount. When you apply for benefits, we’ll tell you what the limits are and whether work would affect your monthly benefits. When you reach full retirement age, the earnings limits no longer apply.

Before you decide to retire...
Carefully consider the advantages and disadvantages of early retirement. If you choose to receive benefits before you reach full retirement age, your monthly benefits will be reduced.

To help you decide the best time to retire, we offer a free publication, When To Start Receiving Retirement Benefits (Publication No. 05-10147), that identifies the many factors you should consider before applying. Most people can receive an estimate of their benefit based on their actual Social Security earnings record by going to www.socialsecurity.gov/estimator. You also can calculate future retirement benefits by using the Social Security Benefit Calculators at www.socialsecurity.gov.

Other helpful free publications include:
— Retirement Benefits (No. 05-10035)
— Understanding The Benefits (No. 05-10024)
— Your Retirement Benefit: How It Is Figured (No. 05-10070)
— Windfall Elimination Provision (No. 05-10045)
— Government Pension Offset (No. 05-10007)
— Identity Theft And Your Social Security Number (No. 05-10064)

We also have other leaflets and fact sheets with information about specific topics such as military service, self-employment or foreign employment. You can request Social Security publications at our website, www.socialsecurity.gov, or by calling us at 1-800-772-1213. Our website has a list of frequently asked questions that may answer questions you have. We have easy-to-use online applications for benefits that can save you a telephone call or a trip to a field office.

You also may qualify for government benefits outside of Social Security. For more information on these benefits, visit www.benefits.gov.

If you need more information — Visit www.socialsecurity.gov on the Internet, contact any Social Security office, call 1-800-772-1213 or write to Social Security Administration, Office of Earnings Operations, P.O. Box 33026, Baltimore, MD 21209-3026. If you’re deaf or hard of hearing, call TTY 1-800-325-0778. If you have questions about your personal information, you must provide your complete Social Security number. If your address is incorrect on this Statement, ask the IRS to send you a Form 8822. We don’t keep your address if you’re not receiving Social Security benefits.
Retirement can have more than one meaning these days. It can mean that you have applied for Social Security retirement benefits, or that you are no longer working. Or it can mean that you have chosen to receive Social Security while still working, either full or part-time. All of these choices are available to you. Your retirement decisions can have very real effects on your ability to maintain a comfortable retirement.

If you retire early, you may not have enough income to enjoy the years ahead of you. Likewise, if you retire late, you’ll have a larger income, but fewer years to enjoy it. Everyone needs to try to find the right balance, based on his or her own circumstances.

We hope the following information will help you as you plan for your future retirement and consider your retirement options.

What is the best option for you?

Everyone’s situation is different. That is why Social Security has created several retirement planners to help you decide what would be best for you and your family. Social Security has an online calculator that can provide immediate and accurate retirement benefit estimates to help you plan for your retirement.

The online Retirement Estimator is a convenient, secure, and quick financial planning tool. It uses your own earnings record information, thereby eliminating any need to manually key in years of earnings information. The estimator also will let you create “what if” scenarios. You can, for example, change your “stop work” date or expected future earnings to create and compare different retirement options. To use the Retirement Estimator, go to our website at www.socialsecurity.gov/estimator.

Avoid a Medicare Penalty

Sign Up at Age 65

Even if you don’t plan to receive monthly benefits, be sure to sign up for Medicare three months before turning age 65. If you don’t sign up for Medicare Part B (medical insurance) when you’re first eligible, your coverage may not start right away and you may have to pay a late enrollment penalty for as long as you have it. You can apply online. Visit www.socialsecurity.gov/medicareonly for information and to apply.

There is one more thing you should remember as you crunch the numbers for your retirement. You may need your income to be sufficient for a long time, because people are living longer than ever before, and generally, women tend to live longer than men. For example:

• The typical 65-year-old today will live to age 83;
• One in four 65-year-olds will live to age 90; and
• One in ten 65-year-olds will live to age 95.

Once you decide on the best age for you to actually retire, remember to complete your application three months before the month in which you want retirement benefits to begin.

It’s so easy to apply online for benefits

The easiest way to apply for Social Security retirement benefits is to go online at www.socialsecurity.gov/applyforbenefits. If you do not have access to the Internet, you can call 1-800-772-1213 (TTY number, 1-800-325-0778) between 7 a.m. and 7 p.m., Monday through Friday, to apply by phone. You also can apply at any Social Security office. To avoid having to wait, call first to make an appointment.
Receiving benefits while you work

When you reach your full retirement age, you can work and earn as much as you want and still receive your full Social Security benefit payment. If you are younger than full retirement age and if your earnings exceed certain dollar amounts, some of your benefit payments during the year will be withheld.

This does not mean you must try to limit your earnings. If we withhold some of your benefits because you continue to work, we will pay you a higher monthly benefit amount when you reach your full retirement age. In other words, if you would like to work and earn more than the exempt amount, you should know that it will not, on average, reduce the total value of lifetime benefits you receive from Social Security—and may actually increase them.

Here is how this works: after you reach full retirement age, we will recalculate your benefit amount to give you credit for any months in which you did not receive some benefit because of your earnings. In addition, as long as you continue to work, we will check your record every year to see whether the additional earnings will increase your monthly benefit.

Many people can continue to work and still receive retirement benefits. If you want more information on how earnings affect your retirement benefits, ask for How Work Affects Your Benefits (Publication No. 05-10069), which has current annual and monthly earnings limits, and is available on our website.

Retirement age considerations

Full retirement age

For persons born during the years 1943-1954, the full retirement age is 66. If you were not born in this period, you can find your full retirement age on page 2 of your Social Security Statement.

Retiring early

If you’ve earned 40 credits (credits are explained on page 2 of your Statement), you can start receiving Social Security benefits at 62 or at any month between 62 and full retirement age. However, your benefits will be reduced based on the number of months you receive benefits before you reach full retirement age.

If your full retirement age is 66, benefits will be reduced:
- 25 percent at age 62;
- 20 percent at age 63;
- 13 1/3 percent at age 64; or
- 6 2/3 percent at age 65.

Delaying retirement

You may decide to wait beyond your full retirement age before choosing to receive benefits. If so, your benefit will be increased by a certain percentage for each month you don’t receive benefits between your full retirement age and age 70. This table shows the rate your benefits increase if you delay retiring:

<table>
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<tr>
<th>Year of birth</th>
<th>Yearly increase rate</th>
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<tr>
<td>1941 - 1942</td>
<td>7.5%</td>
</tr>
<tr>
<td>1943 or later</td>
<td>8.0%</td>
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Rules that may affect your survivor

If you are married and die before your spouse, he or she may be eligible for a benefit based on your work record. If you start benefits before your full retirement age, we cannot pay your surviving spouse a full benefit from your record. Also, if you wait until after your full retirement age to begin benefits, the surviving spouse benefits based on your record will be higher.

Need more information?

You can find answers to frequently asked questions about Social Security, learn about factors that could affect your benefits, and much more by visiting Social Security online at www.socialsecurity.gov.

If you do not have access to the Internet, you can get information about Social Security by calling 1-800-772-1213 (1-800-325-0778 for the deaf or hard of hearing) or by visiting a local Social Security office.

Other useful websites

www.mymoney.gov

This website contains calculators for financial planning and information on money-related matters, such as retirement planning and starting a small business.

www.dol.gov/agencies/ebsa/workers-and-families/preparing-for-retirement

Have you determined how much money you’ll need in retirement? There are many tools available to help you, such as the Taking the Mystery Out of Retirement Planning Workbook available at this link.

www.sec.gov/investor/seniors.shtml

Are you looking for information about the investment options available to you as you enter retirement? The Securities and Exchange Commission has a wealth of information on different investment products and topics available at this website.

www.usa.gov/retirement

This website has a variety of retirement-related resources for seniors including information on Social Security, saving for retirement, and protecting one’s private pension benefits.
GOOD CAUSE FOR MISSING THE DEADLINE TO REQUEST REVIEW

Code Of Federal Regulations

§ 404.911. Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you had good cause for missing a deadline to request review we consider—

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeal Council review or filed a civil suit.

(6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.

(7) You did not receive notice of the determination or decision.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.

# SUPPLEMENTAL SECURITY INCOME (SSI)

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Introduction

SSI BASICS

Supplemental Security Income (SSI), also known as Title XVI, is a federally financed, needs-based program administered by the Social Security Administration (SSA). SSI guarantees a minimum income level for people who are aged (65 and older), blind, or meet the Social Security disability standard with low incomes and resources.

The federal government provides $794 per month for an eligible individual and $1,191 for an eligible couple. This amount is adjusted annually and is known as the Federal Benefit Rate (FBR). There was a 1.3% increase in the federal Cost of Living Adjustment (COLA) in 2021 which resulted in increases of $11 per month for an eligible individual and $16 per month for an eligible couple from 2020 to 2021.

Some states supplement these amounts. Until April 30, 2009, California provided a $233 per month state supplement for aged and disabled individuals and a $568 per month supplement for aged and disabled couples. The state supplement has since been reduced to the current level of $160.72 per month for an individual and $407.14 for an eligible couple, which reflects a one-time state COLA of 2.76% in 2017. Thus, the current combined state and federal SSI benefit rate in California is $954.72 per month for an individual and $1,598.14 for an eligible couple. Persons who are blind or lack access to adequate cooking or food storage facilities are paid a somewhat higher amount.

Note - There is no provision for a lien on the property of an SSI recipient or any other requirement to repay properly paid benefits.

RELATED BENEFITS

Medicaid - Most states, including California, automatically provide Medicaid (Medi-Cal) to persons who qualify for SSI. These states do not make their own Medicaid eligibility determinations for SSI recipients.

In these states, SSA shares SSI eligibility information electronically with the state Medicaid agency. When an individual loses SSI eligibility, and, therefore, automatic Medicaid eligibility, the state Medicaid agency must redetermine Medicaid eligibility and provide due process, i.e., notice and the opportunity for hearing.

Food Stamps - In California, SSI recipients were previously not eligible for Food Stamps. As the result of a state policy change in 2019, SSI recipients are now eligible to receive Food Stamps.

Dependents - Unlike Social Security, the SSI program has no benefits for dependents.
Eligibility

OVERVIEW

An applicant for SSI must meet several different eligibility criteria:

- Categorical Eligibility - Age (65 years or older) or blindness or disability.
- Financial Eligibility - Resource and income test.
- Immigrant Eligibility - Discussed later in this chapter.
- Residence - Residence in the United States is a requirement even for citizens, and residence in California is required to receive the California state supplement.

Whether to Apply as a Couple or as an Individual - Don’t worry about this. SSA will make the decision for you. If you are married and living in the same household and both are over age 65 or disabled, you must apply as a couple. For information on recognition of domestic partnerships and civil unions for same sex and opposite sex couples, see p.19 of this chapter. Also, if you are living with another person and leading people to believe you are married and both of you are over age 65 or disabled, then you must apply as a couple. On the other hand, if you are separated or if only one spouse is over 65 or disabled, then you must apply as an individual.

Financial Eligibility

RESOURCES

Resources of an SSI recipient may not exceed $2,000 in “countable resources” for an individual or $3,000 for a couple.

What is a Resource? SSA Regulations define a resource as: “[C]ash or other liquid assets or any real or personal property that an individual . . . owns and could convert to cash to be used for his or her support and maintenance.”

How are Resources Counted? Resources are generally counted on the basis of the equity an individual has in the resource, i.e., market value minus encumbrances.

When are Resources Counted? Resources are counted only once a month on the first moment of the first day of the month. Resources held in the middle of a month are irrelevant, although a period of ineligibility may be imposed for transfer of a resource, as is discussed later in this chapter.

Excluded Resources - Certain resources are excluded and do not count toward the resource limit. A partial list of the principal exclusions follows. A list containing additional excluded resources with reference to the POMS section that describes each of them is attached to these materials. Resources that are not excluded are “countable resources.”

Because Medi-Cal eligibility rules must track SSI eligibility rules, these exclusions must apply to Medi-Cal eligibility also. See Chapter 6, infra.

- Home - The home in which the SSI recipient resides and all contiguous land is excluded, regardless of value. However, if the recipient lives elsewhere, the home is counted. If the recipient has the intent to return to
the home -- no matter how unrealistic the intent -- the home still is excluded. This rule is important for a resident of a residential care facility or a nursing facility who is prevented from moving home by a medical condition. The “intent to return home” also is discussed in Chapter 6, the Medi-Cal chapter.

- **Automobile** - One automobile is excluded regardless of value.
- **Personal or Household Goods** - No limit on value.
- **Burial Funds and/or Life Insurance Policies** - Up to $1,500 combined value of all burial funds together with face value of life insurance policies for the beneficiary or his/her spouse. These funds must be separately identified and set aside. If the funds are used for another purpose, the individual may face a substantial overpayment.
- **Burial Plot** - A burial plot is excluded regardless of value. This is in addition to the burial funds.
- **Jointly Owned Property** - Undue hardship - Jointly owned property is excluded where the sale would cause undue hardship to the co-owner because of loss of housing.
- **Past-due Social Security and SSI payments** - These payments are excluded from resources for a nine-month period.
- **Earned Income Tax Credit and Child Tax Credit** - These payments are excluded from resources for twelve months, beginning with the month after receipt.

For additional resource exclusions, see POMS SI 01130.050, infra p. 2-20.

**Resource and Income Deeming** - Deeming is when money or property of one person is considered available to another person.

There are three circumstances in which a portion of the income and resources of another person will be considered available to the SSI applicant regardless of actual availability. The formula for determining the amount of the income and resources available to the individual is different in each of the three circumstances.

1. **Spousal Deeming** - The income and resources of an ineligible spouse living in the same household are deemed to the individual. It must be noted that spousal deeming does not apply when the spouses are separated. It should also be noted that spousal deeming applies only when one spouse is categorically eligible for SSI (aged, blind or disabled) and the other is not. If both are categorically eligible and they are living together, then they must apply as a couple.

2. **Parent to Child Deeming** - The income and resources of a parent living in the household are deemed to the child.

3. **Sponsor to Alien Deeming** - Not all immigrants are sponsored. Deeming applies only to some sponsored immigrants, primarily those whose sponsors signed affidavits of support on or after December 1997. These “new affidavits” provide for sponsor deeming to continue until naturalization or until the immigrant has 40 quarters of covered employment, whichever comes first. Earlier affidavits of support provided for sponsor deeming for only a three-year period.

**INCOME**

Income for SSI purposes is a term of art. Income is defined in the SSI regulations as “anything you receive in cash or in kind that you can use to meet your needs for food and shelter.” In other words, if it cannot be used to obtain food or shelter, it is not income for SSI purposes.
Even if something is income under the SSI definition, it still might not be “countable income” under the SSI income counting rules. Only countable income affects SSI eligibility and the amount of the grant.

**What is Not Income?** SSA has compiled a long, but not exhaustive, list of items that are not considered to be income. Among the items on the list are:

- Impairment related work expenses (IRWEs);
- Gifts of domestic airline tickets if they are not cashed in;
- Assistance based on need from a state or local government;
- Proceeds of a loan;
- Income tax refunds;
- Replacement of income previously received;
- The portion of a grant, scholarship or fellowship used for tuition, fees, or other necessary educational expenses;
- Bills paid directly to the supplier by someone else for goods or services other than food or shelter;
- Receipts from the sale, exchange, or replacement of a resource, even if the sale price is higher than the purchase price;
- Interest and dividend income on countable resources; and
- Infrequent or irregular income - up to $60 per quarter of unearned income and $30 per quarter of earned income.

**Tip** - It is best, if at all possible, to formalize any agreements to make repayments, to make it clear that there is a legal obligation to repay. Otherwise, SSA may end up classifying loan proceeds as countable income under the SSI rules.

**How Much Income Is Allowed?** In order to be eligible for SSI an individual cannot have more countable income than the SSI payment level applicable to the individual’s living arrangement. By far the largest category is that of aged or disabled individuals living independently with cooking facilities. The benefit rate [Federal Benefit Rate (FBR) + State Supplementary Payment (SSP)] and thus the maximum countable income allowed for these individuals is $954.72 per month. The benefit rate for similarly situated eligible couples is $1,598.14 per month. Charts containing benefit rates for other categories of SSI recipients in California are attached at p. 2-23.

**When Is Income Counted?** Income is counted on a monthly basis in the calendar month in which it is received. Income for the current month determines eligibility for the month. Income from the previous two months will determine the amount of the benefit for the current month. This is retrospective monthly accounting or RMA. However, income in the first month of eligibility determines the amount of the grant for the first three months, except that non-recurring income in the first month will not be counted in the second and third months.

**Types of Income** - The Social Security Act divides income into two categories for SSI purposes – earned and unearned income. The distinction is of crucial importance because the two types of income are calculated separately and with very different rules.
**Unearned Income** - Unearned income is defined in Social Security regulations by what it is not, i.e., it is not earned income. Of those SSI recipients who have income, the overwhelming majority have only unearned income, and for the majority of those with unearned income, the only income they have is a Social Security benefit.

For those who have only unearned income, the calculation of countable income to determine SSI eligibility and benefit amount is very simple. In order to determine the individual’s countable income, simply take the individual’s unearned income for the month from all sources, except excluded income (as discussed on the following page) and subtract an unearned income disregard of $20. The result is countable income for the month.

**EXAMPLE**

Assume that Javier applies as an individual whose only other income is a $520 monthly Social Security check. Is he income eligible? If so, how much is his grant?

The answer to the first question is “yes.” He has total unearned income of $520. From this, subtract the $20 unearned income disregard. This yields total countable income for the month of $500. Since this amount is less than $954.72, he is eligible. The amount of the grant is determined by subtracting his countable income of $500 from the SSI payment level of $954.72, leading to an SSI grant of $454.72 per month.

Change the facts for Javier. Assume that in addition to his Social Security check, he receives a $420 monthly pension check for a total monthly unearned income of $940. Is he still eligible?

The answer again is “yes,” because his countable income ($940 - $20) is only $920. Thus, he receives a monthly benefit of only $34.72. But, keep in mind he also gets automatic Medi-Cal eligibility with no share of cost deductible. Also, note that although he has two sources of unearned income, he only gets to use the $20 unearned income disregard once.

Change the facts again. Javier still receives his $520 a month Social Security retirement check. However, he has just married Josefina, who receives a $920 a month Social Security disability check. Are either of them entitled to SSI? If so, who? How much? Do you need more information?

**Earned Income** - A very small percentage of all SSI recipients have earned income, about 3%. For elderly recipients it is even smaller, about 1.3%. However, the rules for counting earned income are more generous than those for counting unearned income. The steps for calculating countable earned income are as follows:

- **Step One** - Add up all earnings for the month using gross wages.
- **Step Two** - Subtract any Impairment Related Work Expenses (IRWE), but only if the beneficiary is receiving SSI on the basis of disability or was receiving it on the basis of disability the month before reaching retirement age.
- **Step Three** - Subtract the earned income disregard of $65 per month.
- **Step Four** - Subtract the $20 income disregard, but only if the $20 has not already been applied to unearned income.
- **Step Five** - Divide the remaining amount by 2. The result is countable earned income.
EXAMPLE

Anna earns $1,785 in gross wages per month. She has no other income and has no Impairment Related Work Expenses. Is she eligible for SSI as an individual? If so, how much is her grant?

She is eligible, and is entitled to a grant of $104.72 per month. The calculations are: gross wages of $1,785 minus earned income disregard of $65 equals $1,720, minus unearned income disregard of $20 equals $1,700. $1,700 divided by 2 equals countable income of $850. Subtracting $850 from the monthly payment level of $954.72 leaves a monthly grant of $104.72.

Take another example. Harry is married to and lives with Wanda. Both are 75 years old. Harry does not work. The couple’s only income comes from Wanda’s job at Costco, where she earns $2,985 per month. Wanda has a disability which requires that she spend an additional $300 per month to go to and from work. Neither of them has ever received SSI before. Who, if anyone, is eligible for SSI?

From the start it is clear that either both or neither one is eligible. Why? Since both of them are categorically eligible (i.e., aged, blind, or disabled), and they are husband and wife living together, they must apply as a couple. The arithmetic shows that they are in fact eligible as a couple. First, since they qualify for SSI on the basis of age, they cannot subtract IRWEs even if she has such expenses. Subtracting the $65 and $20 income disregards from her $2,985 in gross wages leaves $2,900. Dividing that by two leaves countable income of $1,450 per month. That means they are eligible for a $148.14 SSI grant, because the monthly SSI/SSP grant standard is $1,598.14 for an eligible couple. Both are eligible for Medi-Cal without a share of cost.

In-Kind Support and Maintenance (ISM) - There are special rules for counting in-kind support and maintenance (ISM). One is the so-called one-third rule, and the other is the presumed value rule. Before discussing the two counting rules, there are two other important points to clarify. The first is that not everything received in-kind is counted; only in-kind food and shelter, or that which can be used to obtain food and shelter. The second point is that items provided with the understanding that the individual will later repay do not constitute ISM. This is a loan. This most frequently occurs when a friend or relative helps out while the SSI application is pending, although it also happens later after the individual is receiving benefits. However, the loan needs to be well-documented.

One-Third Rule - The one-third rule applies when the individual is living in the household of another and that person is providing the individual with both food and shelter. When this rule applies, an amount equal to one-third of the SSI Federal Benefit Rate ($794 ÷ 3 = $264.66, in 2021) is added to the individual’s countable income. This addition is made regardless of the actual market value of the food and shelter provided.

Many factual questions arise in the application of the one-third rule. For example, when a beneficiary is paying something to the owner or prime tenant of a house or apartment, if the amount is the beneficiary’s pro-rata share of expenses, then there is no in-kind support and maintenance. However, if the beneficiary is paying something less than the pro-rata share, then it is ISM, assuming that both food and shelter are provided.

Presumed Value Rule - The presumed value rule applies when there is in-kind support and maintenance but the rules for the one-third rule do not apply, i.e., (1) either food or shelter are provided but not both; or (2) the individual is not living in the household of the other person. Under the presumed value rule, the ISM will have a presumed value equal to one-third the FBR plus the $20 income disregard ($264.66 + $20 = $284.66, in 2021). This amount will be added to the individual’s countable income in calculating the amount of the grant, unless the individual can demonstrate that the actual value of the support is less. The ISM cannot be valued at a greater amount regardless of actual market value.
Transfer of Resources

INTRODUCTION

The Foster Care Independence Act of 1999 added a transfer of resources penalty to SSI. The Act establishes a 36-month look-back period and a period of ineligibility of up to 36 months for the transfer of a resource for less than Fair Market Value (FMV). It is important that anyone receiving SSI or considering the possibility of applying for SSI within the next three years, consider this provision.

What Is A Resource? Anything that fits within the SSI resource definition is a resource for purpose of the transfer penalty.

How is the Penalty Period Calculated? The period of disqualification is calculated by dividing the uncompensated value of the resource by the monthly benefit rate applicable to the individual. The result when rounded down gives the number of months for which the individual is ineligible.

EXAMPLE

Zack, who is 80 years old, decided in May 2021 that he was no longer able to drive. He gave away one of his two cars to his grandson in that month. The car had a fair market value of $12,000. In June 2021, Zack applied for SSI as an individual and is otherwise eligible. At this time the fair market value of the car is $10,000. Does the transfer affect his eligibility?

The answer is “yes.” The transfer took place during the 36-month look-back period immediately preceding the SSI application. Since Zack did not receive fair market value, the penalty applies. The duration of the penalty is determined by the amount of the uncompensated value ($12,000) divided by the monthly combined benefit rate (FBR + SSP or $954.72). This yields 12.57, which is rounded down to 12 months of ineligibility. Since the period of ineligibility begins on the first of the month following the transfer, Zack is ineligible beginning June 1, 2021 and will not become eligible until June 2022.

What if Zack sold the car to his grandson for $5,000, knowing that his grandson could not afford to pay more?

Now the uncompensated value is $7,000. Dividing $7,000 by $954.72 yields 7.33, resulting in a 7-month period of ineligibility.

Q. If there were no transfer penalty, what would be the impact of the $5,000 Zack received in May 2021 on his SSI eligibility for that and subsequent months?

Answer:

Disclaimer of Inheritance: Disclaimer of a right of inheritance is also considered a transfer of a resource for less than Fair Market Value.

EXCEPTIONS TO TRANSFER PENALTY

Fortunately, there are exceptions to the transfer penalty. Exceptions include:
• **All Resources Returned** - In the example above, if the grandson returned the car, Zack would not have a period of ineligibility, even for the period prior to the return of the car.

• **Transfer of a Home To Certain Family Members** - This exception applies to a transfer to a spouse, a child under 21, or a child of any age who is blind or disabled. It also applies to a transfer to a sibling with an ownership interest (including a life estate) who resided in the home for at least a year immediately prior to the individual’s institutionalization. The home transfer exception applies as well to a transfer to an adult son or daughter who resided in the home for at least two years prior to institutionalization, and provided care to the individual allowing that person to live at home instead of an institution.

• **Non-Home Transfers to Certain Family Members** - There is an exception for non-home transfers to a spouse, or a blind or disabled child, or for the sole benefit of a spouse.

• **Transfers to Certain Trusts** - There is an exception for transfers to three types of trusts: (1) a trust for a blind or disabled child; (2) a trust for the sole benefit of an individual (including the grantor) who is under 65 and blind or disabled; (3) a trust that is a countable resource.

• **Transfers for a Purpose Other Than to Obtain SSI** - There is a presumption that a transfer is for the purpose of obtaining SSI which can only be overcome by convincing evidence that the transfer was exclusively for another purpose. Examples of transfers that might satisfy this exception include: (1) court-ordered transfers; (2) transfer occurring prior to the traumatic onset of a disability or blindness that created eligibility for SSI; (3) transfer occurring prior to a diagnosis of a previously undetected disabling condition that created eligibility for SSI; or (4) transfer occurring prior to an unexpected loss of other income or resources that would have precluded SSI eligibility in any case.

• **Transfer of a Resource That Would Have Been Excludable in the Month Of the Transfer** - This exception allows for transfer of the home as long as the individual was residing there at the time of transfer.

• **Undue Hardship** - This exception applies only where failure to receive SSI would result in loss of food or shelter, and the individual’s total available funds do not exceed the applicable monthly payment rate for the individual’s living arrangement.

• **Transfer Of A Small Amount** - This exception applies if the transferred amount, when combined with other resources, is less than the $2,000 ($3,000 for a couple) resource limit.

### FINAL REMINDERS ON TRANSFERS

• Gifts of cash are transfers of resources and will incur a period of ineligibility if, when added to the individual’s other resources, they exceed the resource limit.

• Repayment of a loan which one has a legal obligation to repay is not a transfer for less than fair market value. A written document is helpful, but not absolutely necessary.

• Repayment of a moral obligation may provoke a period of ineligibility.

• An individual spending money on herself will never create a period of ineligibility.
SSI Proposals

SSI RESTORATION ACT OF 2019 (H.R. 4280)/ (S. 2753)

The Act was introduced in Congress to protect and preserve seniors and people with disabilities from the harms of poverty by updating some aspects of the SSI program that have not been changed in decades. The Act was reintroduced in the House and the Senate in the fall of 2019. An updated version of the SSI Restoration Act is likely to be introduced in this Congress.

Under the Act several needed updates to the SSI eligibility rules would be made:

1. Update the General Income Disregard from $20 a month to $123 a month. This amount has not changed since 1972 even though $20 in today’s money is equal to approximately $34 in 1972 dollars.

2. Update the Earned Income Disregard from $65 a month to $399 a month. This figure also has not changed since 1972.

3. Update the Resource Limit from the current $2,000 ($3,000 for a couple) to $10,000 ($20,000 for a couple). The resource limit has only increased 33% since the program was enacted in 1972 even though the cost of living today is many times greater than it was then.

4. Eliminate the In-Kind Support and Maintenance Reduction where someone is receiving in-kind food and/or shelter.

5. Eliminate the Transfer Penalty for transferring a resource for less than fair market value.

6. Remove the Marriage Penalty for SSI Couples. Increase the SSI couples’ rate to equal two times the SSI individual rate.

7. Conform Treatment of State and Local Government Earned Income Tax Credits and Child Tax Credits for SSI. Simplify administration of the SSI program by excluding State EITCs and CTCs, in the manner in which similar federal tax payments are excluded.

State Level Advocacy

A strong grassroots movement has developed over the last several years to restore the California state supplementary payment (SSP), which has been cut from $233 in 2009 to $160.72 today; and to equitably end SSI cash-out, the state policy that previously denied SNAP (CalFresh) benefits to persons enrolled in SSI. The group, Californians for SSI, has the participation of over 200 organizations as well as a number of SSI recipients with the goal of raising the combined SSI/SSP grant to at least the federal poverty level.

In 2017, the first post-Recession restoration of the state (SSP) portion of the grant occurred when a one-time 2.76% cost of living adjustment (COLA) was applied to the SSP grant. In 2019, the state ended SSI cash-out while holding harmless households that would have seen a reduction in SNAP benefits due to the change, and also restored the SSP COLA starting in 2022. At the time this chapter was written, state leaders were considering a proposal to increase the SSP grant for an individual by 6.4%, bringing it up to $171. However, even with this
increase the state supplement for individuals would still be well below the 2009 payment level of $233. Moreover, there is no proposed increase for couples receiving SSI/SSP, who have faced the same cost increases in housing, food and other essentials in the past decade, let alone more recent costs due to COVID-19. The website for Californians for SSI is https://ca4ssi.org/.

Administrative Appeals Process

The administrative appeal process is the same as for Social Security, with the exception of the first level of appeal (reconsideration) when adverse actions (suspension, termination or reduction of benefits) are taken. When SSA proposes to reduce, suspend or terminate SSI benefits, SSA must offer the individual the opportunity for continued payment of full benefits through decision on the first level of appeal, if the adverse action is appealed within ten days (plus five additional days for mailing) of the notice of adverse action. There is no opportunity for continued benefits beyond the reconsideration stage except in the case of an appeal from an adverse CDR (Continuing Disability Review) decision for medical improvement, in which case continued benefits can continue through an Administrative Law Judge (ALJ) decision.

It should be noted that the “good cause” provision governing late filing of appeals applies as well to situations causing an individual to miss the deadline for receiving continued payment of benefits pending appeal. A copy of the good cause regulation (section 416.1411 of Title 20 of the Code of Federal Regulations) is included at the end of this chapter, p. 2-27.

In an adverse action in an SSI case, SSA also must offer the individual a choice of three different processes for reconsideration at the SSA District Office level. The case review is the option most frequently selected and probably the least appropriate for someone facing a proposed suspension or reduction. This is strictly a paper review and offers very limited opportunity to find out more about the agency’s case. The other options are informal conference and formal conference, both of which involve a face to face appearance before the decision-maker. At the formal conference there is also the opportunity to request that documents and witnesses be subpoenaed. There is also a written summary of the proceedings.

Note - The first stage of the appeal process is initiated by filing a Request for Reconsideration at your local Social Security office on the form attached in the Appendix at p. 2-28. Copies of the form are also available on the Social Security Administration website. It is important to retain a copy of the Request for Reconsideration (preferably receipt stamped at the Social Security office) since Social Security offices frequently lose these requests or simply fail to process them.

Overpayments

APPEAL OF OVERPAYMENT DETERMINATION

Overpayments are far more common in the SSI program than in Social Security because of the need to comply with the program’s income and resource eligibility requirements on a monthly basis. If an individual disputes the existence or amount of the overpayment, the determination can be appealed through SSA’s administrative appeals process as described above.
WAIVER

While there is a 60-day time limit for appealing the existence or amount of an overpayment, a waiver can be requested at any time. No matter when waiver is requested, the waiver request should stop all collection efforts until after the waiver request has been considered at a personal conference. The waiver must be granted when (1) the individual is without fault; and (2) collection of the overpayment would either (a) defeat the purpose of the SSI program, (b) be against equity and good conscience, or (c) impede efficient or effective administration of the SSI program due to the small amount involved (generally under $1,000).

For overpayment amounts over $1,000, the most common strategy is to pursue the second prong of the waiver test by demonstrating that collection of the overpayment would defeat the purpose of the SSI program. The individual must show that “the individual’s income and resources are needed for ordinary and necessary living expenses.” An individual currently receiving SSI is considered to have met this requirement if total income does not exceed the FBR plus the SSP, plus the $20 general income disregard. In other words, in July 2021 an individual SSI recipient living independently with cooking facilities in California will be considered to have met this test if total income, including SSI, does not exceed $974.72.

It is important to remember that although the term “waiver” has a discretionary ring to it, once the individual has met the conditions for a waiver, the individual has a right to waiver. If the waiver is denied, the denial may be appealed through SSA’s appeal process.

Generally, recovery of the overpayment out of future benefits is limited to 10% of total monthly income or the total monthly SSI benefit, whichever is less. The amount being recouped can be further reduced on a showing that the individual will not be left with enough to meet “current ordinary and necessary living expenses.” It should be noted that the 10% limit on recoupment does not apply in cases of fraud, willful misrepresentation or concealment of material facts.

CalFresh Eligibility

Since 1974, people who receive SSI had been barred from receiving CalFresh benefits because of a state policy called “cash-out.” In part due to strong grassroots advocacy by the Californians for SSI coalition, the state ended this “cash-out” policy on June 1, 2019. Seniors and people with disabilities who receive SSI are now allowed to receive CalFresh (SNAP) benefits. CalFresh eligibility is not automatic, and individuals who currently receive SSI will need to apply for CalFresh.

Ending cash-out is generally a positive change with many SSI recipients now able to receive both SSI/SSP and CalFresh.

However, a small number of households would have lost CalFresh benefits when a previously excluded household member who receives SSI was added to the CalFresh household.

To help mitigate this loss, the state created two new nutrition benefits for these households, the Supplemental Nutrition Benefit for households that experience a loss, and the Transitional Nutrition Benefit for households that experienced a total loss.
EXAMPLE
Karen, a senior whose only income is SSI, lives with her adult child, Jeremy, and two teenaged grandchildren. The household purchases and prepares their meals together, and Jeremy and the grandchildren receive CalFresh. At their first CalFresh reporting deadline after June 2019, the County would have calculated a new CalFresh benefit for the entire household, including in the calculation Karen’s SSI income.

- If the new CalFresh benefit was more than the previous benefit, the entire household would have simply begun receiving the new higher benefit amount.
- If the new CalFresh benefit is less than the previous benefit, then the household would have started receiving the Supplemental Nutrition Benefit, which would be added to the new lower CalFresh benefit
- If adding in Karen’s income means that the household no longer qualifies to receive any CalFresh benefit, then the household would have started receiving the Transitional Nutrition Benefit.

CALFRESH RULES TO KEEP IN MIND

In working with individuals applying for CalFresh, keep in mind the rules described below that help seniors and people with disabilities who receive SSI to qualify for and continue receiving CalFresh.

Housing Costs - SSI recipients who are approved for CalFresh will receive a benefit that will vary depending on individual circumstances like household size, income, and expenses. Those with higher housing costs qualify for a higher benefit because the CalFresh calculation provides a shelter cost deduction that is uncapped for households that include a senior or person with a disability.

Medical Expense Deduction - Seniors and people with disabilities can also take a deduction for medical expenses, which can help them qualify for a higher CalFresh benefit. CalFresh provides a standard deduction of $120 if there are verified medical expenses between $35.01 and $155 per month; individuals with expenses above $155 can claim a deduction of the actual amount above $35. Expenses can include medical and dental care, prescription medications, over-the-counter medications approved by a medical professional, costs to obtain and maintain service animals, transportation (including mileage) and lodging needed to obtain medical treatment, or medical equipment and supplies.

Minimum Benefit - A CalFresh household consisting of one person who receives SSI or two people who both receive SSI will qualify for at least a $16 minimum CalFresh benefit.

Keeping Benefits - CalFresh households with only seniors or people with disabilities and no earned income qualify for rules that make it easier to stay on CalFresh. These households are recertified for CalFresh every 36 months (instead of every 12 or 24 months) and do not need to do a recertification interview.

CalFresh Households - Some individual SSI recipients who share a home with others may qualify to be their own CalFresh household, which can result in higher CalFresh benefits overall. When people live together and purchase and prepare food together, they are considered one CalFresh household. Households apply together and share a CalFresh allotment calculated based on shared income and expenses. There are two situations where a senior or person with a disability can be a separate CalFresh household:
1. People who share a home but do not purchase and prepare food together can apply for CalFresh independently of one another. Thus, people who are elderly or disabled may apply for CalFresh separately from other people living with them (including roommates, siblings, or adult children) if they do not purchase and prepare food with others in the home. However, there are two groups of people who must apply together, regardless of whether or not they purchase and prepare food together: married couples living together, and parents living with their children under age 22.

In the example on the previous page, if Karen begins purchasing and preparing food separately from Jeremy and the grandchildren, Karen can become a separate CalFresh household. This may result in higher benefits overall, as there would be two CalFresh households from that point forward, each receiving their own CalFresh benefit.

2. A special household rule allows certain seniors who live in low-income households to be their own CalFresh household, even though the senior purchases and prepares food with the rest of the household, if the senior meets all three of the following criteria:
   - The person is both elderly and disabled,
   - Is unable to purchase and prepare meals separately because of a disability, and
   - The income of the rest of the household does not exceed 165% of the federal poverty level.

**COVID-19 ALERT**

Federal pandemic relief legislation passed in March 2020 provides extra benefits to increase each household’s CalFresh allotment to the maximum allotment for their household size for March-June 2020. For example, an SSI senior receiving the $16 minimum benefit from March through June 2020 would have received extra benefits to increase their CalFresh allotment to $194 for each of those months. Households do not need to take any action, as these emergency allotments are issued automatically. After June 2020, these emergency allotments have been approved by the federal SNAP agency on a month-by-month basis. California has continued to request emergency allotments each month since June 2020 and to have those requests be approved by the federal SNAP agency.

Additional federal pandemic relief legislation passed in December 2020 and March 2021 raised the CalFresh maximum allotments by 15% through September 2021, increasing the maximum benefit during this period for a household of one to $234, for example.

**Immigrant Eligibility**

At one time immigrant eligibility was very simple. Before 1996, lawful immigrants were eligible for SSI on the same basis as citizens. The Public Responsibility Work Opportunity and Reconciliation Act of 1996, coupled with the Balanced Budget Act of 1997, established complex special requirements that greatly restricted immigrant eligibility for SSI and other benefits. Unfortunately, SSA personnel are very often not familiar with the details of these requirements, resulting frequently in inappropriate denials. First, any non-citizen who was receiving benefits on August 22, 1996, is grandfathered in and will continue to be eligible for SSI assuming she/he continues to meet other eligibility requirements, i.e., income, resources, etc.
This is true even if benefits are terminated for a period of a few years, and he subsequently reapplies for benefits. It should be noted that anyone whose benefits may have been suspended between August 22, 1995 and August 22, 1996, is considered to have been receiving benefits on Aug. 22, 1996.

For every other non-citizen, it is necessary to look to the individual’s date of entry into the United States, because one set of rules applies to those who entered before August 22, 1996, and another more restrictive set of rules applies to those who entered on or after that date. However, as a threshold matter for both groups, it is a prerequisite for eligibility that the individual is among a limited group of non-citizens who are considered “qualified aliens.” This group includes lawful permanent resident aliens (LPRs), refugees, asylees, persons granted withholding of deportation, Cuban-Haitian entrants, persons paroled into the United States for at least a year or more, and certain domestic violence victims. It is important to remember that this is just a threshold qualification. Inclusion in this group does not by itself establish eligibility.

PRE 8/22/96 ENTRANTS

There are three categories of non-citizens -- other than those who were grandfathered in, i.e., those who entered the United States before 8/22/96 who are eligible for SSI today.

1. Qualified aliens who are blind or disabled and who were “lawfully residing” in the United States on 8/22/96. This group is largely elderly, although eligibility is based on disability rather than age. The overwhelmingly majority of the elderly immigrants who apply for SSI are determined to be disabled on the initial determination.

2. Certain veterans, their spouses, and children.

3. Lawful permanent residents who entered the U.S. before 8/22/96 and who have 40 qualifying quarters of credit under the Social Security Act. This group will be able to receive SSI on the basis of age without the need to prove disability. Unlike Title II of Social Security, an individual in this situation can use not only his own quarters, but also can use quarters earned by a spouse while the couple was married, and quarters earned by parents before the individual turned 18. However, no quarters earned after December 31, 1996, can be used if the individual received a means tested public benefit at the same time.

POST 8/22/96 ENTRANTS

1. Lawful permanent residents who entered the U.S. on or after 8/22/96 may not be eligible for SSI for the first five years as a LPR even if they have 40 qualifying quarters of coverage.

2. Refugees, asylees, persons for whom deportation is withheld, Cuban-Haitian entrants and certain Amerasian immigrants who can receive time-limited benefits based on age, blindness or disability. Eligibility for this group is limited to a period of seven years from the date their immigration status was granted. Almost all of them are eligible for the California Cash Assistance Program for Immigrants (CAPI) upon the expiration of the seven-year period.
SSI For Same Sex Couples

NOTE - This section also applies to opposite sex partners in domestic partnerships and civil unions.

Social Security Administration policy requires that people in a same sex relationship applying for SSI today are to be treated the same as those in an opposite sex relationship when it comes to determining marital status and “holding out” as married. This means that if they are living with someone to whom they are lawfully married or with whom they are in a California Registered Domestic Partnership, or with whom they are holding out as married, they will be treated as married for the purpose of SSI eligibility and benefit amount. Couples who entered into a domestic partnership or civil union in some, but not all, other states or nations will also be recognized as married.

However, prior to the June 26, 2013 decision of the U.S. Supreme Court decision in *U.S. v. Windsor*, the Defense of Marriage Act (DOMA) prohibited any agency of the federal government from recognizing a marriage between two people of the same sex. As a result, a person married to a person of the same sex was recorded in SSA records as single and SSI eligibility was determined on that basis even when the person presented their marriage certificate upon filing the application. This almost invariably resulted in the payment of significantly more benefits than the person would be entitled to if the marriage were recognized.

While SSA began to process new applications in California from people married to someone of the same sex in the beginning of 2014, they did not take any action to recognize the marriages of those already receiving SSI until a year or more after *Windsor*, when they began to do so on a rolling basis. In the process, they reduced future benefits as they should have done beginning in July 2013, and issued overpayment notices for the period from July 2013 demanding repayment of thousands of dollars.

As a result of a lawsuit, *Held v. Colvin*, SSA changed its policy and agreed to stop trying to collect overpayments from those who were married to someone of the same sex and receiving SSI prior to *Windsor*. Instead SSA will waive recovery of all overpayments based on delayed recognition of a marriage to someone of the same sex and will return any money already collected.

When SSA began recognizing marriages between two people of the same sex in California, they did not apply the “holding out” provision to same sex couples. However, when SSA recognized marriages of same sex couples nationwide after another Supreme Court decision, *Obergefell v. Hodges*, they did begin to apply the “holding out” provision on new applications from same sex couples who led others in the community to believe they were married. However, SSA will not be able to identify those who are holding out as married and already receiving SSI until the case comes up for a financial redetermination.

Since SSI redeterminations are done on a rolling basis, there may still be some same sex couples, one or both of whom are receiving SSI, who have not had a redetermination based on the *Windsor* decision and who are still receiving a greater amount of SSI than they should.
Assisting Individuals During the Pandemic

COVID-19 ALERT

Social Security’s physical offices closed to the public in March 2020 due to the COVID-19 pandemic. However, employees of the local SSA offices continue to serve the public by phone and can assist with any issue for which an individual would have gone to the office before the closure. Use the office locator to find the phone number and fax number for any local office: https://secure.ssa.gov/ICON/main.jsp In addition, the national toll-free number and online services that were available before continue to be available now.

Economic Impact Payments - Federal pandemic relief legislation passed in 2020 and 2021 provide for three one-time payments for individuals including SSI and Social Security recipients. For SSI eligibility, these payments do not count as income and also do not count as a resource for 12 months.

- $1,200 for every individual with a Social Security number, plus $500 for each dependent child under age 17. Payments were issued automatically to SSI and Social Security recipients in April and May 2020.

- $600 for every individual with a Social Security number, plus $600 for each dependent child under age 17. Payments were issued automatically to SSI and Social Security recipients at the end of December 2020.

- $1,400 for every individual with a Social Security number, plus $1,400 for each qualifying dependent. Note that qualifying dependents for this third stimulus payment is not age-restricted and can include seniors and adults with disabilities. Payments were issued automatically to SSI and Social Security recipients in April 2021.

Individuals who did not receive these stimulus payments automatically will need to file a tax return for 2020 to receive the payments.

Golden State Grant – State pandemic relief legislation passed in 2021 provides a $600 state supplement payment for each individual who receives SSI. Payments will be issued via paper checks and will be sent weekly by zip code beginning on May 24, 2021 and ending the week of June 21, 2021. The payment is not counted as income the month it is received, but any amount that remains the following month will be counted toward the $2,000 / $3,000 resource limit.

For CAPI recipients, The Golden State Grant Program provides a $600 one-time payment to all CAPI recipients. Payments will be issued via paper checks and will be sent weekly by zip code beginning on May 24, 2021 and ending the week of June 21, 2021. Receipt of this payment is not counted as income for CAPI recipients and will not count as a resource for 12 months.
Supplemental Materials
POMS SI 01130.050, GUIDE TO RESOURCE EXCLUSIONS

Program Operations Manual System (POMS)

Effective Dates: 08/15/2017 - Present

SI 01130.050 Guide to Resources Exclusions

CITATIONS: Social Security Act as amended, §1613(a):
20 CFR 416.1203 - 416.1204, 416.1210 - 416.1239, 416.1245, and 416.1247

A. Introduction

The following is a list of instructions which addresses a partial or total exclusion of resources. Those in **bold** print involve exclusions under a Federal statute other than the Social Security Act (see SI 01130.060).

B. List Of Instructions About Resources Exclusions

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Supplemental Security Income (SSI) in California

What is SSI?
Supplemental Security Income (SSI), is a federal program that provides monthly payments to people who have limited income and few resources. SSI is for people who are 65 or older, as well as people of any age, including children, who are blind or who have disabilities.

