Financial Eligibility for Core Programs

Chapter 7a describes the financial eligibility for HCS programs that provide services that enable individuals to remain in, or return to, their own communities through the provision of coordinated, comprehensive, and economical home and community-based services.
HCS programs are funded by Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), or by the state, and administered by Home and Community Living Administration (HCLA). To be eligible for all HCLA-funded programs, the applicant must meet the target population, functional, and financial criteria.

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

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BACKGROUND

Medicaid, Title XIX of the Social Security Act (the Act), is a program that provides medical assistance for certain individuals and families that meet categorical and financial eligibility requirements. The Medicaid program became law in 1965 as a jointly funded, cooperative venture between the Federal and State governments to assist states in the provision of adequate medical care to eligible, needy individuals. Long Term Services and Supports (LTSS) is an umbrella term that includes both services provided through institutional rules and waivers, and services provided under the State Plan. A subset of LTSS is called long-term care (LTC). LTC refers to programs that use institutional Medicaid rules to determine financial eligibility.

State Plan

Section 1902 of the Act requires states that administer the Medicaid program to describe how they will meet the mandatory Medicaid requirements and the optional services they will provide. This is what we call our state plan. The state plan:

- Establishes eligibility standards;
- Determines the amount (how often), duration (for how long), and scope (exact nature of what is provided) of services;
- Sets the rate of payment for services; and
- Defines program administration.

The State Plan is Washington's agreement that our state will adhere to the requirements of the Act and the official issuances of the Department of Health and Human Services (HHS). The State Plan deems Washington eligible to receive federal funding or federal matching funds for providing Medicaid services.
All state plans are different – each state defines Medicaid eligibility differently and eligibility is not the same across state lines.

Home & Community Based Services (HCBS) Waivers

Granted under Section 1915(c) of the Act, an HCBS waiver is Medicaid's alternative to providing long-term care in institutional settings. The terms waiver, HCBS waiver, 1915(c) waiver, and HCS waiver all refer to HCS waivers granted under Section 1915(c) of the Act. Developmental Disabilities Administration (DDA) also has 1915(c) waivers.

Programs that Use HCBS Waiver Rules for Financial Eligibility

Program of All-Inclusive Care for the Elderly

Medicaid manual link
Program of All-inclusive Care for the Elderly (PACE) is a managed care LTSS option for individuals living within the PACE service area. Though PACE is a state plan option, HCBS waiver rules are used to determine both eligibility and post eligibility. There is one exception; however, PACE eligible clients are

not subject to transfer of asset rules. For all other financial eligibility criteria, see the HCBS Waiver section.

Roads to Community Living

Medicaid manual link

Roads to Community Living (RCL) is a demonstration project funded by the Money Follows the Person grant. It is meant to transition Medicaid eligible persons out of institutions into the community, excluding Adult Family Homes. Eligibility for RCL is dependent on institutional Medicaid eligibility – if a person is receiving Medicaid on the day of discharge from an institution, after a qualifying stay, that person is eligible for RCL. RCL guarantees 365 days of categorically needy (CN) medical coverage. However, for post eligibility, RCL uses the same rules as HCBS waivers (unless the client is eligible under a MAGI-based program). See the HCBS Waiver Post Eligibility section information regarding this.

> NOTE: Although HCBS waiver post eligibility is used throughout the RCL demonstration period, many RCL persons will be placed on non-RCL services at the end of the demonstration period. Eligibility for RCL does not necessarily guarantee eligibility for these services. Be sure to contact the Public Benefits Specialist (PBS) if it is anticipated an RCL recipient will transition to non-RCL HCBS services.

State-Funded Long-Term Care for Non-Citizens

Medicaid manual link

The State-funded LTC program for non-Citizens is for individuals in need of LTSS, but not eligible for federally funded Medicaid or Medical Care Services (MCS). This program is funding limited and currently has a limited number of "slots." Eligibility for residential or at-home settings follows HCBS waiver rules. Availability of a slot is coordinated with HCLA headquarters. See the HCBS Waivers eligibility section for financial eligibility.

