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# **Health Insurance and Home Care Programs**

# ACCESS AGENCIES

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## Program Description:

Access Agencies assist older individuals to receive home and community based services in their own homes, thereby enabling elders to remain at home and to avoid premature institutionalization.

Access Agency care managers, nurses or social workers, conduct comprehensive assessments of an individual's functional status, develop individualized plans of care and arrange for the delivery of services. The Access Agency may also provide ongoing care management which includes monitoring and coordination of home care services. Access agencies may not provide direct services, other than care management, to individuals.

The Department of Social Services administers the Connecticut Home Care Program for Elders through contracts with local Access Agencies in Connecticut.

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## Eligibility Requirements:

Access Agencies must meet the requirements of State Regulations which govern the Connecticut Home Care Program for Elders.

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## For More Information:

Access Agencies cannot directly enroll clients into the Connecticut Home Care Program for Elders. Potential clients or those acting on their behalf must apply to the Department of Social Services (DSS) first.

**DSS, Alternate Care Unit Statewide Phone: (800) 445-5394 or**

### Bridgeport

Phone: (203) 579-6575

Fax: (203) 579-6498

### Hartford

Phone: (860) 424-4890

Fax: (860) 424-4898

### New Haven

Phone: (203) 789-7201

Fax: (203) 789-7202

### Norwich

Phone: (860) 886-6632

Fax: (860) 886-6035

### Waterbury

Phone: (203) 596-4273

Fax: (203) 596-4276

The three (3) Access Agencies in the State which contract with DSS are listed below:

**CT Community Care, Inc.**

North Central CCCI  
43 Enterprise Drive

Phone: (860) 314-2920

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372 West Main Street

Phone: (860) 885-2960

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150  
Waterbury, CT 06705

Waterbury (203) 596-4800

Torrington (860) 496-8080

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**on Aging**

Bridgeport, CT 06604

Toll free (800)811-9808

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**on Aging**

CT Home Care Program for  
Elders

419 Whalley Ave.

New Haven, CT 06511

Phone: (203) 752-3040

Toll free: (888) 811-1222

See also **Connecticut Home Care Program for Elders** on page 86 of this manual.

## ADULT DAY CARE

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and others with functional and/or cognitive impairments who are unable to remain at home. The goal of adult day care is to keep elderly individuals in the community for as long as possible, thereby postponing or preventing the need for nursing home care.

Services include, but are not limited to, supervision, health monitoring, a meal, recreation, personal care and family support. Additional services may include transportation. Centers also provide day care for Alzheimer's patients and those with dementia.

Since adult day care centers are publicly funded, they must be certified through a peer review process by the Connecticut Association of Adult Day Care Centers. The Association has established standards for the operation of adult day care centers in the State of Connecticut.

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### Eligibility Requirements:

To qualify, the person should be considered socially isolated, functionally and/or cognitively impaired. Some funding sources can only be used for elderly persons but the definition of "elderly" varies.

In order to qualify for services funded by the Department of Social Services, individuals must meet the eligibility requirements for particular programs, as established by DSS. To obtain information on specific guidelines and eligibility requirements, contact the individual center.



A list of adult day care centers in Connecticut can be found in Appendix of this Manual.

this list *may not be all inclusive* and Area Agencies on Aging which DSS is unaware. To apply for certification, please contact the Connecticut

300 Research Parkway, CT. 06450.

# ALZHEIMER'S ASSOCIATION

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## Program Description:

The Alzheimer's Association is a national voluntary health agency dedicated to conducting research for the prevention, cure and treatment of Alzheimer's disease and related disorders and to providing education, information and referral, support and assistance to the afflicted patients and their families.

There are three chapters in Connecticut with many local support groups to help the families of those who have been afflicted with this disease. Family and professional education programs are held regularly. Chapters participate in Safe Return, a 1(800) number I.D. bracelet program that returns wanderers to their caregivers and the CT Statewide Respite Care Program, which offers relief to those caring for individuals with Alzheimer's or related dementia.

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## Eligibility Requirements:

None.

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## For More Information Contact:

### State Alzheimer's Association Chapters

Robert Parks  
Alzheimer's Association  
Fairfield County Chapter  
607 Main Ave.  
Norwalk, CT 06851  
Phone: (203) 845-0010  
Fax:(203) 845-0012

Kathleen P, Teso, Executive  
Director  
Alz. Assoc., Northern  
Connecticut Chapter  
443 Franklin Avenue  
Hartford, CT 06114-2317  
Telephone: (860) 956-9560  
Toll free in CT: (800) 356-  
5502  
Fax: (860) 956-9590  
e-mail:  
kathleen.teso@alz.org

Albert Harary, Executive  
Director  
Alzheimer's Association  
South Central CT Chapter  
2911 Dixwell Ave, Suite 104  
Hamden, CT 06518  
Phone: (203) 230-1777  
Fax: (203) 230-1712  
e-mail: Albert.Harary@alz.org

# ADDITIONAL LOW-INCOME MEDICARE BENEFICIARY

## (ALMB Group 1) (also called Qualified Individual: QI-1)

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The Additional Low-Income Medicare Beneficiary program (ALMB Group 1), offered by income Medicare beneficiaries. The ALMB program is available to the elderly and those with disabilities benefits. This program is subject to available funding.

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### Eligibility Requirements

Eligibility is related to assets and the monthly gross income. Monthly gross income includes Social Security, pensions, disability benefits, wages, alimony, rental income,

application must be filed every year.

The income limits are effective until 3/31/00:

Income	*	Couple \$1,611
Assets		\$4,000

\*This amount includes one unearned income disregard of \$183, which most people

\*\*This amount includes two unearned income disregards for a total of \$366, which most



One of the Department of Social Services Regional Offices. See the index in this Manual for the pages listing these offices.

# ADDITIONAL LOW-INCOME MEDICARE BENEFICIARY PROGRAM

## (ALMB Group 2) (also called Qualified Individual: QI-2)

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### Program Description:

The Additional Low-Income Medicare Beneficiary program (ALMB Group 2), offered by the Department of Social Services pays a small portion of the Medicare Part B premium (\$2.87 a month in 2000) for certain low income Medicare beneficiaries. The ALMB program is available to the elderly and those with disabilities who receive Social Security benefits and are eligible for Medicare benefits. This program is subject to available funding.

