MEDICARE, MEDICAID, AND SSI – A GENERAL GUIDE

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MEDICARE, MEDICAID, AND SSI – A GENERAL GUIDE

This guide is intended to provide an overview of the federal Medicare, Medicaid and Supplemental Security Income programs and is not intended to be a comprehensive source of information on these programs. The Texas Young Lawyers Association seeks to make Texas residents generally aware of who is eligible for these programs, the benefits available through these programs, and how the benefits can be obtained. This information is not a substitute for the advice of a lawyer, but instead is designed to assist Texans in learning about their legal rights.

Medicare

Medicare is a health insurance program administered by the Centers for Medicare & Medicaid Services (CMS), which is part of the U.S. Department of Health and Human Services. Medicare is available for the following people:

- Individuals who are age 65 or older;
- Some individuals under age 65 who have a disability; and
- Individuals with a medical diagnosis of End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

An individual must also be a citizen or permanent resident of the United States to be eligible for Medicare. The Medicare program consists of two parts – Part A, which provides hospital insurance, Part B, which provides medical insurance, Part C consists of Medicare Managed Care Plans and Part D is the Medicare Prescription Drug Plan. To receive Medicare benefits, eligible individuals must apply at a local Social Security office.

Medicare Part A

Medicare Part A provides insurance coverage for hospital care. Most people are automatically eligible for Medicare Part A when they reach 65 years of age. Individuals do not have to make monthly premium payments for Part A if either they or a spouse paid Medicare taxes while they were working.

Individuals who did not pay Medicare taxes while working may be able to purchase Part A insurance through the Social Security Administration or local Social Security office for a monthly premium;[1] or if their income and assets are low enough, this premium as well as the Part B premium can be paid by the Qualified Medicare Beneficiary Program discussed on page 5 of this brochure.

Medicare Part A helps individuals to pay for the following care and services, provided they are medically necessary:

- Inpatient hospital care (including inpatient mental health care and care in critical access hospitals that provide limited services to people in rural areas) – Medicare helps to pay for up to 90 days of inpatient hospital care during each benefit period. (Note: A benefit period begins on the first day the individual receives services in a hospital or skilled nursing facility and ends after the individual has been discharged from the hospital or skilled nursing facility and has not been a patient in any other facility for 60 consecutive days. There is no limit on the number of benefit periods an individual can have.)

- Care in skilled nursing facilities – Medicare helps to pay for up to 100 days in a skilled nursing facility in each benefit period for individuals meeting certain conditions. Medicare will pay all approved charges for the first 20 days in the skilled nursing facility, but the individual must pay a coinsurance amount for days 21 through 100.

- Hospice care – Medicare helps to pay for hospice care for terminally ill individuals who select the hospice care benefit. These individuals only pay limited costs for drugs and inpatient respite care.

- Some home health care – Medicare pays the full approved cost for covered home health care, including part-time or intermittent skilled nursing services prescribed by a doctor for treatment or rehabilitation of homebound patients, if certain conditions are met. Eligible individuals must, however, pay a 20% coinsurance charge for medical equipment.

- Blood received at a hospital or skilled nursing facility during a covered stay.

Medicare Part B

Medicare Part B provides medical insurance coverage. Part B is not automatic like Part A, thus eligible individuals must enroll in Part B. Individuals can sign up for Part B at any time during the seven-month period that begins three months before they turn 65 years of age. Individuals enrolled in Part B must pay monthly premium payments.[2] In some cases, Medicaid will pay for an individual to have Medicare Part B insurance coverage. For more information about Medicaid, please refer to the Medicaid section of this brochure.

Individuals who do not elect to enroll in Part B when they are first eligible can only sign up for Part B once a year, between January 1 and March 31. Part B insurance coverage for individuals enrolling during this period will begin on July 1 of the year in which they enroll. Individuals should be aware that if they do not choose Part B when they are first eligible at age 65, the cost of Part B may increase 10% for each 12-month period they could have enrolled in Part B but did not do so. Except in special cases, individuals will be required to pay this 10% increase as long as they are enrolled in Part B. An eligible individual can delay enrolling in Part B, however, if the individual or his or her spouse continues to work *and* the individual is covered under a group health plan from that current employment. Individuals who delay enrolling in Part B because they are covered under a group health plan may avoid the 10% premium increase by signing up for Part B while they are still enrolled in the group health plan or within eight months after either the employment or the group health coverage ends, whichever occurs first.

