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RESOURCES

RESOURCES

Description: Resources are property of all kinds including: real, personal, tangible, and intangible.

Policy: All resources of an SSI-related A/R are reviewed to determine their availability and value as of the first day of the month for which the SSI-related A/R is applying for or receiving Medicaid. When the SSI-related applicant is requesting Medicaid coverage for the three-month retroactive period (See **OTHER ELIGIBILITY REQUIREMENTS** AUTHORIZATION), the value and availability of the applicant's resources are determined as of the first day of the month for each month that the applicant is seeking Medicaid coverage.

References:

SSL Sect.	366 366.2(a) 366-ee
Dept. Reg.	360-2.3 360-4 360-4.4 360-4.6 360-4.7 360-4.8
ADMs	10 OHIP/ADM-1 08 OHIP/ADM-4 04 OMM/ADM-6 97 OMM/ADM-2 91 ADM-17
INFs	05 OMM/INF-2
GISs	09 MA/027 08 MA/22 08 MA/013

Interpretation: Resources are cash or those assets, which can be readily converted to cash, such as financial institution accounts, life insurance, stocks, bonds, mutual fund shares and promissory notes. Resources include property not readily converted to cash (i.e., real property).

Lump sum payments and windfall payments may be considered either income or resources. (See **RESOURCES** LUMP SUM PAYMENTS)

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Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19 if income is at or below the appropriate poverty level.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

Resource requirements continue to apply to SSI-related Medicaid A/Rs whose eligibility is determined using the SSI-related budgeting methodology, unless they are applying for Medicare Savings Program (MSP)-only. Qualified Disabled and Working Individuals (QDWIs) and applicants for the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) have a resource test as do applicants for COBRA Continuation Coverage.

SSI-related Medicaid A/Rs, including MBI-WPD A/Rs, who are not seeking coverage of long-term care services, are allowed to attest to the amount of their resources rather than provide proof. However, if an SSI-related or MBI-WPD A/R is seeking Medicaid coverage of community-based long-term care services, the A/R must provide documentation of current resources only, and if otherwise eligible, is entitled to coverage of all Medicaid covered care and services, except for nursing facility services.

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An SSI-related A/R who also meets the ADC-related categorical requirements has a choice between ADC-related budgeting and SSI-related budgeting. In determining eligibility under ADC-related budgeting, there is no resource test.

Disposition: To determine eligibility for Medicaid for A/Rs who are subject to a resource test, available, countable resources are compared to the applicable resource level. If the value exceeds that level, the A/R has excess resources. (See **RESOURCES** EXCESS RESOURCES for spend down of resources).

Although there is no resource test for non-SSI-related and FHPlus A/Rs, districts must continue to review the Resource File Integration (RFI) reports. Districts are encouraged to minimize the scope of investigation into resources of the non-SSI-related or FHPlus A/R to those resources that are related to current income. Any action associated with the income verification should be maintained in the case record and/or appended to the applicable RFI report.

Interpretation: The following sections describe resources in detail:

- Financial Institution Accounts
- Uniform Gifts to Minors Act/Uniform Transfer to Minors Act
- Retirement funds
- Personal needs allowance accounts
- Lump sum payments
- Windfalls

RESOURCES

FINANCIAL INSTITUTION ACCOUNTS

Description: Financial institution accounts include checking accounts, saving accounts, money market accounts, time deposits (also known as Certificates of Deposit - CDs) and guardianship accounts. Financial Institution accounts do not include stocks, bonds and mutual funds.

Policy: All financial institution accounts are reviewed to determine their availability and value. The value of the account is the amount of monies that the A/R can currently withdraw. If there is a penalty for early withdrawal the value of the account is the amount available after the penalty deduction. Any income taxes due are not deductible in determining the account's value. It is important that local districts evaluate potential unearned income from interest earned from such accounts. (See **INCOME** DIVIDENDS AND INTEREST for a more complete description of income from dividends and interest.)

References:

SSL Sect.	366 366.2(b) 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6(b)(5)
ADMs	10 OHIP/ADM-01 96 ADM-8 92 ADM-11
GIS	09 MA/027

Interpretation: As long as the A/R is designated as the sole owner by the account's title, and can withdraw funds and use them for his or her support and maintenance, the A/R is presumed to own all of the funds in the account, regardless of their source. The presumption cannot be rebutted.

NOTE: When the letters ITF (In Trust For) appear on an account, the account is owned by the person(s) whose name(s) appears before the ITF. The person named after the ITF will receive the proceeds of the account upon the death of the owner(s).

When investigating financial institution accounts, note all major transactions. If large amounts of money have been deposited or withdrawn, the A/R is questioned as to the reason for the transaction, i.e., how the money was acquired or disposed of.

RESOURCES

FINANCIAL INSTITUTION ACCOUNTS

An SSI-related child's savings account of less than $500 is disregarded when determining Medicaid eligibility. The funds must be accumulated from gifts from non-legally responsible relatives and/or from the child's own earned income. Each SSI-related child is allowed one account; when the child has more than one savings account, the A/R is allowed up to 30 days to consolidate the funds into one account.

When an SSI-related A/R and one or more persons jointly own a savings account, the SSI-related A/R is presumed to have a 100% interest in the account. The presumption can be rebutted. Evidence that the account is, in fact, the property of only one of the persons named as an owner or that the ownership is not divided equally is documented in the case record. It is not uncommon for additional names to be listed on savings accounts for tax advantages, convenience in obtaining proceeds or inheritance purposes.

NOTE: In addition when an SSI-related A/R converts his/her resource to a joint account, transfer of assets implications are evaluated.

NOTE: An A/R may deposit recurring income, such as wages or a pension into his/her checking account each month. The A/R may draw on this money during the month to pay rent, utilities and other bills. Care is taken not to count this recurring income as a resource and income in the same month. However, if a balance is carried forward to the next month, it may be considered a countable resource in that month.

When to Verify:

(a) When the SSI-related A/R declares s/he has a financial institution account;

(b) When the SSI-related A/R declares ownership of a money market fund or certificate of deposit;

(c) When the SSI-related A/R declares membership in a credit union;

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FINANCIAL INSTITUTION ACCOUNTS

(d) When current or past maintenance indicates the probability of an existing savings account.

Verification: Verification of financial institution accounts may be accomplished in several ways:

(a) Bank accounts: seeing the bankbook or most recent statement;

(b) Certificates of deposit: seeing the most recent statement including the maturity date of the certificate or account;

(c) Checking accounts: seeing the most recent statement. Seeing the checkbook is not sufficient for verification; however, it may provide information concerning the type and amount of major transactions;

(d) Credit union accounts: seeing the most recent statement.

(e) When the Resource File Integration (RFI) reports indicate that the A/R has income from financial institution accounts.

If the A/R is unable to provide statements, the local district contacts the institution directly.

Documentation: Sufficient to establish an audit trail:

Copy of account statement; the name and address of the institution, account number, amount of current balance, date and amount of highest balance plus the date and amount of all major withdrawals and deposits.

RESOURCES

UNIFORM GIFTS TO MINORS ACT/ UNIFORM TRANSFER TO MINORS ACT

Policy: The New York State Uniform Gifts to Minors Act (UGMA) and the Uniform Transfers to Minors Act (UTMA) provide a simple and inexpensive method of making gifts to minors. The custodian of a UGMA/UTMA custodial account may provide to the minor, or expend for the minor's benefit, as much of the custodial property as the custodian considers advisable for the use and benefit of the minor. However, the minor has no entitlement to the custodial property until he or she becomes an adult, a term which is defined differently under the UGMA and the UTMA.

References:

SSL Sect.	366 366-ee
ADM	10 OHIP/ADM-01
GIS	09 MA/027

Interpretation: The UGMA was repealed in 1997, and the provisions of the UTMA govern accounts established under either statute. The UTMA generally requires the custodian to transfer the custodial property to the minor when the minor reaches the age of 21 (unless the person creating the account, in designating the custodian, elects the age of 18 instead). However, with respect to accounts created before January 1, 1997 (i.e., accounts created when the UGMA was in effect), including deposits made to such accounts on or after January 1, 1997, the custodian is required to turn over the custodial property when the minor reaches the age 18.

For an SSI-related child, UGMA/UTMA funds are disregarded when determining Medicaid eligibility. Disbursements from such accounts may be countable income to the child if used to make certain third party vendor payments. A third party vendor payment is a payment made directly to a vendor (e.g., a merchant, retailer or contractor) by a third party for goods or services the vendor has provided to an A/R.

When the minor reaches age 21 (or age 18, as the case may be), the UGMA/UTMA funds become available. They are treated as unearned income in the month the child turns such age and a resource thereafter, if retained.

RESOURCES

QUALIFIED STATE SAVINGS PROGRAMS (SECTION 529)

Description: Section 529 of the Internal Revenue Code permits account owners and designated beneficiaries of a qualified tuition savings program to qualify for federal tax benefits. The qualified tuition savings program allows for either prepayment of a student's tuition or contributions to an account established for paying a student's qualified higher education expenses at an eligible educational institution. New York's 529 College Savings Program, a qualified tuition program, enables individuals to save for a student's qualified higher education expenses by providing investment choices and tax benefits.

Policy: Assets in a Section 529 account are considered to belong to the account owner. The account owner can withdraw money from the account. An account owner must be a U.S. citizen or resident alien and have a Social Security number or taxpayer identification number. Fiduciaries or agents for trusts, estates, corporations, companies, partnerships, and associations may also be account owners.

For purposes of determining Medicaid eligibility, New York's 529 College Savings Program is a countable resource for the account owner. The assets are not taken into consideration in determining Medicaid eligibility for the designated beneficiary of the account. The amount of the account that is a countable resource is its value minus any penalties (e.g., a 10% federal tax penalty) for a non-qualified withdrawal. Ordinary federal, State, and local income taxes are not deductible in determining the resource value.

If an SSI-related minor is an account owner of a New York's 529 College Savings Program (owning the funds in the account rather than just being a designated beneficiary), the assets are a countable resource for the minor.

RESOURCES

RETIREMENT FUNDS

Description: Retirement funds are annuities or work-related plans for providing income when employment ends. They include but are not limited to: pensions; Individual Retirement Accounts (IRAs); 401(k) plans; and Keogh plans.

Policy: A retirement fund owned by an SSI-related individual is a countable resource if the SSI-related individual is not entitled to periodic payments, but is allowed to withdraw any of the funds. The value of the resource is the amount of money that s/he can currently withdraw. If there is a penalty for early withdrawal, the value of the resource is the amount available after the penalty deduction. Any ordinary income taxes due are not deductible in determining the value of the resources.

References:

Dept. Reg.	360-4.4
	360-4.6(b)(2)(iii)
	366
	366-ee
ADMs	11 OHIP/ADM-07
	10 OHIP/ADM-01
	90 ADM-36
	88 ADM-30
GISs	09 MA/027
	06 MA/004
	98 MA/024

Interpretation: A retirement fund is not a countable resource if an individual must terminate employment in order to obtain any payment. If the SSI-related individual is in receipt of or has elected to receive periodic payments, the retirement fund is not a countable resource. Effective October 1, 2011 retirement funds of a participating MBI-WPD A/R or his/her spouse are disregarded.

NOTE: That the SSI-related individual may choose to take money out of a retirement account on a non uniform and/or inconsistent basis. An example would be an individual electing to withdraw $350 from a retirement fund in February and $600 in October. These irregular withdrawals are not treated as periodic payments. The non-periodic distributions are considered a conversion of a resource and not countable income. In this situation, the retirement fund is treated as an available, countable resource.

Effective January 1, 2006, if a Community Spouse (CS) is NOT

RESOURCES

RETIREMENT FUNDS

receiving periodic payments from his/her available retirement fund, the fund is considered a countable resource for purposes of determining the community spouse resource allowance (CSRA) and the institutionalized spouse's Medicaid eligibility. This includes situations where the retirement fund of the CS exceeds the CSRA.

Medicaid applicants/recipients who are eligible for periodic retirement benefits must apply for such maximized benefits as a condition of eligibility. If individual does not choose to apply for available periodic benefits, the LDSS can deny/discontinue Medicaid based on the failure to pursue potential income that may be available.

Verify Status:

(a) When A/R declares a retirement account;

(b) When A/R is receiving retirement income;

(c) When A/R indicates past employment with an employer that is likely to have provided a retirement plan.

Verification:

(a) Seeing current statements from the employer, mutual fund, insurance company, or bank where the fund is deposited;

(b) If a retirement fund is invested in bonds and stock certificates, the current market value may be verified by a stock broker or newspaper.

Documentation:

(a) current information including names of funds, banks and/or companies controlling funds;

(b) names of stocks and/or bonds, issuer's name, date issued, date of maturity if applicable;

(c) account numbers;

(d) name of owner; and

(e) current value.

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PERSONAL NEEDS ALLOWANCE ACCOUNTS

Description: Personal needs allowance (PNA) is the amount that is set aside to meet the personal needs of persons who: are residing in a medical institution and are in permanent absence status; or have community spouses and are in receipt of home and community-based waivered services. The Personal Needs Allowance (PNA) amount is the reduced standard of need for persons who are residing in a medical facility and are in permanent absence status. (See **GLOSSARY**)

Policy: Medical facilities must offer each resident who is a Medicaid recipient or his/her representative the choice of: depositing his/her PNA in an interest bearing account managed by the facility; or managing his/her own PNA account. The PNA account is intended to meet the recipient's incidental expenses not provided by the medical facility.

References:

SSL Sect.	369(b)(i)&(ii) 366(2)(a)(10)
Dept. Reg.	360-4.9 10 NYCRR 415.26(h)(5)
ADM	94 ADM-17

Interpretation: Services included in a facility's Medicaid per diem rate may not be charged against an individual's PNA account. In addition, no charge may be made against the PNA account for other services provided under Medicaid, Medicare, or other third party coverage. When the recipient selects the medical facility to manage his/her PNA funds, the facility must:

(a) maintain an accurate account of the funds, including the nature and dates of all deposits/withdrawals, any accumulated interest and a continuing balance;

(b) document all transactions by securing and maintaining paid bills, vouchers, and signed receipts. The signature of the resident or his/her designated representative is recorded for each transaction;

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PERSONAL NEEDS ALLOWANCE ACCOUNTS

(c) report quarterly to the local social services district. The report must include the recipient's case number, client identification number (CIN), last quarter balance, total receipts, total expenditures, and the current balance; and

(d) notify the recipient when the account balance is $200 less than the SSI resource level for one person. The facility must also advise the recipient that if his/her total countable resources exceed the SSI resource level for one, s/he may lose eligibility for Medicaid.

When a recipient is discharged to the community, the facility must provide the patient with a final accounting statement and a check for the amount of his/her closing balance.

A recipient being transferred to another facility has the option of receiving the balance in his/her account or transferring the balance to an account in the new facility.

Upon the death of a recipient, PNA funds on deposit with a nursing facility generally are payable to the recipient's estate.

Under certain circumstances, the nursing facility can make payment of the deceased recipient's PNA funds on deposit directly to a local social services district. The local social services district determines if any or all of the PNA is recoverable for medical expenses paid. (See **OTHER ELIGIBILITY REQUIREMENTS** RECOVERIES)

Verification/ Documentation: The local social services district is responsible for reviewing the quarterly report to ensure that PNA funds are not misappropriated, and that the recipient's resources remain below the allowable level.

All quarterly reports submitted by medical facilities are reviewed as part of the recertification process. When the report indicates that a recipient is approaching or has exceeded the appropriate resource level, the case is reviewed to determine if the recipient remains eligible.

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PERSONAL NEEDS ALLOWANCE ACCOUNTS

Quarterly reports are reviewed for: the current balance, any significant withdrawals, and any indication of irregularities or misappropriation of the funds in the account. The local social services district has the right to audit the accounts of patients for whom Medicaid payments are made. The facility assists in resolving any questions related to the account.

RESOURCES

LUMP SUM PAYMENTS

Description: Lump sum payments are deferred or delayed payments. They include, but are not limited to benefit awards, bonuses, year-end profit sharing, severance pay, and retroactive pay increases.

Policy: All lump sum payments are reviewed to determine if they are available and countable. (See **OTHER ELIGIBILITY REQUIREMENTS** OWNERSHIP AND AVAILABILITY)

Countable lump sum payments are considered income in the month received. For SSI-related A/Rs, if any or all of the lump sum is retained beyond the month of receipt, it is considered a resource. To determine if a retained lump sum payment is countable as a resource, consult the resource disregard section and look for the specific payment type. (See **RESOURCES** SSI-RELATED RESOURCE DISREGARDS)

References:

SSL Sect.	366 366.2 366-ee
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 92 ADM-11
GIS	09 MA/027

Interpretation: For all A/Rs, lump sum payments are counted as income in the month they are received.

For SSI-related A/Rs only, the month after the lump sum is received it is added to other countable resources and compared to the appropriate resource level. (See **RESOURCES** EXCESS RESOURCES)

Verify Status: Verify status when:

- the A/R indicates that s/he recently received a benefit award, bonus, yearend profit share, retroactive pay increase, or other lump sum.
- the A/R indicates that s/he is anticipating a lump sum payment.
- the record indicates that the A/R has applied for a benefit and may be eligible for a retroactive payment.

RESOURCES

LUMP SUM PAYMENTS

Verification/ Documentation: Lump sum payments are verified. State computer matches are reviewed to determine the source of income. Documentation is sufficient to establish an audit trail. The amount, date and source of all lump sums are documented. The preferred forms of verification/documentation are checks, check stubs, award letters, or other written statements from the payer of the lump sum.

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WINDFALLS

Description: Windfall payments are one-time only payments. They include, but are not limited to, lottery winnings, inheritances, gifts and court settlements.

Policy: When determining eligibility for SSI-related A/Rs, windfall payments are considered countable income in the month received.

When any or all of a windfall payment is retained beyond the month of receipt, it is considered a resource.

References:

SSL Sect.	366 366.2 366-ee
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 92 ADM-11
GIS	09 MA/027

Disposition: For SSI-related A/Rs, windfall payments are considered income in the month of receipt. (See **INCOME** WINDFALLS)

When an SSI-related A/R retains any or all of a windfall payment beyond the month of receipt, it is considered a resource. Together with other countable resources, the windfall is compared to the appropriate resource level. (See **RESOURCES** LEVELS)

RESOURCES

LIFE INSURANCE

Description: Life insurance is a contract between an individual(s) (owner) and an insurance company. The individual(s) pays premiums to the company that provides the insurance and the company in return agrees to pay a specified sum to the designated beneficiary upon the death of the insured. Banks also issue life insurance.

Face Value**:** The basic death benefit or maturity amount of the policy, which is specified, on its face. The face value does not include dividends, additional amounts payable because of accidental death or other special provisions; and

Cash Surrender Value: This is the amount that the insurer will pay upon cancellation of the policy before death (or maturity). This value usually increases with the age of the policy. This amount may be decreased by loans against the policy.

Policy: A life insurance policy is a resource if it generates a cash surrender value (CSV). Its value as a resource is the amount of the CSV. For SSI-related A/Rs, a life insurance policy is an excluded resource if its face value and the face value of any other life insurance policies the individual owns on the same insured total $1,500 or less.

References:

SSL Sect.	366 366(2)(b)(1) 366-ee
Dept. Reg.	360-4.4
ADMs	10 OHIP/ADM-01
GISs	09 MA/027

Interpretation: The basic types of life insurance are defined as follows:

Ordinary Life Insurance (Whole Life): The insured pays premiums during his/her lifetime (straight life) or until the age 100 (unless purchased by a single premium or by letting dividends accumulate). The company pays the face amount or the cash amount, whichever is higher, of the policy to the beneficiary upon the death of the insured. This type of insurance usually has a cash surrender value after the second year**.** The policy is flexible in premium payments. Dividends may be used to pay off the contract at an earlier date, or the

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LIFE INSURANCE

premium payment period can be limited to suit the financial resources of the insured. In this situation, the policy is a limited payment life insurance policy;

Limited Payment: Similar to ordinary life, but the premiums are higher while the period of payment may be reduced. The result is a larger cash reserve than whole life;

Endowment: The face value is payable after the time period for payment of the premiums has expired, or the insured has died; and

Term Insurance: A contract of temporary protection. The insured pays relatively small premiums for a limited number of years. The company agrees to pay the face amount of the policy only if the insured dies within the time specified in the policy. Generally term insurance does not have a cash surrender value, however some newer types have a cash value.

NOTE: Generally ordinary life, limited payment life and endowment policies carry a cash surrender value. Although term insurance frequently has no cash surrender value, in those instances where the agency is aware of a term life insurance policy with a cash surrender value, that policy is treated in the same manner as ordinary life insurance policies. When an insurance policy pays annual dividends and those dividends have accumulated, the cash value will be increased, thus increasing the value of the resource.

Individual and Group Policies:

Individual policies are issued to a person and are paid for entirely by the owner;

Group policies are usually issued through an employer or organization and may receive some contribution from the employer.

Accelerated Life Insurance Payments (Living Needs Benefits): These are cash payments to the owner of a life insurance policy. These benefits may be payable upon the diagnosis of a terminal illness or if the insured will need long term care or treatment. Accelerated payments may be made as lump sums or monthly payments. They reduce the death

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LIFE INSURANCE

benefit and cash surrender value, if any. The availability of the option to elect accelerated benefits is not considered a resource; however, when cash payments are actually made, the payments are considered income in the month received and a countable resource if retained into the following month.

If the consent of another individual is needed to surrender a policy for its cash surrender value and that consent cannot be obtained, the policy is not included as a resource.

When to Verify:

(a) When the SSI-related A/R indicates on the application that s/he has life insurance or is paying premiums;

(b) When the SSI-related A/R indicates s/he is employed or has present or past membership in a labor union;

(c) When an SSI-related A/R indicates that s/he or a member of the family belongs to a fraternal organization, e.g. Elks, Knights of Columbus, etc.;

(d) When an SSI-related A/R indicates in the application that s/he is paying the premium on a life insurance policy for him/herself, family or a person outside the family household; or

(e) When the SSI-related A/R indicates that s/he or a spouse is a veteran or in the armed forces.

Verification: The life insurance policy itself will generally provide all the information needed to determine when it is counted as a resource and the amount to be counted. If the policy does not provide needed information, contact the insurance company, local agent, or, in the case of group insurance, the employer's payroll office.

Documentation: Sufficient to establish an audit trail:

(a) Name of the insurance company, the owner of the policy, name of the insured and the policy number; and

(b) The type of insurance, cash value, face value and the amount of any outstanding loans against the policy.

Owner: To determine the owner of a policy, contact the insurance company issuing the policy.

RESOURCES

STOCKS, BONDS AND SECURITIES

Policy: Stocks, bonds and other securities owned by the A/R are evaluated when determining eligibility for Medicaid. The value of stocks, bonds and securities is considered a countable resource of an SSI-related A/R.

References:

SSL Sect.	366 366.2 366-ee
Dept. Reg.	360-1.2 360-2.3 360-4.4
ADM	10 OHIP/ADM-01
GISs	09 MA/027 08 MA/006 05 MA/001 04 MA/027

Interpretation: The value of stocks, bonds and securities owned by an SSI-related A/R or a legally responsible relative is considered a countable resource for purposes of determining eligibility. (See **OTHER ELIGIBILITY REQUIREMENTS** OWNERSHIP AND AVAILABILITY for determining ownership of resources)

All stocks, bonds and securities are evaluated as to their availability and values. The available value is counted toward the appropriate resources level. (See **RESOURCES** LEVELS)

NOTE: For all Medicaid categories except SSI-related individuals be sure to consider as potential unearned income, dividends and interest received from stocks, bonds and securities. For SSI-related A/Rs who are subject to community budgeting, interest and dividend income from stocks, bonds and securities is excluded from countable income. (See **INCOME** UNEARNED DIVIDENDS AND INTEREST)

Stocks, bonds and securities include, but are not limited to:

- stocks;
- mutual fund shares;
- corporate, municipal and government bonds;
- U.S. Savings Bonds; and
- zero coupon bonds

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STOCKS, BONDS AND SECURITIES

Stocks

Shares of stock represent ownership in a business corporation. The value of a stock is determined by the demand for it at the time it is bought or sold; thus, it may vary from day to day.