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### Eligibility Requirements:

Eligibility is related to assets and monthly gross income. Monthly gross income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends. Eligibility also depends on available program funding. A new application must be filed every year.

The income limits are effective until 3/31/00:

	Single	Couple
Income	\$1,385*	\$1,979**
Assets	\$4,000	\$6,000

\*This amount includes one unearned income disregard of \$183, which most people receive.

\*\*This amount includes two unearned income disregards for a total of \$366, which most people receive.

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### For More Information Contact:

One of the Department of Social Services Regional Offices. See the index in this Manual for the pages listing these offices.

## **BREAKTHROUGH TO THE AGING (BTA) - Friendly Visitors**

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### **Program Description:**

Provides caring outreach to homebound, frail older adults. The program helps to promote independence, improve quality of life and the personal well-being of socially isolated and homebound elders who are susceptible to acute loneliness, depression and self-neglect. Friendly Visitors are trained to make weekly home visits providing friendship, companionship and some assistance with tasks. Friendly Visitors may also telephone their friends on a regular basis to provide reassurance, social contact and security. The program brings the comfort of being wanted and valued to elderly, homebound persons who have little or no contact with family and friends. In 1999, over 1,200 volunteers served more than 1,500 elders throughout the 60 programs in Connecticut.

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### **Eligibility Requirements:**

Recipients of Friendly Visitors' services must be frail and at least sixty years of age. Volunteers of any age who are willing to receive eight hours of training and provide one to two hours per week in visitations are eligible to become Friendly Visitors. The screening process includes an interview by a program coordinator and reference check. Typically, Friendly Visitors:

- Understand and like older people
  - Possess a sense of humor
  - Are patient and kind
  - Accept people as they are
  - Adjust to new situations
  - Are sensitive to the emotional needs of others
  - Are honest, cheerful, and dependable
  - Are good listeners and
  - Have the ability to help another person express feelings
- 

### **For More information on a program in your area contact:**

Barbara Malcolm and Evelyn Clark, Co-Directors  
Breakthrough to the Aging  
Capitol Region Conference of Churches  
30 Arbor Street  
Hartford, CT 06106  
Phone: (860) 236-1295  
Fax: (860) 236-8071

# BREAKTHROUGH TO THE AGING (BTA) - Friendly Shoppers

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## **Program Description:**

Beginning in 1997, the Friendly Shoppers program began helping homebound seniors with their grocery shopping and some basic errands of necessity, such as the drug store, bank and barber or beauty shop. Volunteers use their own car to drive the elder to the store, bank and barber or beauty shop. Volunteers provide transportation to the store and accompany the senior with their shopping needs including carrying the groceries and putting them away. Shopping is available for those who are homebound. In 1999, 160 volunteers served 180 homebound individuals in 11 Connecticut towns.

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## **Eligibility Requirements:**

Recipients of Friendly Shoppers' services must be frail and at least sixty years of age. The program is provided free of charge. Volunteers of any age who are willing to receive three hours of orientation and provide shopping trips on a regular basis are eligible to become Friendly Shoppers. Volunteers must own and operate an insured, reliable vehicle that would be accessible to an older person. Volunteer must be physically able to lift and carry groceries and be familiar with area supermarkets and stores. The screening process includes an interview by a program coordinator and a reference check.

Typically, Friendly Shoppers:

- Understand and like older people
- Are willing to commit time during traditional business hours
- Are honest, cheerful, and dependable
- Are good listeners
- Have automobile insurance and
- Have a good driving record

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## **For More information on a program in your area contact:**

Barbara Malcolm and Evelyn Clark, Co-Directors  
Breakthrough to the Aging  
Capitol Region Conference of Churches  
30 Arbor Street  
Hartford, CT 06106  
Phone: (860) 236-1295  
Fax: (860) 236-8071

# CONNECTICUT COMMUNITY CARE, INC. (CCCI)

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## Program Description:

supporting independent living opportunities for Connecticut'

The goals of CCCI are:

- To assist frail elderly persons to remain independent in the community by making available appropriate economical, health and social services.  
To coordinate in-home, ambulatory and institutional services.  
To offer support, guidance, and counsel to families and others who are assisting in

These goals are accomplished through an independent management model provided by professionally trained nurses and social workers with extensive experience in the

## Components of Care Management

- Care managers conduct a comprehensive evaluation of an older institution.
- Based on the assessment, a realistic, attainable and affordable care family and any others involved in the care of that person.
- The care manager arranges for the necessary services to meet the informal supporters before turning to the formal system of services.

financing including the Connecticut Home Care Program for Elders, Medicare, funding is contributions from clients and their families.

- CCCI monitors services delivered and modifies person's

## **Evaluation**

necessary. The client's situation is reassessed as required. Any changes in the care

## **Education**

providers and other caregivers about the aging process and how to care for an older

## Other Services

CCCI also offers:

- Continuing education and training services
- Pre-screening services to state agencies, families, physicians, and insurers to evaluate an older person for appropriate placement, whether in a nursing home or in the community with supportive services
- Conservator services to older persons living in the community, nursing homes, or acute care hospitals
- Research and Consultation services to parties providing long term care services

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### **For More Information:**

CCCI services are available statewide in Connecticut as well as nationally through a network of local care management providers. For more information about Connecticut Community Care, Inc., call 1-800-654-2183 or contact one of the offices listed on the following pages.

