FLORIDA MEDICAID & S-CHIP ELIGIBILITY

OVERVIEW OF PROGRAMS

Medicaid services in Florida are administered by the Agency for Health Care Administration (AHCA). Headquarters staff are responsible for planning and policy issues through the following bureaus: Program Analysis, Medicaid Services, Health Systems Development, Pharmacy Services, Research and Contract Management. Medicaid eligibility is determined by either the Department of Children and Families (DCF) or the Social Security Administration. DCF determines eligibility for low-income families with children, children only, pregnant women, non-citizens with medical emergencies, and elderly and/or disabled individuals not currently receiving Supplemental Security Income (SSI).
There are 11 area field offices of AHCA around the state that serve as local liaisons to providers and recipients. Locations of these offices can be found at www.fdhc.state.fl.us/Medicaid/Areas/index.shtml.

The S-CHIP program is part of "Florida KidCare." S-CHIP is a combination Medicaid expansion and separate program. There are five basic components under the KidCare program. Except for the Medicaid expansion, there is a $20 fee per family to participate. Children in one family may be enrolled in different components. Children cannot be insured at the time of enrollment, eligible for Medicaid or a dependent of a state employee. Citizenship or residency requirements apply. There is a cap on enrollment and currently there is a waiting list for services. The components are as follows:

Medicaid expansion: Florida's Medicaid expansion covers infants under age 1 with family income from 185 to 200% of FPL and children ages 15 through 20 from 28% to 100% of FPL.

- MediKids (S-CHIP): For children from age 1 up to age 5 whose household income is more than 133% of FPL and less than 200% of FPL. MediKids was created to provide coverage to the non-school-age children that the Healthy Kids program does not cover. A "Medicaid look-alike" program, MediKids provides the Medicaid benefit package and has periodic open enrollment periods.
- Florida Healthy Kids (S-CHIP): KidCare S-CHIP funding extended the existing Florida Healthy Kids (FHK) program to all counties throughout the state, with modifications designed to meet the requirements of the S-CHIP legislation. Healthy Kids is a school-based health insurance program that covers children ages 5 to 19 in households whose income is above the Medicaid threshold (133% of FPL for children age 5 and 100% for children ages 6 and older). There are no income limitations for participation in FHK, but S-CHIP subsidizes premiums only for children at or below 200% of FPL. Families that earn more than the maximum income may buy FHK insurance at full price if their children are otherwise eligible. Coverage is provided through commercially licensed insurers. There are periodic open enrollment periods.
- Children's Medical Services Network: This is a health plan for children with special, ongoing health care needs, such as Spina Bifida, Leukemia, Diabetes, and behavioral health problems. It provides medical services, therapies, supplies or equipment. B-Net is an option that is part of the CMS network. It is available for children ages 5-19 FCMS screens as having severe behavioral health needs. The KidCare program is also the vehicle for enrolling children in Medicaid. Individuals can call KidCare or go to the KidCare website and get enrollment applications (there is one form for all programs). Children who are eligible for Medicaid are enrolled in Medicaid and children who are eligible for various KidCare programs such as MediKids (the Medicaid look-alike) or Healthy Kids are enrolled in those.

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
MEDICAID			
Pregnant Women	Income cannot exceed 185% of FPL and must have proof of pregnancy. There is a simplified eligibility form and an office visit is not required for eligibility purposes. No asset limit.	When determining eligibility for pregnant women, the unborn children, the father of the baby (if he lives in the home), as well as any other children, are considered when looking at the income limit for the family.	Pregnant women may be presumptively eligible under a program called Presumptive Eligibility for Pregnant Women (PEPW). The program only covers outpatient medical care. It does not cover labor and delivery costs. Women who are found eligible for Medicaid remain eligible throughout the pregnancy and for two months following the birth of the child, as long as the mother remains a resident of Florida. If the pregnant woman is a minor and living at home, the caretaker or the pregnant woman may apply for the pregnant minor. If the caretaker(s) is a parent(s) of the minor, a portion of the parent(s) income is counted.
Medicaid Extended Family Planning Services	Postpartum women who have had Medicaid-financed delivery or termination of pregnancy within two years prior to the date of losing Medicaid eligibility.	These women have access to all Medicaid-covered family planning services. In addition to all family planning-related pharmacy services, antibiotic treatment of sexually transmitted diseases will also be covered. Inpatient services are not included.	Extended family planning benefits are for two years. Waiver is under review by CMS and may be terminated as of November 30, 2003. If extended, women will have to apply to DOH presumptive eligibility workers using a simplified form and have an income 185% of poverty or below. No asset test will apply. Eligibility will have to be renewed annually.