FINANCIAL FUNDAMENTALS FOR CLASSIC MEDICAID RECIPIENTS

Timeframes & Responsibilities

The PBS has 45 days from receipt of application to determine eligibility, and 60 days where a disability determination is needed, unless there is good cause to extend the timeline.
HCS PBS staff are responsible for the medical eligibility for non-MAGI based programs when the person is applying for or receiving HCS services.
DDA PBS staff are responsible for the medical eligibility for non-MAGI based programs when the person is applying for or receiving DDA services, Healthcare for Workers with Disabilities (HWD), hospice, children and family institutional medical, and behavioral health organization (BHO) alternate living facility (ALF) placements.
An overview of what agency is responsible for Medicaid eligibility determinations is found here.

Communicating with HCS Public Benefits Specialists (PBS)

- The HCS Financial / Social Services Communication form (14-443) is used to communicate with PBS staff when initially authorizing HCBS services and at each annual review or significant change if services are extended for a year.
- The 14-443 is available in an electronic format through DMS within the Barcode system.
- Once submitted, the electronic 14-443 is automatically assigned to the PBS of record.

Communicating with DDA PBS

- The Public Benefits Specialist /DDA Case Resource Manager Communication form (15-345) is used to communicate with PBS staff when initially authorizing HCBS services and at each annual review or significant change if services are extended for a year.
- The 15-345 is no longer a paper form but is available in an electronic format through DMS within the Barcode system.
- Once submitted, the electronic 15-345 is automatically assigned to the PBS of record.

Medical Income and Resource Standards

The Health Care Authority (HCA) updates and distributes the Washington Apple Health Income and Resource Standards document. This document lists most financial income and resource standards, plus standards used in determining institutional eligibility and participation such as personal needs allowance (PNA), maintenance needs, community spouse allocation, and housing maximum amounts. Most standards change annually, but changes are staggered at each calendar quarter.

SSI Recipients Applying for HCBS Waiver, or HCBS Waiver-Rule-Based Services

The Act requires all LTC applicants, including SSI recipients, to submit an application for programs that use institutional financial eligibility rules. Those programs include services in a medical institution, an HCBS waiver service, or services based on HCBS waiver rules. SSI recipients in Washington are categorically eligible for Medicaid but may not be financially eligible for these services. To be eligible for these services, a recipient must:

- Not have transferred an asset for less than fair market value (does not apply to PACE or hospice as a program);
- Not have equity interest in a home that is greater than the standard. See WAC 182-513-1350; and
- Have annuities that meet the requirements in Chapter 182-516 WAC, if any annuities are owned.

SSI recipients or their representatives must complete the Eligibility Review for Long-term Care Benefits (DSHS 14-416) when requesting LTC services unless a signed application less than one year old is in the client's Electronic Client Record (ECR). This form contains a question about annuities, transfer of assets, and home equity. They may also apply online at https://www.washingtonconnection.org/home/. Once a signed application or eligibility review is received, another one will not be required, even if there is a break in LTC services. **Do not delay services while obtaining the application or eligibility review**.

An eligibility review or application is required if SSI eligibility ends. Generally, DSHS is responsible to redetermine Medicaid eligibility when a person's SSI stops. If you have any questions about SSI eligibility, talk with the Public Benefits Specialist.

Fast Track

Fast Track is a process that allows the authorization of HCS services prior to a financial eligibility determination when staff can reasonably conclude that the client will be financially eligible. Clients receiving services during the Fast Track period will not receive a Medicaid Services Card until financial eligibility is established. Fast Track is available for CFC, Community Options Program Entry System (COPES), and Medicaid Personal Care (MPC), when authorized by HCS. Further, CFC together with COPES can also be Fast Tracked. Do not use Fast Track for non-citizens unless you know that they will qualify for a CN or MN program.
If a client is found not financially eligible during a Fast Track service month, the services are state-funded, and there is no overpayment responsibility. Any expenditures are recovered through the Estate Recovery process. If the client is found financially eligible, the Fast Track services are federally funded once the Medicaid program is in place.
Ensure you communicate with the PBS regarding a person's potential for Fast Track services.
For specific instructions on the Fast Track process please refer to the Social Service Authorization Manual.

Presumptive Eligibility (PE)

Medicaid Transformation Project (MTP), Long-Term Services and Supports Presumptive Eligibility (LTSS PE), approved under the 1115 waiver, is a package of services that allows the state to waive certain Medicaid requirements. LTSS PE provides individuals with an opportunity for expedited access to both home and community-based services in their own home and Medicaid (Apple Health) medical coverage benefits while full functional and financial eligibility are being determined.