To qualify for SSI, you must also have little or no income and few resources. The value of the things you own must be less than $2,000 if you’re single or less than $3,000 for married couples living together. We don’t count the value of your home if you live in it, and, usually, we don’t count the value of your car. We may not count the value of certain other resources either, such as a burial plot.

To get SSI, you must also apply for any other government benefits for which you may be eligible. You must live in the United States or the Northern Mariana Islands to get SSI. If you’re not a U.S. citizen, but you lawfully reside in the United States, you may still be able to get SSI. For more information, read Supplemental Security Income (SSI) for Non-Citizens (Publication No. 05-11051).

The state of California adds money to the federal payment. The single payment you get at the beginning of each month includes both the federal SSI payment and your supplement from California.

Medical assistance
If you get SSI, you can usually get medical assistance (Medi-Cal) automatically. A separate Medi-Cal application isn’t necessary. If you have questions about Medi-Cal, contact your local county health or human services office.

Supplemental Nutrition Assistance Program (SNAP) — also known as CalFresh
You may apply or recertify for CalFresh benefits at any Social Security office if all of the following apply:

- You are currently living in California.
- You are getting or applying for SSI.
- You live alone or in a household where everyone is either getting or applying for SSI.
- You are not already getting CalFresh benefits.
- You have not filed for CalFresh within the past 90 days.

You can use the online SNAP Pre-Screening Eligibility Tool at www.fns.usda.gov/snap/recipient/eligibility to see if you may be eligible for SNAP. You may also call SNAP’s toll-free line at 1-800-221-6689. Visit www.cdss.ca.gov/food-nutrition/calfresh to apply for CalFresh, or for more details about the CalFresh program.

Other social services
Individuals who qualify for SSI often are eligible for additional programs and services provided by their local county health or human services office. These other services or benefits may include:

- A special allowance for assistance dogs for people who are blind or who have a disability.
- Certain domestic and personal care services provided to eligible people who are elderly, blind, or who can’t perform the services themselves, and who can’t safely remain in their own homes unless such services are provided.
- Protective services.

For more information, contact your local county health or human services office.

Monthly SSI payment amounts
The table on the back of this page lists the combined federal and state payment amounts. Not all SSI recipients get the maximum amount. Your payment may be lower if you have other income.
<table>
<thead>
<tr>
<th>Category</th>
<th>2021 Total Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aged</td>
</tr>
<tr>
<td>Independent living status</td>
<td>$1,844.72</td>
</tr>
<tr>
<td>Non-medical out-of-home care</td>
<td>$1,217.37</td>
</tr>
<tr>
<td>Independent living status, no cooking facilities</td>
<td>$1,041.04</td>
</tr>
<tr>
<td>Living in the household of someone else</td>
<td>$603.58</td>
</tr>
<tr>
<td>Disabled minor child</td>
<td></td>
</tr>
<tr>
<td>Disabled minor child in the household of another</td>
<td></td>
</tr>
<tr>
<td>Aged or disabled complexes</td>
<td></td>
</tr>
<tr>
<td>Independent living status</td>
<td></td>
</tr>
<tr>
<td>Non-medical out-of-home care</td>
<td></td>
</tr>
<tr>
<td>Independent living status, no cooking facilities</td>
<td></td>
</tr>
<tr>
<td>Living in the household of someone else</td>
<td></td>
</tr>
<tr>
<td>Blind complexes</td>
<td></td>
</tr>
<tr>
<td>Independent living status</td>
<td></td>
</tr>
<tr>
<td>Living in the household of someone else</td>
<td></td>
</tr>
<tr>
<td>Non-medical out-of-home care</td>
<td></td>
</tr>
<tr>
<td>Blind person with an aged or disabled spouse</td>
<td></td>
</tr>
<tr>
<td>Independent living status</td>
<td></td>
</tr>
<tr>
<td>Living in the household of someone else</td>
<td></td>
</tr>
<tr>
<td>Non-medical out-of-home care</td>
<td></td>
</tr>
<tr>
<td>Living in a Medicaid Facility</td>
<td>$51.00</td>
</tr>
<tr>
<td>Single people</td>
<td></td>
</tr>
<tr>
<td>Couple</td>
<td>$102.00</td>
</tr>
</tbody>
</table>

**Contacting Social Security**

The most convenient way to do business with us from anywhere, on any device, is to visit www.ssa.gov. There are several things you can do online: apply for benefits; get useful information; find publications; and get answers to frequently asked questions.

When you open a personal my Social Security account, you have more capabilities. You can review your Social Security Statement, verify your earnings, and get estimates of future benefits. You can also print a benefit verification letter, change your direct deposit information, request a replacement Medicare card, get a replacement SSA-1099/1042S, and request a replacement Social Security card (if you have no changes and your state participates).

If you don’t have access to the internet, we offer many automated services by telephone, 24 hours a day, 7 days a week. Call us toll-free at 1-800-772-1213 or at our TTY number, 1-800-325-0778, if you’re deaf or hard of hearing.

A member of our staff can answer your call from 7 a.m. to 7 p.m., Monday through Friday. We ask for your patience during busy periods since you may experience a high rate of busy signals and longer hold times to speak to us. We look forward to serving you.
Sample Notice to SSI Recipient

Social Security Administration
Supplemental Security Income
Notice of Planned Action

Mr. John Doe
1890 Schulte Drive, Apt. 4
San Jose, CA 95133

Dear John Doe

PAY108

Your payments (or those of the individual named above) will change as follows:

TBL010

<table>
<thead>
<tr>
<th>Month</th>
<th>Amount due each month</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONTH YEAR</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

MIS016 (optional)

and continuing

Your Payment Is Based On These Facts (PAYC22)

New UTI
We have reviewed the information available for your case. You are not eligible to receive Supplemental Security Income (SSI) based on The Extension for Elderly and Disabled Refugees Act. You do not have a pending or approved application for naturalization with the U.S. Citizenship and Immigration Services (USCIS) or you chose not to pursue U.S. citizenship.
You Can Review the Information in Your Case (INFC31)

INF087

The decisions in this letter are based on the law and information in our records. You have a right to review and get copies of the information in our records that we used to make the decisions explained in this letter. You also have a right to review and copy the laws, regulations, and policy statements used in deciding your case. To do so, please contact us. Our telephone number and address are shown under the heading “If You Have Questions.”

If You Disagree With The Decision (ALSC04)

ALS033

If you disagree with the decision, you have the right to appeal. We will review your case again and consider any new facts you have. A person who did not make the first decision will decide your case.

• You have 60 days to ask for an appeal.
• The 60 days start the day after you get this letter. We assume you got this letter 5 days after the date on it unless you show us that you did not get it within the 5-day period.
• You must have a good reason if you wait more than 60 days to ask for an appeal.
• You have to ask for an appeal in writing. We will ask you to sign a form SSA-561-U2, called "Request for Reconsideration." Contact one of our offices if you want help.

Please read the enclosed pamphlet, "Your Right to Question the Decision Made on Your Social Security Claim." It contains more information about the appeal.

Appeal In 10 Days To Keep Getting The Same Payment (ALSC17)

ALS035

If you appeal within 10 days, you will continue to get the same payment amount until we decide your case.

• The 10 days start the day after you get this letter.
• If you lose your appeal, you might have to pay back some or all of this money.

However, even if you appeal in 10 days, we may stop the payment in MONTH/YEAR as shown above if both of the following are true:

• Our new decision is the same as the one you appealed, and,
• We send or give you a letter with our new decision in time to stop the payment.

How To Appeal (RPNC26)
There are three ways to appeal. You can pick the one you want. If you meet with us in person, it may help us decide your case.

- **Case Review:** You have the right to review the facts in your file. You can give us more facts to add to your file. Then we will decide your case again. You will not meet with the person who decides your case.

- **Informal Conference:** You will meet with the person who decides your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.

- **Formal Conference:** This is a meeting like an informal conference. The difference is we can make people come to prove you are right. We can make them bring important papers about your case, even if they do not want to help you. You can question these people at your meeting.

**If You Want Help With Your Case (ALSC09)**

**REP002**

You can have a friend, representative or someone else help you. There are groups that can help you find a representative or give you free legal services if you qualify. There also are representatives who do not charge unless you win your appeal. Your Social Security office has a list of groups that can help you with your appeal.

If you get someone to help you, you should let us know. If you hire someone, we must approve the fee before he or she can collect it.

**If You Want An Interpreter To Help You (CAPC55)**

**INF082**

We provide free interpreter services to help you conduct your Social Security business. These interpreter services are available whether you talk to us by phone or in the Social Security office. Call our toll-free number, 1-800-772-1213, press 2 if you need an interpreter in Spanish, and stay on the line until a representative answers. An interpreter who speaks Spanish will be contacted to help with your call. If your business cannot be completed by phone, we will make an appointment for you at a local Social Security office and arrange for an interpreter to be there at the time of your visit.
If You Have Questions (REFC01)

REF032

For general information about SSI, visit our website at www.socialsecurity.gov on the Internet. You will find the law and regulations about SSI eligibility and SSI payment amounts at www.socialsecurity.gov/SSIrules/.

For general questions about SSI or specific questions about your case, you may call us toll-free at 1-800-772-1213 or call your local Social Security office at 555-123-4567. If you call or visit our office, please bring this letter with you and ask for (Name of SSA technician).

APT054

If you plan to visit an office you may call ahead to make an appointment. This will help us serve you more quickly.

John Doe
District Manager

Enclosure(s):
GOOD CAUSE FOR MISSING THE DEADLINE TO REQUEST REVIEW

Code Of Federal Regulations

§ 416.1411. Good cause for missing the deadline to request review.

(a) In determining whether you have shown that you have good cause for missing a deadline to request review we consider—

(1) What circumstances kept you from making the request on time;

(2) Whether our action misled you;

(3) Whether you did not understand the requirements of the Act resulting from amendments to the Act, other legislation, or court decisions; and

(4) Whether you had any physical, mental, educational, or linguistic limitations (including any lack of facility with the English language) which prevented you from filing a timely request or from understanding or knowing about the need to file a timely request for review.

(b) Examples of circumstances where good cause may exist include, but are not limited to, the following situations:

(1) You were seriously ill and were prevented from contacting us in person, in writing, or through a friend, relative, or other person.

(2) There was a death or serious illness in your immediate family.

(3) Important records were destroyed or damaged by fire or other accidental cause.

(4) You were trying very hard to find necessary information to support your claim but did not find the information within the stated time periods.

(5) You asked us for additional information explaining our action within the time limit, and within 60 days of receiving the explanation you requested reconsideration or a hearing, or within 30 days of receiving the explanation you requested Appeals Council review or filed a civil suit.

(6) We gave you incorrect or incomplete information about when and how to request administrative review or to file a civil suit.

(7) You did not receive notice of the initial determination or decision.

(8) You sent the request to another Government agency in good faith within the time limit and the request did not reach us until after the time period had expired.

(9) Unusual or unavoidable circumstances exist, including the circumstances described in paragraph (a)(4) of this section, which show that you could not have known of the need to file timely, or which prevented you from filing timely.

REQUEST FOR RECONSIDERATION

**NAME OF CLAIMANT:**

**CLAIMANT SSN:**

**CLAIM NUMBER:** (If different than SSN)

**ISSUE BEING APPEALED:** (Specify if retirement, disability, hospital or medical, SSI, SVB, overpayment, etc.)

I do not agree with the Social Security Administration's (SSA) determination and request reconsideration. My reasons are:

---

**SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFITS (SVB) RECONSIDERATION ONLY**

**THREE WAYS TO APPEAL**

I want to appeal your determination about my claim for SSI or SVB. I have read about the three ways to appeal. I have checked the box below:

- CASE REVIEW - You can pick this kind of appeal in all cases. You can give us more facts to add to your file. Then we will decide your case again. You do not meet with the person who decides your case.
- INFORMAL CONFERENCE - You can pick this kind of appeal in all SSI cases except for medical issues. In SVB cases, you can pick this kind of appeal only if we are stopping or lowering your SVB payment. You will meet with a person who will decide your case. You can tell that person why you think you are right. You can give us more facts to help prove you are right. You can bring other people to help explain your case.
- FORMAL CONFERENCE - You can pick this kind of appeal only if we are stopping or lowering your SSI or SVB payment. This meeting is like an informal conference, but we can also get people to come in and help prove you are right. We can do this even if they do not want to help you. You can question these people at your meeting.

---

**CONTACT INFORMATION**

**CLAIMANT SIGNATURE - OPTIONAL:**

**NAME OF CLAIMANT'S REPRESENTATIVE: (If any)**

**MAILING ADDRESS:**

**MAILING ADDRESS:**

**CITY:**

**STATE:**

**ZIP CODE:**

**CITY:**

**STATE:**

**ZIP CODE:**

**TELEPHONE NUMBER:** (Include area code)

**DATE:**

**TELEPHONE NUMBER:** (Include area code)

**DATE:**

---

**TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION**

1. HAS INITIAL DETERMINATION BEEN MADE? □ Yes □ No

2. IS THIS REQUEST FILED TIMELY? □ Yes □ No

(If "NO", attach claimant's explanation for delay. Refer to GN 03101.020)

**FIELD OFFICE DEVELOPMENT (GN 03102.300)**

- NO FURTHER DEVELOPMENT REQUIRED
- REQUIRED DEVELOPMENT ATTACHED
- REQUIRED DEVELOPMENT PENDING, WILL FORWARD OR ADVISE STATUS WITHIN 30 DAYS

**SSI CASES ONLY - GOLDBERG KELLY (GK)**

(SI 02301.310) RECIPIENT APPEALED AN ADVERSE ACTION:

- WITHIN 10 DAYS AFTER RECEIVING THE ADVANCE NOTICE;
- AFTER THE 10-DAY PERIOD AND GOOD CAUSE EXISTS FOR EXTENDING THE TIME LIMIT;
- PAYMENT CONTINUATION APPLIES AND INPUT MADE TO SYSTEM

**NOTE:** Take or mail the completed original to your local Social Security office, the Veterans Affairs Regional Office in Manila, or any U.S. Foreign Service post and keep a copy for your records.

Claims Folder

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ADMINISTRATIVE ACTIONS THAT ARE INITIAL DETERMINATIONS
(See GN03101.070, GN03101.080, and SI04010.010)

NOTE: These lists cover the vast majority of administrative actions that are initial determinations. However, they are not all inclusive.

Title II
1. Entitlement or continuing entitlement to benefits;
2. Reentitlement to benefits;
3. The amount of benefit;
4. A recomputation of benefit;
5. A reduction in disability benefits because benefits under a worker's compensation law were also received;
6. A deduction from benefits on account of work;
7. A deduction from disability benefits because of claimant's refusal to accept rehabilitation services;
8. Termination of benefits;
9. Penalty deductions imposed because of failure to report certain events;
10. Any overpayment or underpayment of benefits;
11. Whether an overpayment of benefits must be repaid;
12. How an underpayment of benefits due a deceased person will be paid;
13. The establishment or termination of a period of disability;
14. A revision of an earnings record;
15. Whether the payment of benefits will be made, on the claimant's behalf to a representative payee, unless the claimant is under age 18 or legally incompetent;
16. Who will act as the payee if we determine that representative payment will be made;
17. An offset of benefits because the claimant previously received Supplemental Security Income payments for the same period;
18. Whether completion or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that the claimant will not have to return to the disability benefit rolls and thus, whether the claimant's benefits may be continued even though the claimant is not disabled;
19. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a jail, prison, or other correctional institution for conviction of a criminal offense;
20. Nonpayment of benefits because of claimant's confinement for more than 30 continuous days in a mental health institution or other medical facility because a court found the individual was not guilty for reason of insanity; a court found that he/she was incompetent to stand trial or was unable to stand trial for some other similar mental defect; or, a court found that he/she was sexually dangerous.

Title XVI
1. Eligibility for, or the amount of, Supplemental Security Income benefits;
2. Suspension, reduction, or termination of Supplemental Security Income benefits;
3. Whether an overpayment of benefits must be repaid;
4. Whether payments will be made, on claimant's behalf to a representative payee, unless the claimant is under age 18, legally incompetent, or determined to be a drug addict or alcoholic;
5. Who will act as payee if we determine that representative payment will be made;
6. Imposing penalties for failing to report important information;
7. Drug addiction or alcoholism;
8. Whether claimant is eligible for special SSI cash benefits;
9. Whether claimant is eligible for special SSI eligibility status;
10. Claimant's disability; and
11. Whether completion or continuation for a specified period of time in an appropriate vocational rehabilitation program will significantly increase the likelihood that claimant will not have to return to the disability benefit rolls and thus, whether claimant's benefits may be continued even though he or she is not disabled.

NOTE: Every redetermination which gives an individual the right of further review constitutes an initial determination.

Title VIII (See VB 02501.035)
1. Meeting or failing to meet the qualifying and/or entitlement factors for special veterans benefits (SVB);
2. Reduction, suspension or termination of SVB payments;
3. Applicability of a disqualifying event prior to SVB entitlement;
4. Administrative actions in SVB cases similar to those listed under Title II-items 3, 4, 10, 11 & 16.

Title XVIII
1. Entitlement to hospital insurance benefits and to enrollment for supplementary medical insurance benefits;
2. Disallowance (including denial of application for HIB and denial of application for enrollment for SMIB);
3. Termination of benefits (including termination of entitlement to HI and SMI).
4. Initial determinations regarding Medicare Part B income-related premium subsidy reductions.
HOW TO APPEAL YOUR SUPPLEMENTAL SECURITY INCOME (SSI) OR SPECIAL VETERANS BENEFIT (SVB) DECISION

Now that you picked the kind of appeal that fits your case, fill out this form or we'll help you fill it out. You can have a lawyer, friend, or someone else help you with your appeal. There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

NOTE: DON'T FILL OUT THIS FORM IF WE SAID WE'LL STOP YOUR DISABILITY CHECK FOR MEDICAL REASONS OR BECAUSE YOU'RE NO LONGER BLIND. WE'LL GIVE YOU THE RIGHT FORM (SSA-789-U4) FOR YOUR APPEAL.

The information on this form is authorized by regulation (20 CFR 404.907 - 404.921 and 416.1407 - 416.1421) and Public Law 106-169 (section 809(a)(1) of section 251(a)). While your response to these questions is voluntary, the Social Security Administration cannot reconsider the decision on this claim unless the information is furnished.

Privacy Act Statement
Request for Reconsideration

Sections 205, 702(a)(5), 809(a), 809(b), 1631, 1633, and 1869(b) allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from re-evaluating the decision on your claim.

We will use the information to determine your eligibility for benefits and administer our programs. We may also share your information for the following purposes, called routine uses:

1. To third party contacts in situations where the party to be contacted has, or is expected to have, information relating to the individual's capability to manage his/her affairs or his/her eligibility for or entitlement to benefits under the Social Security program.

2. To contractors and other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration in the efficient administration of its programs.

3. To the Center for Medicare & Medicaid Services (CMS), for the purpose of administering Medicare Part A, Part B, Medicare Advantage Part C, and Medicare Part D, including but not limited to: Medicare Part C enrollment and premium collection processes; Part D enrollment and premium collection processes; Medicare Part B premium reduction based on participation in a Part C plan; and Medicare Part B enrollment and income-related monthly adjustment amount determinations, appeals of determinations, and premium collections.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs). There are several SORNs that govern the collection of this information, including 60-0089, entitled Claims Folder System, and 60-0321, entitled Medicare Database File. Additional information and a full listing of all our SORNs and applicable routine uses are available on our website at www.socialsecurity.gov/foia/bluebook.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 8 minutes to read the instructions, gather the facts, and answer the questions.

SEND THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the
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Now that you picked the kind of appeal that fits your case, fill out this form or we’ll help you fill it out. You can have a lawyer, friend, or someone else help you with your appeal. There are groups that can help you with your appeal. Some can give you a free lawyer. We can give you the names of these groups.

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3. To the Center for Medicare & Medicaid Services (CMS), for the purpose of administering Medicare Part A, Part B, Medicare Advantage Part C, and Medicare Part D, including but not limited to: Medicare Part C enrollment and premium collection processes; Part D enrollment and premium collection processes; Medicare Part B premium reduction based on participation in a Part C plan; and Medicare Part B enrollment and income-related monthly adjustment amount determinations, appeals of determinations, and premium collections.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person’s eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

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# Chapter Three

## California Cash Assistance Program for Immigrants (CAPI)

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CHAPTER THREE: CALIFORNIA CASH ASSISTANCE PROGRAM FOR IMMIGRANTS

Introduction

California established the Cash Assistance Program for Immigrants (CAPI) in 1998 to provide benefits for certain immigrants who previously would have been able to receive Supplemental Security Income (SSI), but who are no longer eligible for SSI because of the restrictions placed on non-citizen eligibility in the 1996 federal welfare legislation. The program is fully funded by the state and is administered by the California Department of Social Services through contracts with the counties. The primary beneficiaries have been elderly immigrants who entered the United States before August 22, 1996 and do not have 40 quarters of earnings. However, an increasing number of people who entered the United States on or after August 22, 1996 have also become eligible. Unfortunately, awareness of the program in many immigrant communities is quite low.

Benefits

CAPI provides a monthly benefit that is the same as the comparable SSI benefit for an individual and an eligible couple. Thus, the monthly CAPI benefit rate for 2021 for an aged and/or disabled individual is $954.72 and $1,598.14 for an aged and/or disabled couple. As in SSI, rates are slightly higher for recipients who are blind and for those who lack access to adequate cooking or food storage facilities. Unlike SSI, CAPI does not confer automatic Medi-Cal eligibility, although individuals can file separately for Medi-Cal. CAPI recipients may be eligible for Food Stamp (Supplemental Nutrition Assistance Program) benefits.

Eligibility

The eligibility requirements for CAPI are the same as for SSI, except for the immigrant status requirements. Income and resources are calculated according to the SSI rules.

Also, if an individual qualifies for SSI, that individual is not eligible for CAPI. It is only those who are ineligible for SSI solely because of immigration status who are potentially eligible for CAPI. Indeed, the county Department of Public Social Services (DPSS) will probably require someone applying for CAPI to apply for SSI in order to establish SSI ineligibility.
Immigration Status

As with SSI, there is a big difference between non-citizens who entered the United States before 8/22/96, and those who entered on or after that date. Anyone who entered before 8/22/96 who would have been eligible for SSI on the immigrant status rules in effect before that date, automatically meets the immigrant status rules for CAPI if they no longer qualify for SSI solely because of immigration status.

Non-citizens who entered the United States before 8/22/96 are no longer able to file new claims for SSI on the basis of age unless they qualify for the veteran exception or 40 quarters exception. They can receive CAPI on the basis of age without the need to prove disability. However, they will be required to pursue an SSI claim based on disability, and will be required to sign an interim assistance reimbursement agreement with the county. Under the terms of this agreement, if the individual does eventually receive SSI, the county will be reimbursed out of the SSI payment for past due benefits that otherwise would have gone to the individual. Once SSI is approved, this must be reported to DPSS and the CAPI benefits will cease. If the SSI claim is denied, the individual will continue to receive CAPI.

Prior to 8/22/96, there was an immigrant eligibility category for SSI known as PRUCOL or Permanently Residing Under Color of Law. These individuals no longer qualify for SSI on any basis, unless they are grandfathered in. However, they may be eligible for CAPI on the basis of age, blindness or disability regardless of date of entry.

Lawful permanent residents who entered the United States on or after 8/22/96 no longer qualify for SSI unless they meet either the veteran or 40 quarters exception. They are eligible for CAPI, but with a significant limitation. Their eligibility is subject to deeming of their sponsor’s income and resources for a period of 10 years from the date they were granted lawful permanent residence status. It should be noted that some people who may have previously been denied CAPI benefits because of the deeming requirement may now be eligible if the ten-year deeming period has since expired.

Generally, deeming of the sponsor’s income makes an individual financially ineligible for benefits. However, there are exceptions to the deeming requirement for (1) victims of abuse, which includes the non-citizen, non-citizen’s minor child, or non-citizen’s parent; and (2) someone who would go “hungry or homeless” without assistance. Someone is considered likely to go “hungry or homeless” without assistance if their total income is less than the SSI Federal Benefit Rate (FBR), which is $794 for an individual and $1,191 for a couple in 2021. However, awareness of the “hungry or homeless” exception appears to be limited in immigrant communities and in the county agencies that are required to apply the exception.

Refugees, Asylees Cut Off SSI After 7 Years Can Receive CAPI - There is also a group of humanitarian immigrants (refugees, asylees, persons for whom deportation is withheld, Cuban- Haitian entrants, Amerasian immigrants) with a seven-year time limit on SSI eligibility. Upon expiration of the seven-year period, these individuals are eligible for CAPI. They should apply for CAPI at the start of their last month of SSI eligibility.
Appeals

Appeals from adverse determinations in the CAPI program are heard by Administrative Law Judges (ALJs) employed by the California Department of Social Services. A request for a hearing must be filed within 90 days after the date of the adverse determination. As with SSI, in the case of suspensions, terminations or reductions of benefits, there is a right to continued assistance pending decision on the first level of appeal.
Supplemental Materials
# CAPI Payment Standards

Effective January 1, 2020

**Rates for Independent Living or in Households with In-Kind Room and Board (Reduced Needs)**

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<td>Per Couple</td>
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**Note:** As authorized by AB 1811 (Chapter 35, Statutes of 2018), W&IC section 18941 has been amended so that, beginning June 1, 2019, CAPI benefits will be equivalent to SSI/SSP payment standards due to the CalFresh SSI Eligibility Expansion.

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These rates reflect an SSI COLA of 1.6%.
# CAPI Payment Standards

Effective January 1, 2020

Rates for Non-Medical Out-of-Home care

## INDIVIDUAL

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<tr>
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<td>Blind</td>
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<td>Disabled Minor – living with non-parent</td>
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<th>Non-Medical Out-of-Home Care</th>
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<td>Disabled Minor – living with non-parent</td>
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## COUPLE

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<tr>
<td>Blind, Aged, or Disabled</td>
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<td>$2,412.74</td>
</tr>
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</table>

**Note:** As authorized by AB 1811 (Chapter 35, Statutes of 2018), W&IC section 18941 has been amended so that, beginning June 1, 2019, CAPI benefits will be equivalent to SSI/SSP payment standards due to the CalFresh SSI Eligibility Expansion.

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These rates reflect an SSI COLA of 1.6%.
# CHAPTER FOUR

## MEDICARE

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Introduction

WHAT IS MEDICARE?

Medicare is a federal health insurance program that is a primary source of coverage for adults 65 and over as well as certain individuals with disabilities. Eligibility is usually based on the work history of an individual or the individual’s spouse. Some individuals may qualify even without a work history: if they are low income, they may get premium assistance, and if not, they may pay privately.

Medicare does not cover all medical needs, and most beneficiaries have additional insurance (Medi-Cal, a private supplement, etc.). There are four “Parts” to Medicare: A, B, C & D.

MEDICARE PARTS A, B, C, & D

There are four “Parts” to Medicare. Part A and Part B are referred to as “original fee-for-service” Medicare, or sometimes as “traditional” Medicare. Part C is a version of Medicare called “Medicare Advantage” - which is offered through private health care insurers. Part D is prescription drug coverage and is discussed in Chapter 5.

Low income individuals may qualify for special programs to assist with Parts A/B/C (see 4-25), and/or for the Low-Income Subsidy for Part D (see Chapter 5).

Medicare Part A is commonly known as “hospital insurance.” Under certain conditions, Medicare Part A pays for a stay in a hospital or nursing home, or pays for certain expenses of home health care. In addition, Medicare Part A pays for certain expenses of hospice care provided to a terminally ill person.

Medicare Part B is commonly known as “medical insurance.” Medicare Part B pays for certain expenses of physician services, therapies, tests, x-rays, and medical equipment. Under some circumstances, Medicare Part B will pay for particular services provided in a nursing home or for home health care.

Medicare Part C is Medicare Advantage, an alternative to fee-for-service Medicare. It is a system where Medicare pays a private plan to manage a beneficiary’s health care. Medicare Part C coverage can include health maintenance organizations (HMOs); preferred provider organizations (PPOs); private fee-for-service plans (PFFs); special needs plans (SNPs); and medical savings accounts (MSAs).

Medicare Part D is the Medicare Prescription Drug program. Each year, prescription drug plans participating in the program are announced for the following year. Enrollment runs from October 15 to December 7 each year. A low income subsidy is available for those who qualify; applications for the subsidy are processed by Social Security. You can read more about Medicare Part D in Chapter 5.
Eligibility

Most individuals are entitled to free Medicare Part A based on their work history. However, some individuals may be eligible to enroll without this history.

PART A ELIGIBILITY WITHOUT PREMIUM

In general, eligibility for Medicare Part A is based on the work history of an individual or that of his or her spouse. In the most common type of eligibility, someone is at least 65 years old, and either the individual or spouse has a work history that creates an entitlement to Social Security retirement benefits (usually 40 quarters, or the equivalent of 10 years of work history). Married individuals, including those in same-sex marriages, can qualify for Medicare Part A coverage based on a spouse's work history. Certain divorced individuals, widows, and widowers can also rely on their spouse's earnings record. Eligibility does not extend to those in civil unions or domestic partnerships.

Part A eligibility is also available to persons who have been receiving Social Security disability benefits or railroad retirement disability benefits for at least 24 months. For people with ALS ("Lou Gehrig's Disease"), the 24-month waiting period is waived. There also are special rules for people with end-stage renal disease (kidney failure).

PART A ELIGIBILITY WITH PREMIUM

If, due to an insufficient work history, an individual is not eligible automatically for Part A coverage, the individual nonetheless may be able to purchase Part A coverage. To purchase Part A coverage, an individual must be:

1. At least 65 years old;
2. Either a U.S. citizen or a lawful permanent resident (green card holder) with five years of continuous residence; and
3. Enrolled in Medicare Part B (by paying a further premium).

The 2021 premium for Medicare Part A is either $259 or $471 monthly, depending on work history.

Those who do not qualify automatically for Part A may choose to purchase only Part B coverage. However, as explained above, an individual wanting to purchase Part A coverage must also enroll in Part B.

Note - Low income individuals may be eligible for premium assistance and will not have to pay these premiums.

PART B ELIGIBILITY

Medicare Part B coverage is available to anyone who is eligible for Part A benefits and/or is at least 65 years old and either a U.S. citizen or a permanent resident who has resided in the United States for the five years prior to enrollment for Part B.

Those receiving Medicare Part B coverage must pay a monthly premium—$148.500 for 2021. The premium is deducted from the enrollee's Social Security, Railroad Retirement or Civil Service Retirement, or disability payment.
Medicare will send a bill every three months to enrollees who do not receive any of these retirement benefits.

People who do not qualify for automatic Part A eligibility may choose to purchase only Part B coverage. However, as explained in the discussion of “Part A Eligibility With Premium,” to purchase Part A coverage, they must also purchase Part B coverage.

**Note** - People with incomes above $88,000 for an individual or $176,000 for a couple will be required to pay a monthly surcharge to their Part B and Part D premiums called the Income-Related Monthly Adjustment Amount, IRMAA.

### PART B DEDUCTIBLE

The beneficiary is responsible for a yearly deductible of $203 in 2021.

### PART B CO-PAYMENT: 20 PERCENT

Medicare Part B payments can be made either to the beneficiary or the health care provider (physician, hospital, etc.). In general, if a provider accepts the Medicare approved amount as payment in full, Medicare will pay 80% of the cost to the provider, and the beneficiary is responsible for the other 20%. If the provider does not limit the costs of the services to the Medicare approved amount, Medicare will pay the claim to the beneficiary and the beneficiary will be responsible for the full payment to the provider, unless a limiting charge applies. Limiting charges apply only to physician and therapist services.

A more detailed explanation of the Part B co-payment, including an explanation of the Part B “limiting charge,” is set forth later in this chapter.

**Note** - Medicare Part B enrollment is not automatic for many people turning 65. Those who haven’t started receiving Social Security or other federal retirement benefits need to contact the Social Security Administration to start their Part B coverage.

### Enrollment in Medicare

#### PART A ENROLLMENT

Enrollment is automatic for individuals who, at age 65, have started receiving benefits from either Social Security or the Railroad Retirement Board. For people who became disabled prior to age 65, enrollment is effective two years after the start of Social Security disability benefit eligibility, although the two-year waiting period is waived if the disability resulted from kidney failure or ALS.

An individual who does not begin receiving retirement benefits until after age 65 must apply for Medicare benefits when turning 65. The individual may apply during the seven-month “Initial Enrollment Period,” which begins three months before the month of the individual’s 65th birthday and ends three months after that.
Note - Most people enrolled in Covered California plans will lose their subsidies when they turn 65. They should promptly enroll in Medicare to avoid high premiums or coverage gaps.

PART B ENROLLMENT

There are three enrollment periods for Medicare Part B.

1. **Initial Enrollment Period**: If an individual is turning 65 and has not yet applied for Social Security or Railroad Retirement benefits, or Medicare Part A, the individual can enroll in Part B during the seven-month Initial Enrollment Period, which begins three months before the month of the individual’s 65th birthday and ends three months after that month.

2. **General Enrollment Period**: If the Initial Enrollment Period has passed, an individual may sign up during the General Enrollment Period.
   - The General Enrollment Period runs from January 1 to March 31 each year.
   - Coverage starts on July 1 of the year enrolled.

3. **Special Enrollment Period**: This period is available to an individual who waited to enroll in Part B because the individual or spouse was working and had group health plan coverage through an employer or union. Individuals can sign up any time while still covered by the group health plan, or during the eight months following the date that the group health plan coverage ends, or employment is terminated, whichever comes first. People who qualify for this special enrollment period are not assessed a penalty for late Medicare enrollment.

Note - This special enrollment period is available to same-sex spouses. It is not available to people with employer coverage based on a civil union or registered domestic partnership.

Penalty for Late Enrollment - The cost of the premium will rise by 10 percent for each 12-month period in which someone who was eligible for Part B coverage did not enroll, except in special cases. This increase will apply as long as the individual receives Part B coverage.

**ALERT** - CMS is offering “equitable relief” to some people who were enrolled in Covered California plans with subsidies and then became eligible for Medicare. Many did not sign up for Part B when they should have, because they thought, incorrectly, that their subsidies for Covered California plans would continue. As a result, they incurring late enrollment penalties. They can file a request with the Social Security Administration to remove the Part B penalty. Details are available at: https://www.medicareinteractive.org/get-answers/medicare-health-coverage-options/original-medicare-enrollment/time-limited-equitable-relief-for-enrolling-in-part-b.
Covered Services

**INPATIENT HOSPITAL CARE UNDER MEDICARE PART A**

Medicare covers up to 90 days of hospital services in each benefit period, including a semi-private room, meals, general nursing, and other hospital services and supplies. Medicare does not cover private duty nursing, a television or telephone in the room, or a private room (unless the private room is medically necessary). Medicare also will cover an additional 60 “lifetime reserve” days, each of which can only be used once.

A “benefit period” (or “spell of illness”) begins when the beneficiary is admitted to the hospital and ends when the beneficiary has been out of the hospital for 60 consecutive days and has not received Medicare-covered care in a nursing home.

For each benefit period, the beneficiary pays:

- A deductible of $1,484 per hospital stay;
- After the deductible has been met, a zero co-pay for days 1-60;
- $371 per day for days 61-90 of a hospital stay; and
- $742 per day after day 90 in a benefit period.

**SPECIALIZED FACILITIES UNDER MEDICARE PART A**

Medicare covers care in a specialized facility - such as a rehabilitation hospital or a psychiatric facility - for up to 190 days during a beneficiary’s life.

**NURSING HOME CARE UNDER MEDICARE PART A1**

**Introduction** - Many clients (and some advocates) are surprised by the very limited availability of Medicare Part A reimbursement for nursing home expenses. It is important to keep in mind that the Medicare program was never intended to be a comprehensive health insurance plan. For example, a general exclusion in the Medicare law forbids Medicare payment for any service or item deemed “custodial” in nature.

**Maximum Duration of Payments** - At most, Part A of the Medicare program pays for 100 days of nursing home care per benefit period, and only the first 20 days are paid in full. During days 21 through 100, the beneficiary must pay a daily co-payment of $185.50 in 2021.

1 This guide’s discussion of Medicare payment for nursing home care is taken in part from the Nursing Home Companion (Bet Tzedek Legal Services) and Chapter Eight of Eric M. Carlson, Long-Term Care Advocacy (Matthew Bender & Co.).

**Qualifying Hospital Stay** - Medicare Part A may pay for a beneficiary’s nursing home stay only if the individual has entered the nursing home within 30 days after being hospitalized in a hospital for at least three nights. Generally, the resident must begin receiving the Medicare-qualifying level of care (see below) within this 30- day period, although there is an exception if that level of care was not “medically appropriate” until after the expiration of the 30-day period.
COVID-19 ALERT: CMS has waived the three-day hospital stay requirement for nursing home coverage during the emergency.

Advocates should also be aware that sometimes, although an individual has spent three nights in a hospital, part or all of that time may not count for a qualifying hospital stay because the individual was in “observation status” and not considered to be an admitted patient. Hospital expenses for patients in observation status are treated as outpatient expenses and covered under Medicare Part B, which usually means that the individual pays more than if the individual had been admitted as an inpatient.

**Note** - Hospitals must give a notice, called a MOON Notice, to patients in observation status for more than 24 hours. The notice includes an explanation of why the patient is in observation status and how it affects Medicare benefits.

**Level of Care** - Medicare Part A pays nursing home charges only for residents who need “skilled nursing or skilled rehabilitation services.” For example, “skilled” nursing services (as defined by the Medicare program) include intravenous feeding, the treatment of widespread skin disorders, and the monitoring of residents who require relatively sophisticated evaluations. “Skilled” rehabilitation services include, for example, “range of motion” exercises, services provided by a speech pathologist, and physical, occupational, and speech therapy.

Note that a resident may qualify for Medicare Part A payment of their nursing home charges if they require only one “skilled” service. Note also that the “skilled” services mentioned in the preceding paragraph are examples only. The Medicare regulations clearly state that a variety of conditions may qualify a resident for Medicare Part A payment of nursing home charges.

For residents receiving therapy, nursing homes frequently – but falsely – claim that Medicare Part A cannot pay unless a resident’s condition is improving. Prescribed therapy can justify Medicare Part A reimbursement even without current progress, if progress can be reasonably expected in the foreseeable future, or if therapy is necessary to maintain a resident’s condition or slow decline.

It should be noted, however, that most long-term residents of nursing homes are not receiving “skilled” services as defined by Medicare and their stay is not being paid by Medicare. The Medicare regulations state that the need for routine personal care services such as administration of medications, the maintenance of catheters, and the turning of residents do not qualify an individual for Medicare Part A payment of nursing home charges.

**Remember** - Reimbursement can continue for therapy even if the resident is not “improving,” if the therapy is medically justified.

**Determining Level of Care** - The nursing home makes the initial decision on whether a resident is qualified for Medicare Part A payment of nursing home charges. Consequently, a resident or family member immediately and consistently should emphasize the “skilled” services required by the resident.

If at any time (including the time of admission) the nursing home decides that the resident is not qualified for Medicare Part A payment of nursing home charges, the nursing home must give the resident written notice of the nursing home’s decision. If the resident or family member feels that the resident is qualified medically for Medicare Part A payment of nursing home charges, and thus disagrees with the nursing home’s decision, the resident or family
member may appeal the nursing home’s decision. The resident or family member begins the appeal by returning the written notice to the nursing home after checking a box that states:

“Yes. I want to receive these items or services. I understand that Medicare will not decide whether to pay unless I receive these items or services. I understand you will notify me when my claim is submitted and that you will not bill me for these items or services until Medicaid makes its decision. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand that I can appeal Medicare’s decision.”

While the Medicare program considers an appeal of a nursing home’s decision, the nursing home cannot bill the resident for the nursing home charges in dispute. If the Medicare program eventually agrees with the nursing home and concludes that the resident was not qualified medically for Medicare Part A payment of nursing home charges, the resident or family member can appeal the Medicare program’s decision as well. During this second appeal, however, the nursing home can bill the resident for the charges in dispute.

If a nursing home fails to provide a resident or the resident’s family members with the required notice, a resident or family member should request in writing that the nursing home submit a bill to Medicare Part A, even if the resident’s medical condition may not meet the requirements described earlier in this chapter. Under Medicare law, a nursing home’s failure to give adequate notice may excuse the resident from paying the charges incurred during certain weeks or months, if the Medicare program finds that the resident could not have known that Medicare Part A would not be covering the charges incurred during that time period.

COVID-19 ALERT: CMS requires facilities to notify residents and their families when there is occurrence of either a single confirmed COVID-19 infection among residents or staff, or three or more residents or staff with new onset of respiratory symptoms within 72 hours of each other.

HOME HEALTH CARE UNDER MEDICARE PART A

The Basics of Home Health Care - Home health care is skilled care that is provided at the beneficiary’s home, rather than in a nursing home. The home may be a residential care facility for the elderly or a similar facility.

If skilled care is required, other non-skilled services may be provided as well.

The Medicare home health benefit may include the following services or supplies:

- Skilled nursing care on a part-time or intermittent basis;
- Physical, speech and/or occupational therapy;
- Home health aide services on a part-time or intermittent basis;
- Medical social services;
- Medical supplies (not including drugs); and
- Medical equipment.

The Medicare home health benefit does not pay for:

- Around-the-clock care at home;
- Prescription drugs;
• Home-delivered meals;
• Shopping, cleaning or laundry service; or
• Transportation.

**Beneficiary Must Be Homebound** - Home health care can be provided only to those beneficiaries considered “homebound,” based on the reasoning that those who are not homebound can travel to a hospital or clinic for routine health care. A beneficiary is considered “homebound” if leaving the home is a very difficult process. In determining whether a beneficiary qualifies as “homebound,” the beneficiary is not penalized for leaving home to receive health care treatment or to attend an adult day care program. Also, attending religious services does not limit a beneficiary’s ability to be considered homebound.

**Note** - A beneficiary can be considered “homebound” even if they leave the house on occasion.

**COVID-19 ALERT:** The homebound requirement can be met if a patient has a confirmed or suspected case of the virus or if a physician confirms that the patient has a condition such that leaving home is medically contraindicated.

**Part-Time or Intermittent Care** - Medicare will provide home health care only if the need for skilled nursing care is part-time or intermittent. This means that care is given less than seven days a week, or less than eight hours a day, with no more than 28 hours per week (although this may be increased to 35 hours on a case-by-case basis).

**Skilled Services** - The nursing care or therapy services must be “skilled.”

Nursing care is considered “skilled” if a nursing service requires the expertise of a licensed nurse. For example, treatment of a wound and administration of an injection are skilled nursing services that qualify for Medicare reimbursement. On the other hand, bathing and helping with dressing are services that do not qualify as “skilled” services. For therapy services to be considered “skilled,” the expertise of a licensed physical therapist or certified speech therapist must be required.

**Note** - If “skilled” care is required, the skilled care can be accompanied by “unskilled” personal care assistance.

**Home Health Aide** - If a beneficiary requires skilled nursing services or skilled therapy, the Medicare home health benefit may also be able to provide the part-time assistance of a home health aide, as appropriate given the beneficiary’s care plan.

A home health aide is a health care worker who doesn’t have a nursing license. At least 75 hours of training is required. Home health aides help with non-medical care such as bathing, dressing, or exercising.

**Authorization of Services** - A physician must order home health care, and a care plan must be developed. Care must be provided by a Medicare-certified home health agency.

**No Deductibles or Copayments** - Medicare pays the full amount of all covered services, with a very limited exception: for durable medical equipment only, the beneficiary is responsible for 20% of the approved amount.

**If a Home Health Agency Believes that Medicare Will Not Pay** - If a home health agency believes that
Medicare will not pay for services, and as a result decides to deny or cut back care, the home health agency first must give the beneficiary a Home Health Advance Beneficiary Notice (ABN). This notice must explain why the home health agency believes that Medicare won’t pay for the services, and must describe how the beneficiary can contest the agency’s decision.

**Forcing a Home Health Agency To Bill Medicare** - If a beneficiary is given a notice of non-coverage, the beneficiary may require that the home health agency bill the Medicare program. The bill submitted by the agency is called a “demand bill.”

When a demand bill has been submitted, the home health agency still can require the beneficiary to pay in advance for the services for which Medicare has been billed.

If the Medicare program subsequently pays for those services, the home health agency must reimburse the beneficiary.

**Appeal** - When the Medicare program denies payment of a bill (including a demand bill), the notice will contain instructions for filing an appeal. The appeals process is described later in this chapter, starting on page 4-25.

**HOSPICE CARE UNDER MEDICARE PART A**

**What is Hospice?** - Hospice care is specialty care for terminally-ill individuals and their families. Hospice care includes both medical care and counseling services. Hospice care focuses on keeping the resident comfortable – physically and emotionally – and does not attempt to cure the illness that is expected to cause the beneficiary’s death. For example, a hospice program might put extra emphasis on pain reduction, supportive services, and/or respite care.

**Eligibility for Hospice Care** - A Medicare recipient who is terminally ill – i.e., certified by a physician as likely having a life expectancy of no more than six months – may elect to receive hospice care under Medicare Part A, in exchange for waiving the right to receive treatment under Part A for the terminal condition. The beneficiary retains the right to Medicare funding for treatment of medical conditions other than the terminal condition. At any time, the beneficiary may elect to leave hospice and return to original Medicare.

A beneficiary is entitled to two 90-day periods of hospice care, and an unlimited number of subsequent periods of 60 days each. For each period, the beneficiary must be certified by a physician as being terminally ill.

**Very Limited Cost to Beneficiary** - Hospice care has no deductibles and very limited co-payments. A beneficiary pays a five percent co-payment for outpatient drugs and inpatient respite care.

**What Services Are Provided?** - The Medicare hospice benefit is similar to the home health benefit, and covers the following services:

- Physician services;
- Nursing services;
- Medical equipment;
- Medical supplies;
- Medication for symptom control and pain relief;
- Short-term hospital care;
• Home health aide and homemaker services;
• Physical, speech and occupational therapy;
• Social worker services;
• Dietary counseling; and
• Grief and loss counseling for the patient and the family.

