Medicaid for the Aged and Disabled (MEDS-AD) in Florida Eligibility and Application Process

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What is Medicaid for the Aged and Disabled?

Medicaid for the Aged and Disabled (MEDS-AD) is a Florida Medicaid program that provides full health coverage to older adults and individuals with disabilities. This program is designed for those who do not require long-term care (such as nursing home placement) but need comprehensive coverage for everyday medical needs like doctor visits, prescriptions, and other essential health benefits.

You may qualify for Medicaid for the Aged and Disabled (MEDS-AD) in Florida if you:

- Are 65 years of age or over or have a qualifying disability;
- Do not financially qualify for Supplemental Security Income (SSI); and
- Do not qualify for Medicare.

Note: Individuals applying for Medicaid are not required to apply for other benefits. This means that anyone who qualifies for Medicare but is not automatically enrolled or who has not applied for SSI could still potentially be eligible for MEDS-AD.

How is medical eligibility for MEDS-AD determined?

If you are under the age of 65, you must meet the federal definition of a "disability" to qualify for MEDS-AD. Florida Medicaid follows the same **guidelines** used by the Social Security Administration (SSA) to make this decision.

- **For Adults:** You must have a physical or mental condition that prevents you from doing any Substantial Gainful Activity, meaning you cannot work and earn over a certain monthly income limit. Earning more than this limit will automatically disqualify you.
- **For Children (Under 18):** Your child must have a physical or mental condition that causes marked and severe functional limitations in their daily life.
- **Timeframe Requirement:** For both adults and children, the medical condition must either be expected to result in death, or it must have lasted (or be expected to last) for a continuous period of at least 12 months.

What if Social Security has already made a decision?

You do not have to apply for Social Security disability benefits before applying for Medicaid. However, if SSA has already made a decision about your disability status, you must report it to the Florida Department of Children and Families (DCF).

If SSA has officially decided that you are not disabled, Florida Medicaid must follow that decision and deny your MEDS-AD application.

However, the state is required to perform an independent review of your disability if you meet one of these exceptions:

- The SSA decision was more than 12 months ago, and your condition has gotten worse or you have a new medical condition, or
- The SSA decision was less than 12 months ago, your condition has gotten worse or you have a new medical condition, and you have already filed an official appeal with SSA.

See ESS Program Policy Manual 1440.1204.

How is Financial Eligibility for MEDS-AD Determined?

Financial eligibility for MEDS-AD is based on the individual's income and assets or the couple's income and assets if the applicant is married (even if the spouse is not disabled or applying for benefits). The number of dependents and dependent income are not considered when DCF assesses financial eligibility.

Highlighted below are the current income and asset limits for MEDS-AD:

SSI-Related Medicaid Coverage Groupd Financial Eligibility Standards: April 2026

Coverage Group SSI/FBR $994-Individual	Income Limit	Asset Limit	
ICP/HCBS/Hospice- Individual (300% FBR) * ICP/HCBS/Hospice – Couple*	$ 2,982 $ 5,964	$ 2,000 $ 3,000	
HCBS/Working People w/Disabilities – Individual (WPwD) (550% FBR) * HCBS/Working People w/Disabilities – Couple (WPwD)*	$ 5,467 $ 10,934	$ 2,000 $ 3,000	$13,000 Disregard $24,000 Disregard
MEDS-AD/ICP-MEDS/Individual (88% FPL) ** MEDS-AD/ICP-MEDS/Couple **	$1171 $1588	$ 5,000 $ 6,000	
Medically Needy, MNIL-(I)-No income limit Medically Needy, MNIL-(C)-No income limit (Subtract from gross income)	$ 180 $ 241	$ 5,000 $ 6,000	
Working Disabled Individual (200% FPL) ** Working Disabled Couple**	$2660 $3607	$ 5,000 $ 6,000	
Medicare Part B* Medicare Part A*	$ 202.90 Free for most or $ 565	N/A	

Appendix A-9 SSI-Related Programs - Financial Eligibility Standards

IMPORTANT: Income "disregards" can be subtracted from your income to determine their countable income for determining eligibility. If your countable income is below the number in the chart, you are financially eligible.
Standard Disregard: There is a standard $20 disregard for any income that is not earned income.
Earned Income Disregard: For earned income, there is a $65 + ½ earned income disregard. "Earned income" includes all gross (before taxes or other deductions) wages and salaries from performance of work.