Mutual funds

A mutual fund is a pool of assets (e.g., stocks, bonds, etc.) administered by an entity that buys and sells securities and other investments. Absent evidence to the contrary, the owner of a mutual fund share should be able to convert it to cash within 20 working days and thus it is considered an available liquid resource. The current value of a mutual fund may vary from day to day.

Bonds

A bond (e.g., municipal, corporate, and government bond) is not cash, but a promise to pay cash at a future specified date. Most bonds (but not U.S. Savings Bonds) are negotiable and transferable. To redeem a corporate or municipal bond for its stated value, it must be held until the specified date of maturity. The current cash value of a bond is determined by the market for it.

A savings bond is a U.S. Treasury security that increases in value until it is cashed or reaches final maturity. A U.S. Savings Bond is not transferable. It can only be sold back to the federal government. Some bonds must be held for a minimum period of time from the date of issue (e.g., twelve months) before they can be converted to cash. Generally these bonds are not considered an available resource until after the minimum retention period has expired.

Effective February 11, 2008, A/Rs who are in receipt of or are applying for coverage of long-term care services and who own a U.S. Savings Bond must, as a condition of eligibility for Medicaid, request to have the minimum bond retention period waived. A/Rs with Electronic Savings Bonds may request early redemption by email on the United States Department of the Treasury website

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STOCKS, BONDS AND SECURITIES

(http://treasurydirect.gov). For paper bonds, the SSI-related A/R or the A/R's legal representative should contact a financial institution that routinely cashes savings bonds. The A/R must sign the bond in the presence of a certifying officer. The certifying officer must also sign the bond and affix the institution's official stamp or seal in the space provided. The bond(s) and a letter explaining the reason(s) for the hardship request are mailed to the United States Department of the Treasury, Bureau of the Public Debt, PO Box 7012, Parkersburg, WV 26106-7012. When sending bonds for consideration of hardship, the front of the envelope should be marked "HARDSHIP", in capital letters, so the request may be expedited. Federal regulations allow the United States Department of the Treasury to waive the minimum retention period in situations including:

- Unusual or excessive medical expenses;
- Bankruptcy;
- Foreclosures;
- Eviction notice;
- Utility shut-off notice;
- Natural disaster (flood, fire, etc.); and
- Inability to meet essential expenses (food, clothing, house/rent).

Pending notification of approval or disapproval of a hardship request, Medicaid eligibility must be determined without regard to the bond.

If a waiver of the minimum retention period is granted, the value of the bond is counted as a resource for SSI-related A/Rs beginning the first day of the month following the month in which the bond is available. Only the amount actually received is counted as a resource, as early redemption of a savings bond may result in a cash penalty being taken from the bond proceeds.

NOTE: Ordinary income taxes due on the interest earned on the savings bonds are not an allowable deduction from the bond proceeds.

If a waiver of the minimum retention period is not granted, the bond is to be excluded as an available resource for SSI-related A/Rs for the duration of the minimum retention period. If a new bond is purchased with the proceeds from an unavailable bond, the individual is required to apply for a hardship waiver.

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STOCKS, BONDS AND SECURITIES

Copies of hardship requests and denials should be kept in the case record.

The owner of the bond is the individual in whose name the bond is registered is the owner.

However, other individuals (e.g., parents or grandparents) may control a child's access to the money. In these cases, the social security number on the bond may not be that of the actual owner. The Social Security number on the bond is not proof of ownership. If a person other than the A/R will not relinquish possession of the bond, the bond is not considered an available resource.

Savings Bond Interest

Interest on U.S. Savings Bonds is treated as follows:

RESOURCES

STOCKS, BONDS AND SECURITIES

(1) Series E or EE and Series I U.S. Savings Bonds

Interest on series E/EE and Series I U.S. Savings Bonds is only available to the individual when the bond is redeemed. At redemption, for SSI-related individuals the interest is to be counted as an increase in the value of the resource (not as income).

(2) Series HH or H U.S. Savings Bonds

Series HH/H bonds pay interest semi-annually (i.e., every 6 months based on the purchase date of the bond) by check or electronic funds transfer until maturity or redemption, whichever comes first. Interest on these bonds is counted as unearned income in the month available to the A/R, either when the check is received or when the interest is credited (i.e., electronically transferred) to the A/R's account, whichever is earlier. As of September 1, 2004, the U.S. Treasury is no longer issuing HH/H Savings Bonds. Investors are no longer able to reinvest HH/H Bonds or exchange Series EE/E Bonds for HH Bonds.

NOTE: Interest on Savings Bonds is not countable income for SSI-related A/R's under community budgeting.

Zero Coupon Bonds

Purchasers of zero coupon bonds buy the bonds at a deep discount from their face value, which is the amount a bond will be worth when it matures or comes due. As the bond matures it increases in value from its purchase price due to the accrued interest.

Owners of zero coupon bonds do not receive periodic interest payments, even though they have to pay taxes on the imputed or "phantom" interest that accrues each year. If the investor holds the zero coupon bond until maturity, he/she will receive the full face value of the bond (i.e., the initial investment plus interest that has accrued over the years). Investors can purchase different

kinds of zero coupon bonds that have been issued from a variety of sources, including the U.S. Treasury, corporations, and state and local government entities.

For all Medicaid A/Rs, except SSI-related A/R's who are subject to community budgeting, the accrued interest is considered countable unearned income in the month the bond matures. The equity value of the zero coupon bond is a countable resource for SSI-related A/Rs.

Coupon Bonds (Bearer Bonds)

A coupon bond is a bond that pays periodic interest (usually every six (6) months) to the bond holder. Previously such bonds had coupons attached to them which the owner would present to the bond issuer or bank for payment. Coupon bonds have also been known as "bearer bonds" meaning the bearer or the person who had physical possession owned it.

Today such bonds are issued as "registered" meaning the bond is registered in your name and interest is mailed to you every six (6) months. Registered bonds generally do not have coupons attached to them; however, if they pay interest periodically they may be called coupon bonds. Interest is counted as income for all A/Rs.

Verify Status:

(a) When the A/R indicates that s/he or a member of the household owns stocks, bonds or securities;

(b) When the A/R's pay stubs show a deduction for profit sharing;

(c) When an A/R or a member of the household currently or formerly has been employed by a company known to offer profit sharing.

RESOURCES

STOCKS, BONDS, SECURITIES

Verification: The existence of stocks, bonds and securities is verified by seeing the actual stock certificate, bond, note or brokerage statement. If not available, the local district contacts the stockbroker or local bank for verification.

The preferred method for verifying the value of stocks is contact with the A/R's stockbroker. The closing price on the date of application or recertification for over-the-counter stocks may also be verified by consulting the following day's financial or local newspaper. The closing price represents the current market value for stock and the bid price or current market price represents the current market value for a bond. The A/R's statement that a stock is worthless can also be supported by a stockbroker's statement that there is no market for that stock.

When determining the current market value of a mutual fund or bond, other than U.S. Savings Bonds, follow the same procedures as for stock.

To establish the value of a U.S. Savings Bond, the date of issue on the face of the bond and the type of savings bond (EE, HH, etc), are the controlling factors. The value depends on the time elapsed from the date of issue. Although some U.S. Savings Bonds have a table of values on the reverse side, this table is often inaccurate since the interest rate may have changed since the bond was issued. Contact a bank for verification of the current value.

If, after local district examination of a promissory note, it cannot be determined whether it is negotiable or not, a bank is able to resolve the question. If the note is not negotiable, it is not a resource. If negotiable, it is a resource in the amount of the outstanding principal balance.

Documentation: Sufficient to establish an audit trail:

(a) Name of the corporation, stock certificate number, issue date, current market value, name of stock broker or newspaper (including date) from which the value was obtained and the number of shares the A/R owns;

RESOURCES

PROMISSORY NOTES

Policy: Promissory notes owned by an SSI-related A/R or a legally responsible relative are evaluated when determining eligibility for Medicaid. The countable values of promissory notes are considered resources of the A/R.

References:

SSL Sect.	366 366.2 366-ee
Dept. Reg.	360-1.2 360-2.3 360-4.4
ADM	10 OHIP/ADM-01
GISs	09 MA/027 98 MA/030

Interpretation: A promissory note is a written, unconditional promise, signed by a person, to pay a specified sum of money at a specified time or on demand to the person named on the note. For the owner, (i.e., seller or creditor) of the agreement, a promissory note, if negotiable, is considered a resource in the amount of the outstanding principal balance. (See **RESOURCES** TRANSFER OF ASSETS for further information on promissory notes.)

A promissory note owned by an SSI-related A/R or his/her legally responsible relative, if negotiable, is considered a resource in the amount of the outstanding principal balance. Districts should obtain a copy of the promissory note and assume, absent evidence to the contrary, that the note is bona fide and negotiable.

Regardless of whether the promissory note is negotiable, any payments of principal and interest made toward satisfaction of the note are considered income to all A/Rs in establishing or evaluating continued eligibility for assistance.

Verify Status: When the A/R indicates that s/he or a member of the household owns a promissory note.

RESOURCES

REAL PROPERTY

Description: Real property is land and generally whatever is erected upon, growing upon, or affixed to the land. Real property also includes rights arising out of or in connection with land, such as air, mineral, water, or access rights. Real property may be owned in whole or in part. When determining eligibility, all real property owned by an A/R is evaluated.

Policy: When determining Medicaid eligibility for an SSI-related individual, ownership of real property is reviewed in order to determine if it is a countable resource.

The equity value of real property is a countable resource and is applied toward the appropriate resource level, with the following exceptions:

- a homestead is exempt; its value is not applied toward the resource level. (See **INCOME** HOMESTEAD for a definition of homestead);
- a portion of the value of real property used to produce income may be exempt (See **INCOME** RENTAL INCOME); and
- the first $12,000 equity value of real property used to produce personal goods/services is exempt (See **INCOME** RENTAL INCOME) .

The equity value of any second home (See **OTHER ELIGIBILITY REQUIREMENTS** OWNERSHIP AND AVAILABILITY) is determined and is applied toward the appropriate resources level. (See **RESOURCES** LEVELS)

The equity value is derived by subtracting any encumbrances, for example liens and mortgages, from the fair market value.

References:

SSL Sect. 366
366.1
366.2
366-ee

Dept. Reg. 352.23(b)
360-1.4(f)
360-4.4(e)
360-4.7(a)(1)

RESOURCES

REAL PROPERTY

ADMs
10 OHIP/ADM-01
97 ADM-23
OMM/ADM 97-2
91 ADM-30

GIS
09 MA/027

Interpretation: The sections that follow discuss these forms of real property:

- Homestead;
- Contiguous property and non-contiguous property;
- Income-producing property; and
- Property used to produce personal goods/services.

RESOURCES
REAL PROPERTY

HOMESTEAD

Description: A homestead is the primary residence occupied by an A/R and/or members of his/her family in which the A/R has ownership interest. Family members include the A/R's spouse, minor children, certified blind or certified disabled children and other dependent relatives. The homestead includes the home, land and integral parts such as garages and outbuildings. The homestead may be a house, condominium, cooperative apartment or mobile home. Vacation homes, summer homes or cabins are generally not considered homesteads.

NOTE: Land adjoining the homestead, which is on a separate deed, is considered contiguous property, and not part of the homestead. See contiguous property.

Policy: A homestead is exempt as long as it is the primary residence of an SSI-related A/R or a family member. The homestead remains exempt during a period of temporary absence. When an SSI-related A/R is absent from his/her homestead, the homestead is not a countable resource as long as the A/R indicates an intent to return home (regardless of the individual's actual ability to return home).

References:

SSL Sect.	366 366.2(a)(1) 366-ee
Dept. Reg.	360-1.4(f) 360-4.7(a)(1)
ADMs	10 OHIP ADM-01 92 ADM-53 91 ADM-30
GISs	09 MA/027 06 MA/009

Interpretation: A homestead, including an income-producing homestead, is an exempt resource for SSI-related A/Rs, as long as it is the primary residence of the A/R or a family member. If the SSI-related A/R or family member no longer resides in the home that home is evaluated to determine if it is a countable resource.

RESOURCES
REAL PROPERTY

HOMESTEAD

The equity value is derived from subtracting any encumbrances, for example liens, mortgages, etc. from the fair market value.

An SSI-related A/R's homestead and any contiguous property remains exempt as a countable resource if the A/R is not occupying the home, but intends to return to the home. When an A/R expresses his/her intent to return home, the homestead and contiguous property will be treated as an exempt resource without regard to the A/R's actual ability to return home. Although the homestead remains exempt, a lien may be imposed against a permanently institutionalized individual's homestead in certain circumstances. (See **RESOURCES** HOMESTEAD further discussions of liens)

NOTE: A homestead that is an exempt resource must be reviewed under the home equity limit provisions if the A/R is applying for Nursing Facility Services or Community-Based Long Term Care.

RESOURCES

HOMESTEAD

Institutionalized SSI-related A/Rs

INTENT TO RETURN HOME	RESOURCE STATUS	PLACE LIEN *
Yes, intends to return home.		
Occupied by spouse, minor or certified blind or certified disabled adult child	Exempt	No
Occupied by a sibling with equity interest who lived in the home for at least 1 year prior to the A/R's admission to a medical facility.	Exempt	No
Occupied by a dependent relative other than one described above.	Exempt	Yes
No, does not intend to return home.		
Occupied by spouse, minor or certified blind or certified disabled adult child.	Exempt	No
Occupied by a sibling with equity interest who lived in the home for at least 1 year prior to the A/R's admission to a medical facility.	Countable**	No
Occupied by a dependent relative other than one described above.	Exempt	Yes
Not occupied by a relative described above.	Countable	No

*If A/R is not reasonably expected to be discharged from the medical institution and return home.

**However, the property is not countable as a resource if: the sibling's name is on the deed and the sibling does not agree to liquidate the property or purchase the A/R's share of the property; or the sibling is a dependent relative of the A/R.

RESOURCES
REAL PROPERTY

CONTIGUOUS PROPERTY AND NON-CONTIGUOUS PROPERTY

Description: Contiguous property is any land adjoining the homestead, which is held on a separate deed from the homestead and may be liquidated separately. Property is considered to adjoin the homestead if the only intervening real property is an easement or public right of way, such as a street, road or utility. Non-contiguous property is property owned by the A/R that does not adjoin the homestead.

Policy: For SSI-related A/Rs, contiguous property is considered part of the homestead and therefore exempt.

References:

SSL Sect	366 366**-**ee
Dept. Reg.	360-1.4(f) 360-4.4 360-4.7 (a)(1)
ADM	10 OHIP/ADM-01
GISs	09 MA/027 06 MA/009

Interpretation: An A/R may own parcels of land contiguous to his/her homestead. Land is considered to be contiguous when the land is on a separate deed from the homestead and may be liquidated separately from the homestead. Contiguous property is considered an essential part of the homestead of SSI-related A/Rs.

The A/R may also own land, which is not contiguous to the homestead. The equity value of non-contiguous land (other than income-producing property) is considered a resource for SSI-related A/Rs. (See **RESOURCES** REAL PROPERTY INCOME PRODUCING for the treatment of income-producing property)

RESOURCES
REAL PROPERTY

CONTIGUOUS PROPERTY AND NON-CONTIGUOUS PROPERTY

Verification: The preferred method of verifying market value is to obtain an independent appraisal by a licensed real estate appraiser. If this is not practical, use the listed asking price accompanied by a market analysis or appraisal, if any; or, if neither is available, use a full value tax assessment. However, if it is clear based on the approximate value of the property that the SSI-related A/R is ineligible due to excess resources, the local district may rely on a statement from the applicant as to the property's value. The A/R cannot be required to pay for an appraisal.

All liens and mortgages against the property are verified by reviewing the documentation.

RESOURCES
REAL PROPERTY

INCOME-PRODUCING

Description: Real property may produce income as part of a business (for example, the building, which houses a store or factory and which, is listed as an asset of the business). In the alternative, real property can be used to produce income and not be part of a business (for example, the A/R owns a house, which s/he rents to someone else).

Policy: Income-producing real property, which is part of the A/R's homestead is exempt. (See **INCOME** HOMESTEAD)

All non-homestead income-producing real property is reviewed to determine if it is a countable resource. Income-producing real property of an SSI-related A/R used in a trade or business is exempt. Income-producing real property not used in a trade or business is subject to the $12,000 and 6% test explained below.

If income-producing real property produces a net return on equity of 6% or more, the first $12,000 of the SSI-related A/R's equity is not counted. Any remaining equity value plus any other countable resources owned by the SSI-related A/R are compared to the appropriate resource level. (See **RESOURCES** LEVELS)

If the net return is less than 6% of the equity value, the entire equity value of one income-producing real property is a countable resource. The entire real property equity value plus any other countable resources owned by the SSI-related A/R are compared to the appropriate resource level. (See **RESOURCES** LEVELS)

References:

SSL Sect	366 366-ee
Dept. Reg.	360-4.3 (c) & (d) 360-4.4 (b)(3) 360-4.4 (d) ADM 91 ADM-30
ADM	10 OHIP/ADM-01
GIS	09 MA/027

RESOURCES
REAL PROPERTY

INCOME-PRODUCING

Interpretation: When an SSI-related A/R owns income producing real property that is not used in a trade or business, that property is subject to the $12,000 and 6% test. The local district determines the SSI-related A/R's equity value in the real property and the amount of net annual income the A/R receives from the property. Equity value is the current market value minus any legal encumbrances (e.g. mortgages). Equity value includes, but is not limited to the value of land and buildings.

In instances where there is a low rate of return, local districts must determine if the low rate of return is due to reasons beyond the A/R's control. Consideration is given for extraordinary circumstances, such as: drought, fire, etc. If the real property is producing a net annual rate of return below 6% due to extraordinary circumstances, beyond the A/R's control (e.g., drought, fire, illness, etc.), the first $12,000 of equity value can be excluded for up to a 24 month grace period. After the 24-month period the property is evaluated to determine if it is producing a 6% net rate of return. The 24-month period begins the first day of the tax year following the year in which the net rate of return dropped below 6%.

If the SSI-related A/R owns more than one income-producing property not used in a trade or business, each parcel of real property producing income is subject to a 6% test. However, only a maximum equity value of $12,000 can be exempt.

Net income is the gross annual income from the real property less the expenses, as allowed by the Internal Revenue Service (except depreciation and personal business deductions), to produce that income.

Verification/ Documentation: Ownership of real property may be verified by:

a) Deed or mortgage records;
b) Property tax records; or
c) Sales agreements or real estate records.

As with other sources of income, documentation of the income produced by real property is obtained. The preferred documentation is the A/R's tax returns.

RESOURCES
REAL PROPERTY

INCOME-PRODUCING

The A/R's most recent income tax returns are used to determine income from real property. Tax returns for at least two (2) years prior to the current tax year are used to determine whether the property is producing a 6% annual rate of return.

When tax returns are not available or do not provide information concerning property expenses, other documentation can be used. Documentation includes, but is not limited to: receipts, check registers, invoices, sales slips and bank statements.

RESOURCES
REAL PROPERTY

PRODUCING PERSONAL GOODS/SERVICES

Description: Real property used to produce personal goods/services includes, but is not limited to: garden plots; wood lots; and pastureland.

Policy: Real property which is used to produce personal goods/services and which is part of the A/R's homestead is exempt. (See **RESOURCES** REAL PROPERTY HOMESTEAD)

All non-homestead real property of an SSI-related A/R used to produce personal goods/services is reviewed to determine if it is a countable resource.

Interpretation: For SSI-related A/Rs, the first $12,000 equity value of any non-homestead real property used to produce personal goods/services is exempt. If the SSI-related A/R owns more than one piece of real property that produces personal goods/services only a total equity value of $12,000 is exempt. The remaining equity value plus any other countable resources owned by the SSI-related A/R are compared to the appropriate resource level.

NOTE: There is no 6% test as there is for income-producing property. (See **RESOURCES** REAL PROPERTY INCOME-PRODUCING)

References:

Dept. Reg.	360-4.4(d)(3) 366 366-ee
ADMs	10 OHIP/ADM-01 91 ADM-30
GIS	09 MA/027

RESOURCES

ESSENTIAL PERSONAL PROPERTY

Policy: Household goods and personal effects determined essential property is exempt from consideration in determining eligibility for Medicaid. If they are non-essential, their value is considered with all other countable resources in determining an SSI-related A/Rs eligibility for Medicaid.

References:

SSL Sect. 366
366.2(a)(2)
366-ee

Dept. Reg. 360-4.4(a)
360-4.7(a)(2)

ADM 10 OHIP/ADM-01

GIS 09 MA/027

Interpretation: Items which are considered essential personal property include but are not limited to:

- household furniture;
- personal effects;
- household appliances;
- televisions;
- radios;
- stereos, records, CDs, and cassette tapes;
- china & flatware;
- clothing;
- jewelry with sentimental value, e.g. wedding or engagement rings, family heirlooms;
- books;
- household tools, such as a lawn mower, garden tools, home repair tools, etc.; and
- tools and equipment which are necessary for a trade, occupation or business.

NOTE: See **RESOURCES** PERSONAL PROPERTY AUTOMOBILES AND OTHER VEHICLES for the treatment of automobiles as essential personal property.

RESOURCES

ESSENTIAL PERSONAL PROPERTY

The major consideration in exempting personal property is that the SSI-related A/R or members of his/her household are currently using it. If, for example, the A/R is in a nursing home, does not intend to return home and there are no other members of the family living in the household, his/her household goods and personal effects are evaluated together with other assets and may be considered as available resources.

Jewelry such as wedding or engagement rings, wristwatches or other similar items of personal property are exempt. If, however, the SSI-related A/R has chosen to invest in jewelry, antiques, etc., the property is not considered an exempt resource.

Collections such as stamps, coins or books are evaluated. If they are of limited value, they need not be considered. Valuable collections, however, are considered together with other available resources of the SSI-related A/R.

Verification: If the SSI-related A/R owns household goods, or personal effects which are not being used, their value may be determined by obtaining appraisals from the appropriate qualified professionals, e.g., jewelers, coin or stamp dealers, furriers, etc.

Documentation: Sufficient to establish an audit trail:

Any household goods, or personal effects, which are determined nonessential, are documented as to their value, including any identifying numbers or characteristics.

RESOURCES
PERSONAL PROPERTY

AUTOMOBILES AND OTHER VEHICLES

Policy: Ownership of one or more automobiles by an SSI-related A/R is reviewed and evaluated.

An automobile of any value is exempt as long as the SSI-A/R or a member of his/her household is using it. An automobile that is temporarily inoperable may be excluded if it is expected to be used for transportation within 12 calendar months after the month of the Medicaid eligibility determination. A second automobile may be exempt if there is a medical need for it, or the automobile is needed for employment-related activities or a Plan for Achieving Self-Support (PASS). If an automobile does not meet any of the exemption criteria, it loses its exempt status, and the full equity value of the automobile is a countable resource. The equity value of an automobile is the price the car can reasonably be expected to sell for on the open market in a particular geographic area, minus any encumbrances.

RESOURCES
PERSONAL PROPERTY

AUTOMOBILES AND OTHER VEHICLES

References:

SSL Sect.	366 366.2(a)(2) 366-ee
Dept. Reg.	360-4.7(a)(2)(iv)
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2
INF	98 OMM/INF-02
GISs	09 MA/027 09 MA/016 05 MA/029

Interpretation: A second automobile is exempt if there is a medical need for it or the automobile is needed for employment-related activities or a Plan to Achieve Self-Support (PASS).

Recreational vehicles such as campers, snowmobiles and boats are not exempt unless the SSI-related A/R can demonstrate that the vehicle is essential for the production of a livelihood or is essential for personal use. An example is a person who lives on an island and needs a boat for such everyday tasks as buying food, going to work, or visiting the doctor.

Verify Status:

(a) When the SSI-related A/R declares ownership of one or more automobiles or other motor vehicles;

(b) When the SSI-related A/R lives a substantial distance from his/her place of employment;

RESOURCES
PERSONAL PROPERTY

AUTOMOBILES AND OTHER VEHICLES

(c) When the SSI-related A/R declares an occupation or business which requires travel;

(d) When the SSI-related A/R states that s/he or a member of the household travels regularly for medical care and services;

(e) When the SSI-related A/R declares ownership of a driver's license.

