

NURSING FACILITY SERVICES**17.9 INCOME**

There is a two-step income process for providing Medicaid coverage for nursing facility services to individuals in nursing facilities. The client must be eligible for Medicaid by being a member of a full Medicaid coverage group, by being a QMB recipient or by meeting a special income test. See Chapter 16 to determine which coverage groups provide full Medicaid coverage. If the client has a spenddown, it must be met before he is eligible for nursing facility services or it must be able to be met by the cost of the nursing facility. Once Medicaid eligibility is established, the client's contribution toward his cost of care in the facility is determined in the post-eligibility process. These processes are described in item D below.

NOTE: The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19. MAGI Medicaid coverage groups do not contribute to the cost of their nursing facility care.

A. EXCLUDED INCOME SOURCES

Income sources that are excluded for the coverage group under which eligibility is determined are also excluded in the post-eligibility process for nursing facility services. See Section 10.3 for the appropriate coverage group.

B. BUDGETING METHOD

See Section 10.6,B. A monthly amount of income is determined based on averaging and converting income from each source.

Regardless of the day of the month on which the client enters or leaves the nursing facility, all income the client is determined to have, according to Chapter 10, for each month he resides even one day in the facility must be counted in determining eligibility and in post-eligibility calculations. No deductions or exclusions are allowed for income already spent in the month the client enters the nursing facility or for expenses he anticipates in the month he leaves.

During the first month and last month that Medicaid participates in the cost of care, it is necessary to prorate the client's contribution to his care when he does not spend the full calendar month in the facility. This proration is accomplished as follows:

- Determine the client's total monthly cost contribution amount as for any other nursing facility resident who expects to remain in the facility a full month.

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- Divide the client's total monthly cost contribution by the actual number of days in the calendar month. This becomes the client's daily contribution rate, which is used for this purpose only.
- Determine the number of days the client resided or expects to reside in the facility in the calendar month and multiply the number of days by the daily contribution rate. The result is the client's total cost contribution for the partial month. After all computations have been completed, any cents calculated as part of the result are dropped.

NOTE: When the contribution is prorated for the last month of nursing facility residence, only days during which the client resides in the facility are calculated. Days during which the client does not reside in the facility, even if they are bed-hold days, are not considered for the purpose of prorating the last month's contribution.

NOTE: This policy applies only to the first and last months of nursing facility residence when Medicaid participates in the payment. It is not used when the client leaves the facility for other medical treatment, for family visits, etc. During all other months, the client must contribute his full resource and be reimbursed by the facility if an overpayment occurs.

When a client is eligible for payment for nursing facility services under a full-Medicaid coverage group, and is also QMB eligible, he must pay his full contribution, even when Medicare participates in his cost of care, unless Medicare participates for the entire month. When the contribution is prorated for the first or last month of care, it is prorated using the procedure above. The contribution is not prorated based on the date that Medicare begins or ceases participation. When the Worker learns that Medicare participated for an entire month for a QMB eligible client, an DFA-NH-3 must be completed manually by the Worker to change the contribution to \$0 for that month. See Section 17.9,C for individuals who are eligible for QMB coverage only.

During the first month of Medicaid participation in the cost of care, when the client is not in the facility for a full month, the Worker may be asked how much the client is to retain for his personal needs and how much may be contributed to the community spouse and other family members. The process used to determine the Worker's response follows:

- Determine the client's total monthly Personal Needs Allowance (PNA), CSMA or FMA as if the client were to remain in the facility a full month.

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- Divide the client's monthly PNA, CSMA or FMA by the actual number of days in the calendar month. This becomes the client's daily deduction rate which is used for this purpose only.
- Determine the number of days in the calendar month the client expects to reside in the facility and multiply the number of days by the daily deduction rate of the specific deduction. The result is the amount of income the client may retain for the PNA, CSMA or FMA. After all computations have been completed, any cents calculated as part of the result are rounded up.

C. FINANCIAL ELIGIBILITY PROCESS

Eligibility for payment for nursing facility services is determined in any of the following four ways, in the following priority order:

1. QMB Eligible

When a client needs nursing facility services and Medicare is participating in the payment or will participate when the client enters the nursing facility, it may be to the client's advantage to receive payment for nursing facility services as a QMB eligible, until Medicare no longer participates. The QMB medical card pays all Medicare co-insurance and deductibles, and QMB recipients are exempt by law from the post-eligibility process. They, therefore, have no contribution toward their cost of nursing facility services as long as Medicare participates in the payment. See Chapter 16.