Medicare Part B helps individuals pay for the following services and supplies, provided they are medically necessary:

- Doctors' services;
- Outpatient hospital care (including emergency room care);
- Ambulance transportation;
- Diagnostic tests;
- Laboratory services;
- Outpatient physical and occupational therapy;
- Outpatient mental health care;
- Durable medical equipment, such as wheelchairs and hospital beds, and supplies; and
- Some home health care for which Part A does not pay.

- Some preventative services such as colorectal cancer screening and a "Welcome to Medicare" physical exam.
- Flu shots.

In addition to these specific services and supplies, Medicare Part B helps pay for a variety of other medical services and some preventive care, such as mammograms and Pap smear screening. Part B generally does *not* pay for most prescription drugs, routine physical exams, services not related to the treatment of illness or injury, dental care or dentures, cosmetic surgery, routine foot care, hearing aids, routine eye care, eyeglasses, or health care received while traveling outside the United States.

Individuals enrolled in Part B must pay a deductible each calendar year ($124 in 2006) as well as 20% of the Medicare approved charges for medical and other services and for durable medical equipment. Under Part B, Medicare pays 80% of the Medicare-approved charges for most covered services. For outpatient mental health care, however, individuals must pay 50% of the charges, and outpatient hospital services require individuals to pay coinsurance or copayment amounts depending on the services. Under Part B, individuals pay nothing for Medicare-approved clinical laboratory services or for Medicare-approved home health care services. Finally, individuals whose doctors do not accept the Medicare-approved charges will also pay the limited additional charges.

Medicare Part C

Medicare Part C (Medicare Advantage) plans allow you to choose to receive all of your health care services through a provider organization. These plans may help lower your costs of receiving medical services, or you may get extra benefits for an additional monthly fee. You must have both Parts A and B to enroll in Part C. Medicare Advantage (formerly Medicare + Choice) Plans are available in many areas. If you have one of these plans, you do not need a Medigap policy because Medicare Advantage Plans generally cover many of the same benefits that a Medigap policy would cover, like extra days in the hospital after you used the number of days for which Medicare pays.

Medicare Advantage Plans include:

- Medicare Managed Care Plans

- Medicare Preferred Provider Organization Plans (PPO)
- Medicare Private Fee-for-Service Plans
- Medicare Specialty Plans

If you decide to join a Medicare Advantage Plan, then you will use the health care card that you get from your Medicare Advantage Plan (provider) for your health care. These plans often give you more choices and, sometimes, extra benefits, like extra days in the hospital. To join a Medicare Advantage Plan, you must have Medicare Part A and Part B. You will have to pay the monthly Medicare Part B premium of $88.50 (in 2006) to Medicare. In addition, you might have to pay a monthly premium to your Medicare Advantage Plan for the extra benefits that they offer.

Medicare Part D

Medicare Part D, prescription drug coverage, is voluntary and the costs are paid for by the monthly premiums of enrollees and Medicare. Medicare prescription drug coverage is insurance that covers both brand-name and generic prescription drugs at participating pharmacies in your area. Medicare prescription drug coverage provides protection for people who have very high drug costs. Everyone with Medicare is eligible for this coverage, regardless of income and resources, health status, or current prescription expenses.

Your decision about Medicare prescription drug coverage depends on the kind of health care coverage you have now. There are two ways to get Medicare prescription drug coverage. You can join a Medicare prescription drug plan or you can join a Medicare Advantage Plan or other Medicare Health Plans that offer drug coverage. Whatever plan you choose, Medicare drug coverage will help you by covering brand-name and generic drugs at pharmacies that are convenient for you.

Like other insurance, if you join, you will pay a monthly premium, which varies by plan, and a yearly deductible (no more than $250 in 2006). You will also pay a part of the cost of your prescriptions, including a copayment or coinsurance. Costs will vary depending on which drug plan you choose. Some plans may offer more coverage and additional drugs for a higher monthly premium. If you have limited income and resources, and you qualify for extra help, you may not have to

pay a premium or deductible. You can apply or get more information about the extra help by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or visiting **www.ssa.gov** .