### **CONNECTICUT COMMUNITY CARE, INC.**

Central Office

Molly Rees Gavin, President

43 Enterprise Drive

Bristol, CT 06010-7474

Phone: (860) 589-6226 or

Toll free: (800) 972-3851

Regional Offices and towns covered are listed on the following pages:

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Eastern Regional Office  
Kovak, Supervisor  
Meitzen, Supervisor

Norwich, CT 06360

Cities and Towns Served under contract with the Department of Social Services,

Ashford	Killingly	Scotland
Brooklyn	Lebanon	Sterling
Chaplin	Lisbon	Thompson
Clinton	Mansfield	Voluntown
Columbia	Middletown	Westbrook
Cromwell	New London Stonington	Windham
Durham		
Haddam	Old	
Lyme	Old	
	Plainfield	
Essex		
	Portland	
Griswold		
Haddam		

Putnam

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North Central Regional Office  
Gayle P. Kataja, Regional Director  
43 Enterprise Drive  
Bristol, CT 06010-7472  
Phone: (860) 314-2920

Cities and Towns Served under contract with the Department of Social Services,  
Connecticut Home Care Program for Elders:

Andover  
Avon  
Berlin  
Bloomfield  
Bolton  
Bristol  
Burlington  
Canton  
East Granby  
East Hartford  
East Windsor  
Ellington  
Enfield

Glastonbury  
Granby  
Hartford  
Hebron  
Manchester  
Marlborough  
New Britain  
Newington  
Plainville  
Plymouth  
Rocky Hill  
Simsbury

Southington  
Stafford  
Suffield  
Tolland  
Vernon  
West Hartford  
Wethersfield  
Windsor  
Windsor Locks

Farmington

Somers  
South Windsor

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North Western Regional Office

150  
Waterbury, CT 06705

Cities and Towns Served under contract with the Department of Social Services,

Barkhamsted		Salisbury
Bethel	Middlebury	Sherman
Bridgewater	Naugatuck	Thomaston
Canaan	New Hartford	Warren
Colebrook	Newtown	Waterbury
Danbury	North Canaan	Winchester
Hartland	Prospect	Woodbury
Kent	Ridgefield	

# CONNECTICUT HOME CARE PROGRAM FOR ELDERS

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## **Program Description:**

The Connecticut Home Care Program for Elders provides a wide range of home health and non-medical services to persons age 65 and older who are institutionalized or at risk of institutionalization. Available services include adult day health, homemaker, companion, chore, home delivered meals, emergency response systems, case management, home health services, mental health counseling, and adult foster care.

The program has a three-tiered structure through which individuals can receive home care services in amounts corresponding to their financial status and functional dependence. Two categories within the program are funded primarily with state funds; the third category is funded under a Medicaid waiver. Eligibility rules are related to those categories. Participation in the program depends on availability of funds and at times enrollment may need to be temporarily suspended and a waiting list initiated.

In order to become eligible, all individuals must be screened by the Department of Social Services to determine whether they are likely to qualify for the program. Individuals who meet the screening criteria are referred to Access Agencies for an independent, comprehensive assessment. This assessment determines the prospective client's needs and, with client/caregiver input, determines whether a plan of care can be developed which will safely and cost effectively meet the client's needs. Access Agency care managers arrange the services and if needed, may provide ongoing care management to monitor and coordinate home care services.

Another component of the program allows individuals to receive home care services without the ongoing intervention of a care manager. This component is called "self directed care." One of the key features of "self directed care" is that it allows home health agencies and other providers to work directly with their clients to assure the delivery of quality home care services which meet the client's total needs. Once the Department of Social Services has determined that a client can be self directed, agencies may directly provide or may subcontract for a wide range of non-medical services which will enable these clients to remain living at home.

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## **Eligibility Requirements:**

Persons aged 65 and over access the program by seeking admission into a nursing home, being hospitalized, or calling the Department of Social Services' Alternate Care Unit. Following the completion of appropriate paperwork, the individual is screened for both financial and functional eligibility. If the applicant meets eligibility criteria, a referral is made to the appropriate Access Agency and an assessment is then conducted.

Specific eligibility information can be obtained from the offices listed on the following page.

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 **For More Information:**

Referrals to the Connecticut Home Care Program for Elders may be made by contacting the Department's toll free number **1-800-445-5394** or by contacting the local field office of the Alternate Care Unit.

Bridgeport

10 Middle Street 9<sup>th</sup> Floor  
Bridgeport, CT 06604  
Phone: (203) 579-6575  
Fax: (203) 579-6498

Hartford

25 Sigourney Street 11<sup>th</sup> Floor  
Hartford, CT 06106  
Phone: (860) 424-4890  
Fax: (860) 424-4898

New Haven

419 Whalley Avenue  
New Haven, CT 06511  
Phone: (203) 789-7201  
Fax: (203) 789-7202

Norwich

West Side Complex  
372 West Main Street  
Norwich, CT 06360  
Phone: (860) 886-6632  
Fax: (860) 886-6035

Waterbury

150 Mattatuck Heights  
Waterbury, CT 06705  
Phone: (203) 596-4273  
Fax: (203) 596-4276

# CONNECTICUT MEDICARE ASSIGNMENT PROGRAM (ConnMAP)

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## Program Description:

The Connecticut Medicare Assignment Program (ConnMAP) assures that participants will be charged no more than the reasonable and necessary rates approved by Medicare for Medicare-covered services.

Seniors and disabled Medicare beneficiaries who meet the program's eligibility guidelines obtain a ConnMAP card by submitting a short application to the Department of Social Services ConnMAP program. The card is then presented to the health care provider prior to treatment. If the service received is covered by Medicare, the provider may charge no more than the rate determined to be reasonable and necessary for that service by the Health Care Financing Administration.

Some services supplied by health care providers other than physicians (such as podiatrists, chiropractors, dentists, optometrists, etc.) are covered by Medicare, but many are not. In addition, some providers are not enrolled in the Medicare program. Patients who are not sure whether services are covered should ask the provider before receiving care.

For ConnMAP cardholders, the patient's share is limited to the annual deductible and co-payments (usually 20%) required by Medicare.

A ConnPACE card is a legal substitute for a ConnMAP card. ConnPACE cardholders do not need to obtain a ConnMAP card if they are enrolled in Medicare Part B.

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## Eligibility Requirements:

To qualify, an individual must be a resident of the State of Connecticut for 183 days prior to the date of application, be enrolled in Medicare Part B, and have incomes below:

\* Single - \$24,255/year

\* Couples - \$29,205/year

\* These levels go into effect on 1/1/2000.

Income is based on the last complete calendar year. Applicants who were over the income limit in the previous year but have experienced a drop in income in the current year may apply using current year income. For purposes of determining eligibility, virtually all income, including Social Security, minus the Medicare Premium, and tax exempt income, is counted.