However, when the client would be disadvantaged in any way by QMB eligibility as opposed to eligibility under another coverage group, the Worker must use one of the following ways to determine eligibility, if one is more beneficial to him. In addition, when Medicare stops participating in the cost of care, QMB eligibility no longer covers nursing care costs and eligibility must be redetermined according to item 2, 3 or 4 below.

2. Client Is Medicaid Recipient

When the client is a recipient, under a coverage group which provides full Medicaid coverage, at the time he is determined to need nursing facility services, his Medicaid eligibility has already been determined, and no further eligibility test is necessary. The Worker must complete only the post-eligibility calculations to determine the client's contribution toward his cost of care, if any.

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NOTE: SSI, Deemed SSI and other full coverage Medicaid recipients, including MAGI Medicaid coverage groups, must complete the DFA-LTC-5 at application for LTC services to evaluate any annuities, trusts and/or other potential resources or transfers. See Section 17.12,D.

NOTE: Individuals already receiving full-coverage Medicaid in the Adult Group, who become eligible for Medicaid payment of nursing facility services, must be dually coded in the data system as receiving nursing home coverage, code MLTN.

All Medicaid coverage groups listed in Chapter 16 are full Medicaid coverage groups, unless there is a statement specifically to the contrary.

Medically Needy individuals must be receiving a Medicaid card to be determined eligible under this provision.

Those Medically Needy individuals who have no spenddown meet the requirement of Medicaid eligibility. Those who meet their spenddowns prior to the need for nursing facility care, have met the requirement of being eligible, through the current POE. After the POE during which nursing facility services begin, the client's situation is treated according to item 3 or 4 below. Those who do not meet their spenddowns prior to the need for nursing facility care are treated according to item 3 or 4 below.

When an applicant is not a recipient of full Medicaid coverage, the following test is made to determine eligibility.*.3

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3. Gross Income Test

If the client is not eligible under items 1 or 2 above, Medicaid eligibility may be established as follows:

- Determine the client's gross non-excluded monthly income.
- Compare the income to 300% of the current maximum SSI payment for one person.

To be Medicaid eligible, his income must be equal to or less than 300% of the SSI payment.

Once Medicaid eligibility is established in this manner, the client's contribution toward his cost of care is determined in the post-eligibility process. There is no spenddown amount for persons determined eligible in this way.

EXAMPLE: When the current maximum SSI payment is \$733, the client's gross, non-excluded monthly income is compared to \$2,199.

NOTE: SSI-Related Medicaid disability and asset guidelines must be met.

Certain individuals who meet the gross income test but are ineligible for Medicaid due to being over the allowable asset limit, may be eligible for the LTCIP Asset Disregard. See Section 17.10.

4. SSI-Related Medicaid Test

If the client is not eligible under items 1, 2 or 3 above, his eligibility as an SSI-Related Medicaid client must be explored as another way to receive financial assistance for the cost of nursing facility services.

All policies and procedures in effect for other SSI-Related cases apply to these cases, including the determination of a spenddown amount, if applicable.

EXCEPTIONS:

- Income is not deemed.
- The MNIL for one person is always used. See Chapter 10, Appendix A.

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- The spenddown amount is determined on a monthly basis.

When the monthly Medicaid rate for the facility in which the client resides equals or exceeds his monthly spenddown amount, the spenddown is assumed to be met and Medicaid eligibility is established. In addition, if the monthly spenddown amount exceeds the monthly Medicaid rate for the facility, the client may become eligible for Medicaid based on a 6-month POC, but not for payment of nursing facility services. The Medicaid daily rate for the facility is multiplied by 30 to determine the average monthly rate. The daily rates for all Medicaid are found only on the DFA intranet page. The rates are updated semi-annually.

NOTE: The Medicaid rates for nursing facilities are provided only for DHHR staff who must determine eligibility for Medicaid. The rates cannot be released by local DHHR staff to the public. Any requests for the rates must be made under the Freedom of Information Act (FOIA) to the DHHR Office of the Deputy Secretary, Division of Accountability and Management Reporting.

Case examples of the entire process of determining eligibility and the amount of the client's contribution are found below in item D.

NOTE: For cases with a community spouse, the amount of the spenddown is used only for comparison with the Medicaid cost. It is not used as a part of the client's contribution toward his cost of care as it is for all other nursing facility cases which must meet a spenddown.

