

# ADMISSIONS NOTICE PACKET

## IMPORTANT INFORMATION FOR NURSING FACILITY RESIDENTS AND THEIR SPOUSES

Important information for nursing facility residents and their spouses. If you need this information in another language or someone to interpret it, please notify the nursing facility or contact your local county assistance office. Language assistance will be provided free of charge.

Información importante para los residentes en hogares de ancianos y sus esposos. Si usted necesita esta información en otro idioma o alguien que se la traduzca, favor de notificar al personal de la residencia o comunicarse con la oficina local de Asistencia del Condado (CAO). Asistencia lingüística será proveída gratis.

ព័ត៌មានសំខាន់សម្រាប់អ្នករស់នៅក្នុងមណ្ឌលគិលានុបដ្ឋាក/នុបដ្ឋាករថែទាំសម្រាប់ប្តី/ប្រពន្ធរស់នៅ។ បើលោកអ្នកត្រូវការព័ត៌មាននេះជាភាសាផ្សេងទៀត ឬអ្នកណាម្នាក់អាចបកប្រែអោយ សូមជំរាបមណ្ឌល គិលានុបដ្ឋាក/នុបដ្ឋាករថែទាំសម្រាប់ព័ត៌មាននៅការិយាល័យដ៏ជិតបំផុតរបស់លោកអ្នក។ ជំនួយក្នុងការបកប្រែនិងផ្តល់អោយដោយឥតគិតថ្លៃ។

Thông tin quan trọng về cơ sở dưỡng lão dành cho thường trú nhân và vị phối ngẫu. Nếu quý vị cần thông tin này bằng một thứ tiếng khác hay một phiên dịch viên, xin thông báo cho cơ sở dưỡng lão hay liên lạc với Văn Phòng Trợ Cấp Quận Hat. Trợ giúp về ngôn ngữ sẽ được cung cấp miễn phí.

这是发给疗养所的居民及其配偶的重要通知。如果您需要此通知翻译成其他语种或需要为您提供翻译，请通知疗养所或联系您所在地区的郡县协助办事处(County Assistance Office)。可提供免费语言协助。

Важные сведения относительно жителей домов престарелых и их супруг (супругов). Если вам нужен данный документ на другом языке или его устный перевод, обращайтесь в дом престарелых либо в местное Бюро помощи (County Assistance Office). Помощь переводчика предоставляется бесплатно.

This information packet contains important information about your rights as a resident of a nursing facility, and information about Medical Assistance (MA), a program which can help pay for nursing facility care for people who cannot pay all of the costs of care by themselves. Federal law, 42 U.S.C. § 1396r (c) (1) (B) and (e) (6), requires the nursing facility to give you this information.

Even if you are paying for your nursing facility care yourself, or if Medicare or another insurance is paying, it is important for you to learn about MA before you might need it.

### There are four (4) parts to this Admissions Notice Packet.

#### PART 1 - Pages 2-6

#### Notice of Rights of Nursing Facility Residents

Applies to Everyone

#### PART 2 - Pages 7-8

#### Medical Assistance Payment for Nursing Facility Care Eligibility Requirements and Procedures

Everyone should read this part - Even if you do not need MA now.

#### PART 3 - Pages 9-11

#### Protecting Resources and Income for the Spouse Living at Home

Applies if you have a spouse who is living in the community, i.e., is not in a nursing facility or medical institution.

#### PART 4 - Pages 12-15

#### Resource Assessment Form (PA 1572)

To be used by a couple when one of them is in a nursing facility or other medical institution, and the other lives in the community.

I certify that the notices required by 42 U.S.C. § 1396r (c) (1) (B) and (e) (6) were provided to me at the time of my admission to:

**Note: A new 401 is needed for each admission.**

\_\_\_\_\_  
Name of Resident

\_\_\_\_\_  
Resident's Social Security Number

\_\_\_\_\_  
Signature of Resident

OR

\_\_\_\_\_  
Signature of Patient or Resident Representative

\_\_\_\_\_  
Relationship to Resident

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Date of Admission

Affix UMR stamp here

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Name of Resident

\_\_\_\_\_  
Name of Facility

\_\_\_\_\_  
Date of Admission

\_\_\_\_\_  
Resident's Social Security Number

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Signature of Resident

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Relationship to Resident

\_\_\_\_\_  
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# ADMISSIONS NOTICE PACKET

IMPORTANT INFORMATION FOR NURSING  
FACILITY RESIDENTS AND THEIR SPOUSES



**pennsylvania**

DEPARTMENT OF PUBLIC WELFARE

# PART 1

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## NOTICE OF RIGHTS OF NURSING FACILITY RESIDENTS

(Applies to Everyone)

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### Dear Resident:

This is your personal copy of the notice of rights given by the law to residents living in nursing facilities as required by Title XIX of the Social Security Act. The applicable sections (Sec.) of the Social Security Act are provided for your information.

The nursing facility is committed to provide you with professional care and support services which will accommodate your medical and personal care services needs.