Verification: The primary verification for ownership of a motor vehicle is the motor vehicle registration. The New York State Department of Motor Vehicles (DMV) can also establish whether or not the A/R owns or has owned an automobile and furnish information on the vehicle. Information available usually includes the purchase price, encumbrances against the vehicle, and the name of the organization financing the purchase. DMV can also establish non-ownership of a vehicle.

The "Blue Book" of car values is an additional source to establish the market value of motor vehicles. Other sources include car dealers who can provide an approximate value based on the make, year, and model of the vehicle.

Documentation: Sufficient to establish an audit trail:

(a) The make, model, year, and identification number of motor vehicles owned by the SSI-related A/R are documented in the case record; and/or
(b) If exempted, the reasons are also recorded in the case record.

RESOURCES

BUSINESS PROPERTY

Policy: When determining eligibility for an SSI-related A/R, business property and all cash reserves necessary for the operation of the business are exempt.

Liquid business resources must be held in a separate business account and cannot be commingled with personal funds.

Business property includes, but is not limited to: motor vehicles; machinery; farm equipment; inventories; supplies; tools; equipment; government permits; livestock; and produce.

(See **RESOURCES** REAL PROPERTY INCOME-PRODUCING for the treatment of real property that is also income-producing.)

Interpretation: For any portion of trade or business property to be exempt, the property must be in current use or there must be a reasonable expectation that the property will be used to produce income within 12 months from the month in which the property stopped producing income. An additional 12 months may be allowed when the property is not in use due to the A/R being disabled. The A/R need not be certified disabled.

References:

SSL Sect.	366 366-ee
Dept. Reg.	352.23(b)(7) 360-4.4(a)(3) 360-4.4(d)
ADMs	10 OHIP/ADM-10 91 ADM-30
GIS	09 MA/027

RESOURCES

BUSINESS PROPERTY

Verification/ Documentation: Indications that an SSI-related A/R has an equity interest in a business or trade include, but are not limited to: the A/R files a business tax return with the appropriate IRS Schedule (F for farms, E for non-business, C for sole proprietorship, 1065 for partnership or 1120 for corporations); a certified statement from an accountant; business expenses or receipts for the last 12 months; the trade or business has separately identifiable assets; the trade or business has a name; the trade or business has consistently produced income; the trade or business has been in continual operation; the A/R has no other occupation; the A/R presents him/herself as operating a trade or business; or the A/R signs a statement detailing the trade or business, including its assets, number of years in operation and the identity of any co-owners.

RESOURCES

LIFE ESTATES

Description: A life estate is limited interest in real property. A life estate holder does not have full title to the property, but has the use of the property for his or her lifetime, or for a specified period. Generally, a person possesses a life estate in property that the person is using, or has used, for a homestead.

Policy: For the purpose of determining an SSI-related A/R's net available resources, a life estate is not considered a countable resource, and no lien may be placed on the life estate. Local social services districts cannot require an SSI-related A/R possessing a life estate to try to liquidate the life estate interest or to rent the life estate property.

References:

SSL Sect	366 366-ee
Dept. Reg.	360-4.4(c)
ADMs	10 OHIP/ADM-01 06 OMM/ADM-5 96 ADM-8
GISs	09 MA/027 06 MA/016

Interpretation: If an SSI-related A/R transfers property and retains a life use for his/her lifetime the value of the life estate is subtracted from the fair market value of the property in determining the uncompensated value of the transfer.

The value of a life estate is determined based on the current fair market value of the property and the age of the person and a life estate table. A life estate and remainder interest table is contained in 96 ADM-8. Local districts may, but are not required to, use this table in calculating the value of life estates and remainder interests. If a life estate terminates at a time other than death, for example, when the life use holder enters a nursing home or leaves the property without intent to return, compensation for the retained/remaining life use can only be given for the time the A/R received life use.

If an SSI-related A/R possessing a life estate sells the life estate interest, the proceeds of this liquidation are a countable resource for purposes

of the A/R's Medicaid eligibility. If the SSI-related A/R sells the life estate interest for less than fair market value, the uncompensated value of the life estate interest is the amount transferred for purposes of the Medicaid transfer-of-assets rule.

If an A/R possessing a life estate rents the property, any net rental income received is counted in determining eligibility. Unless the instrument creating the life estate indicates otherwise, it is assumed the life estate holder pays taxes and maintenance on the property. These costs can be deducted from the rental income. If the life estate holder does not pay any taxes or maintenance, a gross rental figure is used.

When an SSI-related A/R or the A/R's spouse transfers assets to purchase a life estate interest in property owned by another individual on or after February 8, 2006, the purchase is to be treated as a transfer of assets for less than fair market value unless the purchaser resides in the home for at least a continuous period of one year after the date of purchase. (See **RESOURCES**: TRANSFER OF ASSETS for additional information.)

RESOURCES

MORTGAGES AND CONTRACTS OF SALE

Description: A mortgage is a pledge of real property for the payment of a debt or the performance of some other obligation, within a prescribed time period.

A contract of sale is when the A/R sells property but does not receive payment in full for the property. The purchaser pays for the property in installments. The A/R may retain certain rights to the property until the contract is paid in full.

Policy: Mortgage agreements/contracts of sale are assumed to be negotiable unless the A/R presents convincing evidence of a legal impediment to transferring ownership.

For SSI-related A/Rs if there is no legal impediment to transferring the mortgage/contract of sale, the value of the mortgage/contract of sale is an available resource. The debtor's payments against the principal are considered the conversion of part of this resource, and thus are not counted as income in determining eligibility. The debtor's payments of interest are counted as unearned income. The value of the mortgage is the outstanding principal balance, unless the SSI-related A/R documents that the current market value of the mortgage is less by submitting an evaluation from someone regularly engaged in the business of making such evaluations, such as a bank or other financial institution, licensed private investor or real estate broker.

For Medicaid A/Rs who are not subject to a resource test, the debtor's payments of principal and interest are counted as unearned income.

If there is a legal impediment to transferring the mortgage/contract of sale, the value of the mortgage is not counted as an available resource for the SSI-related A/R. However, the debtor's payments of both principal and interest are counted as unearned income for A/Rs of all categories.

If the SSI-related A/R sells a mortgage for less than fair market value, the sale is reviewed as a potential prohibited transfer.

If the mortgage/contract of sale is satisfied (paid off) with a lump sum payment, or sold for a lump sum, that lump sum is considered a countable resource of an SSI-related A/R.

RESOURCES

MORTGAGES AND CONTRACTS OF SALE

References:

SSL Sect.	366 366-ee
Dept. Reg.	352.23
ADMs	10 OHIP/ADM-01 06 OMM/ADM-5 96 ADM-8
GISs	09MA/-027 06 MA/016

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MORTGAGES AND CONTRACTS OF SALE

Interpretation: The local district evaluates whether or not there is a legal impediment to transferring/selling the mortgage/contract of sale. If there is a legal impediment to transferring/selling, the mortgage/contract of sale, then it is considered an unavailable resource in determining eligibility for the SSI-related A/R.

NOTE: For applications filed on or after August 1, 2006, for nursing facility services, including requests for an increase in coverage of nursing facility services, if an A/R or the A/R's spouse purchases a loan, promissory note or mortgage, the funds used are to be treated as a transfer for less than fair market value unless certain criteria are met. (See **RESOURCES** TRANSFER OF ASSETS for more information.)

When to Verify:

(a) When the A/R indicates that s/he owns a mortgage, contract of sale or life estate;

(b) When the A/R indicates ownership of property other than a homestead;

(c) When the A/R indicates that s/he has transferred property;

(d) When the A/R indicates that s/he receives income from property;

(e) When the A/R indicates that s/he does not have a shelter expense.

Verification: The existence and terms of mortgages and contracts of sale are verified by seeing the actual mortgage certificate or contract document. If this is not possible, the attorney who handled the mortgage contract, when one was involved may provide verification.

Documentation: Sufficient to establish an audit trail:

(a) Type of document, name of owner, date of contract/ mortgage, date of maturity, current value, value at maturity;

(b) Name, address and title of person providing information.

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TRUST FUNDS

Description: A trust is a legal instrument by which an individual gives control over his/her assets to another (the trustee) to disburse according to the instructions of the individual creating the trust.

Policy: Trust funds are real or personal property held by a party known as the trustee. The trustee has the duty of administering such funds or property for the benefit of the beneficiary of the trust. The beneficiary does not own trust funds, either private or established by court order. They are under the control of a trustee who must carry out the conditions of payment as specified in the trust.

Trusts must be evaluated to determine if there is any countable income and/or resources and to determine if there has been a transfer of assets for less than fair market value. The treatment of trusts depends on who established the trust and what type of trust it is.

References:

SSL Sect.	366 366.2(b)
Dept. Reg.	360-4.4 360-4.5
ADMs	10 OHIP/ADM-10 04 OMM/ADM-6 96 ADM-8 92 ADM-45 89 ADM-45 88 ADM-32
INFs	05 OMM/INF-1
GISs	09 MA/027 08 MA/020

Interpretation: There are a number of different types of trusts, including escrow accounts and investment accounts.

a. **Exception Trusts** – Exception trusts are trusts established on or after August 11, 1993, which are required to be disregarded as available income and resources for the purposes of determining Medicaid eligibility. Income diverted directly to an exception trust or income received

by an A/R and then placed into an exception trust is not counted as income to the A/R in the Medicaid eligibility determination process. Verification that the income was placed into the trust is required. In order to eliminate a monthly verification, the A/R is advised to have the income diverted directly to the exception trust. Any trust assets actually distributed to the A/R are counted as income in the month received and as a resource for SSI-related A/Rs if retained into subsequent months. Exception trusts generally will conform to the definition of supplemental needs trust. There are two types of exception trusts:

(1) One type of exception trust is a trust created for the benefit of a disabled person under the age of 65. It must:

be created with the individual's own assets;

be created by the disabled person's parent, grandparent, legal guardian, or by a court of competent jurisdiction; and,

include language specifying that upon the death of the disabled person, the local social services district will receive all amounts remaining in the trust, up to the amount of Medicaid paid out on behalf of the individual.

Once established, additional funds can be added to the trust until the person reaches age 65. However, any additions to the trust made after the person reaches age 65 would be treated as a transfer of assets, and may require the imposition of a penalty period. If a local district

has imposed a Social Services Law Section 104-b or Section 369 lien against assets to be used to establish an exception trust, the lien is satisfied (or, in the district's discretion, compromise) before the trust is established.

(2) The other type of exception trust is a trust created for the benefit of a disabled person of any age, and is a pooled trust, as described below:

the trust is established and managed by a non-profit association per Section 1917(d)(4)(C)(i) of the Social Security Act;

the assets are pooled with other assets and are managed by a non-profit organization which maintains separate accounts for each person whose assets are included in the pooled trust;

the disabled individual's account in the trust is established by the disabled individual, by the disabled individual's parent, grandparent or legal guardian, or by a court of competent jurisdiction;

the trust will be disregarded for Medicaid purposes regardless of the age of the individual when the pooled trust account is established, or when the assets are added to the pooled trust account; however, there is no exception to the transfer rules for transfers of assets to trusts created for the benefit of persons 65 years of age or older;

upon the death of the individual, the district's right of recovery is limited to those funds not retained by the non-profit organization; and

if the trust is subject to oversight by the NYS Attorney General's office, no bonding is required.

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NOTE: Although exception trusts created in accordance with the criteria set forth above are exempt as resources in the eligibility determination process regardless of the disabled individual's age, for purposes of the transfer provisions, any additions to the trust after the individual becomes 65 years of age are subject to applicable transfer penalties.

Amounts paid out of the pooled trust for the benefit of the disabled individual subsequent to the transfer and prior to the Medicaid eligibility determination for nursing home care must be used to offset all or a portion of the assets transferred to the trust. It is the responsibility of the disabled individual to provide proof of the amounts that the non-profit association which managed the pooled trust paid for expenses to meet the needs of the individual during this period. (See **RESOURCES** TRANSFER OF ASSETS)

It is the responsibility of the trustee of an exception trust to ensure that the funds are expended for the benefit of the disabled person. In some cases, this disbursal of funds may indirectly benefit someone other than the beneficiary. Such disbursals are valid, as long as the primary benefit accrues to the disabled person. For example, payment of travel expenses for a companion to a disabled person going on vacation may be appropriate. Also, the abilities and capabilities of the person are taken into account. The purchase of sophisticated computer equipment to assist a physically disabled person to communicate would be considered appropriate, while purchase of the same type of equipment for an individual who could not be trained to use it, would not.

b. **Irrevocable Trust** – An irrevocable trust is a trust created by an individual, over which the individual may or may not be able to exercise some control, but which may not be cancelled under any circumstances.

When an irrevocable trust is established by an SSI-related A/R or the A/R's spouse on or after August 11, 1993, any portion of the trust principal, and income generated by the trust principal, from which no payments may be made to or for the benefit of

the A/R or the A/R's spouse, is considered to be an asset transferred for less than fair market value for purposes of the transfer of assets rule. (See **RESOURCES** TRANSFER OF ASSETS)

1. Payments made from the trust to or for the benefit of the A/R of any category or the A/R's spouse are considered available income in the month received. Any portion of the principal of the trust, or the income generated from the trust, which can be paid to or for the benefit of the SSI-related A/R or the A/R's spouse, is considered an available resource. If the language of the trust specifies that the money can be made available for a specific event, that amount is considered an available resource to an SSI-related A/R, whether or not that event has occurred.

2. Payments which are made from trust assets considered available to the SSI-related A/R or the A/R's spouse, as described in paragraph (1) above, and which are not made to or for the benefit of the A/R or the A/R's spouse, are considered assets transferred for less than fair market value for purposes of the transfer of assets rule. (See **RESOURCES** TRANSFER OF ASSETS)

c. **Revocable Trust** – A revocable trust is a trust created by an individual, which the individual has the right to revoke or terminate.

When a revocable trust is established by an SSI-related A/R or the A/R's spouse, the entire value of the trust is considered an available resource.

1. All payments made from the trust to or for the benefit of the A/R of any category or the A/R's spouse are considered available income in the month received.
2. All payments made from the trust fund to a person other than the SSI-related A/R or the A/R's spouse are considered to be assets transferred for less than fair market value for purposes of the transfer of assets rule. (See **RESOURCES** TRANSFER OF ASSETS)

d. **Supplemental Needs Trust (SNT)** – A supplemental

needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trust Law, is a trust established for the benefit of an individual of any age with a severe and chronic or persistent impairment, designed to supplement government benefits for which the individual is otherwise eligible. Under the terms of such a trust:

1. the beneficiary does not have the power to assign, encumber, direct, distribute, or authorize distributions from the trust; and

2. the trust document generally prohibits the trustee from expending funds in any way that would diminish the beneficiary's eligibility for or receipt of any type of government benefit.

If a supplemental needs trust conforms to the rules of an exception trust, the trust is not counted for the purpose of determining the eligibility of the A/R who is the beneficiary of the trust. (See **RESOURCES** EXCEPTION TRUST) If the trust was created from the A/R's own assets and the trust is not an exception trust, the rules for irrevocable trust apply. Payments made to and for the benefit of a disabled person, other than for personal items, are considered available income. If a supplemental needs trust is created with the assets of someone other than the A/R and the trust is not an exception trust, the trust is a third party trust as defined below. Any distribution of trust assets actually made to the A/R of any category is counted as income in the month received.

e. **Testamentary Trust** – A testamentary trust is any trust established by will. Testamentary trusts are third party trusts, as defined below.

f. **Third Party Trusts** – A third party trust is a trust established with the funds of someone other than the A/R. A third party trust may or may not be a supplemental needs trust, as defined in Section 7-1.12 of the Estates, Powers and Trust Law. For purposes of

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determining the eligibility of an A/R who is a beneficiary of a third party trust, the principal and accumulated income of the trust are not considered available to the A/R. However, any distributions of trust assets actually made to an A/R of any category are counted as income in the month received.

Verify Status:

(a) When the A/R states that s/he or a member of the household is the trustee of a trust fund;

(b) When the A/R states that s/he or a member of the household is the beneficiary of a trust fund;

(c) When the A/R states that s/he or a member of the household has created a trust;

(d) When the A/R states that s/he has a child who was injured in an accident.

Verification: The local district contacts the trustee, court or financial institution involved to obtain a copy of the trust, determine the terms of the trust, and whether or not it can be invaded.

NOTE: Although SSI-related Medicaid A/Rs who are not seeking coverage of long-term care services (Community Coverage without Long-Term Care) may attest to the amount of their resources at application (See **RESOURCES** DOCUMENTATION REQUIREMENTS), they must provide documentation of any trust agreement in which the applicant is named the creator or beneficiary. This enables the district to determine the availability of any trust income/principal.

Documentation: Sufficient to establish an audit trail:

(a) Type of trust, name of trustee, name of beneficiary, amount of trust, amount and frequency of payments derived from the trust; and

(b) Name of person contacted for verification of trust, date of contact, determination of availability with reasonable explanation.

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PRE-NEED FUNERAL AGREEMENTS

Description: As a result of changes in State law, effective January 1, 1997, all Medicaid A/Rs may establish an irrevocable pre-need funeral agreement with a funeral firm, funeral director, undertaker, or any other person, firm or corporation which can create such an agreement. The agreement may be made with the assets of the A/R or the assets of a legally responsible relative. Effective January 1, 2011, such irrevocable pre-need funeral agreements may be for the funeral and/or burial expenses of the A/R or his/her family member. Moneys paid for such an agreement are held in trust and cannot be refunded to the Medicaid A/R or other purchaser of pre-need goods and services.

Policy: Pre-need funeral agreements entered into by Medicaid A/Rs on or after January 1, 1997 with assets of the A/R or a legally responsible relative must be irrevocable. As such the A/R is not entitled to have his/her money returned once it is paid. Any funds remaining after payment of all funeral and burial expenses must be paid to the social services official responsible for arranging indigent burials in the district where the decedent resided.

Effective January 1, 2011, pre-need funeral agreements established with assets of an A/R or legally responsible relative for the funeral and/or burial expenses of a family member must also be irrevocable and are subject to the rules described above.

Since the money paid in connection with such agreements must be used only for funeral and burial expenses they are not available resources of the A/R. As long as the A/R pays fair market value for the goods and services to be furnished, the amount paid to the funeral director is a compensated transfer of assets, and does not result in a transfer-of-assets penalty. The A/R, therefore, can purchase non-burial space items in excess of $1,500 ($3,000 for a couple) through an irrevocable pre-need funeral agreement.

Generally, all pre-paid burial space items are covered under the irrevocable pre-need funeral agreement. However, certain burial space items purchased and paid for in full prior to entering into an irrevocable pre-need funeral agreement may remain outside the agreement, such as a cemetery plot, urn, vault, mausoleum, crypt, or headstone.

NOTE: Effective January 1, 2010 the resource test applies ONLY to Medicaid A/Rs who are SSI-related. Therefore a review of a pre-need funeral agreement is not required for Medicaid applicants who do not have a resource test.

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PRE-NEED FUNERAL AGREEMENTS

In certain situations, SSI-related A/Rs may supplement their irrevocable pre-need funeral agreement with a separate burial fund. To determine if a supplemental burial fund would be allowed, the local district determines the amount designated for non-burial space items in the irrevocable pre-need funeral agreement. If that amount does not equal $1,500 ($3,000 for a couple) the SSI-related A/R and the A/R's spouse may establish a supplemental burial fund. A supplemental burial fund must be separately identifiable with a maximum initial value of $1,500 ($3,000 for a couple), or greater if it is court ordered. Court ordered burial funds are allowed in any amount. However, should the court ordered burial fund exceed $1,500 ($3,000 for a couple) the district may appeal the order. If the court ordered burial fund is less than $1,500 ($3,000 for a couple) a supplemental burial fund may be established as appropriate. Exempt burial funds cannot be commingled with non-burial related expenses.

Life insurance policies will be counted first toward the supplemental burial fund, as follows:

1. If the combined face value of the life insurance policies owned by the A/R is $1,500 or less, add the amount designated for non-burial space items in the irrevocable funeral agreement to the combined face value of the life insurance policies. If the total is less than $1,500 a supplemental burial fund for the difference is allowed.
2. If the combined face value of life insurance policies is greater than $1,500, the cash value is a countable resource. The A/R may designate the cash value as a burial fund in order to bring the non-burial space items up to the allowable $1,500. If the life insurance policies have a face value of greater than $1,500 and their cash value exceeds $1,500 only $1,500 of the cash value is exempt as a burial fund. Any cash value in excess of the allowable supplemental burial fund is a countable resource.
3. When the cash value exceeds $1,500 the A/R must provide a written statement that the entire cash value is intended for burial expenses. Although only $1,500 may be disregarded, the excess over $1,500 is considered funds set aside for burial expenses which avoids the prohibition against commingling burial funds with non burial-related funds.
4. If the A/R does not have life insurance or the face/cash value, as applicable, does not equal $1,500 other resources may be used to establish or add to a burial fund.

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The same rules are applied when determining whether a supplemental burial fund may be established for the A/R's spouse.

NOTE: If the SSI-related A/R has more than $1,500 ($3,000 for a couple) designated for non-burial space items in the irrevocable pre-need funeral agreement, the entire amount paid in connection with the agreement is disregarded. However, the SSI-related A/R is not allowed to have a separate burial fund.

In instances when a pre-need funeral agreement contains an amount of $1,500 ($3,000 for a couple) or more which is designated for non-burial space items, an SSI-related A/R is, nevertheless, entitled to a separate disregard of the cash value of life insurance policies with a combined face value of $1,500 ($3,000 for a couple) or less. (See **RESOURCES** BURIAL SPACES for a discussion of burial space items.)

An SSI-related A/R who is eligible to spenddown excess resources must be given ten days from the date they are advised of an excess resource amount to reduce the excess resource by establishing an irrevocable pre-need funeral agreement and/or a burial fund. In establishing eligibility for the three month retroactive period, only amounts used to purchase an irrevocable funeral agreement and/or a burial fund for the applicant and the applicant's spouse can be used to reduce excess resources. The ten day period may be extended if more time is needed.

Pre-1997 Funeral Agreements

An SSI-related A/R who did not have Medicaid eligibility authorized prior to January 1, 1997, and who has a revocable funeral agreement worth more than $1,500, must convert the agreement to an irrevocable pre-need funeral agreement in order to have the entire amount of the agreement disregarded. If the agreement remains revocable, only the amounts designated for non-burial space items (up to $1,500 for an individual and $3,000 for a couple) can be disregarded.

The SSI-related A/R is allowed ten days from the date of notification to convert the revocable agreement to an irrevocable one. The ten-day period may be extended if more time is needed.

An SSI-related Medicaid recipient whose receipt of Medicaid began prior to January 1, 1997 and who had a revocable pre-need funeral agreement in place, which was considered exempt, may either

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PRE-NEED FUNERAL AGREEMENTS

maintain the revocable agreement or establish an irrevocable agreement.

Family Member Irrevocable Pre-Need Agreements

In determining the eligibility of an SSI-related A/R, the district must review any pre-need funeral agreement purchased by the A/R or his/her spouse for a family member of the A/R to determine if it is exempt. If the agreement was established after January 1, 2011, is irrevocable and contains the appropriate irrevocable disclosure statement, it is disregarded. If the purchase of the agreement is prior to the month the A/R is seeking Medicaid coverage, the amount used to purchase the agreement is a considered a countable resource until the month following the month in which the funds are actually paid to a funeral director. Retroactive eligibility cannot be established by spending down excess resources though the purchase of irrevocable pre-need funeral agreements for family members.

Revocable pre-need agreements for an SSI-related A/R's family member established prior to January 1, 2011 and those purchased on or after January 1, 2011 but before the filing of an application for Medicaid must be converted to an irrevocable agreement or the value of the agreement will be treated as a countable resource. The A/R must be allowed ten days from the date of notification to convert the family member's revocable pre-need agreement to an irrevocable agreement. The ten day period may be extended if more time is needed.

