C Share of Cost Deductions

- Policy
  - 1) Personal Needs Allowance (PNA)
  - 2) Spousal Allowance (Non-Community Spouse)
  - 3) Family Allowance (Non-Community Spouse)
  - 4) Home Maintenance Needs Allowance (Non-Community Spouse)
  - 5) Community Spouse Monthly Income Allowance (CSMIA)
  - 6) Community Spouse Family Allowance
  - 7) Health Insurance Premiums
  - 8) Non-Covered Medical Expenses
  - 9) Special Deduction for Some Residents of the Arizona State Veteran Home
  - 10) Changes to the SOC
  - 11) SOC Collection
  - 12) ALTCS Cost Effectiveness Study Share of Cost (CES SOC)
- Definitions
- Programs and Legal Authorities

Revised 06/18/2015

Effective Until 9/30/2015

Policy

Certain deductions are subtracted from the customer's total counted income when determining the SOC. The deductions vary depending upon the policy used to determine eligibility.

If…	Then the customer may qualify for…
Eligibility was determined using non-community spouse policy	● Personal Needs Allowance (PNA); ● One of the following maintenance needs allowances: ○ Spousal Needs Allowance; ○ Family Needs Allowance; or ○ Home Maintenance Needs Allowance; ● Medicare and other TPL health insurance premiums; ● Remedial or non-covered medical expenses; and ● Special deduction for some residents of the Arizona State Veteran Home.
Eligibility was determined using community spouse policy	● Personal Needs Allowance (PNA); ● Community spouse monthly income allowance (CSMIA). The income of the institutionalized spouse must actually be given to the community spouse to allow this deduction; ● A family allowance, for each qualifying family member. Proof of the family's income must be provided to allow this deduction; ● Medicare and other health insurance premiums; ● Non-covered medical expenses; and ● Special deduction for some residents of the Arizona State Veteran Home.

Effective Until 9/30/2015

1) Personal Needs Allowance (PNA)

The amount of the Personal Needs Allowance (PNA) is determined on a month-by-month basis.

The amount of the personal needs allowance depends on the customer's living arrangement during the calendar month.

When the customer enters an acute care hospital during the month, consider the living arrangement that the customer resided in prior to entering the hospital to be the living arrangement during the period of hospitalization. For example, if the customer was living in a nursing facility before entering the hospital, the period spent in the hospital is considered as still living in the nursing facility.

The amount of the PNA is calculated as follows:

If the customer...	Then the PNA is for that month is...
Lives in a long term care medical facility for the entire calendar month	15% of the Federal Benefit Rate (FBR) for ALTCS customers 15% of the FBR plus 50% of the customer's gross earned income for the month for FTW – ALTCS customers
During any portion of the calendar month, lives in: ● His or her own home; ● An HCBS setting; or ● Jail, prison or other detention facility	300% of the FBR

FBR Standards used to determine the PNA:

	Effective 1/1/13 to 12/31/13	Effective 1/1/14 to 12/31/14	Effective 1/1/15 to 12/31/15
FBR – Single	$710.00	$721.00	$733.00
FBR – Couple	$1,066.00	$1,082.00	$1,100.00
15% of the FBR	$106.50	$108.15	$109.95
300% of the FBR	$2,130.00	$2,163.00	$2,199.00

Effective Until 9/30/2015

2) Spousal Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, a customer with a spouse but no dependent children living at home gets a deduction for the maintenance needs of the spouse.

The spousal allowance is calculated by subtracting the spouse's counted income from the amount of the individual FBR.

The customer may be living either in a medical facility or in the community.

3) Family Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, a customer with dependent children living at home gets a deduction for the maintenance needs of the family. The customer may be living either in a medical facility or in the community.

The customer's family includes any of the following living in the home:

- The customer's spouse, and
- The customer's dependent children, including step-children.

The Family Allowance is determined by subtracting the combined counted income of the spouse and children from the AFDC A-1 Need Standard shown in the table below for the number of family (not counting the customer).

Effective Until 9/30/2015

Number of people	Need Standard
1	$567
2	$765
3	$964
4	$1,162
5	$1,360
6	$1,559
7	$1,757
8	$1,955
9	$2,153
10	$2,351
11	$2,549
12	$2,747
13	$2,945

NOTE For families larger than 13, add $198 to the Need Standard for each additional person.