The LTSS PE assessment will be used in CARE to gather preliminary information for LTSS PE eligibility. For PE-eligible recipients, HCLA/HCS will provide a limited benefit package during the PE period, through phases, for individuals residing in their own home and who plan to enroll in one of the following Washington State programs:
- Medicaid Personal Care (MPC)
- Community First Choice (CFC)
- CFC + Community Options Program Entry System (COPES)

Rules governing LTSS PE can be found in WAC 388-106-1800 through 388-106-1855. LTSS PE description and requirements are located in Chapter 30e.

Third Party Resources

Generally, if a person has a third-party resource (TPR), they are required to contribute this resource toward their cost of care. Generally, a TPR is a source of funds that does not meet the definition of income (anything a person receives that can be used for food or shelter). Some sources of TPR are veteran's pensions, LTC insurance, or other third-party insurance. More information on financial eligibility and TPR can be found in the Medicaid Manual.

SERVICES

Community First Choice

Medicaid manual link

Community First Choice (CFC) is a state plan option granted under 1915(k) of the Act. Individuals are financially eligible for CFC if they are eligible for categorically needy (CN) or Alternate Benefit Plan (ABP) scope of care in the community. This includes both non-institutional medical coverage groups and CN coverage through an HCBS waiver. The financial eligibility rules are located in WAC 182-513-1210 through WAC 182-513-1220.

An SSI recipient is financially eligible for CFC.

One benefit of CFC is if an SSI-related married person is found functionally eligible for CFC, and their spouse is not in a medical institution, the CFC eligible person can utilize the financial benefits of spousal impoverishment protections in eligibility for non-institutional Medicaid. Essentially, this means that for both single and married individuals (where the spouse is not in a medical institution):

- Countable income in the name of the CFC eligible person must be at or below the 1-person categorically needy income level (CNIL); and
- Combined resources must be at or below the state resource standard plus $2000.00.

In the case of a functionally CFC eligible SSI-related person residing in an alternate living facility (ALF), as defined in WAC 182-500-0050, contact the PBS to determine whether non-institutional Medicaid or HCBS waiver rules will be used for financial eligibility. A person residing in an ALF has a different income standard for non-institutional Medicaid.

> NOTE: If a CFC eligible person lives in an ALF, and their countable income is above the CNIL for their household size, this person not only pays Room & Board, but also contributes their remaining income after their PNA and Room & Board are deducted. The combination of Room & Board and their remaining income is considered "total client responsibility."

In the case of a functionally CFC eligible SSI-related person who is working and age 16 or older, contact the PBS to determine whether the Healthcare for Workers with Disabilities (HWD) program is more beneficial than other SSI-related programs. The HWD program has a higher income limit and no asset test.

In the case of MAGI-based methodologies, there are no spousal impoverishment protections, and individuals must be eligible for a federally funded CN or ABP scope of care medical program. There is no asset test for MAGI-based methodologies.

For a complete list of medical coverage groups eligible for CFC, see the Medicaid Programs - LTSS Chart .

CFC Financial Eligibility

Use the steps below in ACES Online to verify CFC financial eligibility. You are looking for an *active* medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with the PBS.

1) Look for any of the non-institutional CN or ABP coverage groups listed on the Medicaid Programs - LTSS Chart ;
   a) If a person is a recipient in an active assistance unit (AU) where CFC is available, this person is eligible for CFC services;
2) If the person is not eligible under (1), and the person receives SSI, the person is eligible for CFC. The PBS will update the medical coverage group upon notification from you. Examples include:
   a) Persons discharging from institutions (L01 or L41 – PACE/hospice in an institution);
   b) Persons ending their Roads to Community Living (RCL) demonstration (L41); and
   c) Persons withdrawing from PACE (L31);
3) If the person is not eligible under (2), but is in a medical institution, coordinate with your PBS to establish eligibility;
4) If the person is not eligible under (3), and the person lives in an ALF, coordinate with your PBS to establish eligibility. A financial application may be needed;
5) If the person is not eligible under (4), and the person needs to use HCBS waiver rules to access CFC in any setting, coordinate with your PBS to establish eligibility. Also see the HCBS Waiver section. A financial application will be needed;
6) If the person is not eligible under (5), or you are unsure of a person's Medicaid status, contact the PBS;
7) If the person is not an active recipient in any AU, a financial application is required.