By law you have the following rights:

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### **ADVANCE DIRECTIVE - Sec. 1902(w)**

You have the right to give advance written instructions to your doctor and others, that in the event you become incapacitated, your nursing facility and your physician will honor your wishes regarding your choice to accept, refuse, or discontinue medical care or surgical treatments.

### **FREEDOM OF CHOICE - Sec. 1919(c)(1)**

You have the right to choose a personal attending physician and to be fully informed in advance about the care and treatment you will receive; to participate in planning your care and treatment; and, to be fully informed in advance of any changes in your care plan or treatment.

### **FREEDOM FROM RESTRAINTS - Sec. 1919(c)(1)**

You have the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints unless they are required to treat your medical symptoms and are not used for purposes of discipline or for the convenience of staff. Restraints may only be used to ensure your physical safety or the safety of other residents. These limitations must be based upon the written order of a physician which specifies the duration and circumstances which require such restraints.

### **PRIVACY - Sec. 1919(c)(1)**

You have the right to privacy with regard to accommodations, medical treatment, written and telephone communications, visits and meetings with family and other resident groups. Your right to privacy should not be interpreted as a right to a private room.

### **CONFIDENTIALITY - Sec. 1919(c)(1)**

Neither your personal nor your clinical record may be released to anyone who is not involved in providing or monitoring the care provided to you under your plan of care, except with your consent. Exception - your records will be released when required by law, or when you are transferred to another health care institution.

### **ACCOMMODATION OF NEEDS - Sec. 1919(c)(1)**

You have the right to have your personal needs and preferences provided for to the extent that they do not interfere with the rights of other residents of the nursing facility. You must have advance notice of any intention to change either your room or your roommate in order that your personal preferences may be considered prior to any being made.

## **GRIEVANCES - Sec. 1919(c)(1)**

You have the right to object to any treatment or care which has been furnished as well as that which has not been furnished with the assurance that there will be no reprisals for voicing your grievances which must be resolved promptly and fairly. If the need should arise, you may choose to be represented by an attorney.

## **PARTICIPATION IN RESIDENT AND FAMILY GROUPS - Sec. 1919(c)(1)**

You have the right in your nursing facility to organize and participate in resident groups which may include families and friends.

## **PARTICIPATION IN OTHER ACTIVITIES - Sec. 1919(c)(1)**

You have the right to participate in social, religious, and community activities which do not interfere with the rights of other residents in the nursing facility.

## **EXAMINATION OF SURVEY RESULTS - Sec. 1919(c)(1)**

You have the right to examine the results of the most recent survey of the nursing facility as conducted by state or federal authorities and any plan of correction in effect with respect to your nursing facility. The survey results must be made available for your examination by the facility in a place readily accessible to you.

## **NOTICE OF RIGHTS - Sec. 1919(c)(1)**

Your nursing facility must inform you orally and in writing, at the time of your admission to the facility, of your legal rights while you are a resident of the facility. A written statement of your rights must also be provided to you by your nursing facility upon reasonable request.

## **RIGHTS OF INCAPACITATED RESIDENTS - Sec. 1919(c)(1)**

If you are found to be incapacitated under the laws of the state, a guardian will be appointed under state law to act on your behalf.

## **USE OF PSYCHOPHARMACOLOGIC DRUGS - Sec. 1919(c)(1)**

These drugs may only be administered to you on the orders of a physician and only as part of your written plan of care. Your plan of care must describe the plan to eliminate or modify the symptoms for which the drugs are prescribed. At least annually an independent, external consultant must review the appropriateness of your receiving such drugs.

## **TRANSFER AND DISCHARGE - Sec. 1919(c)(1) and (2)**

You cannot be transferred or discharged from your nursing facility except in an emergency; the nursing facility ceases operations; you may endanger the health and safety of the other residents; nonpayment of your share, if any, of your cost of care; improvement in your health to the point where you no longer need nursing facility care; or an urgent need for medical services the nursing facility cannot provide. Except for an emergency or your urgent need for medical services the nursing facility cannot provide, the nursing facility must give you and a relative or other responsible person you have named, 30 days advance written notice of your transfer or discharge. The nursing facility must arrange for your safe and orderly transfer to a site where your needs can be adequately provided for, and the nursing facility must thoroughly prepare you for your upcoming transfer or discharge.

**Transfer or discharge does not mean movement of a resident to a bed within the same certified facility.**

## **BED HOLD POLICIES - MEDICAL ASSISTANCE RESIDENTS - Sec. 1919(c)(2)**

The Medical Assistance Program will make payment to your nursing facility to hold (reserve) the bed for you when you are away from the nursing facility for a continuous 24 hour period because you are in the hospital or on therapeutic leave. A bed must be available for you when you return to the nursing facility. Pennsylvania's limits on Medical Assistance Program payments for reserved bed days are as follows:

1. Hospitalizations - A maximum of 15 consecutive days per hospitalization. During the 15 day period, the same bed shall be available to you upon your return to the nursing facility.
2. Therapeutic leave - A maximum of 30 days per calendar year (leave days must be included in your Plan of Care and must be ordered by your attending physician.)