D. POST-ELIGIBILITY PROCESS

In determining the client's contribution toward his cost of nursing facility care, the Worker must apply only the income deductions listed below. This is the post-eligibility process. The remainder, after all allowable deductions, is the resource amount, which is at least part of the amount the client must contribute toward his cost of care.

NOTE: The post-eligibility process does not apply to the MAGI Medicaid coverage groups – Adult Group, Parents/Caretaker Relatives, Pregnant Women, Children Under Age 19. MAGI Medicaid coverage groups do not contribute to the cost of their nursing facility care.

EXCEPTION: The one-time \$250 payment and tax credits/refunds issued under the American Recovery and Reinvestment Act of 2009 and excluded. This includes post-eligibility determinations for institutionalized individuals.

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The client's spenddown amount, if any, as determined in item C,4 above, is added to this amount to determine the client's total contribution toward his nursing care, except when there is a community spouse. In cases with a community spouse, the spenddown is not added to the computed resource amount. The spenddown is used only to compare to the cost of care to determine eligibility. See item 2 below.

1. Income Disregards And Deductions

Only the following may be deducted from the client's gross income in the post-eligibility process:

a. Personal Needs Allowance

This amount is subtracted from income to cover the cost of clothing and other personal needs of the nursing facility resident. The monthly amount deducted is \$50. However, for an individual who is receiving the reduced VA pension of \$90, the monthly Personal Needs Allowance is \$90.

b. Community Spouse Maintenance Allowance (CSMA)

When the institutionalized individual has a spouse living in the community, a portion of his income may be deducted for the support of the spouse at home.

To determine the CSMA, the income of the community spouse is subtracted from a Spousal Maintenance Standard (SMS) which is either:

- The minimum SMS. This is 150% of the monthly FPL for 2 persons; or
- The minimum SMS, increased by excess shelter/utility expenses, but not exceeding the maximum SMS.

See Chapter 10, Appendix A for the minimum and maximum Spousal Maintenance Standard amounts.

The remainder is the amount of the institutionalized spouse's income which can be used to meet his community spouse's needs.

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The determined amount must actually be paid to the community spouse for the deduction to be applied. If the client contributes less than the determined amount, only the amount actually contributed to the community spouse is deducted. If he has been ordered by a court or a Hearings Officer to contribute more to his spouse, the higher amount is deducted.

The following steps are used to determine the amount of the CSMA.

- Step 1: Add together the actual shelter cost and the amount of the current SNAP Heating/Cooling Standard (HCS). See Chapter 10, Appendix B. The shelter cost must be from the home the institutionalized spouse and the community spouse shared prior to institutionalization, and in which the community spouse continues to live. It must have been the client's principal place of residence. Shelter costs include rent or mortgage payments, interest, principal, taxes, insurance and required maintenance charges for a condominium or cooperative.
- Step 2: Compare the total of the costs in Step 1 to 30% of the minimum SMS. See Chapter 10, Appendix A. When the shelter/utility costs exceed 30% of the minimum SMS, subtract the 30% amount from the shelter/utility costs.
- Step 3: Add the remainder from Step 2 to the minimum SMS. This amount, not to exceed the maximum SMS, is used in Step 5. See Chapter 10, Appendix A.
- Step 4: Add together the community spouse's gross, non-excluded earned and unearned income.
- Step 5: Subtract the Step 4 amount from the amount determined in Step 3 and if there are any cents, round the resulting amount up. This is the amount subtracted from the income of the institutionalized spouse for the needs of his community spouse.

If the Step 4 amount is equal to or greater than the Step 3 amount, no deduction is allowed.

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NOTE: The amount used from Step 3 cannot exceed the maximum SMS.

If the amount in Step 5 is less than the minimum SMS or the Community Spouse will experience extreme financial duress, a hearing can be requested by the client, community spouse or authorized representative to obtain more of the institutionalized spouse's income and/or assets. See Common Chapters Manual, Chapter 700, Section 710.21.

c. Family Maintenance Allowance (FMA)

When the institutionalized individual has family members who are living with the community spouse and who are financially dependent upon him, an FMA is deducted from his income. This amount is deducted whether or not the individual actually provides the money to the family members.

For purposes of this deduction, family members are the following people only: minor or dependent children, dependent parents of either spouse and dependent siblings of either spouse. This deduction is applied only when the institutionalized individual has a community spouse, and such family members live with the community spouse.

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The amount of the deduction is determined as follows for each family member:

Step 1: Subtract the family member's total gross non-excluded income from the minimum SMS. See Chapter 10, Appendix A. If the income is greater than the minimum SMS, no deduction is allowed for that member.