<Family Allowance (Non-Community Spouse) – Amount Example>

4) Home Maintenance Needs Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, the customer may qualify for a Home Maintenance Needs Allowance for up to six months when the customer:

- Lives in a medical institution for the entire calendar month;
- Does not have a spouse or child living at home;
- Is responsible for paying expenses to maintain his or her home; and
- Is likely to return to the home within 6 months of the date the customer entered the medical institution.

Effective Until 9/30/2015

The Home Maintenance Needs Allowance is based on a federal standard and changes infrequently:

Effective 1/1/89 to 6/30/93	Effective 7/1/93 to Present
$138.00	$210.00

The home maintenance allowance is deducted beginning the first month following the month the customer entered the medical institution. However, past SOC amounts can only be adjusted for the three months before the current month.

In the case of institutionalized couples, only one Home Maintenance Needs Allowance is allowed. If both spouses are expected to return home within the 6-month period, the Home Maintenance Needs Allowance is deducted from the share of cost of the spouse for whom it would be most beneficial.

The home maintenance allowance can be applied to separate periods of institutionalization for the same customer. A temporary absence from an institution, however, is not a basis for beginning a new six-month period for the deduction. The customer must be discharged from the institution before another six-month period is allowed.

<Home Maintenance Needs Allowance Examples>

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Shelter Expenses

The customer must provide proof that he or she has shelter expenses that need to be paid to maintain the home. Shelter expenses include rent, mortgage, property tax, homeowner's insurance and utilities.

SEE <HOW TO ENTER SHELTER EXPENSES IN ACE> FOR KEYING INSTRUCTIONS.

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Likely to Return Home

A physician must state in writing that the customer is likely to return to the home within six months from the date the customer entered the institution. The physician's statement must be provided before the date the customer is expected to return home and must show the potential discharge date.

Effective Until 9/30/2015

SEE <SYSTEM INSTRUCTIONS> FOR INFORMATION THAT MUST BE ENTERED IN ACE TO ENABLE A HOME MAINTENANCE ALLOWANCE.

5) Community Spouse Monthly Income Allowance (CSMIA)

When eligibility is determined using community spouse policy, a customer may qualify for a Community Spouse Monthly Income Allowance (CSMIA) when the customer actually makes his or her income available to the community spouse.

If a court has ordered the customer to pay monthly financial support for the community spouse, the CSMIA is the higher of:

- The amount of the monthly support ordered by the court; or
- The calculated CSMIA.

The customer or spouse may appeal the amount of the Minimum Monthly Maintenance Needs Allowance (MMMNA).

An Administrative Law Judge may increase the amount of the MMMNA if either spouse proves that the community spouse needs income above the established MMMNA amount due to exceptional circumstances resulting in significant financial duress.

<u>Steps used to calculate the CSMIA</u>

The following steps are used to calculate the CSMIA. Detailed information about the amounts used in the steps is included below the table:

Effective Until 9/30/2015

Step	Action
1	Add the Utility Allowance to the Community Spouse's verified shelter costs.
2	Take the total from step 1 and subtract the 30% of the Monthly Spousal Need Standard. Any remaining amount is the Excess Shelter Allowance.
3	Add the Excess Shelter Allowance and the Monthly Spousal Need Standard. The result is the Minimum Monthly Maintenance Needs Allowance (MMMNA).
4	Compare the MMMNA from step 3 to the Maximum Monthly Maintenance Needs Standard.
5	Take the lower of the amounts from step 4 and subtract the counted monthly income of the community spouse. The result is the CSMIA.

Standards used to calculate the CSMIA

The following standards are used in calculating the Community Spouse Monthly Income Allowance (CSMIA) for a community spouse. These are federal standards that change annually:

	Effective 7/1/12 to 6/30/13	**Effective 7/1/13 to 6/30/14**	**Effective 7/1/14 to 6/30/15**	**Effective 7/1/15 to 6/30/16**
Monthly Spousal Need Standard	$1,892.00	$1,939.00	$1,967.00	$1,992.00
30% of the Monthly Spousal Need Standard	$568.00	$582.00	$590.00	$598.00

Effective Until 9/30/2015

	Effective 1/1/13 to 12/31/13	**Effective 1/1/14 to 12/31/14**	**Effective 1/1/15 to 12/31/15**
Maximum Monthly Spousal Need Standard	$2,898.00	$2,931.00	$2,981.00

Standard Utility Allowance (SUA)

Effective 10/1/10	**Effective 10/1/11**	**Effective 10/1/12**	**Effective 10/1/13**
$342.00	$341.00	$341.00	$341.00

Utility Allowance

When calculating the CSMIA, the customer qualifies for a Utility Allowance when:

- The customer or community spouse pays for heating or cooling the home where the community spouse resides; and
- The costs are billed separately from their rent or mortgage on a regular basis.