   NOTE: If you determine a Medicare-entitled SSI-related person is eligible for CFC without using HCBS waiver rules, there could be financial advantages to accessing an HCBS waiver service anyway. One such advantage is that a Medicare-Medicaid entitled person has their Medicare Part D prescription copayments waived when receiving HCBS waiver services, whereas a CFC-only person does not. Be sure to ask the PBS if you have questions about CFC only versus HCBS waiver plus CFC.

CFC Post Eligibility

- A CFC-only person (i.e., without HCBS waiver services) does not participate towards their cost of care. If living in an ALF, they pay only Room & Board. However, if SSI-related, living in an ALF, and their income is above the CNIL for their household size, they contribute their total client responsibility towards their cost of care. This does not apply to HWD – see last bullet below.
- A CFC eligible person who also receives HCBS waiver services participates towards their cost of care. If living in an ALF, they pay participation along with Room & Board.
- A CFC eligible person who used HCBS waiver rules to access hospice services participates towards their cost of care. If living in an ALF, they pay participation along with Room & Board.
- A CFC eligible person who is CN eligible through the HWD program continues to pay their HWD premium, along with Room & Board if in an ALF.

HCBS Waivers (COPES, New Freedom, Residential Support)

Medicaid manual link

HCBS waivers allow clients the choice of receiving institutional services in the community instead of in a medical institution. These waivers are granted under section 1915(c) of the Act. All HCS HCBS waivers follow the same financial eligibility rules described in Chapter 182-515 WAC. However, some HCBS waivers may only be offered in certain settings. See LTC Manual Chapter 7 for more information regarding settings.

DDA HCBS waivers also follow the same financial eligibility rules in Chapter 182-515 WAC; however, there is one key difference in financial eligibility between HCS and DDA HCBS waivers:

> Income eligibility for DDA HCBS waivers is capped at the special income level (SIL), whereas HCS HCBS waiver recipients can have income above the SIL. This is referred to as Mega COPES.

HCBS Waiver Eligibility

Core eligibility: a person must either be receiving SSI or be SSI-related. MAGI-based medical coverage groups are not eligible for HCBS waiver services, though they may apply, and be related to SSI via a non-grant medical assistance (NGMA) determination (a disability / blindness determination).

HCBS Waiver Eligibility by Medical Coverage Group

Generally, an HCBS waiver recipient will always be placed on the L21 or L22 medical coverage group once financial eligibility and functional eligibility are established. For individuals in a medical institution active on Medicaid (L01 or L02), they are financially eligible for HCBS waiver services upon transition to the community. For individuals on L95 or L99, coordinate with the PBS because their income may be too high for HCBS waiver services.

There are a few other medical coverage groups that a person will be an active recipient on where they can receive HCBS waiver services. These medical coverage groups are:

Group	Description
S08	HWD
D01/D02*/D26*	Foster Care

*Coordinate HCBS waiver eligibility with your PBS and HCA

For all other SSI and SSI-related medical coverage groups, if an active recipient, a person has met most financial eligibility criteria, but the PBS will need to verify the following three criteria:

- No uncompensated transfers that may incur a penalty period;
- No equity interest in a home that exceeds the standard. See WAC 182-513-1350; and
- All annuities owned by the client or spouse meet the annuity requirements of Chapter 182-516 WAC.

Persons active only on a Medicare savings program (MSP) – S03, S04, S05, or S06 – are not eligible under the group discussed above. Coordinate with the PBS to determine these individuals' eligibility.

HCSB Waiver Eligibility via Application

Financial and functional eligibility for HCBS waiver is completed concurrently. Consider Fast Track where it is reasonably determined that a person may be financially eligible for HCBS waiver. Coordinate Fast Track with the PBS. Please note – Fast Track for New Freedom or DDA HCBS waivers is not allowed. Refer to the Fast Track section for services that can be Fast Tracked.

Income – For both single and married persons, income eligibility is only based on income in the name of the HCBS waiver applicant, and one-half of any community income (if married).
Generally, a person's income can be significant, and they are still income eligible for HCBS waiver. The monthly state nursing facility rate, medically needy income disregards, along with recurring medical expenses are subtracted from a person's income before comparing it to the 1-person medically needy income level (MNIL).

For example, this means that as of 01/01/2026, a person can have countable income approximately as high as $11,503 and still be income eligible for HCS HCBS waiver.