Step 2: Divide the remaining amount by 3, and round the resulting amount up.

EXAMPLE: $\$201.07 = \202

Step 3: Add together the individual deductions for all family members to determine the total FMA which is deducted from the income of the institutionalized individual.

NOTE: The FMA for each family member must not exceed one-third of the minimum SMS. See Chapter 10, Appendix A.

d. Outside Living Expenses (OLE)

Single individuals and couples, when both spouses are institutionalized, receive a \$175 deduction from income for maintenance of a home when a physician has certified in writing that the individual, or in the case of a couple, either individual, is likely to return to the home within 6 months. The amount may be deducted for up to 6 months.

When both spouses are institutionalized, only one spouse may receive the OLE. They may choose which spouse receives the deduction.

The OLE may be deducted during subsequent nursing facility admissions if the individual or couple meets the criteria listed above.

EXAMPLE: An individual is admitted to a nursing home for 6 months and then discharged to his home. His condition worsens after 4 months and he is readmitted to the nursing home again. He can receive the OLE again, if his physician certifies he is likely to return home again within 6 months.

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e. Non-Reimbursable Medical Expenses

When the client is Medicaid eligible, only as determined in items C,2, 3 or 4 above, certain medical expenses which are not reimbursable may be deducted in the post-eligibility process. These allowable expenses are listed in Section 10.22,D,11,c. Only the expenses of the eligible individual are used. Incurred medical expenses, including nursing facility costs (except for nursing facility costs for clients with a community spouse), for which the client will not be reimbursed, are subtracted from his remaining income. When the client becomes eligible for nursing facility services after expiration of a penalty period for transferring resources, nursing facility expenses incurred during the penalty period which are non-reimbursable from another source may be used as a deduction. Non-reimbursable means the expense will not be or has not been paid to the provider or reimbursed to the client by any third-party payer, such as, but not limited to, Medicare, Medicaid, private insurance or another individual. This includes any portion of the Medicare Part D Premium that is not covered by the Low Income Subsidy (LIS). The incurred expense must be the responsibility of the client.

NOTE: The total deduction for medical insurance premiums is given to the person who pays the premium, regardless of which individual carries the insurance coverage. The deduction is not split between the spouses, even if both are receiving nursing facility services. See Chapter 4 for sources of insurance premium verification.

EXAMPLE 1: An institutionalized individual carries the insurance and pays the premium for himself and his community spouse. The institutionalized spouse receives a deduction for the full premium amount.

EXAMPLE 2: An institutionalized spouse, Mrs. Green, pays the premium for the insurance coverage that her community spouse, Mr. Green, carries for them both. The community spouse, Mr. Green, is admitted to the nursing facility. The insurance premium continues to be a deduction for Mrs. Green since she pays the premium.

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The total of all non-reimbursable medical expenses is entered in RAPIDS. The total amount is not rounded.

NOTE: For all AG's except those with a community spouse, the amount of the client's spenddown, if any, which was calculated during the eligibility determination process, is treated as a non-reimbursable medical expense and subtracted from the client's income along with any other medical expenses the client may have

(1) Time Limits and Verification Requirements for Expenses

Applicants

A non-reimbursable medical expense may be permitted only for services provided in the month of application and the 3 months prior to the month of application. This includes nursing facility expenses incurred during a penalty period for transferring resources.

EXCEPTION: A deduction may be given if there is evidence of a payment in the 3 months prior to application, even when the expense was incurred prior to that time.

EXAMPLE: Mrs. C applies for Medicaid for payment of nursing home expenses in October. She obtained a wheelchair in June and made payments in July, August and September. She still owes 10 more payments. The payment may be used as a deduction, even though she purchased it prior to the 3-month period, since there is evidence of a payment in the 3 months prior to application.

EXAMPLE: Same situation as above, except that Mrs. C did not make any payments during July, August or September. Since she did not incur the expense in the 3 months prior to the month of application or the month of application and made no payments during the 3-month period, no deduction is given.

Recipients

The request for consideration of a non-reimbursable medical expense must be submitted within 1 year of the date of service(s).

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Documentation must consist of the following:

- An order and statement of the medical necessity from a prescribing physician, dentist, podiatrist or other practitioner with prescribing authority under West Virginia law; and
- An itemization of the services provided.