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 **For More Information:**

Applications and information may be obtained from most Senior Centers, Area Agencies on Aging and Municipal Agents for the Elderly or contact the program directly:

ConnMAP

Department of Social Services

25 Sigourney Street

Hartford, CT 06106

Tel: (860) 424-4925

Toll Free 1-800-443-9946

# CONNECTICUT PARTNERSHIP FOR LONG-TERM CARE

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## **Program Description:**

The Connecticut Partnership for Long-Term Care is a State program that enables Connecticut residents to pay for future long-term care expenses without depleting their assets. The Partnership offers quality long-term care insurance (sold only by a select group of private insurers) and a promise that if additional care is needed after the insurance runs out, the individual can apply for Medicaid and keep more in assets than Medicaid normally allows. The amount of assets an individual can keep depends on the amount of long-term care services paid for by the Partnership policy.

The State offers free, impartial information to educate consumers about long-term care expenses and help identify what to look for when buying long-term care insurance policies. Connecticut residents can obtain free, easy-to-read publications or request a trained volunteer to assist them in comparing policies or understanding written material by calling 1-800-547-3443. While volunteers help consumers understand relevant material, they do not make decisions or choices for consumers. Speakers can also be requested for group presentations. Each year, 6 free public forums are held around the state to present information and answer questions about the Connecticut Partnership. These services are available through the Elderly Services Division of the Department of Social Services.

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## **Eligibility Requirements:**

Anyone who is generally healthy, has sufficient income to pay the insurance premiums, and who has sufficient assets (at least \$40,000) to benefit from having the policy could be appropriate for this program. Applicants must provide a health statement from a doctor and/or submit to a physical exam. The insurance company will determine who can buy a policy based on the physical or mental condition and age of the consumer. Anyone already in a nursing home is not eligible to buy a policy. Each company determines the health criteria and age limits for selling policies. If you are turned down by one company, another company may agree to sell you a policy. Prices vary for the premiums, therefore, consumers are encouraged to shop for comparisons.

The Connecticut Partnership for Long-Term Care is only available to Connecticut residents. Anyone planning finances for retirement or future long-term care needs should examine the program.

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 **For More Information:**

Partnership policies can be purchased only from agents trained in selling Partnership insurance. For a free information packet including a list of insurance companies selling Partnership policies, contact:

The Connecticut Partnership for Long-Term Care  
Department of Social Services, Elderly Services Division/10th Floor  
25 Sigourney Street  
Hartford, CT 06106  
Phone: (800) 547-3443  
Fax: (860) 424-4966  
Website: [WWW.STATE.CT.US/PDPD4/LTC/HOME.HTM](http://WWW.STATE.CT.US/PDPD4/LTC/HOME.HTM)

# QUALIDIGM: FORMERLY CONNECTICUT PEER REVIEW ORGANIZATION (CPRO)

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Qualidigm is a private, non-profit physician member quality improvement which has a contract with the Federal Government to review the use and quality of services provided in Connecticut to Medicare patients. The organization's physicians, assisted by nurses and medical records professionals, review the care provided by

and selected HMOs. The objective is to assure that patients receive the care that they need, when they need it, and in the right setting.

-free telephone assistance to patients or their representatives who have questions about the concerns about the quality of the care they receive.

notice from that hospital, she/he can appeal the decision to

Qualidigm has a Speakers Bureau which makes available physicians and staff to Qualidigm Program and the Medicare beneficiaries rights within the Program. The service is free and available for any sized group, anywhere in Connecticut.

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## **Eligibility Requirements:**

To qualify, the person must be a Medicare beneficiary or a representative of a



Barry Waite

Qualidigm  
100  
Middletown, CT 06457  
Phone: (860) 632-6347 or Toll-free in CT: (800) 553-7590

# CONNECTICUT PHARMACEUTICAL ASSISTANCE CONTRACT TO THE ELDERLY AND THE DISABLED (ConnPACE)

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## Program Description

ConnPACE helps eligible elderly and disabled individuals pay for prescription drugs, insulin, and insulin syringes and needles \*. Participants pay a \$12.00 co-payment for each prescription; enrollment fee.

however, a limit on the quantity dispensed, which is either 120 doses or a 30 day supply, whichever is greater.

the prescribing physician.

### ConnPACE

the date issued. Applicants must present this card at participating pharmacies to receive ConnPACE benefits.

participants 75 days before their card expires.

\* Drugs are: antihistamines, contraceptives, cough preparations, diet pills, insulin Administration, multivitamin combinations, products prescribed for cosmetic purposes, and over-the-counter companies

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## Eligibility Requirements

To qualify, an applicant must:

be 65 years of age or older or be a disabled person over the age of 18 and

enrolled in the Social Security Income Program (Title II) or the Supplemental Security Income Program (Title XVI).

Have lived in Connecticut for at least six (6) months prior to application.

Have an adjusted gross income for the previous year plus Social Security of less than \$12,000 \*

Not be

enrolled in all or a portion of each prescription, or a deductible insurance plan that includes

5)

ConnPACE,

maximum benefit of your private insurance coverage. Eligibility will be pending until you submit a letter showing that you have exhausted your benefit and the

To receive benefits, each applicant must submit:

- 1)
- 2) Photocopies of documents which prove eligibility in the areas of age, residency,  
Policy.
- 3)

\* As of January 1, 1998, income limits will increase every January 1 to reflect cost of



:

You may obtain a  
Municipal Agents for the Elderly, and other social service organizations or call  
- 4:30 p.m.

Hartford Area: (860) 832-9265 or  
-800-423

# CONNECTICUT STATE DENTAL ASSOCIATION

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## **Program Description:**

The Connecticut State Dental Association provides a list of reduced fee dental clinics available in Connecticut.

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## **Eligibility Requirements:**

Available to all Connecticut residents.

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## **For More Information Contact:**

Theresa P. Tostarelli  
Connecticut Dental Association  
62 Russ Street  
Hartford, CT 06106  
Phone: (860) 278-5550  
Fax: (860) 244-8287

# THE CONNECTICUT STATEWIDE RESPITE CARE PROGRAM

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This program enables caregivers to receive respite care services by establishing a care

Such care, while beneficial to the patient, can be intrinsic to the well being of the stressed caregiver. The eligibility criteria are as follows  
thousand five hundred dollars available per year to each applicant, and a maximum of 30 days of out of home respite care services (excluding Adult Day Care) available per

income and a Physician's statement certifying the condition of the individual with Alzheimer's disease or a related disorder. This program is a joint partnership between Association, the Area Agencies on Aging, and the State of Connecticut Department of Social Services, Elderly Services Division.