The household does not need to be billed by a utility company to get this allowance. If the utility bill is in another person's name but the customer or spouse pays the bill, the customer gets the Utility Allowance.

The customer can get the Utility Allowance even when the household has heating or cooling costs for only part of the year. (This includes those who have heating but not cooling costs, or cooling costs but not heating costs).

A SUA is allowed when household receives Low Income Home Energy Assistance (LIHEA) payments directly or through a vendor.

The customer must provide proof that they pay for heating or cooling. Because the Utility Allowance is based on a set standard, it is not necessary to prove the exact amount.

When the household qualifies for a Utility Allowance, the amount allowed is either:

- The Standard Utility Allowance (SUA); or
- A portion of the SUA.

Effective Until 9/30/2015

When the household shares utility expenses with another household, or does not have a separate utility meter:

- The SUA is divided equally by the number of households which share the expense, if each pays an equal share; or
- The SUA is prorated among the households based on the portion paid by each.

When the household pays a required condominium or cooperative maintenance charge that includes a utility expense, that utility expense amount is subtracted from the SUA to get the Utility Allowance.

NOTE The following expenses do not qualify the household for the Utility Allowance:

- Costs of operating fans for cooling, portable space heaters, electric blankets, and heat lamps;
- Costs for cooking stoves, unless the stove is the primary heating source
- The costs of cutting wood for heating;
- Costs for water for evaporative coolers; or
- Costs only for excess heating or cooling expenses (ex., lives in public housing with utilities included in the rent, up to a certain usage level or dollar amount).

If both spouses are living in the community, each spouse gets the full Utility Allowance calculated.

<u>Excess Shelter Allowance</u>

A customer may get an Excess Shelter Allowance only for verified shelter expenses.

Examples of acceptable proof of shelter costs include:

- Signed, dated rent receipts, or a written statement from the landlord with the amount billed, period covered, and the landlord's address and telephone number;
- Mortgage payment coupons; and
- The most current bills for property taxes or insurance.

Shelter expenses that are paid annually, semi-annually or quarterly, such as taxes, and homeowners insurance, are divided by the number of months they cover to determine a monthly amount.

Effective Until 9/30/2015

If both spouses are receiving or intending to receive HCBS, share the same residence, and are eligible for ALTCS benefits, each is entitled to half of the verified shelter expenses for the Excess Shelter Allowance.

<Excess Shelter Allowance Calculation Example>

<Community Spouse Monthly Income Allowance (CSMIA) Example>

6) Community Spouse Family Allowance

When eligibility is determined using community spouse policy, a customer may qualify for a Community Spouse Family Allowance when the customer has a dependent family member living at home with the community spouse.

A family member must meet all of the following to be considered a dependent:

- Income low enough to be claimed as a tax dependent;
- Support; and
- Citizenship or residence.

If both spouses are eligible for ALTCS benefits and living in the community, each is gets one-half of the Family Allowance.

Income Requirement

The family member's must not receive enough income during the year to have to file a tax return. For current information about who must file a tax return, go to the IRS web-page listed below and select Publication (Publ.) 501.

- http://apps.irs.gov/app/picklist/list/formsPublications.html

EXCEPTION:

A child whose income is high enough to have to pay taxes can still be considered a dependent if he or she meets any of the following:

- Was under 19 years of age at the end of the calendar year;

Effective Until 9/30/2015

- Was under 24 years of age at the end of the calendar year and was enrolled as a full-time student at a school during any 5 months of the calendar year, or
- Was under 24 years of age at the end of the calendar year and took a full-time, on-farm training course given by a school or a state, county or local government agency during any 5 months of the calendar year.

NOTE The school must have a regular teaching staff, a regular course of study, and a regularly enrolled body of students in attendance. School does not include on-the-job training courses or correspondence schools.