For individuals applying for coverage of nursing facility services, where a pre-need funeral agreement was purchased for a family member during the look –back period, an itemized statement of services and merchandise purchased under the irrevocable pre-need agreement must be reviewed to determine whether an uncompensated transfer of assets has been made.

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PRE-NEED FUNERAL AGREEMENTS

Reference:

SSL Sect. 366
366-ee
209.6
141.6

General Business Law Sect. 453

Dept. Reg. 360-4.6(b)(1)
360-4.6(b)(2)(ii)
360-4.7(a)(3)

ADMs 11 OHIP/ADM-4
10 OHIP/ADM-01
04 OMM/ADM-6

GIS 09 MA/027

Interpretation:

Although the entire amount of money in an irrevocable pre-need funeral agreement is exempt for an SSI-related A/R, the local district reviews a copy of the pre-need burial agreement to make sure that it is irrevocable.

NOTE: Although SSI-related Medicaid A/Rs who are not seeking coverage of long-term care services (Community Coverage without Long-Term Care (See **RESOURCES** DOCUMENTATION REQUIREMENTS) may attest to the amount of their resources at application, they must provide a copy of their irrevocable pre-need funeral agreement to the local social services district for verification of the type of agreement.

In determining whether a pre-need funeral agreement established for the A/R or a family member with assets of the A/R or the A/R's legally responsible relative is irrevocable, the local social services district must review:

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1. the date of the agreement: pre-need funeral agreements entered into by Medicaid A/Rs on or after January 1, 1997 are required by law to be irrevocable; and

2. the language of the agreement. Irrevocable pre-need funeral agreements are required by law to contain the following disclosure statement:

   "NEW YORK LAW REQUIRES THIS AGREEMENT TO BE IRREVOCABLE FOR APPLICANTS FOR RECEIPT OF SUPPLEMENTAL SECURITY BENEFITS UNDER SECTION TWO HUNDRED NINE OF THE SOCIAL SERVICES LAW OR OF MEDICAL ASSISTANCE UNDER SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW, AND FOR THE MONEYS PUT INTO A TRUST UNDER THIS AGREEMENT TO BE USED ONLY FOR FUNERAL AND BURIAL EXPENSES. IF ANY MONEY IS LEFT OVER AFTER YOUR FUNERAL AND BURIAL EXPENSES HAVE BEEN PAID, IT WILL GO TO THE COUNTY. YOU MAY CHANGE YOUR CHOICE OF FUNERAL HOME AT ANY TIME."

Effective January 1, 2011 all irrevocable pre-need funeral agreements created in New York are required by law to contain the following revised disclosure statement:

"NEW YORK LAW REQUIRES THIS AGREEMENT TO BE IRREVOCABLE FOR APPLICANTS FOR AND RECIPIENTS OF SUPPLEMENTAL SECURITY BENEFITS UNDER SECTION TWO HUNDRED NINE OF THE SOCIAL SERVICES LAW OR OF MEDICAL ASSISTANCE UNDER SECTION THREE HUNDRED SIXTY-SIX OF THE SOCIAL SERVICES LAW, AND FOR THE MONEYS PUT INTO A TRUST UNDER THIS AGREEMENT TO BE USED ONLY FOR FUNERAL AND BURIAL EXPENSES. WHETHER THIS AGREEMENT IS FOR YOUR FUNERAL AND BURIAL EXPENSES OR FOR THOSE OF A FAMILY MEMBER, IF ANY MONEY IS LEFT OVER AFTER YOUR FUNERAL AND BURIAL EXPENSES HAVE BEEN PAID, IT WILL GO TO THE COUNTY. YOU MAY CHANGE YOUR CHOICE OF FUNERAL HOME AT ANY TIME. IF THIS AGREEMENT IS FOR THE FUNERAL AND BURIAL EXPENSES OF A FAMILY MEMBER, AFTER YOUR DEATH SUCH FAMILY MEMBER MAY CHANGE THE CHOICE OF FUNERAL HOME AT ANY TIME."

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In reviewing an irrevocable pre-need funeral agreement, the only reason for a local social services district to break out the non-burial space items from the burial space items is to determine whether an SSI-related A/R has paid at least $1,500 ($3,000 for a couple) for non-burial space items under the agreement. As described above, if less than $1,500 ($3,000 for a couple) has been paid for non-burial space items, the SSI-related A/R may establish a supplemental burial fund in addition to the pre-need funeral agreement.

Burial space items include conventional gravesites, crypts, vaults, mausoleums, caskets, urns, or other repositories customarily and traditionally used for the remains of deceased persons. Opening and closing the grave, perpetual care of gravesite, headstones, and headstone engraving are also considered burial space items. Non-burial space items include topical disinfection, custodial care, dressing/casketing, cosmetology, supervision for visitation and/or funeral service, hearse, death notices, flowers and out-of-town shipping.

NOTE: Pre-existing irrevocable pre-need funeral agreements established in another state do not have to be converted and shall be disregarded. In addition, an out-of-state irrevocable pre-need funeral agreement does not have to contain the disclosure language set forth above.

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BURIAL FUNDS

Description: A burial fund consists of liquid resources set aside for the purpose of paying for the A/R's or the A/R's spouse's burial expenses.

Policy: When an SSI-related A/R does not have an irrevocable pre-need funeral agreement (See **RESOURCES** PRE-NEED FUNERAL AGREEMENTS) or the funeral agreement includes less than $1,500 designated for non-burial space items, the A/R may have an exempt burial fund.

An exempt burial fund is separately identifiable with a maximum initial value of $1,500, or greater if it is court ordered. Funds set aside for burial expenses cannot be commingled with non-burial related resources. When burial funds are combined with non-burial related funds, the burial funds are not exempt.

Interpretation: An SSI-related A/R who does not have an irrevocable pre-need funeral agreement or has less than $1,500 designated for non-burial space items in the funeral agreement, may have an exempt burial fund. The A/R may also set aside up to $1,500 as a burial fund for his/her spouse.

At the time of the initial application, the SSI-related applicant cannot have more than $1,500 or $3,000 for a couple set aside as a burial fund. If the burial fund contains more than $1,500/$3,000, the excess is considered a countable resource.

A burial fund may be established from liquid resources, such as: a bank account; a funeral agreement entered into prior to January 1, 1997 or in the case of a non-applying spouse an agreement entered into on or after January 1, 1997 (See **RESOURCES** PRE-NEED FUNERAL AGREEMENTS); or life insurance with a cash value.

When reviewing a burial fund, the first item considered is the face value of all the SSI-related A/R's life insurance policies. When the total face value of all the SSI-related A/R's policies are equal to or less than $1,500, that face value is applied to the burial fund. The policies are considered excludable.

When the combined face value exceeds $1,500, the cash value is a countable resource. The SSI-related A/R may designate the cash value as a burial fund. When the burial fund contains life insurance policies with a face value greater than $1,500 and their cash value exceeds $1,500, only $1,500 of the cash value is exempt as a burial fund. Any cash value in excess of $1,500 is

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applied toward the appropriate resource exemption level. (See **REFERENCE** MEDICAID RESOURCE LEVEL and **RESOURCES** MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD) RESOURCE LEVEL) A burial fund cannot be combined with funds that are not intended for burial expenses. When the cash value exceeds $1,500, the SSI-related A/R must provide a written statement that the entire cash value is intended for burial expenses. The excess is then considered funds set aside for burial expenses, which avoids the prohibition against commingling. However, the excess is still applied to the appropriate resource exemption level. If the A/R does not provide a statement, the $1,500 is not exempt.

When the SSI-related A/R does not have life insurance or the face/cash value as appropriate does not equal $1,500 other resources may be used to establish or add to a burial fund.

Any interest accumulated in an exempt burial fund is also exempt. Interest accrued on non-exempt burial funds is also exempt.

Court ordered burial funds are allowed in any amount. When the court ordered burial fund exceeds $1,500 or $3,000 for a couple, the district may appeal the court order. When the court ordered burial fund is less than $1,500/$3,000 a supplemental burial fund may be established as appropriate.

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BURIAL SPACES

Description: Burial space items include, but are not limited to: conventional grave sites, crypts, vaults, mausoleums, caskets, urns, or other repositories customarily and traditionally used for the remains of deceased persons. Opening and closing the grave, perpetual care of the gravesite, headstones, and headstone engravings are also considered burial space items.

Policy: Generally, all pre-paid burial space items are included in the A/R's irrevocable pre-need funeral agreement. (See **RESOURCES** PRE-NEED FUNERAL AGREEMENTS) However, certain items may have been purchased and paid for in full prior to the establishment of an irrevocable pre-need funeral agreement. These items remain outside of the agreement. Such items and any appreciation in their value are exempt.

Burial space items designated for an SSI-related A/R's immediate family member are also exempt. An immediate family member includes the SSI-related A/R's spouse, minor and adult children, stepchildren, brothers, sisters, parents, and the spouses of these persons. These persons need not be dependent on the A/R or living in the same household. Burial space items purchased for an immediate family member will not be in the A/R's irrevocable pre-need funeral agreement.

Since, funeral agreements and contracts which purchase burial space items on installment, other than irrevocable pre-need funeral agreements, do not provide the A/R with a burial space until the contract is paid in full, the amount paid cannot be exempt as a burial space. However, the equity may be applied toward an SSI-related A/R's burial fund. (See **RESOURCES** BURIAL FUNDS)

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RESOURCE DOCUMENTATION REQUIREMENTS

Description: Resource documentation requirements vary depending on the Medicaid coverage option selected by the A/R. In some instances, the A/R is allowed to attest to the value of their resources.

Policy: Coverage options must be offered to all Medicaid A/Rs who have a resource test.

References:

SSL Sect.	366 366-a(2) 366-ee
Dept. Reg.	360-2.3(c)(3) 360-2.3 360-4.4 360-4.6(b)
ADMs	11 OHIP/ADM-1 10 OHIP/ADM-01 04 OMM/ADM-6
INF	05 ADM/INF-2
GISs	09 MA/027 05 MA/012 05 MA/004

Interpretation: When SSI-related individuals, who have a resource test apply for Medicaid, they are asked to choose one of the following coverage options:

1. Community Coverage Without Long-Term Care;
2. Community Coverage with Community-Based Long-Term Care; or
3. Medicaid coverage for all covered care and services (this option is available only to individuals in Nursing Home Level of Care).

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent

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RESOURCE DOCUMENTATION REQUIREMENTS

child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents). In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

1. Community Coverage without Long-Term Care services include all Medicaid covered care and services except nursing facility services and community-based long-term care services. If a Medicaid SSI-related A/R elects this coverage, the A/R may attest to the amount of his/her resources. The SSI-related A/R is not required to itemize their resources on the application but is required to do so at renewal.

NOTE: A/Rs of all categories continue to be required to provide documentation of any trust agreement in which the A/R is named the creator or beneficiary. This enables the district to determine the availability of any trust income and/or principal. If an SSI-related A/R has an irrevocable pre-need funeral agreement, a copy of the agreement must be provided to the district in order for the district to verify the type of agreement.

Short-term Rehabilitation Services – SSI-related individuals who attest to their resources can receive Medicaid coverage for short-term rehabilitation services (one commencement/admission in a 12-month period, of up to a maximum of 29 consecutive days of each of the following (for a total of 58 days before being required to provide applicable resource documentation): Certified Home Health Agency (CHHA) services; and nursing home care.) Short-term rehabilitation begins on the first day the A/R receives CHHA services or is admitted to a nursing home on other than a permanent basis, regardless of the payer of care and services. If an SSI-related individual does not apply

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RESOURCE DOCUMENTATION REQUIREMENTS

for Medicaid coverage for a commencement of CHHA services or nursing home admission, that commencement/admission is not counted toward the one commencement/admission limit per the 12-month period.

NOTE: If an SSI-related Medicaid A/R states a transfer was made but does not provide documentation of the transfer, the SSI-related A/R is not eligible for short-term rehabilitative nursing home care admission and that commencement/admission is not counted toward the one commencement/admission limit per the 12-month period.

In the event that that short-term rehabilitation exceeds 29 days, the SSI-related individual must provide proof of his/her resources in order for Medicaid coverage to be established for the rehabilitation services beyond the 29th day. Proof of resources includes resource documentation for prior periods in accordance with transfer of resource policies for nursing facility services (See **RESOURCES** TRANSFER OF ASSETS) and current resource documentation for CHHA services.

If an SSI-related recipient who attested to his/her resources subsequently requests coverage for long-term care services, the date of the request shall be treated as the date of a new application for purposes of establishing the effective date and the three-month retroactive period for increased coverage. The SSI-related recipient must complete the "ACCESS NY Supplement A" and send in the requested resource documentation in order for eligibility to be determined for the requested coverage.

SSI-related Medicaid A/Rs who attest to the amount of their resources may enroll in a managed care plan, provided the SSI-related individual is not enrolling in a managed long-term care plan. Participation in a managed long-term care plan requires resource documentation of current resources for care in the community and resource documentation for prior periods in accordance with transfer of resource policies for care in a nursing home. (See **RESOURCES** TRANSFER OF ASSETS) Once enrolled, the SSI-related recipient will be eligible for all care and services covered by the plan as well as any wraparound services that are covered under Medicaid fee-for-service.

Attesters who are eligible for Medicaid subject to a spenddown requirement may participate in the Excess Income/Optional Pay-In

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Program. (See **INCOME** EXCESS and PAY-IN) Local social services districts may continue to verify the accuracy of the resource information provided by the A/R through collateral investigations. If there is an inconsistency between the information reported by the A/R, and the information obtained by the district is current, the district shall redetermine the recipient's eligibility based on the new information. If the district requires further information about a particular resource in order to make an eligibility decision, the recipient must be notified to provide the necessary information.

2. Community Coverage with Community-Based Long-Term Care includes all Medicaid covered care and services including HCBS waiver services but not nursing facility services. The coverage does, however, include short-term rehabilitative nursing home care. If an SSI-related Medicaid A/R elects this coverage, the A/R must provide documentation of his/her current resources at application. However, the A/R may itemize and attest to the amount of his/her resources at renewal/recertification.

NOTE: If an SSI-related Medicaid A/R states a transfer was made but does not provide documentation of the transfer, the A/R is not eligible for short-term rehabilitative nursing home care.

An otherwise eligible SSI-related individual who fails or refuses to provide adequate resource documentation shall be denied Community Coverage with Community-Based Long-Term Care and shall be authorized for Community Coverage without Long-Term Care if adequate information (not documentation) regarding the individual's resources is provided.

SSI-related recipients with Community Coverage with Community-Based Long-Term Care may be enrolled in managed care and managed long-term care.

3. Medicaid coverage for all covered care and services includes nursing facility services. If an SSI-related Medicaid A/R elects this coverage, the A/R must be in receipt of nursing home care and provide documentation of his/her resources for the prior periods in accordance with transfer of resource policies. (See **RESOURCES** TRANSFER OF ASSETS)

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RESOURCE DOCUMENTATION REQUIREMENTS

If an SSI-related Medicaid A/R does not provide documentation of his/her resources for prior periods in accordance with transfer of resource policies, but does provide current resource documentation, the local district determines eligibility for Community Coverage with Community-Based Long-Term Care. If the SSI-related A/R provides information on the amount of his/her current resources but does not provide supporting documentation, the district determines eligibility for Community Coverage without Long-Term Care.

Temporary Assistance and Supplemental Security Income (SSI) recipients are authorized for Medicaid coverage for all covered care and services. Individuals who lose SSI eligibility continue to be eligible for Medicaid coverage of all covered care and services until a separate determination is made. (See **CATEGORICAL FACTORS** SEPARATE HEALTH CARE COVERAGE DETERMINATION) Unless the individual's SSI was discontinued due to a prohibited transfer, the individual is not required to provide documentation of his or her resources for the purpose of the ex-parte eligibility determination.

Individuals who are ineligible or lose Temporary Assistance for failure to document resources are referred to Medicaid for a separate determination.

Disposition: Although SSI-related Medicaid applicants choose a coverage option at application, such recipients have the right to supply proof of their resources at any time for a change in coverage. If an individual becomes in need of a service for which he/she does not have coverage, the individual must contact his/her local district immediately for assistance in obtaining the Medicaid coverage required.

RESOURCES

RESOURCE DOCUMENTATION REQUIREMENTS

Resource Verification Indicator (RVI) values are used by local districts to identify if a Medicaid recipient:

attested to his/her resources; verified current resources; verified resources for prior periods in accordance with transfer of resource policies; transferred resources; or is exempt from resource verification.

LONG-TERM CARE SERVICES

LONG-TERM CARE		
Community-Based Long-Term Care Services	**Nursing Facility Services**	**Short-Term Rehabilitation Services**
▪ **Adult day health care** ▪ **Assisted living program (ALP)** ▪ **Certified home health agency (CHHA)** ▪ **Hospice in the community** ▪ **Residential treatment facility** ▪ **Managed long-term care in the community** ▪ **Personal care services** ▪ **Waiver and Non-waiver services in the following programs** **a) Long-Term Home Health Care Program** **b) Traumatic Brain Injury Waiver Program** **c) Care at Home Waiver Program** **d) Office for People with Developmental Disabilities Home and Community-Based Waiver Program** **e) Nursing Home Transition and Diversion Waiver (NHTD)** ▪ **Consumer directed personal assistance program** ▪ **Limited licensed home care services** ▪ **Personal emergency response services** ▪ **Private duty nursing**	▪ **Alternate level of care provided in a hospital** ▪ **Hospice in a nursing home** ▪ **Nursing home care** ▪ **Intermediate care facility** ▪ **Managed long-term care in a nursing home**	**Once commencement/admission in a 12-month period of up to 29 consecutive days of:** ▪ **Nursing home care** ▪ **Certified home health care**

RESOURCES

LEVELS

Description: The resource level is an amount of money and/or other resources which an SSI-related A/R is allowed to retain as a reserve in order to meet any potential needs and still be eligible for Medicaid.

Policy: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

References:

SSL Sect.	366 366.2 366-ee
Dept. Reg.	360-4.7(a)(4) 360-4.8
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 90 ADM-42 89 ADM-38
GIS	09 MA/027

RESOURCES

LEVELS

Interpretation: When determining eligibility for Medicaid and Family Health Plus, a clear distinction is made between current income and resources.

As described in the Income Section, income is considered in the month in which it is received. Any income remaining after the month in which it was received is generally considered a resource. All resources of an SSI-related A/R are reviewed and analyzed to determine if they are countable. All countable resources are added together and compared to the appropriate level. Treatment of resources that exceed these levels is discussed in **RESOURCES** EXCESS RESOURCES.

RESOURCES

MEDICAID RESOURCE LEVEL

Policy: A/Rs may retain resources up to the appropriate Medicaid Resource level, when the A/ Rs are applying as or for:

- SSI-related;
- Qualified Disabled and Working Individuals (QDWIs);
- Medicaid Buy-In for Working People with Disabilities (MBI-WPD);
- COBRA continuation coverage;

The Medicaid resource levels are established according to family size, and generally change effective January each year. (See **REFERENCE** MEDICAID RESOURCE LEVELS.

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

RESOURCES

MEDICAID RESOURCE LEVEL

References:

SSL Sect. 366
366-ee

Dept. Reg. 360-4.4
360-4.7(a)(4)
360-4.8(b)

ADMs 10 OHIP/ADM-01
06 OMM/ADM-4
05 OMM/ADM-4
05 OMM/ADM-2
04 OMM/ADM-2
98 OMM/ADM-6
90 ADM-42

GISs 09 MA/027
08 MA/013
06 MA/029
05 MA/047

Interpretation:

Persons who are SSI-related, QDWIs, and A/Rs of the MBI-WPD Program, or COBRA continuation may keep a certain amount of resources in reserve and still receive Medicaid. These A/Rs are entitled to resources as set forth in **REFERENCE** MEDICAID RESOURCE LEVELS.

When countable resources are equal to or less than the resource level for the household such individuals are eligible for Medicaid, provided all other eligibility requirements are met.

Countable resources in excess of the appropriate resource level are considered available to meet the cost of medical care and services. An SSI-related A/R may be eligible for Medicaid when s/he incurs medical bills equal to or greater than his/her excess.

NOTE: An SSI-related A/R (including individuals who are 65 years of age or older) who also meets the ADC-related categorical requirements has a choice between ADC and SSI-related budgeting. However, if the individual is found eligible under both budget types, and is not eligible for or does not wish to participate in the MBI-WPD such individual must be given the ADC category which is not limited based on resources. A certified blind or certified disabled individual who documents or attests to resources in excess of the Medicaid resource level must have eligibility considered for FHPlus. Resources are not considered in the eligibility determination for FHPlus.

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

Policy: Not all of the resources available to an A/R are counted when determining his/her financial eligibility for Medicaid. Certain types and amounts of resources are disregarded. After these resources are disregarded, what remain are the A/R's countable resources. All countable resources are compared to the appropriate resource level. (See **REFERENCE** MEDICAID RESOURCE LEVEL)

The following is a list of disregarded resources:

AUTOMOBILES - Essential personal property including one automobile if in use by the A/R or a member of his/her household. A second vehicle may be exempt when there is a medical need for it, or the automobile is needed for employment-related activities or a Plan for Achieving Self-Support. (See **RESOURCES** ESSENTIAL PERSONAL PROPERTY AUTOMOBILES AND OTHER VEHICLES) If an automobile is not in use it loses its exempt status and the full equity value of the automobile is a countable resource.

BLOOD PLASMA SETTLEMENTS - Payments received as a result of a federal class action settlement with four manufacturers of blood plasma products on behalf of hemophilia patients who are infected with human immunodeficiency virus (HIV).

BURIAL FUNDS - When the A/R does not have an irrevocable pre-need funeral agreement (See **RESOURCES** PRE-NEED FUNERAL ARRANGEMENTS or has less than $1,500 designated for non-burial space items in the funeral agreement. The A/R may set aside up to $1,500 as a burial fund. A $1,500 burial fund may also be exempt for the A/R's spouse. (See **RESOURCES** BURIAL FUNDS)

BURIAL SPACES - Items customarily and traditionally used for the remains of deceased persons. (See **RESOURCES** BURIAL SPACES) Burial space items included in the A/R's irrevocable pre-need funeral agreement are exempt. Certain items paid for in full prior to entering into an irrevocable pre-need funeral agreement are also exempt. Burial space items for the A/R's immediate family member(s) or agreements purchasing burial space items for the A/R'S immediate family member(s) are disregarded. One burial plot or space per immediate family member is disregarded.

DISASTER RELIEF AND EMERGENCY ASSISTANCE - Any federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974 (P.L. 93-288), as amended by the

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-107), and any comparable disaster assistance provided by states, local governments, and disaster assistance organization.

ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PROGRAM (EEOICP) – Compensation paid to employees for diseases suffered as a result of their work in the nuclear weapons industry. Survivors of these employees may receive compensation under certain circumstances.

EQUITY VALUE OF A TRADE OR BUSINESS - The equity value of a trade or business, including any real property and liquid resources used to operate it. (See **RESOURCES** BUSINESS PROPERTY)

FEDERAL RELOCATION ASSISTANCE - Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

HOMESTEAD - A homestead and contiguous property as long as the A/R lives there, expresses an intent to return home or certain family members reside there. (See **RESOURCES** REAL PROPERTY HOMESTEAD)

LIFE INSURANCE POLICIES - Life insurance policies with a combined face value of $1,500 or less. (See **RESOURCES** LIFE INSURANCE)

NATIVE AMERICAN PAYMENTS - Seneca Nation Settlement Act payments made by the State and Federal governments, under P.L. 101-503, to the Seneca Nation.

Distribution to Native Americans of funds appropriated in satisfaction of judgments of the Indian Claims Commission or the United States Court of Federal Claims. This includes up to $2,000 per year of income for interests of individual Native Americans in trust or restricted lands, from funds appropriated in satisfaction of the Indian Claims Commission or the United States Court of Federal Claims.

Alaskan Native Claims Settlement Act (ANCSA) distributions - The following distributions from a native corporation formed pursuant to ANCSA are exempt as income or resources:

a. cash, to the extent that it does not, in the aggregate, exceed $2,000 per individual per year;

b. stock;

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

c. a partnership interest;
d. land or an interest in land; and
e. an interest in a settlement trust.