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## Eligibility Requirements:

The individual with Alzheimer's must meet financial eligibility requirements to participate in this program. Applicants (individuals with Alzheimer's or a related disorder) must have an income of \$30,000 a year or less, liquid assets of \$80,000 or less, and cannot be enrolled in the Medicaid (Title 19) program. Income is considered to be Social Security (minus the Medicare Part B premiums), Supplemental Security Income, Railroad Retirement Income, veteran's benefits, and any other payments received on a one-time or recurring basis. Liquid assets include checking and savings accounts, stocks, bonds, IRAs, certificates of deposit, or other holdings that can be converted into cash.

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## For More Information Contact:

Eastern Connecticut

47 Town Street  
Norwich, CT 06360

North Central  
Area Agency on Aging

Hartford, CT 06105-476  
(860) 724-6443

Area Agency on Aging  
201 Noble Street

(203) 933-5431

Southwestern Connecticut  
Area Agency on Aging  
10 Middle Street  
Bridgeport, CT 06604  
(203) 333-9288

Western Connecticut  
Area Agency on Aging  
255 Bank Street, 2<sup>nd</sup> Flr.  
Waterbury, CT 06702  
(203) 757-5449

Northern Connecticut Chapter  
Alzheimer's Association  
443 Franklin Avenue  
Hartford, CT 06114-2317  
(860) 956-9560

Fairfield County  
Alzheimer's Association  
607 Main Avenue  
Norwalk, CT 06851  
(860) 845-0010

South Central Chapter  
Alzheimer's Association  
2911 Dixwell Ave, Suite 104  
Hamden, CT 06518  
(203) 230-1777

State of CT  
DSS-Elderly Services  
Cynthia Grant, Field Representative  
25 Sigourney Street  
Hartford, CT 06106  
(860) 424-5279

# ELDERLY HEALTH SCREENING

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## **Program Description:**

Elderly Health Screening programs provide multiphase health screening to the elderly in the North Central, Southwestern, South Central and Western parts of the State. The primary goal of these programs is the early detection of disease. The health screening tests include blood analysis, electrocardiograms, glaucoma testing, blood pressure testing, pap/pelvic/breast/rectal cancer examinations and other health screening procedures as well as health education. Tests are available to people 60 years of age and over.

Participants are encouraged to make a donation toward the cost of the services.

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## **Eligibility Requirements:**

To qualify, the person must be 60 years of age or older.

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## **For More Information Contact:**

1) Elderly Health Screening Service, Inc.  
161 North Main Street  
Waterbury, CT 06702  
Phone: (203) 753-9284

2) Fair Haven Community Health Center, Inc.  
Bella Vista Satellite Clinic/Elderly Health Services  
221 Eastern Street  
New Haven, CT 06513  
Phone: (203) 469-5331

3) City of Bridgeport, Department of Health  
Elderly Health Screening Program  
752 East Main Street  
Bridgeport, CT 06608  
Phone: (203) 576-7690

4) Charter Oak Terrace/Rice Heights Health Center, Inc.  
21 Grand Street  
Hartford, CT 06106  
Phone: (860) 550-7500

# **NURSING HOMES**

## **SKILLED NURSING FACILITIES (SNFs)**

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### **Program Description:**

Nursing home care is available when an individual can no longer remain at home because the care and supervision required are too extensive for family members or available home care services to manage. This level of care is also appropriate for discharged hospital patients who require sub-acute care and are not yet ready to return home.

Residents of skilled nursing facilities require ongoing nursing care and substantial assistance with activities of daily living. All skilled nursing facilities are required by federal and state law to provide a variety of medical and social services which will promote and maintain the highest level of physical, mental, and psycho-social functioning for the resident.

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### **Eligibility Requirements:**

To qualify for admission to a skilled nursing facility, the applicant must have a physician's certification of the need for nursing home care. Nursing homes maintain a waiting list of applicants and must take people on a "first come, first serve" basis unless they have been granted a waiting list waiver from the Department of Social Services. Nursing homes accept private pay, Medicaid and Medicare for various services. Be sure to consult specific nursing homes for other admission information.

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### **For More Information Contact:**

Questions and/or requests for information related to SNFs or hospital discharge planning complaints should be directed to the Division of Health Systems Regulation of the Department of Public Health at (860) 509-7400.

For a complete list of nursing home facilities licensed by the State of Connecticut, contact:

Department of Public Health  
Division of Health Systems Regulation  
410 Capitol Avenue, P.O. Box 340308  
Hartford, CT 06106-0308  
Phone: (860) 509-7444

If problems arise concerning admission to a facility or for a resident within a facility, contact the State Long Term Care Ombudsman Program (LTCOP). Consult the index of this Manual for the page listing for the central and regional program offices of the LTCOP.

For the most current listing and description of all nursing facilities in the state and the nation, and to see the results of their last state inspection (called a survey), visit the Medicare web site at: [www.medicare.gov/nursing/home.asp](http://www.medicare.gov/nursing/home.asp)

## MEDICAID (TITLE XIX)

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### Program Description:

Medicaid is a program designed to help persons who are 65 years of age or older, disabled, blind or receiving public assistance to pay medical expenses. Medicaid is funded by the Federal and State governments. In Connecticut, the program is administered by the Department of Social Services. The Medicaid program is different from the Medicare program which is administered by the Social Security Administration.

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### Eligibility Requirements:

#### Income and Asset Requirements: Community

An income and asset test is part of the eligibility process. An individual may have up to \$1,600 worth of assets. A married couple living together may have up to \$2,400 of combined assets. In addition to these amounts, each person may also have life insurance with a total face value of no more than \$1,500 and an irrevocable burial contract worth up to \$5,400 or a revocable burial contract. The value of the applicant's home is also excluded.