NOTE A married family member who is required to file a tax return and files a joint return cannot be a dependent. If the married family member is not required to file and only filed to get a refund, the person can be a dependent.

Effective Until 9/30/2015

Support Requirement

To be considered a dependent, the institutionalized or community spouse must have paid over half of the family member's support in the calendar year, including such items as:

- Basic needs like food, clothing and housing;
- Medical and dental care;
- Recreation; and
- Education.

In general, when both parents together paid more than half of the child's support, the child is considered the dependent of the custodial parent if the parents are divorced or separated.

The child is only the dependent of a non-custodial parent when

- The custodial parent signs IRS Form 8332, or similar written statement, agreeing not to claim the child as a dependent, or
- A divorce decree or other court order states that the non-custodial parent can take an income tax exemption for the child, and the non-custodial parent provided at least $600 for the child's support in the calendar year.

Citizenship or Residency Requirement

To be considered a dependent, the family member must meet one of the following:

- A citizen or national of the U.S.;
- A non-citizen who is a resident of the U.S., Canada or Mexico; or

- A non-citizen child adopted by and living the entire calendar year with a U.S. citizen parent in a foreign country.

Calculation

The Family Allowance is calculated for each dependent as follows:

Step	Action
1	Start with the Monthly Spousal Need Standard and subtract the dependent's counted monthly income.
2	Divide the remainder from step 1 by three. The result is the Community Spouse Family Needs Allowance for that family member

<Family Allowance Calculation Examples>

SEE <ACE: COMMUNITY SPOUSE FAMILY ALLOWANCE> FOR SYSTEM INSTRUCTIONS.

7) Health Insurance Premiums

A SOC deduction is allowed for health insurance premiums the customer pays for his or her own coverage. A deduction is not allowed for premiums paid by anyone else or for any part of the premium that covers anyone else. If the premium covers people in addition to the customer, only the customer's share of the premium is allowed as a SOC deduction. Health insurance includes any of the following:

- Medicare;
- Group health insurance;
- Dental insurance;
- Hearing aid insurance;
- Vision care insurance; and
- Prescription drug plan.

<Medicare and Other TPL Health Insurance Premiums Example>

Effective Until 9/30/2015

EXCEPTION:

Premiums for insurance policies that pay a flat rate benefit (a set amount) to the person regardless of the actual charges or expenses are not allowed as share of cost deductions.

Prorating Health Insurance Premiums

If the premium is billed less often than monthly, (quarterly or annually for example), the customer can choose to have the health insurance premium payment either:

- Deducted from the share of cost for the month in which the payment is due, or
- Divided by the number of months it is meant to cover to get a monthly SOC deduction.

<Prorating Health Insurance Premiums Example>

Pension Supplements for Health Insurance Premiums

When the customer's pension benefit includes an amount to pay for all or part of the cost of health insurance premiums, a SOC deduction is only allowed for the amount of the health insurance premium that exceeds of the amount of reimbursement. When the customer also pays health insurance premiums for a spouse, the customer's share of the insurance premium is compared to the total reimbursement received. A SOC deduction is allowed only for the amount of the customer's share of the insurance premium that exceeds the total reimbursement.

<Pension Supplements for Health Insurance Premiums Examples>

Extra Help for Medicare Part D Coverage

When a customer's Medicare part D premiums is all or partly paid by the Extra Help program, a SOC deduction is only allowed for the amount of the Medicare part D premium the customer actually pays.

<Extra Help for Medicare Part D Coverage Example>

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Proof

Effective Until 9/30/2015

Proof of the amount of the premium and who is responsible to pay the Medicare or other health insurance premium must be provided before the premium amount can be deducted from the share of cost. When proof of a future premium amount is received, the premium amount is deducted from the future SOC.

If someone other than the customer is paying the premium, it is not necessary to prove the amount of the premium since it is not an allowable deduction from the share of cost.

TO VERIFY THE MEDICARE PART D OR MEDICARE HMO PLAN MONTHLY PREMIUM AMOUNT SEE <HOW TO PROVE THE MEDICARE PART D PRESCRIPTION DRUG PLAN OR MEDICARE HMO PLAN PREMIUM AMOUNT>.