## **ACCESS AND VISITATION RIGHTS - Sec. 1919(c)(3)**

You have the right to say who may or may not have access to your nursing facility for the purpose of visiting with you. This includes your family, relatives, or others. Also, you have the right to immediate access by your attending physician or any representative of the federal Department of Health and Human Services, the state Departments of Public Welfare and Health, and the Department of Aging Ombudsman Program. Organizations or individuals providing health, social, legal, or other services may, with your consent, have reasonable visits with you.

## **EQUAL ACCESS TO QUALITY CARE - Sec. 1919(c)(4)**

Your nursing facility must establish and maintain the same policies and practices for all residents regardless of source of payment, regarding transfer, discharge and provision of nursing facility services required under the state plan.

## **ADMISSION POLICY - Sec 1919(c)(5)**

Your nursing facility cannot prohibit or discourage you from applying for or receiving Medicare or Medical Assistance benefits. Your nursing facility must prominently display or provide you with individually written and oral information about how to apply for Medicare or medical assistance benefits, how to use these benefits and how to receive refunds for any prior payments made by you that are covered by these benefits.

If you are entitled to Medical Assistance for nursing facility services, neither you nor anyone on your behalf may be required by the nursing facility to make any payments to the nursing facility as a condition of your admission, to speed up your admission or to guarantee your continued stay in the nursing facility. This requirement does not stop the nursing facility from requesting, accepting, or receiving genuine charitable, religious or humanitarian contributions from organizations or people that are not related to you, if the contribution is not a condition of your admission, to speed up your admission or to guarantee your continued stay in the nursing facility.

The nursing facility must advise you in advance when payments for items or services to be delivered are not covered by the Medical Assistance Program. You must be advised of the costs of the noncovered items or services, and be given the option of accepting or rejecting the charges and the noncovered items or services. This requirement does not stop a nursing facility from charging you for items or services which you requested and received that are not covered by the Medical Assistance Program.

## **PROTECTION OF PERSONAL FUNDS - Sec 1919(c)(6)**

You are not required to deposit your personal funds with your nursing facility.

If you choose, however, to deposit your personal funds with your nursing facility, your nursing facility must provide you with a written authorization form which you must sign, that requires the nursing facility to manage and account for your personal funds OVER \$50.00 in an interest-bearing account. This account must be kept separate from any of your nursing facility's operating accounts. If your funds are kept in the same account (pooled accounts) as other residents, there must be an accounting of each resident's share of the funds and interest in the account.

Any of your personal funds **UNDER** \$50.00 must be kept in a noninterest-bearing account, interest-bearing account, or petty cash fund. Your nursing facility must maintain a full and complete separate accounting of your personal funds; a written record of all financial transactions involving your personal funds; and permit you or your legal representative reasonable access to the records of your account.

If you are a resident receiving Medical Assistance benefits, your nursing facility must let you know when the balance in your account plus the value of your other nonexempt resources reaches \$200.00 less than the amount that may cause you to lose your eligibility for Medical Assistance benefits.

In the event of your death, your nursing facility must promptly (within 30 days) turn over to the executor of your estate your personal funds with a final accounting of those funds.

Your nursing facility must provide assurances to the appropriate state authorities that the personal funds you deposited with your nursing facility are safe and can be accounted for.

If you are a resident receiving Medicare or Medical Assistance benefits, your nursing facility may not deduct from your personal funds the cost of any service or item for which payment is covered by Medical Assistance or Medicare, whichever is applicable.

## **MEDICAL ASSISTANCE ELIGIBILITY AND PROTECTION OF INCOME AND RESOURCES FOR THE SPOUSE IN THE COMMUNITY**

Medical Assistance payment for long term care is available for people who do not have enough income and resources to pay for their care. You can learn more about Medical Assistance by reading Part 2 of this Admissions Notice Packet.

There are special Medical Assistance rules (Section 1924 of the Social Security Act) for protecting income and resources for a person whose spouse is in a nursing facility.

Generally, one-half of the couple's total countable resources at the time of admission to the nursing facility can be set aside for the spouse at home, subject to a minimum and a maximum set by federal law. In 2009, the minimum is \$21,912; the maximum is \$109,560. In some circumstances, more resources may be retained to produce income if the community spouse's income is below the maximum amount established by federal law. In 2009, the maximum monthly income amount is \$2,739.

These minimum and maximum figures are revised annually. You can get updated figures for income and resource limits from your nursing facility, the local county assistance office or the Welfare Help Line: 1-800-692-7462.