The amount of income allowed for a person who resides in the community applying for Medicaid is based on where he or she lives. The regional income limits are:

	<u>Single</u>	<u>Couple</u>
Region A	\$574.86	\$733.59
Regions B and C	\$476.19	\$633.49

(see end of this section to determine which income limit applies to a specific town)

#### Income and Asset Requirements: Long Term Care

Long term care is defined as either the admission to a long term care facility or the receipt of home and community based services. To be eligible for Medicaid, an institutionalized individual's countable assets cannot exceed \$1,600. In addition, each person may also have life insurance with a total value of no more than \$1,500 and an irrevocable burial contract worth up to \$5,400, or a revocable burial contract. An individual who entered an institution on or after September 30, 1989 who has a spouse living in the community is also able to have a portion of the couple's combined assets protected for the use of the community spouse. This amount is called a Community Spouse Protected Amount (CSPA). The value of the protected assets is not counted when the eligibility of the institutionalized individual is determined. The maximum and minimum amounts are set by Federal law and the State is required to update the amounts yearly. The Community Spouse Protected Amount cannot exceed the maximum amount set, except by a Fair Hearing decision or through a court order.

When an institutionalized individual and his or her spouse have assets which exceed the amount established as the CSPA and the \$1,600 asset limit, the excess assets are considered to be available to the institutionalized individual. This is true regardless of which spouse is the owner of the assets. The institutionalized individual is not eligible for Medicaid until the couple's combined assets are reduced to the total of the \$1,600 asset limit and the CSPA combined. The couple is not required to "spend down" the excess to pay for the institutionalized individual's medical expenses. As long as fair market value is received, the excess assets may be spent in any way the couple wishes.

When an institutionalized individual has a spouse who lives in the community, some of his or her income can be used for the spouse's needs. This income, which is called a Community Spouse Allowance (CSA), is determined by subtracting the community spouse's monthly gross income from a Minimum Monthly Needs Allowance (MMNA). The MMNA is calculated according to a formula which uses the spouse's actual monthly shelter costs including an allowance to cover monthly utility costs. The maximum and minimum amounts are set by federal law and the state is required to update the amounts yearly. The MMNA cannot exceed the maximum amounts set, except by a Fair Hearing decision.

When an institutionalized individual applies for Medicaid, DSS currently examines any transfers of assets made by the individual and the individual's spouse within the 36 month period immediately before the date the person applied for Medicaid and was institutionalized. The look back period could be longer if the transfer involved the setting up of a trust. Not all asset transfers are considered to be improper. If an improper transfer was made, a penalty period is established during which time the Department will not pay for long term or home care.

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 **For More Information:**

To apply for Medicaid contact the Department of Social Services office in your area. Consult the index of this manual for the Connecticut Department of Social Services Regional Offices listing.

If problems arise in obtaining Medicaid or if benefits are denied an individual is entitled to a Fair Hearing. If help is needed in pursuing a Fair Hearing, assistance can be had through the nearest legal services office. Consult Legal Services Organizations for Older Persons in this Manual for a listing of the nearest legal services office.

To request a Fair Hearing, you may contact:

State of Connecticut  
Department of Social Services  
Administrative Hearings and Appeals  
25 Sigourney Street  
Hartford, CT 06106-5033

## **MEDICAID**

### Region A

Bethel	New Fairfield	Sherman
Bridgewater	New Canaan	Stamford
Brookfield	Newtown	Washington
Danbury	Norwalk	Weston
Darien	Redding	Westport
Greenwich	Ridgefield	Wilton
New Milford	Roxbury	

### Region B and C

All towns not listed above are in Regions B and C and should use the income limits listed on page 101.

# MEDICARE

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## **Program Description:**

Medicare is a federal health insurance program for people 65 or older and certain disabled individuals. The program, administered by the Health Care Financing Administration (HCFA), has two separate parts (Part A and Part B) for hospital and medical insurance. In Connecticut, beneficiaries have the option to receive their benefits either through the original fee-for-service plan or elect coverage through a Medicare managed care plan. Although both plans provide basic Medicare hospital and medical benefits, there are important differences in the way services are delivered, how and when payment is made, and how much a beneficiary may have to pay out of pocket.

### PART A - Hospital Insurance

Medicare Part A (Hospital Insurance) is financed by part of the Social Security payroll withholding tax paid by workers and their employers (FICA) and by part of the Self-Employment Tax paid by self-employed persons. If an individual or his/her spouse is entitled to benefits under either the Social Security or Railroad Retirement systems or has worked long enough in federal, state or local government employment to be insured, s/he does not have to pay a monthly premium for Part A. Other people over 65 and certain disabled persons can purchase Part A by paying a monthly premium.

### PART B - Medical Insurance

Medicare Part B (medical insurance) is optional, and paid for in part by the premiums from persons who elect to enroll in the program. The monthly premium in 2000 is \$45.50, and most enrollees have it deducted from their monthly Social Security check. Beneficiaries are automatically enrolled in Part B when entitled to premium-free Part A unless coverage is declined. Those who do not qualify for premium-free Part A and are over 65 can generally buy Part B.

### Medicare Enrollment Periods

Premium-free Part A coverage generally starts in the month of a beneficiary's 65<sup>th</sup> birthday or shortly thereafter, depending on when the beneficiary applies. The initial enrollment period for Part B and premium Part A runs for seven months beginning three months before the month of the 65<sup>th</sup> birthday. Otherwise, there is a "general enrollment period" which occurs from January 1 through March 31 each year, with coverage beginning after July 1. Premiums for both Part A and Part B are generally higher for those who enroll during the "general enrollment period." Under certain circumstances, enrollment can be delayed without having to pay a higher premium. Individuals 65 or over or their spouses who have group health insurance based on current employment

may enroll at any time while still covered or may wait to enroll during an eight month “special enrollment period” which begins the earlier of (1) the month employment ceases or (2) when no longer covered under the employer plan.

### Original Fee-for-Service

Persons enrolling in Medicare automatically become a part of the fee-for-service program unless they choose to enroll in a Medicare managed care plan. The original fee-for-service program is similar to indemnity insurance in that it helps to cover the medically necessary expenses of acute care (i.e. illness). Although it provides for basic coverage, it doesn't pay 100% of health care costs. Deductibles and co-insurances apply to some of the benefits under both parts. In the fee-for-service program, a beneficiary can receive services from any licensed medical provider anywhere in the country and use any facility certified by Medicare. Generally, a fee is paid each time a service is used. Medicare pays a share of the cost; the patient pays what Medicare does not.