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Breast and Cervical Cancer	Must be diagnosed by Mary Brogan Breast and Cervical Cancer Prevention Program. Income must be below 200% of FPL. Must be under age 65.		
Emergency Medical Assistance for Non-Citizens	Non-citizens who would be Medicaid-eligible on all factors other than their citizenship status may be eligible for Medicaid to cover medical emergencies, including the birth of a child.	Before Medicaid may be authorized, applicants must provide proof from a medical professional stating the treatment was due to an emergency condition. Medicaid can be approved only for the period of the emergency.	
Families and Children			
KidCare Medicaid Children under age 1	Income cannot exceed 200% of FPL. No asset limit. Be a Florida resident and meet citizenship or qualified non-citizen		If a child is living with a caretaker other than a parent, only the child's income is counted. The child must be living with a responsible adult, however, the adult does not have to be related or have any legal custody to apply for the child. Families who wish to apply for Medicaid for their children may do so through the KidCare program (www.floridakidcare.org).
KidCare Medicaid Children ages 1 through 5	Income cannot exceed 133% of FPL. No asset limit. Be a Florida resident and meet citizenship or qualified non-citizen		
KidCare Medicaid Children ages 6 through 20	Income cannot exceed 100% of FPL. No asset limit. Be a Florida resident and meet citizenship or qualified non-citizens		
Emergency Medical Assistance for Non-Citizens	Non-citizens who would be Medicaid-eligible on all factors other than their citizenship status may be eligible for	Before Medicaid may be authorized, applicants must provide proof from a medical professional stating the treatment	

PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
	Medicaid to cover medical emergencies, including the birth of a child.	was due to an emergency condition. Medicaid can be approved only for the period of the emergency.	
Temporary Assistance for Needy Families (TANF)/Temporary Cash Assistance (TCA)			
Family Coverage (Section 1931 Medicaid) • Individuals that are receiving Temporary Cash Assistance (TCA) • Individuals that are eligible for TCA but choose not to receive it • Children up to age 18 • Children age 18 who are still in high school may also be eligible for Medicaid • Caretakers of children under 18 (or 18 and still in high school) • Pregnant women without other children	Technical requirements: • Be a Florida resident • Have a dependent child in the home • Have or applied for a Social Security Number • Disclose any third party liability • Be a U.S. Citizen or qualified non-citizen • File for any other benefits to which they may be entitled • Parents or caretakers who wish to receive Medicaid must cooperate with Child Support Enforcement • Women applying based on being pregnant must verify pregnancy Income must be equal to or less than 25% of FPL. Certain income disregards apply such as day care and work related expenses. Asset limit: $2,000 Homestead and cars up to $4,500 do not count as assets.	Individuals that are receiving TCA are eligible for Medicaid unless they choose not to receive it. However, individuals who are eligible for TCA but choose not to receive it may still be eligible for Medicaid. Applications are made to the Department of Children and Families (DCF) or DCF vendor. An office visit is required and proof of income, etc, must be provided.	By Federal definition, families can be eligible for Section 1931 Medicaid even if both parents are in the home. Children between age 18 - 21 may still be eligible for this type of Medicaid. However, the caretakers of these children are not eligible for Medicaid unless eligibility can be met on another factor. Children and pregnant women may be eligible for other “non-1931 Medicaid.”

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
Medically Needy			
For families whose income and/or resources exceed the eligibility requirements for other Medicaid programs.	The technical requirements of Section 1931 Medicaid (see above) OR SSI-Related Medicaid (see below) must be met in order to be eligible. Pregnant women who are over the income limit for regular Medicaid can also be covered by the Medically Needy Program. These individuals and families must incur a certain amount of medical bills each month before Medicaid can be approved. This is referred to as a "share of cost" (like a deductible) and the amount varies depending on the family's size and income. There is no income limit to qualify for the Medically Needy program; however, gross income after medical expenses must be below limits for regular Medicaid. There are asset limits – see chart below.	Once an individual incurs and documents medical bills equal to their share of cost, they become eligible for Medicaid for the remainder of that month. Individuals must meet their share of cost each month to be eligible for the month.	

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
Elderly/Disabled			
Individuals receiving Supplemental Security Income (SSI)	Automatically eligible for Medicaid. To be eligible for SSI, an individual must: • Be aged (65 or older), blind or disabled; • Be a U.S. citizen (certain immigrants may be eligible); • Meet other technical requirements (such as Florida residency, etc.); • Have income less than $552/month for an individual; and • Have countable resources/assets that do not exceed $2,000. Homestead and car valued under $4,500 are not considered assets.	Eligibility determined by federal government.	SSI recipients who need nursing facility care services must meet additional requirements for those benefits.
Medicaid for Aged or Disabled (MEDS-AD)	To be eligible, a person must: • Be aged (65+) or disabled; • Be a U.S. citizen or a qualified non-citizen; • Be a Florida resident; • Have a Social Security Number or apply for one; • File for any other benefits for which they might be entitled; and • Disclose other third party liability (i.e., health insurance).		MEDS-AD does not cover blind individuals unless they are considered disabled. MEDS-AD recipients who need nursing facility care must meet additional eligibility criteria to qualify for institutional care benefits. Note: Florida Legislature reduced the MEDS-AD standards from 90 to 88% of the FPL effective July 1, 2002.