**DETAILED INFORMATION ABOUT THESE SPECIAL RULES FOR PROTECTING INCOME AND RESOURCES FOR THE SPOUSE AT HOME ARE IN PART 3 OF THIS ADMISSIONS NOTICE PACKET. IT IS IMPORTANT FOR YOU TO READ THE INFORMATION IN PART 3 NOW EVEN IF YOU DO NOT NEED MEDICAL ASSISTANCE NOW.**

## **ESTATE RECOVERY PROGRAM**

The Department of Public Welfare is required by federal law to recover Medical Assistance costs paid to certain individuals who have died. Individuals affected are those 55 years of age or older, who received Medical Assistance for any nursing facility services, home and community based services, and any related hospital and prescription drug services on or after August 15, 1994. Costs will be recovered from the assets of the person's probate estate. A probate estate exists when a person dies and his or her assets are distributed by will or by state law.

Generally, the Department does not seek Medical Assistance reimbursement from assets that are not part of the probate estate. Recovery will be delayed until the last of the following conditions occurs:

- the death of the surviving spouse;
- the death of any child who is blind or totally and permanently disabled;
- the date any surviving child is 21 years of age;

- the death of a sibling, who has an equity interest in the property and has been living in the home for at least one year prior to the death of decedent; or;
- the sibling, who has an equity interest in the property and who has been living in the home for at least 1 year prior to the death of the decedent, vacates or transfers the home

If estate recovery would cause undue hardship to the surviving family, the executor may request a waiver by writing to:

**Estate Recovery Program  
P.O. Box 8486  
Harrisburg, PA 17105-8486**

**QUESTIONS REGARDING THIS PROGRAM MAY BE ADDRESSED TO 1-800-528-3708, (Nationwide).**

## **PAYMENT TOWARDS THE COST OF CARE - MEDICAL ASSISTANCE RESIDENTS**

If you are found eligible for payment of nursing facility services, the Department will pay the nursing facility its established MA rate. The resident will also be required to make a payment towards the cost of care.

The payment towards the cost of care is determined after allowing certain deductions. One such deduction is the monthly Personal Needs Allowance. The Personal Needs Allowance is used by the resident to pay for incidentals of his or her own choosing.

The payment towards the cost of care may be reduced by the cost of medically necessary services not covered by the Medical Assistance Program. When the amount of the payment towards the cost of care is reduced appropriately, the Medical Assistance payment amount is increased proportionately so that the nursing facility continues to receive its full established Medical Assistance rate.

## **RIGHT TO APPEAL**

If you do not agree with an action taken by the Department of Public Welfare you or someone on your behalf may request a fair hearing. If you do not agree with an action taken by your nursing facility which affects your eligibility for Medical Assistance, you or someone on your behalf may request a fair hearing.

## **INFORMATION SOURCES**

The following information publications may be posted by your nursing facility, in a prominent and accessible location for your observation:

- Pennsylvania Bulletins (published weekly);
- Medical Assistance Bulletins;
- Income Maintenance Directives;
- Medical Assistance Estate Recovery Program and Related Topics, Questions and Answers  
(brochure available from the Estate Recovery Program)
- Other appropriate resident information to which your nursing facility has access.



## **PART 2**

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### **MEDICAL ASSISTANCE PAYMENT FOR NURSING FACILITY CARE ELIGIBILITY REQUIREMENTS AND PROCEDURES**

(Everyone should read this part even if you do not need Medical Assistance now)

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Medical Assistance, is a program of financial assistance funded by the federal and state governments to help pay for medical care, including care in a nursing facility.

In order for Medical Assistance to help pay for a person's nursing facility care, the person must be financially eligible and must be medically in need of such care. Financial need for Medical Assistance is determined by the local county assistance office. Medical need for nursing facility care is determined through an assessment done by the local Area Agency on Aging.

If you meet the eligibility requirements, Medical Assistance will pay the difference between the cost of your care and the amount the state determines you should pay from your income each month.

This informational notice gives you the basics of eligibility to help you determine if and when you might be eligible. If you are married, you should also read Part 3 of the Admissions Notice Packet you receive from the nursing facility. That part discusses how to protect income and resources for your spouse who is still living at home. Contact your local county assistance office to get more information or to schedule an appointment to apply for Medical Assistance.

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#### **ELIGIBILITY**

The most important factors in the determination of financial eligibility for Medical Assistance are your countable resources, your income, and whether you have transferred assets (income or resources) since February 8th, 2006 to anyone other than your spouse, or within the last five (5) years in the case of certain transfers involving trusts.

#### **THE APPLICATION PROCESS**

When it is time to apply for Medical Assistance, the nursing facility can direct you to the county assistance office or can help you file an application.

Anyone -- relative, friend, attorney -- can help you file the application for Medical Assistance, but you or your representative have the responsibility to provide complete and accurate information and verify information. Once you are determined eligible for Medical Assistance, an annual renewal is required. You or the person who applies on your behalf will be required to cooperate and provide information at renewal. You are also required to provide any information should there be any change in your income, resources or other circumstances regarding your eligibility for Medical Assistance.

#### **RESOURCES**

The amount of resources that you may keep and still be eligible for Medical Assistance depends on the amount of your gross monthly income.

- If your gross monthly income is greater than \$2,022 in 2009, your countable resources can not exceed \$2,400 to be eligible for Medical Assistance.
- If your gross monthly income is equal to or less than \$2,022 in 2009, your countable resources can not exceed \$8,000 (\$2,000 resource limit plus a \$6,000 resource disregard).