(2) Additional Limits for Expenses

For the items or services listed below, the following limits apply:

- Eye examination and eyeglasses - \$300 in a 12-month period
- Eyeglasses - 2 pair in a 12-month period, unless medical necessity is established. The \$300 limit in a 12-month period applies.
- Dentures - \$3,000 in a 12-month period, unless medical necessity is established
- Hearing Aids - \$1,500 in a 12-month period, unless medical necessity is established

NOTE: Medical necessity is determined by the Worker and/or Supervisor, based upon the documentation provided.

(3) Expenses Which Cannot Be Used

The following expenses cannot be used as a deduction for non-reimbursable medical.

- Durable medical equipment, unless purchased by the client prior to Medicaid payment for nursing facility services, and the cost was not reimbursable from any source

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- Bills for non-payment of the client contribution after Medicaid eligibility for nursing facility services is approved
- Medical expenses incurred during a period of Medicaid eligibility which are covered by Medicaid
- Nursing facility expenses incurred during a period of Medicaid ineligibility for excess assets, when the reason for excess assets is non-payment of the client contribution
- Co-insurance payments while the individual is Medicaid eligible and has Medicare or private health insurance
- Charges for an ambulance or transportation which is medically necessary for an individual in a nursing facility who is Medicaid and/or Medicare eligible or has private insurance
- Charges incurred during temporary periods of Medicaid ineligibility when the reason is failure to complete a redetermination and the AG is subsequently reopened with no break in eligibility periods
- Nursing facility charges when the reason for Medicaid ineligibility is the facility's failure to obtain an approved PAS
- Charges for bed hold days

NOTE: When the request to deduct non-reimbursable medical expenses originates from a nursing facility or is presented by the client as a bill from a nursing facility, a detailed itemization of the services must be provided. The itemization must include the date of the service or expense, the specific medical service, the reason no payment was received by the facility and the amount of the expense. Charges billed to Medicare, Medicaid or private insurance must be accompanied by an explanation of benefits (EOB) to be considered. Only charges denied because they are not covered services may be used.

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2. Determining The Client's Total Contribution

Because the amount of medical expenses used to meet the client's spenddown cannot be paid by Medicaid, the spenddown amount becomes part of the client's contribution toward his cost of care.

NOTE: When the client has a community spouse, the spenddown amount is not part of his contribution to his cost of care.

This amount is added to the resource amount determined in item 1 above to determine the client's total monthly contribution toward the cost of his nursing care.

If the client is Medicaid eligible without a spenddown according to items C,2 and C,3 above, the resource amount from item 1 is his total cost contribution.

When the client resides in more than one nursing care facility during the same calendar month, the Worker must determine the portion of the client's cost contribution which must be paid to each facility. The Worker follows the steps below to determine how much of the client's total contribution must be paid to the first facility he entered. If the client's total contribution must be paid to the first facility, no additional calculation is required. If not, the amount(s) paid to the other(s) is determined in the same way. The ES-NH-3 is used for notification of the amount due each facility.

Step 1: Determine the client's monthly contribution toward his cost of care.

Step 2: Multiply the number of days the client was in the first facility by the per diem rate for the facility. The result is the client's cost of care for this facility for the month.

Step 3: Compare Step 1 to Step 2.

If Step 1 is less than or equal to Step 2, the client's entire contribution toward his cost of care is paid to the first facility.

If Step 1 is greater than Step 2, the Step 2 amount is paid to the first facility and the difference between Step 1 and Step 2 is paid to the second facility.

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E. EXAMPLES

EXAMPLE: Single Individual with OLE, Categorically Needy

A Pass-Through Medicaid recipient enters a nursing home and wants Medicaid to pay toward his cost of care. He has \$2,200 month unearned income. He is a single individual with OLE.

Medicaid eligibility is already established. Even though his income exceeds 300% of the SSI payment level, he is eligible without a spenddown as a Categorically Needy Medicaid recipient. Therefore, only post-eligibility calculations must be performed. The Worker records that the client was a Deemed SSI Recipient prior to nursing care eligibility so that eligibility may be restored if he no longer requires nursing care. Post-eligibility calculations are as follows:

\$2,200.00	Client's gross monthly non-excluded income
- 50.00	Personal Needs Allowance
<u>\$2,150.00</u>	Remainder
- 175.00	OLE
<u>\$1,975.00</u>	Client's resource amount which is also his total contribution toward his cost of care.

EXAMPLE: Single Individual With OLE, Medically Needy

Same situation as above except that the client is not a Deemed SSI Recipient. His Medicaid eligibility must be established as an SSI-Related individual.