PENSION PLANS OF AN INELIGIBLE OR NONAPPLYING LEGALLY RESPONSIBLE RELATIVE - On or after September 1, 1987, pension funds belonging to an ineligible or non-applying legally responsible relative which are held in individual retirement accounts or in work-related pension plans, including plans for self-employed individuals such as Keogh plans. However, amounts disbursed from a pension fund to a pensioner are income to the pensioner, which will be considered in the deeming process.

PERSECUTION PAYMENTS - Benefits received by eligible Japanese-Americans, Aleuts, or Pribilof Islanders under the Civil Liberties Act of 1988, the Wartime Relocation of Civilians Law, and the Aleutian and Pribilof Islands Restitution Act.

Payments made to individuals because of their status as victims of Nazi persecution, including: German Reparation Payments; Austrian Reparation Payments made pursuant to sections 500-506 of the Austrian General Social Insurance Act; and Netherlands Reparation Payments based on Nazi, but not Japanese, persecution.

PERSONAL PROPERTY, ESSENTIAL - Household goods and personal effects. (See **RESOURCES** ESSENTIAL PERSONAL PROPERTY)

PLAN TO ACHIEVE SELF-SUPPORT (PASS) - For certified blind or certified disabled persons under 65 years of age and for certified blind or certified disabled persons aged 65 or over who received SSI payments or aid under the State Plan for the certified blind or certified disabled for the month preceding the month of their 65th birthday, any remaining countable income may be set aside for a plan to achieve self-support. The plan must:

a. specify planned savings and/or expenditures to achieve a designated feasible occupational objective and a specific period of time to achieve the objective;
b. provide for identification and segregation of money and goods, if any, being accumulated and saved;
c. current, in writing and approved by the local commissioner of social services for not more than 18 months, with the possibility of an extension for an additional 18 months.

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

A second extension for an additional 12 months may be allowed in order to fulfill a lengthy educational or training program; and

d. be followed by the individual;

PRE-NEED FUNERAL AGREEMENTS - Irrevocable pre-need funeral agreements for the A/R. (See **RESOURCES** PRE-NEED FUNERAL AGREEMENT)

PREVENTATIVE HOUSING SERVICE - Payments provided as a preventative housing service under 18 NYCRR 423.4(l).

RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS – Payments for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining.

REAL PROPERTY – INCOME PRODUCING - The first $12,000 equity value of real property producing income that is not part of a trade or business.

SAVINGS ACCOUNT (CHILD) - A child's savings account under $500. The funds must be accumulated from gifts from non-legally responsible relatives and/or from the child's own earnings. (See **RESOURCES** FINANCIAL INSTITUTION ACCOUNTS)

STUDENT – **Student Loans -** Student loans received and retained by a graduate or undergraduate student for educational purposes. Any interest accrued is considered unearned income in the month received.

TIME LIMITED DISREGARDS - Certain resources are disregarded for a limited time period. (See **RESOURCES** TIME-LIMITED SSI-RELATED RESOURCE DISREGARD)

VIETNAM VETERANS **– Agent Orange Settlement fund** - Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the Agent Orange product liability litigation, and payments from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicide in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975.

Children - Monthly allowances paid to certain Vietnam Veteran's Children with Spina Bifida.

RESOURCES

SSI-RELATED RESOURCE DISREGARDS

References:

SSL Sect.	366 366-ee
Dept. Reg.	360-4.6(b)
ADMs	10 OHIP/ADM-01 92 ADM-32 92 ADM-11 91 ADM-8
GISs	09 MA/027 97 MA/022

RESOURCES

TIME LIMITED SSI-RELATED RESOURCE DISREGARDS

Policy: Certain resources, available to an A/R, are disregarded for a limited time period. When the period has expired, these resources are reviewed to determine their value and availability. All countable resources are compared to the appropriate resource level.

The following is a list of resources which are disregarded for a limited time period:

AID AND ATTENDANCE, RETROACTIVE VETERANS BENEFITS - Moneys from Retroactive Veterans Benefits Awards for Aid and Attendance, unusual medical expenses and/or House-bound Allowances, are disregarded in the month received and the following month.

CASH PAYMENTS FOR MEDICAL SERVICES OR SOCIAL SERVICES - Certain cash payments that enable A/Rs to pay for medical services or social services are disregarded in the month received and for nine (9) months following the month of receipt.

EARNED INCOME TAX CREDIT PAYMENTS (including federal child tax credit payments and any advanced earned income credit made by an employer) - Moneys from Earned Income Tax Credit payments are disregarded in the month received and for nine (9) months following the month of receipt.

EDUCATIONAL-RELATED RESOURCES **-** Any portion of a grant, scholarship, fellowship or gift used to pay the cost of tuition and other education-related fees at any educational (including technical or vocational) institution are disregarded in the month received and for nine (9) months following the month of receipt. This resource disregard does not apply to any portion set aside or actually used for food, clothing or shelter.

INSURANCE PAYMENTS - Moneys from insurance payments for the purpose of repairing a disregarded resource, which was lost, damaged or stolen, are disregarded for nine (9) months following the month of receipt. An additional nine-month disregard can be given if the A/R has good cause not to have replaced the resource. Any interest received from such payments is also disregarded. If the A/R uses the insurance money to purchase a countable resource prior to the expiration of the nine or eighteen months, the value of the resource is countable.

RESOURCES

TIME LIMITED SSI-RELATED RESOURCE DISREGARDS

REAL PROPERTY SALES - Moneys from the proceeds of the sale of exempt real property are disregarded for a reasonable period of time, not to exceed six months, while the A/R reinvests the proceeds.

RELOCATION ASSISTANCE PAYMENTS – State or local government relocation assistance payments (not federal or federally assisted funds) for 9 months following the month of receipt.

RETROACTIVE SSI, SOCIAL SECURITY AND RAILROAD RETIREMENT *BENEFITS* - Retroactive SSI, Social Security and Railroad Retirement benefits are disregarded resources for nine (9) months following the month of receipt.

STATE OR LOCAL GOVERNMENT RELOCATION ASSISTANCE - Relocation assistance payments from a state or local government are disregarded from resources for nine (9) months following the month of receipt.

STATE VICTIMS' ASSISTANCE FUNDS - Payments from State Victims Assistance funds are exempt resources for nine (9) months following the month of receipt.

References:

SSL Sect. 366
366-ee

ADMs 10 OHIP/ADM-01
97 ADM-23
97 ADM-2
92 ADM-32
92 ADM-11

GISs 09 MA/027
05 MA/001
04 MA/030
96 MA/028

RESOURCES

SSI-RELATED DEEMING OF RESOURCES

Policy: The basis for deeming is inherent in the concept that husbands and wives living together have a responsibility to each other and generally share income. Parents living with their children also have a responsibility for their children and generally provide income for their needs.

References:

20 CFR	416.1165
SSL Sect.	366.2
Dept. Reg.	360-4.4 360-4.6(b)(1)(ii) 360-4.6(b)(2) 360-4.7
ADMs	91 ADM-27 87 ADM-27

Interpretation: The budgeting of resources for SSI-related persons involves the deeming of resources from one spouse to another and from parents to their SSI-related child under age 18. When determining eligibility for an SSI-related individual who is living with his or her spouse, the resources of such spouse, not otherwise excluded under the SSI-related disregards, are considered to be available to the SSI-related individual.

When budgeting the resources of an SSI-related person living with his/her spouse, the final net resources of the SSI-related person and his/her spouse are compared to the Medicaid resource level for two. Children's resources are not counted in determining the SSI-related parent's eligibility.

To determine the amount of resources to be deemed to the child by a single parent, the parent's countable resources are compared to $2,000, the resource level for one used by the Social Security Administration, to determine eligibility for SSI recipients. The countable resources of a two-parent household are compared to $3,000, the SSI resource level for two.

In the case of an SSI-related child, the child’s resources are deemed to include any resources, not otherwise excluded under the SSI-related disregards, of a parent who is living in the same household to the extent that the parent’s countable resources exceed the resource level used by the Social Security

RESOURCES

SSI-RELATED DEEMING OF RESOURCES

Administration. If a child is living with only one parent, the resource level for an individual applies ($2,000). If the child is living with both parents, the resource levels for a couple apply ($3,000). Resources in excess of these levels are deemed available to the SSI-related child (if there is more than one SSI-related child in the household, the deemed amount is distributed equally among them). The deemed resources are added to the child's own resources (if any) and compared to the Medicaid resource level for one found in the **REFERENCE** MEDICAID RESOURCE LEVELS.

The deeming of parental resources to an SSI-related child does not reduce the countable resources available to the parents when determining eligibility for them.

Unlike income budgeting for SSI-related persons, there is no allocation of resources to non-SSI-related children in the household.

RESOURCES

MEDICAID BUY-IN PROGRAM FOR WORKING PEOPLE WITH DISABILITIES (MBI-WPD)

Policy:

SSI-related budgeting, including disregards and deeming, is used for determining countable resources. (See **RESOURCES** SSI-RELATED RESOURCE DISREGARDS, **RESOURCES** TIME LIMITED SSI-RELATED RESOURCE DISREGARDS and **RESOURCES** SSI-RELATED DEEMING OF RESOURCES)

To be eligible for the MBI-WPD program, effective October 1, 2011, the A/R may have countable resources equal to or less than $20,000 for a one-person household and $30,000 for a two-person household. (See **REFERENCE** MEDICAID RESOURCE LEVELS)

Effective October 1, 2011 monies in a retirement account of the MBI-WPD A/R are disregarded. (See **RESOURCES** RETIREMENT FUNDS)

See **CATEGORICAL FACTORS** MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES, **INCOME** MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES, and **OTHER ELIGIBILITY REQUIREMENTS** MEDICAID BUY-IN FOR WORKING PEOPLE WITH DISABILITIES for a discussion of other eligibility criteria for MBI-WPD.

Reference:

SSL Sect. 366(1)(a)(12)&(13)

ADMs
11 OHIP/ADM-07
04 OMM/ADM-5
03 OMM/ADM-4

GIS
08 MA/013
98 MA/024

RESOURCES
PERSONS IN MEDICAL FACILITIES

ASSESSMENT/DETERMINATION

Description: Either spouse may request an assessment/determination of the combined countable resources owned by the couple. An assessment may be requested at the beginning or after the commencement of a continuous period of institutionalization. The request may or may not be accompanied by an application for Medicaid.

Policy: Upon receipt of an assessment request or application and all relevant documentation, the local social services district reviews the total value of the couple's countable resources as of the date of the request for an assessment/application. Countable resources are determined by applying SSI-related disregards. Each spouse is provided with a copy of the assessment and the documentation on which it was based. The notice includes a determination of the community spouse's resource allowance and advises the couple of their right to a fair hearing regarding the assessment and the determination of the community spouse resource allowance, after the institutionalized spouse's eligibility for Medicaid has been determined.

References:

SSA	1924
SSL	366-c
Dept. Reg.	360-4.3 (f) 360-4.9 360-4.10 360-2.6
ADMs	06 OMM/ADM-3 04 OMM/ADM-4 03 OMM/ADM-7 96 ADM-11 91-ADM-33 90 ADM-29 89 ADM-47
INF	92 INF-14

RESOURCES
PERSONS IN MEDICAL FACILITIES

ASSESSMENT/DETERMINATION

GISs
07 MA/001
06 MA/006
06 MA/004
05 MA/049
05 MA/002
04 MA/032
03 MA/027
03 MA/012
01 MA/037
00 MA/021

Interpretation: When a request for assessment is not accompanied by a Medicaid application, the assessment is based on the couple's combined countable resources as of the date of the request. When a Medicaid application is filed, the assessment is based on the first month covered by the Medicaid application. (See **OTHER ELIGIBILITY REQUIREMENTS** AUTHORIZATION) In cases where the date of the first continuous period of institutionalization is prior to the date of the request for assessment or the first month for which Medicaid eligibility is sought, an assessment of the couple's resources may be required for both the first month of institutionalization and the date of request for an assessment or the first month for which coverage is sought.

When the total countable resources are greater than $149,640 for the first continuous period of institutionalization, the local social services district calculates the couple's spousal share in order to determine the maximum amount of resources that can be retained by the community spouse. Local districts determine the spousal share as of the date of the first continuous period of institutionalization of the institutionalized spouse on or after September 30, 1989.

RESOURCES
PERSONS IN MEDICAL FACILITIES

ASSESSMENT/DETERMINATION

Regardless of which spouse's name the resources are in, all countable resources are combined and considered available to the institutionalized spouse. The community spouse is permitted to retain from the couple's countable resources an amount equal to the greatest of the following amounts: (1) the State minimum community spouse resource allowance amount; (2) the spousal share up to the federal maximum resource amount; or (3) the amount established by court order or fair hearing. The minimum community spousal resource allowance amount and the federal maximum resource amount can be found in **REFERENCE** MINIMUM/ MAXIMUM COMMUNITY SPOUSE ALLOWANCE.

If the couple's combined countable resources are less than the state minimum community spouse resource allowance, the community spouse may retain all of the couple's countable resources. When the combined countable resources exceed the maximum community spouse amount, the excess is considered available to the institutionalized spouse. The institutionalized spouse is allowed the appropriate SSI-related resource level for one.

NOTE: Effective January 1, 2006 if a community spouse is NOT receiving periodic payments from his/her available retirement fund, the fund is considered a countable resource for purposes of determining; the community spouse resource allowance (CSRA) and the institutionalized spouse's Medicaid eligibility.

After the month for which the institutionalized spouse is determined eligible for Medicaid, the community spouse's resources cannot be considered available to the institutionalized spouse, even if the community spouse's resources increase. The community spouse resource allowance must actually be made available to the community spouse in order for it to be excluded when determining the continuing eligibility of the institutionalized spouse. The community spouse resource allowance must be legally transferred to the community spouse or for his/her sole benefit within 90 days of the eligibility determination. The local social services district may allow a longer period for the transfer, when required.

RESOURCES
PERSONS IN MEDICAL FACILITIES

ASSESSMENT/DETERMINATION

When a community spouse fails or refuses to provide information concerning his/her resources, the institutionalized spouse's eligibility cannot be determined and the A/R may be denied Medicaid. However, if such a denial would result in undue hardship and an assignment of support is executed or the institutionalized spouse is unable to execute an assignment, due to physical or mental impairment, Medicaid is authorized. The case is then referred to the district's legal staff for appropriate action.

Undue hardship is a situation where:

(1) a community spouse fails or refuses to cooperate in providing necessary information about his/her resources;

(2) the institutionalized spouse is otherwise eligible for Medicaid;

(3) the institutionalized spouse is unable to obtain appropriate medical care without the provision of Medicaid; and

(4) (a) the community spouse's whereabouts are unknown; or

(b) the community spouse is incapable of providing the required information due to illness or mental incapacity; or

(c) the community spouse lived apart from the institutionalized spouse immediately prior to institutionalization; or

(d) due to the action or inaction of the community spouse, other than the failure or refusal to cooperate in providing necessary information about his/her resources, the institutionalized spouse will be in need of protection from actual or threatened harm, neglect, or hazardous conditions if discharged from an appropriate medical setting.

After a Medicaid eligibility determination for the institutionalized spouse is completed, if either spouse is dissatisfied with the determination of the community spouse resource allowance, s/he may request a fair hearing.

RESOURCES
PERSONS IN MEDICAL FACILITES

ASSESSMENT/DETERMINATION

If either spouse establishes, pursuant to fair hearing or court order, that the income generated from the community spouse resource allowance is inadequate to raise the community spouse's income (including any income from the institutionalized spouse) to the Minimum Monthly Maintenance Needs Allowance (MMMNA), the local district establishes a community spouse resource allowance adequate to provide the additional necessary income. (See **REFERENCE** MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE (MMMNA))

NOTE: The policy of raising the community spouse's income to the MMMNA does not apply in instances when the institutionalized spouse is a participant in certain waiver programs. (See **INCOME** PERSONS IN MEDICAL FACILITIES BUDGETING FOR INSTITUTIONALIZED SPOUSES IN SPECIFIED HOME AND COMMUNITY BASED WAIVERS (HCBS)

If the institutionalized spouse does not make the community spouse income allowance available to the community spouse, an additional community spouse resource allowance **cannot** be established.

NOTE: A community spouse who refuses to make his or her resources (in excess of the community spouse resource allowance) available to the cost of care for the institutionalized spouse is allowed the appropriate community spouse monthly income allowance. If the community spouse refuses to provide information concerning his/her resources, the community spouse is not entitled to a monthly income allowance, because the amount of income generated by the resources is not known.

(See **REFERENCE** MINIMUM/MAXIMUM COMMUNITY SPOUSE ALLOWANCE)

References: ADMs
06 OMM/ADM-4
05 OMM/ADM-5
05 OMM/ADM-2
04 OMM/ADM-5
04 OMM/ADM-2
03 OMM/ADM-4
02 OMM/ADM-7
02 OMM/ADM-1

RESOURCES
PERSONS IN MEDICAL FACILITES

ASSESSMENT/DETERMINATION

01 OMM/ADM-5
99 OMM/ADM-3
98 OMM/ADM-28
96 ADM-11
91 ADM-33
89 ADM-47

GISs
08 MA/024
06 MA/029
06 MA/006
05 MA/013
05 MA/047
05 MA/045
04 MA/032
03 MA/027
01 MA/038
00 MA/027
00 MA/030

RESOURCES
PERSONS IN MEDICAL FACILITIES

BUDGETING FOR INSTITUTIONALIZED SPOUSES IN HOME AND COMMUNITY BASED WAIVERS (HCBS)

Policy: HCBS waiver participants with a community spouse are budgeted for resource eligibility in the same manner as institutionalized spouses in permanent absence status. (See **RESOURCES** PERSONS IN MEDICAL FACILITIES**)**

References:

SSL Sect.	366-c (4)
Dept. Reg.	360-4.9 360-4.10
ADMs	08 OLTC-01 95 ADM-19 92 ADM-32 89 ADM-47
GISs	08 MA/024 01 MA/021

RESOURCES
PERSONS IN MEDICAL FACILITIES

DETERMINATION FOR INDIVIDUALS

Policy: A single person who enters a medical facility is entitled to retain countable resources up to the Medicaid level for one. (See **REFERENCE** MEDICAID RESOURCE LEVELS)

References:

SSL- Sect. 366
366-ee

ADMs 10 OHIP/ADM-01
89 ADM-47

GIS 09 MA/027

Interpretation: Unmarried ADC and S/CC Medicaid recipients who are temporarily placed in a nursing home and subsequently become "permanently absent" will be budgeted using community budgeting rules until a disability determination is completed. Until the disability determination is complete, no resource test is applied; however, once disability is certified, a resource look-back for the past 60 months or to February 8, 2006 whichever is shorter, (60 months for trusts) must be done. The resource look-back begins with the first day of the month preceding the month of initial institutionalization. The effective date of Chronic Care budgeting is the first day of the month following the 10-day notice of the change in the budgeting methodology.

NOTE: An S/CC or ADC-related individual who requires temporary nursing home care (i.e., the individual is expected to return home) is budgeted under community rules, and therefore, will have no resource test. There is no durational restriction for temporary placement as long as medical evidence documents that the individual is expected to return home.

NOTE: When both spouses are in permanent absence status, they are budgeted as individuals, whether or not they share a room.

RESOURCES
PERSONS IN MEDICAL FACILITIES

TREATMENT OF REAL PROPERTY

Description: Real property is land and generally whatever is erected upon, growing upon, or affixed to the land. Real property also includes rights arising out of or in connection with land, such as air, mineral, water, or access rights. Real property may be owned in whole or in part. When determining eligibility, all real property owned by an A/R is evaluated.

Policy: The homestead of any SSI-related institutionalized A/R who expresses intent to return home remains exempt (regardless of any medical evidence to the contrary). However, if an institutionalized SSI-related A/R is not reasonably expected to be discharged from the medical institution and to return home, it may be appropriate to place a lien against such a homestead or exempt income-producing real property. If an institutionalized SSI-related A/R possesses non-exempt real property (e.g., vacation home or unoccupied homestead to which the A/R does not express an intent to return), the value of such property is counted in the determination of eligibility. (See **RESOURCES** REAL PROPERTY HOMESTEAD for the treatment of a homestead, **OTHER ELIGIBILITY REQUIREMENTS** LIENS for the treatment of liens and **RESOURCES** REAL PROPERTY for the treatment of real property).

References:

SSL Sect .	366 366-ee 367-f 369.2
Dept. Regs	360-7.11
ADMs	10 OHIP/ADM-01 92 ADM-53
GIS	09 MA/027

RESOURCES

SUBSTANTIAL HOME EQUITY

Description: The home equity of an SSI-related applicant for nursing facility services or community based long-term care services cannot exceed the home equity limit. (See **REFERENCE** SUBSTANTIAL HOME EQUITY LIMIT)

Policy: An SSI-related A/R whose equity interest in their home exceeds the home equity limit must be denied Medicaid coverage for Nursing Facility Services and Community Based Long-Term Care services. The equity value is derived by subtracting any legal encumbrances (liens, mortgages, etc.) from the fair market value. Absent any evidence to the contrary, if the home is owned jointly with one or more individuals, each owner is presumed to have an equal interest in the property. Individuals cannot spend down excess equity through the use of medical bills to obtain eligibility. Individuals whose equity interest in the home exceeds the home equity limit may, if otherwise eligible, receive Medicaid coverage of Community Coverage Without Long-Term Care.

References:

SSL Sect.	366-a(2) 366 366-c 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6
ADMs	10 OHIP/ADM-01 09 OHIP/ADM-3 06 OMM/ADM-5
GISs	10 MA/025 09 MA/027 07 MA/007 06 MA/016

Interpretation: SSI-related individuals applying for nursing facility services or community based long-term care services, or for an increase in coverage for long-term care services on or after January 1, 2006, are to be denied Medicaid coverage for such services if the equity interest in the individual's home exceeds the home equity limit.

The home equity provisions do not apply to persons who are Qualified Partnership Policyholders (QPP) who hold either a Total Asset

RESOURCES

SUBSTANTIAL HOME EQUITY

Protection or Dollar-for-Dollar policy. However, consideration of the home as a countable resource or exempt homestead applies to a QPP who has a Dollar-for-Dollar Asset Protection policy.

The home equity provision does not apply to individuals who applied and were determined eligible for and in receipt of long- term care services before January 1, 2006 and have no break in eligibility for long–term care services after January 1, 2006.

The home equity limitation does not apply if the SSI-related individual's spouse, minor child or certified blind or certified disabled child lawfully resides in the home.

SSI-related individuals may use a reverse mortgage or home equity loan to reduce their equity interest in the home.

NOTE: Although payments received from a reverse mortgage or home equity loan are not counted in the month of receipt for eligibility purposes, if the funds are transferred during the month of receipt, the transfer is to be considered a transfer for less than fair market value for SSI-related individuals applying for coverage of nursing home care.

SSI-related individuals who are subject to the home equity limitation may claim undue hardship. Undue hardship exists if the denial of Medicaid coverage would:

- Deprive the A/R of medical care such that the individual's health or life would be endangered; or
- Deprive the A/R of food, clothing, shelter, or other necessities of life; AND
- There is a legal impediment that prevents the A/R from being able to access his or her equity interest in the property.

Undue hardship determinations must be made within the same period that districts have to determine eligibility. Additional time for providing documentation to determine undue hardship may be approved by the district. If an individual disagrees with the district's determination of undue hardship, the recipient may request a conference and/or fair hearing.

If the SSI-related individual is not eligible for nursing facility services and community-based long-term care services due to substantial home equity, districts should not authorize short-term rehabilitative nursing home care nor certified home health care (CHHA) services.

RESOURCES

SUBSTANTIAL HOME EQUITY

Verification/ Documentation:

When an SSI-related A/R indicates that s/he owns and resides in his/her own home. The preferred method of verifying market value is to obtain an independent appraisal by a licensed real estate appraiser. If this is not practical, use the listed asking price accompanied by a market analysis or appraisal, if any; or, if neither is available, use a full value tax assessment. However, if it is clear based on the approximate value of the property that the SSI-related A/R is ineligible due to excess resources, the local district may rely on a statement from the applicant as to the property's value. The A/R cannot be required to pay for an appraisal.