8) Non-Covered Medical Expenses

Costs a customer must pay for medically necessary services that are not covered by the Program Contractor or any other health insurance may be allowed as a SOC deduction. The customer does not have to pay the entire cost of the service for it to qualify. A deduction may be allowed for health insurance deductibles, co-insurance, and co-payments for these costs.

A SOC deduction is not allowed for any service that is covered as part of the AHCCCS benefits package. Costs for the following services may qualify for a SOC deduction if not covered by other insurance:

- Non-emergency dental services for persons who are age 21 or older;
- Hearing aids, hearing aid repairs and hearing aid batteries for persons who are age 21 or older;
- Non-emergency eye care and prescriptive lenses for persons who are age 21 or older;
- Chiropractic services, including treatment for subluxation of the spine, demonstrated by x-ray;
- Orthognathic surgery (aligning the lower jaw with the upper jaw so that it does not protrude or recede) for persons 21 years of age or older;
- Co-payments for Medicare Part D prescriptions; and
- On a case-by-case basis, other non-covered medically necessary services that are requested of AHCCCS and approved by the Director.

If the service is not specifically listed, and the customer asks that the expense be allowed as a SOC deduction, send a policy clarification request to the PCR Mailbox.

The customer must be notified of how to report non-covered medical or remedial expenses.

Effective Until 9/30/2015

SEE <HOW TO NOTIFY THE CUSTOMER TO REPORT NON-COVERED MEDICAL OR REMEDIAL EXPENSES> FOR INFORMATION THAT MUST BE GIVEN TO CUSTOMERS AT APPLICATION AND EACH RENEWAL.

SEE <HOW TO REPORT NON-COVERED MEDICAL OR REMEDIAL EXPENSES> FOR INFORMATION ON REPORTING THIS INFORMATION IN ACE.

Expenses Incurred While an Application is Pending

A SOC deduction is allowed for a non-covered medical or remedial expense when the expense:

- Was billed while the application was pending; and
- Is reported while the application is pending.

The customer may have non-covered medical expenses deducted from the SOC even if the expense was incurred in a month that the customer is not ALTCS-eligible when:

- The expense is unpaid; or
- The expense was paid during a month in which the customer is eligible for ALTCS. (If the expense was both incurred and paid in a month in which the customer was not eligible for ALTCS it cannot be allowed as a share of cost deduction.)

<Expenses Incurred While an Application is Pending Examples>

Current Payments for Services

A SOC deduction is allowed for a non-covered medical or remedial expense only for the month in which the payment was made when:

- The expense is a current payment for a service; and
- The expense was not previously deducted from the SOC.

Current payments include:

- Payments reported to AHCCCS no later than the end of the month following the month the payment was made; and
- Payments made while the application is pending or which are reported while the application is pending.

A payment is not current when the payment is reported to AHCCCS after the end of the month following the month the payment was made.

Current payments are deducted only for the month in which the payment was made. When the expense exceeds the SOC (prior to the deduction), for the month, the difference between the current payment and the share of cost is lost as a deduction and there is no carryover of the expense to the following month.

Effective Until 9/30/2015

<Current Payments for Services Example>

Unpaid Balances

A SOC deduction is allowed for a non-covered medical or remedial expense when:

- The amount represents the unpaid balance of a non-covered expense; and
- This expense was not previously deducted from the SOC.

The unpaid balance equals the total charge for the medical expense minus the amount covered by Third Party Liability (other health insurance) minus any payments that have been made.

A non-covered medical expense paid by a friend, relative or other concerned party is treated as the customer's unpaid expense when the customer has an agreement to reimburse that person for payment.

There is no time limit on when the expense may have been incurred.

When an unpaid balance is more than the share of cost (prior to the deduction) for the next month, the remaining unpaid balance is carried forward and allowed as a deduction against future months' share of cost until the full balance has been applied:

- When an unpaid balance is reported during the application period, the balance is applied beginning with the month the unpaid balance was reported.
- After ALTCS approval, SOC deductions for an unpaid balance are deducted from the next months SOC.

<Unpaid Balances Example>

Proof of Non-Covered Medical Services

To allow a SOC deduction for a non-covered or remedial medical expense, the following must be verified:

- That the expense is for a non-covered medical service;
- That the services were medically necessary; and
- The amount and date the expense was incurred or paid.