The inpatient care is used for pain control, chronic symptom management, and/or providing a respite to regular caregivers.

Note - Hospice care can continue indefinitely, if physician continues to certify that the beneficiary is expected to die within the next six months.

COVID-19 ALERT: During the emergency, many hospice services may be performed remotely.

Care Plans and Services - The hospice organization works with the beneficiary and the physician to form an individualized plan of care. Hospice care may be provided by a physician, a nurse, counselors and clergy members, social workers, home health aides, and trained volunteers.

Where Is Care Provided? - Hospice services mostly are provided where the beneficiary is living, whether the beneficiary is living in a house, apartment, assisted living facility, or nursing home.

Inpatient care is available for pain control and chronic symptom management. Also, for periods of no more than five days at a time, the Medicare hospice benefit may cover inpatient care to give at-home caregivers a respite from the rigors of caregiving.

SERVICES UNDER MEDICARE PART B

Part B covers a wide range of medical services and supplies, including (but not limited to) the following:
• Annual wellness visit with no deductible or co-pay;
• Physician services;
• Outpatient hospital services;
• Home health care;
• Outpatient physical therapy, speech therapy, and occupational therapy;
• Psychologist and clinical social worker services;
• Durable medical equipment (wheelchairs, walkers, braces, oxygen equipment, etc.)*;
• Medical supplies (ostomy bags, surgical dressings, splints, etc.)*;
• Artificial limbs*;
• Ambulance services;
• X-rays;
• Laboratory and other diagnostic tests;
• Immunosuppressive drugs;
• Pneumonia and Hepatitis B vaccine (no co-pays). other vaccines are covered with co-pays;
• Flu vaccine (no co-pays);
• Diabetes self-management training and supplies;
• Glucose monitors and testing strips;
• Annual glaucoma screening for beneficiaries at a high risk for glaucoma;
• Pap smears and pelvic exams once every two years, or annually for high-risk women;
• Yearly mammograms for women age 40 and above (for those 35-39, one baseline mammogram);
• Annual prostate cancer screening test for men age 50 and above; and
• Colorectal cancer screening for beneficiaries age 50 and above.
• Expanded opioid use disorder treatment and therapy, including methadone
• Expanded telehealth coverage

* Special rules apply in the Competitive Bidding program for durable medical equipment, prosthetics, orthotics, and supplies. In 2021, Competitive Bidding rules only apply to off-the-shelf back and knee braces, but they will expand to other items in future years.

**No Co-Payment for Some Services** - No co-payment is required for clinical laboratory services such as blood tests and urinalysis. Also, no co-payment is required for covered opioid treatment services, and for home health care, with the exception of the 20% co-payment that a beneficiary is required to pay for durable medical equipment provided as a part of the home health care. Also, there are no out-of-pocket costs for a wide range of preventive services, such as screenings for various cancers (including breast, colon, prostate, and cervical), heart disease, osteoporosis, glaucoma, diabetes, and mammograms.

**COVID-19 ALERT:** During the emergency, Medicare covers many services offered remotely, including physical and occupational therapy. Co-insurance is the same as for in-person services, but providers are permitted to waive payment.

All COVID-19 treatment services and testing, including vaccines, diagnostic and antibody testing, have zero co-insurance. Medicare coverage has been expanded for respiratory devices and many prior authorization requirements are waived.

**SERVICES NOT COVERED UNDER MEDICARE PART B**

Medicare Part B does not offer comprehensive coverage of health care services. Among those services and items not included in the Part B benefit are the following:

• Dental services;
• Eyeglasses or contact lenses (except as a follow-up to cataract surgery); and
Note - Medicare allows a provider to charge a beneficiary for a missed appointment if the provider has the same policy for all patients, not just those with Medicare.

**SUBMISSION OF MEDICARE PART B CLAIMS**

Part B claims must be submitted by a Medicare Part B provider. The beneficiary generally does not submit these claims directly to the Medicare carrier. The time limit for submitting a claim to Medicare generally is the close of the calendar year after the year the services were provided.

**Refusing to Accept Assignment** - When a provider does not accept an assignment, the beneficiary is liable for the 20% co-payment plus the amount by which the provider’s charge exceeds the Medicare-approved amount. The beneficiary pays the provider directly, and Medicare will pay the beneficiary rather than the provider.

To protect beneficiaries from exorbitant charges, Medicare imposes a “limiting charge” of 115% of the Medicare-approved amount on physician services, and the charges of independent occupational, speech or physical therapists. Providers bound by the charge limit must accept 115% of the Medicare-approved amount as payment in full.

**EXAMPLE**

The Medicare-approved amount for a physician’s visit is $100. Even if a physician charges $150, the Medicare program will impose a limiting charge of $115. Of that $115, Medicare will pay $80 (80% of the approved amount), and the beneficiary will pay $35 (20% of the approved amount, plus the $15 difference between the approved amount and the limiting charge).

- Office Visit - $150
- Approved Charge - $100
- Medicare Payment (80% of what is approved) - $80
- Medicare Charge Limit (115% of the approved charge) - $115

**Hospital Discharge Planning**

Federal Medicare law requires hospitals to provide Medicare-covered patients with discharge plans. A discharge plan should be prepared by the hospital staff in conjunction with the beneficiary and family.

A discharge plan describes the care and services a beneficiary may need after leaving the hospital and explains how such services may be provided. Also, a discharge plan gives the beneficiary guidance in how to improve or maintain health after leaving the hospital.

**CHALLENGING HOSPITAL DISCHARGES**

**Expedited Appeals of Part A Hospital Discharge Decisions - Notice of Non-Coverage** - A Medicare beneficiary must be provided with notice of discharge rights twice during the course of the hospital stay (this occurs...
when a beneficiary is given a notice called “An Important Message from Medicare” (IM) within two days after admission and again two days to four hours before discharge; if the stay is three days or less, once is sufficient. The information provided must include a description of the beneficiary’s hospital discharge appeal rights.

The IM notice must contain explicit information about 1) the process for requesting appeals of discharge decisions, 2) the right to remain in the hospital without charge if an expedited decision is requested, and 3) the right to receive a detailed notice of the reasons for discharge.

**EXAMPLE**

On Monday, March 19, Maria received a written Notice of Non-Coverage from her hospital, notifying her that hospital care was no longer required for her condition, and that Medicare Part A would no longer pay for hospital care. Maria’s physician agreed with this determination. Maria appealed to Livanta the following morning (March 20). Livanta denied her appeal on March 22. Accordingly, the hospital could not begin charging Maria until noon of Friday, March 23.

**BFCC-QIO Expedited Review** - If the beneficiary believes that they are not medically ready to be discharged from the hospital, the beneficiary has the right to appeal the discharge in an expedited appeal process. The appeal is made to Livanta, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for California. Contact Livanta online or by phone at 1-877-588-1123 or 1-855-887-6668 (TDD for the hearing impaired). The patient may remain in the hospital at least until noon of the day after the BFCC-QIO decision.

If the beneficiary’s physician agreed with the discharge decision, the beneficiary has the right to appeal the decision by requesting an expedited review. The beneficiary should contact the BFCC-QIO before noon of the first working day after the date the Notice of Non-Coverage was received and ask the BFCC-QIO to review the case. This request may be verbal or written.

If the BFCC-QIO issues a favorable decision, Medicare will continue to pay for the care.

If the BFCC-QIO is contacted within the above time limit and decides against the beneficiary, the hospital may charge the beneficiary for any costs incurred starting at noon of the day after the day the BFCC-QIO decision is received.

**Note** - A beneficiary should not be shy in requesting an appeal if they believe that further hospital care is appropriate.

**QIC Expedited Reconsideration** - If the BFCC-QIO decision is unfavorable, the beneficiary has the right to request a reconsideration by the Quality Independent Contractor (QIC). The QIC for California is Maximus Federal Services. The request for a reconsideration must be made by no later than noon of the calendar day following the receipt of the BFCC-QIO decision. If the beneficiary requests the reconsideration within this timeframe, the hospital may not bill the beneficiary until the QIC makes a decision.

If the QIC is not contacted in a timely manner, the beneficiary will be liable for all costs of hospitalization starting at noon of the day after the receipt of the Notice of Non-Coverage.

If the beneficiary does not file a request for reconsideration within this specified timeframe, they must use the standard appeal process.
Expedited appeal rights around hospital discharge decisions are equally available to beneficiaries in fee-for-services Medicare and to those who are members of Medicare managed care plans.

**Additional Appeal Rights for Hospital Discharge** - Following the expedited reconsideration, the beneficiary can appeal a hospital discharge using the same appeal rights available for standard Medicare Part A appeals.

**Expedited Appeals of Skilled Nursing Facility, Home Health, Hospice, and Comprehensive Outpatient Rehabilitation Facility Services** - A beneficiary has the right to an expedited appeal when services are terminated by a skilled nursing facility, home health agency, hospice or comprehensive outpatient rehabilitation facility. The provider must provide written notice to the beneficiary at least two days or two visits before the services are to be terminated.

**Expedited Determination** - If the beneficiary wants to appeal the decision to terminate services, they must request an expedited determination by Livanta, the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for California. Contact Livanta online or by phone at 1-877-588-1123 or 1-855-887-6668 (TDD for the hearing impaired). Contact Livanta by noon of the day prior to the termination of services.

The beneficiary can make this request online, in writing, or by phoning. The provider must provide a second notice that includes detailed information regarding why the services were terminated. The provider must also continue to provide services until two days after the first notice was given or until the service termination date (whichever is later).

Once the request for an expedited appeal is made, Livanta has 72 hours to make a determination. The decision is communicated by telephone, and a written decision is also provided. The determination must provide an explanation of the decision, the beneficiary’s liability for services, and information on the beneficiary’s appeal rights.

**Expedited Reconsideration** - A beneficiary has the right to appeal the expedited determination. To do so, the beneficiary requests an expedited reconsideration by Maximus, the Quality Independent Contractor (QIC). The request can be made by phone or in writing and must be submitted by noon of the calendar day following the decision by Livanta. The QIC must make a decision within 72 hours of receiving the expedited reconsideration request. The QIC decision may be communicated by phone with a written notice that follows. The notice must provide the same type of information that is given in the determination decision. If the reconsideration is unfavorable, the beneficiary has the right to continue using the standard fee-for-service appeals process.

**Note** - Medicare Advantage enrollees have the same expedited discharge review and appeal rights for hospital, skilled nursing facility, home health, hospice and comprehensive outpatient rehabilitation facility services as beneficiaries who use fee-for-service Medicare.
Medicare Managed Care Organizations

INTRODUCTION

Medicare managed care plans provide hospital, outpatient and other health care services to Medicare beneficiaries who have assigned their Medicare benefits to these health plans. Medicare managed care plans are called Medicare Advantage (MA) plans in federal Medicare law. Most Medicare MA plans include prescription drug coverage and are referred to as MA-PD plans.

Many Medicare beneficiaries join Medicare MA plans in order to reduce their out-of-pocket medical expenses and to obtain benefits not covered by fee-for-service Medicare, such as the dental care and vision care offered by some plans.

The Medicare program pays a Medicare MA plan a monthly capitation payment for each Medicare enrollee.

Medicare MA plan members must use the plan for all their medical care needs except in certain circumstances such as emergency and urgent care situations. If they use a provider outside the plan’s network without plan authorization, they will have to pay a higher co-payment or, in many cases, the full cost of the service. Because the Medicare program pays the plan a flat fee in advance, the Medicare claims process does not exist in MA plans.

COVID-19 ALERT: During the emergency, MA plans must allow members to use out-of-network facilities without additional co-pays and without prior authorization. MA plans also are permitted, but not required, to waive required provider referrals, to waive co-pays and to add services mid-year.

A Medicare beneficiary must have Medicare Parts A and B in order to join a Medicare MA plan.

All Medicare beneficiaries are eligible to enroll in a Medicare MA plan. A Medicare MA plan cannot screen out applicants based on health history or disability. Medicare beneficiaries receiving hospice care may enroll in a Medicare Advantage plan. Their hospice benefit will be covered under original Medicare.

Note- Starting with the 2021 plan year, people with end-stage renal (kidney) disease can now enroll in MA plans without restriction.

Some Medicare Advantage Plans, called Special Needs Plans (SNPs) can limit enrollment to particular groups of individuals. SNPs are required to show that they are designed to meet the particular needs of the population they serve. There are three types of SNPs: those for people dually eligible for Medicare and Medicaid (D-SNPs), those for people with certain chronic conditions (C-SNPs) and those for people needing institutional care (I-SNPs). Most SNPs are D-SNPs.

Note- Medicare plans have limited provider networks. A beneficiary should check carefully to see whether their providers are part of the network of any Medicare MA plan the beneficiary is thinking of joining. MA plans cannot impose cost-sharing that exceeds that of original Medicare for the following: chemotherapy administration, renal dialysis services, and skilled nursing facility care.
CAL MEDICONNECT

California is one of several states participating in a demonstration project that combines Medicare benefits with Medicaid benefits through enrollment in a managed care plan. Cal MediConnect plans are available in Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara counties. Cal MediConnect is part of a broader program in California called the Coordinated Care Initiative (CCI). For more about the CCI, go to Chapter 6.

PACE

Programs for All-Inclusive Care for the Elderly (PACE) are available in many California counties, including Los Angeles, and provide comprehensive community-based care for older adults who have high care needs. To qualify for PACE, a Medicare beneficiary must be 55 or older, live in the service area of a PACE organization, be certified by the state as needing a nursing home-level of care and, at the time of enrollment, be able to live safely in the community with the help of PACE services. A large majority of PACE participants are dually eligible and they receive both their Medicare services and their Medi-Cal services through PACE. Medicare beneficiaries who do not qualify for Medi-Cal can also enroll in PACE, but are required to pay a monthly premium for the long-term services portion of the PACE benefit and a premium for Medicare Part D drugs.

ENROLLMENT IN MEDICARE ADVANTAGE PLANS

Enrollment Process and Effective Enrollment Date - Beneficiaries enroll in a Medicare Advantage plan by filling out and signing a Medicare Advantage enrollment form and submitting it to the Medicare Advantage plan. Beneficiaries also can enroll online at the Enrollment Center section of the Medicare website, www.Medicare.gov. Beneficiaries also can contact the Medicare Advantage plans to enroll by phone.

The effective date of the Medicare Advantage enrollment depends on when the beneficiary has applied for enrollment. If the enrollment occurs during an open enrollment period, October 15 through December 7, the enrollment is effective on January 1.

A beneficiary may also disenroll from a Medicare Advantage Plan from January 1 to March 31, and return to original fee-for-service Medicare and a Part D plan or change to another Medicare Advantage plan.

Enrollment Periods - There are four types of enrollment periods during which a Medicare beneficiary can enroll in a Medicare Advantage plan. Some of these enrollment periods overlap, and the enrollment rules are complicated.

1. Initial Coverage Election Period (ICEP) - The initial coverage election period is the time period during which a person becomes newly eligible for Medicare A and B. The ICEP is the same seven-month period as the initial enrollment period in Medicare Part B; it begins three months before an individual is eligible, includes the month of first eligibility, and ends three months later.

2. Open Enrollment Period (OEP) - The open enrollment period is the time period during which a beneficiary can change from one Medicare Advantage plan to another or enroll in and disenroll from a Medicare Advantage plan. The OEP extends from October 15 to December 7 of each year. Enrollment changes made during the OEP are effective January 1 of the following year.

3. Medicare Advantage Open Enrollment Period (MA OEP) - An individual who enrolls in an MA plan may
switch to another Medicare Advantage plan or return to original Medicare and a Part D plan during the first three months of a year, January 1 to March 31. If the individual is new to Medicare and Medicare eligibility begins mid-year, the three-month period begins the first month of MA plan enrollment.

4. **Special Enrollment Period (SEP)** - Medicare provides for special enrollment periods for Medicare Advantage enrollees. They can enroll at any time in a plan that receives a five-star quality rating from Medicare. Enrollees who receive the Low Income Subsidy have an opportunity to change plans once each quarter. Those in nursing homes can change plans at any time. Special Enrollment Periods also are available in a variety of circumstances including:

- the enrollee no longer lives in the Medicare Advantage plan service area
- the Medicare Advantage plan no longer contracts with Medicare or no longer provides services in the service area
- the beneficiary wishes to enroll in a Medicare Advantage plan with a 5-star rating or to disenroll from a plan identified by CMS as a poor performing plan
- the enrollee has enrolled in or disenrolled from a Medicare Advantage plan due to bad information or action by a federal employee
- the beneficiary has lost creditable retiree drug coverage or the coverage has been reduced so that it is no longer creditable
- other situations that are approved by CMS (Medicare)

See the Supplemental Materials at the end of Chapter 5 for a full list of Special Enrollment Periods.

**Disenrollment from Medicare Advantage** - Medicare beneficiaries can disenroll from a Medicare Advantage plan only during one of the prescribed enrollment periods. Signing up for another plan automatically causes disenrollment from the old plan. A beneficiary also can disenroll by completing, signing and submitting a disenrollment form to the Medicare Advantage plan or by calling 1-800-MEDICARE. The effective date of the disenrollment depends upon the enrollment period. If the beneficiary disenrolls during the annual open enrollment period, it will be effective January 1.

**Note** - Beneficiaries with the Medicare Part D Low Income Subsidy (Extra Help) have a special enrollment period that permits them to change plans once per quarter. The effective date of the change is the first day of the following month except when a change is made in the last quarter of the year. That change will be effective January 1.
Medicare Part A & B Appeals

INTRODUCTION

As discussed in earlier sections of this manual, Medicare Part A and B claims are processed by Medicare contracting carriers and intermediaries. These Medicare contractors are responsible for processing the initial claim determination on Medicare claims and for some of the earlier stages of the Part A and B appeals process.

In this section of the manual, we will discuss the Medicare Part A and B appeals process in detail.

Detailed descriptions of the Medicare Advantage and Part D appeals processes are outlined in the respective sections on Medicare Advantage plans and the Part D program.

OVERVIEW OF THE PART A AND B APPEALS PROCESS

Medicare Part A and B fee-for-service appeals follow a standard pattern of steps:

1. Initial determination made by a Medicare carrier or intermediary;
2. Redetermination made by the same Medicare carrier or intermediary;
3. Reconsideration, an external review that is made by an independent entity that contracts with Medicare;
4. Administrative Law Judge hearing;
5. Medicare Appeals Council review;
6. Federal District Court.

INITIAL DETERMINATION

When a Medicare carrier or intermediary processes a claim, a Medicare Summary Notice (MSN) is sent to the Medicare beneficiary. MSNs are mailed once each quarter unless the beneficiary is due a payment from Medicare. The notice informs the beneficiary whether Medicare has approved payment of the claim for services and the amount of that payment. If Medicare has not approved payment, the notice provides information on why the claim was denied or partially paid. The notice informs the beneficiary of their appeal rights.

REDETERMINATION

The first level of the fee-for-service appeal process is called redetermination. A beneficiary who wants to appeal an initial determination must file a written, signed request for redetermination to the Medicare carrier/intermediary within 120 days of the initial determination. Medicare providers and suppliers can also file a request for redetermination. The Medicare carrier/intermediary must issue a redetermination decision in 60 days.

Expedited Appeals of Hospital, Skilled Nursing Facility, Home Health, Hospice and Comprehensive Outpatient Rehabilitation Facility Services - The Medicare appeals process provides for an additional expedited or “fast track” independent review when hospital, skilled nursing facility, home, health, hospice and comprehensive outpatient rehabilitation facility services are terminated. See pp. 14-16 of this chapter.
RECONSIDERATION

A beneficiary can appeal a redetermination decision by filing a request for reconsideration. Beneficiaries have 180 days to request a reconsideration of a redetermination. Providers and suppliers also can file reconsideration requests. Reconsiderations are conducted by Medicare Qualified Independent Contractors (QICs). The QICs are responsible for conducting an external, independent review of redeterminations. The QIC for California is Maximus.

QICs must issue a reconsideration decision within 60 days. Beneficiaries can request a 14-day extension if needed to provide more evidence. If a QIC does not issue a decision within the required timeframe, the beneficiary can request an administrative law judge hearing. This is called a request for “escalation.” The QIC then has five days to issue a decision or send the case to the ALJ (Administrative Law Judge) level. If an appeal is escalated to the ALJ level, the ALJ has 180 days, rather than the standard 90-day timeframe to make a decision.

ADMINISTRATIVE LAW JUDGE (ALJ) HEARING

Beneficiaries who want to appeal a reconsideration decision have the right to request an administrative law judge hearing. Beneficiaries have the right to an ALJ hearing only if the amount of money at issue is at least $180. The request for an ALJ hearing must be filed within 60 days of receiving an unfavorable reconsideration decision. An ALJ has 90 days to issue a decision, but the timeframe can be extended to review additional evidence, to permit an in-person hearing or because of an escalated request from a QIC.

ALJ hearings are conducted by the Department of Health and Human Services (HHS). In most cases, the hearings are conducted by telephone or video teleconference. In-person ALJ hearings are conducted only if the beneficiary can show “good cause” for an in-person hearing. When a request for an in-person hearing is granted, the 90-day decision deadline is waived.

COVID-19 ALERT: No in-person hearings are being conducted during the COVID-19 emergency.

MEDICARE APPEALS COUNCIL (MAC)

The Medicare Appeals Council review is conducted by the Departmental Appeals Board of HHS. A beneficiary who wants to appeal an unfavorable ALJ decision has 60 days to request a MAC review. This review is generally a paper review where a decision is made without a hearing. The timeframe for a MAC decision is 90 days but can be extended.

FEDERAL DISTRICT COURT

A beneficiary can appeal a MAC decision by filing a lawsuit in federal district court. The suit must be filed within 60 days of receiving an unfavorable MAC decision. To appeal at this level, a beneficiary must show that at least $1,760 is at issue.
Medicare Advantage Managed Care Appeals

Medicare provides an appeals process for Medicare Advantage managed care plan members who have disputes with their Medicare MA plans. Medicare beneficiaries may use the appeals process to:

- Obtain payment for emergency or out-of-area urgently needed services;
- Seek payment for health services furnished by a provider not in the MA plan’s network that the MA plan member believes are covered by Medicare and should have been furnished, arranged or paid for by the MA plan; or
- Challenge the MA plan’s refusal to provide services or the MA plan’s termination of services.

There are five steps in the appeals process:

1. **Organization Determination** - Requests for claim payment for non-MA plan services or requests for medical services from the MA plan should be considered requests for an organization determination.

   There are different time frames for service and claim payment requests. Claim payment requests must be reviewed in 60 days. Service requests must be reviewed in 14 calendar days. All of the following situations should be treated as an organization determination that is a denial:
   
   - The plan has denied the level of care requested, but approved another level of care. For example, the request for skilled nursing care was not authorized, but home health services were approved;
   - The plan has denied the request for service or has not approved the amount of service requested;
   - The plan has reduced or discontinued services;
   - The plan has failed to approve, provide or arrange the requested health care services in the time frame required;
   - The plan has denied payment of the claim submitted or only partially paid the claim.

   If the organization determination is a denial, it must be in writing and must provide the following information:
   
   - The reason for the denial; and
   - Information on how to appeal the denial and on the expedited appeal process.

2. **Reconsideration** - If the organization determination results in a partial or total denial, or the MA plan fails to issue a written determination within the specified time frames, the member may request reconsideration. The reconsideration review is performed by the MA plan. The member must file the reconsideration request with the MA plan within 60 days of the date of the organization determination. The beneficiary or their representative is entitled to present evidence, either in person or in writing.

   The MA plan has 60 days to reconsider a claim payment denial. On service request denials, however, the
MA plan has 30 days, but it may extend this 30-day period by an additional 14 days if the member requests an extension, or if the MA plan can show that additional information is needed and that the extension will benefit the member’s reconsideration request.

3. **Outside Review by Independent Review Entity** - If the MA plan decides to uphold the organization determination, in whole or in part, it must forward the case to Maximus/Center for Health Care Dispute Resolution, the Independent Review Entity (IRE) that is contracted to review reconsideration cases for the federal government. The MA plan also must inform the member, in writing, either that the claim has been approved in full, or that the case has been forwarded to the Independent Review Entity for further review. Depending on the case, the Independent Review Entity has up to 60 days to make a decision.

4. **Administrative Law Judge Review** - The beneficiary has 60 days from the date of an unfavorable determination from the Independent Review Entity to request a hearing before an Administrative Law Judge. At least $180 must be at issue.

5. **Medicare Appeals Council** - If the decision from the Administrative Law Judge is unfavorable, the beneficiary has 60 days to request review by the Medicare Appeals Council.

**Federal Review** - If the Medicare Appeals Council decision is unfavorable, further review may be sought in federal District Court. The amount in controversy must be at least $1,760.

**Note** - When an MA plan denies an appeal on reconsideration, the appeal is automatically sent to the Independent Review Entity.

## Expedited Appeals Process For Medicare Advantage Managed Care Enrollees

A Medicare Advantage (MA) plan member has the right to request an expedited review if the timeframe for a standard appeal could seriously jeopardize the member’s health or ability to gain maximum function. This faster appeal process can be used to request medical care from the MA plan, and to appeal an MA plan denial of service or termination of care. An expedited appeal must be decided within 72 hours.

A request for expedited review by the MA plan can be made in person, by phone, or in writing. If the member requests the expedited review, the plan has the option to deny expedited processing. If, however, a physician requests expedited treatment, the MA plan must review the case within the 72-hour timeframe. An MA plan member who wants an expedited review should contact the MA plan’s member services department.

Medicare Advantage plan members also have the right to a special fast track appeal directly to the BFCC-QIO when hospital, skilled nursing facility or home health services are terminated. In the case of skilled nursing facility or home health services, the provider must give the member a written notice at least two days before the services are terminated. To request a fast track appeal, a member must contact Livanta (1-877-588-1123) by noon of the day before coverage ends.
Private Medicare Supplemental Insurance

INTRODUCTION

“Medicare Supplemental Insurance” is insurance that supplements fee-for-service Medicare coverage and meets specified coverage standards. It is usually paid for out-of-pocket, or may be offered by an employer or former employer.

Note - Most low-income individuals do not need such coverage, because they may qualify for other ways to supplement Medicare and/or may qualify for Medi-Cal coverage. See page 4-31 for more information on Medicare Savings Programs, and Chapter 6 for information on Medi-Cal.

A Medicare Supplemental Insurance policy, often referred to as a “Medigap” policy, is designed to cover part or all of Medicare’s co-payments and deductibles. Medigap policies are available primarily to persons 65 and over who have both Medicare Part A and Part B. Policies are available to under-65 beneficiaries with disabilities on a more limited basis. Because Medigap policies are designed to go along with, or track, Medicare, most of the services excluded or denied by Medicare are also excluded or denied by Medigap policies.

Note - Individuals who choose Medicare Part C (“Medicare Advantage”) coverage do not need Medigap policies. Insurance companies and their agents are prohibited from selling Medigap policies to Medicare Advantage members.

When evaluating any Medigap policy, beneficiaries and their advocates should remember that Medigap policies won’t cover all health care expenses not paid for by Medicare. Medigap insurance pays for only a portion of the remaining costs.

Note - A Medigap policy is not comprehensive coverage. Medigap policies are limited in the same ways that Medicare coverage in general is limited.

BASIC BENEFITS

Insurance companies may offer standardized Medigap policies, labeled A, B, D, G, K, L, M, and N. Insurers may no longer offer plans labeled C, E, F, H, I, & J. Because all plans are standardized, consumers will receive the same benefits within a category regardless of which insurer they choose.

PART A HOSPITAL BENEFITS

All new policies must offer:

- All coinsurance for hospital days 61-90 in a benefit period;
- Coinsurance for the 60 hospital lifetime reserve days; and
• 100% of the cost for hospital care beyond the Medicare-covered days in a benefit period, up to a maximum of 365 days.

OTHER BENEFITS

• All plans provide coverage for Part B coinsurance and copayments, the first three pints of blood, and hospice co-insurance. Coverage is at 100% except for plans K and L, which provide coverage at the 50% and 75% level respectively.

• Coverage for skilled nursing coinsurance, Part A deductibles, Part B deductibles, and emergency health care during foreign travel varies among plan types.

• 100% of Part B Excess Charges. These are the Part B physician charges that exceed the Medicare-approved amount up to the physician charge limit of 115% of the approved amount. For example, if Medicare approves $100 of a $115 physician bill, this benefit will pay both the 20% of the Medicare approved amount and also the $15 excess amount. Note that some plans sold before June 1, 2010 have a more limited 80% excess charge benefit.

• Medigap plans sold to people newly eligible in January 2020 or later do not cover the Part B deductible. Note that the Part B deductible is covered by some older policies.

Note - Plans C, F, E, H, I & J are no longer sold but some people still have these plans.

For a good source on Medicare supplements go to: https://www.cms.gov/medicare/health-plans/medigap/index.

Programs To Help Low-Income Medicare Beneficiaries With Medicare Costs

Low-income Medicare beneficiaries may be eligible for Medi-Cal in addition to Medicare (see Chapter 6). In addition, they may be eligible for one of the following Medicare Savings Programs (MSP): QMB, SLMB, or QI (see below for MSP descriptions). Persons who may qualify for any of these programs should apply at the county (in Los Angeles, at the Department of Public Social Services).

QUALIFIED MEDICARE BENEFICIARY (QMB)

The QMB program is for individuals and couples with low incomes but with resources up to $7,970 for individuals, and $11,960 for couples. In 2021, the QMB income limit for a single person is $1,094 per month and $1,472 per month for a couple (these include a $20 disregard that applies to all income). These figures change early each calendar year when the annual income poverty guidelines are issued.

See the Supplemental Material for a California QMB/SLMB/QI application.
The QMB program will pay the Medicare Part A premium (if not already free), the Medicare Part B premium, and all Medicare cost-sharing (deductibles and co-payments), and automatically entitles the individual to the Medicare Part D Low-Income Subsidy (see Chapter 5).

**Note** - QMB applicants who do not already have Medicare Part A must also apply at the Social Security office. Unless they are in their Medicare Initial Enrollment Period or the Special Enrollment Period for people who were employed with health coverage, they must do so during the January 1 to March 31 General Enrollment Period of a given year, with benefits to start July 1. They must file a “conditional” Part A application with the Social Security office during the filing window and show evidence of the Part A application with their QMB application at the county or DPSS office. QMB coverage, including coverage of Part A premiums, will start on July 1 of the same year.

Providers may not bill any QMB (most dual eligibles are also QMBs) for Medicare deductibles, co-pays or co-insurance. This protection applies both to beneficiaries in fee-for-service Medicare and to those in Medicare Advantage plans. For more information on improper billing of QMBs and dual eligibles, see Justice in Aging’s Improper Billing Toolkit: [https://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/](https://www.justiceinaging.org/our-work/healthcare/dual-eligibles-california-and-federal/improper-billing/)

**SPECIFIED LOW-INCOME BENEFICIARY (SLMB)**

SLMB is a program similar to QMB, for individuals and couples with monthly incomes too high for QMB but no more than $1,308 for an individual, or $1,762 for a couple (these include a $20 disregard that applies to all income). These figures change early each calendar year when the annual income poverty guidelines are issued.

The resource requirements are the same as for QMB ($7,970 for individuals, and $11,960 for couples). The SLMB program pays the Medicare Part B premium only. It does not cover deductibles and co-pays.

**QUALIFIED INDIVIDUAL (QI)**

Again (as is the case for QMB and SLMB), the resource limit is $7,970 for an individual, or $11,960 for a couple. The income limits for the QI program are $1,469 for an individual and $1,980 for a couple. These figures change early each calendar year when the annual income poverty guidelines are issued.

Like SLMB, the QI program pays the Medicare Part B premium. QI is only available to individuals who do not also qualify for another Medi-Cal program.

**Note** - All MSP recipients automatically receive the Medicare Part D Low Income Subsidy (LIS).

### Claims Processing

**Role of Medicare Administrative Contractors** - Payments for fee-for-service Medicare Part A and Part B services are administered by private companies known as Medicare Administrative Contractors (MACs).

Medicare contracting providers are required to submit Medicare claims to the MAC for the region where the service was provided. After the claim is processed, a Medicare Summary Notice is generated and sent to the
beneficiary each quarter. The Medicare Summary Notice informs the beneficiary that a claim has been processed for a particular provider and date of service. The notice includes information on the status of Medicare payment, along with the beneficiary's appeal rights.

Coordination with Medigap Policies - After a beneficiary receives a Medicare Summary Notice (MSN), there are three ways to make a claim with a supplemental insurance policy (Medigap) or retiree plan:

1. Medicare may have an electronic claims processing arrangement called “crossover” with the insurance company or retiree plan.

2. If the provider accepts Medicare assignment, the provider may submit the claim to the insurance company or retiree plan.

3. If neither Medicare nor the provider submits the claim, the beneficiary will need to take the following steps:
   - If required, fill out the claim form provided by the insurance company.
   - If required, attach copies of the bills being submitted for payment. Attach copies of the MSN related to those bills.
   - Make copies of everything for personal records. Mail the claim packet to the insurance company.

The beneficiary subsequently will receive an Explanation of Benefits (EOB) from the insurance company or retiree plan.

**Note** - The MSN for QMBs shows that the QMB has zero payment liability for each covered service. The provider remittance that the doctor or other provider receives also shows that the QMB owes nothing. This process should help both providers and their QMB patients to better understand when a QMB billing protection applies.
Supplemental Materials
Page 1 – Your Dashboard

1. **DHHS Logo**
The redesigned MSN has the official Department of Health & Human Services (DHHS) logo.

2. **Your Information**
Check your name and the last 4 numbers of your Medicare number, as well as the date your MSN was printed and the dates of the claims listed.

3. **Your Deductible Info**
You pay a Part A deductible for services before Medicare pays. You can check your deductible information right on page 1 of your notice!

4. **Medicare Summary Notice**

   **for Part A (Hospital Insurance)**

   The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

   JENNIFER WASHINGTON
   TEMPORARY ADDRESS NAME
   STREET ADDRESS
   CITY, ST 12345-6789

   **THIS IS NOT A BILL**

   Your Claims & Costs This Period
   Did Medicare Approve All Claims? YES
   See page 2 for how to double-check this notice
   Total You May Be Billed $2,062.50

   Facilities with Claims This Period
   June 18 – June 21, 2020
   Otero Hospital

   **Your Deductible Status**
   You pay a Part A deductible for services before Medicare begins to pay.
   Part A Deductible: You have now met your $1,184.00 deductible for inpatient hospital services for the benefit period that began May 27, 2020.

   **Be Informed!**
   Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

5. **Title of your MSN**
The title at the top of the page is larger and bold.

6. **Total You May Be Billed**
A new feature on page 1, this summary shows your approved and denied claims, as well as the total you may be billed.

7. **Facilities You Went To**
Check the list of dates for services you received during this claim period.

8. **Help in Your Language**
For help in a language other than English or Spanish, call 1-800-MEDICARE and say "Agent." Tell them the language you need for free translation services.

After reading this summary, you can find more information and assistance from the Medicare Overview Guide or Medicare Part A Disclosure Statement. This notice is the Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services.
Jennifer Washington

Making the Most of Your Medicare

How to Check This Notice
Do you recognize the name of each facility? Check the dates.
Did you get the claims listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

How to Report Fraud
If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).
Some examples of fraud include offers for free medical services or billing you for Medicare services you didn’t get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

Your Benefit Periods
Your hospital and skilled nursing facility (SNF) stays are measured in benefit days and benefit periods. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven’t received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have 56 out of 90 covered benefit days remaining for the benefit period that began May 27, 2020.
Skilled Nursing Facility: You have 63 out of 100 covered benefit days remaining for the benefit period that began May 27, 2020.

See your “Medicare & You” handbook for more information on benefit periods.

Your Messages from Medicare
Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.

To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the “Blue Button” feature to help keep track of your personal health records.

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)
Ask for “hospital services.” Your customer-service code is 05535.
TTY 1-877-486-2048 (for hearing impaired)
Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call 1-855-555-5555.

General Messages
These messages get updated regularly, so make sure to check them!
### Your Inpatient Claims for Part A (Hospital Insurance)

**Jennifer Washington**

**THIS IS NOT A BILL**

**Page 3 of 4**

<table>
<thead>
<tr>
<th>Benefit Period starting May 27, 2020</th>
<th>Claim Approved?</th>
<th>Non-Covered Charges</th>
<th>Amount Medicare Paid</th>
<th>Maximum You May Be Billed</th>
<th>See Notes Below</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 18 – June 21, 2020 Otero Hospital, (555) 555-1234 PO Box 1142, Manati, PR 00674 Referred by Jesus Sarmiento Forasti</td>
<td>4 days</td>
<td>$0.00</td>
<td>$4,886.98</td>
<td>$0.00</td>
<td>A, B</td>
</tr>
</tbody>
</table>

**Benefit Periods**

- **Benefit Days Used:** The number of covered benefit days you used during each hospital and/or skilled nursing facility stay. (See page 2 for more information and a summary of your benefit periods.)

- **Claim Approved:** This column tells you if Medicare covered the inpatient stay.

- **Non-Covered Charges:** This is the amount Medicare didn't pay.

- **Amount Medicare Paid:** This is the amount Medicare paid your inpatient facility.

- **Maximum You May Be Billed:** The amount you may be billed for Part A services can include a deductible, coinsurance based on your benefit days used, and other charges.

**For more information about Medicare Part A coverage, see your “Medicare & You” handbook.**

**Notes for Claims Above**

- **A** Days are being subtracted from your total inpatient hospital benefits for this benefit period. The “Your Benefit Periods” section on page 2 has more details.

- **B** $2,062.50 was applied to your skilled nursing facility coinsurance.

---

1. **Type of Claim**
   - Claims can either be inpatient or outpatient.

2. **Definitions**
   - Don’t know what some of the words on your MSN mean? Read the definitions to find out more.

3. **Your Visit**
   - This is the date you went to the hospital or facility. Keep your bills and compare them to your notice to be sure you got all the services listed.

4. **Benefit Period**
   - This shows when your current benefit period began.

5. **Approved Column**
   - This column lets you know if your claim was approved or denied.

6. **Max You May Be Billed**
   - This is the total amount the facility is able to bill you. It’s highlighted and in bold for easy reading.

7. **Notes**
   - Refer to the bottom of the page for explanations of the items and supplies you got.
### How to Handle Denied Claims or File an Appeal

#### Get More Details
If a claim was denied, call or write the hospital or facility and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn’t, ask the facility to contact our claims office to correct the error. You can ask the facility for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

#### If You Decide to Appeal
You have 120 days to appeal your claims. The date listed in the box is when your appeal must be received by us.

#### If You Need Help Filing Your Appeal
Contact us: Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your facility: Ask your facility for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

#### Find Out More About Appeals
For more information about appeals, read your “Medicare & You” handbook or visit us online at www.medicare.gov/appeals.

#### File an Appeal in Writing
Follow these steps:
1. Circle the service(s) or claim(s) you disagree with on this notice.
2. Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.
3. Fill in all of the following:
   - Your or your representative’s full name (print)
   - Your telephone number
   - Your complete Medicare number
4. Include any other information you have about your appeal. You can ask your facility for any information that will help you.
5. Write your Medicare number on all documents that you send.
6. Make copies of this notice and all supporting documents for your records.
7. Mail this notice and all supporting documents to the following address:
   - Medicare Claims Office
   - c/o Contractor Name
   - Street Address
   - City, ST 12345-6789

#### Appeals Form
You must file an appeal in writing. Follow the step-by-step directions when filling out the form.
Page 1 – Your Dashboard

1. **DHHS Logo**
   - The redesigned MSN has the official Department of Health & Human Services (DHHS) logo.

2. **Your Information**
   - Check your name and the last 4 numbers of your Medicare number, as well as the date your MSN was printed and the dates of the claims listed.

3. **Your Deductible Info**
   - You pay a yearly deductible for services before Medicare pays. You can check your deductible information right on page 1 of your notice!

---

**Medicare Summary Notice**

**JENNIFER WASHINGTON**
Temporary Address Name
Street Address
City, ST 12345-6789

**THIS IS NOT A BILL**

**Notice for Jennifer Washington**

Medicare Number 1A23BC4DE56
Date of This Notice March 1, 2020
Claims Processed Between January 1 – March 1, 2020

**Your Deductible Status**

Your deductible is what you must pay for most health services before Medicare begins to pay.

Part B Deductible: You have now met $85.00 of your $147.00 deductible for 2020.

**Your Claims & Costs This Period**

Did Medicare Approve All Services? NO
Number of Services Medicare Denied 1
See claims starting on page 3. Look for NO in the “Service Approved?” column. See the last page for how to handle a denied claim.

Total You May Be Billed $90.15

**Providers with Claims This Period**

January 21, 2020
Craig I. Secosan, M.D.

---

**Be Informed!**

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare.

---

**Help in Your Language**

For help in a language other than English or Spanish, call 1-800-MEDICARE and say "Agent." Tell them the language you need for free translation services.
Page 2 – Making the Most of Your Medicare

How to Check
Do you recognize the name of each doctor or provider? Check the dates. Did you have an appointment that day?
Did you get the services listed? Do they match those listed on your receipts and bills?
If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

How to Report Fraud
If you think a provider or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).
Some examples of fraud include offers for free medical services or billing you for Medicare services you didn’t get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.
You can make a difference! Last year, Medicare saved tax-payers $4.2 billion—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

How to Get Help with Your Questions
1-800-MEDICARE (1-800-633-4227)
Ask for “doctors services.” Your customer-service code is 05535.
TTY 1-877-486-2048 (for hearing impaired)
Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call 1-555-555-5555.

Medicare Preventive Services
Medicare covers many free or low-cost exams and screenings to help you stay healthy. For more information about preventive services:
• Talk to your doctor.
• Look at your “Medicare & You” handbook for a complete list.
• Visit www.medicare.gov for a personalized list.

Your Messages from Medicare
Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.
To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.
Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.
Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the “Blue Button” feature to help keep track of your personal health records.

Justice in Aging • www.justiceinaging.org • 99
### Jennifer Washington

**Type of Claim**

Claims can either be assigned or unassigned.

**Definitions**

Don’t know what some of the words on your MSN mean? Read the definitions to find out more.

**Your Visit**

This is the date you went to your doctor. Keep your bills and compare them to your notice to be sure you got all the services listed.

**Service Descriptions**

User-friendly service descriptions will make it easier for you to know what you were treated for.

**Approved Column**

This column lets you know if your claim was approved or denied.

**Max You May Be Billed**

This is the total amount the provider is able to bill you. It’s highlighted and in bold for easy reading.

**Notes**

Refer to the bottom of the page for explanations of the services you got.

---

**Your Claims for Part B (Medical Insurance)**

Part B Medical Insurance helps pay for doctors’ services, diagnostic tests, ambulance services, and other health care services.

**Definitions of Columns**

- **Service Approved?** This column tells you if Medicare covered this service.
- **Amount Provider Charged**: This is your provider’s fee for this service.
- **Medicare-Approved Amount**: This is the amount a provider can be paid for a Medicare service. It may be less than the actual amount the provider charged.
- **Amount Medicare Paid**: This is the amount Medicare paid your provider. This is usually 80% of the Medicare-approved amount.
- **Maximum You May Be Billed**: This is the total amount the provider is allowed to bill you, and can include a deductible, coinsurance, and other charges not covered. If you have Medicare Supplement Insurance (Medigap policy) or other insurance, it may pay all or part of this amount.

---

<table>
<thead>
<tr>
<th>Service Provided &amp; Billing Code</th>
<th>Service Approved?</th>
<th>Amount Provider Charged</th>
<th>Medicare-Approved Amount</th>
<th>Amount Medicare Paid</th>
<th>Maximum You May Be Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye and medical examination for diagnosis and treatment, established patient, 1 or more visits (90801)</td>
<td>Yes</td>
<td>$143.00</td>
<td>$107.97</td>
<td>$86.38</td>
<td>$21.59</td>
</tr>
<tr>
<td>Destruction of skin growth (17000)</td>
<td>NO</td>
<td>68.56</td>
<td>0.00</td>
<td>0.00</td>
<td>68.56 A</td>
</tr>
</tbody>
</table>

**Total for Claim #02-10195-592-390**

$211.56 | $107.97 | $86.38 | $90.15

---

**Notes for Claims Above**

- **A** This service was denied. The information provided does not support the need for this service or item.
- **B** Your claim was sent to your Medicare Supplement Insurance (Medigap policy), Wellmark BlueCross BlueShield of N. Carolina. Send any questions regarding your benefits to them.
Last Page – How to Handle Denied Claims

1. Get More Details
   Find out your options on what to do about denied claims.

2. If You Decide to Appeal
   You have 120 days to appeal your claims. The date listed in the box is when your appeal must be received by us.

3. If You Need Help
   Helpful tips to guide you through filing an appeal.

### How to Handle Denied Claims or File an Appeal

#### If a claim was denied
Call or write the provider and ask for an itemized statement for any claim. Make sure they sent in the right information. If they didn’t, ask the provider to contact our claims office to correct the error. You can ask the provider for an itemized statement for any service or claim.

Call 1-800-MEDICARE (1-800-633-4227) for more information about a coverage or payment decision on this notice, including laws or policies used to make the decision.

#### If You Need Help Filing Your Appeal

Contact us:
Call 1-800-MEDICARE or your State Health Insurance Program (see page 2) for help before you file your written appeal, including help appointing a representative.

Call your provider: Ask your provider for any information that may help you.

Ask a friend to help: You can appoint someone, such as a family member or friend, to be your representative in the appeals process.