Note: This calculation does not apply to DDA HCBS waivers.

Resources - For both single and married individuals, the resource limit is $2000.00 However, if married, a person can allocate up to the state spousal resource standard to their spouse before counting resources towards this $2000.00 limit. This can only occur when the spouse is not in a medical institution. Further, any resources above the standard can be reduced by medical expenses.
Other resource considerations –

- A person with an equity interest in their home above the standard is not eligible for HCBS waiver. See WAC 182-513-1350;
- A person (and their spouse if married) must disclose their interest in any annuities, and the annuities must meet the requirements of Chapter 182-516 WAC; and
- HCBS waiver services are subject to transfer of asset considerations. If the person, or their spouse, has transferred an asset in the five years prior to their application, coordinate with your PBS to determine whether eligibility, or a transfer penalty, will be established.

HCBS Waiver Post Eligibility

A person otherwise eligible for non-institutional CN in the community, described in WAC 182-515-1507, does not participate towards their cost of care. If living in an ALF, the person is responsible for Room & Board. If eligible for HWD, a person continues to pay their HWD premium, along with Room & Board if in an ALF.

A person eligible for HCBS waiver under WAC 182-515-1508 does participate toward their cost of care. If living in an ALF, the person is responsible for Room & Board in addition to participation.
A person only participates up to their total cost of care for services that month. If HCBS waiver rules are required to determine eligibility for CFC, a person participates towards the cost of both their HCBS waiver services and CFC services.
The rules regarding post eligibility and participation are found in WAC 182-515-1509 for HCS HCBS waivers and WAC 182-515-1514 for DDA HCBS waivers.
If a person is Fast Tracked, participation must be estimated. Coordinate with the PBS to complete this.

Medicaid Personal Care

Medicaid manual link
MPC is a state plan entitlement similar to CFC. However, access to MPC services is through a non-institutional CN or ABP medical program. Unlike CFC, individuals who access CN through an HCBS waiver are not eligible for MPC. Financial eligibility for MPC is described in WAC 182-513-1225.
An SSI recipient is financially eligible for MPC.
Generally, for SSI-related individuals, the income and resource standards for non-institutional CN are as follows:

- Countable income for a one-person household is no greater than the 1-person CNIL. Countable income for a married person living with their spouse is no greater than the 2-person CNIL.
- Countable resources for a one-person household are no greater than $2000.00. Countable resources for a married person living with their spouse are no greater than $3000.00.

In the case of a functionally MPC eligible SSI-related person residing in an Alternate Living Facility (ALF), contact the PBS to determine whether the person is eligible for non-institutional CN. A person residing in an ALF has a different income standard for non-institutional CN.

> NOTE: If an MPC eligible person lives in an ALF, and their countable income is above the CNIL for their household size, this person not only pays Room & Board, but also contributes their remaining income after their PNA and Room & Board are deducted. The combination of Room & Board and their remaining income is considered “total client responsibility.”

In the case of a functionally MPC eligible SSI-related person who is working, and 16 years old or older, contact the PBS to determine whether the HWD program will get the person access to non-institutional CN. The HWD program has a higher income limit and no asset test.
In the case of MAGI-based methodologies, individuals must be eligible for a federally funded CN or ABP scope of care. There is no asset test for MAGI-based methodologies.
For a complete list of medical coverage groups eligible for MPC, see the Medicaid Programs - LTSS Chart
.

MPC Eligibility

Use the steps below in ACES Online to verify MPC financial eligibility. You are looking for an *active* medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with your PBS.

1) Look for any of the non-institutional CN or ABP coverage groups listed on the Medicaid Programs - LTSS Chart ;
   a) If a person is a recipient in an active AU where MPC is available, this person is eligible for MPC services;
2) If the person is not eligible under (1), and the person receives SSI, the person is eligible for MPC. The PBS will update the medical coverage group upon notification from you. Examples include:
   a) Persons discharging from institutions (L01 or L41 – PACE/hospice in an institution);
   b) Persons ending their Roads to Community Living (RCL) demonstration (L41); and
   c) Persons withdrawing from PACE (L31);
3) If the person is not eligible under (2), but is in a medical institution, coordinate with your PBS to establish eligibility;
4) If the person is not eligible under (3), and the person lives in an ALF, coordinate with your PBS to establish eligibility. A financial application may be needed;
5) If the person is not eligible under (4), or you are unsure of a person's Medicaid status, contact the PBS;
6) If the person is not an active recipient in any AU, a financial application is required.