All liens and mortgages against the property are verified by reviewing the documentation.

Sufficient to establish an audit trail:

a) date of appraisal, name of official or appraiser, value of property from real estate appraisal or a copy of the same in the case record;

b) listed asking price, accompanied by a marketing analysis;

c) location of tax records, and date and amount of full value assessment;

d) name of bank or party holding the mortgage, amount due on mortgage, date of mortgage and any identifying information;

e) name of party holding a lien against the property and the amount of the lien; and/or

f) the A/R's written statement concerning the value of the property or a notation in the case file concerning the A/R's statement.

RESOURCES

CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS

Description: Continuing Care Retirement Communities (CCRCs) entrance fees may be considered a resource in determining eligibility.

Policy: CCRCs are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. CCRCs that are certified to accept Medicaid and/or Medicare payment may require in their admissions contracts that residents spend their declared resources on their care, before they apply for Medicaid.

References:

SSL Sect.	366 366-a(2) 366-c 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6
ADMs	10 OHIP/ADM-01 06 OMM/ADM-5
GIS	09 MA/027 06 MA/016

Interpretation: Effective for Medicaid applications filed on or after August 1, 2006, an SSI-related individual's entrance fee in a CCRC or life care community shall be considered a resource to the extent that:

- The SSI-related individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;
- The SSI-related individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; AND
- The entrance fee does not confer an ownership interest in the CCRC or life care community.

RESOURCES

CONTINUING CARE RETIREMENT COMMUNITY CONTRACTS

For SSI-related applicants with a community spouse, only that part of the entrance fee that is not protected by the community spouse's resource allowance would be considered in the computation of the applicant's available resources.

Verification/ Documentation: When the SSI-related A/R indicates that s/he resides in a continuing care retirement community or life care community.

Sufficient to establish an audit trail:

(a) a copy of the CCRC or life care community contract.

(b) a written statement from the CCRC or life care community. a copy of the cancelled CCRC or life care community contract.

RESOURCES

BUDGETING FOR LEGALLY RESPONSIBLE RELATIVES

Description: Spouses are financially responsible for each other and parents are financially responsible for their children under the age 21 who are not certified blind or certified disabled. Parents are financially responsible for their certified blind or certified disabled children under the age 18 unless the child is expected to be living out of the household for at least 30 days. **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES (LRR) contains a detailed description of legally responsible relatives (LRRs) and their obligation to support their dependents.

Policy: The resources of legally responsible relatives (LRRs) living in the same household as their SSI-related dependents are considered to be available unless the legally responsible relative refuses to make them available.

For married couples, where one member of the couple is an SSI-related institutionalized spouse, See **INCOME** CHRONIC CARE BUDGETING METHODOLOGY FOR INSTITUTIONALIZED SPOUSE to determine the countable resources considered available to the institutionalized spouse.

References:

SSL Sect.	101 101-a 366 366-ee
Dept. Reg.	360-4.3(f)(2)
ADMs	10 OHIP/ADM-01 89 ADM-47
GIS	09 MA.027

Interpretation: When determining Medicaid eligibility, countable resources belonging to the SSI-related A/R and his/her LRRs residing in the same household are considered available to the SSI-related A/R. If an LRR refuses to make his/her countable resources available, eligibility is determined without regard to the LRR's resources. The granting of Medicaid in this situation creates an implied contract with the LRR and the cost of care may be recovered through a referral to Family or Supreme Court.

When an SSI-related A/R residing in the community has an LRR also residing in the community, but in a separate household, each person is allowed to retain resources up to the appropriate level. The LRR is

RESOURCES

BUDGETING FOR LEGALLY RESPONSIBLE RELATIVES

allowed to retain resources up to the appropriate level. The LRR is asked to contribute his/her excess resources toward the cost of the A/R's medical care. Only the amount actually contributed by the LRR is considered available to the SSI-related A/R. However, the local social services district may seek to recover the cost of any Medicaid provided through a referral to court. The SSI-related A/R and LRR are notified when a referral is made to Family or Supreme Court.

Legally responsible relatives who are living apart from an SSI-related A/R are sent the DSS-939 (legally responsible relative questionnaire and letter). If the relative fails to respond to the questionnaire, Medicaid may be granted if the SSI-related A/R is otherwise eligible. Medical support may be pursued in Family or Supreme Court.

Cases which include an SSI-related child under the age of 21, whose parent is absent from the home, are referred to the appropriate agency/unit for possible support. Generally this referral is made to the Child Support Enforcement Unit (IV-D). (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES IV-D REQUIREMENTS) for the establishment of the parent's contribution toward the cost of care. See **CATEGORICAL FACTORS** CHILDREN IN FOSTER CARE for the treatment of children in foster care.

Parents are not required to make their countable resources available to meet the medical needs of a certified blind or certified disabled child who ceases to live with them or is in receipt of home and community-based waivered services under a model waiver program (i.e. Care at Home Program). For Medicaid purposes, a certified blind or certified disabled child ceases to live with his/her parents when s/he is expected to occupy a separate "residence" for at least 30 days.

Verify Status:

a) When an SSI-related A/R states that a spouse or parent is living outside the household;

b) When an SSI-related A/R or a family member is residing in a medical facility or in receipt of home and community-based waivered services;

c) When it appears that a legally responsible relative has available resources;

d) When a potentially certified blind/disabled child is living in a separate residence or in a medical facility.

Verification: Completion of the DSS-939 by the legally responsible relatives.

RESOURCES

EXCESS RESOURCES

Description: Countable resources in excess of the appropriate Medicaid level are considered available to meet the cost of medical care and services of SSI-related A/Rs. The countable value of all resources is determined as of the first day of the month for which the applicant is requesting Medicaid coverage.

Policy: SSI-related applicants, may be eligible for Medicaid coverage during a month in which their medical bills are equal to or greater than their excess resources.

References:

SSL Sect	366 366-ee
Dept. Reg.	360-4.8(b)
ADMs	10 OHIP/ADM-01 OMM/ADM 97-2 91 ADM-31 91 ADM-17
GIS	09 MA/027

Interpretation: An SSI-related applicant's resources are evaluated as of the first day of the month for which s/he is requesting coverage. Certain resources are disregarded (See **RESOURCES** MEDICAID RESOURCE LEVEL) when determining eligibility for Medicaid. Countable resources are compared to the appropriate Medicaid level. With the exception of transfers of the community spouse resource allowance, countable resources possessed by the applicant on the first day of a month are considered available in that month, even if subsequently transferred.

NOTE: Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

RESOURCES

EXCESS RESOURCES

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

Disposition:

(1) Determine the value of the SSI-related applicant's resources as of the first day of the month for which the applicant is seeking coverage. If the SSI-related applicant is seeking coverage for medical bills during the three-month retroactive period (See **OTHER ELIGIBILITY REQUIREMENTS** AUTHORIZATION), the local district determines the value of the SSI-related applicant's resources as of the first day of the month for each retroactive month that the applicant is seeking coverage. Compare the SSI-related applicant's countable resources to the appropriate resource level.

(2) Determine whether or not an irrevocable pre-need funeral agreement exists.

(3) Determine the amount of the applicant's medical bills. Bills are applied against excess resources in the following order:

- viable bills as of the first of the month for which the provider is seeking payment (viable bills are those that providers seek payment for and have not written off their books);
- viable bills for medical expenses incurred during the month;
- bills paid by the applicant during the month;
- bills paid by public programs.

Public program bills are considered viable for up to six consecutive months after payment. The six-month count begins on the first day of the month for which Medicaid coverage is sought.

RESOURCES

EXCESS RESOURCES

NOTE: Bills which are paid by the Child Health Plus program cannot be considered viable because a child cannot be dually eligible for Medicaid and Child Health Plus.

In determining the amount of such bills, first deduct the amount of any third party payment or liability. Third party payments include, but are not limited to health insurance and payments by friends and/or non-applying, non-legally responsible relatives.

When the amount of the SSI-related applicant's medical bills (minus any third party payment or liability) equals or exceeds his/her excess resources, s/he is resource eligible. The excess resource amount is the amount of the client's liability.

NOTE: When an SSI-related applicant with excess resources also has excess income, excess income (See I**NCOME** EXCESS) and excess resource rules both apply. Bills or portions of bills applied to meet excess income cannot be applied to excess resources and vice versa.

A community case may be authorized for up to six (6) months of coverage. Coverage for an applicant residing in a medical facility may be authorized for up to 12 months. The SSI-related applicant is not required, as a condition of eligibility, to pay the medical bills used to determine his/her liability. When the local district is notified that the SSI-related applicant's resources have increased, that his/her viable medical bills are being paid by means other than his/her resources, or that the provider is no longer seeking payment for the bills, the case is reviewed to determine if the A/R is still eligible.

After the initial certification period, another snapshot comparison of resources to medical bills is made. The viability of incurred bills is reevaluated. The same viable bills (or portions of bills) used to offset excess resources may again be used to offset these resources if they continue to be available. If the amount of excess resources exceeds the amount of viable bills, the SSI-related A/R is no longer eligible and Medicaid is discontinued after appropriate notification. (See **OTHER ELIGIBILITY REQUIREMENTS** DECISION AND NOTIFICATION) Procedures to continue coverage depend upon what has happened to the resources and what viable bills remain.

RESOURCES

THIRD PARTY RESOURCES

Description: Third party resources include health, hospital, assignable income protection, and/or accident insurance policies. Benefits under these policies partially or fully pay or reimburse the cost of medical care and services. Third party benefits are available through employers, unions, colleges, fraternal organizations, liability carriers, court actions, trust funds, private insurers, the federal and state government, etc.

Policy: Health, hospital, assignable income protection, and/or accident insurance benefits are applied to the fullest extent to insure that Medicaid is the payer of last resort.

The exceptions to this policy occur when individuals are covered by the Children with Physical Disabilities Program or the Crime Victims' Compensation Program. In cases where individuals are covered by either of the above programs, Medicaid becomes the payer of first resort after any other available third party resources have been applied.

With the exception of the types of coverage listed in **CATEGORICAL FACTORS** FAMILY HEALTH PLUS AND PREMIUM ASSISTANCE PROGRAM (FHP-PAP) individuals with third party health insurance (TPHI) may not be eligible for Family Health Plus but may be eligible for the Family Health Plus Premium Assistance Program.

References:

SSL Sect.	104(b) 366.2(f) and (g) 367.a
Dept. Reg.	360-3.2(a)-(f) 360-7.2 360-7.3 360-7.4 360-7.7
ADMs	08 OHIP/ADM-1 05 ADM-5 99 ADM-5 94 ADM-14 89 ADM-23 87 ADM-40

RESOURCES

THIRD PARTY RESOURCES

INFs	09OHIP/INF-1 88 INF-56
GISs	06 MA/003 01 MA/019

RESOURCES

THIRD PARTY RESOURCES

Interpretation: Benefits which pay for the cost of medical care and/or services are used to pay for or reimburse the cost of all inpatient and outpatient medical care and services. Some plans pay for the complete cost of all care and services. However, most plans are limited in the amount of payment, length of care, and type of services. Many plans require the recipient to pay a deductible and/or co-insurance.

When a provider accepts a Medicaid enrollee as a patient the provider agrees to bill Medicaid for services provided or in the case of a Medicaid managed care enrollee agrees to bill the enrollees managed care plan for services covered by the contract.

The provider is prohibited from requesting any monetary compensation from the enrollee or his/her responsible relative except for any applicable Medicaid co-payments. Medicaid enrollees can not be billed and must not be referred to a collection agency for collection of unpaid bills, except for applicable Medicaid co-payments, when the provider has accepted the enrollee as a Medicaid patient.

A provider may charge a Medicaid enrollee, including a Medicaid enrollee enrolled in a managed care plan, only when both parties have agreed prior to the rendering of the services that the enrollee is being seen as a private pay patient. This must be a mutual and voluntary agreement. It is recommended that the provider maintain the patient's signed consent to be treated as private pay in the patient record.

WRAP AROUND POLICIES are no different than other health insurance policies and are treated like any other health insurance in determining eligibility.

Health insurance may be available through an absent parent's employer, union, etc. Generally, a Medicaid household that includes a child with an absent parent is referred to the Child Support Enforcement Unit (IV-D) for pursuit of support. [89 ADM-23 explains the Third Party Resource Unit's (TPRU) responsibility to obtain third party health insurance for Medicaid A/Rs. Also see 92 ADM-19, for information on subrogation of court-ordered health insurance benefits from an absent parent. (See **OTHER ELIGIBILITY REQUIREMENTS** LEGALLY RESPONSIBLE RELATIVES PARENTS AND CHILDREN IV-D REQUIREMENTS)

RESOURCES

THIRD PARTY RESOURCES

Generally, insurance plans allow parents to cover students and disabled children, after they have reached adulthood. Adult disabled children are persons who become disabled prior to the age of 19. Disability is defined by Title II of the Social Security Act.

When an A/R owns an income protection policy, the local district determines if the policyholder can assign payment to a hospital or nursing home. The local district enters the appropriate codes into eMedNY, indicating that the A/R has an assignable income protection policy. If the A/R is admitted to a medical facility, the facility takes an assignment from the A/R. Payments from the income protection policy are made directly to the medical facility. The income is not available to the A/R. In the event that the income protection policy payments are greater than the A/R's bill, it is the responsibility of the facility to return the excess to the A/R. If the income protection policy is not assignable, any income received by the recipient would be counted as income in the month received and a resource thereafter.

MEDICARE is a federal health insurance program administered by the Social Security Administration. Medicare consists of three parts, A (hospital insurance) and B (outpatient care) and D (pharmacy). Part A provides hospital insurance to the elderly (age 65 and over) who are eligible for Social Security or Railroad Retirement benefits and persons who have been in receipt of Social Security disability benefits for twenty-four consecutive months**,** or suffers from chronic renal (kidney) disease or has Amyotrophic Lateral Sclerosis (ALS). Persons entitled to Part A are automatically enrolled in Part B, unless they decline coverage. In addition, all citizens and lawfully admitted aliens having resided in the U.S. for 5 years who are age 65 or older are eligible for Part B. A person age 65 or older is eligible for Part B, whether or not s/he is eligible for Social Security or Railroad Retirement benefits. Not all persons eligible for Part B are in receipt of Part B. Because there is a premium charge for Part B, individuals may decline Medicare Part B coverage. (See **INCOME** FEDERAL POVERTY LEVELS MEDICARE SAVINGS PROGRAM)

RESOURCES

THIRD PARTY RESOURCES

NOTE: Enrollment in Medicare is a condition of eligibility for Medicaid.

Beginning in 2006, persons entitled to Part A and/or enrolled in Part B are eligible for the prescription drug program, Medicare Part D. The Part D prescription drug program is insurance coverage offered by insurance companies and other private companies and covers both generic and brand name drugs. Those firms serving the fee-for-service Medicare population are called Prescription Drug Plans (PDPs) and those serving Medicare Advantage (Medicare HMO) enrollees are called Medicare Advantage Prescription Drug Plans (MA-PDs). Full-benefit dual eligible beneficiaries (Medicare beneficiaries who are also in receipt of Medicaid) will receive their prescription drug coverage through Medicare rather than through the Medicaid program. Medicare Part D replaced Medicaid as the primary pharmacy coverage for dual eligible recipients. All dual eligibles are required to enroll and remain enrolled in a Medicare prescription drug plan. An exception to this rule is applied in situations where it is determined that the Medicaid applicant/recipient has cost effective health insurance AND will lose that insurance if the recipient enrolls in Part D.

NOTE: This good cause exception will not be allowed in instances where Medicaid has been furnished to an individual whose legally responsible relative has failed or refused to provide medical support.

Medicare individuals who are eligible for Medicare Part A or Part B who are eligible for the QMB, SLIMB, or QI programs or are eligible for Medicaid based on a spenddown are deemed eligible for a subsidy to assist with the premiums, deductibles and co-payments of the Part D program.

The prescription benefit for Medicaid recipients under Medicare Part D includes the following:

RESOURCES

THIRD PARTY RESOURCES

- No premiums if enrolled in a plan with a monthly premium at or below the low income premium subsidy amount (referred to as the "benchmark" plan);
- No deductibles;
- No coinsurance;
- No "donut hole" (the amount of out-of-pocket drug costs that standard beneficiaries are required to pay once their initial coverage limit is reached);
- Co-payment for generic and brand drugs (See **REFERENCE** CO-PAYMENT);
- No co-payment for Medicaid recipients residing in a medical facility. A medical facility is defined as a nursing home, psychiatric center, residential treatment center, developmental center, intermediate care facility. Medicaid recipients residing in other group residences such as Assisted Living Facilities (ALPs), group homes, and adult homes are subject to co-payments.

Spenddown recipients may apply out-of-pocket Part D premiums, coinsurance and deductibles or co-payments to meet a spenddown for the initial month only. Thereafter only the premium paid over the full subsidy amount is allowed as a deduction and copayments may be used to off-set the spenddown. Additionally Medical expenses other than prescription drug costs may continue to be used to meet the spenddown.

Chronic care recipients may only deduct the premium amount that exceeds the full subsidy amount.

MEDICARE ADVANTAGE PLANS (sometimes referred to as Medicare Part C or Medicare Managed Care, or Medicare HMOs) are health plan options available to Medicare beneficiaries. In order to enroll in a Medicare Advantage Plan, the individual must have both Medicare Part A and Part B. Individuals who join these plans receive their Medicare-covered health care through the plan. The plans may or may not include prescription drug coverage. In most of the plans there are additional services and lower co-payments than in the Medicare Program (traditional fee-for-service). Co-payments and premiums can vary by plan. Enrollment in Medicare Advantage Plans is voluntary.

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Enrollees may have to see doctors who participate in the plan or go to certain hospitals to get Medicare covered services. However, there is **NO** requirement for a Medicaid recipient who has enrolled in a Medicare Managed Care Plan to only receive services from the Medicare Managed Care Plan. If an applicant receives a Medicaid covered service from a provider who is enrolled in Medicaid, but does not participate in the recipient's Medicare Managed Care Plan, Medicaid will cover the service.

When a Medicaid recipient is enrolled in the Medicare Buy-In System in eMedNY, and the plan charges a reduced Part B premium, the State is only charged for the lesser amount. If a Medicaid recipient is enrolled in a Plan that charges a premium that is higher than the traditional Part B premium, the local district must pay the difference as a health insurance premium when it has been determined to be cost effective. Medicare Advantage Plan premiums may also be used to meet a spenddown obligation, or may be used as a deduction from income in the determination of eligibility.

Medicaid must pay all deductibles, coinsurance and co-payments for Medicaid recipients enrolled in a Medicare Advantage Plan as long as the provider is also a Medicaid enrolled provider.

Not all Medicare Advantage prescription drug pans offer benchmark plans (a plan that is available to dual eligibles at no cost). Dual eligibles who are enrolled in certain Medicare Advantage Plans may have to pay an additional monthly premium for the prescription drug benefit. If a dual eligible does not want to pay the higher cost, they must disenroll from that Medicare Advantage Plan and choose a different Medicare Advantage Plan or choose traditional fee-for-service Medicare along with a stand-alone prescription drug plan that is a bench mark plan.

Individuals are responsible to pay the Medicare Part D co-payments regardless of whether they receive their drug benefit through a Medicare Advantage Plan or a stand-alone prescription drug plan. Part D co-payments or Part D premiums cannot be submitted to Medicaid for payment or reimbursement. However, such costs may be used to meet a spenddown obligation.

MEDICAID ADVANTAGE AND MEDICAID ADVANTAGE PLUS PLANS are two integrated care plans designed for dual eligible

recipients. Both plans allow dual eligibles to enroll in the same health plan for most of their Medicare and Medicaid benefits.

Both plans achieve integration of Medicare and Medicaid through a State contract with Medicare Advantage Plans (or Medicare Advantage Special Needs Plans) to provide a defined set of Medicaid wrap-around benefits to dual eligible enrollees on a capitated basis. The Medicaid Advantage Plan benefit includes acute care services not covered by Medicare; the Medicaid Advantage Plus Plan benefit also covers Medicaid long-term care benefits.

To enroll in a Medicaid Advantage Plus Plan, recipients must be eligible for nursing home level of care. If such individuals are residing in the community, they must document current resources and be otherwise eligible in order to participate. If the person enters a nursing home for other than short term rehabilitation, s/he must document resources for the lookback period in order to continue to be eligible to participate.

Dual eligible beneficiaries may enroll in the same managed care organization's Medicare Advantage Plan or Medicare Advantage Special Needs Plan (SNP) and corresponding Medicaid Advantage or Medicaid Advantage Plus Plan product. The Managed Care Organization (MCO) receives two capitation payments; one from CMS for the Medicare Advantage product and one from the State for the Medicaid Advantage or Medicaid Advantage Plus product. Because the State pays the plan directly for any recipient cost-sharing associated with the Medicare Advantage product, Medicaid will not pay Medicaid enrolled providers for co-payments or deductibles for covered benefits for recipients enrolled in Medicaid advantage or Medicaid Advantage Plus. However, enrollees in Medicaid Advantage or Medicaid Advantage Plus are entitled to all Medicaid services they would normally get under the State Medicaid Plan. Therefore, any Medicaid services not included in the combined Medicare and Medicaid Advantage or Medicaid Advantage Plus benefit package offered by the health plan continue to be available to the enrollee when provided by any Medicaid enrolled provider on a Medicaid fee-for-service basis.

Participation by Medicare Advantage Plans or SNPs in Medicaid Advantage or Medicaid Advantage Plus is voluntary. Enrollment in these integrated plans by dual eligibles is also voluntary, and is not limited to the open enrollment period. Medicaid Advantage Plus Plans may also enroll individuals who have a spenddown.

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THIRD PARTY RESOURCES

TRICARE (formerly known as CHAMPUS) is the Department of Defense health care program for members of the uniformed services and their families and survivors, and retired members and their families. All active duty members in the Army, Navy, Air Force, Marines, Coast Guard, National Oceanic and Atmospheric Administration (NOAA) and Public Health Service (PHS), their family members and survivors, retirees and their family members who are under age 65, Medicare eligible because of a disability, and enrolled in Medicare Part B are eligible to participate in TRICARE.

The TRICARE program offers the following three options:

- TRICARE Prime is the managed care option offered by the Department of Defense.

- TRICARE Standard is a fee-for-service option that is the same as the former CHAMPUS benefit. The beneficiary is responsible for deductibles and co-payments.

- TRICARE Extra is similar to TRICARE Standard but offers discounts to patients when they use TRICARE network providers. After paying the deductible, the beneficiary would pay a reduced co-payment.

For additional information regarding TRICARE eligibility and benefits, refer to http://www.tricare.osd.mil/.

When injuries are the result of an accident, medical payments may be available from Workers' Compensation, auto, homeowners' liability insurance, or a civil court action.

When a court action is pending, Medicaid may be authorized, provided the A/R is otherwise eligible and a lien is placed against the court settlement. (See **OTHER ELIGIBILITY REQUIREMENTS** RECOVERIES) When the action is settled, the A/R's financial eligibility is re-evaluated, considering any assets gained from the settlement.

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Individuals involved in an automobile accident in New York State are covered under the No-Fault Insurance Law. Benefits include all reasonable and necessary medical and rehabilitation expenses incurred as the result of an automobile accident. Benefits are also available to compensate the victim for non-medical losses resulting from the accident.

When No-Fault, Workers' Compensation, or a liability insurance company is responsible for medical expenses, no payment is made by Medicaid for treatment of the injuries or illness covered.

When No-Fault Insurance is available or potentially available, the local district considers the type of benefit payment. The local district determines if payments are specifically for incurred medical expenses or for a loss. Losses include loss of wages and services (such as the need to hire a baby-sitter, because the accident victim cannot care for his/her children). An injured A/R may also sue the person negligently causing the accident, when the medical expenses and other losses exceed No-Fault benefits.