Medicare prescription drug coverage provides greater peace of mind by protecting you from unexpected drug expenses. Even if you do not use a lot of prescription drugs now, you should still consider joining. As we age, most people need prescription drugs to stay healthy. For most people, joining now means protecting yourself from unexpected prescription drug bills in the future. There is extra help for people with limited income and resources. Almost 1 in 3 people with Medicare will qualify for extra help and Medicare will pay for almost all of their prescription drug costs. You can apply or get more information about the extra help by calling Social Security at 1-800-772-1213 (TTY 1-800-325-0778) or visiting **www.socialsecurity.gov**.

Supplemental Insurance and Health Plan Options

The traditional Medicare option is known as the Original Medicare Plan. Under the Original Medicare Plan, individuals make payments for services, as has been previously described in this brochure. With this plan, an individual may go to any doctor or hospital that accepts Medicare. The individual pays his or her portion and Medicare pays its portion.

Private insurance companies also sell Medicare supplemental insurance policies (Medigap or Medicare SELECT) to help pay the costs individuals are required to pay under the Original Medicare Plan, such as coinsurance amounts and deductibles or other health care costs. An individual must have both Part A and Part B to purchase a supplemental insurance policy. There is an open enrollment period that is available for individuals to purchase supplemental insurance for the six-month period after they first enroll in Part B. Individuals should consider purchasing supplemental insurance policies during this open enrollment period because during this period, insurance companies cannot refuse to cover individuals or charge individuals higher premiums based on their health status. Individuals who enroll after the open enrollment period could be denied supplemental insurance or charged higher premiums.

In addition, the Medicare program offers other ways for individuals to receive their Medicare health insurance benefits if they are enrolled in both Part A and Part B. Individuals may be able to enroll in Medicare managed care plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), provider sponsored organizations (PSOs), private fee-for-service plans, or Medicare medical savings account plans. These other Medicare plans provide insurance coverage for all of the services covered by Part A and Part B. Most of these other Medicare options also offer benefits not covered by the Original Medicare Plan, such as preventive care, prescription drugs, dental care, hearing aids, and eyeglasses.

Qualified Medicare Beneficiary (QMB) and Other "Medicare Savings Programs"

Under the Qualified Medicare Beneficiary (QMB) Program, the Texas Health and Human Services Commission will pay Medicare Part A and B premiums, copayments, and deductibles for persons whose incomes are below the poverty line and whose countable assets do not exceed $4,000 for an unmarried individual or $6,000 for a married couple.[3] There are QMB income limits for individuals and for couples who are both eligible for QMB.[4] Income from certain sources is exempt, including the first $65 of earned income and half the rest of earned income.

The Specified Low-Income Medicare Beneficiaries (SLMB) program pays the Medicare Part B premiums[5] of Medicare beneficiaries who meet the asset requirements for QMB and whose incomes fall within certain ranges.[6] Those amounts include the $20 per month that is "exempt" but do not take into account other possible exemptions such as part of earned income (as discussed above.)

The "Qualifying Individuals-1" program also pays the Medicare Part B premium. The only difference is that it is available only to persons who are *not* certified for any other Medicaid funded program in the same month. Income eligibility requirements are also applicable.[7] Those amounts include the $20 per month that is "exempt" but do not take into account other possible exemptions such as part of earned income as discussed above. Asset requirements are the same as for QMB.

Although these "Medicare Savings Programs" can make a big difference to people struggling to pay medical expenses, about half the persons who are eligible for QMB are not receiving it. For information on how to apply, contact any office of the Texas Department of Human Services.

Helpful Contact Information

The following offices can provide more information about enrolling in Medicare or the Medicare options in Texas:

Social Security Administration:
1-800-772-1213
1-800-325-0778 (TTY number for the deaf and hard of hearing)

Centers for Medicare and Medicaid Services (CMS), Dallas regional office:
1-214-767-6401

Texas Department on Aging's State Health Insurance Program (SHIP):
1-800-252-9240
1-800-252-9108 (TDD)

Texas Department of Insurance (TDI) Consumer Help Line: (can provide information about Medicare supplemental insurance policies available in Texas)
1-800-252-3439
1-512-332-4238 (TTY)
www.tdi.state.tx.us/consumer/medsup.html

In addition, for Medicare information on the Internet, visit www.medicare.gov.