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
	Currently, the income limit is $659 for an individual and $889 for an eligible couple. Asset limit: $5,000 for an individual and $6,000 for an eligible couple.		
Medicaid Institutional Care Program (ICP)	To meet technical requirements, the individual must: • Be aged (65+) or disabled as determined by Social Security criteria; • Be a U.S. citizen or a qualified non-citizen; • Be a Florida resident; • Have a Social Security Number or apply for one; • File for any other benefits for which they might be entitled; and • Disclose other third party liability (i.e., health insurance); • Be determined to be in need of nursing facility services using a CARES assessment; • Be placed in a nursing home that participates in the Medicaid program.	In general, all of a patient's monthly income, except for $35 for personal needs, must be paid to the nursing facility for the patient's care. This is the "patient responsibility". Some veterans and certain individuals earning special wages may be allowed to keep more of their income. All or part of the patient's income may be set-aside for a spouse or dependents. There are special rules on income and assets/resources for couples where one spouse is institutionalized and one remains in the community. See eligibility manual.	If the individual or couple has income within the MEDS-AD limit, they are entitled to an asset limit of $5,000 or $6,000 respectively. Individuals whose income is over the Medicaid income standard may still be eligible if they set up an income trust and deposit sufficient funds into a "qualified income trust" account in order to reduce their income outside the trust to within the required standard. To qualify, the income trust must: • Be irrevocable; • Be comprised of income only; and designate that the state will receive any funds remaining in the trust at the recipient's death, up to the amount of Medicaid payments paid on behalf of the individual. • The institutionalized individual keeps $ 35 for personal needs.

PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
	Current income limit is $1,656 for an individual and $3,312 for an institutionalized couple in the same facility. If a community spouse, some of the institutionalized individuals may be assigned to community spouse. See eligibility manual. Asset limit: $2,000 for an individual and $3,000 for a couple if both are institutionalized. Community Spouses may have assets up to $90,660.		
Medicaid Hospice Program	To meet technical requirements, an individual must: Medicaid eligible under regular requirements • Have a medical prognosis that life expectancy is 6 months or less except for a special children's initiative; and • Elect Hospice services. • If enrolled in certain waivers such HIV/AIDS cannot be enrolled in Hospice. Asset limits: None for eligible children, $2,000 for an individual and $3,000 for an eligible couple.		If residing in a nursing home, most of the patient's monthly income, except for personal needs allowance and income set-aside for a spouse or dependent, goes to the hospice provider. Individuals residing in a nursing home keep $35 for their personal needs. Individuals who receive SSI checks or qualify for Medicaid under MEDS-AD have no patient responsibility.

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
Qualified Medicare Beneficiary (QMB)	Income cannot exceed $749 per month. Asset limits: $5,000 for one person and $6,000 for a couple.	Medicaid pays Medicare premiums, deductibles and coinsurance.	
Specified Low-income Medicare Beneficiary (SLMB)	Income must be greater than $749 but cannot exceed $898. Asset limits: $5,000 for one person and $6,000 for a couple.	Medicaid pays Medicare Part B premiums.	
Silver Saver Prescription Drug Program	Eligibility requirements: • Be enrolled in Medicare Part A; • Be age 65 or older; • Be a Florida resident; • Be a U.S. citizen or qualified non-citizen; • Have a Social Security Number or apply for one; • Apply for any other benefits to which they may be entitled; • Disclose any third party liability (i.e., health insurance); and • Not have prescription drug coverage through a Medicare HMO. Countable gross income must be greater than $659/month but not greater than $898 for an individual. There is no asset limit.	Individuals who meet all the criteria to be eligible and are enrolled in the Silver Saver program are eligible for $160/month in prescription drug benefits.	Individuals who are approved for the QMB or SLMB Medicare cost-sharing program will automatically be enrolled in the Silver Saver Program if space is available. In January 2004, income limits will rise to 200% of FPL.