When No-Fault payments are made to the A/R for other than medical care and service expenditures, the payments are considered a windfall (See **RESOURCES** WINDFALLS for the treatment of windfalls depending on the category of the A/R).

An A/R may have more than one insurance plan or liability claim in existence at one time; for example, an automobile accident suffered while driving on the job. In this instance, the A/R may have hospitalization coverage through his/her employer, a Workers' Compensation claim and a liability claim against another motorist.

When to Verify: Third Party health insurance benefits are verified when:

- The A/R indicates that s/he has health insurance coverage;
- The A/R is employed;
- The A/R is enrolled in college (health insurance is often a mandatory college fee);

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- A member of the household, absent parent or absent spouse is a member of a union, fraternal organization, or armed forces;
- The A/R indicates that s/he was involved in an accident;
- The A/R indicates that s/he has a work related illness/disability;
- The A/R is over age 65 or has been disabled for at least 24 months, suffers from chronic renal (kidney) disease, has Amyotrophic Lateral Sclerosis (ALS) or is a disabled widow; or
- The A/R is a disabled dependent widower between ages 50 and 65.

Verification/ Documentation: Sufficient to establish an audit trail.

- Copies of both sides of benefit cards;
- Name of insurance carrier, persons covered, dates of coverage, name of the policy holder, kinds of coverage, address to which claims are sent;
- Employer or Union name and address; or
- If an accident claim, name of the party who is liable for claim, copy of the police report, date of claim, names of attorneys, status of any legal action and a copy of lien.
- Completion of the Employer Sponsored Health Insurance Request for Information form (DOH-4450)

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Disposition:

Third party benefits are fully used in order to reduce the amount of Medicaid paid. As a condition of eligibility an A/R assigns his/her third party benefits. In addition, s/he assigns the rights of any other applying household members for whom s/he has the legal right to make an assignment. The A/R automatically assigns these rights, when s/he signs the application.

The following four sections discuss additional eligibility requirements related to third party resources:

- Good cause not to bill third party health insurance;
- Assignment and subrogation;
- Enrollment in employer group health insurance; and
- New York State Partnership for Long Term Care.

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THIRD PARTY RESOURCES

GOOD CAUSE NOT TO BILL THIRD PARTY HEALTH INSURANCE

Description: Medicaid providers are instructed to bill any available health insurance prior to submitting a bill to the Medicaid program. However, in situations where the billing could jeopardize the health, safety and/or confidentiality of the recipient, the State Department of Health (SDOH) or the local district may determine that there is "good cause" not to bill third party health insurance.

Policy: When appropriate, individuals or providers may request a determination of "good cause" and authorization not to bill third party health insurance. Examples of circumstances in which the recipient's health, safety or confidentiality could be compromised by third party billing include domestic violence situations, or instances when individuals do not want their families to know they are receiving pregnancy/family planning services.

The eMedNY Third Party Subsystem includes a "good cause" indicator; users can inquire about, add or change information in this field. In situations where available third party insurance should not be billed, the local district can set the good cause indicator on eMedNY for either the date that a service will be provided (if known), a specific period of time, or an open-ended time period. Setting the good cause indicator will also prevent the third party contractor from making a post-payment recovery. Districts should periodically check the eMedNY Mobius reports of individuals for whom the indicator is set, to be certain "good cause" is still appropriate.

In the case of a minor applying for the Family Planning Benefit Program (FPBP), third party health insurance should not be billed unless the local district has an affirmative statement that the insurance can be billed. To prevent billing third party coverage for FPBP, the district may either:

- Not enter the third party insurance information in eMedNY, or
- Enter the third party information and set the good cause indicator.

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GOOD CAUSE NOT TO BILL THIRD PARTY HEALTH INSURANCE

If third party coverage is already on eMedNY, the district may either end-date the insurance or set the good cause indicator.

In situations where a provider is requesting good cause not to bill a patient's third party insurance for reproductive health services, the provider may contact the State Department of Health (SDOH) for a determination of good cause. If granted, the provider must document the call and determination in the client's billing record.

For more information about setting the "good cause" indicator, districts should refer to the "eMedNY Implementation, Third Party Training Manual."

References:

Dept Reg.	360-3.2(a)-(f) 360-7.4(a)(3)
GIS	01 MA/019

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ASSIGNMENT AND SUBROGATION

Description: Subrogation is the right to substitute one creditor for another. Assignment is the means by which this is accomplished.

Policy: As a condition of eligibility for Medicaid, an A/R assigns any third party benefits to which s/he is entitled to the local district.

References:

SSL Sect.	366.2(f) 366-a
Dept. Regs.	360-3.2(a), (b), (c)
ADMs	92 ADM-19 82 ADM-17

Interpretation: By virtue of his/her signature on the Medicaid application, the A/R assigns to the local department of social services any third party benefits to which s/he is entitled.

The insurance company is also notified of the local district's right to any benefits paid to the A/R. In most cases the insurance company can be notified at the time the health insurance benefit claim is filed. The notices attached to 92 ADM-19 are used to notify the insurance company of the local district's right of subrogation.

If it is determined that medical care and services that have already been paid by Medicaid could have been covered by third party benefits, the local district may exercise its right to subrogation for up to two years after the medical services have been rendered.

When to Verify Status:

a) When the A/R or a member of the family has health insurance;

b) When the A/R or member of the family has been injured or killed by accident;

c) When the A/R or a member of the family is employed;

d) When the A/R or a member of the family is in the military service or is a veteran;

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e) When the A/R or a member of the family belongs to a union or fraternal organization.

Verification Process: a) Seeing the insurance ID card;

b) Obtaining information on the benefits from the employer, union, fraternal organization, veteran's group, or college;

OTHER ELIGIBILITY REQUIREMENTS RECOVERIES contains additional information on recoveries, assignments and liens.

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ENROLLMENT IN GROUP HEALTH INSURANCE

Policy: An employed A/R, eligible for Medicaid without having to reduce excess income and/or resources, must enroll in any group health insurance plan offered by the employer (including health insurance offered by an employer as a COBRA extension) when an employee contribution is not required. When an employee contribution is required, the local district determines if enrollment is cost effective. When enrollment is determined to be cost effective, the local district may require the A/R to enroll, if the local district allows or pays for the employee's contribution.

References:

SSL Sect.	366.2(g) 367-a
SSA Sect	1906 (b)(1)and (c)(1)(B)
Dept. Reg.	360-3.2(a) (1)
ADMs	91 ADM-53 87 ADM-40 84 ADM-19 82 ADM-48 82 ADM-20
INFs	88 INF-56
GISs	11 MA/008 06 MA/026 02 MA/19

Interpretation: An A/R whose employer or union provides group health insurance at no cost to the A/R, must apply for and use such benefits as a condition of eligibility for Medicaid. When the employer or union provides group health insurance benefits, at a cost to the A/R, the local district determines if enrollment is cost effective. In most districts, this determination is done by the Third Party Resources Unit (See 87 ADM-40). If enrollment is cost effective, the A/R may be required to enroll. When more than one insurance plan is available, the district determines which plan is the most cost effective, before requiring the A/R to enroll. The A/R's contribution is an allowable deduction from income for all categories except S/CC. When the A/R is employed, and is required by the local district to enroll in an available non-contributory health insurance plan, s/he is allowed 30 days to join the plan. The A/R must also utilize benefits available to his/her spouse

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ENROLLMENT IN GROUP HEALTH INSURANCE

and/or child under such insurance plan. An A/R who fails to comply with the requirement to enroll in an available health insurance plan may be denied Medicaid. Only the employed A/R may be denied. After proof of enrollment is received, OHIP-0052, "Notice of Decision to Pay Third Party Health Insurance Premiums", shall be used to advise the recipient of eligibility for the Medicaid premium payment or reimbursement.

When an A/R has private health insurance coverage in force at the time of application, the local district determines if continuation of the coverage is cost effective. The local district offers to pay health insurance premiums on behalf of all Medicaid A/Rs whenever the health insurance is determined to be cost effective and the A/R's net income and resources are at or below the allowable income/resource levels. Premium Payments are only paid for prospective months as it is generally not cost effective to pay premiums in a retro period. The exception to this may be in the instance where an A/R is at risk for losing the cost-effective insurance if the past premiums are not paid.

Cost effectiveness is determined by comparing the cost of the premiums to the Medicaid costs for the eligible Medicaid family member(s). If the group policy is cost effective, then the local district pays for the entire premium, even if the policy covers non-Medicaid eligible family members. If the group policy is not cost effective, the health insurance premium may be prorated to include the payment of the premium that covers the eligible recipient.

NOTE: With the implementation of Medicare Part D, a policy determined to be cost effective may no longer be cost effective if the policy was used primarily for prescription drug coverage. A review of the policy and the A/Rs circumstances should be made**.**

If a medically needy recipient pays health insurance premiums from income and such payment, together with other applicable income disregards, reduces the individual's net available income below the appropriate income eligibility standard, the local social services district must pay or reimburse the recipient for the health insurance premium if the premium is determined to be cost-effective. The payment/reimbursement of the health insurance premium cannot exceed the difference between the individual's net available income and the appropriate income eligibility standard. For example, if the individual has a monthly spenddown of $150.00 and the health

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ENROLLMENT IN GROUP HEALTH INSURANCE

insurance premium is $200.00, the local district would reimburse the individual $50.00.

NOTE: The A/R must be fully eligible for Medicaid without the deduction for a health insurance premium before the cost effective premium can be paid by the local district. The health insurance premium is allowed as a deduction from income for all categories except S/CC.

Documentation: Written verification from his/her employer that s/he has enrolled in an available employer group health insurance plan.

- Seeing the ID for the health insurance plan.

RESOURCES

NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE

Description: The Partnership for Long-Term Care (Partnership) provides an alternative means to fund long-term care while promoting financial independence of New York State residents. This means New York State will share with participating consumers in planning for their long-term care expenses. Individuals and couples who purchase and keep in effect Partnership for Long-Term Care insurance policies will be protected, if they are otherwise eligible, against the costs of extended care situations through the Medicaid Program. State approved Partnership for Long-Term Care insurance policies are sold through private insurance companies. The Insurance Department of the State of New York must approve all Partnership insurance policies, and insurance companies marketing Partnership policies must enter into an Insurer Participation Agreement with the NYSDOH.

Policy: Persons who utilize the required amount of benefits under one of the four Partnership Plans become a Qualified Partnership Policyholder (QPP) and are eligible for Medicaid Extended Coverage (MEC) appropriate to the type of policy purchased. (See **GLOSSARY** for definitions) Although the private insurance component of a Partnership policy may be used outside of New York State to pay for long-term care services, Medicaid Extended Coverage is ONLY available for a QPP who is a resident of New York State. Provided a Partnership policyholder is not placed in a New York State institution by another state, or by a public or private organization contracting with the other state for such purposes, an A/R returning to New York State is a resident of New York State upon entering the State. (See **OTHER ELIGIBILITY REQUIREMENTS** STATE RESIDENCE AND RESPONSIBILITY FOR ASSISTANCE DISTRICT OF FISCALLY RESPONSIBILITY (DFR) for determining the district of fiscal responsibility.)

For Total Asset Protection (TAP) plans, income is considered in determining Medicaid eligibility, but resources are exempt. No liens or recoveries are pursued for correctly paid Medicaid.

For Dollar-for-Dollar Asset Protection (DDAP) plans, income AND unprotected resources are considered in determining Medicaid eligibility. The amount of any lien or recovery against the A/R's estate is reduced by the amount of asset protection provided to the A/R as a qualified Partnership policyholder.

All Medicaid income rules in effect at the time of application will apply.

NOTE: The income level used for married QPPs who are subject to SSI-Related community budgeting is the Spousal Impoverishment Minimum Monthly Maintenance Needs Allowance (MMMNA). The income level used for single QPPs subject to SSI-Related community budgeting is one-half of the Minimum Monthly Maintenance Needs Allowance. If the QPP

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NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE

has income in excess of these levels, the QPP may spend down to the appropriate MEC income level rather than the Medicaid level. The MMMNA levels do not apply when the QPP is subject to chronic care budgeting.

Local districts are notified of an A/R's qualification for Medicaid Extended Coverage by a 90-day Notice of Qualifying Status for Medicaid Extended Coverage letter which will be provided to the local district by the State Department of Health and/or the A/R. Different 90-day notices are issued depending on whether the A/R is participating in the TAP or DDAP plan and its minimum duration requirement. Such notices will be on insurance company letterhead, and serve as verification that the A/R is a Partnership policyholder who is about to achieve qualifying status.

References:

ADMs
09 OHIP/ADM-3
06 OMM/ADM-5
05 OMM/ADM-1
04 OMM/ADM-6
02 OMM/ADM-3
96 ADM-8
91 ADM-17

LCM
97 OMM LCM-3

GISs
10 MA/016
07 MA/020

Informational References: http://www.nyspltc.org

Interpretation:

Total Asset Protection (TAP)

Total Asset 50 policies are identified by the number "3/6/50" and provide a minimum benefit of three years in a nursing home; or six years of home care (community-based long-term care services). In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 36 months of paid nursing home care, home care (where two days of home care equal one nursing home day), and certain other policy benefits may be used to satisfy this requirement.

Total Asset 100 policies are identified by the number "4/4/100" and provide a minimum benefit of four years in a nursing home; or four years of home care (community-based long-term care services); or four years in a residential care facility, such as an assisted living program. In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 48 months of paid nursing home care or its equivalent. A combination of nursing home care, home care, care in a

residential care facility, and certain other policy benefits may be used to satisfy this requirement.

The resources of the TAP QPP are exempt from consideration in determining Medicaid eligibility. If the TAP QPP is married, his/her spouse's resources are not considered in determining the QPP's Medicaid eligibility. It is not necessary to collect and/or document information on the TAP QPP's resources or the resources of his/her spouse, except to the extent that such information documents income derived from such resources. Transfer of resources provisions do not apply. However, since income is not exempt, if there is a transfer of a lump sum income payment or a stream of income during the look-back period a transfer penalty may result. If an exempt resource that generates income is transferred, no transfer penalty is imposed. TAP QPPs are exempt from liens and recoveries, annuity requirements and substantial home equity requirements.

Dollar-for-Dollar Asset Protection Plan (DDAP)

Dollar-for-Dollar Asset 50 policies are identified by the number "1.5/3/50" and provide a minimum benefit of one and one-half years in a nursing home; or three years of home care (community-based long-term care services), where two days of home care equal one nursing home day. In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 18 months of paid nursing home care or its equivalent. A combination of nursing home care, home care (where two days of home care equal one nursing home day), and certain other policy benefits may be used to satisfy this requirement.

Dollar-for-Dollar Asset 100 policies are identified by the number "2/2/100" and provide a minimum benefit of two years in a nursing home; or two years of home care (community-based long-term care services); or two years in a residential care facility, such as an assisted living program. In order to be eligible for Medicaid Extended Coverage, a QPP must use benefits under the policy equal to 24 months of paid nursing home care or its equivalent. A combination of nursing home care, home care, care in a residential care facility, and certain other policy benefits may be used to satisfy this requirement.

The DDAP QPP is allowed standard Medicaid resource exemptions in addition to the amount of his/her Partnership resource disregard. The amount of the Partnership resource disregard is the dollar amount paid by the policy for benefits received by the QPP. If the DDAP QPP is married, his/her spouse's resources are counted in the eligibility determination to the extent that the couple's combined resources exceed the dollar amount paid by the Partnership policy for benefits. If the DAPP QPP is an institutionalized spouse, the couple's countable resources that exceed

the sum of the community spouse resource level, the dollar amount paid by the Partnership policy for benefits, and the Medicaid resource level for one are considered available for the institutionalized spouse's cost of care.

The resource disregard is applied first to reduce the resources of the QPP that exceed the appropriate resource standard. If excess resources exist, the DDAP QPP can become eligible for Medicaid by spending down the excess resources by incurring or paying for medical expenses.

The collection and documentation of resources for the transfer of assets look-back period is required if a DDAP QPP applies for Medicaid coverage of nursing facility services and is determined to be otherwise eligible for Medicaid. If a DDAP QPP or his/her spouse made a prohibited transfer of resources within the look-back period any remaining dollar – for-dollar disregard not used to establish resource eligibility may be used to offset the transferred resources. In cases where the uncompensated value of a prohibited transfer is entirely offset by the remaining amount of the dollar-for-dollar disregard, no transfer penalty is imposed. Any uncompensated transfer or a portion thereof, is not offset by the dollar-for-dollar disregard may result in a transfer penalty period. Any dollar-for-dollar disregard amount used to offset a prohibited transfer cannot be used again for eligibility purposes, nor can the same dollar-for-dollar amount be used to offset any lien or recovery amount from the DDAP QPP's estate.

If an annuity, such as a deferred annuity, is a countable resource at the time of application for Medicaid Extended Coverage (MEC) the dollar-for-dollar Partnership policy/certificate holder may use the asset protection earned by the Partnership insurance to establish resource eligibility. If the dollar-for-dollar asset protection is not sufficient to disregard the entire value of the annuity, any portion of the annuity value not disregarded is a countable resource for purposes of determining eligibility for MEC. In **no** instance is the dollar-for-dollar policy/certificate holder or his/her spouse required to name the State as a remainder beneficiary of the annuity when the annuity has been determined to be a countable resource.

In instances where the annuity is **not** a countable resource (e.g., a qualified annuity in payment status) and the dollar-for-dollar Partnership policy/certificate holder is applying for Medicaid coverage of nursing facility services, the policy/certificate holder and his/her spouse will be required to name the State as a remainder beneficiary or the annuity will be treated as an uncompensated transfer. Effective August 8, 2006, if the policy/certificate holder or his/her spouse refuse to name the State as remainder beneficiary, any dollar-for-dollar disregard remaining after the establishment of resource eligibility

may be used to offset the amount of the transfer (purchase price of annuity less any monies actually received from the annuity). A note must be maintained in the case record to avoid re-applying this disregard in the future.

NOTE: Individuals may purchase Partnership Policies of greater duration than the minimum duration requirement. However, Dollar-for-Dollar Asset 50 policies cannot exceed two and one-half years of nursing home care and five years of home care. Dollar-for-Dollar Asset 100 policies cannot exceed two and one-half years of nursing home care, two and one-half years of home care and two and one-half years of care in a residential care facility. Partnership insurance policy coverage that exceeds the minimum required standards for Medicaid Extended Coverage shall be used like any other third-party health insurance to offset Medicaid expenditures for the QPP.

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MEDICARE SAVINGS PROGRAM

Policy: Certain A/Rs who receive Medicare may be eligible for Medicaid to pay the Medicare premium, coinsurance and deductible amounts.

References: SSL Sect. 367-a (3) a

GISs 10 MA/010
08 MA/016
05 MA/033
05 MA/013

Interpretation: The A/R may spend down income to become eligible for Medicaid and also be eligible for QMB or SLMIB, however, the Medicare premium cannot be applied in whole or in part to reduce excess income. At the time of application, the applicant is encouraged to make a choice to apply the Medicaid Premium to their spenddown to attain Medicaid eligibility **OR** to forego Medicaid eligibility for eligibility in the Medicare Savings Program. The advantages and disadvantages of both programs must be fully explained. An A/R may switch between spenddown and Medicare Savings Program; however, in the interest of accuracy and administrative efficiency, the A/R is encouraged to select and remain in one of the two programs.

Eligibility for the MSPs must be determined even if an applicant does not indicate that he or she is applying for the MSP on the DOH-4220 or LDSS-2921. If applying for MSP only, the DOH-4328 is used.

NOTE: The ACCESS NY Supplement A is not required for persons applying for the MSP only.

NOTE: When two spouses reside together in a household, eligibility for MSP will be determined by comparing income to a household of two, regardless of the income or category of the spouses.

There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles, through the Medicare Savings Program.

NOTE: See **REFERENCE** MEDICALLY NEEDY INCOME AND FEDERAL POVERTY LEVELS for a chart displaying the Medicaid Levels and Federal Poverty Levels.

RESOURCES

MEDICARE SAVINGS PROGRAM

Qualified Medicare Beneficiaries (QMBs)

The A/R must:

1. be entitled to benefits under Part A of Medicare; and
2. have income equal to or less than 100% of the federal poverty level.

If the A/R meets the above criteria, s/he is eligible for Medicaid payment of the Medicare Part A and B premiums, coinsurance and deductible amounts.

There is no resource test.

The DOH-4328 application should be used for individuals applying for QMB only.

Specified Low-Income Medicare Beneficiaries (SLIMBs)

The A/R must:

1. have Part A of Medicare; and
2. have income between 100% but less than 120% of the federal poverty level.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums.

There is no resource test.

The DOH-4328 application should be used for individuals applying for SLMB only, unless there is a spenddown in which case the DOH-4220 must be used.

NOTE: The ACCESS NY Supplement A is not required for persons applying for the MSP only.

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MEDICARE SAVINGS PROGRAM

Qualified Disabled and Working Individuals (QDWIs)

The A/R must:

1. have lost Part A benefits because of return to work;
2. be a disabled worker less than 65 years of age;
3. have income equal to or less than 200% of the federal poverty level;
4. have resources not in excess of twice the SSI limit; therefore, resources cannot exceed $4,000 for a household of one or $6,000 for a household of two; and
5. not be otherwise eligible for Medicaid.

If the A/R meets the above five criteria s/he is eligible for Medicaid payment of the Medicare Part A premium, not the Medicare Part B premium.

The applicant is required to attest to the amount of his/her resources but does not need to provide proof.

Qualifying Individuals – (QI)

The A/R must:

1. have Part A of Medicare; and
2. have income between 120% - 135% of the federal poverty level.

If the A/R meets the above criteria s/he is eligible for Medicaid payment of the Medicare Part B premiums each month.

Applicants should use the DOH-4328 when applying for this benefit.

Each state has been given a capped allocation to fund these premium payments.

There is no resource test.

RESOURCES

VETERANS NURSING HOME PER DIEM PAYMENTS

Description: The Veteran's Administration (VA) pays states a per diem payment for nursing home care provided to eligible veterans in a facility recognized as a state home for nursing home care.

Policy: Public Law 108-422 prohibits Medicaid from offsetting the Veteran's Administration "per diem" payment from the cost of nursing home care.

References: GIS 05 MA/040

Interpretation: Prior to the enactment of the Veteran's Health Program Improvement Act (VHPIA), the VA per diem payment was considered a third party resource under Medicaid law, and was used to offset the Medicaid payment to nursing homes. Effective November 30, 2004, these VA payments are no longer considered a third party resource, and cannot be used to reduce Medicaid's share of the cost of providing nursing home services to Medicaid recipients. The facility may retain the per diem payment.

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Description: Sometimes an SSI-related A/R, the A/R's spouse, or someone acting on his/her behalf, makes a voluntary assignment or transfer of non-exempt assets for less than its fair market value. Under certain circumstances, an SSI-related A/R may be subject to a period of restricted Medicaid coverage or penalty period, when a transfer of assets for less than the fair market value has occurred within the look-back period.

Policy: Once an SSI-related A/R is found financially eligible for Nursing Facility Services a review is made to determine if any assets were transferred during the look-back period for less than fair market value. A/Rs are initially requested to provide an explanation of each bank transaction of $2,000 or more. If the district identifies that transfers for less than fair market value been made, a review of all transactions made during the look-back period may be performed.

For applications of Medicaid coverage for nursing facility services and for SSI-related recipients who request an increase in coverage for nursing facility services, the look-back period increases from 36 months to 60 months (60 months for trusts) for transfers made on or after February 8, 2006.

The look-back period increases each month by 1-month increments beginning March 1, 2009 (37 months) until February 2011. Effective February 1, 2011, the full 60 month look-back period will be in place for ALL transfers of assets.

NOTE: In cases where the initial days of nursing facility care were covered as short-term rehabilitation under Community Coverage Without Long-Term Care, the look-back period is the period immediately preceding the month the SSI-related individual started to receive the short-term rehabilitation service. Any transfer penalty for an otherwise eligible individual would start the first month the individual started to receive the short-term rehabilitation service.

Once eligibility is established for an SSI-related institutional spouse, any transfers made by the community spouse do not affect the institutionalized spouse's Medicaid eligibility.