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### File an Appeal in Writing

Follow these steps:
1. Circle the service(s) or claim(s) you disagree with on this notice.
2. Explain in writing why you disagree with the decision. Include your explanation on this notice or, if you need more space, attach a separate page to this notice.
3. Fill in all of the following:
   - Your or your representative’s full name (print)
   - Your telephone number
   - Your complete Medicare number
4. Include any other information you have about your appeal. You can ask your provider for any information that will help you.
5. Write your Medicare number on all documents that you send.
6. Make copies of this notice and all supporting documents for your records.
7. Mail this notice and all supporting documents to the following address:
   Medicare Claims Office
   c/o Contractor Name
   Street Address
   City, ST 12345-6789

### Appeals Form

You must file an appeal in writing. Follow the step-by-step directions when filling out the form.
QUALIFIED MEDICARE BENEFICIARY (QMB),
SPECIFIED LOW-INCOME MEDICARE BENEFICIARY (SLMB),
AND QUALIFYING INDIVIDUALS (QI) APPLICATION

Name Social security number Medicare number Date

Phone number Date of birth Sex Marital status

Married Divorced

Male Female Separated Single Widowed

Address (number, street) City State ZIP code

This information is to help you apply for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or the Qualifying Individual-1 (QI-1) programs. The State will pay Medicare Parts A and B premiums, deductibles, and coinsurance fees for persons eligible for the QMB program. The State will pay Medicare Part B premiums for persons eligible for SLMB or QI-1. You may apply for QMB, SLMB, or QI-1 by completing and mailing this form to your local county social services agency.

To be eligible for QMB, SLMB, or QI-1, you must:

- Be eligible for Medicare Part A (hospital insurance).
- Be eligible for Medicare Part B (medical insurance).
- Meet the following income requirements:
  - **QMB**: Net countable income at or below 100% of the Federal Poverty Level (FPL) (at or below $908* for a single person, or $1,226* for a couple).
  - **SLMB**: Net countable income below 120% of the FPL (below $1,089* for a single person, or $1,471* for a couple).
  - **QI-1**: Net countable income below 135% of the FPL (below $1,226* for a single person, or $1,655* for a couple).
  * If you have a child living in the home with you, these amounts may be higher. These amounts are expected to increase each year in April. If you received a Title II Social Security cost of living adjustment in January, this amount will not be counted until April.
- Have no more than $6,680 in nonexempt property for a single person, or $10,020 for a couple.
- Meet certain requirements and conditions, such as being a resident of California.

**IMPORTANT:**

You may be eligible for other Medi-Cal programs in addition to the QMB and SLMB programs, such as food stamps and/or Medi-Cal with a monthly spenddown (share-of-cost). You may also be eligible for Medi-Cal with a monthly share-of-cost if you are over the income limits of the QMB, SLMB, and QI-1 programs. This coverage would include payment of the Medicare Part B premium. If you wish to apply for these other programs, check yes and the county will send you other forms to complete.

Do you wish to apply for three months of retroactive coverage for the SLMB and QI-1 programs (there is no retroactive coverage for QMB).

**List all persons living in your household (spouse/children).** If you have more than three persons living with you, you may list them on a separate page.

<table>
<thead>
<tr>
<th>Name</th>
<th>Social Security Number</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Relationship to You</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

MAIL COMPLETED FORM TO YOUR COUNTY SOCIAL SERVICES AGENCY.

*(Addresses at the bottom of this form)*
A. COUNTABLE INCOME

1. Fill in the MONTHLY unearned income received by the QMB/SLMB/QI-1 applicant:
   a. Social security check $_______________
   b. VA benefits $_______________
   c. Interest from bank accounts or certificate(s) of deposit $_______________
   d. Retirement income $_______________
   e. Any other unearned income $_______________
   f. Total UNEARNED INCOME—add lines a. through e. $_______________

2. If you are married and living with your SPOUSE, fill in the MONTHLY unearned income received by your spouse:
   g. Social security check $_______________
   h. VA benefits $_______________
   i. Interest from bank accounts or certificate(s) of deposit $_______________
   j. Any other unearned income $_______________
   k. Retirement income $_______________
   l. Total SPOUSE’S UNEARNED INCOME—add lines g. through k. $_______________

3. Fill in the MONTHLY earned income received by the QMB/SLMB/QI applicant and spouse:
   m. Gross earnings for the person who wants to be a QMB, SLMB, or QI-1 $_______________
   n. Gross earnings for the spouse $_______________
   o. Total—add lines m. and n. $_______________
   p. Subtract $65 $_______________
   q. Remainder $_______________
   r. Divide by 2 $_______________
   s. Total EARNED AND UNEARNED INCOME—add lines f., l., and r. $_______________

4. Potential QMB, SLMB, or QI-1 eligibles:
   □ You are potentially eligible as a QMB if your income is at or below 100% of the FPL (at $908* for a single person, or at $1,226* for a couple).
   □ You are potentially eligible as a SLMB if your income is below 120% of FPL (below $1,089* for a single person, or below $1,471* for a couple).
   □ You are potentially eligible as a QI-1 if your income is below 135% of FPL (below $1,226* for a single person, or below $1,655* for a couple).
   * If you have a child in the home, these amounts may be higher.
B. PROPERTY

A QMB, SLMB, or QI-1 who is not married or not living with his/her spouse may have countable property which is equal to or less than $6,600. A QMB, SLMB, or QI-1 who is married and living with his/her spouse must have countable property which is equal to or less than $9,910.

The following are examples of countable property. Important: The home you and/or a spouse live in does not count. One car used for transportation does not count. If you apply at the county welfare department as a QMB, SLMB, or QI-1, the county may treat the property listed on this form differently. There are other types of property which the county welfare department, will also look at, i.e., certificates of deposit. This other property may or may not count towards the property limit.

Fill in the value of the following property which belongs to you, your spouse, or both of you.

1. Checking accounts $________________
2. Savings accounts $________________
3. Certificate(s) of deposit $________________
4. Stocks $________________
5. Bonds $________________
6. A second car (value minus amount owed) $________________
7. A second home (value minus amount owed) $________________
8. The cash surrender value of life insurance policies if the face value of all policies combined exceeds $1,500 (Do not include “term” insurance policies) $________________
9. Total PROPERTY—add lines 1 through 8 **$________________

** This total cannot exceed $6,680 for a single person or $10,020 for a couple.

Additional information: You may be eligible for up to three months of retroactive coverage of your Medicare Part B premiums under the SLMB and QI programs.

NOTE: Individuals enrolled in traditional Medi-Cal, in addition to the QMB/SLMB/QI programs, may be subject to Estate Recovery. Medi-Cal benefits received by an individual after age 55 may be recoverable by the State. Recovery may be made from the estate or the distributee/heir of the Medi-Cal beneficiary if the beneficiary does not leave a surviving spouse, minor children, or a totally disabled or blind son or daughter. Individuals enrolled in only the QMB/SLMB/QI programs, however, are not subject to Estate Recovery.

I declare under penalty of perjury, under the laws of the United States of America and the State of California, that information I have given on this form is true, correct, and complete.

Signature (or mark) of applicant Date

COUNTY USE

☐ QMB approved ☐ SLMB approved ☐ QI-1 approved ☐ QMB/SLMB/QI-1 denied

Eligibility Worker’s signature Date

Privacy Statement

This information given in this application is private and confidential under Welfare and Institutions Code 14100.2. This information will be disclosed only in accordance with those laws.

Sections 14011 and 14012 of the Welfare and Institutions Code allow county welfare departments to get certain facts from you, or the person(s) you represent, so that you can get Medi-Cal benefits. You must provide these facts to get some or all of your Medicare costs paid by Medi-Cal. You are required to provide your Social Security Number under the Social Security Act, Section 1137(a)(1) and the Welfare and Institutions Code, Section14011.2.
CHAPTER FIVE

MEDICARE PART D (PRESCRIPTION DRUG COVERAGE)

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Medicare Part D

Medicare Part D provides prescription drug coverage. Benefits are provided by many different private drug plans that contract with Medicare. People who get their Medicare health benefits through original Medicare can get Medicare Part D through a stand-alone Prescription Drug Plan, referred to as a PDP. California has 32 of these plans available in 2021. Those who get their health benefits through a Medicare Advantage plan can get their prescription drug benefit as part of that managed care plan. Medicare Advantage plans that include Part D coverage are referred to as MA-PDs. Their availability varies by county.

ENROLLMENT

All Medicare beneficiaries, including those who are only enrolled in Part A or only enrolled in Part B, are eligible for the program. Dual eligible recipients (those with both Medi-Cal and Medicare coverage) are automatically enrolled in the program. All others who receive the Low Income Subsidy (“Extra Help”), including individuals in Medicare Savings Programs, have enrollment facilitated into a Part D plan.

Most participants in Medicare Part D can only switch Part D plans during the annual open enrollment period, from October 15 to December 7. Special Enrollment Periods (SEPs) provide some exceptions, such as when a person is new to Medicare, or moves out of state, or loses an alternative source of prescription drug coverage. Dual eligibles and other people who get the Low Income Subsidy or “Extra Help,” have a SEP that allows them to switch plans once each quarter during the year. Individuals living in institutions such as nursing homes can change plans at any time. A list of SEPs is attached in the Supplemental Materials section at the end of this chapter.

LATE ENROLLMENT POLICY

Beneficiaries who do not enroll in Part D when they first become eligible potentially face increased monthly premiums if they sign up later. The late enrollment penalty, which is based on the national average premium, is $.33 in 2021 for each uncovered month. The penalty is permanent and continues for as long as the person has Part D coverage. The penalty does not apply to people with other drug coverage that is at least as good as Part D coverage. This is called “creditable coverage.” Employers, unions, the Veterans Administration and others operating those plans are required to send notices to their members with Medicare and tell them whether the drug coverage in their plan is at least as good as Part D coverage. People who do not sign up for Part D because of other coverage should keep those notices to prove that the penalty does not apply to them. The penalty is waived for people who qualify for the Low Income Subsidy.

Note - People with incomes above $88,000 for an individual or $176,000 for a couple will be required to pay a monthly surcharge to their Part D premium called the Income-Related Monthly Adjustment Amount, (IRMAA).
PART D COSTS

Medicare beneficiaries have a number of out-of-pocket costs associated with Part D. People with low incomes are subsidized for many of these out-of-pocket costs. Premium amounts vary widely depending on the plan: the cheapest monthly PDP premium in California in 2021 is $13.30, and the most expensive is $130.40. Without a subsidy, beneficiaries also may need to make significant co-payments. Beneficiaries with higher incomes who pay a higher Part B premium will also pay a higher Part D premium; this affects those with incomes of at least $88,000 for an individual, and $176,000 for a couple.

Plans are permitted to impose a deductible of up to $445. Once the deductible is met, beneficiaries must still pay co-payments for each medication they receive. Plans typically have up to five co-payment tiers. Co-payment amounts can also vary depending on whether a beneficiary uses a preferred or non-preferred pharmacy or uses a mail order option.

Note - In recent years, plans have increased their use of tiers with co-payments that are a percent of the drug price, rather than set amounts like $30 per 30-day prescription.

Most Part D plans also have a coverage gap, referred to by many as the “donut hole.” Once a beneficiary’s drug costs reach about $4,130 in 2021 (this amount may vary depending on the plan), the beneficiary is in the “donut hole.” Although in the past the beneficiary paid all costs while in the “donut hole,” health care reform laws have changed this and now the donut hole has closed. This means that plans can only charge 25% of covered drug costs. Once these out-of-pocket costs exceed $6,350, Part D catastrophic coverage begins, and co-pay liability may be reduced (if the plan has lower cost sharing outside of the donut hole). Enrollees must continue to pay premiums even when they are in the donut hole.

Beneficiaries needing a drug on a non-preferred tier can file a “tiering exception” if they can show that a similar drug is available on a lower cost tier, but that the lower-priced drug will not work as effectively for them. They can then get the lower co-payment. Tiering exceptions are not available if the needed drug is on a “specialty tier.”

Note - The Plan Finder at www.medicare.gov is the best tool available to help individuals decide on a Part D plan. The Plan Finder shows whether a plan covers particular drugs and if any restrictions apply. It also estimates total costs based on a combination of premiums, deductibles and co-payments for the drugs the individual lists, allowing for comparisons among plans.

LOW INCOME SUBSIDY

A Low Income Subsidy program for Part D (also called “Extra Help”) provides subsidies automatically for beneficiaries who are dual eligibles receiving Medi-Cal benefits (including Medicare Savings Program enrollees). People who do not receive Medi-Cal benefits but who have incomes at or below 150% of the poverty level also can receive the Low Income Subsidy, but they must apply. For 2021, the threshold for 150% of the poverty level is $19,560 in annual income for an individual and $26,370 for a couple (including $20/mo. income disregard); asset value may not exceed $14,790 and $29,520, respectively.
They can apply through the Social Security Administration. Individuals are divided into categories based on their income and asset levels. Those who apply based on income will pay either no premium or a reduced premium. They will pay no deductible or a low deductible. They will have lower co-pays and they will not face the donut hole.

Dual eligible beneficiaries receive prescription drugs with no cost for premiums, no deductibles and no donut hole. Co-pays for each prescription filled range from $1.30 to $9.20, depending upon their income, and whether the drug is generic or brand name. Dual-eligible residents of nursing homes have no co-pays and have additional protections. Most dual eligibles receiving home and community-based services in the community also are eligible for zero co-pays.

Only certain Part D plans, those with monthly premiums below a “benchmark” amount, are available to people receiving the full Low Income Subsidy with zero premium. They can choose to enroll in plans with higher premiums, but they must pay the difference between the benchmark amount and the monthly premium. Plan premiums change every year, and the “benchmark” amount also changes. This means that every year some dual eligibles must face the choice of either changing plans or having to pay some premium. For 2021, the benchmark amount in California is $31.45. Seven California PDP plans are below the benchmark.

Problems can arise for Medi-Cal recipients who start to qualify for Medicare on the basis of age or disability. Once they qualify for Medicare, most of their Medi-Cal prescription drug coverage stops immediately and they must get their drug coverage through Medicare Part D. For these new dual eligible beneficiaries, the transition of prescription drug coverage from Medi-Cal to Medicare Part D can be hard. The “Limited Income Newly Eligible Transition Program” (LI-NET), currently contracted to Humana, functions as a safety net during the transition.

MEDICATION CHOICE

Every Part D plan has its own formulary, a list of drugs that the plan covers. A plan formulary can also contain restrictions, such as requirements that one drug be tried before another can be approved (“step therapy” or “fail first”), or limits on the number of doses of a medication. Part D plans tend to be more restrictive than Medi-Cal in covering various medications. Though not every drug is covered, plans are required to have at least two drugs within each pharmaceutical category. If a patient needs medication not covered by the plan, the patient or prescribing doctor may file for an “exception.” Plans are required to make exception decisions within 24 or 72 hours of receipt of a supporting statement by the prescriber, depending on medical urgency. Five subsequent levels of appeal are available if beneficiaries are unsatisfied with the result of their initial appeal.

Note - Plans must follow specific rules in authorizing opioids in order to reduce misuse. Rules, for example, limit first-time opioid prescriptions to a 7-day supply. For more information, see https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18016.pdf.

For prescription coverage, medication must be purchased in the United States. Only drugs that are approved by the Food and Drug Administration are covered. When a drug is prescribed for an off-label use not specifically approved by FDA, it can only be covered if the use is supported by a citation in a compendium such as DRUGDEX. Drugs brought in from Mexico, Canada, or elsewhere are not covered, nor do expenditures on such medicines count towards a beneficiary’s deductible or out-of-pocket expenses. Over-the-counter drugs also generally are not covered. These choice restrictions may not be appealed.
Note - Transitions between plans can cause disruption. A plan must provide a 30-day supply (unless fewer are prescribed) within the first 90 days of membership in the new plan. Transition supplies also are available when a plan changes its formulary at the start of a plan year. Special transition protections apply to nursing home residents and people changing care settings, for example, someone returning to the community after a nursing home stay. For details, see “Medicare Part D-2017 Transition Rights” at justiceinaging.org/wp-content/uploads/2017/02/Final_2017-Transition-Rights-to-Medications-Under-the-Medicare-Part-D.pdf.

COVID-19 ALERT: Plans must allow 90-day refills at the pharmacy and must relax “refill-too-soon edits” during the emergency. Plans must ensure enrollees have access to covered drugs at out-of-network pharmacies when enrollees cannot reasonably be expected to use in-network pharmacies. Plans also are allowed to, but not required to, relax many other restrictions.

Common Medicare Part D Problems and Solutions

MEDICARE BENEFICIARY ISN’T ENROLLED IN A PART D PLAN

Problem: Medicare beneficiaries may think that they have prescription drug coverage, but the pharmacist is unable to find a record of enrollment in a particular plan.

Solution: Most Medicare beneficiaries (other than dual eligibles and other low-income individuals) must take affirmative action to sign up for Medicare Part D. They can sign up by calling 1-800-MEDICARE, by using the “Plan Finder” on www.medicare.gov, by calling the plan, or by contacting their local HICAP (contact information for HICAPs is at the end of this chapter). In general, Medicare participants can only sign up during the annual open enrollment period (October 15 - December 7) or during a “Special Enrollment Period” (SEP) (for instance, after losing other creditable drug coverage). Low income beneficiaries have more options for enrollment. Medicare will automatically enroll dual eligible beneficiaries and other recipients of the Low Income Subsidy who are not already in a drug plan. The LI-NET program will assist these individuals in getting immediate coverage and provides retroactive coverage for dual eligibles (see Supplemental Materials for more on LI-NET).

These individuals may also pick their own plan via 1-800-MEDICARE or www.medicare.gov, by calling a plan, or with assistance from HICAP.

Dual eligible beneficiaries and Low Income Subsidy recipients who go to the pharmacy and learn that they are not in a plan can get immediate temporary coverage at the pharmacy through LI-NET. They will remain in LI-NET for two months and then be auto-enrolled in a benchmark plan unless they affirmatively choose a plan.

LOW INCOME SUBSIDY DOESN’T SHOW UP AT PHARMACY

Problem: Sometimes a Medicare beneficiary who is already enrolled in a plan will go to the pharmacy and be
charged full cost-sharing (e.g., a deductible or 25% of the drug cost) because the pharmacist does not have current Low Income Subsidy information.

**Solution:** The beneficiary should contact the Part D plan and provide evidence showing current eligibility for either Medi-Cal or the Low Income Subsidy. Evidence could be a Medi-Cal card, a letter from the Social Security Administration, or contact information for a Medi-Cal caseworker who can verify that the individual is eligible for Medi-Cal. Sometimes the pharmacist can help to forward the information, so that the beneficiary can get needed drugs right away. Part D plans are supposed to accept evidence that a person is entitled to the Low Income Subsidy. If a plan still refuses to update its system with current Low Income Subsidy status, beneficiaries or advocates should file a complaint with 1-800-MEDICARE or the Centers for Medicare and Medicaid Services (CMS) Regional Office.

Individuals who cannot provide the required evidence of Medi-Cal eligibility can contact the plan and ask for assistance. The plan is required to contact the Regional Office, which will contact Medi-Cal to confirm the individual’s Medi-Cal eligibility. If a plan refuses to provide this assistance, advocates should file a complaint.

In some cases, dual eligible beneficiaries and other Low Income Subsidy recipients who overpaid for drugs can get retroactively reimbursed. Beneficiaries should save their receipts and contact the Part D plan about reimbursement. If there are long delays, they should contact HICAP or a local advocacy office for help.

**Note** - Beneficiaries should tell their plan that they are calling about “best available evidence” of Low Income Subsidy status. Using that term will help ensure that their call is handled properly.

**PLAN REFUSES TO PAY FOR A DRUG**

**Problem:** Part D plans will refuse to pay for specific drugs that are not on the plan’s formulary, its list of covered drugs. Plans may also refuse to pay for a drug because the prescription does not meet the plan’s special restrictions. For instance, a plan may have a dosage limitation that limits covered drugs to a certain number of doses per month.

**Solution:** The beneficiary should talk to the prescribing doctor to decide whether to switch to a different medication that is on the plan’s formulary. If the doctor and beneficiary decide that switching would not be appropriate for the beneficiary’s health, then the beneficiary can file an exception with the plan, requesting coverage for the drug. The doctor must provide a supporting statement showing that the requested drug is “medically necessary.” If the plan denies the request, there are several levels of appeal. The denial letter will explain why coverage was denied and how to ask for reconsideration. To be successful in an appeal, beneficiaries need the cooperation of their doctor.

If the beneficiary is new to the plan and has already been taking a drug, the beneficiary may be entitled to a 30-day transition supply of the drug. If a current member is taking a drug and the plan takes the drug off its formulary for a new plan year, the member also is entitled to a 30-day transition supply. Nursing home residents are entitled to 90-day transition supplies. For newly prescribed drugs, plans are not required to give transition supplies. Again, nursing home residents have more protections.
Note - Some drugs are not covered by Part D, but instead are covered by Part B. As a general rule, Part B covers prescription drugs that cannot be self-administered. At times, confusion can arise at the pharmacy when Part B drugs are being sought. Contact a local HICAP for assistance in these instances.

Because people who qualify for the Low Income Subsidy (including dual eligible beneficiaries) have the right to change plans once in each quarter, they often find that the simplest way to get the drugs they need is to move to another plan that covers their prescribed medications. Advocates can help the beneficiary choose a different plan using the Plan Finder at www.medicare.gov, by calling 1-800-MEDICARE, or by contacting their local HICAP. Plan enrollment changes are effective the first day of the month following the date of the request, except that changes made in the fourth quarter are effective January 1.

Medi-Cal will cover some drugs for dual eligibles, including certain over-the-counter drugs, that Medicare Part D does not cover. Also, some drugs that are not covered by Medicare Part D are covered by Medicare Part B.

Detailed information on how to appeal a plan’s denial of prescription drug coverage is available at www.medicareadvocacy.org/medicare-info/medicare-part-d/#Appeals_and_Grievances.

Filing a Medicare Part D Complaint

The Centers for Medicare and Medicaid Services (CMS, the agency that administers Medicare Part D) recommends that beneficiaries try first to fix problems directly with their plan. If they are unsuccessful, they should file a complaint with 1-800-MEDICARE. When filing a complaint, it’s important to explain if a beneficiary has little or no medication left, stating the number of days of medication the beneficiary has remaining, because urgent complaints are given higher priority.

Sometimes people have trouble reaching the 1-800-MEDICARE number, experience long wait times, or receive incorrect information. If you receive information that sounds wrong to you, or if you are unable to get a response, hang up and call again. Whenever possible, write down the time you called and the name of the person with whom you spoke.

If calling 1-800-MEDICARE does not resolve a complaint, Justice in Aging also recommends sending complaints to CMS in writing. This provides proof of when the complaint was made. Complaints can be filed online with CMS using a complaint form available at www.medicare.gov. You can also file complaints with the CMS regional office. The email address for Region 9 (which includes California) is Part-DComplaints_RO9@cms.hhs.gov, and the mailing address is CMS Region 9, 90 Seventh Street, Suite 5-300 (5W), San Francisco, CA 94103-6706. The phone number for the regional office is 415-744-3605. Complaints are worth filing because they provide CMS with important information about problems faced by beneficiaries.
Note - Complaints, also referred to as “grievances,” are different from appeals of decisions to deny drug coverage because a drug is not on the plan formulary or because a utilization management requirement has not been met. Complaints cover such things as a plan not following its own procedures, rude service, inability to reach a representative, and similar matters.

BOX: Both 1-800-MEDICARE and plan numbers offer free interpreter services. There is an automatic prompt for Spanish. For other languages, beneficiaries should say “agent” and then when a representative comes on, simply identify the needed language, e.g., “Vietnamese.” Advocates should encourage their clients to use interpreter services whenever they need information or have questions about their Medicare coverage.

Consumer Information

- CMS - (Centers for Medicare and Medicaid Services) 1-800-MEDICARE, www.medicare.gov
- Justice in Aging, www.justiceinaging.org
- HICAP – (Health Insurance Counseling and Advocacy Program) 1-800-434-0222
- Medicare Rights Center, www.medicarerights.org
- California Health Advocates 916-231-5110, www.cahealthadvocates.org
- Legal Services Programs (Bet Tzedek, local legal aid organization)
- Center for Medicare Advocacy, www.medicareadvocacy.org
- Kaiser Family Foundation, www.kff.org/medicare

Legal Citation, Reference

STATUTE


REGULATIONS, PROGRAM MANUALS

- 42 C.F.R. § 423 et. seq.
- 20 C.F.R. § 418.3001 (Low Income Subsidy Regulations)
- POMS HI 03001.001, HI 03001.015, HI 03050.005 (POMS is the Social Security Administration’s Program Operations Manual System, the manual used by Social Security Administration employees to administer its programs.)
Supplemental Materials
Special Enrollment Periods for Medicare Advantage Plans and Medicare Part D Drug Plans

You are limited in when and how often you can join, change or leave a Medicare Advantage Plan (also known as a Medicare private health plan) or prescription drug plan (Part D).

- You can enroll in a Medicare Advantage or Part D plan during the initial period when you first qualify for Medicare.1
- You can switch from your Medicare Advantage Plan to another MA Plan, or to Original Medicare with or without a Part D plan, during the Medicare Advantage Open Enrollment Period (MA OEP). The MA OEP occurs each year from January 1 through March 31. You can only use this period if you have a Medicare Advantage Plan.
- You can change your health coverage and add, drop, or change your drug coverage during Fall Open Enrollment. Fall Open Enrollment occurs each year from October 15 through December 7.

Outside of the above three periods, you can only change your health and/or drug coverage if you qualify for a Special Enrollment Period (SEP).

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1 The information in this chart comes from the “Medicare Prescription Drug Manual: Eligibility, Enrollment and disenrollment, Section 30” and the “Medicare Managed Care Manual: Medicare Advantage Enrollment and Disenrollment, Section 30.”

2 Eligibility requirements and initial enrollment periods for Medicare Advantage and Part D are different. You are eligible to enroll in a Medicare Part D drug plan if you have Part A, Part B or both and live in the service area of a Medicare Part D drug plan. The Part D Initial Enrollment Period is usually the same as the Initial Enrollment Period for Part B, which is the seven-month period that begins three months before you qualify for Part B and ends three months after the month you qualify. You’re eligible to enroll in a Medicare Advantage Plan if you have both Parts A and B. You usually can’t get a Medicare Advantage Plan if you have End-Stage Renal Disease. The Initial Coverage Election Period (ICEP) for Medicare Advantage begins three months before you are enrolled in both Parts A and B and ends either the last day of the month before you enrolled in both Parts A and B or the last day of your Part B initial enrollment period, whichever is later.

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**Special Enrollment Periods**

The length of the Special Enrollment Period (SEP) and the effective date of your new coverage vary depending on the circumstances that trigger your SEP. The plan and, in some cases, the Centers for Medicare & Medicaid Services (CMS), determine whether you qualify for an SEP.

**The SEPs in the tables below let you change your Medicare Advantage Plan, Medicare drug plan or both.** The rules for changing Medicare drug plans are the same whether you are in a stand-alone drug plan that only covers drugs or a Medicare Advantage Plan that covers both health care and drugs.

**Retroactive Disenrollment**

In some cases, CMS may let you retroactively disenroll from your Medicare Advantage or drug plan. CMS decides the date the disenrollment starts. For example, if you thought you were enrolling in a stand-alone drug plan but instead were misled into joining a Medicare Advantage Plan that includes drug coverage, you can request for your plan disenrollment to go back to the date you first joined the Medicare Advantage Plan.

If you are granted retroactive disenrollment, it would be as if you never enrolled in the Medicare Advantage Plan. The plan will likely take back any payments it made for your health care and drugs. In this case, you will want to make sure you have health and drug coverage for the period for which you were retroactively disenrolled. You may have another type of insurance that will pay bills from the retroactive period. Or you may request retroactive reinstatement into the Medicare coverage you had before enrolling in the plan you did not want. Bills for care and drugs you got while in the plan you did not want would have to be resubmitted to that other plan.

If you got a lot of health care and drugs while in the plan you did not want, think carefully about whether it is a good idea to request retroactive disenrollment. You can also request prospective disenrollment, which will change your coverage going forward. In this case, the plan will not recoup payments it has already made.

**If you want to switch from one plan to another, it is usually better to just enroll in the plan you want to enroll in.** You will be automatically disenrolled from your old plan. It’s best to call 1-800-MEDICARE to enroll in a new plan rather than calling the plan directly.

**Premium Penalty for Late Enrollment into Part D**

If you do not enroll in Part D when you are first eligible, and you do not have creditable drug coverage, you will likely have to pay a premium penalty if you later enroll in a Part D plan.
While SEPs let you enroll in Part D outside of a standard enrollment period, you will still owe a premium penalty for late Part D enrollment in many cases. There are two exceptions: You will not have a penalty if you qualify for Extra Help—a federal program that helps pay for most of the costs of the Medicare drug benefit—or if you show that you got inadequate information about the creditability of your other drug coverage.

**Table of Contents**

The table in the following pages explains when a Special Enrollment Period may apply to you, how long each SEP lasts, and when your new coverage will begin. If you qualify for different SEPs at the same time, pick the one that is most convenient for your circumstances.

1. You have creditable drug coverage or lose creditable coverage through no fault of your own
2. You choose to change employer/union coverage (through either current or past employment)
3. You are institutionalized
4. You are enrolled in a State Pharmaceutical Assistance Program (SPAP)
5. You have Extra Help, Medicaid, or a Medicare Savings Program (MSP)
6. You gain, lose, or have a change in your Medicaid, MSP, or Extra Help eligibility status
7. You want to disenroll from your first Medicare Advantage Plan
8. You enroll in/disenroll from PACE (Program of All-Inclusive Care for the Elderly)
9. You move (permanently change your home address)
10. You have had Medicare eligibility issues
11. You are eligible for a Special Needs Plan (SNP) or lose eligibility for your SNP
12. You are passively enrolled into a Part D plan or Dual-eligible SNP (D-SNP)
13. You experience contract violations or enrollment errors
14. Your plan no longer offers coverage
15. You disenroll from your Medicare Advantage Plan during the Medicare Advantage Open Enrollment Period
16. You qualify for a new Part D Initial Enrollment Period when you turn 65
17. You want to enroll in a five-star Medicare Advantage Plan or Part D plan
18. You have been in a consistently low-performing Medicare Advantage or Part D plan
19. Your Medicare Advantage Plan terminates a significant amount of its network providers
20. You experience an “exceptional circumstance”
## Special Enrollment Periods

### 1. You lose creditable drug coverage through no fault of your own or want to keep or enroll in creditable coverage.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
</table>
| You, through no fault of your own, lose drug coverage that is at least as good as or better than Medicare’s (creditable) or your drug coverage is reduced so that it is no longer creditable. (This does not include losing your drug coverage because you do not pay, or cannot afford, your premiums.) | Your SEP to join a Medicare Advantage Plan with drug coverage or a stand-alone Medicare Part D drug plan begins the month you are told your coverage will end and lasts for:  
  - 2 months after you lose your coverage; or  
  - 2 months after you receive notice, whichever is later. | The first day of the month after you submit a completed application; or Up to two months after your SEP ends, if you request it. |

You want to **disenroll** from Medicare drug coverage to maintain or enroll in another type of creditable drug coverage such as VA, TRICARE, or a state pharmaceutical assistance program (SPAP) that offers creditable coverage.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
</table>
| You choose to:  
  - enroll in or disenroll from a employer/union-sponsored Medicare Advantage Plan or Part D plan  
  - disenroll from a Medicare Advantage Plan or Part D plan to take employer/union-sponsored coverage.  
  - disenroll from employer/union- | You can use this SEP to disenroll from a Medicare Advantage Plan with drug coverage or a stand-alone Medicare Part D drug plan whenever you are able to enroll in another type of creditable coverage. | The first day of the month after your plan receives your disenrollment request. |

### 2. You join or drop employer/union health and/or drug coverage regardless of whether it is creditable. Employer coverage may be current or former (retiree plan).

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
</table>
| You choose to:  
  - join or disenroll from a Medicare Advantage Plan or Part D plan, or to switch Medicare Advantage Plans or Part D plans is available to persons who have or are enrolling in an employer plan and ends two months after the month in which your employer or union coverage ends.  
  - disenroll from employer/union- | Your SEP to join or disenroll from a Medicare Advantage Plan or Part D plan, or to switch Medicare Advantage Plans or Part D plans is available to persons who have or are enrolling in an employer plan and ends two months after the month in which you submit a completed enrollment application.  
  - disenroll from employer/union- | Up to three months after the month in which you submit a completed enrollment application. 
  - disenroll from employer/union- |

If your employer/union was late sending in the application, your coverage may begin **retroactive** to when you submitted the application.
### 3. You are institutionalized.

<table>
<thead>
<tr>
<th>You move into, reside in, or move out of a qualified institutional facility: a skilled nursing facility, nursing home, psychiatric hospital or unit, Intermediate Care Facility for Individuals with Intellectual Disabilities—ICF/ID, rehabilitation hospital or unit, long-term care hospital, or swing-bed hospital or;</th>
</tr>
</thead>
<tbody>
<tr>
<td>You qualify to enroll in a Special Needs Plan (SNP) for institutionalized people</td>
</tr>
<tr>
<td>Your SEP if…</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>You have an SEP if…</td>
</tr>
<tr>
<td>In addition, after you move out of the facility, you have two months to <strong>enroll in or disenroll from a Medicare Advantage Plan or Part D plan,</strong> or to <strong>switch to another plan</strong> (including Original Medicare if you are in a Medicare Advantage Plan).</td>
</tr>
<tr>
<td>You can enroll in or disenroll from the SNP for institutionalized people at any time.</td>
</tr>
</tbody>
</table>

---

3 If you are disenrolling from COBRA and signing up for a Medicare Advantage Plan you must already have enrolled in Parts A and B. You can only delay enrollment into Part B without penalty if you have health insurance from a current employer. COBRA is not considered current employer insurance. You do not need to have Medicare Part B to enroll in a Part D plan.

4 Only residents of a skilled nursing facility, nursing home, psychiatric hospital or ICF/MR will be eligible to pay a $0 copay for prescription drugs with Extra Help in 2010 and 2011.

5 You qualify for an institutional SNP if: (1) Have lived, for at least 90 days, in a long-term care facility that is served by the SNP or (2) have met your state's guidelines for requiring an institutional level of care for at least 90 days, whether you live in an institution or in a community setting (for example, at home or in a group residence). You can still qualify for an institutional SNP before you have received care for at least 90 days if it is likely that you will need long-term care for at least 90 days.

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4. You are enrolled in a qualified State Pharmaceutical Assistance Program (SPAP) or lose SPAP eligibility.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You're enrolled in a qualified SPAP (no matter how long you have been a member).</td>
<td>You have an SEP to choose once per year, at any time during the year, to join a Medicare Advantage Plan or Part D plan for the first time or to change to another Medicare Advantage Plan or Part D plan, including joining one that works with your SPAP. (If you are automatically enrolled in a Part D plan by your SPAP, you will not have this SEP.) You may not drop Part D coverage using this SEP.</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
<tr>
<td>You lose SPAP eligibility</td>
<td>You have an SEP to join or switch to another Medicare Part D plan or Medicare Advantage Plan with drug coverage. This applies even if you didn’t have Part D before. The SEP starts the month you lose the SPAP because you’re no longer eligible or are notified of the loss (whichever comes first) and continuing for two months after you’re notified of the loss or lose the SPAP (whichever comes later).</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
</tbody>
</table>

5. You have Medicaid, a Medicare Savings Program (MSP) and/or Extra Help. (You will have no Part D premium penalty if you have Extra Help.)

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You get Extra help automatically because you have Medicaid, a Medicare Savings Program (MSP), or Supplemental Security</td>
<td>You will get an SEP to join, disenroll from,6 or switch Medicare Advantage Plans or Part D plans once per calendar</td>
<td>The first day of the month after you submit a completed application to the Medicare Advantage Plan or Part D plan.</td>
</tr>
</tbody>
</table>

---

6 Don’t drop Part D coverage if you have Medicaid. In most cases you will lose your Medicaid benefits. For more information, call your local Medicaid office.
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| You have Extra Help because you applied for it. (You do not have Medicaid or a Medicare Savings Program.) | quarter during the first nine months of the year. This SEP can be used once during each of the following periods:  
- January through March  
- April through June  
- And, July through September  
You cannot use this SEP during the fourth calendar quarter of the year (October through December). You should use Fall Open Enrollment during this time to make prescription drug changes. | • If you do not select a Part D plan yourself, CMS will auto-enroll you in a Part D plan effective the first day of the second month after CMS identifies your Extra Help status. CMS will enroll you in the Limited Income NET (LINET) program through Humana from the month you qualified for Extra Help until the month your auto-enrolled plan starts.  
• If you recently qualified for Extra Help and choose your own Medicare Part D plan instead of waiting to be auto-enrolled in one by CMS, you may receive coverage of any uncovered months through the Limited Income NET program through Humana.  
• If you enroll in a Medicare Advantage Plan without drug coverage, Medicare will automatically enroll you in a Medicare Advantage Plan with drug coverage offered by that same company. Your Medicare Advantage Plan with drug coverage enrollment could be retroactive.  
• You will get an SEP to join, disenroll from, or switch Medicare Advantage Plans or Part D plans once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following periods:  
- January through March  
- April through June  
- And, July through September  
The first day of the month after you submit a completed application to the Part D plan.  
• If you do not select a Part D plan yourself, CMS will auto-enroll you in a Part D plan effective the first day of the second month after CMS identifies your Extra Help status. CMS will enroll you in the Limited Income NET (LINET) program through Humana from the month you qualified for Extra Help until the month your auto-enrolled plan starts.  
• If you recently qualified for Extra Help and choose your own Medicare Part D plan instead of waiting to be auto-enrolled in one by CMS, you may receive coverage of any uncovered months through the Limited Income NET program through Humana.  
• If you enroll in a Medicare Advantage Plan without drug coverage, Medicare will automatically enroll you in a Medicare Advantage Plan with drug coverage offered by that same company. Your Medicare Advantage Plan with drug coverage enrollment could be retroactive.  
• You will get an SEP to join, disenroll from, or switch Medicare Advantage Plans or Part D plans once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following periods:  
- January through March  
- April through June  
- And, July through September  
The first day of the month after you submit a completed application to the Part D plan.

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You cannot use this SEP during the fourth calendar quarter of the year (October through December). You should use Fall Open Enrollment during this time to make prescription drug changes. Through Humana from the month you qualified for Extra Help until the month your auto-enrolled plan starts.
- If you recently qualified for Extra Help and choose your own Medicare private drug plan instead of waiting to be auto-enrolled in one by CMS, you may receive coverage of any uncovered months through the Limited Income NET (LINET) program through Humana.

### 6. You gain, lose, or have a change in your Medicaid, MSP, or Extra Help eligibility status.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You become eligible for Medicaid, any MSP, or Extra Help.</td>
<td>You have a one-time SEP to disenroll from or switch your Medicare Advantage Plan or Part D plan for three months after you are notified.</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
<tr>
<td>You lose eligibility for Medicaid, an MSP, or Extra Help.</td>
<td>You have a one-time SEP to disenroll from or switch your Medicare Advantage Plan or Part D plan for three months after you are notified.</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
<tr>
<td>The level of assistance you receive changes (for example, you move from full to partial Extra Help, or you stop receiving Medicaid but still qualify for Extra Help).</td>
<td>You have a one-time SEP to disenroll from or switch your Medicare Advantage Plan or Part D plan for three months after you are notified.</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
</tbody>
</table>

### 7. You want to disenroll from your FIRST Medicare Advantage Plan.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You select a Medicare Advantage private health plan when you first qualify for</td>
<td>You can disenroll from your Medicare Advantage Plan at any time during the 12-</td>
<td>Depends upon the situation.</td>
</tr>
</tbody>
</table>

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Medicare Part B based on age (65 years old)\(^7\) | months after your health plan coverage first started and go back to Original Medicare with or without joining a stand-alone Medicare Part D drug plan.  
---|---
You dropped your Medigap policy to enroll in a Medicare Advantage Plan for the first time and want to re-enroll in a Medigap policy during your “trial period.”\(^8\) The trial period lasts for 12 months after you enroll in a Medicare private health plan for the first time. | You can disenroll from your Medicare Advantage Plan at any time during the trial period – the 12-months after your Medicare Advantage coverage first started-- and go back to Original Medicare with or without joining a stand-alone Medicare Part D drug plan.  
---|---
You dropped your Medigap policy to enroll in a Medicare Advantage Plan for the first time and want to re-enroll in a Medigap policy during your “trial period.”\(^8\) The trial period lasts for 12 months after you enroll in a Medicare private health plan for the first time. | Depends upon the situation.

### 8. You enroll in/disenroll from PACE (Program of All-Inclusive Care for Elderly).

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You disenroll from a Medicare Advantage Plan or Part D plan to enroll in PACE.</td>
<td>You can disenroll from your Medicare Advantage or Part D plan <strong>at any time</strong> to enroll in PACE.</td>
<td>Depends upon the situation.</td>
</tr>
<tr>
<td>You disenroll from PACE to join a Medicare Advantage Plan or Part D plan.</td>
<td>Your SEP to join another Medicare Advantage Plan or Part D plan lasts up to two months after the effective date of your disenrollment from the PACE program.</td>
<td>Depends upon the situation.</td>
</tr>
</tbody>
</table>

### 9. You move (permanently change your home address).

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You move, permanently. You will have an SEP if you move out of your Medicare Advantage Plan’s or Part D plan’s service area or if you move to an area covered by your plan but more plans are available to you in your new coverage area.</td>
<td><strong>If you notify your Medicare Advantage Plan or Part D plan of a permanent move in advance,</strong> you have an SEP to <strong>switch</strong> to another Medicare Advantage or Part D plan beginning as early as the month before your move and lasting up to two months</td>
<td>You may choose to begin coverage any time between the first day of the month you moved (as long as you have submitted a completed application), and up to three months after your Medicare Advantage Plan or Part D plan receives the completed...</td>
</tr>
</tbody>
</table>

---

\(^7\) In this instance, under federal law if you joined a Medicare Advantage Plan when you first qualified for Medicare at age 65, you would have guaranteed issue rights to buy certain Medigap policies. Laws in your state may offer additional protections.

\(^8\) In this instance, under federal law if you are 65 and over, you will have guaranteed issue rights to buy certain Medigap policies. Laws in your state may offer additional protections.

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If you notify your Medicare Advantage or Part D plan of a permanent move after you move, you have an SEP to switch to another private health or drug plan, beginning the month you tell your plan, plus two more full months thereafter.

(Note: You can also choose to return to Original Medicare and select a stand-alone Part D plan if you move out of your Medicare Advantage Plan’s service area.)

If you did not notify your private health or drug plan about a move:

- and your Medicare Part D plan learns from CMS or the post office that you moved over twelve months ago, the plan should disenroll you twelve months after your move. Your SEP to switch to another Part D plan begins at the beginning of the twelfth month and continues through the end of the fourteenth month after your move.

- and your Medicare Advantage Plan learns from CMS or the post office that you moved over six months ago, the plan should disenroll you twelve months after your move. Your SEP to switch to another Medicare Advantage Plan begins at the beginning of the sixth month and continues through the end of the eighth month after your move.

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<table>
<thead>
<tr>
<th><strong>You have had Medicare eligibility issues.</strong></th>
<th><strong>You have an SEP if...</strong></th>
<th><strong>Your SEP lasts...</strong></th>
<th><strong>Your coverage begins...</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>You have received retroactive enrollment into Medicare.</td>
<td>Your enrollment period to join a Medicare Advantage or Part D plan for the first time begins the month that you receive notice of your Medicare entitlement and continues for an additional two months after the month the notice is received.(^9)</td>
<td>Depends on the situation.</td>
<td></td>
</tr>
<tr>
<td>You do not have premium-free Part A and you enroll in Part B during the General Enrollment Period (January 1 to March 31 of each year) with your Part B coverage beginning July 1.</td>
<td>You have an SEP to join a Medicare Part D plan from April 1-June 30 (after you have enrolled in Part B).</td>
<td>July 1 of that year.</td>
<td></td>
</tr>
<tr>
<td>You lost Part B but still have Part A and are involuntarily disenrolled from your Medicare Advantage Plan.</td>
<td>You have an SEP to enroll in a Medicare Part D drug plan that begins when you learn you lost Part B and continues for two additional months.</td>
<td>The month following the month you applied.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>You are eligible to join a Special Needs Plan (SNP) or you lose SNP eligibility.</strong></th>
<th><strong>You have an SEP if...</strong></th>
<th><strong>Your SEP lasts...</strong></th>
<th><strong>Your coverage begins...</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>You’re eligible to enroll in a Medicare SNP.</td>
<td>You can leave your Medicare Advantage</td>
<td>The first day of the month after you submit</td>
<td></td>
</tr>
</tbody>
</table>

\(^9\) This enrollment period serves as your initial enrollment period for Medicare drug coverage, so you will not face a premium penalty as long as you enroll in a plan within the time limits of your SEP.

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<table>
<thead>
<tr>
<th>Plan or Part D plan at any time to enroll in a SNP if you are eligible. If you have a chronic condition and want to join a chronic care SNP for which you are eligible, you can do so at any time. The SEP ends when you join the private health or drug plan. <strong>Note:</strong> If you have another chronic condition, you get another SEP to join a different SNP that covers this other condition.</th>
<th>a completed application.</th>
</tr>
</thead>
<tbody>
<tr>
<td>You lose eligibility to continue getting coverage through your SNP. (SNPs must continue to cover you for at least one month if you become ineligible and for up to six months if it’s likely that you will re-qualify within six months.)</td>
<td>You can <strong>join</strong> another Medicare Advantage Plan or Part D plan beginning the month you no longer qualify for the SNP and ending either three months after your continued period of enrollment ends or when you enroll in another plan, whichever comes first.</td>
</tr>
<tr>
<td>You’re enrolled in a chronic care SNP, but your provider fails to confirm that you have the chronic condition required for eligibility by the end of the first month of enrollment.</td>
<td>You have an SEP to enroll in a Medicare Advantage Plan or Part D plan. The SEP begins the month the SNP plan notifies you that you don’t qualify and ends two full months after the month of notification or when you enroll in another Medicare Advantage Plan or Part D plan, whichever is earlier.</td>
</tr>
</tbody>
</table>

### 12. You are passively enrolled into a Part D plan or Dual-eligible SNP (D-SNP).

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS auto-enrolls you in a Part D plan after identifying your Extra Help status.</td>
<td>You have three months to <strong>switch</strong> to another plan, beginning after you are notified of the enrollment or after its effective date, whichever is later.</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
<tr>
<td>CMS auto-enrolls you in a new D-SNP after your previous D-SNP ends.</td>
<td>You have three months to <strong>switch</strong> to another plan, beginning after you are</td>
<td>The first day of the month after you submit a completed application.</td>
</tr>
</tbody>
</table>
notified of the enrollment or after its effective date, whichever is later.