Some resources are **NOT COUNTED**, including:

- household goods
- personal items such as clothing and jewelry
- one motor vehicle
- all burial spaces/plots
- a reasonable amount of money specifically set aside for an irrevocable burial fund
- your home, if you intend to return to it or your spouse or dependent child lives in it
- your spouse's individual retirement account, Keogh plan or other qualified retirement funds

Resources that **ARE COUNTED** include but are not limited to:

- cash
- bank accounts
- stocks and bonds
- mutual funds
- all vehicles except one
- non-resident real property
- the applicant's IRA or Keogh fund
- some of the cash value of certain life insurance

## **INCOME**

Once your resources are down to the required level, you will be eligible for Medical Assistance if your income is not high enough to cover the costs of your nursing facility care. Generally, all of your income is counted as available for your care. This includes Social Security, pension, and interest from savings and investments. You are allowed \$45 per month for personal needs. In addition, any support you provide to your spouse or dependent child is deducted from your income, within limits. All the rest of your income will need to be used for medical expenses, including nursing facility care. Your spouse's income is not considered available for your care.

## **TRANSFER OF ASSETS**

If you or your spouse transfers assets (resources or income) to anyone other than each other, this can make you ineligible for payment of Long Term Care services through the Medical Assistance Program for a period of time. Any assets you have transferred since February 8th, 2006 may affect your eligibility. Any assets you have transferred, involving a trust, within the last five (5) years may affect your eligibility.

## **RIGHTS OF THE SPOUSE LIVING AT HOME IN THE COMMUNITY**

If you have a spouse living at home in the community (referred to in the law as a "community spouse"), you are affected by special rules for the treatment of income and resources that allow you to protect some resources and income for the community spouse. Those rules are described in Part 3 of the Admissions Notice Packet you receive from the nursing facility, titled "Protecting Resources and Income for the Community Spouse."

## **REPAYMENT OF MEDICAL ASSISTANCE**

Federal law requires the state to seek repayment from the probate estate, if any, of a person (age 55 or older) who received Medical Assistance for any nursing facility services, home and community based services, and related hospital and prescription drug services received on or after August 15, 1994. The state cannot seek reimbursement from the spouse's estate.

**THE REMAINDER OF  
THIS PACKET APPLIES  
ONLY TO A MARRIED  
RESIDENT WITH A SPOUSE  
IN THE COMMUNITY.**

## **PART 3**

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### **PROTECTING RESOURCES AND INCOME FOR THE COMMUNITY SPOUSE**

**(Applies if you have a spouse who is living in the community,  
i.e., is not in a Nursing Facility or Medical institution)**

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If you or your spouse are in a nursing facility, it is important for you to read the following information even if you do not need Medical Assistance now. There are special Medical Assistance rules that apply to couples when one spouse is in a nursing facility and the other is not in a nursing facility (this spouse is referred to as the community spouse). You can take action to protect resources and income for the community spouse before the institutionalized spouse needs or is eligible for Medical Assistance, and it is to your benefit to do this.

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#### **TREATMENT OF RESOURCES**

The community spouse is allowed to keep a portion of the resources (called the “spousal share” or the “protected share”) owned by either or both of you, in addition to those resources which are not counted by the state in determining eligibility for Medical Assistance (“exempt resources”). This spousal share need not be used to pay for the care of the spouse in the institution. The standard spousal share is one-half of the couple’s total non-exempt resources, but no less than \$21,912 (for 2009) and no more than \$109,560 (for 2009). These minimum and maximum figures are revised annually.

You can file a Resource Assessment Form (Part 4 in this Admissions Notice Packet) to determine the standard spousal share. A couple should file this form as soon as they can after one of them enters a nursing facility. Under some circumstances, more than the standard spousal share of resources may be retained if it is needed to produce the minimum income which the community spouse at home is permitted to have under the Medicaid rules (see information that follows), but you will need to apply for Medical Assistance, file an appeal and have a hearing to get this approved.

#### **TREATMENT OF INCOME**

The community spouse is not required to support you in the nursing facility or use part of their income to pay for your care. The community spouse is allowed to keep all of his/her own income, regardless of the amount, and that income is not included in determining your eligibility for Medical Assistance.

Federal law has established a protected income level for the community spouse, referred to as the community spouse minimum monthly maintenance needs allowance (CSMMNA). Effective July 1, 2009, this allowance is \$1,822 per month (the “standard allowance”) plus shelter costs over \$547 per month, up to a maximum total of \$2,739. Allowable shelter costs include real estate taxes, condominium fees, rent, mortgage, a utility allowance (up to \$491 per month) and homeowners insurance. These figures are revised annually. You can get the revised annual figures by calling the Welfare Help Line at 1-800-692-7462 or by calling your local county assistance office.

If the community spouse’s income is below their CSMMNA, you may be able to contribute a portion of your income in an amount equal to the difference between the community spouse’s income and their CSMMNA.