	<u>Eligibility</u>
\$2,200.00	Income
- 20.00	SSI Income Disregard
<u>\$2,180.00</u>	Remainder
- 200.00	MNIL for 1
<u>\$1,980.00</u>	Monthly Spenddown

The monthly Medicaid cost for his care in the facility is \$4,383. Therefore, his spenddown is met for the month and post-eligibility calculations are performed for any additional contribution he must make.

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\$2,200.00	Income
- 50.00	Personal Needs Allowance
\$2,150.00	Remainder
- 175.00	OLE
\$1,975.00	Remainder
- 104.90	Medicare Part B premium (non-reimbursable medical expense)
\$1,870.10	Remainder
- 1,980.00	Spenddown (non-reimbursable medical expense)
0.00	Resource Amount

The client has no resource amount, so his total contribution is \$1,980, his spenddown amount. The Department will not pay any part of the \$1,980 because it is the client's spenddown and he is, by definition, liable for it.

EXAMPLE: Single Individual Without OLE, Medically Needy

Same as above except the client has no OLE. The client's spenddown amount is the same as determined above.

Post-Eligibility

\$2,200.00	Income
- 50.00	Personal Needs Allowance
\$2,150.00	Remainder
- 104.90	Medicare Part B premium (non-reimbursable medical expense)
\$2,045.10	Remainder
- 1,980.00	Spenddown (non-reimbursable medical expense)
\$ 65.10	Resource Amount

The client's total contribution toward his cost of care is:

\$1,980.00	Spenddown
+ 65.10	Resource Amount
\$2,045.10	Total Contribution

EXAMPLE: Married Individual Without Community Spouse, Medically Needy

Mr. Smith is married, but has been separated from his wife for 10 years. He has 1 dependent child still living in his home. His monthly income is \$2,200. He has non-reimbursable medical expenses of \$104.90 (Medicare Part B premium). The monthly Medicaid cost for his care is \$4,600.

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\$2,200.00	Income
<u>- 20.00</u>	SSI Disregard
\$2,180.00	Remainder
<u>- 200.00</u>	MNIL
\$1,980.00	Monthly Spenddown

Post-Eligibility

\$2,200.00	Income
<u>- 50.00</u>	Personal Needs
\$2,150.00	Remainder
<u>- 104.90</u>	Medicare Part B premium (non-reimbursable medical)
\$2,045.10	Remainder
<u>- 1,980.00</u>	Spenddown (non-reimbursable medical)
\$ 65.10	Resource
<u>+1,980.00</u>	Spenddown
\$2,045.10	Total Contribution

NOTE: Mr. Smith is not eligible for the FMA, because there is no community spouse.

EXAMPLE: Married Individual With Community Spouse. Medically Needy

Mr. Holley has the following income:

\$1,225.00	RSDI
<u>+ 900.00</u>	Retirement
\$2,125.00	Total Income

He has a community spouse who has \$585/month RSDI income and \$365/month earned income, for a total of \$950. His child receives \$585/month RSDI. The monthly Medicaid cost for his care is \$5,322.

Eligibility

\$2,125.00	Income
<u>- 20.00</u>	SSI Disregard
\$2,105.00	Remainder
<u>- 200.00</u>	MNIL
\$1,905.00	Monthly Spenddown

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	<u>Post-Eligibility</u>	
Community Spouse	\$ 600.00	Shelter
Deduction:	+ 345.00	SUA
	\$ 945.00	Total Shelter/Utilities
	- 598.00	30% Min. SMS
	\$ 347.00	Excess Shelter/Utilities
	+ 1,992.00	Min. SMS
	\$ 2,339.00	
	- 950.00	Total gross monthly non-excluded income of Community Spouse
	\$1,389.00	CSMA (rounded up per 17.9,D,1,b, Step 5)
Family Maintenance	\$1,992.00	Min. SMS
Deduction:	- 585.00	Income
	\$1,407.00	Remainder ÷ 3 = \$469.00 FMA (rounded up per 17.9,D,1,c, Step 2)
	\$2,550.00	Income
	- 50.00	Personal Needs
	\$2,500.00	Remainder
	- 1,389.00	CSMA
	\$1,111.00	Remainder
	- 469.00	FMA
	\$ 642.00	Remainder
	- 158.50	Medicare premium and doctor bill
	\$ 483.50	Resource and total contribution toward his care

The client has a \$55.50 resource to contribute to his care. Because there is a community spouse, the spenddown amount determined in the eligibility process is not subtracted as a non-reimbursable medical expense and is not added to the resource to determine his total contribution.