### 13. You experience contract violations (such as misleading marketing) or enrollment errors.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Medicare Advantage Plan or Part D plan violated a material provision of your contract such as:</td>
<td>You have one SEP to <strong>switch</strong> to another Medicare Advantage Plan or Part D plan begins once the regional CMS office has determined that a violation has occurred. (If you are in an Medicare Advantage Plan, your SEP allows you to <strong>disenroll</strong> from your plan and either <strong>change</strong> to Original Medicare or join another Medicare Advantage Plan)</td>
<td>The effective date of the new Medicare Advantage Plan or Part D plan will be the first of the month following the month the new private health or drug plan receives the completed application or up to three months after it receives the completed application.</td>
</tr>
<tr>
<td>• Failing to provide you on a timely basis with benefits available under the plan;</td>
<td>You can <strong>switch to</strong> another Medicare Advantage Plan or Part D plan during the last month of enrollment in your current plan. If you do not choose another private health or drug plan immediately, your SEP is extended for 90 days from the time of your disenrollment in the plan.</td>
<td>In some cases, CMS may process a retroactive disenrollment and/or retroactive enrollment in another Medicare Advantage or Part D plan.</td>
</tr>
<tr>
<td>• Failing to provide benefits in accordance with applicable quality standards;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Giving misleading information in the private health or drug plan’s marketing to get you to enroll in the plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A federal employee made a mistake in your enrollment or disenrollment in a Medicare Part D plan.</td>
<td>You have one SEP to <strong>enroll</strong> in and/or <strong>disenroll</strong> from a Medicare Part D plan that begins the month of CMS approval and lasts two additional months.</td>
<td>Depends on the situation.</td>
</tr>
<tr>
<td>CMS sanctions (finds fault with) a Medicare Advantage Plan or Part D plan and you disenroll in connection with that sanction.</td>
<td>The length and start date of your SEP to <strong>join</strong> a new Medicare Advantage Plan or Part D plan depends on the situation.</td>
<td>Depends on the situation.</td>
</tr>
<tr>
<td>CMS determines that your previous drug coverage did not adequately inform you of a loss of creditable coverage or that your drug coverage was not creditable.</td>
<td>You have one SEP to <strong>enroll</strong> in or <strong>disenroll</strong> from a Medicare Part D plan that begins the month of CMS approval and lasts two additional months. (In this case, CMS may waive your premium penalties.)</td>
<td>Depends on the situation.</td>
</tr>
</tbody>
</table>

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### 14. Your Medicare Advantage Plan or Part D plan no longer offers Medicare coverage.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Medicare Advantage Plan or Part D plan doesn’t renew its service. (Your</td>
<td>Your SEP to <strong>switch</strong> to another Medicare Advantage Plan or Part D plan lasts from</td>
<td>• Enrollments made from October 15 through December 31 are effective January 1.</td>
</tr>
<tr>
<td>Medicare Advantage Plan or Part D plan must notify you by October 1 if it won’t offer</td>
<td>December 8 of that year through the last day of February of the next year. (This SEP</td>
<td>• Enrollments made during January are effective February 1.</td>
</tr>
<tr>
<td>Medicare drug or health coverage next year, and it must continue to provide</td>
<td>is in addition to the Fall Open Enrollment period from October 15 through December</td>
<td>• Enrollments made in February are effective March 1.</td>
</tr>
<tr>
<td>coverage through the end of the current calendar year.)</td>
<td>7, when you can switch Medicare health coverage and enroll or disenroll from Part D</td>
<td></td>
</tr>
<tr>
<td></td>
<td>drug coverage.</td>
<td></td>
</tr>
<tr>
<td>Mid-year, your Medicare Advantage Plan or Part D plan closes or changes its contract</td>
<td>Your SEP to <strong>switch</strong> to another Medicare Advantage Plan or Part D plan begins two</td>
<td>You can ask that your new Medicare Advantage Plan or Part D plan coverage start the</td>
</tr>
<tr>
<td>with CMS so that you will be forced to disenroll from the plan. (Your Medicare</td>
<td>months before the proposed closing or changes take place and ends one month after they occur.</td>
<td>month after you get notice and up to two months after your old Medicare Advantage</td>
</tr>
<tr>
<td>Advantage Plan or Part D plan must notify you 60 days before the proposed date of</td>
<td></td>
<td>Plan or Part D plan coverage ends.</td>
</tr>
<tr>
<td>termination or modification.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS terminates your Medicare Advantage Plan’s or Part D plan’s contract because of</td>
<td>Your SEP to <strong>switch</strong> to another Medicare Advantage Plan or Part D plan begins one</td>
<td>You can choose to have your new Medicare Advantage Plan or Part D plan coverage begin up to three months after the month your old coverage ended.</td>
</tr>
<tr>
<td>misconduct or other problems. (Your plan must give you 30 days notice before the</td>
<td>month before the termination occurs and lasts for two months afterward.</td>
<td></td>
</tr>
<tr>
<td>termination date.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMS decides to immediately terminate its contract with your Medicare Advantage Plan</td>
<td>CMS will notify you of the termination and your SEP. The termination may be mid-</td>
<td>Depends on the situation.</td>
</tr>
<tr>
<td>or Part D plan.</td>
<td>month.</td>
<td></td>
</tr>
</tbody>
</table>

### 15. You disenroll from your Medicare Advantage Plan during the Medicare Advantage Open Enrollment Period (MA OEP).

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<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You disenroll from your Medicare Advantage Plan during the Medicare Advantage Open Enrollment Period (January 1 – March 31 of each year).</td>
<td>You have an SEP to enroll in a Medicare stand-alone Part D drug plan when you disenroll from your Medicare Advantage Plan. You can disenroll from your Medicare Advantage Plan by submitting a disenrollment request or by simply enrolling in a stand-alone Part D drug plan. If you disenroll from your Medicare Advantage Plan during the MA OEP, you can either enroll in Original Medicare with a stand-alone Part D plan or switch your Medicare Advantage Plan.</td>
<td>The month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>

16. You qualify for new Part D initial enrollment period when you turn 65.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You qualify for new Part D initial enrollment period to join a stand-alone Medicare Part D drug plan because you are a person with a disability who is turning 65. (Note: If you are already enrolled in a Medicare Part D plan and are paying a late premium penalty, the penalty will end when the enrollment period starts.)</td>
<td>You have an SEP to disenroll from a Medicare Advantage Plan (that does or does not include drug coverage) to join Original Medicare or to enroll in a Medicare Advantage Plan that does not include drug coverage. You may also use your additional IEP to join a stand-alone Part D drug plan. The SEP begins and ends with the additional Part D IEP to join a Medicare Part D plan—usually the seven-month period including three months before you turn 65, the month you turn 65, and the three months after you turn 65.</td>
<td>If you are not already enrolled in a Part D plan, your coverage will usually start the month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>

17. You want to enroll in a five-star Medicare Advantage Plan or Part D plan.

<table>
<thead>
<tr>
<th>You have an SEP if...</th>
<th>Your SEP lasts...</th>
<th>Your coverage begins...</th>
</tr>
</thead>
<tbody>
<tr>
<td>You want to enroll in a Medicare Advantage or Part D plan that has an overall Plan Performance Rating of five stars.</td>
<td>Plan Performance Ratings are released every fall and apply to the following calendar year. Your SEP to join a five-star plan...</td>
<td>• Enrollments December 8 through December 31 are effective January 1.</td>
</tr>
</tbody>
</table>

© 2020 Medicare Rights Center
stars and you’re otherwise eligible to enroll in the plan. (For example, you live in the plan’s service area.) Medicare Advantage or Part D plan starts December 8 of the year before the plan is considered a five-star plan. It lasts through November 30 of the year the plan is considered a five-star plan. You can use this SEP to change plans one time per year.

- Enrollments January 1 through November 30 are effective the month following the month you submit an enrollment request.

### 18. You have been in a consistently low-performing Medicare Advantage or Part D plan.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>You have been in a consistently low-performing plan, meaning that the plan has received an overall Medicare star rating of less than three stars for three consecutive years.</td>
<td>You have an SEP to enroll into a higher quality plan throughout the year. You should receive a notice from CMS in late October, saying that you are in a low-performing plan. You have the remainder of that year, as well as the following year, to switch to a plan rated 3 stars or more. To use this SEP, you must call 1-800-MEDICARE directly. Note: This is separate from the five-star SEP listed above.</td>
<td>The month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>

### 19. Your Medicare Advantage stops contracting with many of its providers.

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Medicare Advantage Plan stops contracting with many providers in its network during the course of the calendar year and CMS determines these terminations are substantial. If the terminations are significant enough, you will have a one-time SEP to enroll in a different Medicare Advantage Plan (with or without Part D coverage) or switch to Original Medicare with or without a stand-alone Part D plan. Your plan will mail you a notice if CMS determines the terminations are substantial.</td>
<td>From the month you get notified of the network change and two additional months after that. You should be notified via mail at least 30 days in advance of the network terminations and of your SEP to switch to a new Medicare Advantage Plan, or to join Original Medicare with a Part D plan. You do not have a guaranteed right to purchase a Medigap via this SEP.</td>
<td>The month following the month you submit an enrollment request to a new plan.</td>
</tr>
</tbody>
</table>

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### 20. You experience an “exceptional circumstance.”

<table>
<thead>
<tr>
<th>You have an SEP if…</th>
<th>Your SEP lasts…</th>
<th>Your coverage begins…</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your circumstances do not fit into any of the other SEP categories, you have the right to ask CMS to grant you an SEP based on your particular exceptional circumstances.(^\text{10})</td>
<td>Depends on the SEP.</td>
<td>Depends upon the circumstances.</td>
</tr>
</tbody>
</table>

\(^{10}\) CMS can also grant “exceptional circumstance” SEPs to groups identified by a common problem or characteristic (for example, members of a particular plan who were all misled about the plan’s offerings). Many of the SEPs mentioned in this chart were created as “exceptional circumstance” SEPs.

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Medicare’s Limited Income NET Program

Medicare’s Limited Income NET provides immediate prescription drug coverage for people with Medicare who are at the pharmacy counter and qualify for Extra Help, but aren’t enrolled in a Medicare Prescription Drug Plan. Medicare’s Limited Income NET Program covers all Part D covered drugs, and there are no network pharmacy restrictions during the time period covered by this program. The person will be charged the reduced copayment based on the level of Extra Help they get.

Medicare’s Limited Income NET Program also covers prescriptions that eligible people filled within the last 30 days. See “Medicare’s Limited Income NET Program for People with Retroactive Medicaid & SSI Eligibility” tip sheet in the “Publications for Partners” section on cms.gov for more details about how Medicare’s Limited Income NET Program works.

How does the pharmacist know if a person is eligible?

If a pharmacy has reasonable assurance that a person is eligible for Medicaid or Extra Help (and they have no other Part D drug coverage), the pharmacy can submit the claim to Medicare’s Limited Income NET Program.
How does the pharmacist know if a person is eligible? (continued)

A pharmacy can confirm if a person qualifies for Extra Help either through an E1 query to Medicare’s online eligibility/enrollment system (TrOOP Facilitator), or with one of these:

- A copy of the person’s Medicaid card that includes his/her name and effective eligibility date
- Documentation that shows Medicaid status, such as a copy of a state document, a printout from the state electronic enrollment file, or a screen print from the state’s Medicaid system
- A copy of one of these Extra Help letters from Social Security:
  - “Notice of Award”
  - “Notice of Change” indicating an award increase
  - “Notice of Planned Action” indicating an award reduction
  - “Notice of Important Information” indicating no change to the person’s award

What if a person’s eligibility can’t be confirmed?

If Medicare’s Limited Income NET Program can’t confirm if a person is eligible for Medicaid or Extra Help through a Medicare system, they’ll send a notice to the person asking for proof of eligibility. Proof of Medicaid or Extra Help eligibility can be faxed to Medicare’s Limited Income NET Program at 1-877-210-5592. A state or county Medicaid staff person can also call Medicare’s Limited Income NET Program on behalf of a person with Medicare at 1-800-783-1307 to verify the person qualifies for Medicaid or Extra Help.

If the person fails to provide proof, then the person (not the pharmacy) will have to pay out-of-pocket for the prescription.

For more information

- To learn more about Medicare’s Limited Income NET Program, call 1-800-783-1307. TTY users should call 711. Someone will be available to take your call from 8 a.m. – 8 p.m. in each U.S. time zone (may be different in Alaska and Hawaii).
- Call 1-800-MEDICARE (1-800-633-4227) to get the phone number for your State Medical Assistance (Medicaid) office. TTY users should call 1-877-486-2048. Or, visit Medicare.gov/contacts.
### Full Low-Income Subsidy (LIS)/Extra Help (2021) - 48 STATES + DC

<table>
<thead>
<tr>
<th>Beneficiary Group</th>
<th>Annual Income Eligibility Requirement</th>
<th>Monthly Income Eligibility Requirement</th>
<th>Asset Eligibility Requirement</th>
<th>Need to apply for LIS?</th>
<th>Monthly Premium</th>
<th>Annual Deductible</th>
<th>Copay/Coinsurance Plan’s Formulary Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Benefits Duals: Institutionalized or receiving Home and Community-based Services</td>
<td>Meet State Medicaid financial eligibility</td>
<td>Meet State Medicaid financial eligibility</td>
<td>Meet State Medicaid financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Full-Benefit Duals: income ≤ 100% FPL</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>Copay: $1.30 generic /$4.00 brand Catastrophic Copay: $0</td>
</tr>
<tr>
<td>Full-Benefit Duals: income &gt; 100% FPL</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>Copay: $3.70 generic /$9.20 brand Catastrophic Copay: $0</td>
</tr>
<tr>
<td>Non-duals: income &lt; 135% FPL AND lower asset levels</td>
<td>Single: $17,388/$17,628* Couple: $23,517/$23,757*</td>
<td>Single: $1,449/$1,469* Couple: $1,960/$1,980*</td>
<td>Single: $7,970 /$9,470** Couple: $11,960/$14,960**</td>
<td>No, if receiving SSI; otherwise, yes</td>
<td>No</td>
<td>No</td>
<td>Copay: $3.70 generic /$9.20 brand Catastrophic Copay: $0</td>
</tr>
</tbody>
</table>

### Partial Low-Income Subsidy (LIS)/Extra Help (2021) - 48 STATES + DC

<table>
<thead>
<tr>
<th>Beneficiary Group</th>
<th>Income Eligibility Requirement</th>
<th>Monthly Income Eligibility Requirement</th>
<th>Asset Eligibility Requirement</th>
<th>Need to apply for LIS?</th>
<th>Monthly Premium</th>
<th>Annual Deductible</th>
<th>Copay/Coinsurance Plan’s Formulary Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non duals with income ≤ 135% FPL AND assets between lower and higher limits</td>
<td>Single: $17,388/$17,628* Couple: $23,517/$23,757*</td>
<td>Single: $1,449/$1,469* Couple: $1,960/$1,980*</td>
<td>Single: between $7,970/$9,470 - $13,290/$14,790** Couple: between $11,960/$14,960 - $26,520/$29,520**</td>
<td>Yes</td>
<td>No</td>
<td>$92</td>
<td>Copay: 15% Catastrophic Copay: $3.70 generic /$9.20 brand</td>
</tr>
<tr>
<td>Non duals with income between 135-150% FPL</td>
<td>Single: $19,320/$19,560* Couple: $26,130/$26,370*</td>
<td>Single: $1,610/$1,630* Couple: $2,178/$2,198*</td>
<td>Single: $13,290/$14,790** Couple: $26,520/$29,520**</td>
<td>Yes</td>
<td>Yes, Sliding scale</td>
<td>$92</td>
<td>Copay: 15% Catastrophic Copay: $3.70 generic /$9.20 brand</td>
</tr>
</tbody>
</table>

* Income amounts reflect threshold without/with the $20 monthly income disregard (annually = $240); income is rounded to the nearest whole dollar.
** Asset limits include amount without/with $1,500/person burial allowance.

Income Levels Source: [https://aspe.hhs.gov/poverty-guidelines](https://aspe.hhs.gov/poverty-guidelines)

Updated January 2021
### Full Low-Income Subsidy (LIS)/Extra Help (2021) - ALASKA

<table>
<thead>
<tr>
<th>Beneficiary Group</th>
<th>Income Eligibility Requirement*</th>
<th>Monthly Income Eligibility Requirement*</th>
<th>Asset Eligibility Requirement**</th>
<th>Need to apply for LIS?</th>
<th>Monthly Premium</th>
<th>Annual Deductible</th>
<th>Copay/Coinsurance Plan’s Formulary Drugs</th>
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<td>Meet State Medicaid financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>None</td>
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<tr>
<td>Full-Benefit Duals: income ≤ 100% FPL</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
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<td>Meet State Medicaid/MSP financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>Copay: $1.30 generic /$4.00 brand</td>
</tr>
<tr>
<td>Full-Benefit Duals: income &gt; 100% FPL</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>Copay: $3.70 generic/$9.20 brand</td>
</tr>
<tr>
<td>Non-duals: income &lt; 135% FPL AND lower asset levels</td>
<td>Single: $21,722/$21,962* Couple: $29,390/$29,630*</td>
<td>Single: $1,810/$1,830* Couple: $2,449/$2,469*</td>
<td>Single: $7,970 /$9,470** Couple: $11,960/$14,960**</td>
<td>No, if receiving SSI; otherwise, yes</td>
<td>No</td>
<td>No</td>
<td>Copay: $3.70 generic/$9.20 brand</td>
</tr>
<tr>
<td>Non duals with income &lt; 135% FPL AND assets between lower and higher limits</td>
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<td>Yes</td>
<td>No</td>
<td>$92</td>
<td>Coinsurance: 15% Catastrophic Copay: $3.70 generic/$9.20 brand</td>
</tr>
<tr>
<td>Non duals with income between 135-150% FPL</td>
<td>Single: $24,135/$24,375* Couple: $32,655/$32,895*</td>
<td>Single: $2,011/$2,031* Couple: $2,721/$2,741*</td>
<td>Single: $13,290/$14,790** Couple: $26,520/$29,520**</td>
<td>Yes Yes, Sliding scale</td>
<td>Yes</td>
<td>$92</td>
<td>Coinsurance: 15% Catastrophic Copay: $3.70 generic/$9.20 brand</td>
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</tbody>
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Updated January 2021
### Full Low-Income Subsidy (LIS)/Extra Help (2021) - HAWAII

<table>
<thead>
<tr>
<th>Beneficiary Group</th>
<th>Income Eligibility Requirement</th>
<th>Monthly Income Eligibility Requirement</th>
<th>Asset Eligibility Requirement</th>
<th>Need to apply for LIS?</th>
<th>Monthly Premium</th>
<th>Annual Deductible</th>
<th>Monthly Income Eligibility Requirement*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Benefits Duals: Institutionalized or receiving Home and Community-based Services</td>
<td>Meet State Medicaid financial eligibility</td>
<td>Meet State Medicaid financial eligibility</td>
<td>Meet State Medicaid financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>None</td>
</tr>
<tr>
<td>Full-Benefit Duals: income ≤ 100% FPL</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>Copay: $1.30 generic /$4.00 brand</td>
</tr>
<tr>
<td>Full-Benefit Duals: income &gt; 100% FPL</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>Meet State Medicaid/MSP financial eligibility</td>
<td>No, receive it automatically</td>
<td>No</td>
<td>No</td>
<td>Copay: $3.70 generic/$9.20 brand</td>
</tr>
<tr>
<td>Non-duals: income ≤ 135% FPL AND lower asset levels</td>
<td>Single: $20,007/$20,247*</td>
<td>Single: $1,667/$1,687*</td>
<td>Single: $7,970 /$9,470**</td>
<td>No, if receiving SSI; otherwise, yes</td>
<td>No</td>
<td>No</td>
<td>Copay: $3.70 generic/$9.20 brand</td>
</tr>
</tbody>
</table>

### Partial Low-Income Subsidy (LIS)/Extra Help (2021) - HAWAII

<table>
<thead>
<tr>
<th>Beneficiary Group</th>
<th>Income Eligibility Requirement</th>
<th>Monthly Income Eligibility Requirement</th>
<th>Asset Eligibility Requirement</th>
<th>Need to apply for LIS?</th>
<th>Monthly Premium</th>
<th>Annual Deductible</th>
<th>Monthly Income Eligibility Requirement*</th>
</tr>
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<tbody>
<tr>
<td>Non-duals with income ≤ 135% FPL AND assets between lower and higher limits</td>
<td>Single: $20,007/$20,247*</td>
<td>Single: $1,667/$1,687*</td>
<td>Single: between $7,970/$9,470 - $13,290/$14,790**</td>
<td>Yes</td>
<td>No</td>
<td>$92</td>
<td>Coinsurance: 15%</td>
</tr>
<tr>
<td>Non-duals with income between 135-150% FPL</td>
<td>Single: $22,230/$22,470*</td>
<td>Single: $1,853/$1,873*</td>
<td>Single: $13,290/$14,790**</td>
<td>Yes</td>
<td>Yes, Sliding scale</td>
<td>$92</td>
<td>Coinsurance: 15%</td>
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Income Levels Source: [https://aspe.hhs.gov/poverty-guidelines](https://aspe.hhs.gov/poverty-guidelines)

Updated January 2021
# CHAPTER SIX

## MEDI-CAL

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</tbody>
</table>
Introduction

This overview of the Medi-Cal program addresses issues relevant to older adults and persons with disabilities. At the end of this chapter is a listing of other sources of information about Medi-Cal, including information about consumer informational fliers and Medi-Cal mental health services.

Also listed at the end of this chapter are the sources of the law governing Medi-Cal, as well as websites with access to Medi-Cal regulations and the All-County Letters issued by the State Department of Health Care Services to the counties.

COVID-19 ALERT: In an effort to ensure people are able to stay on the Medi-Cal program during the COVID-19 crisis, the Department of Health Care Services has instructed counties to delay processing Medi-Cal annual redeterminations and to delay discontinuances and negative actions for Medi-Cal through the end of the Public Health Emergency. This means that recipients should continue to receive Medi-Cal even if their eligibility changes and they are no longer actually eligible. More information is available in MEDIL I-20-25 (https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Documents/I20-25.pdf).

WHAT IS MEDI-CAL?

Medi-Cal is California’s Medicaid program. In short, Medi-Cal = Medicaid. Medi-Cal provides health care coverage to more than 13 million low-income Californians, including low-income children, families, single adults, seniors, and persons with disabilities. More than 2 million persons qualify for Medi-Cal on the basis of age, blindness or disability. Of these, more than 54,000 are in Medi-Cal-funded, facility-based long-term care.

In January 2014, the Medi-Cal program was expanded under the Affordable Care Act to cover low-income individuals ages 19 to 64. Approximately 3.9 million individuals have been newly enrolled in Medi-Cal under the Affordable Care Act. See pg. 7 for more information about expansion Medi-Cal.

Medi-Cal is administered through the California Department of Health Care Services (DHCS) and is overseen by the federal Centers for Medicare and Medicaid Services (CMS). California’s Department of Managed Health Care (DMHC) provides oversight of Medi-Cal when Medi-Cal benefits are delivered through managed care plans.

As a condition of California being reimbursed by the federal government for half or more of the costs of the program, California must follow federal Medicaid rules. However, California has substantial leeway as to how it operates the program, who it covers, and what services it offers. The approved state Medicaid plan sets forth these details. In order to deviate from this plan, state officials must seek a waiver, also known as a “Medicaid waiver.” California’s DHCS currently has several waivers from CMS, including, for example, the Assisted Living Waiver.
MEDI-CAL VS. MEDICARE

Although “Medi-Cal” and “Medicare” sound alike, they are two separate programs. There are at least two fundamental distinctions between Medi-Cal and Medicare:

• Medi-Cal eligibility is based on financial need, but Medicare eligibility is based on the work history of the person or the person’s spouse.

• Because Medi-Cal is designed for persons in financial need, Medi-Cal provides for ongoing long-term care, either in a nursing home or (to a more limited extent) at home. Medicare, by contrast, focuses more on acute or short-term care, and provides more limited coverage for long-term care.

DUAL ELIGIBILITY (MEDICARE & MEDI-CAL)

Some people – termed “dual eligibles” or “medi-medis” - qualify for both Medicare and Medi-Cal. More than 1.4 million individuals are on both Medi-Cal and Medicare. For those persons with dual eligibility, Medi-Cal will pay the premiums, deductibles, and co-payments required by Medicare. The Medi-Cal program also will cover the cost of certain items that the Medicare program doesn’t cover, like long-term stays in a nursing home.

Dual-eligible persons generally have no need for Medicare supplemental insurance (“Medi-gap” insurance) because Medi-Cal covers the gaps. However, purchasing supplemental insurance may sometimes be advantageous if the purchase reduces the person’s countable income down to a level that will qualify the person for zero-share-of-cost Medi-Cal. See pg. 11 of this chapter for more information.

Applications

APPLYING

If a person has automatic eligibility, no application is necessary (those who are automatically eligible are discussed in more detail later in this chapter). Otherwise, an application must be submitted. Applications are processed in the local office of the Department of Public Social Services (DPSS). Applications can also be made through Covered California.

In the case of older persons, applications generally are submitted directly to the local DPSS office. Nursing home residents may receive substantial assistance from the facility’s social worker in completing and filing an application. Also – although this service is generally used more by younger Medi-Cal beneficiaries – an application may be submitted at a hospital or clinic, if a county DPSS eligibility worker is stationed there.

The application for SSI/SSP is also an application for Medi-Cal. If SSI is approved, an individual will automatically be enrolled in Medi-Cal. If SSI is denied because the individual’s income is too high, the applicant can take the SSI denial letter to Medi-Cal within 30 days of the date of the denial, and the SSI application date will become the Medi-Cal application date.
RETROACTIVE ELIGIBILITY

Eligibility for Medi-Cal can be made retroactive for up to three months preceding the month in which the application is filed. Of course, the applicant must have been financially eligible for each month in which retroactive eligibility is requested.

PROCESSING OF APPLICATION

The county must make an eligibility determination within 45 days unless state needs to make a disability determination, in which case the county has up to 90 days to make the determination.

NOTICE OF ACTION

The Medi-Cal program’s decision is mailed in a Notice of Action, which must describe the action taken and the reasons for that action. The Notice of Action will describe how a decision can be appealed.

Usually an appeal is made with the Notice of Action form itself, by writing in the reason for appeal in the space provided and mailing the Notice of Action to the address listed. An applicant or advocate should make a copy of the Notice of Action before mailing it back.

Medi-Cal Eligibility

GENERAL

Financial Eligibility - Financial eligibility for Medi-Cal depends in large part on the requirements of the specific Medi-Cal program, but is always broken up into two categories: income and resources. Traditional Medi-Cal programs have a resource limit and complicated counting rules. Expansion Medi-Cal does not have a resource test.

In order to be financially eligible for traditional Medi-Cal, an unmarried person must have less than $2,000 in available countable resources. For a couple, the resource limit is $3,000. For more information about what property is counted and what property is excluded, see pg. 8.

All free Medi-Cal programs have an income limit as well. The specific limits are discussed in the following sections. For aged and disabled individuals who are over the countable income limit, they may qualify for Medi-Cal with a share of cost. A share of cost is a monthly deductible that a person must meet each month.

Citizenship and Residency - In order to qualify for Medi-Cal, a person generally must be a resident of the United States, or a noncitizen who is lawfully residing here. Emergency Medi-Cal services are available even to those persons whose immigration status does not otherwise allow Medi-Cal coverage. For a summary of eligibility for federal programs for immigrants, see https://www.nilc.org/issues/economic-support/overview-immeligfedprograms/.

The person must also reside in California. No particular duration of time is required; the key is whether the person intends to remain in the state, and eligibility is possible even if the person has just moved into the state. A California nursing home resident automatically is considered to have an intent to remain in the state.
**Age or Disability** - For the purposes of this guide, Medi-Cal eligibility depends on the person being either aged (at least 65 years old) or disabled. A person is considered disabled if she is determined to be unable to work for at least one year, due to a physical, mental, or emotional limitation. Eligibility is established after the Medi-Cal program makes this determination, even if the person at that point has been disabled for only a few weeks or even (theoretically) a few days as long as the disability will continue for at least 12 months or result in death.

More precisely, the Medi-Cal disability standard is the same as that used under the Social Security disability programs. A person automatically meets the disability standard if they:

- are receiving Social Security benefits based on disability,
- are receiving Medicare benefits, or
- have received Social Security disability, SSI, or Medicare benefits within the last 12 months and termination or suspension of those benefits was based on something other than no longer being disabled.

If determined disabled, an individual can be eligible for Medi-Cal in a number of different ways. The most common possibilities are the following: automatic eligibility (e.g., on a linked program such as SSI), through the “Pickle” program, the Aged & Disabled Federal Poverty Level Program, the “Medically Needy” program, or the 250% Working Disabled Program. Each of these is discussed in the following pages.

**AUTOMATIC (CATEGORICAL ELIGIBILITY): SSI**

Some persons are automatically eligible for Medi-Cal based on eligibility for other public benefits programs. These persons are termed “categorically eligible” for Medi-Cal. Medi-Cal does not concern itself with these persons’ income or resources because those issues have been addressed by another program.

Automatic eligibility is granted if a person receives payments from Supplemental Security Income/State Supplementary Payment (SSI/SSP).

This is the basis for automatic eligibility that is most applicable to older Californians and Californians with disabilities. Other grounds for automatic eligibility apply to families and children, and are not discussed in this guide.

**Note** - There is no automatic eligibility for CAPI recipients.

**ELIGIBILITY AS A “PICKLE PERSON”**

If a person formerly received both SSI and Social Security benefits, but a Social Security cost-of-living increase now makes them ineligible for SSI, they will nonetheless remain eligible for Medi-Cal coverage as if they were still SSI-eligible. The key is whether they would have been eligible for SSI “but for” the Social Security cost-of-living increase. It is not required that the SSI termination be caused by the increase.

The term “Pickle” or “Pickle amendment” comes from the name of J. J. Pickle, a congressman from Texas who was responsible for the Pickle amendment which allows a person to maintain Medicaid eligibility.

**Advocacy Tip:** Ask if your client has ever been eligible for SSI and Social Security. If so, see the resource available at: [https://healthlaw.org/resource/2018-screening-for-medicaid-eligibility-under-the-pickle-amendment/](https://healthlaw.org/resource/2018-screening-for-medicaid-eligibility-under-the-pickle-amendment/).
EXAMPLE

Jane received both Social Security retirement benefits and a small amount of SSI benefits. After receiving an inheritance of $60,000, she became ineligible for SSI because she had gone over the $2,000 resource limit. Six years later, her resources had been spent to below $2,000 but, because of Social Security cost-of-living increases, she was not eligible for SSI. If her Social Security benefits had remained the same for those six years, she would have been SSI-eligible. Jane is a Pickle Person and eligible for Medi-Cal with no share of cost deductible.

AGED & DISABLED FEDERAL POVERTY LEVEL PROGRAM (A&D FPL)

Effective December 1, 2020, a senior or a person with a disability is eligible for free Medi-Cal if their countable income is not more than 138% of the federal poverty level. This is a major increase in the income limit for Medi-Cal. In 2021, 138 % FPL is equal to $1,482 for an individual and $2,004. This amount will increase each year.

In determining the countable income, all the SSI rules that relate to countable income apply, PLUS the applicant may deduct any out-of-pocket health plan premium costs. Thus, where countable income is above the free limit, it is recommended that dental or vision insurance be purchased to bring the person's income below the limit so the person can avoid paying a huge share of cost under the Medically Needy Medi-Cal program (discussed below). Dental or vision insurance is often recommended because the costs are typically reasonable and it will not interfere with the Medicare and Medi-Cal insurance.

Most individuals with countable income above the free Medi-Cal limit are only eligible for Medi-Cal with a share of cost through the Medically Needy program.

MEDI-CAL MEDICALLY NEEDY PROGRAM

Under the Medically Needy program, an individual with income above the free income eligibility limit pays a monthly share of cost equal to the amount of their countable income minus $600. For a couple, the share of cost is the couple’s countable income minus $934. These income limits ($600 for a person, $934 for a couple) have not been updated since July 1989.

The formula is as follows:
Countable income (see pg. 10) - income limit ($600/$934) = Medi-Cal Share of Cost (SOC)

EXAMPLE

John has $1,500 per month in countable income. His share of cost is $1,500 - $600 = $900.

Maria and Jose have $2,100 per month in countable income. Their share of cost is $2,100 - $934 = $1,166.

For more details on Share of Cost see pg. 11-12.
MEDI-CAL 250% WORKING DISABLED PROGRAM

The Working Disabled Program allows individuals with disabilities, including those 65 and over, to access Medi-Cal if they receive or have received disability income and work. The work can be minimal and likely should be so it doesn't interfere with the individual's disability benefits. Income counting in the Working Disabled Program is complicated. The individual must have total countable income less than 250% of federal poverty level and unearned nondisability income below the SSI/SSP maximum. Social Security Disability, private or public disability, or retirement that converted from disability benefits are not counted toward income. The regular Medi-Cal resource limits apply. For more information, see pg. 96: https://wclp.org/wp-content/uploads/2019/07/Western_Center_2016_Health_Care_Eligibility_Guide_Full_rev.1.pdf.

EXPANSION MEDI-CAL

Starting in January 2014, Medi-Cal eligibility was expanded as part of the federal Affordable Care Act (ACA).

Prior to the ACA, individuals needed a link to access Medi-Cal, like SSI, disability, or age. Now, low-income individuals without a link are eligible for Medi-Cal. This has particularly helped low-income single adults between ages 19-64. These single adults must have income at or below 138% of the federal poverty level to qualify. Income is measured differently for expanded Medi-Cal: it is based on “Modified Adjusted Gross Income” (MAGI) as reported on federal tax returns. There is no resource limit for expanded Medi-Cal.

The benefits package for expanded Medi-Cal is the same as that of regular Medi-Cal, including the availability of long-term services and supports like In-Home Supportive Services.

Anyone who is 65 or over or who has Medicare, with a small exception, will not be eligible for expanded Medi-Cal, but can still be eligible for the traditional Medi-Cal programs discussed above.

This guide does not address the health insurance exchange, Covered California, or tax credits or subsidies that will be available to help people purchase insurance. For more information about these new programs, go to: www.coveredca.com.

Calculating Countable Resources and Income

COUNTABLE RESOURCES

Almost every Medi-Cal program that covers seniors and people with disabilities has a resource limit. Currently, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources include money, bank accounts, real estate, investments, insurance policies, and other items.

The Medi-Cal program, however, considers many resources unavailable or exempt, and will not count those resources against the applicable resource limit. For example, the value of a house used as the principal residence is considered exempt. An exemption for six months is granted for the proceeds from the sale of a house to be used to purchase another house, or to be used to move to the new house or repair and furnish it.
The Medi-Cal program also considers unavailable the value of household goods, a necessary automobile, term life insurance, burial plots, rings and/or jewelry, and irrevocable burial plans. The cash surrender value of a whole life insurance policy is considered unavailable only if its face value is no more than $1,500. Similarly considered unavailable is a revocable burial plan of not more than $1,500.

Property or equipment used in a business is considered exempt, including a bank account used in connection with the business. Rental property does not qualify as business property. However, if a person lives in a unit and rents out other units in the same building, the whole property is exempt under the home exemption.

Whether pensions and retirement accounts are considered exempt, a countable resource or countable income can be complicated. If held in the name of the beneficiary’s spouse, or if the beneficiary qualifies for Medi-Cal under the 250% Working Disabled Program, work-related pensions and retirement accounts (IRAs, for example) are automatically considered unavailable. When pensions and retirement accounts are owned in the beneficiary’s name, however, they are considered unavailable only if payment actually cannot be made from the pension or retirement account at the present time, or if periodic payments of principal and interest are being made to the beneficiary from the pension or account. If periodic payments are being made, the payments are considered income and accordingly are considered in the calculation of the beneficiary’s countable income.

An annuity may be considered unavailable under certain circumstances. However, resources held in trust for a beneficiary generally will be considered available to the beneficiary. A detailed discussion of these issues is beyond the scope of this manual; contact a knowledgeable attorney for advice.

Is the Home Counted as a Resource When a Person is Living Elsewhere?

In general, a principal residence remains an exempt resource as long as the person intends to return home. This is true even when the individual moves into a nursing home or other long-term institutional care.

**Tip:** It should never be necessary to sell a home used as a principal residence in order to establish eligibility.

In other words, a nursing home resident does not have to sell her home in order to qualify for Medi-Cal. Under virtually all circumstances, the resident’s home is considered an unavailable resource and is not counted against the Medi-Cal resource limitations.

Specifically, a home is an exempt resource simply if the resident intends to return to their home. The Medi-Cal application asks the resident if they intend to return to home; if that question is answered “yes,” the Medi-Cal program will not count the value of the home against the resource limitation, even if the resident medically has no realistic chance of returning to their home.

The relevant question on the Medi-Cal application could be paraphrased as follows: “If the resident were completely healthy, would the resident live in her home?” If the answer to this paraphrased question is “yes,” the answer on the Medi-Cal application should be “yes.” And even if the question originally were answered “no,” the Medi-Cal program has specified that the answer can be changed to “yes” at any time.

In addition, the home is considered an unavailable resource if the resident’s spouse or dependent relative lives in the home. Also, the home is an unavailable resource if the resident’s child or sibling both (1) lives in the home, and (2) began living in the home at least one year before the resident entered the nursing home.
Regardless of the preceding discussion, nursing home residents and their families often are told to sell the resident’s home to pay for nursing home care. This is particularly bad advice: such a sale converts an unavailable resource (the home) into an available resource (cash), which will likely make the resident ineligible for Medi-Cal for an extended time period.

It should be noted that an intent to return to a home does not exempt a home from a Medi-Cal estate recovery claim, following the resident’s death. For obvious reasons, an intent to return home matters only when a Medi-Cal beneficiary is alive. Following the beneficiary’s death, the Medi-Cal program may attempt to obtain repayment from a home’s value before the home is passed on to the heirs of the deceased Medi-Cal beneficiary. Medi-Cal estate claims are discussed in more detail later in this chapter.

**Joint Accounts** - The entire contents of a joint account are presumed to be available to the applicant, unless she clearly can trace all or part of the joint account to income or transfers of the other person listed on the account.

**COUNTABLE INCOME**

There are two categories of income: unearned income (for example, Social Security retirement benefits) and earned income (for example, wages from a job). Since older Medi-Cal beneficiaries are likely retired or disabled, unearned income is more common than earned income.

Almost all unearned income is counted. Only $20 can be disregarded.

In order to encourage employment, the Medi-Cal rules treat earned income more generously. A Medi-Cal beneficiary can disregard $65 plus one-half of the remainder when determining countable income.

Income received from a reverse mortgage is exempt. However, the income remaining as of the first of the next month is counted as a resource.

See Chapter 2 for further discussion of the income counting rules.

**EXAMPLE**

Q. If an applicant has $1,300 of unearned income, how much is countable?
A. $1,280 is countable ($1,300 - $20 = $1,280).

Q. If an applicant has $1,300 of earned income, how much is countable?
A. $618 is countable ($1,300 - $65 = $1,235/2 = $617.50).

**MEDICALLY NEEDED: SHARE OF COST**

Generally - As discussed above, free Medi-Cal is provided to persons who are categorically eligible, who are eligible through the Pickle program, or who are eligible under a no-share-of-cost program, like the Aged and Disabled FPL program and the 250% Working Disabled Program. For the purposes of this guide, other beneficiaries are eligible under the “medically needy” program and are required to pay—or incur an obligation to pay—a monthly share of cost.

The share of cost is the difference between the person’s countable income and the state’s maintenance need allowance. As mentioned previously, the allowance is $600 for an individual and $934 for a married couple.
Note the drastic consequences of having income even slightly above the free Medi-Cal eligibility limit. If a person has a countable monthly income of $1480, they automatically receive free Medi-Cal with no share of cost under the A&D FPL program. If, however, their income increases by just $20, to $1,500 (just $8.00 over the eligibility limit), their monthly share of cost is $700 ($1,500-$600 = $900).

As discussed above, purchasing health insurance, including dental or vision insurance, makes sense if the insurance premium reduces the person’s countable income enough to qualify for the free program, especially when they are close to the free limit.

Individuals who pay out of pocket for in-home care can count those payments toward their Share of Cost.

EXAMPLE

Q. Mr. Zheng has $1,500 in resources. His only income is a monthly pension of $1,460. Is he eligible for Medi-Cal? Does he have a share of cost?

A. Mr. X is eligible because he has less than $2,000 in resources. His countable income is $1,440 ($1,460 - $20). His countable income is below the Aged & Disabled FPL ceiling of $1,482. He does not have a share of cost.

Incurring the Obligation to Pay is Enough for Share of Cost - A share of cost can be met by paying or incurring a debt for health care. It is not necessary that the health care provider be paid at that time, only that the obligation be incurred.

Bunching Health Care Expenses in Same Month - To the extent possible, a Medi-Cal beneficiary with a relatively significant share of cost should try to bunch her health care expenses in the same month.

EXAMPLE

Assume that a beneficiary has a monthly share of cost of $900. Their payment of $250 each month for therapy will never meet the deductible by itself. If, on the other hand, they were to pay $1,000 for four months of therapy at once, they would meet the deductible, and Medi-Cal at that time would pay for other needed health care expenses in the same month.

Share of Cost May Be Met by Payment For Healthcare That Would Not Be Covered By Medi-Cal - For purposes of meeting a share of cost, it is irrelevant whether the health care would be covered by Medi-Cal.

Paying a past-due health care bill is one example of a way to spend the share of cost amount on an expense that would not be covered by Medi-Cal. The past-due bill must have been incurred prior to the month in which the beneficiary became Medi-Cal eligible.

This share-of-cost strategy can be very useful in the not uncommon situation where a Medi-Cal beneficiary has a health care bill that they otherwise would never be able to pay. A Medi-Cal office will know this strategy as the Hunt v. Kizer procedure.

The Tardy Medi-Cal Application - It’s an unfortunately common situation. An older person, has spent their resources down to the brink of Medi-Cal eligibility. If just a bit more of the resources were to be spent on medical expense or other needed expenses, their Medi-Cal application would be approved without a problem.
But the resources were not spent below the Medi-Cal eligibility level, and a Medi-Cal application was not filed in a timely manner. Instead, the older adult struggles to pay for incurred health care expenses because they can’t afford to.

When Medi-Cal finally is approved, after the passage of many months, the older person has Medi-Cal coverage for future health care expenses, but has no way to pay the thousands of dollars of health care expenses that were incurred during the time before their successful Medi-Cal application.

The problem can be moderated somewhat by the availability of three-month retroactive coverage, although retroactivity is only useful if the applicant was eligible during the three months prior to the filing of the application.

The best remedy for this problem is applying the past-due bill towards the person’s monthly share-of-cost obligation, for those persons who have enough income to cover the monthly deductible. Assume for example, that person owes $5,000 for past-due medical expenses, and has a monthly share-of-cost of $500. If the person can pay $500 per month towards the past-due balance (rather than towards the current month expenses), the Medi-Cal program will pay the entirety of the current month’s health care expenses. After ten months, the past-due balance will be paid off, and the person can resume using the $500 towards current monthly expenses.

Financial Eligibility Rules for Nursing Home Residents

ELIGIBILITY FOR UNMARRIED NURSING HOME RESIDENTS

Resource limits for an unmarried nursing home resident is $2,000 and all the rules for determining countable resources are the same as in the community Medi-Cal programs.

As discussed above, the home is not counted if an unmarried nursing home resident states her intent to return to the home.

The income counting rules for long-term care residents who live in the nursing home for more than 30 days are different than the income counting rules in the community Medi-Cal programs explained above. Instead, a resident is allowed to retain $35 per month. This amount is based on the Medi-Cal program’s assumptions that a resident’s basic needs – room and board, plus necessary health care – all are furnished by the nursing home. It means in almost all situations, the resident will have a share of cost.

SSI PAYMENT WHEN RESIDENT HAS NO OTHER INCOME

In rare instances, a resident will have no income. The SSI/SSP program will provide an income of $50 per month (assuming that the resident’s resources are no more than $2,000), and the resident automatically will be eligible for Medi-Cal. If, however, an SSI recipient is expected to be in the nursing home for no more than 90 days and needs the full monthly SSI benefits in order to maintain a home, full SSI benefits may be continued on a temporary basis even if the resident’s stay ends up exceeding 90 days.
EXAMPLE

Q. Mr. Montero is a resident in a nursing home. He is single. The nursing home charges $5,000 each month. Mr. Montero has savings of $1,500 and a monthly income of $700. Is he eligible for Medi-Cal? How much does he pay the nursing home each month? How much will he have to pay monthly if the nursing home is not certified for Medi-Cal?

A. Mr. Montero is eligible because his resources are under the $2,000 limit. His monthly share of cost is $665. ($700 - $35 = $665) If the nursing home is not certified, Medi-Cal will not pay, and he will be liable for the entire $5,000 each month.

MAINTAINING THE HOME WHILE IN NURSING HOME

Because $35 per month is not enough to allow a nursing home resident to keep up with monthly rent or mortgage payments, the Medi-Cal program allows a resident to keep an additional income allocation for home-related expenses if a doctor certifies that the resident will need nursing home care for no more than six months.

However, this allocation is only $209 per month, which is likely not enough to allow a resident to keep up with rent or mortgage obligations.

SPOUSAL IMPOVERISHMENT RULES

Resources - Different financial eligibility rules apply when one member of a married couple or registered domestic partnership requires long-term care or Home and Community-Based Services (HCBS) at a nursing home level. These are known as the spousal impoverishment rules.