MPC Post Eligibility

A person on MPC does not participate toward their cost of care. If living in an ALF, they pay only Room & Board. However, if SSI-related, living in an ALF, and their income is above the CNIL for their household size, they contribute their total client responsibility towards their cost of care.

An MPC eligible person who is CN eligible through the HWD program continues to pay their HWD premium, along with Room & Board if in an ALF.

Medical Care Services

Medicaid manual link

Medical Care Services (MCS) is a state-funded medical program where eligibility is driven by a person's eligibility for the Aged, Blind, Disabled (ABD) cash program; or eligibility for the Housing and Essential Needs (HEN) program.

In order to be eligible for MCS, a person must be eligible for ABD cash or a HEN referral (but not necessarily receiving a cash grant). Further, the person must not be eligible for any federally funded medical assistance solely due to their citizenship or immigration status. In essence, MCS serves the population of individuals who are qualified aliens that are subject to and within their five-year bar for Medicaid eligibility; and those persons who are lawfully present, but never able to become eligible for Medicaid (i.e., "nonqualified alien").

Eligibility for Residential Services under MCS

Use the steps below in ACES Online to verify residential services eligibility under MCS. You are looking for a medical coverage group where the person is a *recipient*. If you are unsure of the information in ACES, check with your PBS.

1) Look for an *active recipient* of an A01 or A05 medical coverage group. See the Medicaid Programs - LTSS Chart for information on these medical coverage groups;
2) If not eligible under (1), but eligible in a medical coverage group that is specific to non-citizens, or another state-funded program, coordinate eligibility with your PBS. An application for cash through DSHS is required;
3) If not eligible under (2), an application for cash through DSHS is required.

Post Eligibility for Residential Services under MCS

No cost of care letters are sent to individuals eligible for residential services under the MCS program. They are responsible for Room & Board. To calculate Room & Board, subtract a person's PNA from their countable income. The remaining income is contributed up to the Room & Board standard.

Chore

Chore is an HCS program using state-only funds. Chore is not available to new applicants as of August 2001. Current Chore clients have been grandfathered into the program. If terminated from Chore, individuals will never be financially eligible for Chore again.
HCS financial does not determine financial eligibility for Chore. Financial eligibility for Chore is in WAC 388-106-0610.

Chore Eligibility

Financial eligibility is determined by the social services case worker at least annually, or at an income change. This is accomplished by:

- Completing a CHORE PROGRAM INCOME AND RESOURCES DECLARATION form (DSHS 14-404) to determine financial eligibility and calculate participation;
- Giving a copy to the client
- Placing the original signed copy in the file through DMS

NOTE: If the client does not have an ACES number you will need to work with HCS HQ staff to create a "negative" ACES number which will enable you to create an electronic client record in Barcode.

To remain financially eligible for Chore, a person must:

- Have income that does not exceed the cost of Chore services and not exceed 100% of the Federal Poverty Level (FPL) for their household size;
- Have resources no greater than $10,000 (one person), $15,000 (two-person family). An additional $1,000 is added to the two-person standard for each additional family member; and
- Have not transferred an asset for less than fair market value on or after November 1, 1995.

Chore Post Eligibility

HCS financial does not determine Chore post eligibility. A person's contribution toward their cost of care for Chore services is very different than for HCBS waivers and is calculated by the case manager/social services specialist. For post eligibility, see WAC 388-106-0625.

Healthcare for Workers with Disabilities

Medicaid manual link

HWD is a unique program, in that it is SSI-related, however:

- There is no asset test like other SSI and SSI-related programs;
- Disability determinations are not subject to substantial gainful activity concerns;
- Income limits are much higher than other SSI-related programs; and
- An HWD eligible person is financially eligible for CFC, HCBS waiver, and MPC;
    - For CFC or CFC plus HCBS waiver, coordinate with your PBS to ensure the person meets the home equity requirements in WAC 182-513-1350, and the person disclosed interest in any annuities; and
    - For HCBS waiver, coordinate with your PBS to ensure the person is not subject to a transfer of asset penalty.

HWD Eligibility

Determine if a person is an active recipient of an S08 AU. If not, and the person meets (or may meet) the following criteria, contact your local HCS HWD specialist:

a) Be at least age 16;
b) Meet the federal disability requirements; and
c) Be employed full or part-time (including self-employment);

Your local HCS HWD specialist can be found here.