If you are medically eligible for MEDS-AD but are over the income limit, you may qualify for Medically Needy. See our Medically Needy Guide for more information on that program.

How do I apply for Medicaid for MEDS-AD?

You can apply for MEDS-AD through the **Department of Children and Families (DCF)**, just like any other type of Medicaid.

IMPORTANT: You must check the "disabled" box on the application or you will not be assessed for MEDS-AD eligibility. After you check "disabled", you are given the opportunity to fill in more information about your disability that is necessary for an accurate determination.

What should I expect after applying?

1. **Initial Review:** DCF will first check if you qualify for Family-Related Medicaid (which covers children, pregnant women, parents, and young adults).
2. **Disability Review:** If you do not fit into those categories and you checked the "disabled" box, your application should be sent to the Division of Disability Determinations (DDD) to review your medical eligibility for MEDS-AD.
3. **The Disability Packet:** Before your file goes to DDD, DCF should send you a "disability packet" to fill out.

What documents do I need to provide?

If you do not receive the disability packet in the mail, you can download the forms and upload them to your MyACCESS account, or send them to DCF by mail or fax. The forms include:

- **Disability Report Form** (CF-ES 2911): This requires descriptions of your conditions, contact info for all your doctors and clinics, dates of treatment, a list of your medications, details on your education, and how your illness affects your daily life.
- **Medical Records:** You can request records from your doctors, therapists, labs, and hospitals from the last 1 to 2 years.
- **Authorization to Disclose Information** (CF-ES 2514)
- **Financial Information Release** (CF-ES 2613)

→**TIP:** Even if DCF asks you questions over the phone regarding your medical conditions and tells you that they already have your medical records, we strongly recommend uploading the completed Disability Report Form and submitting your own copies of the medical records to ensure that DDD has all of the necessary details regarding your medical conditions to make an accurate assessment.

Note: If you have a mental health condition, a caseworker will likely contact you to complete an additional form—the Supplemental Disability Report (CF-ES 2912)—either over the phone or in person.

When can I expect to receive a decision?

Standard Medicaid applications are usually processed within 45 days. However, because verifying a disability takes extra time, the state has up to 90 days to make a final decision. When you apply, make sure to choose whether you want to receive updates by mail or electronically. This ensures you do not miss your decision notice. You can also monitor your application status at any time by logging into your online MyACCESS account.

What if I am denied Medicaid or there is a delay in the decision?

If your application was denied within 45 days or less and the decision states that you were denied because your income is too high, your application was most likely only assessed under the Family-Related Medicaid categories. This means your application was likely not forwarded to DDD for a disability determination.

You can submit a question about your eligibility to DCF directly through its **Online Inquiry Form** on their website. You can describe the concerns that you have about your eligibility and ask DCF to explain or correct its decision.

If you still believe DCF's determination is incorrect after receiving a response to the inquiry form, you can appeal this decision within 90 days of the date of the notice. An appeals caseworker should reach out to you prior to hearing to try to resolve the case. You can explain to the caseworker that you selected "disabled" on your application and are concerned that your application was not forwarded to DDD, despite selecting "disabled" on the application and completing the required forms in the disability packet.

If you were denied for failure to meet the disability requirements, you may also appeal the determination. In that case, we recommend that you seek the assistance of a legal aid or Social Security Disability attorney to assist you, since proving disability can be highly complex.

If you do not receive a decision within 90 days, you may also request a fair hearing. Instructions on how to appeal can be found in our **Florida Medicaid Appeals Toolkit**.

If the issue remains unresolved after taking these steps, you can complete our **online intake** to speak with an advocate who may be able to assist you or contact your **local legal aid program**.