Specifically, the Medi-Cal program allows the spouse remaining in the community (“community spouse”) to retain additional resources and income while allowing the spouse who needs long-term care (“institutionalized spouse”) to qualify for Medi-Cal.

In 2021, the resource limit for the community spouse is $130,380, while the institutionalized spouse is allowed to keep up to $2,000 in their own name. Within 90 days after Medi-Cal eligibility of a married recipient is established, the couple must allocate their resources between themselves so that no more than $2,000 in available resources is held in the recipient’s name. Once this allocation is complete, the recipient will remain eligible for Medi-Cal as long as their available resources do not exceed $2,000, regardless of the amount of their spouse’s resources.

It is important to note that these rules apply even if the “institutionalized spouse” still lives in the home and qualifies for HCBS at a nursing home level. These HCBS programs include IHSS –Community First Choice Option program (see Chapter 7 for more information), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and several Medi-Cal waiver programs.

Income - The community spouse is allowed to keep an individual monthly income of at least their individual monthly income or $3,259.50 (2021 limit), whichever is greater. The institutionalized spouse will then have their Medi-Cal eligibility determined based on the remaining income. At that point, the usual Medi-Cal income counting rules for the specific program apply. For example, if the institutionalized spouse actually lives in a nursing home, their countable income will be subtracted from $35 and the rest will be their share of cost. If the institutionalized spouse is living at home then the community Medi-Cal rules will apply.
EXAMPLE

Q. Marcus lives in a nursing home; his wife Evelyn lives in an apartment. The nursing home charges $4,000 per month. Marcus and Evelyn jointly have $80,000 in savings. Marcus receives $1,100 monthly from Social Security; Evelyn receives $900 a month. Is Marcus eligible for Medi-Cal? How much will he have to pay the nursing home each month?

A. Marcus is eligible because the couple’s joint resources ($80,000) are less than the resource maximum of $130,380. However, all but $2,000 will have to be held in Evelyn’s name. Marcus will not have to pay the nursing home anything. Evelyn will keep the $900 in her name and Marcus will be able to allocate his full income of $1,100 to Evelyn. Marcus will have no countable income for Medi-Cal purposes and so will qualify for free Medi-Cal without a share of cost.

Q. What if Evelyn’s monthly income increases to $2,500 per month?

A. Evelyn will keep her $2,500 income, and will be allowed to allocate $759.50 of her husband’s income. This means Marcus will have $340.50 in countable income. His share of cost will be $306 per month. ($340.50 - $35 = $305.50, rounded to $306)

Q. What if Evelyn’s monthly income increases to $3,500 per month?

A. Evelyn is allowed to keep her entire income. The income allocation of $3,259.50 does not limit her income; it just limits the amount of income that Marcus can allocate to her. In this case, Marcus will retain his full $1,100 in income. His share of cost is $1,065 ($1,100 - $35 = $1,065).

INCREASED RESOURCE ALLOCATION FOR GENERATING ADEQUATE INCOME

Under certain circumstances, an at-home spouse can obtain an order from a court or an administrative law judge which will allow the community spouse to retain additional resources. An order may be granted if the community spouse needs the resources in order to generate an adequate income. Specifically, an order can allow the couple to retain more than $130,380 in available resources, if the income which could be generated by the retained resources would not cause the total monthly income available to the community spouse to exceed $3,259.50. This can be an extremely important provision for clients who have low incomes but have managed to save significant amounts of money.

INCREASED INCOME ALLOCATION FOR EMERGENCY SITUATIONS

A court or administrative law judge may increase the spouse’s income allocation above $3,259.50 if the extra income is necessary “due to exceptional circumstances resulting in significant financial duress.” Courts and administrative law judges rarely grant such orders.

GIVING AWAY RESOURCES TO BECOME MEDI-CAL ELIGIBLE

Giving away resources without receiving anything in exchange can affect Medi-Cal eligibility. Sometimes these gifts have nothing to do with Medi-Cal eligibility – an older person just wants to have the pleasure of giving the gift during their lifetime, rather than waiting until after their death, through operation of a will or trust. However, sometimes these gifts are made with Medi-Cal eligibility in mind, such as when an older person who is in a nursing
home or expects to enter a nursing home in the near future, gives away resources in order to create or accelerate Medi-Cal eligibility.

For understandable reasons, the Medi-Cal program does not want nursing home residents to give their resources away and immediately apply for Medi-Cal. As explained below, the Medi-Cal program can assess a period of ineligibility if the transfer was made for the purpose of gaining Medi-Cal eligibility. The length of the period of ineligibility is based on the size of a gift.

It is important to note that the relevant law is complicated; more than this short answer suggests. No one should make an eligibility-accelerating give-away without first consulting with a knowledgeable attorney.

 Generally, transferring or giving away property will only result in ineligibility if: (1) the property being transferred was not exempt; (2) the individual is institutionalized or applying for institutional care; (3) the property was given away in order to establish Medi-Cal eligibility; and (4) the property was transferred to someone other than a spouse or a permanently disabled child.

In general, giving away resources causes the resident to be ineligible for Medi-Cal reimbursement from the month of the give-away for the amount of time those resources could have paid for nursing home care. (For this calculation, the Medi-Cal program assumes nursing home costs of approximately $10,298 per month.) Any transfer of resources for which the resident received adequate compensation is considered a sale, not a give-away, and does not result in Medi-Cal ineligibility.

The lookback period is 30 months. The most important fact is that the period of ineligibility starts in the month in which the give-away was made, even if the Medi-Cal application was not filed until much later.

As shown in the examples on the next page, a period of ineligibility can be essentially irrelevant if it expires before the resident is otherwise eligible for Medi-Cal.

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**EXAMPLES**

Q. Priscilla lives in a nursing home. She has $1,400 in savings, and a monthly income of $1,500. In June 2020, she gave $63,000 as a cash gift to her daughter. Is she eligible for Medi-Cal today? When could she successfully apply for Medi-Cal?

A. Priscilla is eligible today. The money given away ($63,000) would have been enough to pay for six months of nursing home care. The six-month penalty period began in June 2020, and ended December 2020.

Q. Frank also lives in a nursing home. In June 2020 he gave $684,000 to his daughter. When could he successfully apply for Medi-Cal? What would happen if he applied for Medi-Cal today?

A. Frank should not file an application until January 2023. The Medi-Cal program will look back two and a half years, so if an application is filed in January 2023, the look-back will not include June 2020, the month in which the gift was made.
SHARE OF COST IF BENEFICIARY LIVES IN RESIDENTIAL CARE FACILITY FOR THE ELDERLY

A resident’s payment to a Residential Care Facility for the Elderly (RCFE) is taken into account in the calculation of the Medi-Cal monthly “share of cost.”

As discussed above, health care services are provided with no share of cost if a single Medi-Cal beneficiary has a countable monthly income of no more than $1,482 for 2021. RCFE residents with a countable monthly income of more than $1,482 generally will have a Medi-Cal share of cost. If, however, the resident pays out-of-pocket for the RCFE, income above the maintenance need level of $600 paid to the facility is considered unavailable. This can significantly reduce an RCFE resident’s Medi-Cal share of cost.

Medi-Cal is now covering care (but not room and board) in RCFEs in several California counties. This includes services for several hundred Medi-Cal recipients in Los Angeles County who otherwise would require care in a nursing facility. The services are being provided under an HCBS waiver called the Assisted Living Waiver. For contact information for Los Angeles and for the other counties, see https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx.

EXAMPLE

An RCFE resident has a countable monthly income of $1,620. In general, they will have a monthly Medi-Cal share of cost of $1,000 ($1,620-$20 - $600 = $1,000). If, however, the facility costs $1,620 monthly, Medi-Cal will consider all income above $600 unavailable since it is being used to pay the facility. This means that the resident has no available income.

If the facility only charged $1,570 per month, the resident would have a share of cost of $30. Because the resident pays the facility $970 over the $600 maintenance need level, $970 of the resident’s income is considered unavailable – which leaves the resident with $50 available income. After the $20 “any income” deduction, the resident would be left with a $30 share of cost.

Medi-Cal Estate Recovery

MEDI-CAL ESTATE CLAIMS

After a resident’s death, the Medi-Cal program may bill the resident’s estate to repay the Medi-Cal program for benefits paid on behalf of the resident. However, there are significant limits on which beneficiaries and for which services the Department of Health Care Services can seek estate recovery.

The Medi-Cal estate recovery rules changed significantly for those who die on or after January 1, 2017. Generally, Medi-Cal recovery is limited to:

- Those 55 years and older or those who were permanently disabled and living in institutional care;
- For nursing home and home and community-based services and related care;
- Assets subject to California probate law;
- Beneficiaries or heirs who are not a surviving spouse, registered domestic partner, minor child or disabled child.
There are additional exemptions to estate recovery claims and hardship waivers that can be applied for if necessary. For additional information about estate recovery rules, see: CANHR, “The New Medi-Cal Recovery Laws” at http://www.canhr.org/publications/PDFs/Medi-Cal_Recovery.pdf.

Medi-Cal Services

MEDI-CAL MANAGED CARE

Over the last decade, California has been moving most populations eligible for Medi-Cal benefits from fee-for-service into managed care. Today, approximately 10.8 million Medi-Cal beneficiaries residing in 30 counties receive their medical services through health plans mirroring traditional health maintenance organizations (HMOs). The movement of Medi-Cal only beneficiaries into managed care began in 2011. Los Angeles County uses a two-plan model where there is one Local Initiative plan (LA Care) and one commercial plan (HealthNet).

Under Medi-Cal managed care, a beneficiary is enrolled in a plan to receive her Medi-Cal benefits. In Los Angeles, beneficiaries can also choose to enroll in a partner plan. LA Care partners with Anthem Blue Cross, Care1st, and Kaiser. Health Net partners with Molina. The plan is paid a single rate from the State to deliver a beneficiary’s health care services. Plans contract with providers, including doctors, specialists, hospitals, and pharmacies to develop a “network.” Individuals enrolled in a managed care plan will be assigned a primary care physician who is responsible for referring the beneficiary to other care providers. Unlike fee-for-service where a provider obtains approval through the Treatment Authorization Request (TAR) process, under managed care the health plan must approve services.

In Los Angeles County, dual eligibles, those enrolled in Medicare and Medi-Cal, generally have to be enrolled in a Medi-Cal plan for their Medi-Cal benefit. The Medi-Cal managed care plan primarily covers their long-term services and supports as well as services not covered by Medicare (e.g. transportation and supplies). This is because as a dual-eligible, their medical and hospital care is typically covered by Medicare. Medi-Cal is known as the payer of last resort. The Medi-Cal plan is also responsible for paying any co-insurance payable after Medicare has paid. A dual eligible beneficiary’s Medicare provider does not need to be contracted with their Medi-Cal plan in order to provide treatment because Medicare is primary.

FEE-FOR-SERVICE PRIOR APPROVAL

Though rare, some individuals do still access their Medi-Cal through a fee-for-service model. Fee-for-service Medi-Cal requires prior approval for some services and medications. No prior approval is needed for emergency care, most physician services, or for up to six per month of medications on Medi-Cal’s formulary (list of medications).

To obtain prior approval, health care providers submit a Treatment Authorization Request (TAR). If a TAR is denied, the Medi-Cal program should send a Notice of Action to the health care provider and the beneficiary, with an explanation of the denial and information about appeal rights.

Except TARs for medical transportation, the Medi-Cal program will look only at the documents submitted by the provider in support of the TAR. Many TARs are denied because the medical justification is not complete. Before a beneficiary appeals a denied TAR, they should look at the packet submitted to Medi-Cal to see if there was enough information to show that the item was really needed, and that the Medi-Cal medical necessity definition had been
met. The Medi-Cal program covers services, medicines, supplies and devices necessary to protect life, prevent
significant illness or disability, or alleviate severe pain. The standard is much more limited than a commonsense
definition of necessity.

Physician documentation can be essential. For instance, for medications not on the Medi-Cal formulary, the
beneficiary’s physician should write a letter explaining why medications on the formulary are inadequate, and what
could happen if the beneficiary did not receive the medication. The pharmacist then can fax the physician’s letter
together with the TAR form for review by the Medi-Cal program.

Medication TARs that are not acted on by the close of the next business day are automatically approved. Other
TARs are automatically approved if they are not acted on within 30 days of the date of receipt by the Medi-Cal
program.

**Appeals of Denied TARs in Fee-For-Service**

The reality is that TAR denials often are not sent to beneficiaries. The Medi-Cal program will often wrongly treat
TAR-related matters as private correspondence between Medi-Cal and the provider.

Don’t be shy in requesting copies of documents (including TARs and TAR denials) from the health care provider.
Also, of course, don’t be shy in filing appeals of denied TARs. If you were not sent a denial notice, an appeal
probably will be timely even if it is submitted more than 90 days after the denial.

**SERVICES PROVIDED**

The Medi-Cal program covers a wide range of services. These services include the following:

- Doctor visits;
- Hospital inpatient and outpatient care;
- Nursing home care;
- Medications (although Medicare Part D covers medications for many dual eligible beneficiaries);
- Home health care;
- Personal care services, including In-Home Supportive Services;
- Hospice care;
- Physical therapy;
- Hearing aids;
- Ambulance services;
- Medical transportation to and from medical appointments;
- Durable medical equipment, including wheelchairs, suctioning machines, shower chairs, oxygen, ostomy
  supplies, etc.;
- Specialty mental health services including psychiatric services through local Mental Health Plans;
- Drug and alcohol treatment programs;
- Dental benefits fully restored as of January 1, 2018, and
• Non-Medical Transportation: as of July 2017, health plans became responsible for providing transportation to medical services by any mode (e.g. car, bus, train, etc.)

**MEDICAL NEED FOR NURSING HOME CARE**

In contrast to the Medicare program, the Medi-Cal program does not have restrictive medical requirements for the coverage of nursing home care. It is only required that the resident require nursing home care; it is irrelevant whether the nursing home care is considered skilled care or custodial care.

**MEDI-CAL WILL PAY FOR CARE IN A RESIDENTIAL CARE FACILITY FOR THE ELDERLY (RCFE)**

*In Los Angeles County and selected other counties*

Medi-Cal, under a waiver, pays for several hundred slots in Los Angeles County RCFEs. Also, both the Medicare and Medi-Cal programs can pay for certain health care services provided in an RCFE by licensed health care professionals. Generally, these services are provided through an outside agency - a home health agency or, in the case of a terminally-ill resident, a hospice agency. For more information, see [www.dhcs.ca.gov/services/ltc/pages/AssistedLivingWaiver.aspx](http://www.dhcs.ca.gov/services/ltc/pages/AssistedLivingWaiver.aspx).

**COMMUNITY-BASED ADULT SERVICES (CBAS)**

CBAS, formerly known as Adult Day Health Care (ADHC), can be provided to Medi-Cal beneficiaries who have intensive health care needs. Center-based services provided can include medical and nursing services; physical, occupational and speech therapy; psychiatric and psychological services; social services; recreational and social activities; hot meals; nutritional counseling; laundry; bathing; and transportation to and from the center.

Provision of CBAS under Medi-Cal requires a doctor’s authorization and subsequent approval by the Medi-Cal program/plan. Participants must meet the criteria for Nursing Facility-A Level of care, or have certain mental or cognitive impairments, as well as CBAS eligibility and medical necessity criteria.

For more information about the new CBAS program, see [https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/](https://www.aging.ca.gov/Providers_and_Partners/Community-Based_Adult_Services/).

In addition, CBAS participants who are in counties where Medi-Cal managed care is available must enroll in the Medi-Cal managed care plan in order to get CBAS. They can continue to see their Medicare doctor for Medicare services.

**COVID-19 ALERT** - It should be noted that during the COVID pandemic, CBAS services have been converted to an alternative model that offers services outside of the normal congregate setting.

**TRANSPORTATION**

The Medi-Cal program provides emergency transportation as well as transportation to and from routine medical appointments. Payment for non-emergency transportation is only authorized for beneficiaries who are physically or mentally unable to use other forms of private or public transportation.
Prior authorization is not required for emergency transportation to the nearest qualified facility. However, prior authorization is generally required for non-emergency medical transportation.

Since July 2017, the Medi-Cal program pays for Non-Medical Transportation (NMT) to medical services. This includes transportation or reimbursement for transportation by car, bus, train, etc.

MULTIPURPOSE SENIOR SERVICE PROGRAM (MSSP)

The MSSP waiver provides social and health care management for seniors who are certifiable for placement in a nursing home, but who wish to remain in the community. An MSSP client must be 65 years of age or older, live within an MSSP site’s service area, and have health care needs that would qualify them for nursing home admission.

The word “waiver” refers to a waiver of the federal Medicaid law that generally requires that all Medicaid services be available equally across a state. MSSP services are limited; each MSSP site has only a certain number of waiver slots and many maintain waiting lists.

Married individuals or those in a registered domestic partnership who are eligible for MSSP can have spousal impoverishment rules applied to their income and/or assets, if needed to qualify for Medi-Cal. See above for more information.

MSSP waiver services can include:

- Intensive medical case management, including nursing and psychosocial assessments;
- Attendant care and homemaker services;
- Transportation;
- Nutritional supplements and home delivered meals;
- Counseling;
- Durable medical equipment and supplies;
- Adult day care;
- Housing assistance (i.e., replacement of stove or refrigerator) and modifications;
- Money management and assistance with bill paying;
- Protective supervision; and
- Respite care (care in facility, to provide respite to regular caregivers).

OTHER WAIVER PROGRAMS

There are additional waiver programs that can provide services for persons with disabilities and seniors with a very high need for medical or social services These include the Home and Community-Based Alternatives (HCBA) waiver, HCBS-Developmental Disabilities waiver, and the HIV/AIDS waiver.

All waivers that require a nursing home level of care should apply the spousal impoverishment rules described above when determining Medi-Cal eligibility and share of cost.

For more information about the different waivers, see https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx.
GETTING SERVICES FOR PERSONS ELIGIBLE FOR MEDI-CAL AND MEDICARE

For services covered by both Medi-Cal and Medicare, the Medi-Cal program defers to the Medicare program’s more common-sense definition of medical necessity. Usually billings are sent electronically to Medicare and then are sent electronically to Medi-Cal. When a dual eligible is enrolled in a Medi-Cal plan (as is the case now for almost all dual eligibles residing in Los Angeles County), Medicare providers will submit the bill to Medicare and then separately submit the claim to the person’s Medi-Cal plan. Technically, Medi-Cal will supplement the 80% of reasonable cost that Medicare pays (see Chapter 4) up to the amount that Medi-Cal would pay were it the sole payor. Practically however, that amount is usually zero given that Medi-Cal reimbursement rates are generally lower than the Medicare rate.

The one area where different rules apply is with respect to durable medical equipment, especially custom or power wheelchairs. With respect to wheelchairs, the Medicare and Medi-Cal standards are incompatible because of Medicare’s “homebound” rule for home health care (see Chapter 4). Under Medicare, a beneficiary receives the wheelchair that she needs to get around the house. Under Medi-Cal, she receives a wheelchair that allows her also to travel in the community.

If a dually-eligible person needs a power wheelchair or wheelchair with any kind of custom feature, she should get a good assessment from an outpatient rehabilitation facility like Rancho Los Amigos or Northridge Hospital. Their outpatient programs know how to put together a report explaining what the person needs and why. These outpatient programs also will be able to help them find a provider who will accept someone with both Medicare and Medi-Cal.

The person’s physician can prescribe the equipment recommended by the outpatient program. The person then brings the following documents to the durable-medical-equipment-provider: the physician’s letter, the assessment report, and any other medical records – such as a hospital discharge summary describing disability-related limitations. The provider submits a Treatment Authorization Request (TAR) to the Medi-Cal program or a prior authorization to the Medi-Cal plan.

If the authorization is approved, the provider delivers the equipment and then submits billing to the Medicare plan. The Medicare program pays 80% of what it says is the reasonable cost (see Chapter 4), and then sends the claim to the Medi-Cal program, which pays the other 20%. After this, the provider bills the Medi-Cal program separately for the difference between what Medi-Cal would pay were it the sole payor, and what the provider received jointly from Medi-Cal and Medicare in the crossover electronic billing system. This procedure is known as the Charpentier procedure based on a case, Charpentier v. Kizer.

Of course, the most common overlap between Medi-Cal and Medicare involves the payment for medications by Medicare Part D. This topic is covered in detail in Chapter 5.

Appeals

From the date listed on a Notice of Action, an applicant or beneficiary generally has 90 days in which to appeal an adverse action by the county. The applicant or beneficiary should follow the directions on the Notice of Action, but generally a person just needs to fill out the form appeal on the back of the Notice of Action and indicate that they disagree with the decision.
If a Notice of Action is not available, an appeal request should be mailed to Office of the Chief Administrative Law Judge, State Hearings Division, Department of Social Services, 744 “P” Street, Mail Station 9-17-37-95814, Sacramento, California 95814. The applicant or beneficiary should indicate that she is asking for a Medi-Cal fair hearing, and should list her name and Social Security number. Alternatively, an appeal request can be made by calling (800) 952-5253, or faxing an appeal request to (916) 651-5210 or (916) 651-2789.

It is recommended that a faxed request also be mailed. You can also mail a copy to your county office.

**Tip:** When making an appeal by phone (the fastest way to preserve aid paid pending) call: (800) 952-5253, then
- press 1 for English when prompted
- then press 1 for state fair hearing
- then press 1 for hearing info
- then press 3 and hold for a live person (8-12, 1-5 on weekdays except holidays).

**CONTINUATION OF BENEFITS WHILE APPEAL IS PENDING (AID PAID PENDING)**

If an appeal is requested within 10 days of the Notice of Action or before the adverse action takes effect, existing benefits will continue at least until the hearing decision is issued. This is called “aid paid pending.” It is helpful to write “aid paid pending” on the top of the appeals form.

**APPEAL HEARINGS**

Appeals are somewhat informal, and are conducted by an Administrative Law Judge (ALJ), also known as a hearing officer, employed by the state. Although Medi-Cal beneficiaries can represent themselves, representation by an attorney or advocate is often helpful.

**NOTE:** The COVID-19 prohibition on Medi-Cal terminations and negative actions applies to hearing decisions as well. This means even if the ALJ finds that the beneficiary is no longer eligible for Medi-Cal or that they should have a new or higher share of cost, that negative action will not take effect until the end of the Public Health Emergency.

**APPEAL IN MANAGED CARE**

If a Medi-Cal managed care plan denies, reduces, or terminates a service, a beneficiary has appeal rights. Managed care organizations never issue negative actions to Medi-Cal eligibility, however, they can terminate or deny services. A beneficiary must first file an internal appeal with the health plan. If it is denied, the beneficiary can then request a state fair hearing (the same process as in FFS Medi-Cal) or an Independent Medical Review (IMR), or both.

If the appeal is made within 10 days of the Notice of Action reducing or terminating ongoing services, the plan must provide aid paid pending. A request for a fair hearing must be made within 90 days of the Notice of Action from the plan unless there is a good reason that the deadline was missed (e.g., the notice was not received). An IMR must be requested within six months of the plan’s internal appeal decision. A beneficiary cannot get an IMR if she...
has already received a state fair hearing decision. However, a beneficiary can ask for a state fair hearing after an IMR if she does not receive a favorable decision, as long as the request for a fair hearing is still within 90 days of the original decision denying, reducing, or terminating services.

For all other complaints, the beneficiary should file a grievance with the plan.

**Billing the Beneficiary**

**MEDI-CAL MUST BE ACCEPTED AS PAYMENT IN FULL**

A provider can accept Medi-Cal payments only after being certified. A certified provider must accept Medi-Cal as payment in full.

A beneficiary can be asked to pay up to the monthly share of cost (if any) and some nominal co-payments for medications, no more.

**Prohibition Against Balance Billing:** Pursuant to state and federal law, providers cannot bill Medi-Cal beneficiaries, including dual eligibles, for medically covered services. If your client has received a bill, the bill should be disputed. For sample letters and resources on balance billing, Justice in Aging has a toolkit for advocates available at [http://www.justiceinaging.org/balance-billing-toolkit-for-advocates/](http://www.justiceinaging.org/balance-billing-toolkit-for-advocates/).

**COORDINATED CARE INITIATIVE**

The Coordinated Care Initiative (CCI) is a California program that changed the delivery of Medi-Cal, Medicare and long-term services and supports to dual eligibles and Medi-Cal recipients living in seven demonstration counties, including Los Angeles County. The CCI included three changes:

1. Medi-Cal beneficiaries, including dual eligibles, who do not currently receive their Medi-Cal benefit through managed care have to enroll in a Medi-Cal managed care plan to receive their Medi-Cal benefits.

2. Long-Term Supports and Services (LTSS) are added to the Medi-Cal managed care benefit package, including Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) and nursing facility care. However, MSSP is in the process of being carved out of managed care effective January 1, 2022.

3. Dual eligible beneficiaries, those with both Medicare and free Medi-Cal, have the option to enroll in a new health plan called Cal MediConnect that is responsible for both their Medicare and Medi-Cal benefits.

Automatic enrollment into Cal MediConnect began in July 2014 and ended in June 2015. While automatic enrollment ended, dual eligibles can voluntarily enroll in the program at any time. Those dual eligibles enrolled in Cal MediConnect will receive their Medicare, Medi-Cal (including LTSS) and additional benefits including vision, transportation, and care coordination through a Cal MediConnect plan. Care1st, CareMore, Health Net, L.A. Care, and Molina act as Cal MediConnect plans in L.A. County.

Cal MediConnect enrollment is voluntary, but all Medi-Cal beneficiaries including dual eligibles, with few exceptions, must be enrolled in a Medi-Cal plan to receive their Medi-Cal benefits.
The Department of Health Care Services will be winding down the CCI and CMC plans at the end of 2022. Justice in Aging has published an “Advocates’ Guide” to the CCI that describes the CCI in detail available here: http://justiceinaging.org/wp-content/uploads/2017/12/Advocates-Guide-to-Californias-Coordinated-Care-Initiative-Version-6.pdf?eType>EmailBlastContent&xId=474754a8-4d6c-4d56-9b0a-88393485b3ca.

There are also additional resources available at: www.calduals.org/dualsdemoadvocacy.org/california
Supplemental Materials
MEDI-CAL LEGAL RESOURCES

California Statutes

- General - Welfare & Institutions Code §§ 14000- 14685

Website for statutes

- https://leginfo.legislature.ca.gov/faces/codes.xhtml

California Regulations

- General – California Code of Regulations, Title 22, §§ 5000- 5660
- Mental Health – California Code of Regulations, Title 9, §§ 1700- 1850.505
- Drug Treatment Programs – California Code of Regulations, Title 9, §§ 9000- 9444 Website for regulations: www.oal.ca.gov

California Department of Health Care Services Publications

- All-County Letters: https://www.cdss.ca.gov/inforeresources/letters-regulations/letters-and-notices/all-county-letters
- Provider Manuals and Bulletins: https://files.medi-cal.ca.gov/pubsdoco-Manuals_menu.aspx
- Statistics: https://www.dhcs.ca.gov/dataandstats

Federal Information from the Centers for Medicare and Medicaid Services (CMS)

- California's state Medicaid plan and state Medicaid plan amendments: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Title-XXI-SPAs.aspx

OTHER INFORMATION ABOUT THE MEDI-CAL PROGRAM

- www.healthconsumer.org – This is the website for the Health Consumer Alliance, including the Los Angeles County HCA office with Neighborhood Legal Services. Useful information includes a Medi-Cal Manual plus information about Medi-Cal for consumers, including information about different Medi-Cal programs. The Medi-Cal consumer information is in multiple languages. https://healthconsumer.org/your_rights/
- www.disabilityrightsca.org – Disability Rights California has a good handout on the new Mandatory Enrollment of Seniors and Persons with Disabilities in Managed Care: http://www.disabilityrightsca.org/pubs/549501.pdf. DRC also has extensive resources on mental health issues: https://www.disabilityrightsca.org/resources/mental-health
- www.healthlaw.org – The National Health Law Program’s website includes general information about Medi-aid along with information unique to California.
- www.chcf.org/publications/ – Medi-Cal publications start with #170 on this website of the California Health-Care Foundation. The main website links to statistical information about the Medi-Cal program.
• www.disabilitybenefits101.org – This website includes information about benefits for persons with disabilities who are attempting to work.

• www.justiceinaging.org – Justice in Aging is a national legal nonprofit. Its website has extensive resources on Medicaid, Medicare, Social Security, and SSI.

• www.wclp.org – The Western Center on Law & Poverty. Click onto the Health page.

• www.calduals.org - This website includes materials and resources regarding the Coordinated Care Initiative.
# Chapter Seven

**In-Home Supportive Services (IHSS)**

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**Introduction**

**WHAT IS THE IN-HOME SUPPORT SERVICES (IHSS) PROGRAM?**

In-Home Supportive Services (IHSS) is California’s largest in-home care program. The IHSS program helps low-income individuals with disabilities, including older adults, remain safely in their own homes. IHSS does this by paying someone chosen by the individual with a disability to provide the needed help.

IHSS provides help to individuals with disabilities who are age 65 or older, who are blind, or who meet the Social Security definition of disability. The IHSS program is administered locally by county welfare departments— in Los Angeles, the Department of Public Social Services (DPSS). The California Department of Social Services administers the program at the state level.

The supplement to this chapter’s text includes a list of the statutes, regulations, and other materials governing the IHSS program, as well as a list of other sources of information.

**COVID-19 ALERT:** The state made several temporary changes to the IHSS program during the COVID-19 crisis many of which will last to the end of the Public Health Emergency. For an overview of these changes, see Disability Rights California, “COVID-19 – Tips for Getting Help at Home and IHSS Program Changes,” Sept. 16, 2020 at https://www.disabilityrightsca.org/publications/covid-19-coronavirus-tips-for-getting-help-at-home-and-ihss-program-changes. It is also important to check the California Department of Social Services website to see if deadlines for the temporary changes have been changed or extended at https://www.cdss.ca.gov/.

**WHO RECEIVES IHSS?**

As of April 2021, more than 646,000 people receive IHSS services in California. More than 236,000 of those recipients live in Los Angeles County, which is more than 36% of the statewide total.

Statewide, approximately 55% of people receiving IHSS are aged 65 or older and almost 50% speak a language other than English as their primary language. Approximately 33% of IHSS consumers are severely impaired.
The IHSS Programs

IHSS is made up of four different programs. Three of the programs are authorized by the federal Medicaid Act and are partially funded with federal money. The remaining program is very small and is funded entirely through state and local dollars. To the beneficiary, it is all the same program: IHSS.

IHSS - COMMUNITY FIRST CHOICE OPTION (IHSS-CFCO)

More than 47% of IHSS recipients are in IHSS-Community First Choice Option (IHSS-CFCO). This program includes people who need a nursing home level of care. Married individuals or registered domestic partners who qualify for IHSS-CFCO can have the spousal impoverishment rules applied if needed. See Chapter 6 for more information.

MEDI-CAL PERSONAL CARE SERVICES PROGRAM (PCSP)

Most IHSS recipients who do not qualify for IHSS-CFCO are in the Medi-Cal Personal Care Services Program (PCSP). The PCSP is a part of the California’s Medicaid State Plan and does not require a recipient to be at a nursing home level of care. Approximately 49% of recipients are in this program.

IHSS PLUS OPTION (IPO)

The IHSS Plus Option (IPO) is a 1915 state plan option (formerly the IHSS Plus Waiver). It applies to almost all the remaining IHSS recipients. Recipients will be enrolled in the IPO program if they do not qualify for IHSS-CFCO and:

- Are minor children with parents as care providers;
- Hire their spouse as a provider;
- Advance pay cases;
- Need the Restaurant Meal Allowance because they lack cooking facilities.

ORIGINAL OR RESIDUAL IHSS (IHSS-R) PROGRAM

The IHSS-R program is available for the relatively rare cases of individuals who are not eligible under the CFCO, PCSP, or IPO programs. Consumers in IHSS-R are primarily persons with a satisfactory immigration status who are eligible under California law for state-only Medi-Cal, but not Medi-Cal with federal reimbursement. Sometimes people who temporarily lose their Medi-Cal can get IHSS-R. There are very few people in this category.
FINANCIAL ELIGIBILITY

IHSS is a covered Medi-Cal benefit, therefore financial eligibility for IHSS is established through the Medi-Cal determination process. In order to qualify for IHSS, the beneficiary will also have to establish a need for in-home care. IHSS recipients who are on free Medi-Cal, including expansion or MAGI Medi-Cal, have all IHSS hours paid for by the state.

IHSS recipients on share of cost Medi-Cal must meet or incur their share of cost before the state will pay for any medical services, including IHSS. For more information about eligibility for different Medi-Cal programs, see Chapter 6.

Those who meet the Medi-Cal financial eligibility standards, but do not get federally funded Medi-Cal, can receive personal care services through the IHSS-R program (see p. 3)

MEDI-CAL SHARE OF COST

Individuals who do not qualify for free IHSS because their income is too high may be eligible for Medi-Cal with a share of cost (also known as the Aged-Blind-Disabled Medically Needy program or ABD-MN). A “share of cost” is not a premium, it works more like a monthly deductible. A recipient must meet their share of cost before Medi-Cal will pay for IHSS or other medical costs. The amount of the Medi-Cal share of cost is the difference between a recipient’s monthly net countable income and $600 for an individual or $934 for a couple.

IHSS SHARE OF COST

The IHSS-R program has its own share of cost that is different than the Medi-Cal share of cost. It is the difference between income and the applicable SSI/SSP level. Only people on the IHSS-R program pay the IHSS share of cost.

HOW SHARE OF COST WORKS

When the IHSS provider’s time sheet is being entered, the system will check how much of the IHSS recipient’s share of cost is remaining at that time. The provider’s check will be reduced by the amount of the share of cost remaining when the paycheck information is entered into the system. Both the IHSS recipient and the IHSS provider will get a notice about how much the IHSS recipient must pay the worker.

Once an IHSS recipient’s share of cost is met for the month, all remaining covered services will be billed to Medi-Cal. (Example on next page)
EXAMPLE

Jorge receives $1,600 gross a month in Social Security benefits. His countable income thus is $1,580 (including the $20 any-income deduction). His countable income is above the income ceiling under the A&D FPL program which is $1,482 per month in 2021. His share of cost under the ABD-MN program is $980 ($1,580 – $600 = $980).

At the beginning of the month, Jorge spends $365 on wheelchair repairs, which reduces his share of cost to $615. The check his provider is sent for the first half of the month is reduced by $615. This means Jorge owes his provider $615 in wages. It also means he has met his share of cost for the month so any other medical services he may need during the rest of the month will be fully covered.

COUNTY WELFARE DEPARTMENTS & PUBLIC AUTHORITIES

The County Welfare Department and the Public Authority fill different roles. The Welfare Department takes the IHSS application, performs the needs assessment, determines how many hours can be authorized, and inputs information so that the IHSS-providers can be paid. The County Welfare Department does most of the administrative work involved in administering the program.

The Public Authority is an entity governed by the County Board of Supervisors that act as the “employer of record” for IHSS providers for purposes of negotiating wage rates with unions. The Public Authority maintains a registry and does criminal background checks for all potential IHSS providers. It also provides training to providers and sometimes also to recipients, and many act as an ombudsman to address recipient complaints. The Public Authority also provides support to each county’s IHSS advisory committee. The public authority in Los Angeles County is the Personal Assistance Services Council (PASC). Their website is below: http://www.pascla.org/pascla/.

FEDERAL, STATE, AND COUNTY FINANCIAL PARTICIPATION IN THE IHSS PROGRAMS

The federal government through its Medicaid program pays for more than half the costs of services covered under the Medi-Cal program. The remainder is split between the state and the counties. There is a formula to determine how much the counties must pay toward IHSS costs each year. This agreement does not directly affect or reduce a recipient’s services or a provider’s hourly wage or benefits.

For the IHSS Residual program, there is no federal contribution. The State pays 65% and the Counties 35%.

Services Offered

Social workers conduct in-home assessments to determine how many hours of help an IHSS recipient needs in order to stay safely at home. IHSS authorized services may include any of the tasks listed below. Some tasks like assistance using the bathroom or having a meal may involve multiple services depending on the recipient’s individual needs. Examples are below.

State regulations set guideline ranges of time for 12 IHSS tasks that can be authorized per week. The guideline ranges are in 10ths of hours, not minutes. So .58 of an hour is about 35 minutes a week, or five minutes a day. The remaining tasks may have time guidelines without specific ranges or may require allotments based on actual time needed.
The regulations say that more or less time can be authorized based on individual need and circumstances. The guidelines depend partly on functional “ranks.” More information about ranks is below.

In 2017, the Department of Social Services released an All County Information Notice (ACIN) I-82-17 providing important information about how IHSS assessments should be performed. The intent of the ACIN is to clarify the assessment process, including the use of the hourly task guidelines, ranges, and functional rankings for counties. The Department reissued this guidance as ACIN I-97-20 in December 2020.

**Personal Care (in alphabetical order)**

- **Ambulation** - .58 to 3.50 - including moving from place to place within the home, moving or retrieving assistive devices like a walker, cane, wheelchair, assistance from front door to vehicle and from vehicle to medical appointment or alternative resources.

- **Bathing, oral hygiene, and grooming** - .50 to 5.10 - includes cleaning the body, obtaining water and supplies and putting them away, assistance getting into and out of the tub/shower, applying lotion, powder, deodorant, and washing/drying hands. Time to get to and from the bathroom is covered under ambulation.

- **Bowel and bladder care** - .58 to 8.00 - Assistance with getting on and off commode/toilet, diapers and associated cleaning, help with urinals and bed pans, cleaning and emptying ostomy, enema and/or catheter receptacles, cleaning provider’s and recipient’s hands. (Help getting to and from the bathroom is covered under ambulation; to and from commode in same room covered under transfer; enemas, catheters, suppositories, digital stimulation, colostomy and similar tasks are covered under paramedical even though the emptying and cleaning part is covered under personal care.)

- **Care of and assistance with prosthetic devices** (brace, hearing aid, glasses, brace) and **assistance with self-administration of medications** -.47 to 1.12- includes reminders to take prescribed and over-the-counter medications, setting up medi-sets. The Department takes the position that help with assistive animals are not covered here or anywhere else.

- **Dressing and undressing** - .56 to 3.50, putting on/taking off, fastening/unfastening, buttoning/unbuttoning, zipping/unzipping, and tying/untieing of garments and undergarments; changing soiled clothing.

- **Feeding** - .70 to 9.33 – includes assistance with putting on devices to enable the person to feed himself; assistance with between meal snacks and fluids. Also includes washing/drying hands before and after meals. Cutting up or pureeing food is covered under meal preparation.

- **Respiration** – No guideline range. - Assistance with self-administration of oxygen, cleaning IPPB machines, help in blowing nose. Other services related to respiration are covered under paramedical.

- **Repositioning and rubbing skin** - .75 to 2.80 – repositioning includes turning in bed, repositioning in bed, chair, wheelchair; rubbing skin to promote circulation and/or prevent skin breakdown; range of motion exercises and other exercises to maintain function. Home therapy provided pursuant to a prescription by a health care professional would be covered under “paramedical.” Care for pressure sores (decubiti) is covered under paramedical services. Setting up and monitoring equipment for ultraviolet treatment of pressure sores is covered under “assistance with prosthetic devices.”

- **Routine bed baths** - .50 to 3.50 – includes applying lotion, powder, deodorants and provider washing/drying hands before and afterwards.
• **Routine menstrual care** – .28 to .80 – includes external application and removal of sanitary napkins, managing clothing, wiping and cleaning and washing/drying hands. Time under this category is not allowed if the recipient wears diapers.

• **Transfer** - .50 to 3.50 – including help going from standing, sitting, prone to another position or to or from bed, chair/stairglide/walker, couch, etc., in the same room. Help on or off commode is covered under “bowel and bladder.”

**Paramedical Services** - This includes administration of medication, puncturing the skin, inserting a medical device into a body orifice, activities requiring sterile procedures and other activities requiring judgment based on training given by a licensed health care professional.

Unlike all other IHSS services, paramedical services can be provided only with an order from a licensed health care professional. The order must include a signed statement of informed consent from the beneficiary. See CDSS form SOC 321—Request for Order and Consent-Paramedical Services at [https://cdss.ca.gov/cdssweb/entres/forms/english/soc321.pdf](https://cdss.ca.gov/cdssweb/entres/forms/english/soc321.pdf).

The following is a non-exhaustive list of paramedical services available through IHSS:

• Administration of medications;
• G-Tube feedings;
• Catheter changes;
• Suctioning through a tracheotomy;
• Injections;
• Breathing or nebulizer treatments;
• Implementation of a home therapy program when there is a prescription;
• Assessing skin for indications of possible skin breakdown or level of oxygenation;
• Wound care

**Domestic Services** - 6.0 hours per month per household, includes cleaning floors, bathrooms, kitchen counters and sinks, stove and oven; cleaning and defrosting refrigerator; dusting and picking up; bringing in wood or other cooking/heating fuel; changing bed linens; miscellaneous including changing light bulbs, wheelchair cleaning, changing and recharging wheelchair batteries.

“Heavy cleaning” is a separate service that may be authorized to get the home ready before ongoing domestic services begin.

**Related Services**

• **Meal preparation** - 3.02 to 7.00 hours per week – includes menu planning, setting the table, serving the meal, pureeing or cutting up food as needed.

• **Meal cleanup** - 1.17 to 3.5 hours per week – includes cleaning, drying and putting away dishes, utensils, pots and pans, putting away leftovers, wiping up tables, counters, stove/oven, sink and, when spills, floor and chair. Does not include general cleaning out of the refrigerator, stove/oven, counters, sink which is covered under “domestic services.” Restaurant meal allowance available in lieu of time authorized for meal preparation and cleanup services.
• **Laundry services** - 1.0 hours per week per household if laundry facilities in the home; 1.5 hours per week per household if out of the home – includes mending, ironing, folding and storing clothing and bedding. Additional time may be provided especially if consumer is incontinent.

• **Food shopping** - 1.0 hour per week per household – and other shopping/errands – .5 hours per week per household. Includes making grocery or shopping list, putting away food purchases, picking up prescriptions, and buying clothing.

**Other Services**

• **Protective supervision** - observing the behavior of a beneficiary who cannot safely be left alone and intervening to prevent injury. See below for more information on protective supervision.

• **Teaching and demonstration** - teaching a recipient to perform a service or services that she currently receives from IHSS. Teaching and demonstration are authorized for no more than three months, and only when the teaching and demonstration will likely reduce the recipient’s need for IHSS-funded services within that time period.

• **Accompaniment to medical appointments and alternative resource sites** - includes accompaniment to and from appointments with doctors and other health practitioners, or to alternate resource sites. Wait time is compensable if the appointment is of unknown duration and the provider cannot use that time for his own purposes.

**MAXIMUM HOURS AND SEVERELY IMPAIRED**

Under the Personal Care Services (PSCP) and the Community First Choice Option (CFCO) programs, a beneficiary may receive up to 283 hours per month. Under the Residual Program and the IPO program, a beneficiary is entitled only to a maximum of 195 hours of service per month unless she qualifies as “severely impaired.” If severely impaired, she may be authorized up to 283 hours of services per month. Severely impaired individuals are eligible for advance pay.

A person is severely impaired if she needs 20 or more service hours per week in one or more of these categories: non-medical personal care, paramedical services, meal preparation, and, if the person requires assistance with eating, and meal cleanup. You would count against the 20 hours service needs met outside the IHSS program, such as personal care needs met at an adult day health care program or volunteer care through a caregivers respite program.

In addition to their IHSS hours, individuals who qualify for services under the Medi-Cal Home and Community-Based Alternatives waiver (formerly the Nursing Facility/Acute Care waiver) may opt for additional personal care services as waiver personal care services instead of nursing services. Participation in this program requires that the individual qualify medically for placement in a nursing facility or hospital.

Waiver personal care services can fill in the gaps between the time authorized for specific tasks so that IHSS recipients can receive services for blocks of time.

**PROTECTIVE SUPERVISION**

Protective Supervision is a type of service covered by IHSS, which consists of observing people who cannot safely be left alone and intervening to prevent injury. It is only available for people with severe mental impairments who have poor judgement, orientation, or memory. Such impairments may be caused by any kind of mental impairment including developmental disabilities, Alzheimer’s and dementia, or psychiatric disabilities.
A person who qualifies for protective supervision must be supervised 24 hours per day. Since the maximum IHSS available is much less than that, someone who needs protective supervision will need to show that other resources are available to provide constant supervision (e.g., additional waiver services, family or friend volunteers, or other community programs).

Protective supervision, unlike other covered services, is authorized for blocks of time. The amount of the time authorized is based on whether the IHSS recipient is classified as severely impaired or non-severely impaired. If severely impaired, up to a maximum of 283 hours for protective supervision and all other services would be authorized. If non-severely impaired, 195 hours or more a month is allowable. (Example on next page)

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**EXAMPLE**

Marco has been assessed as needing protective supervision and has been authorized 70 hours a month for other services.

If Marco is classified as nonseverely impaired and is receiving services under PCSP, he will be authorized 265 hours a month (195 + 70).

If Marco is classified as nonseverely impaired and is receiving services under the IPO or Residual Program, he would be authorized 195 hours a month (195 maximum – 70 = 125 protective supervision hours).

If Marco is classified as severely impaired under any of the IHSS programs, he would be authorized 283 hours a month (283 maximum – 70 = 213 protective supervision hours).

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**BUDGET CUT TO HOURS**

In previous years, budget cuts have resulted in across-the-board reductions to needed IHSS hours. However, beginning July 1, 2015, the 7% across-the-board cut to IHSS hours was fully restored. The restoration continued in 2020 and 2021. The Governor’s May Revision Budget for FY 2021-22 proposes to permanently restore these cuts.

The seven-percent cut resolved a lawsuit against the state, which stopped a bigger 20% cut. For more information about the current status of IHSS budget cuts, go to [http://www.disabilityrightsca.org/](http://www.disabilityrightsca.org/).