Medicare Part A pays part of the costs of certain services from a hospital, skilled nursing facility, hospice and home health agency. There is a substantial deductible for each benefit period (\$776 in 2000) and a co-insurance share of daily costs if hospitalized more than 60 days in a benefit period.

Part B pays for a wide range of medical services and supplies, including doctor's bills, whether care is received at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. There is a \$100 deductible each year before Part B begins to pay its share of Part B services. Then, Part B generally pays 80 percent of the Medicare-approved amount for all covered services received during the rest of the year. The beneficiary is responsible for the remaining 20% and any amount in excess of what Medicare has approved. There will be no excess charges, however, if the physician or medical supplier agrees to accept the Medicare-approved amount as full payment. This is referred to as “accepting assignment”.

Recently, Medicare began covering some preventive health care screening tests. The Medicare Part B deductible and co-insurances may be waived for some of these services. These Medicare preventive health care benefits include:

- Annual screening mammography
- Screening pap smear and pelvic exam
- Colorectal cancer screening
- Diabetes screening tests and self-management training
- Bone mass measurement
- Influenza and pneumococcal vaccinations
- Prostate cancer screening tests (beginning 1/1/00)

Many other medical expenses—such as self-administered prescription drugs, dental care, and routine physicals—are not covered either through Part A or Part B. To help

pay for these out-of-pocket expenses, beneficiaries often buy supplemental private insurance policies, called Medigap. For more information about Medigap insurance, please refer to the section of this Manual called “Medigap Insurance Policies.”

### Medicare Managed Care Plans

In Connecticut, beneficiaries also have the option of receiving Medicare services through one of several federally approved Medicare managed care plans. Unlike fee-for-service, these plans are “preventive” in nature, and attempt to coordinate all health care services an individual receives, in order to maximize benefits and minimize cost. Plans use a limited network of health care providers and facilities and a system of “prior approval” from a primary care physician, sometimes referred to as a “gatekeeper,” to achieve these goals. Generally, the doctor authorizes, arranges for, and coordinates your care, and decides what care is reasonable and necessary.

In Connecticut, most plans now require an additional monthly premium, especially if there is a prescription drug benefit associated with the plan. Each plan requires co-payments most times that you go to the doctor or use other services. You must also continue to pay the Part B premium, but you do not have to pay Original fee-for-service Medicare’s deductible and co-insurance. While the benefits vary from plan to plan, every plan is required by Medicare law to provide all of the Medicare benefits generally available in the plan’s service area.

All of the plans available in Connecticut have a “lock-in” requirement. That means that you generally must receive all covered care from the doctors, hospitals, and other health care providers who are affiliated with the plan. Exceptions include emergency care, urgent care, and certain care provided under an additional “point of service” (POS) option.

The following companies are currently marketing plans for Medicare beneficiaries: Aetna U.S. Healthcare; Anthem Blue Cross and Blue Shield; CIGNA; ConnectiCare, Inc.; Medspan; Oxford Health; and Physicians Health Services.

To enroll in a Medicare managed care plan, you must be enrolled in Medicare Parts A and B and continue to pay the Part B premium, you must not be medically determined to have end-stage renal disease, and you must live within the area served by the plan. except for the current end-stage renal disease prohibition, you may not be denied membership because of otherwise poor health, a disability, or other pre-existing condition.

If you enroll in a Medicare managed care plan and later decide to return to original fee-for-service Medicare, currently you may disenroll at any time although certain time restrictions will be phased in during the next few years. In addition, be aware that if you decide to return to fee-for-service Medicare, your choice of a Medigap policy may be limited. If you want to change from one Medicare managed care plan to another, you may do so by enrolling in the other plan and you will automatically be disenrolled from the first plan. If your Medicare managed care plan will no longer be providing coverage in your region, you do have options. Please contact The CHOICES Program (1-800-994-9422) for more information.

### Choosing the Best Medical Plan

The original fee-for-service Medicare and Medicare managed care plans, both have their advantages and disadvantages or trade-offs depending upon an individual's personal circumstances. Information detailing each program option, including plan comparison guides and other considerations, and general assistance can be obtained through the **CHOICES** programs at any one of Connecticut's five Area Agencies on Aging.

Beneficiaries should read program materials, ask questions, and consider the important personal aspects of each option. Following these steps is a good start to making sure that a beneficiary chooses the best medical program for his/her needs. An informed and intelligent decision whether to stay in the "fee-for-service" program or opt into a managed care program is the key to long term well-being.

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**Eligibility Requirements:**

Medicare is available to people 65 or older and certain disabled individuals. See Program Description above for more detailed explanation of eligibility and enrollment periods.

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 **For More Information Contact:**

*(All programs which are capitalized can be found in this Manual, see index for corresponding page numbers)*

- Local Social Security Offices for enrollment in Medicare, listed under the SOCIAL SECURITY section of this Manual
- **CHOICES** Health Insurance Assistance program at the Area Agencies on Aging, for general information about Medicare managed care plans, original fee-for-service Medicare or for a copy of the Medicare Choices Managed Care Plan Comparison Chart for 2000.
- ConnMAP for further information on accepting assignment
- MEDIGAP INSURANCE POLICIES for an explanation of supplemental private insurance policies
- MEDICARE APPEALS to address concerns about coverage denials either in the fee-for-service or managed care programs.

## MEDIGAP INSURANCE POLICIES

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### Program Description:

Medigap, also referred to as Medicare Supplement Insurance, supplements Medicare benefits for Medicare beneficiaries. Medicare usually does not cover all of the costs of healthcare. Medigap insurance policies fill in some of these gaps in coverage. Medigap policies only work with original Medicare, not Medicare managed care plans.

Ten standardized Medigap insurance policies are offered and are identified by letters A through J. Policy A contains basic benefits while policies B through J contain these basic benefits as well as additional benefits. The only policies which offer some prescription drug coverage are H, I, and J.