NOTE: If an SSI-related Medicaid recipient has been on Medicaid for the past 60* months, has documented current resources at each renewal; not created or funded a trust which requires a 60-month look-back; and not made a prohibited transfer, a separate resource review

RESOURCES

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for the past 60* months is not required for requests of increased coverage for nursing facility services.

* The look-back period increases each month by one-month increments beginning 3/1/09 until February 2011. Effective February 1, 2011, the full 60 month look-back period will be in place.

The transfer of assets rules do not apply to persons whose eligibility is determined without a resource test. Effective for eligibility periods beginning on or after January 1, 2010 FHPlus and non-SSI-related Medicaid A/Rs will not have resources considered in determining eligibility. This change includes the following Medicaid categories: Singles/Childless Couples (S/CC), Low Income Families (LIF), ADC-related (including adults who spend down excess income to the Medicaid income level), children under 21 years of age when comparing income to the Medicaid income level (Under age 21), and parents living with their dependent child(ren) under age 21 with income at or below the Medicaid income level (FNP Parents).

In determining eligibility, resources are never considered for pregnant women and infants under one year of age. Resources are also not considered for children over age one but under age 19.

In addition, there is no resource test for applicants for the Family Planning Benefit Program, Medicaid Cancer Treatment Program, the Medicare Savings Program including the Qualified Individual Program (QI), Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLIMB), AIDS Health Insurance Program (AHIP) and policy holders who have utilized the minimum required benefits under a total asset Partnership for Long-Term Care insurance policy. (See **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG-TERM CARE)

Transfer of assets provisions do not apply to individuals applying for or receiving coverage for HCBS waiver services.

References:

SSL Sect. 104-a
366
366.5
366-a(2)
366-c
366-ee

Chapter Laws 109 of the Laws of 2006

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Dept. Reg. 360-1.4
360-2.3
360-4.4(b)(2)
360-4.4(c)
360-4.6
360-4.7(a)(1)

ADMs 10 OHIP/ADM-01
09 OHIPADM-3
08 OLTC-01
06 OMM/ADM-5
04 OMM/ADM-6
96 ADM-8
91 ADM-37
91 ADM-31
90 ADM-36
90 ADM-29
89 ADM-45
85 ADM-27

GISs 09 MA/027
09 MA/016
09 MA/007
08 MA/019
07 MA/018
07 MA/007
06 MA/016
05 MA/012

Interpretation: When an institutionalized SSI-related A/R or spouse makes a prohibited transfer, but is otherwise eligible for Medicaid, a penalty period is imposed. During this penalty period, the SSI-related A/R will not be eligible for nursing facility services. (See **RESOURCES** RESOURCE DOCUMENTATION REQUIREMENTS for a complete list of nursing facility services.)

Exceptions:

- The transfer of exempt assets, other than a homestead, does not affect the SSI-related A/R's eligibility.
- An SSI-related A/R and/or the spouse may transfer the homestead, without penalty, to his/her:
- Spouse;

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TRANSFER OF ASSETS

- Child under the age of 21;
- Certified blind/disabled child of any age;
- Sibling who has an equity interest in the SSI-related A/R's home and has resided in the home for at least one (1) year immediately prior to the A/R's most recent institutionalization; or
- Adult child who resided in the SSI-related A/R's home for at least 2 years, immediately prior to the A/R's most recent institutionalization and who provided care to the SSI-related A/R which permitted the A/R to reside at home rather than in a medical facility. It is presumed that the child "provided care" unless there is evidence to the contrary.

The transfer of a homestead to any other person for less than fair market value may render the SSI-related A/R ineligible for Medicaid coverage of nursing facility services.

Transfer of assets penalties are not imposed against an SSI-related A/R when an asset other than the individual's home is transferred:

- to the individual's spouse, or to another for the sole benefit of the individual's spouse;
- from the individual's spouse to another for the sole benefit of the individual's spouse;
- to the individual's child who is certified blind or certified disabled; or
- to a trust established solely for the benefit of an individual under 65 years of age who is disabled.

Sole Benefit – A transfer is considered to be for the "sole benefit of the SSI-related individual's spouse" if the transfer is arranged in such a way that no individual or entity other than the spouse can benefit from the assets transferred in any way, whether at the time of the transfer or any time in the future. A remainder man is someone who will inherit property in the future (e.g., after a person's death). A transfer is not for the sole benefit of the spouse if the transferred asset has a remainder person. For example, if an SSI-related institutionalized spouse takes money that is in his/her name, purchases an annuity so that only the community spouse receives payments, and there is a designation of a remainder man (beneficiary other than the community spouse's estate), this would be evaluated as an uncompensated transfer.

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TRANSFER OF ASSETS

A transfer penalty is not imposed against an SSI-related A/R when a satisfactory showing is made that:

- the SSI-related A/R or the A/R's spouse intended to dispose of the asset for its fair market value or exchange it for other consideration of similar value;

- all of the assets transferred for less than the fair market value have been returned to the individual.

Assets Transferred to Purchase Life Estate Interest

If an SSI-related A/R or the A/R's spouse transfers assets to purchase a life estate interest in property owned by another individual on or after February 8, 2006, the purchase is to be treated as a transfer of assets for less than fair market value, unless the purchaser resides in the home for at least a continuous period of one year after the date of purchase.

The amount used to purchase the life estate interest is the amount to be treated as the uncompensated transfer of assets in the eligibility determination. This policy applies to applications filed on or after August 1, 2006 for nursing facility services, including requests for an increase in coverage for nursing facility services.

Assets Transferred to Purchase Loans, Promissory Notes and Mortgages

Applications filed on or after August 1, 2006 for nursing facility services, including requests for an increase in coverage for nursing facility services, if an SSI-related A/R or the A/R's spouse purchases a loan, promissory note or mortgage, the funds used are to be treated as a transfer for less than fair market value, unless the note, loan or mortgage:

- Has a repayment term that is actuarially sound;
- Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- Prohibits the cancellation of the balance upon the death of the lender.

The amount of the transfer is the outstanding balance due as of the date of the individual's application for nursing facility services.

RESOURCES

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Assets Transferred to Purchase a Personal Service Contract

A personal service contract that does not provide for the return of any prepaid monies in the event the caregiver becomes unable to fulfill his/her duties under the contract, of it the SSI-related A/R dies before his/her calculated life expectancy, must be treated as a transfer of assets for less than FMV. If a personal service contract does provide for the return of funds in the events the caregiver is unable to fulfill his/her obligation under the contract or the SSI-related A/R dies before his/her calculated life expectancy, a determination must still be made as to whether the SSI-related A/R will receive FMV in exchange for funds transferred.

If the personal service contract provides that services will be delivered on an "as needed" basis, no determination that FMV will be received and a transfer of assets penalty must be calculated.

In calculating the transfer penalty, the value of services actually received from the time the personal service contract was signed and funded through the date of the Medicaid eligibility determination must be "credited" by reducing the transferred amount before calculating the period of ineligibility.

NOTE: Credit is not allowed for services that are provided as part of the Medicaid nursing home rate.

In assessing the value of furnished services, districts must be provided with credible documentation, such as a log with dates specific services were provided and the hour(s) each service was provided. The value of the caregiver services must be commensurate with a reasonable wage scale, based on fair market value for the actual job performed and the qualifications of the caregiver. If credible documentation is not provided, no credit is deducted in calculating the uncompensated transfer amount. When a district determines that a reasonable pay rate for a job/service is less than the amount spelled out in the personal services contract, the district must use the lesser amount in calculating the amount of compensation received for the transfer.

NOTE: Assistance in evaluating job duties and pay rates may be found in the U.S. Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook at: http://www.bls.gov/oco/. This handbook includes information on training and other qualifications needed for particular jobs.

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The SSI-related A/R or the A/R's spouse is allowed a minimum of twenty days to present evidence that the transfer was made exclusively for a purpose other than to qualify for Medicaid coverage of nursing facility services. An SSI-related A/R's Medicaid coverage may not be restricted due to a transfer of assets without first advising the SSI-related A/R and the spouse, in writing, of the right to present evidence. Some factors suggesting that the transfer was made exclusively for another purpose include:

- The traumatic onset of a disability after the transfer (e.g., A/R has a heart attack shortly after the transfer and there was no previous record of heart disease); or

- The unexpected loss of other resources which would have precluded Medicaid eligibility.

Rebuttal Presumption of Prohibited Transfer

If an SSI-related individual transfers resources (e.g. gives them away or sells them for less than fair market value), there is a rebuttable presumption that the resources were transferred for the purpose of establishing or maintaining eligibility for Medicaid coverage of nursing facility services. The presumption is rebutted only if the SSI-related individual provides convincing evidence that the resources were transferred exclusively for a purpose other than to become or remain eligible for Medicaid. If the SSI-related individual had some other purpose of transferring the resource but an expectation of establishing and maintaining Medicaid eligibility was also a factor, the transfer will result in a period of ineligibility for Medicaid coverage of nursing facility services.

An SSI-related A/R's Medicaid coverage may not be restricted due to a transfer of assets without first advising the SSI-related A/R and the spouse, in writing, of the right to present evidence to rebut the presumption that a transfer was made in order to qualify for Medicaid coverage of nursing facility services. To meet this requirement, the "Explanation of Effects of Transfer" must be given to the applicant who is applying for Medicaid coverage of nursing facility services.

The SSI-related individual must provide convincing evidence (i.e. written documentation) that the transfer was exclusively for a purpose other than to qualify for Medicaid benefits. An individuals' signed statement regarding the circumstances of the transfer should include the individual's:

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- Purpose of transferring the resource;
- Attempts if any, to dispose of the resource at fair market value (FMV);
- Reason for accepting less than FMV for the resource;
- Means or plans for self-support after the transfer;
- Relationship, if any, to the person(s) to whom the resource was transferred;
- Belief that he/she received FMV, if applicable.

NOTE: A signed statement by the SSI-related individual is not, by itself, convincing evidence. Pertinent documentary evidence includes, but is not limited to, legal documents, real estate agreements, relevant correspondence, medical reports, etc.

The following are examples of situations that while not conclusive, may indicate that the transfer was made exclusively for some purpose other than to qualify for Medicaid coverage of nursing facility services. After the transfer:

- There is a traumatic onset (e.g. traffic accident) of disability or blindness; or
- There is a diagnosis of a previously undetected disabling condition (e.g., heart attack when there was no previous record of heart disease), or
- There is an unexpected loss of other income or resources which would have precluded Medicaid eligibility.

If the SSI-related A/R is unable to present evidence that the A/R or his/her spouse intended to dispose of the asset for the fair market value, or that the asset was transferred exclusively for a purpose other than to qualify for Medicaid, the case is evaluated to determine if the restriction of Medicaid coverage would cause the SSI-related A/R "undue hardship". Undue hardship occurs when the SSI-related A/R is otherwise eligible for Medicaid; is unable to obtain appropriate medical care without Medicaid coverage; and despite the best efforts of the A/R and/or the spouse, is unable to have the transferred assets returned or to receive fair market value for the assets. Best efforts include cooperating, as deemed appropriate by the local social services district, in the pursuit of the return of such assets.

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NOTE: Effective February 8, 2006 to meet the definition of undue hardship, the SSI-related individual must meet all of the conditions described above and be deprived of food, clothing, shelter or other necessities of life.

Uncompensated Value

The uncompensated value of a transfer is the difference between the fair market value at the time of transfer (less any outstanding loans, mortgages or other legal encumbrances on the asset) and the amount received for the asset. If the SSI-related A/R's resources are below the appropriate resource level, the amount by which the resource level exceeds the SSI-related A/R's resources must be deducted from the uncompensated value of the transfer. In addition, amounts specified in regulations for burial funds ($1,500 for SSI-related A/Rs), but not for burial space items, must be deducted, if the SSI-related A/R does not have an irrevocable pre-need funeral agreement with $1,500 designated for non-burial space items or a burial fund.

Example: An SSI-related applicant makes a prohibited transfer in April, 2005 of $20,000 and applies for Medicaid coverage of nursing home care in May, 2005. The only resource the SSI-related applicant has is $2,000 in a bank account. To determine the uncompensated value of the prohibited transfer, subtract the SSI-related applicant's countable resources from the Medicaid Resource Level for a household of one ($4,000 - $2,000 = $2,000). If there is a remainder, subtract the remainder from the prohibited transfer amount ($20,000 - $2,000 = $18,000). $18,000 is the uncompensated value of the transfer.

If the SSI-related applicant also does not have an irrevocable pre-need funeral agreement with $1,500 designated for non-burial space items or a $1,500 burial fund, the prohibited transfer amount is further reduced by $1,500 ($18,000 - $1,500 = $16,500). $16,500 is the uncompensated value of the transfer**.**

The uncompensated value cannot be reduced by applying it to the maximum community spouse resource allowance.

Except as provided below concerning multiple transfers, for transfers made prior to February 8, 2006 the penalty period begins on the first day of the month following the month in which the assets were transferred.

RESOURCES

TRANSFER OF ASSETS

For transfers made on or after February 8, 2006, the penalty period starts the first day of the month after assets have been transferred for less than fair market value, OR the first day of the month the otherwise eligible SSI-related institutionalized individual is receiving nursing facility services for which Medicaid would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility.

The penalty period is a period of months equal to the total uncompensated value of the transferred assets divided by the average regional rate for nursing facility services in the region where the SSI-related individual is institutionalized. There is no cap on the length of the penalty period. The regional rates are revised annually and are based on average nursing home costs in each of the seven regions of the State. (See **REFERENCE** REGIONAL RATES FOR TRANSFER OF ASSETS)

Once a penalty period has been established for an otherwise eligible SSI-related individual, the penalty period continues to run regardless of whether the individual continues to receive nursing facility services or remains eligible for Medicaid. Upon reapplication for Medicaid coverage of nursing facility services, any uncompensated transfer that still falls within the new look-back period which has already resulted in an expired penalty period, would not again be assessed a penalty. Only subsequent transfers can result in a transfer penalty period.

Partial Month Penalty Period

If the uncompensated value of the transferred assets is less than the regional rate, or the penalty period results in a partial month penalty, count the uncompensated value attributable to the partial month as part of the Net Available Monthly Income (NAMI) or, in the case of an individual receiving waiver services in the community, spenddown liability for the month.

> Example: An SSI-related applicant in the Northern Metropolitan region makes an uncompensated transfer of $29,162 in April, 2005. The uncompensated transfer amount of $29,162, divided by $8,332 (the 2005 Medicaid monthly regional rate for the Northern Metropolitan region), equals 3.5 months. The 3-month penalty period runs from May, 2005, the month following the month of transfer, through July, 2005, with a partial month penalty calculated for August, 2005. The calculations follow:

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$ 8,332	Medicaid monthly regional rate (for Northern Metropolitan region)
X 3	three-month penalty period
$24,996	penalty period amount for three full months
$29,162	uncompensated transfer amount
-24,996	penalty period amount for three full months
$ 4,166	partial month penalty amount

For August, 2005, the partial month penalty amount of $4,166 would be added to the SSI-related institutionalized person's NAMI.

Recalculation of Returned Assets

If all or a portion of the transferred assets is returned after the Medicaid eligibility determination, the existing penalty period is recalculated, reducing the penalty period by the amount of assets returned. For transfers made after February 8, 2006, the recalculated penalty period cannot begin before the assets retained by the individual at the time of transfer, combined with the assets transferred, and subsequently returned to the individual, have been spent down to the applicable Medicaid resource level.

Multiple Transfers

For multiple transfers during the look-back period, where assets have been transferred in amounts and/or frequency that would make the calculated penalty periods overlap, add together the uncompensated values of all the assets transferred, and divide by the Medicaid regional rate. The period of ineligibility begins with the first day of the month following the month in which that first transfer occurred.

Multiple transfers of assets for less than fair market value made on or after February 8, 2006, must be accumulated and treated as one transfer. The penalty period starts the first day of the month after assets have been transferred for less than fair market value, OR the first day of the month the otherwise eligible SSI-related institutionalized individual is receiving nursing facility services for which Medicaid would be available but for the transfer penalty, whichever is later, and which does not occur during any other period of ineligibility.

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Apportioning Penalty Periods Between SSI-related Spouses

When an SSI-related institutionalized spouse applies for Medicaid and either spouse has made a prohibited transfer and if the SSI-related institutionalized spouse is otherwise eligible, he/she is authorized with restricted coverage for a penalty period based on the full uncompensated value of the transferred resources.

If the other member of the SSI-related couple subsequently applies for Medicaid as an SSI-related institutionalized individual (both SSI-related spouses are institutionalized), prior to the expiration of the penalty period the penalty period is apportioned equally between the SSI-related spouses. If one spouse is no longer subject to a penalty (e.g., one spouse dies), the remaining penalty period for both spouses is applied to the remaining spouse.

An institutionalized SSI-related A/R who is being penalized for making a prohibited transfer may receive Medicaid coverage for ancillary services, not included in the per diem rate, if otherwise eligible. The SSI-related A/R is budgeted by deducting the SSI-related disregards, the Medically Needy Income level for a household of one. (See **REFERENCE** MEDICALLY NEEDY INCOME LEVELS and the MEDICAID RESOURCE LEVEL) An SSI-related institutionalized spouse is budgeted as if s/he was in his/her first month of permanent absence from the community. Only those resources in excess of the community spouse resource allowance (See **REFERENCE** MINIMUM/MAXIMUM COMMUNITY SPOUSE ALLOWANCE are considered.

It is essential that the local district carefully document the actual date of any transfer. When an SSI-related A/R or spouse deeds property to another person, the effective date of the transfer is the date the deed is delivered to and accepted by the transferee/purchaser. The deed need not be recorded to complete the transfer. When a person promises to transfer a gift or resource to another person, the date the promise is made is not significant. The date of transfer is the date the resource changed ownership.

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Verify Status:

(a) When the SSI-related A/R or spouse indicates that someone else pays the mortgage or property tax;

(b) When the SSI-related A/R or spouse indicates that s/he is provided with a home at no cost;

(c) When previous records indicate resources that are no longer claimed;

(d) When the SSI-related A/R's or spouse's financial institution accounts indicate substantial withdrawals;

(e) When the SSI-related A/R or spouse declares resources in the name of another person.

Verification:

(a) Obtaining an appraisal by a real estate broker;

(b) Seeing property tax statements;

(c) Seeing mortgage statements;

(d) Seeing financial institution account statements;

(e) Seeing court records.

Disposition:

When the local social services district becomes aware that a transfer of resources was made by an SSI-related A/R or his/her spouse, the local district determines the date on which the resources were transferred. The SSI-related A/R is notified and given a reasonable amount of time to present evidence that the transfer was not made for the purpose of qualifying for Medicaid. When a penalty period is imposed, an adequate and timely notice is sent to the SSI-related A/R.

RESOURCES
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ANNUITIES

Description: An annuity is contract with a life insurance company, designed to provide payments on a regular basis either for life or a term of years.

Policy: As a condition of eligibility, all persons applying for Medicaid coverage of nursing facility services, including requests for an increase in coverage for nursing facility services, must disclose a description of any interest he/she, or his/her spouse, may have in an annuity. The disclosure of interest in an annuity is required regardless of whether the annuity is irrevocable or counted as a resource. Additionally, for annuities purchased by an SSI-related A/R or the A/R's spouse on or after February 8, 2006, the State must be named as a remainder beneficiary in the first position for at least the amount of Medicaid paid on behalf of the institutionalized individual. In cases where there is a community spouse or minor or disabled child of any age, the State must be named the remainder beneficiary in the second position or named in the first position if such spouse or representative of such child disposes of any such remainder for less than fair market value.

NOTE: In instances where the annuity has been determined to be a countable resource, the State is NOT named a remainder beneficiary.

The social services district must require a copy of the annuity contract owned by the SSI-related A/R or the A/R's spouse in order to verify that the State has been named the remainder beneficiary. If the SSI-related A/R or the A/R's spouse fails or refuses to provide the necessary documentation, the district must treat the purchase of the annuity as a transfer of assets for less than fair market value.

Individuals who are applying for or receiving care, services or supplies pursuant to a waiver under subsection (c) or (d) of Section 1915 of the Social Security Act (SSA) are **not** subject to these requirements regarding annuities. In New York, such waiver services are provided through the Long Term Home Health Care Program (LTHHCP), Traumatic Brain Injury Waiver Program (TBI), Care at Home Program (CAH), the Office for People with Developmental Disabilities (OPWDD) Home and Community-Based Services (HCBS) Waiver, Home and Community- Based Services Waiver for Children with Serious Emotional Disturbance (Office of Mental Health [OMH]) and the Nursing Home Transition and Diversion Waiver (NHTD).

NOTE: Treatment of annuities for Partnership policy/certificate holders with Total Asset Protection OR Dollar for Dollar Asset Protection plans is discussed in **RESOURCES** NEW YORK STATE PARTNERSHIP FOR LONG TERM CARE.

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ANNUITIES

References:

SSL Sect.	366-a (2) 366 366-c 366-ee
Dept. Reg.	360-2.3 360-4.4 360-4.6
ADMs	10 OHIP/ADM-01 06 OMM/ADM-5 06 OMM/ADM-2 04 OMM/ADM-6 96 OMM/ADM-8
GISs	09 MA/027 07 MA/020 07 MA/018 07/MA/011 06 MA/016

Interpretation: The purchase of an annuity that does not name the State as a remainder beneficiary in the first position (or in the second position as explained above) will be treated as an uncompensated transfer of assets for SSI-related A/Rs. In addition, if an annuity is purchased by or on behalf of an SSI-related A/R, the purchase will be treated as a transfer of assets for less than fair market value unless the annuity is:

- An annuity described in subsection (b) or (q) of Section 408 of the Internal Revenue Code of 1986; or
- Purchased with the proceeds from an account or trust, described in subsection (a), (c), or (p) of Section 408 of such Code; a simplified employee pension (within the meaning of Section 408 (k) of such Code); or a Roth IRA described in Section 408A of such Code; or

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TRANSFER OF ASSETS

ANNUITIES

The annuity is:

- Irrevocable and non-assignable;
- Is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); **AND**
- Provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

NOTE: These provisions apply to transactions, including purchases which occur on or after February 8, 2006. Transactions subject to these provisions include any action by the individual that changes the course of payment from the annuity or that changes the treatment of the income or principal of the annuity. These transactions include additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and similar actions.

RESOURCES
TRANSFER OF ASSETS

REGIONAL RATES

Policy: Regional rates are used to determine the period of restricted Medicaid coverage when a prohibited transfer is made. The districts included in each region are identified below. Districts must use the rate for the region in which the facility is located. The regional rates for persons who apply for Medicaid as an SSI-related institutionalized person on or after January 1, each year can be found in the **REFERENCE** REGIONAL RATES TRANSFER OF ASSETS. The regional rates are based on the average nursing home costs in each of the seven regions of the State.

NORTHEASTERN			WESTERN	
Albany	Fulton	Saratoga	Allegany	Orleans
Clinton	Greene	Schenectady	Cattaraugus	Wyoming
Columbia	Hamilton	Schoharie	Chautauqua	
Delaware	Montgomery	Warren	Erie	
Essex	Otsego	Washington	Genesee	
Franklin	Rensselaer		Niagara	

ROCHESTER		NORTHERN METROPOLITAN	
Chemung	Steuben	Dutchess	Westchester
Livingston	Wayne	Orange	
Monroe	Yates	Putnam	
Ontario		Rockland	
Schuyler		Sullivan	
Seneca		Ulster	

CENTRAL			NEW YORK CITY
Broome	Lewis	Tioga	Bronx
Cayuga	Madison`	Tompkins	Kings (Brooklyn)
Chenango	Oneida		NY (Manhattan)
Cortland	Onondaga		Queens
Herkimer	Oswego		Richmond (Staten Island)
Jefferson	St. Lawrence		

LONG ISLAND	
Nassau	Suffolk

RESOURCES
TRANSFER OF ASSETS

REGIONAL RATES

References:

SSL Sect. 366
366-ee

ADMs 10 OHIP/ADM-01
96 ADM-8
06 OMM/ADM-2
05 OMM/ADM-1

GISs 09 MA/027
07 MA/002
06 MA/001
04 MA/033