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**Eligibility**

**PLACE OF RESIDENCE**

In order to be eligible for IHSS, an individual must reside in his or her own home. A broad category of residences can qualify as someone’s home, including: a house, an apartment, a hotel or motel, a single-room occupancy (SRO) hotel, or a mobile home. In the past, there have been a few cases in which homeless persons were found eligible for IHSS. However, recent guidance instructs counties that while temporary housing, like a shelter, will be considered someone’s “own home,” IHSS will not be approved unless the applicant has an address where services can be administered.

IHSS services are not available to individuals residing in an institutional setting like a nursing home or residential care facility for the elderly (see Chapter 8), or to someone receiving SSI at the Board and Care Rate (see Chapter 2).
Seniors and persons with disabilities can receive the Board and Care rate instead of IHSS if they live with a family member.

The exclusion of facility residents and board-and-care rate SSI beneficiaries is a blanket exclusion. This means that even if someone is not receiving the same services in the institutional setting as they were receiving through IHSS, they may not use their IHSS hours.

**TEMPORARY ABSENCE FROM STATE**

An absence from California for 30 days or more may affect a recipient’s eligibility. A beneficiary planning to leave the state for 30 days or more must notify the county IHSS office. In some cases, eligibility may be extended until the individual returns to California, or payment may be made during the absence when, for instance, the recipient is going out of state for medical treatment.

### Applying

**INITIAL STEPS**

1. The applicant calls the county welfare department for IHSS applications. In Los Angeles County, an applicant should call the Department of Public Social Services (DPSS) at (888) 944-IHSS (4477), or (213) 744-4477.

2. If the applicant is not currently enrolled in Medi-Cal, the applicant will be referred to the Medi-Cal unit to start an application to determine eligibility for the Medi-Cal program.

3. There is no financial screening unless the person is found ineligible for the federally funded Medi-Cal program and then is screened for eligibility under the IHSS-Residual program using SSI rules. There are now very few people in this program.

4. A county social worker comes to the applicant’s home to determine their need for IHSS services. It is important that the applicant be prepared for that assessment or the applicant may not be authorized the hours needed. During COVID some assessments were performed virtually so a social worker did not have to enter an applicant’s home.

5. The social worker determines the type of IHSS services the applicant needs, and the amount of time it will take to provide those services through a needs assessment. The social worker will use functional rankings and hourly task guidelines when determining services and hours. If it appears the applicant will be approved, the social worker will explain how the program works, how to sign up a provider, how a provider gets paid, including information about timesheets. If the applicant will need paramedical services, the worker will take the physician’s contact information and send a form to the physician to fill out and authorize paramedical services. The physician will indicate the authorized time for each paramedical service.

6. The recipient is also required to provide a completed and signed Health Care Certification form (SOC 873) to the social worker before IHSS-funded services can be authorized. If the applicant is seeking the authorization of time for paramedical services or protective supervision services, additional forms may be sent to the doctor.
or other health care professional. We recommend that applicants be proactive and get their doctors and health care professionals to fill in the forms ahead of time.

7. At the end of the application process, the applicant receives a Notice of Action (NOA), a letter telling them whether they are eligible for services, and if not, why services were not approved.

A sample NOA is attached in the supplemental materials. The NOA contains a list of all IHSS services. If a particular service has been authorized, the amount of time authorized will be listed next to the service. All services are authorized per week, except Domestic Services, which are authorized per month. In an approval NOA, the applicant is told what services have been approved, and for how many hours per month.

In a denial NOA, the applicant is told why she was not eligible for services. After an individual is approved for IHSS, she will receive information about various responsibilities, including the responsibility to hire workers, turn in time sheets and how to comply with the Federal Labor Standard Act (FLSA) including overtime rules. If a recipient or applicant disagrees with her assessment, she may appeal the decision. See page 20 for more information on Appeals.

**MEDICAL CERTIFICATION REQUIREMENT**

IHSS recipients submit a certification form from a medical professional that IHSS is needed and that he or she would otherwise be at risk of out-of-home placement. The form is SOC 873 - Health Care Certification form and can be found here: [https://www.cdss.ca.gov/cdssweb/entres/forms/english/soc873.pdf](https://www.cdss.ca.gov/cdssweb/entres/forms/english/soc873.pdf).

**SCOPE OF ASSESSMENT**

An applicant is evaluated for needs related to the following functions:

- Housework;
- Laundry;
- Errands;
- Meal Preparation and Cleanup;
- Mobility;
- Bathing and Hygiene;
- Dressing;
- Toileting;
- Repositioning;
- Eating;
- Respiration;
- Memory;
- Orientation; and
- Judgement
FUNCTIONAL RANKINGS

For most of the functions listed above, the applicant is given a ranking from 1 (high functioning) to 5 (low functioning), as explained below:

**Rank 1: The applicant does not need assistance.** The applicant may experience difficulty in performing the function, but her safety is not at risk.

IHSS services will not be authorized for any function for which the applicant has been assessed in Rank 1.

**Rank 2:** The applicant is able to perform the function, but needs verbal assistance such as reminding, guidance, or encouragement.

**Rank 3:** The applicant can perform the function with some human assistance, including, but not limited to, direct physical assistance from an IHSS provider.

**Rank 4:** The applicant can perform a function only with substantial human assistance.

**Rank 5:** The applicant cannot perform the function, with or without human assistance.

The respiration function can be assessed only at Rank 1 (independent) or Rank 5 (completely dependent). The memory, orientation and judgment functions can only be assessed at Rank 1 (independent), Rank 2 (needs verbal assistance), or Rank 5 (completely dependent). Rankings may affect the hours a consumer receives.


ASSESSMENT AND SHARED LIVING ARRANGEMENTS

A shared living arrangement may affect the number of service hours that are deemed necessary. If a recipient has a housemate(s), the following services may be pro-rated:

**Domestic Services and Heavy Cleaning** - The living area is divided into areas used solely by the recipient, areas used in common with others, and areas not used by the recipient.

No need is assessed for areas not used by the recipient. The need for services in common living areas is prorated among all housemates. For areas used solely by the recipient, the assessment is based on the recipient’s individual need and should not be prorated.

**Yard Hazard Abatement** - If a recipient has a housemate, the IHSS program generally will not pay for yard hazard abatement, based on the expectation that a housemate could perform the necessary work.

**Exception to Pro Rata Assessments Among Housemates** - The pro rata assessments above do not apply when the living space is shared with a spouse who is able to perform functions, or with a live-in provider. Different rules apply to an able and available spouse. Also, those pro rata assessments do not apply if the landlord is obligated to provide services, or the IHSS recipient moved into a relative’s home for the primary purpose of receiving services.
UPDATE: Effective July 1, 2020, Protective Supervision will NO longer be prorated. This is an important change that will substantially increase hours for some recipients. For more information, see ACL 20-111 at https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2020/20-111.pdf and Disability Rights California’s fact sheet at: https://www.disabilityrightsca.org/publications/new-rules-for-ihss-elimination-of-proration-of-protective-supervision-services.

REASSESSMENT BASED ON A CHANGE OF CIRCUMSTANCES

A reassessment may be requested by the recipient, family member, service provider, or Regional Center (for Regional Center clients) when there is a change of circumstances. A recipient can request extra hours even for a short period – such as the extra help needed upon a return home from a hospital stay. The IHSS program also can order a reassessment, upon receiving information of a change in the recipient’s condition. A doctor’s note is not needed to get a reassessment.

Once a reassessment is completed, the recipient will receive a Notice of Action that details the new services and number of hours to be received, and the difference from what was previously authorized.

In order for a county to reduce hours, it must show that the reduction is justified by either changed circumstances, (i.e., laundry facilities now in the home) or medical improvement.

WHEN THE RECIPIENT IS IN A HOSPITAL OR NURSING FACILITY

While a recipient is out of the home in a hospital or nursing facility, their IHSS worker cannot be paid. The recipient must ensure that time for those days is not included on timesheets. However, some time can be claimed for the day the recipient goes into the facility and the day they come home.

Counties will be checking the Medi-Cal computer to see if IHSS hours were claimed for any day the recipient was in the facility.

One exception to the general rules exists, specifically, workers paid for supplemental personal care services under a Medi-Cal waiver can be paid for two weeks while a recipient is in the hospital or nursing facility.

MOVING FROM ONE COUNTY TO ANOTHER

When an IHSS recipient moves from one county to another, the county IHSS office of origin is responsible for the transfer of the case to the new county. There should be no interruption in services or funding. However, the new county has the right to reassess the newly arrived IHSS recipient. If the recipient disagrees with the new county’s assessment and timely appeals, then the recipient is entitled to continue benefits at the old level until a decision is issued. In a hearing, the new county has the burden of justifying a reduction.

Providers

An IHSS recipient may choose their provider. A provider may be a friend, family member, spouse or someone with no previous connection to the recipient. The recipient is the employer, and thus is responsible for hiring, firing, and supervising.
SPOUSE PROVIDERS

A spouse may be a paid IHSS provider. The more limited scope of services that can be provided by a spouse provider and “able and available” issues are discussed on page 16 of the “IHSS Fair Hearing and Self-Assessment Packet,” which can be found at www.disabilityrightsca.org/pubs/501301.pdf.

IHSS wages received by a spouse – unlike other earnings – do not affect the SSI/SSP grant or the Medi-Cal eligibility of the spouse receiving the services. Earnings under the federally funded IHSS programs are exempt for all Medi-Cal purposes. That exemption extends to earnings of a parent for an IHSS recipient child who is 18, 19 or 20. However, they count as income to the provider spouse under the IHSS-R program.

PROVIDER REQUIREMENTS

• A Provider Must Fill-Out an Enrollment Form (SOC 426) and Return it to the County Office.
  - The provider must bring 1) an ORIGINAL unexpired identification document issued by the state or federal government (e.g. driver’s license, passport, green card, military ID, etc.), and an ORIGINAL Social Security card (if unavailable, a letter from Social Security that includes the Social Security number may be allowed). Social Security numbers will be verified by IHSS. During the COVID-19 Public Health Emergency, anyone interested in becoming an IHSS provider should check the county welfare department website to see what alternative procedure exist to lessen in-person requirements. In Los Angeles county, additional information can be found here: https://dpss.lacounty.gov/en/senior-and-disabled/ihss/providers.html.
  - Any time any of the information provided in the SOC 426 form changes, the provider must tell IHSS within ten days.

  **Tip:** For information about how to replace a lost Social Security card for free, contact your local Social Security office. More information is at: www.ssa.gov/ssnumber.

  - Providers must sign a sworn statement that they are eligible to be IHSS providers and have not been convicted for certain crimes (like fraud against a government healthcare or supportive services program, child abuse, or elder abuse). The current form is at: https://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC426.pdf.

  **Tip:** Some forms only have space for a street address, but IHSS providers can get their paychecks sent to a Post Office box. They must ask permission from the county.

  A client or provider who is limited English proficient can always ask the county for language assistance.

• A Provider Must Get Fingerprinted and Pay for a Background Check.
  - IHSS providers have to provide their Social Security number and submit to a background check that will check for past criminal history. An IHSS provider cannot do IHSS work if they were
convicted or in prison for a crime involving child abuse, elder abuse or fraud against a government health care or supportive services program in the last 10 years. Additional crimes may prevent employment as an IHSS provider unless a waiver is granted.

- IHSS providers have to pay a fee for the background check. This costs about $35 – 70. The IHSS recipient does not have to pay for the background check.

**Tip:** Complete a background check as soon as possible to allow time for processing. Check with your county office for a list of best places to get fingerprinted.

If the background check shows information that is wrong, a provider can appeal within 60 days. If they cannot afford the appeal fee, they may ask that it be waived. Contact the county for the form or contact your local legal aid office for assistance.

- **A Provider is Required to Attend Orientation.**
  - Every new provider has to attend an orientation that explains IHSS rules. To find out more about IHSS provider orientation go to: [https://dpss.lacounty.gov/en/senior-and-disabled/ihss/providers.html](https://dpss.lacounty.gov/en/senior-and-disabled/ihss/providers.html). The county is currently offering online orientations because of the COVID-19 Public Health Emergency.

- **A Provider Must Sign New Provider Enrollment Agreement (SOC 846).**
  - All providers must sign and turn in a form saying they have undergone the orientation and that they understand and agree to the rules and requirement for IHSS. See: [www.cdss.ca.gov/cdssweb/entres/forms/English/SOC846.pdf](http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC846.pdf).

**PAYMENTS TO PROVIDERS**

An IHSS provider is paid in one of the following ways:

- Almost all providers are paid by the State directly through submission of a provider and recipient-signed timesheet either through the online portal, known as the Electronic Timesheet System (ETS) or through the Telephone Timesheet System (TTS). Payment for work done from the 1st to the 15th will be paid by the 25th. Payment for work performed from the 16th to the end of the month is paid by the 10th of the following month. To register for ETS, providers can sign up through the CDSS IHSS Electronic Services portal at [https://www.etimesheets.ihss.ca.gov/login](https://www.etimesheets.ihss.ca.gov/login). For more information about ETS and TTS, providers and consumers can go to [https://www.cdss.ca.gov/inforesources/esphelp](https://www.cdss.ca.gov/inforesources/esphelp).

- A small number of providers are paid directly by their recipient through a payment option known as Advance Pay. The recipient receives advance payment from the State which can be direct deposited into the recipient’s bank account. The recipient then pays the provider directly from those funds. The provider still must fill out and sign timesheets showing the days and hours they worked and verifying that they were paid. The time sheets need to be submitted timely or advance payment will be stopped. Only recipients who are considered severely impaired and able to manage their own finances and legal affairs qualify for Advance Pay. For more information about Advance Pay, see: [https://www.cdss.ca.gov/agedblinndisabled/res/Advance_Pay_Handout.pdf](https://www.cdss.ca.gov/agedblinndisabled/res/Advance_Pay_Handout.pdf).
• By an agency which has a contract with the county; or
• By the county, if the provider is a county employee.

The State withholds FICA (employee Social Security contribution) and SDI (state disability insurance). IHSS providers are covered by Worker’s Compensation Insurance and unemployment insurance.

If the IHSS recipient qualifies for services with a share of cost, at the time the first check of the month is issued, the State will determine the amount of the remaining share of cost. The provider’s pay will be reduced by the amount of the remaining share of cost. Both the IHSS provider and the IHSS recipient will receive a notice saying how much the recipient owes in wages to the provider.

The rate of pay in Los Angeles County is $15.00 per hour. If a provider works more than 80 hours per month, they are also eligible for health care benefits.

If a provider signs up to be an emergency back-up provider, they will receive $18.00 per hour.

OVERTIME RULES

On February 1, 2016, new federal and state rules took effect which require that IHSS providers be paid overtime if they work more than 40 hours in a workweek. The new rules also allow a provider who works for more than one consumer on the same day to get paid for up to 7 hours per week of travel time. A provider can also be paid while waiting for a recipient at medical appointments under certain conditions.

There are very specific rules governing how overtime and related provisions are implemented in the IHSS program. The State has established a workweek that starts at 12:00 am on Sunday and ends the following Saturday at 11:59 to determine when a provider has earned overtime. All hours in excess of 40 in a workweek are paid at time and a half.

Overtime is not unlimited. Currently, overtime is limited to 66 hours per workweek for providers who care for multiple recipients and 70.75 hours per week for providers who care for one recipient. In 2017, two statutory exemptions to overtime were codified allowing eligible providers to work up to 360 hours per month. For more information about overtime rules, violations, and exemptions, see Disability Rights California’s materials, “New Rules for IHSS: Overtime and Related Changes,” https://www.disabilityrightsca.org/system/files/file-attachments/558601_1.pdf and “Recent Changes to In-Home Supportive Services (IHSS) and Waiver Personal Care Services (WPCS) Workweek Exemptions for Providers” at https://www.disabilityrightsca.org/publications/recent-changes-to-in-home-supportive-services-ihss-and-waiver-personal-care-services.

ADVANCE PAY

Advance pay is an option under the IHSS-CFCO, the IPO and IHSS-R programs. Advance pay allows recipients to receive an advanced payment for their monthly IHSS services and pay their enrolled provider directly. The consumer must be severely impaired and capable of handling their financial and legal affairs or have an authorized representative who can.

The IHSS program may stop advance payment if the recipient has misused IHSS funds, has not paid providers timely, or has not submitted timesheets in a timely fashion. For more information, see https://www.cdss.ca.gov/agedblinddisabled/res/Advance_Pay_Handout.pdf.
Appeals

NOTICE OF ACTION

If the IHSS program intends to deny or change approved services or hours, the County must first send the recipient a Notice of Action (NOA), at least ten days prior to the intended action.

The Notice of Action must include the specific regulations allegedly supporting the action, an explanation of the right to appeal, and (if applicable) the circumstances under which benefits will be continued pending a hearing. It is not unusual for a recipient to receive an inadequate notice of action which does not give a clear reason for a denial or reduction.

Tip: The ten days does not include the date of the mailing or the date the action is to take effect.

APPEAL DEADLINES

If a recipient's IHSS hours are set to be reduced or terminated and the recipient or their advocate files an appeal before the Notice of Action's effective date or within ten days of the date of the notice, whichever comes first, the recipient's IHSS hours will continue. It is important to save the envelope the notice came in because sometimes there is a significant difference between the date on the notice and the postmarked date. The date the fair hearing request is considered filed is the date the request was postmarked.

A request for hearing must be filed within 90 days of the date of the Notice of Action if the individual currently is not receiving benefits. However, if a recipient is receiving benefits and disagrees with the number of hours authorized, she can appeal at any time. In 2018, the rules governing how Administrative Law Judges handle appeals to ongoing IHSS services has changed to be more restrictive. For more information, see Manual of Policies and Procedures § 22-009.21 at http://www.cdss.ca.gov/Portals/9/Regs/4CFCMAN.pdf.

HOW TO REQUEST AN APPEAL

A Notice of Action will contain a form that can be filled out to request an appeal, along with the instructions on where the form should be submitted. Even without a Notice of Action, an appeal can be requested by writing a letter to the Office of the Chief Administrative Law Judge, State Hearing Division, 744 “P” Street, Sacramento, California 95814. The letter should include at least the individual’s name, address, telephone number, and the statement that an IHSS hearing is requested.

A written appeal request is the best method, but an oral request for appeal also can be made by going to the county IHSS office, or by calling (800) 743-8525 (TDD: (800) 952-8349). In addition, a written hearing request can be submitted by faxing the hearing request to the Department of Social Services State Hearing Division in Sacramento: (916) 229-4110.

Most hearings are now held via videoconferencing. But an individual can request an in-person hearing either at the county offices or at their home. A home hearing can be requested as part of the appeal request. A home hearing request also can be made after receipt of the acknowledgment of the hearing request.
AT A HEARING

The hearing process for disputes about IHSS hours is designed to be accessible to laypersons without representatives. The county should attempt to resolve the dispute before hearing if possible.

When the individual is not represented, the Administrative Law Judges generally make an extra effort to ensure that the case is fully developed. For more information, see the “IHSS Fair Hearing and Self-Assessment Packet,” which can be found at [https://www.disabilityrightsca.org/system/files/file-attachments/501301.pdf](https://www.disabilityrightsca.org/system/files/file-attachments/501301.pdf).

FURTHER APPEALS

An unfavorable hearing decision can be appealed to the local Superior Court through a writ of administrative mandamus. Consult with a knowledgeable attorney for more information.
Supplemental Materials
RESOURCES ON CALIFORNIA HOME AND COMMUNITY-BASED SERVICES

CALIFORNIA’S HOME AND COMMUNITY BASED SERVICES: RESOURCES FOR ADVOCATES

There are many helpful In-Home Supportive Services program and other Home and Community-Based Services resources for California legal services attorneys and advocates to refer to for assistance when representing low-income seniors and individuals with disabilities.

IHSS RULES AND REGULATIONS

State Statutes

- California Welfare & Institutions Code §§ 12300 et seq.—the Original or Residual Program.
- California Welfare & Institutions Code §§ 14132.95, 14132.951 –the Medi-Cal Personal care Services Program and IHSS Plus Option.
- Website for Statutes: https://leginfo.legislature.ca.gov/faces/codes.xhtml

Regulations

- Medi-Cal regulations: California Code of Regulations, Title 22, § 51015.2, 51145.1, 51183, 51350.
- Website for Regulations: www.oal.ca.gov.

Department of Social Services Publications

- IHSS Program forms, www.cdss.ca.gov/inforesources/Forms-Brochures/Forms-by-Program.
- Hourly Task Guidelines (HTG) Quick Reference Tool: Defines IHSS covered tasks, with cites to the MPP; grids with low and high time guidelines depending on functional index; and lists exceptions and factors for social workers to consider when assessing time for services.
OTHER SOURCES OF INFORMATION ABOUT THE IHSS AND MEDI-CAL PERSONAL CARE SERVICES PROGRAMS

- Bet Tzedek Legal Services - Resources on IHSS and for caregivers. [www.bettzedek.org/our-services/resources/](http://www.bettzedek.org/our-services/resources/).
  - “The Caregiver Companion: A User-Friendly Guide to Providing At-Home Care,” Bet Tzedek (2016). Intended for family caregivers, this guide gives a good overview of other services that may be available to provide at-home assistance (e.g., Adult Day Care), and discusses other important issues for those with a family member in need of at-home care (e.g., how to find a care provider).
  - “The IHSS Companion: A User-Friendly Guide to In-Home Supportive Services,” Bet Tzedek (2016). Intended for IHSS consumers, this guide provides an overview of the IHSS program, including eligibility, application, services and appeals and includes an IHSS assessment worksheet.

HOME AND COMMUNITY-BASED SERVICES WAIVERS

- “Medi-Cal Waivers’, California Department of Health Care Services, [https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx](https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx).

MULTIPURPOSE SENIOR SERVICES PROGRAM

- New Multipurpose Senior Services Program Waiver Aid Codes,” California Department of Health Services, [https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx](https://www.dhcs.ca.gov/services/Pages/Medi-CalWaivers.aspx).

MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION: CALIFORNIA COMMUNITY TRANSITIONS

- “California Community Transitions Project,” California Department of Health Care Services, [www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/CCT.aspx).
- “California Community Transitions, , California Department of Health Services, [https://www.dhcs.ca.gov/services/ltc/Documents/2017-CCT-OP.pdf](https://www.dhcs.ca.gov/services/ltc/Documents/2017-CCT-OP.pdf).

ASSISTED LIVING WAIVER

- Assisted Living Waiver, California Department of Health Care Services, [www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx](http://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx).
USEFUL CONTACTS FOR ADVOCATES:

- Bet Tzedek, (323) 939-0506, www.bettzedek.org
- Disability Rights California, (800) 776-5746, www.disabilityrightsca.org
- California Advocates for Nursing Home Reform, www.canhr.org
- California Health Advocates, www.cahealthadvocates.org
- Local legal aid and Title III legal service organizations, https://aging.ca.gov/Providers_and_Partners/Legal_Services/
IHSS SAMPLE NOTICE OF ACTION

NOTICE OF ACTION

IN-HOME SUPPORTIVE SERVICES (IHSS)

APPROVAL

NOTE: This notice relates ONLY to your In-Home Supportive Services. It does NOT affect your receipt of SSI/SSP, Social Security, or Medi-Cal. KEEP THIS NOTICE WITH YOUR IMPORTANT PAPERS.

[ADDRESS]

COUNTY OF

STATE OF CALIFORNIA

HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

Notice Date:

Case Name:

Case Number:

Social Worker Name:

Social Worker Number:

Social Worker Telephone:

Social Worker Address:

TOTAL HOURS:Minutes of IHSS you can get each month: ______________________

Based on an assessment done on ______________________, you can get the services shown below for the amount of time shown in the column "Authorized Amount of Service You Can Get."

1) If there is a zero in the "Authorized Amount of Service You Can Get" column or the amount is less than the "Total Amount of Service Needed" column, the reason is explained on the next page(s).

2) "Not Needed" means that your social worker found that you do not require assistance with this task. (MPP 30-750.11)

3) "Pending" means the county is waiting for more information to see if you need that service. See the next page(s) for more information.

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>TOTAL AMOUNT OF SERVICE NEEDED</th>
<th>ADJUSTMENT FOR OTHERS WHO SHARE THE HOME (PRORATION)</th>
<th>AMOUNT OF SERVICE YOU NEED</th>
<th>SERVICES YOU REFUSED OR YOU GET FROM OTHERS</th>
<th>AUTHORIZED AMOUNT OF SERVICE YOU CAN GET</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOURS: MINUTES</td>
<td>HOURS: MINUTES</td>
<td>HOURS: MINUTES</td>
<td>HOURS: MINUTES</td>
<td>HOURS:MINUTES</td>
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<tr>
<td>DOMESTIC SERVICES (per MONTH):</td>
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<td>RELATED SERVICES (per WEEK):</td>
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<tr>
<td>Prepare Meals</td>
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<tr>
<td>Meal/Clean-up</td>
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<tr>
<td>Routine Laundry</td>
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</tr>
<tr>
<td>Shopping for Food</td>
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<tr>
<td>Other Shopping/Errands</td>
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<tr>
<td>NON-MEDICAL PERSONAL SERVICES (per WEEK):</td>
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<tr>
<td>Respiration Assistance (Help with Breathing)</td>
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<tr>
<td>Bowel, Bladder Care</td>
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<tr>
<td>Feeding</td>
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<tr>
<td>Routine Bed Bath</td>
<td></td>
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<tr>
<td>Dressing</td>
<td></td>
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<tr>
<td>Menstrual Care</td>
<td></td>
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<tr>
<td>Ambulation (Help with Walking, Including Getting In/Out of Vehicles)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Transferring (Help Moving In/Out of Bed, On/Off Seats, etc.)</td>
<td></td>
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<tr>
<td>Bathing, Oral Hygiene, Grooming</td>
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<tr>
<td>Rubbing Skin, Repositioning</td>
<td></td>
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</tr>
<tr>
<td>Help with Prosthetic (Artificial Limb, Visual/ Hearing Aid) and/or Setting up Medications</td>
<td></td>
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<tr>
<td>ACCOMPANIMENT (per WEEK):</td>
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<tr>
<td>To/From Medical Appointments</td>
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<tr>
<td>To/From Places You Get Services in Place of IHSS</td>
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<tr>
<td>PROTECTIVE SUPERVISION (per WEEK):</td>
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<tr>
<td>PARAMEDICAL SERVICES (per WEEK):</td>
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<tr>
<td>TOTAL WEEKLY HOURS-MINUTES OF SERVICE YOU CAN GET:</td>
<td></td>
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<tr>
<td>MULTIPLY BY 4.33 (average # of weeks per month) TO CONVERT TO MONTHLY HOURS-MINUTES: ( \times 4.33 = )</td>
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<tr>
<td>ADD MONTHLY WEEKLY HOURS-MINUTES OF SERVICE YOU CAN GET (from above):</td>
<td></td>
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</tr>
<tr>
<td>TOTAL HOURS-MINUTES OF SERVICE YOU CAN GET PER MONTH:</td>
<td></td>
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</tr>
<tr>
<td>TIME LIMITED SERVICES (per MONTH):</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy Cleaning</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yard/Hazard Abatement</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Remove Ice, Snow</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching and Demonstration</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL HOURS-MINUTES OF TIME LIMITED SERVICES YOU CAN GET PER MONTH:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Questions?: Please contact your IHSS social worker. See top of page for phone number.

State Hearing: If you think this action is wrong, you can ask for a hearing. The back of this page tells how.

NA 1250 (11/11) - IHSS APPROVAL
Functional Index Rankings and Hourly Task Guidelines

As an In-Home Supportive Services (IHSS) applicant/recipient, it is helpful to know what IHSS Functional Index (FI) Rankings are and how they impact your assessment. The FI rankings range from 1-6 (see below description) and indicate the level of assistance you need to perform tasks safely. A county IHSS social worker will assign a rank to each service category to help determine the amount of assistance needed.

**Rank 1:** Independent. Able to perform function without human assistance.

**Rank 2:** Able to perform a function but needs verbal assistance, such as reminding, guiding, or encouragement.

**Rank 3:** Can perform the function with some human assistance, including, but not limited to, direct physical assistance from a provider.

**Rank 4:** Can perform a function with only substantial human assistance.

**Rank 5:** Cannot perform the function, with or without human assistance.

**Rank 6:** Requires Paramedical Services.

**Prescribed by a licensed health care professional.**

After assigning a rank in each service category and taking into consideration your individual needs, the social worker will authorize time within or outside the Hourly Task Guidelines. If time is needed outside the guidelines, this is called an exception. If you need more or less time outside the guidelines for a specific rank within a service, your social worker will review whether exceptions are needed, as appropriate.

For more information, contact your local county IHSS office.
### Hourly Task Guidelines

Social workers also use Hourly Task Guidelines (HTGs) as specified in State regulations to determine the appropriate time needed on a weekly basis in each service category. **Regulatory Authority:** Manual of Policies and Procedures (MPP) section 30-757.11 through 30-757.14(k).

**NOTE:** This tool does not invalidate current HTG regulations.

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Rank 2 (Low)</th>
<th>Rank 2 (High)</th>
<th>Rank 3 (Low)</th>
<th>Rank 3 (High)</th>
<th>Rank 4 (Low)</th>
<th>Rank 4 (High)</th>
<th>Rank 5 (Low)</th>
<th>Rank 5 (High)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation of Meals **</td>
<td>3:01</td>
<td>7:00</td>
<td>3:30</td>
<td>7:00</td>
<td>5:15</td>
<td>7:00</td>
<td>7:00</td>
<td>7:00</td>
</tr>
<tr>
<td>Meal Clean-up **</td>
<td>1:10</td>
<td>3:30</td>
<td>1:45</td>
<td>3:30</td>
<td>1:45</td>
<td>3:30</td>
<td>2:20</td>
<td>3:30</td>
</tr>
<tr>
<td>Bowel and Bladder Care</td>
<td>0:35</td>
<td>2:00</td>
<td>1:10</td>
<td>3:20</td>
<td>2:55</td>
<td>5:50</td>
<td>4:05</td>
<td>8:00</td>
</tr>
<tr>
<td>Feeding</td>
<td>0:42</td>
<td>2:18</td>
<td>1:10</td>
<td>3:30</td>
<td>3:30</td>
<td>7:00</td>
<td>5:15</td>
<td>9:20</td>
</tr>
<tr>
<td>Routine Bed Baths</td>
<td>0:30</td>
<td>1:45</td>
<td>1:00</td>
<td>2:20</td>
<td>1:10</td>
<td>3:30</td>
<td>1:45</td>
<td>3:30</td>
</tr>
<tr>
<td>Dressing</td>
<td>0:34</td>
<td>1:12</td>
<td>1:00</td>
<td>1:52</td>
<td>1:30</td>
<td>2:20</td>
<td>1:54</td>
<td>3:30</td>
</tr>
<tr>
<td>Ambulation</td>
<td>0:35</td>
<td>1:45</td>
<td>1:00</td>
<td>2:06</td>
<td>1:45</td>
<td>3:30</td>
<td>1:45</td>
<td>3:30</td>
</tr>
<tr>
<td>Transfer</td>
<td>0:30</td>
<td>1:10</td>
<td>0:35</td>
<td>1:24</td>
<td>1:06</td>
<td>2:20</td>
<td>1:10</td>
<td>3:30</td>
</tr>
<tr>
<td>Bathing, Oral Hygiene, and Grooming</td>
<td>0:30</td>
<td>1:55</td>
<td>1:16</td>
<td>3:09</td>
<td>2:21</td>
<td>4:05</td>
<td>3:00</td>
<td>5:06</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Low (Time Guidelines)</th>
<th>High (Time Guidelines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menstrual Care</td>
<td>0:17</td>
<td>0:48</td>
</tr>
<tr>
<td>Repositioning and Rubbing Skin</td>
<td>0:45</td>
<td>2:48</td>
</tr>
<tr>
<td>Care of and Assistance with Prosthetic Devices</td>
<td>0:28</td>
<td>1:07</td>
</tr>
</tbody>
</table>

### Services with Time Guidelines:

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Time Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Services</td>
<td>6:00 total maximum per month per household unless adjustments* apply; Prorations may apply**</td>
</tr>
<tr>
<td>Shopping for Food</td>
<td>1:00 per week per household unless adjustments* apply; Prorations may apply **</td>
</tr>
<tr>
<td>Other Shopping/Errands</td>
<td>0:30 per week unless adjustments* apply; Prorations may apply **</td>
</tr>
<tr>
<td>Laundry</td>
<td>1:00 per week (facilities within home); 1:30 per week (facilities out of home); per household; Prorations may apply **</td>
</tr>
</tbody>
</table>

* Adjustments refer to a need met in common with housemates.

** When prorating Domestic Services, the natural or adoptive children of the recipient who are under 14 are not considered (MPP section 30-763.46). Other children in the household (i.e., grandchildren, nieces, nephews, etc.) under 14 are considered.

Updated 5/29/2019

**NOTE:** Current MPP regulations define the HTGs in decimal format, e.g., 1.50 hours. To align service assessment/authorization with the Case Management, Information, and Payrolling System (CMIPS) data entry, time allocations are re-formatted to hours:minutes. This change in format does not contradict current program regulation and reduces confusion regarding the entry of time into CMIPS (MPP sections 30-757.11 through 30-757.14(k)).
In-Home Supportive Services (IHSS) Program Services

The In-Home Supportive Services (IHSS) program provides paid assistance to income-eligible aged, blind, and/or disabled individuals so they can remain safely in their own homes, and offers the following services:

**DOMESTIC SERVICES:**

General household chores to maintain the cleanliness of the home.

**Related Services:**

- **Meal Preparation:** Preparing foods, cooking, and serving meals
- **Meal Clean-up:** Cleaning up the cooking area and washing, drying, and putting away cookware.
- **Routine Laundry:** Washing, drying, folding, and putting away clothes and linens
- **Shopping for Food:** Making a grocery list, traveling to/from the store, shopping, loading, and storing food purchased.
- **Other Shopping/Errands:** Includes shopping for other necessary items and performing small and necessary errands (e.g., picking up a prescription)

**NON-MEDICAL PERSONAL CARE SERVICES:**

- **Respiration/Assistance:** Assisting recipient with non-medical breathing related services, such as self-administration of oxygen, nebulizer, and cleaning breathing machines
- **Bowel and Bladder Care:** Assistance using the toilet (including getting on/off), bedpan/bedside commode, or urinal; emptying and cleaning ostomy bag, enema, and/or catheter receptacles; applying diapers, disposable undergarments, and disposable barrier pads; wiping and cleaning recipient; and washing/drying recipient’s and provider’s hands
- **Feeding:** Assisting the recipient to eat meals, cleaning his/her face and hands before/after meals
- ** Routine Bed Baths:** Giving a recipient who is confined to bed a routine sponge bath
- **Dressing:** Assisting the recipient to put on and take off his/her clothes as needed throughout the day
- **Menstrual Care:** Assistance with the external placement of sanitary napkins and barrier pads
ATTACHMENT A

- **Ambulation and Getting In/Out of Vehicles**: Assisting the recipient with walking or moving about the home, including to/from the bathroom and to/from and into/out of the car for transporting to medical appointments and/or alternative resources

- **Transfer (Moving In/Out of Bed and/or On/Off Seats)**: Assisting recipient from standing, sitting, or prone position to another position and/or from one piece of furniture or equipment to another

- **Bathing, Oral Hygiene, and Grooming**: Assisting the recipient with bathing or showering, brushing teeth, flossing, and cleaning dentures; shampooing, drying, and combing/brushing hair; shaving; and applying lotion, powder, and deodorant

- **Repositioning and Rubbing Skin**: Rubbing skin to promote circulation and/or prevent skin breakdown, turning in bed and other types of repositioning, range of motion exercises, assisted walking, and strengthening exercises

- **Care of and Assistance with Prosthetic Devices and Help Setting up Medications**: Taking off/putting on and maintaining prosthetic devices, including vision/hearing aids, reminding the recipient to take prescribed and/or over the counter medications, and setting up Medi-sets

**MEDICAL ACCOMPANIMENT:**

Accompanying recipient to and from appointments and waiting with recipient for physicians, dentists, and other health practitioners’ appointments; or sites necessary for fitting health-related appliances/devices and special clothing, and may be authorized for an IHSS recipient only after it has been determined that non-emergency medical transportation (NEMT) is not being provided under the Medi-Cal Program, and in only those cases in which the social worker has determined that the recipient receives NEMT through Medi-Cal but the recipient also needs assistance with an IHSS authorized task either in transit to/from or at the location of the appointment with the health care professional.

**SPECIAL CIRCUMSTANCES:**

- **Heavy Cleaning**: Thorough cleaning of the home to remove hazardous debris or dirt. Authorized one time only and only under certain circumstances

- **Yard Hazard Abatement**: Light work in the yard to remove high grass or weeds and rubbish when these materials pose a fire hazard (authorized one time only); or remove ice, snow, or other hazardous substances from entrances and essential walkways when these materials make access to the home hazardous
• **Protective Supervision:** A benefit to watch an individual, who has a mental impairment, to keep the individual safe and prevent injuries and accidents. Certain limitations apply

• **Teaching and Demonstration:** Teaching and demonstrating those services provided by IHSS providers so the recipient can perform services which are currently performed by IHSS

• **Paramedical Services:** Services ordered by a licensed health care professional which recipient could perform themselves if they did not have functional limitations. When such services are necessary to maintain the recipient’s health, paramedical services include activities such as administration of medications, checking blood sugar, administering insulin injections, inserting a medical device into a body orifice; activities requiring sterile procedures; or range of motion to improve function. Special limitations apply.

  For more information, contact your local county IHSS office.
In-Home Supportive Services (IHSS) Recipient Right to File A Hearing

As an In-Home Supportive Services (IHSS) applicant/recipient, you have a right to understand what is happening with your application and program services. The social worker is available anytime you have questions about your application or services.

You can ask for a state hearing if you disagree with a county’s action on your benefits or services. You can also ask for a state hearing if the county is not giving you benefits or services which you believe you should get. If you request a hearing prior to the effective date of the county’s action you disagree with, your benefits will not change until there is a hearing and a decision is issued. You can ask for a hearing by calling the California Department of Social Services, State Hearings Division, at 800-743-8525 or 855-795-0634. You may also Request a Hearing Online.

A state hearing is heard by a state Administrative Law Judge (ALJ). The county will have someone at the hearing to explain why they took their action.

A state hearing is not a court hearing. You have the right to have a representative with you. Free legal services are available in every county and are listed on the back of your county notices. You can bring witnesses. You have the right to a free interpreter; ask the county how to get one.

For more information, contact your local IHSS office.
CHAPTER EIGHT

QUALITY OF CARE IN LONG-TERM CARE FACILITIES

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Nursing Homes

FEDERAL LAW

In 1987, Congress passed the Nursing Home Reform Law. The Reform Law applies to every nursing home certified to accept Medicare and/or Medicaid (called “Medi-Cal” in California). Significantly, the Reform Law protects a resident of a federally-certified nursing home regardless of whether the resident is eligible for Medicare or Medicaid reimbursement, or is paying privately.

The Nursing Home Reform Law is based upon the premise that each resident deserves individualized care. A critical federal regulation (42 C.F.R. Section 483.21) states that a nursing home must provide the services that a resident needs “to attain or maintain the resident’s highest practicable physical, mental, and psychosocial well-being.”

Most of the discussion below is based on the Reform Law although, as indicated, some of the discussion is based on California law.

NURSING HOME FALSEHOODS

Falsehood #1: “The nursing staff will determine the care that Ruben will receive.”

This statement is false because care planning for a resident should be shared by the resident, the resident’s family, the physician, and the nursing home staff.

Initially, a resident receives care under a baseline care plan that includes physician orders and other vital instructions. A nursing home must complete a full assessment of a resident’s condition within 14 days after admission, and at least once every 12 months thereafter. More limited assessments must be done at least quarterly. Assessments are done with a standardized assessment instrument called the Minimum Data Set (“MDS”).

Assessments are used for development of a comprehensive care plan, which must be prepared initially within seven days after completion of the first full assessment. Every three months, care plans must be reviewed and, if necessary, revised.

A resident and/or resident’s representative has a right to participate in a care plan conference. A care plan must include measurable objectives and timetables.

TIP: Too many care plans are perfunctory. Residents and family members should take care plans seriously, so that care really can be individualized.
Falsehood #2: “Ruben can’t receive Medicare reimbursement because we have determined that he needs custodial care only.”

Part of this statement is true – Medicare Part A indeed does not pay for custodial care. The untrue part is the assertion that the nursing home has the sole authority to determine whether the resident’s care is custodial. A resident has the right to force a nursing home to bill under Medicare Part A, even if the nursing home believes that the resident needs custodial care only.

The Medicare program pays for up to 100 days of nursing home care if the resident enters the nursing home after a hospital stay of at least three nights. For Medicare Part A coverage, the resident must need skilled nursing services or skilled rehabilitation services (see Chapter 4).

COVID-19 ALERT - During the pandemic, the three-night hospital stay requirement in order to receive Medicare coverage at a nursing home is waived. This waiver is still effective as this chapter is being revised in June 2021.

Even if the care is covered, days 21 through 100 have a daily co-payment of $185.50 (in 2021). Medicare supplemental insurance policies cover this co-payment, if a resident has such a policy.

The nursing home makes the initial determination on whether or not to bill Medicare, but the resident has the right to force the nursing home to submit a “demand bill.” While the demand bill is being considered by the Medicare contractor, the resident cannot be charged for any amount for which Medicare subsequently may pay.

Falsehood #3: “We can’t give Ruben therapy services because he isn’t making progress.”

This denial may be blamed on medical judgment or Medicare rules.

If the facility makes the denial based on medical judgment, the nursing home should be informed that a facility is responsible for trying to “maintain” a resident’s condition: according to a relevant federal regulation, a facility must “ensure that a resident’s abilities in activities of daily living do not diminish unless circumstances of the individual’s clinical condition demonstrate that such diminution was unavoidable.”

If the facility blames the denial on Medicare rules, there are two rebuttal points to be made. According to a federal regulation, the type of payment source should not affect the care provided. Also, Medicare Part A reimbursement does not require “progress.” Payment is possible merely if a resident needs “skilled nursing services” or “skilled rehabilitation services.” See Medicare’s “Jimmo Settlement” webpage for more information.

TIP: Talk to the nurses or therapists. They likely will want to continue their work for the resident’s benefit, and can help to explain and document why skilled services are appropriate.

Falsehood #4: “We can’t give Ruben therapy services because his Medicare reimbursement has expired, and Medi-Cal doesn’t pay for therapy.”

Nursing homes constantly attempt to tie care to payment source. This way of thinking must be resisted.

This payment-source discrimination is most obvious when a resident transfers from Medicare eligibility to Medi-Cal eligibility. There is a gross disparity between the per diem rates for the Medicare and Medi-Cal programs; a nursing home might receive $400 daily from Medicare and $200 daily from Medi-Cal.
For two reasons, appropriate therapy should be provided regardless of the form of payment. First, as discussed above, a federal regulation requires that residents receive services necessary “to attain or maintain the highest practicable physical, mental, and psychosocial well-being.”

Second, services must not vary by source of payment. As set forth in another federal regulation, a nursing home “must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State [Medicaid] plan for all residents regardless of payment source.”

**Falsehood #5: “Because Ruben is no longer eligible for Medicare reimbursement, he must leave his Medicare-certified bed.”**

A nursing home may seek Medicare certification for all or some of the facility’s beds. However, such “distinct-part” certification does not prevent a bed from being used for a resident paying privately or through Medi-Cal. Furthermore, a resident has the right under the Reform Law to refuse a transfer within a facility if the purpose of the transfer is to move the resident to or from a Medicare-certified bed.

In short, Ruben can refuse to leave and, even though his bed may be Medicare-certified, the facility can accept private payment or Medi-Cal reimbursement for the nursing home care provided to Ruben.

**Falsehood #6: “Ruben must be tied into his chair so that he doesn’t wander away from the nursing home.”**

Under the relevant federal regulation, a resident has the right to be free from “any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.” The term “physical restraint” includes (among other things) vest restraints, hand mitts, seat belts, bed rails, and chairs that are angled to prevent the resident from getting out.

A restraint can only be used with the consent of the resident or the resident’s agent. (See Chapter 9 for a discussion of agents for persons who have lost decision-making capacity.) If use of a restraint is appropriate, the nursing home must use the least restrictive alternative, for as little time as possible. The need for restraints should be re-evaluated regularly.

Although, as listed above, the law recognizes the use of restraints to protect residents, current nursing research increasingly sees the use of restraints as increasing the likelihood of falls, and/or the severity of injury in the falls that occur.

**Falsehood #7: “Ruben has to wake up at 6:00 a.m. because we don’t have enough nurse aides to accommodate individual schedules.”**

The Nursing Home Reform Law is meant to ensure that residents are treated as individual human beings. The Reform Law states that a resident has the right “to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered.” Also, federal regulations specify that “a resident has a right to choose activities, schedules (including sleeping and waking times), health care, and providers of health care services consistent with his or her interests, assessments, [and] plan of care.”

**TIP:** A resident should approach these issues with a reasonable sense of entitlement. The nursing home is receiving $4,000 to $8,000 monthly for the resident’s care, and should be able to make reasonable accommodations for a resident’s preferences. For example, Ruben should be free to sleep as late as he wishes.
In any case, a reasonable accommodation should be a win-win situation. Accommodations can improve the residents’ quality of life, and give the nursing home’s operator an attractive selling point when speaking with prospective residents.

**Falsehood #8: ”Ruben’s children can visit only during visiting hours.”**

A limitation on visiting hours conflicts with the idea that a nursing home should be “home.” Accordingly, family and friends have the right to visit at any time. For visits late at night, official federal guidelines suggest that visits might take place outside of the resident’s room – the dining room or lobby, for example.

**Falsehood #9: ”We don’t have to readmit Ruben from the hospital because his bed-hold period has expired.”**

California law provides for a seven-day bed-hold. The Medi-Cal program will pay for those seven days.

In addition, a federal law provides an open-ended right of return for a resident eligible for Medi-Cal or Medicare payment of nursing home expenses. Even if a bed-hold has expired, a nursing home must accept the return of such a resident from the hospital whenever the nursing home first has an available bed. Return must be allowed to the same room if that room remains available.

