CNS Paragraph Form

Date: 01.27.10

Program Area	**03**	**(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number	**X0001**	
Version Number	**00005**	
Effective Date	**2010**	**(YYMMDD)**
Title	**Accept Excess Income Monthly Spenddown**	
Comment		
Reason Code	**S20/AA**	

We have accepted your application dated _____ for Medicaid with a spenddown requirement effective _____ for:

Name	Client I.D. #
Name	#
Name	#

This is because your net income (gross income less Medicaid deductions) of $_____ is over the allowable Medicaid income limit of $_____. The amount over the limit is called excess income or spenddown. Your monthly excess income amount is $_____.

Please look at the budget calculation section to see how we figured your excess income.

Because you have shown us paid or unpaid medical expenses not covered by insurance which are equal to or more than your monthly excess income amount for the period _____ to _____, we will pay any additional outpatient covered medical expenses for this period.

After _____, you will have to submit paid or unpaid medical expenses each month that are equal to or more than your monthly excess income amount of $_____ in order to be eligible for payment of any additional covered outpatient expenses. You may also pay your excess income amount to this agency for any month you need outpatient coverage.

You can become eligible for Medicaid for both inpatient and outpatient coverage if you become hospitalized and have medical expenses (paid or unpaid) that are equal to or more than your six month excess income amount of $_____, or have other medical expenses (paid or unpaid) that are equal to or more than your six month excess income amount.

Please read the Sections: "Explanation of the Excess Income Program" and "Optional Pay-In Program."

Choose one of the following messages:

Message 1 (Community Coverage: No LTC) (S0024)

Message 2 (Community Coverage With Community-Based LTC) (S0025)

Message 3 (No Longer Eligible For LTC) (S0022)

Message 4 (None of the Above)

Use for all

Please review the Medical Assistance Utilization Threshold information found in the Medical Assistance section of the booklet, "LDSS-4148B: What You Should Know About Social Services Programs." The information explains any services limitations. The LDSS-4148B was given to you when you applied for assistance.

Choose one of the following messages:

Message 1 (FH+ Over income)

We also evaluated your eligibility for Family Health Plus. You were not eligible for Family Health Plus because your gross income of $ _____ is over the Family Health Plus income limit of $ ____.

Message 2 (FH+ Chose spenddown of income)

The options of Family Health Plus and Medicaid with a spenddown of income were explained to you. You chose to participate in Medicaid with a spenddown of income. If you decide that you want to change to Family Health Plus, contact your worker.

Message 3 (FH+ Equivalent Insurance)

We also evaluated your eligibility for Family Health Plus. Family Health Plus is a health care program for people who do not have any other health insurance, except for very limited exceptions. You have a health insurance plan that is not one of these exceptions. Therefore, you are not eligible for Family Health Plus.

Message 4 (FH+ Federal Employee)

We also evaluated your eligibility for Family Health Plus. A person who is eligible for health care coverage through a federal benefit plan is not eligible for Family Health Plus. Therefore, you are not eligible for Family Health Plus.

Message 5 (FHP Over 65)

No message.

Use for all:

This decision is based on Regulations 18 NYCRR 360-2.3, 360-4.1, 360-4.4, 360-4.5, 360-4.7, 360-4.8 and 366-a(2) and 369-ee of Social Services Law.

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Hemos aceptado su solicitud de fecha _____ para Medicaid con requisito de sobrante con fecha efectiva del _____ para:

Nombre	# de ID del cliente:
Nombre	# de ID del cliente:
Nombre	# de ID del cliente:

El motivo es porque su ingreso neto (ingreso bruto menos las deducciones de Medicaid) de $_____ sobrepasa el limite de ingresos de $_____ fijado por Medicaid. El monto que sobrepasa el limite de ingresos se denomina ingreso excesivo o sobrante. El monto mensual de su ingreso excesivo es $_____.

Vea la seccion de calculo de presupuesto para entender la manera en que calculamos el ingreso excesivo.

Debido a que usted nos ha presentado facturas medicas pagas e impagas no cubiertas por un seguro medico y cuyo monto iguala o sobrepasa la cantidad mensual de sus ingresos excesivos durante el periodo de _____ a _____, pagaremos todo gasto medico adicional por atencion de paciente externo incurrido durante ese periodo.

Despues del _____, tendra que someter mensualmente las facturas medicas pagas e impagas que igualen o sobrepasen la cantidad de su ingreso mensual excesivo de $_____ para que le podamos pagar las facturas adicionales de atencion medica de paciente externo. Tambien, puede pagar a esta agencia la cantidad del ingreso excesivo durante un dado mes en el que necesite cobertura de paciente externo.

Usted puede recibir Medicaid para cubrir gastos de atencion medica de paciente interno y externo si se encuentra hospitalizado y sus facturas medicas (pagas o impagas) son iguales o sobrepasan la cantidad de sus ingresos excesivos de seis meses de $_____; o tiene otras facturas medicas (pagas o impagas) que igualen o sobrepasen la cantidad del ingreso excesivo de seis meses.

Favor de consultar las secciones tituladas: “Explicacion del Programa de Ingresos Excesivos" y el "Programa Opcional de Contribucion de Pagos”.

Choose one of the following messages:

Message 1 (Community Coverage: No LTC) (S0024)

Message 2 (Community Coverage With Community-Based LTC) (S0025)

Message 3 (No Longer Eligible For LTC) (S0022)

Message 4 (None of the Above)

Use for all

Favor de consultar la informacion sobre el Umbral de Utilizacion de Asistencia Medica que aparece en el folleto, “LDSS-4148B -SP: Lo que usted debe saber sobre los programas de servicios sociales”. Aqui encontrara informacion sobre limites en los servicios. El folleto LDSS-4148B-SP se le entrego cuando usted solicito los beneficios de asistencia.

Choose one of the following messages:

Message 1 (FH+ Over income)

Tambien le hemos considerado para Family Health Plus. Usted no reune los requisitos para recibir Family Health Plus debido a que su ingreso bruto de $_____ sobrepasa el limite de ingresos de Family Health Plus establecido en $_____.

Message 2 (FH+ Chose spenddown of income)

Se le explicaron las opciones de Family Health Plus y Medicaid con el requisito de sobrante. Usted escogio participar en Medicaid con requisito de sobrante de ingresos. Si desea cambiarse a Family Health Plus, comuniquese con la persona a cargo de su caso.

Message 3 (FH+ Equivalent Insurance)

Tambien le hemos considerado para Family Health Plus. Family Health Plus es un programa de seguro medico para aquellas personas que no tienen ningun otro tipo de seguro medico, aparte de ciertas excepciones. Usted tiene un seguro medico que no esta incluido en estas excepciones. Por lo tanto, usted no reune los requisitos para recibir Family Health Plus.

Message 4 (FH+ Federal Employee)

Tambien le hemos considerado para ver si puede recibir Family Health Plus. La persona que reune los requisitos para recibir cobertura medica por medio de un plan de salud federal no reune los requisitos para recibir Family Health Plus. Por lo tanto, usted no reune los requisitos para recibir Family Health Plus.

Message 5 (FHP Over 65)

No message.

Use for all

Esta decision se basa en Reglamentacion 18 NYCRR 360-2.3, 360-4.1, 360-4.4, 360-4.5, 360-4.7, 360-4.8 y 366-a(2) y 369-ee de la Ley de Servicios Sociales.