MEDICAID SPEND-DOWN

Medicaid is intended to provide medical care for certain public assistance recipients (such as those on Temporary Assistance for Needy Families [TANF] or Supplemental Security Income [SSI]), and for medically needy persons. Medically needy persons are those with low income who may be able to meet their basic living needs but have insufficient income to pay for the cost of medical care.

When the eligibility worker at Social Services evaluates the Medicaid application and finds that you have too much income to be eligible, the caseworker will notify you that full Medicaid coverage is denied. The notice will also tell you that you may become eligible by meeting the "spend-down" requirement.

The "spend-down" requirement is similar to an insurance deductible. It means that if you are over the income limit for full Medicaid coverage, you will need to have medical expenses that bring you under the limit. You do not have to actually pay those medical expenses to meet the spend-down, but only to show that you owe those expenses for purposes of qualifying for Medicaid. The expenses may be any type of medical expenses for anyone in your household, not just for you personally.

Social Services will tell you what the spend-down amount is and the time period during which you must incur those expenses (which may vary from one to six months). After you have shown that you have incurred the amount of your spend-down, then Medicaid will cover your expenses over the spend-down amount. You are still responsible for the medical bills up to the amount of the spend-down liability amount. That is why it's said the spend-down requirement works like an insurance deductible.

You will be asked to list any medical bills that you owe on a worksheet provided by Social Services. You must list the date you received the service, the name of the provider, and the

amount you owe after any insurance payments. You will also be asked to list any health insurance premiums and other health care expenses. Medical expenses paid by Medicaid, Medicare or insurance are not deducted from the spend-down amount. You will submit the form and a copy of the medical bills and verification of insurance payments to the eligibility worker. Once the allowable medical expenses are equal to or greater than the spend-down liability, Medicaid eligibility can be established for the remainder of the spend-down period.

You are responsible for promptly reporting all changes in income, resources and living arrangements to the eligibility worker. The worker may require you to verify the changes. The eligibility worker will re-evaluate Medicaid eligibility within 30 days of receiving verification of medical expenses or notice of changes. The worker will send written notice to you advising you of the results of the re-evaluation of Medicaid eligibility.

When the spend-down budget period ends, you will have to file another application with Social Services to see if you are eligible and to see what new spend-down requirements you may have.

If at any time you disagree with decisions by Social Services, you have the right to appeal within 30 days of notice of their decision. If you have been receiving Medicaid benefits but are then told that your coverage will be terminated or reduced by a certain date, if you file your appeal before the effective date of their proposed action, you may continue to receive benefits while your appeal is pending. However, if you lose your appeal, you may be required to pay back any benefits you received during the time you were not eligible.

If you receive an adverse decision from Social Services about your eligibility or your spend-down requirement, you should call us back for further assistance.

THIS INFORMATION IS NOT LEGAL ADVICE. *Legal advice is dependent upon the specific circumstances of each situation. Therefore, the information contained in this pamphlet cannot replace the advice of competent legal counsel.*

Free Legal information by Web and Phone: www.vlas.org and
1-866-LeglAid (534-5243)