Unscrupulous nursing homes sometimes use a temporary hospital admission as a way of evicting a resident deemed undesirable for some reason. A resident illegally denied return to the nursing home has a right to an immediate hearing from the California Department of Health Care Services. The hearing request should be made by telephone to the Department’s Office of Administrative Hearings and Appeals at (916) 445-9775 or (916) 322-5603. Emphasize that the resident wants a hearing in order to return to the nursing home; the “return to facility” hearings are somewhat different than the transfer/discharge/eviction hearings that also are conducted by the Office.

**TIP:** In a hearing, a resident should not be overly concerned with proving that the nursing home has an available bed at that time. That issue is adequately covered as long as any order from the hearing officer specifies that the nursing home must admit the resident to the next available bed. With such an order, the resident is protected whether a bed is available that day or is not available until the following week (for example).

**Falsehood #10: ”Ruben must pay any amount set by the nursing home for ‘extra’ charges.”**

Nursing homes commonly charge residents separately for a host of items, and charges can amount to several hundred dollars per month. If these charges generally are not authorized by the original admission agreement, they are improper and illegal. Since 2012, California nursing facilities have been required to use a state-developed standard admission agreement. Any extra charges must be listed in Attachment B-2 to the standard agreement. California law requires that a nursing home in the initial admission agreement specify items which carry “extra” charges, along with the amount of those charges. Also, Medicare and Medi-Cal must be accepted as payment in full, except for any share of cost deductible (see Chapters 4 & 6).
Falsehood #11: "We are not responsible for Ruben’s property unless he had requested that the property be placed in the nursing home’s safe."

Under California law, a nursing home is responsible for lost or stolen property if the nursing home fails to make “reasonable efforts” to safeguard that property. An admission agreement cannot reduce a nursing home’s responsibility for a resident’s property.

Falsehood #12: "Ruben must leave the nursing home because he is a difficult resident."

Under the Nursing Home Reform Law, there are only six legitimate reasons for eviction:

- The resident has failed to pay.
- The resident no longer needs nursing home care.
- The nursing home is going out of business.
- The resident’s needs cannot be met in a nursing home.
- The resident’s presence in the nursing home endangers others’ safety.
- The resident’s presence in the nursing home endangers others’ health.

Thus “difficulty” is not a justification for eviction. Nursing homes exist in order to care for people with physical and mental problems.

A resident threatened with eviction is entitled to an administrative hearing conducted by the California Department of Health Care Services. These hearings are conducted at the nursing home. An appeal hearing can be requested by calling (916) 445-9775 or (916) 322-5603.

Falsehood #13: “Ruben must leave the nursing home because he is refusing medical treatment.”

A nursing home resident, like any other individual, has a constitutional and common-law right to refuse medical treatment. Accordingly, an involuntary transfer or discharge cannot be based on a resident’s refusal of treatment. Refusal of treatment is not one of the six specified justifications for eviction.

Federal guidelines state that refusal of treatment does “not constitute grounds for discharge, unless the facility is unable to meet the needs of the resident or protect the health and safety of others.”

Residential Care Facilities for the Elderly (Assisted Living)

Residential Care Facilities for the Elderly (“RCFEs”) are governed by California law only. This law is to a certain extent a muddle, because RCFEs are defined as non-medical facilities, although recent regulatory changes authorize RCFEs to admit and retain many residents with significant medical needs.

RCFE FALSEHOODS

Falsehood #14: "We won’t help Ruben get dressed, because our RCFE is for independent persons only.”
RCFE residents by definition need care and supervision. A state regulation specifies that an RCFE must meet its residents’ needs: “Based on the individual’s preadmission appraisal, and subsequent changes to that appraisal, the facility shall provide assistance and care for the resident in those activities of daily living which the resident is unable to do for himself/herself.”

Facility assistance must include necessary assistance in at least the following:

- Bathing;
- Dressing;
- Grooming;
- Eating;
- Toileting;
- Continence;
- Walking;
- Transferring in and out of a bed or chair;
- Seeing;
- Hearing; and
- Speaking.

**Falsehood #15: ”We have no programming because Ruben should be able to entertain himself.”**

Activities must be extensive, and should include education, physical activities, and socialization.

An RCFE must assure that residents maintain contact with the community. For example, residents should be able to attend church services, concerts and senior citizens events.

If a facility has a capacity of between 16 and 49 residents, one staff member must have primary responsibility for activities. If a facility has a capacity of 50 residents or more, one staff member must have full-time responsibility for activities.

**Falsehood #16: ”Even though Ruben now is eligible for SSI (Supplemental Security Income), he must pay the higher private rate, because he was not admitted to the RCFE as an SSI resident.”**

Actually, there is no such thing as an “SSI resident.” All residents should get the same treatment regardless of their source of payment.

Section 87464 of Title 22 of the California Code of Regulations states that “[i]f the resident is an SSI recipient, then the basic services shall be provided and/or made available at the [SSI] basic rate at no additional charge to the resident.” This regulation applies whether or not a resident was SSI-eligible when he or she was admitted.

Under 2021 SSI payment levels, an RCFE resident receives $1,217.37 monthly, and must pay an SSI basic rate of $1,079.37 monthly. This leaves the resident with a monthly personal needs allowance of $138.

If an SSI-eligible resident also has a source of income other than SSI, he will receive a total (SSI plus the other income) of $1,237.37 each month. Because this total amount is $20 more than the SSI-only amount, the resident will end up with $20 extra in his personal needs allowance. If, however, the RCFE’s admission agreement stated that
the facility will receive this extra $20, then the RCFE will receive a rate of $1,099.37, and the resident will receive the regular personal needs allowance of $138.

**Falsehood #17: "Ruben must leave the RCFE because he doesn’t get along with the administrator."**

An RCFE resident can only be evicted for one of five reasons:

1. The resident fails to pay for basic services within 10 days of the due date.
2. The resident fails to comply with state or local law after receiving written notice of the alleged violation.
3. The resident fails to comply with general facility policies set forth in the admission agreement. These facility policies explicitly “must be for the purpose of making it possible for residents to live together.”
4. A formal reappraisal has found that the resident’s needs have changed, and an RCFE cannot meet those changed needs.
5. The RCFE is giving up its license.

A facility must give a 30-day notice of any proposed eviction.

This notice must include information (date, place, witnesses, etc.), of any incident that allegedly justifies eviction. The notice must also include the following language, verbatim:

In order to evict a resident who remains in the facility after the effective date of the eviction, the residential care facility for the elderly must file an unlawful detainer action in superior court and receive a written judgment signed by a judge. If the facility pursues the unlawful detainer action, you must be served with a summons and complaint. You have the right to contest the eviction in writing and through a hearing.

**TIP:** If a resident feels that an RCFE does not have justification for an eviction, the resident should stay put, and force the facility to follow the steps for a formal eviction. An RCFE often will let the matter drop at this point because in fact the facility does not have grounds for eviction, and because the facility is likely unfamiliar with the court processes for eviction.
CHAPTER NINE

PLANNING FOR (AND DEALING WITH) INCAPACITY

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This chapter was originally prepared in part by Janet Morris of Bet Tzedek Legal Services. Much of the material is drawn from the “Residents’ Health Care Decision Making” chapter of the Nursing Home Companion published by Bet Tzedek Legal Services which can be ordered from Bet Tzedek by calling (323) 549-5897.
CHAPTER NINE: PLANNING FOR (AND DEALING WITH) INCAPACITY

Health Care Decisions

BENEFITS OF ADVANCE PLANNING

An individual has the ability and the right to make her own health care decisions as long as she is of sound mind. If, however, she lacks capacity (due to a stroke, coma, disease, or accident), she legally can receive health care only if the care is authorized by her legal representative, or she previously had executed adequate written instructions. Capacity is the ability to understand the nature and consequences of the proposed health care, and the ability to communicate decisions.

DOCUMENTS FOR ADVANCE PLANNING

California law authorizes three types of documents for advance planning of health care.

- **Advance Health Care Directive:** This is the official new name for advance directives executed after July 1, 2000. It has two parts: (1) the “Power of Attorney for Health Care” allows a person to appoint an agent; and (2) the “Instruction for Health Care,” which describes a person’s wishes regarding end-of-life care. This form replaces all older forms. Other optional terms may also be included, if decided (e.g., designation of primary care physician, personal care powers and requests, giving the right to visit, etc).

- **Durable Power of Attorney for Health Care:** Until June 2000, California law specifically authorized a Durable Power of Attorney for Health Care, and all such documents executed prior to that date are still valid (as well as pre-printed forms from prior to July 2000). These documents allowed one to appoint an agent (and alternates) to make health care decisions in the event one became incapacitated. Optional provisions also allowed one to state one’s wishes regarding terminal illness, autopsy, donation of organs, and other specific instructions.

- **Request Regarding Resuscitative Measures:** As the name suggests, these documents are used to specify a person’s wishes regarding CPR and other resuscitative measures. They are signed both by the person (or the person’s authorized agent) and the person’s physician. There are two types of these documents: 1) the POLST form (Physician Order for Life-Sustaining Treatment) and 2) the Pre-Hospital Do Not Resuscitate (DNR) form. The POLST form is useful broadly in hospitals and other health care settings. The Pre-Hospital DNR form is useful primarily with paramedics for persons who are living at home, or in assisted living facilities or other community care settings.

In addition to the three documents listed above, a “living will” often is mentioned. This is a general, non-California term used for instructions that set forth wishes regarding life support. In California, an Advance Health Care Directive format should now be used, where possible.
WHY APPOINT A REPRESENTATIVE?

An individual of any age may become incapacitated or be in a life-threatening accident in the future. Consequently, an individual should prepare now to assure that she receives appropriate health care if she ever becomes incapacitated and unable to communicate about health care decisions.

If an individual has no legal representative when the individual becomes incapacitated and unable to communicate, she may not be able to receive needed medical treatment. Likewise, an individual without a legal representative may not be able to refuse medical treatment, which will only prolong the individual’s treatment, even if she has no real prospect of recovery.

On the other hand, if a legal representative has been appointed to make health care decisions for a mentally incapacitated individual, those decisions can be made in a way most consistent with the individual’s expressed desires.

Tip: Every mentally competent adult, regardless of age or health, should select a health care agent and complete an Advance Health Care Directive.

HOW TO APPOINT ANOTHER PERSON TO MAKE HEALTH CARE DECISIONS

In California, an adult of sound mind can create an advance health care directive, which is a legally binding document that allows the person appointed (the “agent”) to make health care decisions for the individual if the individual becomes unable to make such decisions. The Advance Health Care Directive thus allows a physician, hospital, or nursing home to receive clear instructions, even if the individual no longer can make health care decisions.

WHOM TO SELECT AS AGENT

An individual probably should select an agent who knows the individual well, can follow the individual’s wishes, and can discuss life and death issues with the individual. The agent can be a family member, friend, or other person. The agent cannot be a health care provider to the individual.

The individual should always select one or two alternate agents in case the primary agent is unable or unwilling to act. It is not a good idea to appoint co-agents; appointing a primary agent and alternates is preferred. The doctor will go down the list to find the first available agent.

INSTRUCTIONS TO AGENT

Common forms for an Advance Health Care Directive provide an optional section in which an individual can declare her desire to receive or not receive life-sustaining treatment under certain conditions. These optional sections also often provide space for an individual to list any instructions relating to health care decisions that she wishes to express.
In addition to written instructions, an individual should discuss her desires with the agent. Discussing health care decisions now, while the individual is able to explain her desires, can give the agent a greater sense of comfort about difficult decisions that may have to be made in the future. Your Way, a helpful guide to discussing and choosing future health care, is available from the Healthcare and Elder Law Programs Corporation (H.E.L.P.) of Torrance, California, (310) 533-1996.

**Note:** An individual should discuss personal desires and beliefs with her health care agent.

### DECISIONS THAT CAN BE MADE BY AGENT

An Advance Health Care Directive allows an agent to make any and all health care and treatment decisions for an incapacitated individual, or one who is unable to communicate, subject to the individual’s instructions listed in the Advance Health Care Directive. The agent can consent to diagnostic procedures and surgery, and (as discussed later in this chapter) decide whether to withhold or withdraw life-sustaining procedures and make other personal health-related decisions subject to the principal’s instructions.

### INSTRUCTIONS WITHOUT APPOINTING AN AGENT

An Advance Health Care Directive enables an individual to state her desires about future health care even without an agent. These instructions must be honored by future health care providers, if at that time the individual no longer is capable of making her own health care decisions.

To give adequate direction to those health care providers, the individual should list her instructions as specifically as possible.

**EXAMPLE**

Q. What are some optional provisions that can be included in an Advance Health Care Directive?

A. California allows the statement of additional medical treatment desires and specific health care instructions to be added to the Advance Health Care Directive. Some optional provisions include:

- Naming primary physician
- Giving the power to make personal care decisions (e.g., arranging where to live and how meals will be provided; and arranging household help, transportation, mail, recreation and entertainment)
- Giving non-immediate family members the right to visit in the hospital (e.g., “I wish for Mrs. Jones to have the same visitation rights as my immediate family.”)
- Adding a No-Contest Clause if the choice of agent is likely to be controversial (e.g., “If anyone contests my choice of agent, that individual shall be disqualified from acting as my agent.”)
- Nominating a conservator (and alternatives) of the person and/or estate should one become necessary

If there is insufficient space in the form to add desired provisions, make an attachment on a new page and reference it (e.g., “See Attachment A for my additional instructions.”).
WITNESSING REQUIREMENTS

An Advance Health Care Directive must be witnessed by two qualified adult witnesses or notarized. If the document is being signed by an individual who is a nursing home resident, the document also must be witnessed by a representative of the Ombudsman Program, either as one of the two adult witnesses or in addition to the notarization. (The telephone numbers for the Ombudsman Program are listed as an appendix to Bet Tzedek Legal Service’s Nursing Home Companion, and are available online at https://www.aging.ca.gov/Programs_and_Services/Long-Term_Care_Ombudsman/).

A witness cannot be the appointed agent or the individual’s physician. At least one of the two witnesses must be someone who is neither related to the individual, nor entitled to any of the individual’s property after the individual’s death.

DO-IT-YOURSELF FORMS

Although attorneys prepare Advance Health Care Directives, they also can be completed with a relatively inexpensive fill-in-the-blanks form. If an individual’s desires are relatively straightforward, a form document generally is adequate. A mentally competent individual can complete a form simply by following the directions on the form. Some hospitals and health plans provide them at no cost.

A form can be obtained from Bet Tzedek Legal Services, (323) 939-0506 or (818) 769-0136, the California Medical Association (forms in English or Spanish), (800) 882-1262, or from the Healthcare and Elder Law Programs Corporation (H.E.L.P.), www.help4srs.org.

California residents should be sure to use forms that comply with California law as each state has its own laws governing advance directives.

What is HIPAA? The Health Insurance Portability and Accountability Act of 1996, requires health care providers to follow strict rules regarding patients’ medical information. California law provides that an agent appointed under an AHCD (or a Power of Attorney for Health Care) can access patient records. Many of the newer AHCDs include a specific HIPAA provision.

HOW LONG ARE DOCUMENTS EFFECTIVE?

Once completed, an Advance Health Care Directive remains effective indefinitely. While the individual is of sound mind, she may revoke the document at any time. It is best to revoke an Advance Health Care Directive in writing, and to provide an updated document to all persons and institutions who had the old documents, so there can be no confusion.

Tip: Make multiple copies of health care documents and distribute them to family, friends, physicians, hospitals, HMOs, and other health care personnel and facilities.

LETTING OTHERS KNOW

An individual should give copies of an Advance Health Care Directive to family members and to her physician and hospital. Under California law, a copy is just as authoritative as an original. It is a good idea to keep a list of all persons and institutions who receive a copy.
An individual also can register the document with the California Secretary of State ((916) 653-3984) for a cost of $10. See: http://ahcdr.cdn.sos.ca.gov/forms/sfl-461.pdf. If an individual has appointed an agent through an Advance Health Care Directive, the individual should prepare a card that lists the telephone number(s) of the individual’s agent(s), and keep the card in her wallet or purse.

WHO DECIDES WHEN AN INDIVIDUAL HAS LOST CAPACITY?

Unless otherwise specified in an Advance Health Care Directive, an individual’s primary physician determines the individual’s ability to make health care decisions.

Where can I get health care decision making forms?

- Bet Tzedek Legal Services (323) 939-0506 or (818) 769-0136
- California Medical Association (800) 882-1262
- Hospitals and other health care providers

MUST PHYSICIANS COMPLY WITH AGENT’S DECISIONS?

A physician or other health care provider must comply with the decisions of a legally appointed agent or with a written instruction, with three rare exceptions. A health care provider is not required to obey a request for health care if that health care is (1) medically ineffective; (2) contrary to generally accepted health care standards; or (3) contrary to a conscience-based policy of the provider. A provider must give a patient clear advance notice of any conscience-based policies that may affect the provision of care. A provider who refuses the request of a patient or agent must also arrange for transfer of the patient to another provider or facility who will provide the care requested.

If a health care provider refuses to obey an appropriate decision or instruction, and none of the three above described exceptions apply, the provider is liable for $2,500 or actual damages, whichever is greater, and must pay the other party’s attorney’s fees.

EXAMPLE

Q. What happens at the time of death of the individual?

A. An Advance Health Care Directive may allow the agent to make certain provisions after the death of the individual, if specifically provided for in the document.

This includes the following:

- making a disposition under the Uniform Anatomical Gift Act;
- authorizing an autopsy; and/or
- directing the disposition of remains.

FAMILY’S RIGHTS IF NO AGENT WAS APPOINTED

According to California case law, the nearest relative of an individual who is unable to communicate can make the health care decisions for that individual if no one else has been appointed to make those decisions. This case
law, however, does not give a relative any formal documentation of her authority over the incapacitated individual’s health care decisions. As a result, a health care provider often is hesitant to accept the health care decision of the nearest relative of an incapacitated individual, unless the proper decision is obvious or unless the entire family of the incapacitated individual agrees with the decision of the nearest relative.

This law applies to domestic partners as well as spouses.

CONSERVATORSHIPS

When a difficult health care decision must be made for an incapacitated individual, or when the family members and friends of an incapacitated individual disagree on the proper medical treatment, a family member or friend should seek formal, documented authority to make health care decisions on behalf of the individual. The family member or friend can petition the court: (1) to be appointed conservator over the individual; or (2) to be given authority to make a particular health care decision for the individual.

If there is no family, a private professional conservator or the Public Guardian can be appointed by the court. Their fees are paid by the incapacitated individual’s estate.

In a conservatorship, a court appoints someone to act indefinitely on behalf of an incapacitated adult. The person appointed (the “conservator”) can be given the power to determine the medical treatment, residence, and/or finances of the incapacitated adult (the “conservatee”).

If an incapacitated individual does not need an ongoing conservator, a family member, friend, or other interested person can petition a court for authority over a particular health care decision of the individual. Unlike a conservatorship, this procedure cannot give a family member or friend authority over the individual’s residence or finances, and expires at the conclusion of the particular medical treatment.

A family member or friend desiring a conservatorship or a particularized authorization should consult an attorney.

**Tip:** To have health care wishes carried out, it is best to put them in writing.

End Of Life Decision-Making

REFUSING TREATMENT

In California, any competent adult has the right to refuse medical treatment just as they have the right to accept any given medical treatment. Case law defines medical treatment to include “furnishing food and water,” even if such refusal causes death. The agent under a Power of Attorney for Health Care has the same rights as the principal to accept or refuse treatment subject to the known wishes or instructions of the principal.

A person (or the person’s authorized agent) can specify the person’s wishes through a POLST form (Physician Order for Life-Sustaining Treatment) and/or a Pre-Hospital Do Not Resuscitate (DNR) form. Each form must also be signed by the person’s physician. These forms should be used when someone is terminally ill to supplement, but not to replace, an Advance Health Care Directive.
The POLST form is used chiefly in hospitals and other health care settings. The advantage is that the POLST form is an order and can be used and followed by health care personnel.

The Pre-Hospital DNR form is used with paramedics. Again, the advantage of the form is that it can be used and followed by health care personnel – in this case, the paramedics. The California Emergency Medical Services Authority has developed a form that is recognized by paramedics across the state. In addition to signing such a DNR form, a person can wear a DNR medallion that will be recognized and honored by paramedics. These medallions are available from Medic Alert.

**Note:** POLST forms and DNR forms are not advance planning documents for healthy persons. The POLST and DNR forms are generally used near the end of life, and are not substitutes for Advance Health Care Directives.

Many times an Advance Health Care Directive has instructions to forego life-sustaining treatment if the principal is terminally ill or will not benefit from such treatment. In the hospital setting, the agent can authorize palliative (comfort) care, a Do Not Resuscitate Order, and even withdrawal of life-sustaining treatments such as a feeding or breathing tube. It is sometimes necessary to convene a conference with the hospital’s ethics committee or request the assistance of an attorney or patient advocate to enforce the principal’s rights to stop active medical treatment. Some hospitals have their own Palliative Care departments, which should be called on for consultation with terminally ill patients.

If the patient is in an assisted living facility or at home, hospice care is a benefit that transitions the patient and the family in the dying process, providing the assistance of bathing, nursing, pain control, and spiritual support to the patient and family. Hospice care is usually delivered through a licensed hospice agency and is covered by Medicare, Medi-Cal, or private insurance. It requires a doctor’s prescription to get started.

When a person chooses to live at home throughout their illness, it is a good idea to have a Pre-Hospital Do Not Resuscitate form signed, so that the patient is not unnecessarily resuscitated by emergency personnel. Most hospice agencies will coordinate and assist with this document.

Whether the decision is made by the patient, the patient’s agent, conservator or family member, the patient’s desires and choices should be of primary importance to create a peaceful end of life.

**END OF LIFE OPTION ACT**

The End of Life Option Act was passed in California on October 5, 2015. California became the fifth state to allow physicians to prescribe medications to end the life of terminally ill patients.

The law (AB X2-14), goes into effect June 9, 2016 and ends on January 1, 2026 unless it is re-authorized. In order to access the prescription from an attending physician, the patient must:

- Be diagnosed with a terminal illness
- Have medical decision-making capacity
- Be a California resident
- Comply with the request requirements (two oral and one written)
- Have the physical and mental ability to self-administer the aid-in-dying drug
Patient protections include specific requirements of the attending physician to ensure that the patient is making an informed decision. Under no circumstances can a surrogate (spouse, parent, conservator or power of attorney agent) make the request on behalf of the patient. A patient may withdraw or rescind his/her request and may decide not to ingest the drug. If the patient does decide to ingest the drug, he/she must complete a "Final Attestation for an Aid-in-Dying Drug to End my life in a Humane and Dignified Manner" form within 48 hours of taking it. The patient’s family (or representative) is required to return that form to the physician who includes it in the patient’s health record.


**PARAMEDICS AND THE RIGHT TO DIE**

A paramedic will perform life-sustaining treatment, unless the paramedic is shown that the individual has signed a “Pre-Hospital Do Not Resuscitate” form developed by the California Medical Association, or unless the individual is wearing a “Do Not Resuscitate” bracelet or medallion approved by a paramedic agency.

“Do Not Resuscitate” bracelets and medallions can be obtained from the MedicAlert Foundation (888) 633-4298. These forms, bracelets, and medallions are honored by paramedics throughout California.

**REFUSING TREATMENT ON BEHALF OF AN INCAPACITATED INDIVIDUAL WITHOUT WRITTEN ADVANCE DIRECTIVE**

A court-appointed conservator or the individual’s nearest relative may be given authority to halt an individual’s life-sustaining medical treatment. In addition, health care providers may accept informal, non-binding indications of an individual’s treatment desires, although certainly many health care providers will demand formal written authority.

The Documentation of Preferred Intensity of Care Form is sometimes used by doctors to summarize the patient’s or family’s wishes about end-of-life care, especially if there is no legally designated agent or conservator. A preferred intensity of care form can be obtained through the California Medical Association by calling 1-800-882-1262.

**Financial Decisions**

**POWERS OF ATTORNEY FOR FINANCES**

In a power of attorney for finances, an individual of sound mind selects an agent who will have authority to make the individual’s financial decisions. Powers of attorney for finances should be signed and notarized.

It is best if a power of attorney for finances is prepared by an attorney as part of the estate planning process. Broad powers of attorney for finances are sold in stationery stores, but they can easily be abused by an unscrupulous agent. With the involvement of an attorney during the drafting process, the power of attorney can more accurately direct the agent, and protect the individual from agent misconduct. If a form is to be used, the best form is the Uniform Statutory Form Power of Attorney found in California Probate Code § 4401.
In planning for incapacity, it is best to write a “springing” document, i.e., one that springs into effect only at a future time when the individual loses capacity. A springing document then can be used when the individual no longer has the ability to make her own decisions. However, the power of attorney must contain “durable” language, so that it is effective if the principal becomes incapacitated.

Unfortunately, some banks do not honor a power of attorney for finances unless it was prepared on the bank’s power of attorney form. The bank’s position is legally wrong but, as a practical matter, it is best if an individual supplements a power of attorney for finances by also designating the same agent on the power of attorney form used by the individual’s bank.

Remember—a power of attorney can be revoked as long as the individual retains the mental capacity to do so. A power of attorney ceases to be valid upon an individual’s death.

Note: Powers of attorney for finances are very powerful documents, and should be tailored carefully to the individual’s needs.

WILLS

Wills by themselves are not useful in planning for incapacity, although they can be used in conjunction with powers of attorney and trusts.

Wills pass property to specified heirs after the individual’s death. In the absence of a will or any other estate planning, the individual’s property is distributed among family members based on a priority system set by California law.

A downside of a will is the required payment of probate fees, although small estates are exempted from probate. A benefit of the probate process is the certainty that it offers: the court’s order at the conclusion of probate settles the distribution of property, and bars creditors from filing subsequent claims.

Tip: Don’t be too stingy in developing an estate plan. A few thousand dollars is a small investment to make sure that a home and savings are handled and distributed appropriately.

TRUSTS

Trusts are commonly used both to distribute an individual’s property after her death, and to manage her property if and when she becomes incapable of handling her own affairs. The trust document appoints a trustee for managing the individual’s property.

It is important that the individual make sure that the trust is properly funded – for example, that the individual’s bank accounts are listed as belonging to the trust, and that the title to the individual’s home be held by the trust.

Trusts are drafted by attorneys as part of an estate plan. There are both advantages and disadvantages to using a trust, rather than a will. An advantage is that administration of a trust does not require Probate Court administration and does not incur statutory probate fees. A disadvantage is that a trustee is not monitored, and therefore there is a greater risk that property will not be distributed properly.

Newspapers frequently run ads for trust seminars, which promise trusts for $500 or less. These seminars should be avoided at all costs. Trusts should be personalized by an attorney and, in many cases, the trust seminars are designed to attract customers for annuity sales.
Supplemental Materials
CALIFORNIA POWER OF ATTORNEY FOR HEALTH CARE AND HEALTH CARE DIRECTIVE

NOTE: COMPLETION OF THIS FORM IS ONLY THE FIRST STEP.
YOU SHOULD DISCUSS YOUR WISHES IN DETAIL WITH YOUR DESIGNATED AGENT(S).

• WITH THIS FORM YOU MAY DO ANY OR ALL OF THE FOLLOWING:
  1. NAME AN AGENT TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT.
  2. INSTRUCT DOCTORS AND OTHER HEALTH CARE PROFESSIONALS HOW YOU WOULD LIKE TO BE TREATED IF YOU ARE HURT OR SERIOUSLY ILL AND UNABLE TO TELL THEM YOUR WISHES.

• READ THE FORM CAREFULLY. CROSS OUT ANY PROVISION YOU DO NOT WANT.
• THIS FORM REVOKES ANY PRIOR DIRECTIVES YOU HAVE MADE.
• AFTER YOU COMPLETE THIS FORM SIGN AND DATE IT. TWO WITNESSES OR A NOTARY MUST ALSO SIGN AND DATE IT.

My name is: _______________________________________________________.
also known as/formerly known as: _____________________________________________________.

In this document I appoint an agent. That agent will make health care decisions for me in the future, if and when I no longer have the capacity to make my own health care decisions. My primary care physician will determine when I am unable to make my own health care decisions.

OPTIONAL: I want my agent's authority to make health care decisions for me to take effect immediately.
Initial here if this statement reflects your desires:   [ ]

Part 1 - NAMING YOUR AGENT (If you do not have an agent, please proceed to Part 2 on page 3.)

Do not select any of the following persons as your agent or alternate agent:
• Your primary physician.
• An employee or operator of the health care institution, community care facility, or residential care facility where you receive care (unless you are related to that person).

AGENT

Name: __________________________________________________________

Address: ______________________________________________________

City State Zip

Phone: (____) ___________ Alt. Phone: (____) ___________ Email: ________________________________

1ST ALTERNATE AGENT (If Agent is not reasonably available to make a health care decision for me.)

Name: __________________________________________________________

Address: ______________________________________________________

City State Zip

Phone: (____) ___________ Alt. Phone: (____) ___________ Email: ________________________________
2nd ALTERNATE AGENT (If Agent and 1st Alternate Agent is not reasonably available to make a health care decision for me.)

Name: ____________________________________________________________

Address: ____________________________________________________________  
City State Zip

Phone: ( ) ___________________   Alt. Phone: ( ) ___________________   Email: _______________________________

AGENT’S AUTHORITY

Except as limited by this document, my agent will have authority to make all health care decisions for me. This authority includes, but is not limited to, the authority 1) to accept or refuse treatment, nutrition and hydration, 2) to choose a particular physician or health care facility, and 3) to receive, or consent to the release of, medical information and records.

Agent’s Post Death Authority: My agent is authorized to donate all or part of my body, to authorize an autopsy and/or determine the disposition of my remains. The agent’s actions must be consistent with my will or trust, and with any arrangements which I have made. (Cross this out if you do not wish your agent to have this authority.)

Agent’s Authority Under HIPAA & CMIA: My agent shall be my personal representative under HIPAA and legal representative under CMIA and shall have the same rights to inspect, obtain and disclose my protected health information as I have.

AGENT’S OBLIGATIONS

1. My agent shall make decisions for me in accordance with this power of attorney, other instructions I make in this form and my personal wishes, to the extent my agent knows them. If my wishes on a subject are not known, my agent shall make health care decisions for me consistent with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known by my agent.

2. My agent shall provide a copy of this advance health care directive to any health care provider or facility that takes on responsibility for my care.

NOMINATION OF CONSERVATOR

If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

Initial here if this statement reflects your desires: [ ]
Part 2 - HEALTH CARE INSTRUCTIONS I make the following health care instructions to my agent, or to my health care provider if my agent is not reasonably available or I do not have an agent:

I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued:

(1) If I am in an irreversible coma or persistent vegetative state; or  
(2) if I am terminally ill and the use of life sustaining procedures would serve only to artificially delay the moment of my death; or  
(3) under any other circumstances where the burdens of treatment outweigh the expected benefits.

In making decisions about life sustaining treatment under (3) above, I want my agent or health care provider to consider the relief of suffering and the quality of my life as well as the extent of the possible prolongation of my life.

Initial here if this statement reflects your desires: ☐

I authorize all treatments to prolong my life for as long as possible.

Initial here if this statement reflects your desires: ☐

Other instructions/authorizations:

REVOCATION OF PREVIOUS DOCUMENTS: I revoke any previously-executed Power of Attorney for Health Care, Individual Health Care Instruction, or Natural Death Act Declaration.

SIGNATURE OF PRINCIPAL (Sign and date form here in front of witnesses or a notary.)

Date: ____________________ Signature: ________________________________ ___________________________

(If principal is not physically able to sign, he or she can instruct another person to sign the principal’s name, if signature is done in the principal’s presence.)

STATEMENT OF WITNESSES

This document must either be notarized, or signed by two witnesses. If the principal (the person appointing the agent) currently resides in a nursing facility, this document also must be witnessed by a representative of California’s Long-Term Care Ombudsman Program. If the two-witness method is chosen, the Ombudsman Program representative may serve as one of the two witnesses, or may serve as a third witness. If the notarization method is chosen, the Ombudsman Program representative serves as a separate witness. Certain individuals cannot serve as witnesses. Those rules are set forth in the following witness statements.
I declare under penalty of perjury under the laws of California
(1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence,
(2) that the individual signed or acknowledged this advance directive in my presence,
(3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence,
(4) that I am not a person appointed as agent by this advance directive, and
(5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First Witness: __________________________
Name (printed) Signature
Date: _________________ Address: ____________________________________________
City State Zip

Second Witness: __________________________
Name (printed) Signature
Date: _________________ Address: ____________________________________________
City State Zip

ONE OF THE PRECEDING WITNESSES ALSO MUST SIGN THE FOLLOWING DECLARATION:
I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.
Date: ____________________ Signature: __________________________________________

DECLARATION OF OMBUDSMAN PROGRAM REPRESENTATIVE
(Required if person appointing the agent currently resides in a nursing facility.)
I declare under penalty of perjury under the laws of California that I am an ombudsman designated by the California Department of Aging and that I am serving as a witness as required by Section 4675 of the California Probate Code.
Date: ____________________ Signature: __________________________________________

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC
(Not required if two-witness method is followed.)
A Notary Public or other officer completing this certificate verifies only the identity of the individual who signed the document to which the certificate is attached, and not the truthfulness, accuracy, or validity of that document.
State of California, County of ______________________________
On _____________________ before me, (name and title of officer) __________________________________________, personally appeared ____________________________ ____________________________, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.
I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct:
WITNESS my hand and official seal.
Signature __________________________________________

NOTE: USE OF THIS FORM IS NOT APPROPRIATE FOR EVERY PERSON OR EVERY SITUATION.
FOR MORE INFORMATION ABOUT POWERS OF ATTORNEY FOR HEALTH CARE, CONSULT WITH AN ATTORNEY.
CHAPTER TEN

KINSHIP CARE

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CHAPTER TEN: KINSHIP CARE

INTRODUCTION

BACKGROUND

Millions of children in the United States live with caregivers who are not their parents. The majority of these caregivers are grandparents. Due to various socioeconomic factors, this trend in “kinship care” has seen a dramatic increase over the last decade.

This chapter gives a general review of the issues involved in kinship care, and provides assistance in dealing with problems that often arise.

WHAT IS KINSHIP CARE?

Kinship care means different things to different people. In its broadest sense (in a definition used by the Child Welfare League of America), it is the “full time care, nurturing and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child.” The State of California’s definition of kinship care is significantly narrower, limited to the care of children by “relatives.”

Regardless of the scope of kinship care’s definition, the goal of kinship care is to allow a child to grow into adulthood in a family environment.

GROWTH OF KINSHIP CARE

The 1990’s saw a dramatic increase in the number and proportion of children living with relatives. According to the Child Welfare League of America, this increase can be attributed to the benefits of kinship care, and to various other factors that have contributed to the breaking-up of parent-child relationships:

- Increased reporting of abuse and neglect;
- Increased use of crack cocaine and other drugs;
- Increased levels of poverty;
- Spread of HIV/AIDS;
- Parents’ struggles with physical and mental health problems;
- Family violence and parental incarceration;
- Decline in availability of traditional foster homes; and
- Increased number of children in foster care.
THE NUMBERS

In 2012, 10 percent of the grandparents in the United States were living with a grandchild; of these 7 million grandparents, 2.7 million were raising their grandchildren without either parent in the home. According to the Child Welfare Information Gateway, 32 percent of the 437,465 children in foster care in the United States on September 30, 2016 were living with relatives. More than half of the nearly 19,000 children in Los Angeles County foster care in 2020, were placed with relatives.

FORMS OF CAREGIVING

RELATIVE CAREGIVERS WITH INFORMAL AUTHORITY

Many times, a child is placed in the care of a grandparent not through the courts, but via some informal agreement with the parent(s). In this kinship care situation, relatives simply assume responsibility for a child in need without involvement from the court system, child protective services, or other authorities.

Caregivers with informal authority may have physical custody of the child, but have limited rights to make decisions regarding the child. A grandparent may find it difficult to consent to medical procedures for the child, or to enroll the child in school. Additionally, the grandparent may not be eligible for as much financial assistance from the state and federal governments, and the type of care of assistance and medical care may be limited in scope.

Another disadvantage of an informal caregiving relationship is the lack of a sense of permanence. In most informal caregiver situations, the child’s parents have the authority at any time to return and take the child away.

It should be noted that a caregiver with informal authority may obtain greater authority by preparing a “Caregiver Authorization Affidavit.” The Affidavit is short, simple and very easy, and can address health care and school enrollment. The Affidavit is signed by the caregiver, who certifies that he or she has informed (or tried to inform) the child’s parent(s) of the caregiver’s intent to make decisions on the child’s behalf. A copy of the Affidavit is included at the conclusion of this chapter.

The chart following compares some of the main differences and similarities between informal relative caregivers and legal guardians.

<table>
<thead>
<tr>
<th>Informal Custody</th>
<th>Legal Guardianship</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents have full rights, including right to reclaim child at any time</td>
<td>• Parents’ rights suspended and transferred temporarily to legal guardian; parent must go to court to terminate legal guardianship before reclaiming child</td>
</tr>
<tr>
<td>• Child ineligible for health care coverage under caregiver’s employee health plan</td>
<td>• Child eligible for health care coverage under caregiver’s employee health plan</td>
</tr>
<tr>
<td>• Caregiver cannot consent if consent of “parent or legal guardian” required</td>
<td>• Legal guardian can give consent</td>
</tr>
<tr>
<td>• Parents have responsibility to financially support child</td>
<td>• Parents have responsibility to financially support child</td>
</tr>
</tbody>
</table>
RELATIVES AS FOSTER PARENTS

When a child is placed in foster care by a county, the county social worker and court must give preferential consideration to an approved relative caregiver.

The parent must disclose all known relatives. Then, the social worker must contact the relatives given preferential consideration, to determine if any of those relatives wish that the child be placed with them. If a relative wishes to have the child placed with him, that relative must be assessed.

There have been significant changes in California law regarding foster care. One result of those changes is that a relative caregiver’s home must meet the same licensing standards as all other foster parent homes.

ADOPTION

Adoption is a process in which the mother’s and father’s parental rights are terminated. Relative caregivers who adopt are considered the child’s parents under the law. Adoption permanently terminates all of the biological parents’ rights and obligations; this includes visitation and financial support. Traditionally, adoption had been the long-term solution preferred by the dependency court, the court that oversees cases where a child has been removed from a parent’s home by the Department of Children and Family Services. However, adoption may not be an appropriate solution for many kinship families and guardianship is now recognized as another appropriate option for provide stability in such a child’s life.

LEGAL GUARDIANSHIP

A guardianship is a court-ordered change in custody by which parental rights are suspended and a “legal guardian” is appointed to provide care, custody, and control of the child. A legal guardian has the ability to act on the child’s behalf and make decisions regarding the child. The establishment of a guardianship does not terminate parental rights altogether, and a parent, or any other interested person, can petition the court to terminate the guardianship. A guardianship can be established in any juvenile court; however, most guardians are appointed in Probate Court.

AVAILABLE ASSISTANCE FOR INFORMAL RELATIVE CAREGIVERS

FINANCIAL ASSISTANCE

Grandparents who find themselves in an informal relative caregiver situation may be able to obtain financial assistance through CalWORKs (California Work Opportunities and Responsibility to Kids). CalWORKs is a statewide program that provides cash assistance to families with children under 19 years of age. The amount of the monthly payment for a child is based on the total number of children in the home and whether the adult caregiver also receives CalWORKs assistance.
All children who are U.S. citizens or legal permanent residents (green card) are eligible. The income of the caregiver relative is irrelevant. Financial assistance generally is greater if the child is in the foster care system, rather than in an informal relative caregiver situation.

**HEALTH CARE ASSISTANCE**

Medi-Cal is the primary means of medical assistance for children in informal caregiver situations. Medi-Cal is a statewide medical assistance program that provides coverage for minor children, and in some cases, the relative caring for them, if financial eligibility standards are met. A child receiving CalWORKs is automatically eligible for medical coverage through the Medi-Cal program, regardless of the relative caregiver’s household income.

**AVAILABLE ASSISTANCE WHEN RELATIVE HAS LEGAL AUTHORITY OVER CHILD**

**FINANCIAL ASSISTANCE AND HEALTH CARE ASSISTANCE**

When a child is under the care of a legal guardian, assistance from the CalWORKs and Medi-Cal programs can be available, just as that assistance can be available for a child in an informal caregiver situation. See above for a discussion of CalWORKs and Medi-Cal.

**FOSTER CARE RELATIVE CAREGIVERS**

When a child is removed from a parent’s home due to neglect or abuse, the Department of Children and Family Services (DCFS) acquires legal custody of the child, and the child is placed in the state foster care system. Under state law, relatives are given the first opportunity to take care of the child. The state retains legal custody of the child unless foster care relative caregivers obtain guardianship or adopt.

As discussed on the following pages, approved foster care relative caregivers are eligible for a wider range of financial and medical assistance, as compared to the assistance available to informal relative caregivers. Some of this assistance remains applicable even if the foster care relative subsequently obtains legal guardianship or adopts.

**ADDITIONAL FINANCIAL ASSISTANCE**

The rate structure for foster care benefits in California has been drastically overhauled effective January 1, 2017. For many years, the foster care rate for a child was based upon a myriad of factors including the age of the child, the income of the home from which the child was removed, and the familial relationship of the child and the person with whom they are placed. California’s foster care rates are now tied to the health and behavioral needs of the child.

As part of the restructure process, the rates for families that had been receiving assistance through the Kinship Guardianship Assistance Program (Kin-GAP) or the Non-Related Legal Guardian (NRLG) Program, where
guardianship was established prior to or after May 1, 2011 will not change. However, for Kin-GAP cases in which the guardianship was established and the dependency proceedings were terminated on or after May 1, 2011, the Kin-GAP rate may be increased upon reassessment of the circumstances of the caregiver and the needs of the child.

Similarly, the rates for families that had been receiving assistance through the Adoption Assistance Program (AAP) benefits, the monthly payments given to relative caregivers who adopt a child in the foster care program, will not change in cases where the AAP agreement was signed and the adoption was finalized prior to May 27, 2011. However, in cases where the AAP agreement was signed or the AAP eligible adoption was finalized on or after May 27, 2011, the rate may be reassessed based on the changing needs of the child or the circumstances of the adoptive parent.

ADVANTAGES OF ADOPTION

Even if a foster care relative caregiver chooses to forgo the legal guardianship process, he or she can obtain formal custody by adopting the child. Indeed, this process provides the most permanent solution. The caregiver will still be able to get both medical and financial assistance after the process is complete; AAP benefits (explained on prior page) will continue until the child is 18.

Grandparents may consider adopting the child in an effort to secure permanency. Significantly, informal relative caregivers who adopt do not receive automatic financial or medical assistance from the state. Foster care relative caregivers, on the other hand, may be eligible to receive both Adoptive Assistance Program Benefits (AAP) and Medi-Cal benefits.

RESOURCES

ADDITIONAL BENEFITS

Besides the core set of benefits available to relative caregivers already mentioned, other benefits or resources may be available, including:

- Child support payments;
- Food programs;
- In-Home Supportive Services;
- Regional center services;
- Social Security Administration benefits; and
- Veteran’s benefits.

In-Home Supportive Services and Social Security Administration benefits are discussed elsewhere in this manual.

SUPPORT SERVICES

Relative caregivers often can benefit from support services. Resources in the Los Angeles County area include the following:
• The Kinship Care Project of Bet Tzedek Legal Services ((323) 939-0506) may provide legal assistance under certain circumstances.

• The Children’s Rights Project of Public Counsel ((213) 385-2977) also may provide legal assistance under certain circumstances.

• Advocates 4 Family Caregivers – Office of Samoan Affairs Community Center, ((310) 538-0546) provides advocacy and guidance for families involved with Dependency Court, Family Court, Probate Court, DCFS, and Individualized Education Plans.

• Grandma’s House, a program of the Children’s Institute International (CII), provides kinship care support services in the Los Angeles area. Drop-in counseling and assessments for children and families are available along with weekly support groups and social/recreational activities for relative caregivers and their children. Information can be obtained by calling (213) 807-1821, or reviewing Internet information at https://www.childrensinstitute.org/.

• Grandparents as Parents, Inc.(GAP), currently operates support groups in Sherman Oaks, Inglewood, Panorama City, Pasadena, Carson, Long Beach and Compton. GAP can be reached at (818) 789-1177 or (714) 761-2231.
SUPPLEMENTAL MATERIALS
Caregiver's Authorization Affidavit

Use of this affidavit is authorized by Part 1.5 (commencing with Section 6550) of Division 11 of the California Family Code.

Instructions: Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related medical care. Completion of items 5-8 is additionally required to authorize any other medical care. Print clearly.

The minor named below lives in my home and I am 18 of age or older.

1. Name of minor: 

2. Minor's birth date: 

3. My name (adult giving authorization): 

4. My home address: 

5. □ I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back of this form for a definition of "qualified relative").

6. Check one or both (for example, if one parent was advised and the other cannot be located):

□ I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care and have received no objection.

□ I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time to notify them of my intended authorization.

7. My date of birth: 

8. My California driver's license or identification card number: 

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: ___________________    Signed: ___________________
Notices:

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor and does not mean that the caregiver has legal custody of the minor.

2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

3. This affidavit is not valid for more than one year after the date on which it is executed.

Additional Information:

To Caregivers:

1. "Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

2. The law may require you, if you are not a relative or currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions, please contact your local department of social services.

3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.

4. If you do not have the information requested in item 8 (California driver's license or I.D.), provide another form of identification such as your social security number or Medi-Cal number.

To School Officials:

1. Section 48204 of the Education Code provides that this affidavit constitutes a sufficient basis for determination of residency of the minor, without the requirement of a guardianship or other custody order, unless the school district determines from actual facts that the minor is not living with the caregiver.

2. The school district may require additional reasonable evidence that the caregiver lives at the address provided in item 4.

To Health Care Providers and Health Care Service Plans:

1. No person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or to civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the form are completed.

2. This affidavit does not confer dependency for health care coverage purposes.