Proof that Services Were Medically Necessary

Effective Until 9/30/2015

Proof that the service was medically necessary includes:

- A physician's prescription or written statement; or
- If the physician is not directly involved with providing the service, a billing statement may be used as secondary proof for the following services:
    - Routine dental services (cleaning, fillings, denture repair and replacement, and extractions for persons age 21 or over and some non-routine services such as oral surgery, caps and new dentures;
    - Hearing aids, hearing aid repairs and hearing aid batteries for customers age 21 or over; and

SEE THE FOLLOWING PROCESSES FOR SOC DEDUCTIONS FOR NON-COVERED EXPENSES

<HOW TO DETERMINE WHETHER AN EXPENSE CAN BE DEDUCTED FROM THE SOC>

<HOW TO PROVE THE AMOUNT AND DATE THE EXPENSE WAS INCURRED OR PAID>

<CALCULATING THE SOC DEDUCTION FOR NON-COVERED MEDICAL EXPENSES>

<Allowable SOC Deduction Amount Calculation Example>

9) Special Deduction for Some Residents of the Arizona State Veteran Home

A customer who is a resident of the Arizona State Veteran Home gets a special SOC deduction when:

- The customer is a veteran or the surviving spouse of a veteran; and
- The customer has no spouse or dependent children.

Up to $90.00 of the VA pension benefits, including increases for aid and attendance and unusual medical expenses, is allowed as a deduction from the SOC.

The deduction may not exceed the total VA payment. When the customer receives less than $90.00 in VA benefits, the deduction is equal to the VA payment.

10) Changes to the SOC

The SOC is refigured each time there is a change in the:

- Customer's income; or
- Amount of the SOC deductions.

Also, changes in the income or shelter expenses of a spouse or dependent child may affect

Effective Until 9/30/2015

the amount of the customer's SOC deductions.

11) SOC Collection

The ALTCS Program Contractor is responsible for collecting the SOC when the customer enrolled for one or more days in the month.

Exceptions:

If the customer...	**Then...**
Is eligible, but not enrolled during a month	The Program Contractor is not responsible for collecting the customer's SOC for that month.
Changes Program Contractors during the month	Each Program Contractor is entitled to a portion of the monthly SOC based on the number of days the customer is enrolled with that Program Contractor. The Program Contractor with whom the customer is first enrolled during the month is responsible for collecting the SOC, figuring each Program Contractor's share, and transferring the prorated SOC amount to the receiving Program Contractor. <Changes Program Contractors during the month example>

12) ALTCS Cost Effectiveness Study Share of Cost (CES SOC)

Program Contractors cannot by law pay more for a person's HCBS than they would pay for that same person in a nursing facility, except for a very short amount of time.

The Cost Effectiveness Study Share of Cost (CES SOC) gives the Program Contractor a figure to use in determining if providing HCBS to a customer is cost effective.

The Program Contractor may advise the person to consider other alternatives or options if the cost of the HCBS needed is more than the Program Contractor would be allowed to pay if the customer were in a nursing facility.

SEE COST EFFECTIVENESS STUDY SHARE OF COST FOR DETAILS ON CALCULATING AND PROVIDING INFORMATION ABOUT THE CES SOC.

Effective Until 9/30/2015

Definitions

Term	Definition
Arizona State Veteran Homes (ASVH)	The Arizona State Veteran Homes (ASVH) are Medicare certified skilled nursing facilities. These are State owned and operated facilities. ASVH serves the long term care and rehabilitative needs of the veterans of Arizona.
Heating and Cooling costs	Heating costs include expenses of electricity, gas, wood and other heating fuels. Cooling costs include costs for room air conditioners, central air conditioning or evaporative coolers.
Qualified Family Member	Minor or dependent children, dependent parents, or dependent siblings of the customer or the community spouse who are living with the community spouse.
Non-covered Medical Services	Non-covered medical services are medically necessary medical or remedial services that are not covered by the ALTCS Program Contractor.
Shelter Costs	Shelter costs include rent, mortgage, real property taxes, homeowner's association fees, and home owner's insurance.

Programs and Legal Authorities

Effective Until 9/30/2015

Program	Legal Authorities
ALTCS	42 USC 1382a 42 USC 1396a(q) and 42 USC 1396r-5(d) for Community Spouse 42 CFR 435.601, 435.725, 435.726 ARS 36-2932(L) AAC R9-28-408, 410

Effective Until 9/30/2015

back to top