Your income must be used first. However if a shortfall still exists after the contribution of all your available income, an additional amount of resources exceeding the protected portion of the couple’s resources can be made available to your spouse to generate additional monthly income up to the CSMMNA.

In addition, if the community spouse needs more income in excess of the CSMMNA because of exceptional circumstances that result in significant financial duress, you may request an increase in the CSMMNA.

To request the protection of additional resources or an increase in the CSMMNA, you must submit an

application for Medical Assistance and request a hearing. If you believe that the community spouse's income will not be adequate, you should apply for Medical Assistance while you still have extra resources.

## **HOW TO GET YOUR ASSESSMENT OF RESOURCES**

To get an assessment by the Medical Assistance program of the amount of resources your community spouse can keep, you should complete the Resources Assessment Form (Part 3 in this packet) and return it to the county assistance office in the county in which the facility is located.

Even though you have not applied for Medical Assistance or won't be applying for some time, it is to your benefit to fill out this form AS SOON AS POSSIBLE after admission to avoid spending more resources than necessary on nursing facility care and so that you can accurately account for the resources you had on the day of admission. Your spouse, a friend, relative or attorney can fill out the form if you need help. You and your spouse are responsible for providing verification of your resources.

The county assistance office will review and evaluate the information you provide. Be sure to supply all the information requested, including verification, so that the assessment process can be completed.

After evaluating the information received, the county assistance office will provide you, your spouse and your legal representative, if you have one, with a notice of its findings, titled "Results of Resource Assessment." This notice will inform you of the standard portion of your total resources that can be protected for your community spouse (the "protected share").

Along with the notice advising you of your protected spousal share, you will receive a worksheet and set of instructions which will help you to assess your income needs. It is important that you or someone acting on your behalf assess the income needs of the community spouse to determine whether the individual may qualify for resources in excess of the protected share in order to produce income. Without making this income assessment, it is possible that you will spend more resources than necessary for care in the nursing facility and that you will not retain an adequate amount of resources to provide needed income for your community spouse.

These special rules for spouses help the married couple keep as much of their resources as permitted to provide for both the spouse needing nursing facility care and the community spouse. The only way to insure you realize all the benefits of these provisions is to submit the Resource Assessment Form, PA 1572 (Part 4 in this packet), as soon as possible after admission to a nursing facility.

## **NEED HELP?**

**Questions can be answered by the  
Welfare Help Line at 1-800-692-7462.**

# PART 4

## Instructions for Completing Resource Assessment Form, PA 1572

(To be used by a couple when one of them is in a nursing facility, other medical institution or assessed eligible for Home and Community Based Services (HCBS), and the other lives in the community.)

Important information for nursing facility residents and their spouses. If you need this information in another language or someone to interpret it, please notify the nursing facility or contact your local County Assistance Office. Language assistance will be provided free of charge.

Información importante para los residentes en hogares de ancianos y sus esposos. Si usted necesita esta información en otro idioma o alguien que se la traduzca, favor de notificar al personal de la residencia o comunicarse con la oficina local de Asistencia del Condado (CAO). Asistencia lingüística será proveída gratis.

ព័ត៌មានសំខាន់សម្រាប់អ្នករស់នៅក្នុងមណ្ឌលគិលានុបដ្ឋាក/នុបដ្ឋាករថែទាំសម្រាប់ប្តី/ប្រពន្ធរស់គ្នា។ បើលោកអ្នកត្រូវការព័ត៌មាននេះជាភាសាផ្សេងទៀត ឬអ្នកណាម្នាក់មិនអាចអាន ឬមិនយល់អំពី គិលានុបដ្ឋាក/នុបដ្ឋាករថែទាំសម្រាប់ប្តី/ប្រពន្ធនៅក្នុងមណ្ឌលគិលានុបដ្ឋាក។ ជំនួយក្នុងការអាន/ប្រែប្រួល ឬផ្តល់ការបកប្រែឥតគិតថ្លៃ។

Thông tin quan trọng về cơ sở dưỡng lão dành cho thường trú nhân và vị phôi ngẫu. Nếu quý vị cần thông tin này bằng một thứ tiếng khác hay một phiên dịch viên, xin thông báo cho cơ sở dưỡng lão hay liên lạc với Văn Phòng Trợ Cấp Quận Hạt. Trợ giúp về ngôn ngữ sẽ được cung cấp miễn phí.  
Важные сведения относительно жителей домов престарелых и их супруг (супругов). Если вам нужен данный документ на другом языке или его устный перевод, обращайтесь в дом престарелых либо в местное Бюро помощи (County Assistance Office). Помощь переводчика предоставляется бесплатно.

这是发给疗养所的居民及其配偶的重要通知。如果您需要此通知翻译成其他语种或需要为您提供翻译，请通知疗养所或联系您所在地区的郡县协助办事处(County Assistance Office)。可提供免费语言协助。

The Medical Assistance Program - known as MA - helps meet the medical costs of individuals in need of payment of Long Term Care (LTC) services. Generally, an individual must use most of his own resources and income before Medical Assistance will help pay for LTC services. There are, however, special rules (sometimes called the Spousal Impoverishment Provisions) which recognize the importance of *protecting* a portion of a married couple's total resources and evaluating the income needs of the spouse who remains in the community.