Medicaid

Medicaid is a broad, need-based medical assistance program serving certain individuals who are unable to pay for necessary healthcare. In the State of Texas, Medicaid eligibility is usually determined by the Texas Health and Human Services Commission ("HHSC").[8] Medicaid consists of two primary components: Community Medicaid and Long-Term Care Medicaid. Community benefits are provided for younger, disabled persons and families receiving public assis-

tance. Medicaid for persons in nursing homes and assisted living facilities and for those needing care at home is called Long-Term Care Medicaid. The distinction is important because the regulations for each program are very different. The discussion of Medicaid in this section of the brochure will be limited to Long-Term Care Medicaid. For more information regarding other Medicaid programs, contact HHSC or go to its website at www.hhsc.state.tx.us.

Requirements

In order to receive Long-Term Care Medicaid in a nursing home, the general requirements are that the person must:

- Be at least 65 years of age or be blind or disabled;
- Be a citizen or permanent resident of the United States;
- Have a medical condition requiring nursing care; and
- Meet certain financial requirements (discussed below).

In addition, a determination of medical necessity must be made. HHSC contracts with the National Heritage Insurance Company to determine medical necessity. Professionally developed written criteria are used to evaluate the medical necessity for admission and continued stay of Medicaid recipients based on each recipient's need for care under daily supervision of licensed nurses. The director of nurses at a nursing facility can determine whether the recipient will meet medical necessity criteria upon request of a "pre-admission assessment of a medical necessity" by a Medicaid applicant or a family member. Finally, an applicant must reside in a Medicaid-contracted nursing facility or skilled nursing facility for a period of 30 consecutive days before being certified for Medicaid. Medicaid coverage may be retroactive to the date of entry, however, if all eligibility requirements were met on that date.

Financial Limits

Individuals must meet certain financial requirements to be eligible for the long-term care benefits provided by Medicaid. The financial limits apply to both an individual's income and assets.

Income is defined as the receipt of any property or service an individual can use, either directly or by sale or conversion, to meet basic needs for food, clothing, and shelter.[9] Gross income, not net income, is used for determining eligibility.

Countable income includes, but is not necessarily limited to, the following:

- Social Security Benefits
- Veteran's Benefits
- Private Pension Benefits
- Interest and Dividends
- Earnings and Wages
- Civil Service Annuities
- Railroad Benefits
- State and Local Retirement Benefits
- Royalty and Rental Payments
- Gifts and Contributions

An individual's income is applied to the cost of his or her nursing care and Medicaid pays the difference. Before applying an individual's income to the costs of his or her nursing care, HHSC allows certain deductions, which include but are not necessarily limited to the following:

- A personal spending allowance;[10]
- An allowance for a spouse and/or dependent living outside the nursing facility, if certain criteria are met;
- All medical and dental expenses not covered by Medicare, Medicaid or insurance;
- Cost of Medicare Part A and/or Part B premiums and all other health insurance premiums, such as Medicare supplemental insurance; and
- Court-approved fees paid to a guardian,[11] if applicable.

In some cases, an individual may have too much income to qualify for the Long-Term Care Medicaid Program, but too little income and assets to pay the private pay rate for his or her nursing care. In these cases, a specialized trust known as a "Miller Trust" or "Qualified Income Trust" may be used to qualify the individual for the Long-Term Care Medicaid Program. This specialized trust is designed only to hold the income of the Medicaid recipient and should not be confused with other types of trusts that are created for different purposes. Furthermore, this trust should not be confused with a special/supplemental needs trust, the purpose of which is to hold and apply assets that would otherwise be given to or inherited by individuals receiving government assistance.

Individuals seeking eligibility for Long-Term Care Medicaid must also satisfy certain asset limitation requirements.[12] A larger amount of assets may be excluded where one spouse is in a long-term care facility and the other lives in the community; however, a qualified attorney should be consulted for assistance in determining the amount of assets which

can be excluded in such a circumstance.

In determining eligibility, some assets are counted and others are excluded. Countable assets include, but are not necessarily limited to:

Bank Accounts	Stocks and Bonds
Certificates of Deposits	Oil/Gas/Mineral Rights
Real Estate	Jewelry and Antiques
Life Insurance	Cars and Other Vehicles
Burial Plots and Funds	

Assets excluded by HHSC in determining an unmarried individual's eligibility are:

- Homestead where the individual intends to return, including all adjacent land;
- Life insurance, if the face value is $1,500 or less;
- Burial funds of $1,500, less any excluded life insurance;
- Car worth less than $4,500, or more if needed for medical transportation;
- Burial spaces for the individual, spouse, and close relatives;
- Irrevocable pre-paid burial policy;
- Wedding rings;
- Certain business property (sometimes including farms and ranches); and
- Tangible property worth not more than $6,000 that produces income of at least 6% per year.