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
WAIVER PROGRAMS – individuals must meet the following technical requirements for all waiver programs listed below, unless otherwise indicated: • Be a U.S. citizen or qualified non-citizen; • Be a Florida resident; • Have a Social Security Number or apply for one; • File for any benefits to which they may be entitled; • Disclose and third party liability (i.e., insurance); • Meet nursing facility level-of-care criteria as determined by the Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES); and • Be enrolled in the waiver. Income limits: $1,656 for an individual and $3,312 for an eligible couple Asset limits: $2,000 for an individual and $3,000 for an eligible couple (higher if MEDS-AD eligible).			
Traumatic Brain/Spinal Cord Injury	Must be age 18 or older and medically stable. Must be referred by Brain and Spinal Injury Program Central Registry.		
Aged/Disabled Adult Waiver Program	Must be age 18 - 64 and determined disabled or blind according to social security standards OR be age 65 years and older.		
Assistive Care Services	Must be age 18 or older and reside in ALF, RTF or AFHC. Must need two of four services such as assistance with ADLs or taking medications. Eligible for Optional State Supplement.		Income must be provided for care except that the resident may keep $54 in personal needs allowance.
Channeling Waiver	Individuals must reside in Dade, Monroe or Broward counties and be age 65 or older.		

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
Nursing Home Diversion Waiver	65 and older and impairment criteria. Dually eligible Medicare/ Medicaid.		
Developmental Services Waiver Program	Must be age 3 or older and disabled as determined by Social Security criteria. Rather than CARES, must meet level-of-care criteria for ICF/DD as determined by Developmental Services within the Department of Children and Families.		
Adult Cystic Fibrosis Waiver	Must be age 18 through 59 with cystic fibrosis and at risk of hospitalization. Must meet SSI or ICP income and asset requirements.		
Project AIDS Care Waiver Program	Must be Medicaid eligible under regular categories or age 65 or over, or determined disabled according to Social Security Administrative standards. Must have a medical diagnosis of AIDS. Must be at risk of institutionalization in a hospital or nursing facility based on an assessment by CARES.		
Florida Kid Care (S-CHIP)			
MediKids	Children from age 1 up to age 5 whose household income is more than 133% of FPL and less than 200% of FPL. No asset limit. Be a Florida resident and meet citizenship or qualified non-citizen.	Benefits package and delivery systems for MediKids are the same as KidCare Medicaid.	A family's monthly premium for MediKids is $20. There are no costs for services. Families must choose an HMO if two or more operate in their county. Otherwise they have a choice of MediPass and state-contracted HMOs if one operates in their area.

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PROGRAM	QUALIFICATIONS	PROCESS	SPECIAL CONSIDERATIONS
Florida Healthy Kids (FHK)	Children age 5 with incomes between 133% and 200% of FPL and children ages 6 through 18 with incomes between 100% and 200% of FPL. No asset limit. Be a Florida resident and meet citizenship or qualified non-citizen.	This is public/private partnership that provides comprehensive health insurance for school-age children. Coverage is provided through commercially licensed insurers.	A family's monthly premium is $20 per month. Families that earn more than the maximum income may buy FHK insurance at full price, if their children are otherwise eligible. There is no cost for well-child care. Some services have copayments, such as prescriptions ($3) and eyeglasses ($10). FHK does not enroll children all year. There are periodic open enrollment periods. Costs including premiums are limited to 5% of income
Children's Medical Services (CMS) Network Mover the B-net program	For children ages 0 through 18 with special health care needs in families with income below 200% of FPL. No asset requirements Be a Florida resident and meet citizenship or qualified non-citizen	This is a health plan for children with special, ongoing health care needs, such as spina bifida, leukemia, diabetes, and behavioral health problems. It provides medical services, therapies, supplies or equipment. Note: S-CHIP funding covers children above the Medicaid threshold of 133% for children ages 1 through 5 and 100% for children ages 6 and older. Children below the Medicaid thresholds are still enrolled in the CMS Network but are covered under Medicaid funding.	A monthly premium of $20 is required. Children may be served with other funds if meet criteria. The Behavioral Health Specialty Care Network (BHSCN) works in partnership with the CMS Network to provide comprehensive behavioral health services (mental health and substance abuse) to children with severe needs. Services are delivered by provider networks that contract with the Florida Department of Children and Families.

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MEDICALLY NEEDY ASSET LIMITS

Household Size	Asset Limit	Household Size	Asset Limit	Household Size	Asset Limit
1	$5,000	9	$9,000	17	$13,000
2	$6,000	10	$9,500	18	$13,500
3	$6,000	11	$10,000	19	$14,000
4	$6,500	12	$10,500	20	$14,500
5	$7,000	13	$11,000	21	$15,000
6	$7,500	14	$11,500	22	$15,500
7	$8,000	15	$12,000	23	$16,000
8	$8,500	16	$12,500	24	$16,500
Add $500 for each additional household member above 24.					