The purpose of this Resource Assessment Form is to determine how much of a married couple's total resources may be protected or set aside for the community spouse, and how much, if any, must be spent before the individual in the nursing facility or assessed eligible for HCBS may be eligible for Medical Assistance benefits. Completing this form will help you to protect the maximum amount of your resources under the law.

The Resource Assessment is not an application for Medical Assistance, and you are not obligated to apply for Medical Assistance. If you need help in completing this form, your spouse, family member, friend, attorney, or legal services agency can help you. If you or your spouse are over 60 years of age, your local Area Agency on Aging also can help you. If you need Medical Assistance now, contact your county assistance office or your local Area Agency on Aging **BEFORE** you fill out this form.

A community spouse may keep a minimum amount of resources, or one-half of the couple's combined countable resources, up to a maximum amount. Some resources do *not* affect the determination of the protected amount. In order to make the determination as to which resources do and do not count and the protected amount, it is very important that you list *all* resources regardless of whether they are wholly owned by one person (e.g., an IRA owned by the community spouse), are owned by both spouses, or owned with others. The information on this form should reflect the value of the resources as of the DATE OF ADMISSION to the nursing facility, or the DATE OF ASSESSMENT for HCBS, NOT the date you fill out this form.

Photocopies *verifying* all resources MUST be sent with this form. Do *not* send original documents as they will NOT be returned to you. *An assessment cannot be completed unless all resources are verified and the verification is submitted with the Resource Assessment Form.*

Please read and complete this form carefully. Do NOT complete shaded areas. Sign the form and review the checklist to be certain you have provided all necessary verification. You, your spouse, and if applicable, your legal representative, will be notified in writing of the amount of resources that can be set aside and the amount, if any, that must be spent before you apply for Medical Assistance.

Mail (or deliver) the completed form and verification to the county assistance office in the county where the nursing facility is located, or you are receiving HCBS. The LTC Service Provider can provide you with the address, or check the telephone book.

## RESOURCES/ACCEPTABLE PROOF

VERIFICATION OF ALL RESOURCES MUST BE ATTACHED TO THE FORM. FOR EXAMPLE:

| CODE | RESOURCE                                                                  | VERIFICATION                                                                                                                                                                                                         |
|------|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 01   | CASH ON HAND                                                              | Your written statement showing the total amount of money not in the bank or otherwise invested.                                                                                                                      |
| 02   | SAVINGS ACCOUNT(S)                                                        | Photocopies of your bank statements, bank books or a written statement from the financial institution.*                                                                                                              |
| 03   | CHECKING ACCOUNT(S)                                                       | Photocopies of your bank statement or written statement from the financial institution.*                                                                                                                             |
| 04   | CHRISTMAS AND/OR VACATION CLUB                                            | Photocopies of the bank statement or written statement from the financial institution.*                                                                                                                              |
| 05   | STOCKS AND/OR BONDS, ETC.                                                 | A written statement from the brokerage firm, issuing agent or authority or institution where the stocks, bonds, etc. were purchased or held; or copy of the stock certificate or bond and a statement of the value.* |
| 06   | TRUST FUND                                                                | Photocopy of the trust agreement and inventory of trust assets or other documentation of value.*                                                                                                                     |
| 07   | IRREVOCABLE BURIAL RESERVE                                                | Photocopy of the burial reserve agreement.                                                                                                                                                                           |
| 08   | REVOCABLE BURIAL RESERVE                                                  | Photocopy of the burial reserve agreement.                                                                                                                                                                           |
| 09   | RESERVED                                                                  |                                                                                                                                                                                                                      |
| 10   | LIFE INSURANCE                                                            | A document identifying ownership for each insurance policy and a written statement of cash value from the insurance company.*                                                                                        |
| 11   | NON-RESIDENT REAL PROPERTY                                                | Your real estate tax bill or a broker's statement of the fair market value of the property; and if the property is rented, the rental agreement or lease.*                                                           |
| 12   | MOTOR VEHICLE(S)                                                          | A written statement of the value, from a car dealer; or list the year, make, and model of the vehicle, and we will use the automobile red book to determine the value.                                               |
| 13   | BOATS, SNOWMOBILES, TRAILERS AND OTHER VEHICLES                           | A written statement of the fair market value of the vehicle, from a dealer.*                                                                                                                                         |
| 14   | CERTIFICATES OF DEPOSIT                                                   | A written statement from the financial institution listing the value and ownership.*                                                                                                                                 |
| 15   | ANNUITIES                                                                 | A photocopy of the document that explains the terms, date of purchase, and value of the annuity at the time of admission/or assessment for HCBS.*                                                                    |
| 16   | SAVINGS BONDS                                                             | Photocopies of the bonds or a written statement from a bank that identifies the owner(s) of the bonds, the serial number(s), purchase date, and the value of the bonds at the time of admission.*                    |
| 17   | MUTUAL FUNDS                                                              | An itemized written statement of the value from the mutual fund or brokerage firm.*                                                                                                                                  |
| 18   | INCORPORATED OR UNINCORPORATED BUSINESS (PARTNERSHIP/SOLE PROPRIETORSHIP) | For a corporation, a statement of the value of your stock; for an unincorporated business, documents that established the business and that verify the value of your share of the business.                          |
| 19   | IRA OR KEOGH                                                              | A written statement from the bank or financial institution that identifies the owner(s) and the value.*                                                                                                              |
| 20   | OTHER                                                                     | Photocopy(ies) of any agreement(s) or statement(s) regarding any money or other resources not already listed.*                                                                                                       |