Transferring Assets

Transfers of an individual's assets can cause him or her to be ineligible for Medicaid. Generally, a person must be very careful about making uncompensated transfers of assets ("gifts") within a 36-month period preceding his or her application for the Long-Term Care Medicaid Program. This period is known as the "look back period." The look back period for gifts to an irrevocable trust is 60 months. HHSC will examine any transfers made during the look back period and, in many circumstances, the transfers will result in a period of ineligibility for the Medicaid program. The rules in this area are very complex, and a qualified attorney should be consulted prior to making any gifts or transfers of assets for less than fair market value. A law passed by Congress in 1997 that pur-

ported to make it a criminal offense for an attorney to advise a client about the Medicaid "transfer rules" has been declared unconstitutional. Because such transfers can result in unintended consequences, an attorney's advice is often crucial to transferring property wisely if at all. Failure to report a transfer can result in criminal penalties for fraud, as can any fraudulent statement in the application process.

Medicaid Programs for Care at Home and in Assisted Living Facilities

The Community-Based Alternatives Program provides an alternative to institutionalization in a long-term care facility. Although the applicant must meet the criteria for nursing home care in the Long-Term Care Medicaid Program, he or she may receive personal care services provided in the home or in an assisted living facility. Unfortunately, enrollment in this program is limited, and the long waiting list for this program frequently causes applicants to seek long-term nursing care instead. Other programs that provide some home care (and are more likely to be available) are referred to generally as "Community Care." They include Primary Home Care, Family Care, and others.

Medicaid Estate Recovery Program

On March 1, 2005, HHSC implemented the Estate Recovery Program. Recipients of Medicaid long-term care services who applied for coverage of these services before March 1, 2005 will not be subject to recovery. The funds collected by the State of Texas pursuant to this program will be used by the state to fund Medicaid long-term care services, including community-based care and institutional-based care.

Under the new rules, the State of Texas may file a claim against the estates of deceased persons, age 55 and older, who received Medicaid benefits. Claims include the cost of services, hospital care and prescription drugs supported by Medicaid programs. The claim may attack to real or personal property of the deceased Medicaid recipient, such as a home or a car. The claim will not attach to:

- Insurance policy proceeds
- Retirement accounts, such as IRAs
- Pension plans

- Joint savings and checking accounts that are to be paid directly to the survivor
- Mutual funds
- Deferred compensation plans

Medicaid Estate Recovery Program claims will not be filed when it is not cost effective. Claims are not considered cost effective when the value of the estate is $10,000 or less, the recoverable amount of Medicaid costs is $3,000 or less, or the cost of the sale of the property would be equal to or greater than the value of the property.

A claim may not be filed should one or more of the following exist:

- There is a surviving spouse;
- There is a surviving child or children under 21 years of age;
- There is a surviving child or children of any age who are blind or permanently and totally disabled under Social Security requirements;
- There is an unmarried adult child residing continuously in the Medicaid recipient's homestead for at least one year before the time of the Medicaid recipient's death.

A waiver for undue hardship may be granted in the following situations:

- the estate property is a family business, farm or ranch, is the primary income-producing asset of the heirs, produces at least 50% of the livelihood for heirs for at least 12 months prior to the death of the Medicaid recipient, and recovery by the state would affect the property and result in heirs losing their primary source of income;
- Beneficiaries of the estate will be eligible for public or medical assistance if recovery claim is collected;
- Allowing one or more heirs to receive the estate enables them to discontinue eligibility for public or medical assistance;
- The Medicaid recipient received medical assistance as the result of being a crime victim;
- The value assessed by the tax appraisal district is less than $100,000, and heirs have gross family income below 300% of the federal poverty level.

When the lien claim is assessed, a deduction will be allowed for necessary and reasonable expenses previously paid for moe maintenance, including real estate taxes, utility bills, home insurance, home repairs, and other maintenance expenses such as lawn care. A deduction will also be allowed for necessary and reasonable costs previously incurred that delayed institutionalization of the Medicaid recipient.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal program administered by the Social Security Administration with help from the states to provide a minimum income for people who meet certain requirements.

Requirements

In order to receive SSI, the general requirements are that a person must:

- Be at least 65 years of age or blind or disabled;
- Be a U.S. citizen or qualified alien and resident (for at least 30 days) of the United States;
- Meet certain financial requirements (discussed below); and
- File the necessary applications.