The basic benefits include:

- ◆ Hospitalization: Part A coinsurance plus coverage for 365 additional lifetime days after Medicare benefits end
- ◆ Medical: Part B coinsurance, which is generally 20% of Medicare-approved expenses
- ◆ Blood: First three pints of blood each year

In Connecticut, any company offering Medigap insurance products is required to offer at a minimum, policy A to Medicare beneficiaries over age 65. Many companies choose to offer some of the policies B through J as well. Companies which offer policies A, B, or C to Medicare beneficiaries over age 65 must also offer those policies to Medicare beneficiaries with disabilities who are under 65.

Companies cannot deny coverage to persons age 65 and older within the first six months during which the applicant is both 65 and enrolled in Medicare Part B. In addition, for Medicare beneficiaries over age 65, coverage may not be denied at any time for policies A through G because of age, gender, previous claim history or medical condition. However, for policies H, I, and J, after the first six months during which a Medicare beneficiary is both 65 and enrolled in Medicare Part B, coverage may be denied only due to previous claim history or medical condition.

There may be a waiting period of up to six months for coverage of a pre-existing condition. Federal law provides protections under certain circumstances under which a pre-existing condition limitation on coverage may not be imposed. More details can be found in materials available from CHOICES (1-800-994-9422) including “Medigap: A Summary of Rights” prepared by the Center for Medicare Advocacy.

It is unlawful for a company to sell a duplicate Medicare supplement policy to a Medicare beneficiary. However, if a beneficiary is covered under a retiree health plan

and is considering the purchase of a Medigap policy, s/he may wish to ask for further information.

At the time of application, the applicant should expect to receive an outline of coverage which provides future premium change information, a policy summary, and notice that the policy may be returned with full refund within 30 days after receipt. The applicant should answer all questions on the application fully and truthfully, and not cancel existing policies until sure about the replacement.

No one should ever be pressured into purchasing a Medigap policy. Consumers should compare costs and the benefits of policies before making a purchase, and need to understand the circumstances under which a company can raise its premium.

Under Connecticut law, a person who feels that s/he has made a mistake in purchasing a policy has 30 days from the receipt of the policy to return it for a full and timely refund.

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**Eligibility Requirements:**

Must be enrolled in Medicare.

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** For More Information:**

For more information about Medicare supplement policies including additional regulatory standards and a rate comparison guide, contact the CHOICES program at your regional Area Agency on Aging. See CHOICES or Area Agencies on Aging in this manual for addresses and phone numbers.

# NATIONAL EYE CARE PROJECT

## Program Description:

The National Eye Care Project is a nationwide outreach program designed to provide medical eye care to elderly persons. Through a toll-free help line, the program provides eligible seniors referrals to qualified ophthalmologists who provide eye care. The ophthalmologist will check for cataracts, glaucoma and other eye diseases, and treat any condition or disease diagnosed.

The following services are not covered:

- eyeglasses, contact lenses, prescription drugs
- hospital services (charged by the hospital)
- associated services of other medical professionals, such as an anesthesiologist

Those callers who want information only are sent an easy to read brochure discussing common eye diseases of aging, such as cataract, glaucoma, diabetic retinopathy, and macular degeneration. The Project also has access to over 75 eye care related brochures. "Resources for Individuals with Visual Impairment," a publication of the American Academy of Ophthalmology is also available through the National Eye Care Project.

The National Eye Care Project is co-sponsored by The Foundation of the American Academy of Ophthalmology and the Knights Templar Eye Foundation, Inc.

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## Eligibility Requirements:

Volunteer ophthalmologists provide eye examinations to US citizens or legal residents who are 65 and older and who do not have access to an ophthalmologist they have seen in the past. Medicare and private insurance will be billed, with co-payments waived. For those with no insurance, there is no charge.

Individuals enrolled in prepaid health care plans (HMOs) or who receive care through the armed forces or VA hospitals are not eligible. Those who are not eligible are provided with information on how to contact a local ophthalmologist.

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## For More Information Contact:

National Eye Care Project  
P.O. Box 429098  
San Francisco, CA 94142-9098

**1 (800) 222-EYES (1-800-222-3937)**

# QUALIFIED MEDICARE BENEFICIARY PROGRAM (QMB)

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## Program Description:

For those who qualify, the Qualified Medicare Beneficiary (QMB) program provides financial help to pay for Medicare monthly premiums, deductibles and co-insurances.

The QMB program is available to all people who are eligible for Medicare Part A and meet income and asset eligibility. For those who are eligible, the QMB program will pay the Medicare Part A and Part B monthly premiums, Part A deductibles and co-insurances, and the Part B annual deductible and 20% co-insurance amounts.

For Medicare beneficiaries who are eligible for QMB, Medigap insurance coverage is usually not necessary. The QMB program offers the equivalent of some Medigap insurance coverage.

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## Eligibility Requirements:

Eligibility is related to assets and monthly gross income. Monthly gross income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends.

The income limits are effective until 3/31/00:

Income	\$870*	\$1,288 **
Assets	\$4,000	\$6,000

\*This amount includes one unearned income disregard of \$183, which most people receive.

\*\*This amount includes two unearned income disregards for a total of \$366, which most people receive.

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## For More Information Contact:

One of the Department of Social Services Regional Offices. See the index in this Manual for the page listing of these offices.

# SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM (SLMB)

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**Program Description:**

The Specified Low-Income Medicare Beneficiary (SLMB) program, offered by the Department of Social Services, pays the Medicare Part B premium for certain low income Medicare beneficiaries. The SLMB program is available to the elderly and those with disabilities who receive Social Security benefits and are eligible for Medicare benefits.

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 **Eligibility Requirements:**

Eligibility is related to assets and monthly gross income. Monthly gross income includes Social Security, pensions, disability benefits, wages, alimony, rental income, interest and dividends.

The income limits are effective until 3/31/00:

	Single	Couple
Income	\$1,007*	\$1,472 **
Assets	\$4,000	\$6,000

\*This amount includes one unearned income disregard of \$183, which most people receive.

\*\*This amount includes two unearned income disregards for a total of \$366, which most people receive.

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** For More Information Contact:**

Any of the Department of Social Services Regional Offices. See the index in this Manual for the pages listing these offices.