# RESOURCE ASSESSMENT

YOUR INFORMATION IS CONFIDENTIAL FOR USE ONLY BY THE DEPARTMENT OF PUBLIC WELFARE

| GENERAL INFORMATION             |            |        |                      |                                             |  |
|---------------------------------|------------|--------|----------------------|---------------------------------------------|--|
| LAST NAME                       | FIRST NAME | M.I.   | DATE OF BIRTH<br>/ / | SOCIAL SECURITY NO.                         |  |
| ADDRESS<br>(STREET AND CITY)    |            | COUNTY | STATE                | ZIP CODE                                    |  |
| NAME OF LTC SERVICE PROVIDER    |            |        | TELEPHONE NO.<br>( ) | DATE OF ADMISSION OR HCBS ASSESSMENT<br>/ / |  |
| SPOUSE'S LAST NAME              | FIRST NAME | M.I.   | DATE OF BIRTH<br>/ / | SOCIAL SECURITY NO.                         |  |
| SPOUSE'S STREET ADDRESS<br>CITY |            | STATE  | ZIP CODE             | SPOUSE'S TELEPHONE NO.<br>( )               |  |

## RESOURCES

VERIFICATION MUST ACCOMPANY THIS FORM FOR EACH RESOURCE LISTED. ACCEPTABLE VERIFICATION AND CORRESPONDING RESOURCE CODES ARE LISTED ON THE BACK OF THE INSTRUCTION PAGE.

**DO NOT SEND ORIGINAL DOCUMENTS, AS VERIFICATIONS WILL NOT BE RETURNED.** If a resource is owned by you and another person other than your spouse, list on a separate sheet of paper the resource and the names of the joint owners. Indicate if you or someone else purchased the asset. If it is not owned in equal shares, provide proof of the division of ownership as well as total value.\*

BE CERTAIN TO LIST **ALL** RESOURCES, SINGLY OR JOINTLY-OWNED

| OWNER(S) OF RESOURCE |            |      | RESOURCE CODE | *As of the date of admission or HCBS assessment. |             |           | DOCUMENTED |    |
|----------------------|------------|------|---------------|--------------------------------------------------|-------------|-----------|------------|----|
| LAST NAME            | FIRST NAME | M.I. |               | TOTAL VALUE                                      | AMOUNT OWED | NET VALUE | YES        | NO |
|                      |            |      |               |                                                  |             |           |            |    |
|                      |            |      |               |                                                  |             |           |            |    |
|                      |            |      |               |                                                  |             |           |            |    |
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|                      |            |      |               |                                                  |             |           |            |    |
|                      |            |      |               |                                                  |             |           |            |    |
|                      |            |      |               |                                                  |             |           |            |    |

IF YOU NEED ADDITIONAL SPACE, USE NOTES/INFORMATION SECTION OF THE FORM

**NOTE: IF YOUR INTEREST IN ANY RESOURCE IS A LIFE INTEREST, PLEASE INDICATE**

ENTER THE TWO DIGIT CODE IN THE "RESOURCE CODE" COLUMN THAT BEST DESCRIBES THE RESOURCE THAT YOU ARE IDENTIFYING

- |                            |                               |                            |                 |
|----------------------------|-------------------------------|----------------------------|-----------------|
| 01 CASH ON HAND            | 07 IRREVOCABLE BURIAL RESERVE | 13 BOATS, SNOWMOBILES,     | 18 BUSINESS     |
| 02 SAVINGS ACCOUNT(S)      | 08 REVOCABLE BURIAL RESERVE   | TRAILERS & OTHER VEHICLES  | 19 IRA OR KEOGH |
| 03 CHECKING ACCOUNT(S)     | 09 RESERVED                   | 14 CERTIFICATES OF DEPOSIT | 20 OTHER        |
| 04 CHRISTMAS/VACATION CLUB | 10 LIFE INSURANCE             | 15 ANNUITIES               |                 |
| 05 STOCKS, BONDS, ETC.     | 11 NON-RESIDENT REAL ESTATE   | 16 SAVINGS BONDS           |                 |
| 06 TRUST FUND              | 12 MOTOR VEHICLE(S)           | 17 MUTUAL FUNDS            |                 |