Additionally, a person will typically not be eligible if he or she is residing in a public institution, such as a mental institution or prison. Residency in some public institutions will not cause ineligibility but may instead result in a reduction of SSI benefits or no adverse effect at all. A person may also be denied SSI benefits if he or she fails to apply for other benefits for which he or she may be entitled, or if he or she fails to accept rehabilitation or treatment if offered.

Financial Limits

Eligibility for SSI depends on financial requirements as well as the requirements mentioned earlier. The applicant must qualify in both the income category and the asset category. To be eligible for SSI, an individual's "countable" income must be below a certain level.[13] The calculation of income a person may have and qualify for SSI will depend on whether the income is "earned" or "unearned." There is also a limit on the value of

assets a person may have and qualify for SSI.[14] Not all assets are considered in this limit. The same assets are exempt as those listed for an unmarried individual applying for nursing home Medicaid (even if the applicant for SSI is married).

Benefits

SSI pays meager benefits. An eligible individual can receive from the SSI program a maximum amount[15] depending on the types and amounts of income he or she is receiving. The benefit amount is increased slightly each year due to a cost of living increase.

Applying for SSI

Applicants should visit their local Social Security office or call the Social Security Administration at 1-800-772-1213 to schedule an appointment. They can also obtain information from the Internet by visiting www.ssa.gov. The parents or guardians of blind or disabled children and of adults needing assistance can typically complete the application for their children or wards. To give assistance to an adult who does not have a guardian, one must be appointed his or her "representative" on an "Appointment of Representative" form. This and other forms are available at www.ssa.gov/online/forms.html.

Receiving SSI Payments

SSI payments will begin later of the month after the month in which the applicant has become eligible for SSI or has completed the application for SSI. After that, payments will be made on the first day of the month. Payments to an eligible couple are made by sending each spouse a separate check. An individual or couple may also receive payments in advance of regular SSI payments in special situations. To do so, the individual or couple must present evidence of eligibility and must be faced with a financial emergency, such as inability to obtain food, shelter, or medical care.

Appealing an SSI Determination

A person who receives an adverse determination regarding SSI benefits may appeal the determination. Such a situation is normally handled similarly to a Social Security Disability Insurance case. It should be noted, however, that if SSI bene-

fits are being lowered, suspended, or terminated, the person must be given prior written notice before such action can be taken. Also, if an appeal is filed within 10 days from receipt of the notice, the SSI benefits must continue unreduced until the appeal is resolved. If, however, the denial of benefits was valid and the appeal is denied, any payments received after the initial notice of denial must be repaid to the Social Security Administration.

ENDNOTES

1 This amount was $393 in 2006.

2 In 2006, the monthly premium amount was $88.50, but this amount typically increases each year.

3 The same assets are exempt (not "countable") as those listed for unmarried individuals applying for Medicaid nursing home care (discussed in the Medicaid section of this brochure).

4 The QMB income limit for 2006 was $837 per month for an individual and $1,120 per month for a couple in which both were eligible for QMB. Those amounts included the $20 per month that is "exempt."

5 This amount was $88.50 per month in 2006.

6 In 2006, the eligibility ranges were as follows: unmarried individuals with monthly incomes greater than $837 and not more than $1,000, and couples with monthly incomes greater than $1,120 and not more than $1,340.

7 In 2006, it was available to unmarried individuals with monthly incomes greater than $1,000 and not more than $1,123; and couples with monthly incomes greater than $1,340 and not more than $1,505.

8 Note that eligibility for Community Medicaid is determined by the Social Security Administration in SSI cases because all SSI beneficiaries are eligible for that type of Medicaid.

9 The maximum amount of countable income a single person may have and still qualify for Medicaid is $1,809 as of January 1, 2006.

10 In 2006, the amount was $45 per month, or more if it was for VA Aid & Attendance.

11 This generally does not include attorney fees or court costs associated with a guardianship.

12 In 2006, single persons could not have countable assets in excess of $2,000. A married couple, both of whom apply for Medicaid, could not have countable assets in excess of $3,000.

13 This amount was $1,040 per month in 2006 if you are full retirement age.

14 In 2006, a single individual could have assets worth up to $2,000 and a married couple could have up to $3,000.

15 The amount was $603 per month in 2006 (or no more than $904 for an eligible individual with an eligible spouse).