HWD Post Eligibility

A person on HWD does not participate, regardless of service or setting. In all cases, the person must continue to pay their HWD premium to remain eligible for HWD. If living in an ALF, the person is responsible for Room & Board along with their HWD premium.

Note: HWD premiums for American Indians or Alaska Natives are waived.

Children's Health Insurance Program (CHIP)

CHIP is healthcare coverage for children funded under Title XXI of the Act. It provides coverage to children up to the age of 19 who are not eligible for Medicaid (Title XIX) because family income exceeds

the Medicaid standard (215% FPL). Once a child is determined eligible for CHIP, the child remains continuously eligible for 12 full months of coverage.

Income eligibility for CHIP

Families pay a premium for coverage in CHIP that is based on net income of the medical assistance unit that includes the child. The maximum income limit is 317% FPL. Coverage is based on MAGI methodologies and families apply for coverage through the Health Benefit Exchange.

Premium requirements

Households with income between 215% and 265% FPL pay a premium of $20 per child per month (maximum $40 per month) and households with income between 265% FPL and 317% pay a premium of $30 per child per month (maximum $60 per month). Premiums are waived for American Indian/Alaskan Native clients and pregnant women.

Eligibility for HCS/DDA services

DDA provides services to children; however, HCS does not provide services until a child turns 18. Since CHIP provides coverage through a child's 19th birthday, it is possible that a CHIP eligible child will qualify for HCS services. HCS can authorize services, which are equivalent to Medicaid's MPC and CFC, to a child on CHIP coverage – the difference is the funding source used to pay for the services. A child on CHIP is eligible under the ACES coverage group N13 and has special CHIP functional RACs which must be used for correct authorizations.

Service	HCS	DDA
Personal Care (CFC-lookalike)	3251	3521
Personal Care (MPC-lookalike)	3250	3520

Children on CHIP coverage are not eligible for HCBS waiver services. A child on CHIP who needs waiver services must be transitioned to the L22 coverage group and disability must be established.

State-Funded CHIP

Washington State also administers a state-funded CHIP program for children who do not meet the citizenship criteria for the federal program. The eligibility for the program mirrors the federal program; however, eligibility will be under the ACES coverage group N33. These children are eligible for state-funded services that mirror the Medicaid's MPC and CFC services. The functional RACs that must be approved to authorize state-funded services are below.

Service	HCS	DDA

Personal Care (CFC-lookalike)	3350	3910
Personal Care (MPC-lookalike)	3351	3911

RESOURCES

Medicaid 101.pptx
Medicaid Programs - LTSS Chart 7.2023.doc
Apple Health Medicaid Manual
Eligibility A-Z Manual (Cash & Food)
ACES Manual - Inquiry Search Information
Title 182 WAC (Health Care Authority)
Chapter 182-500 WAC Definitions
LTSS Definitions WAC
Financial Eligibility & Policy SharePoint (Available to State Employees Only)

Acronyms

ABD	Aged, Blind, Disabled
ABP	Alternate Benefit Plan
ALF	Alternate Living Facility
AU	Assistance Unit
BHO	Behavioral Health Organization
CFC	Community First Choice
CHIP	Children's Health Insurance Program
CN	Categorically Needy
CNIL	Categorically Needy Income Level
COPES	Community Options Program Entry System
DDA	Developmental Disabilities Administration
DMS	Document Management System
ECR	Electronic Case Record
FPL	Federal Poverty Level
HCA	Health Care Authority
HCBS	Home and Community Bases Services
HCLA	Home and Community Living Administration
HCS	Home and Community Services
HEN	Housing and Essential Needs
HHS	Health and Human Services

HWD	Healthcare for Workers with Disabilities
LTC	Long-term Care
LTSS	Long Term Services and Supports
MCS	Medical Care Services
MNIL	Medically Needy Income Level
MPC	Medicaid Personal Care
MSP	Medicare Savings Program
NGMA	Non-Grant Medical Assistance
PACE	Program of All-Inclusive Care for the Elderly
PBS	Public Benefits Specialist
PE	Presumptive Eligibility
PNA	Personal Needs Allowance
RCL	Roads to Community Living
SIL	Special Income Level
TPR	Third-Party Resource

REVISION HISTORY

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