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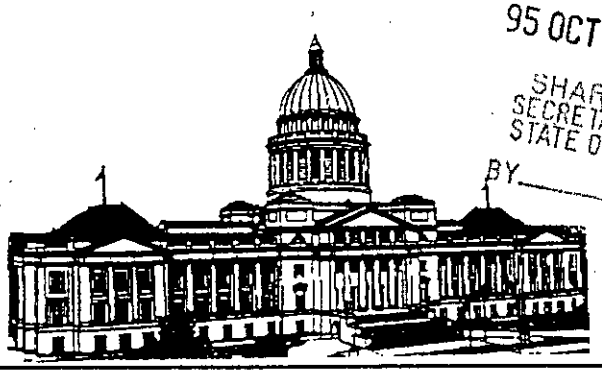

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Transmittal Sheet

Sharon Priest
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State Capitol Room 017
Little Rock, AR 72201-1094

For Office Use Only: Effective Date 10/01/95 Code Number 016.20.95-014

Name of Agency Department of Human Services

Department Division of County Operations

Contact Person Carol McKnight 682-8259

Statutory Authority for Promulgating Rules AR Code Ann. 20-76-201 et Seq. and AR Code Ann. 25-15-201 et Seq.

Intended Effective Date

- ☐ Emergency
- ☐ 20 Days After Filing
- ☒ Other

	Date
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Reviewed by Legislative Council	
Adopted by State Agency	11-01-95

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Signature

Acting Director, Division of County Operations
Title

9-1-95
Date

NOTICE OF RULE MAKING

Pursuant to AR Code Ann. 25-15-201 et seq. and AR Code Ann. 20-76-201 et seq., the Director, Division of County Operations, issues proposed changes to the Long-Term Care/AA5D section of the Medical Services Policy Manual.

Copies of the proposed changes may be obtained by writing the Division of County Operations, P.O. Box 1437 - Slot 1223, Little Rock, Arkansas 72203-1437. All comments must be submitted in writing to the address above no later than thirty days from the date of this publication.

If you need this material in a different format, such as large print, contact our Americnas with Disabilities Act Coordinator at 682-8920 (voice) or 682-8933 (TDD).

The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act and operates, manages, and delivers services without regard to age, religion, disability, political affiliation, veteran status, sex race, color, or national origin.

/s/Roy Hart, Director

6607387

Arkansas Democrat Gazette
Legal Notices 1200

MANUAL TRANSMITTAL

Arkansas Department of Human Services

Division of County Operations

[X] Policy [ ] Form [ ] Policy Directive

Issuance Number MS 95-9

Medical Services Policy Manual

Issuance Date 11-01-95

From: Roy Hart, Director

Expiration Date Until Superseded

Subj: Revised Policy

Pages to be Deleted,	Dated	Pages to be Added,	Dated
MS 3000 - 3650.1*	Various Dates	MS 3000 - 3650.1*	11/01/95

Directives to be Deleted

PD 95-5	PD 93-6	PD 92-18	PD 92-8	ED 91-19
PD 95-2	PD 93-5	PD 92-15	ED 91-29	ED-91-17
PD 94-10	PD 93-4	PD 92-14	ED 91-27	ED 90-22
PD 94-1	PD 93-2	PD 92-13	ED 91-26	

*Entire Section

Summary

The entire policy section has been updated to include changes resulting from the recent Agency reorganization. Other policy changes are indicated below:

MS 3140 - For single veterans and surviving spouses of veterans who receive a VA Pension and who have no dependents, a $90 personal needs allowance will be given. The $90 PNA will not be given until VA has reduced the pension to $90.

MS 3170 - Exceptions to participation in the Medicaid Managed Care Program are residents of nursing and ICF/MR facilities, and AABD recipients with Medicare as their primary insurance.

MS 3310 #1 - The exception to the 30-day institutionalization requirement for individuals who die has been added.

MS 3310 #6 - Individuals who have established an income trust may be eligible for Long Term Care benefits.

MS 3320 - Reference is made to the begin date for services in cases involving ICF/MRs and PASARRs.

MS 3322 - Parts of this section have been renumbered.

MS 3322.5 - Dual MRT and Social Security Disability applications will, in most cases, be processed the same as MRT/SSI applications. For cases involving dual MRT and SSI applications, approval of facility services may be made when SSI has been approved.

- Medicaid cases will not be kept open pending an appeal of SSA disability denial. ANY OPEN MEDICAID CASES WHERE DISABILITY HAS BEEN APPROVED BY MRT, LATER DENIED BY SSA, AND PENDING A FINAL SSA DETERMINATION SHOULD BE CLOSED AFTER APPROPRIATE NOTICE.

MS 3323 - Parts of this section have been renumbered.

MS 3323.7 - The SGA section has been updated. SGA is $500.

MS 3324 - The address for the Memphis INS office has been changed.

MS 3331.3 #4 - A new section has been added Re. calculation of the value of dower/curtesy interests.

MS 3331.5 #1 - The requirement to document an LTC client's intent to return home has been changed from every six months to every 12 months.

MS 3331.5 #2 - The entire section on nonhome income producing property has been rewritten for clarification.

MS 3332.3 #5 - Applicants who separate burial from nonburial funds may be certified effective date of entry, if otherwise eligible.

- Prepaid burial contracts that do not specify services and merchandise equal to the purchase price may result in a period of ineligibility for uncompensated transfer. Sections have been added Re. Out-of-State Burial Arrangements and Transfer of Assets Penalty.

MS 3334.4 - Transfers for love and consideration are considered transfers for uncompensated value. The life expectancy tables have been moved to 3336.17.

MS 3335.2 - Undue hardship provisions have been changed.

MS 3336.8 - The rules applicable to trusts prior to OBRA of 1993 have been reentered as historical policy.

MS 3336.9 #2 - The income limit for income trusts from 7/1/95 - 6/30/96 is $2198. Annual cost of living adjustments which cause income to exceed the LTC maximum skilled care rate will not affect eligibility for cases previously certified under the income trust provisions. A paragraph has been added regarding assignment of income to an income trust.

MS 3336.9 #6 - Effective for cases certified 11/1/95, the ONLY fee which may be deducted from an income trust is the bank service charge for maintaining the trust.

MS 3336.10 - Parts of this section have been rewritten Re. overlapping penalty periods. New section has been added Re. transfer to annuities.

MS 3337.1 - The "likely to remain" 30 days in an institution policy applies ONLY to individuals who have community spouses.

MS 3338 - A statement regarding income trusts has been added.

MS 3338.2 - A note has been added Re. rebuttal of pension and other retirement income.

MS. 3338.3#2c - VA A&A and CME/UME are not income to a CS.

MS 3338.3#4 - The noncovered medical expense section has been rewritten. Premiums for Medicare and for insurance which pays cash are not allowable medical expenses.

MS 3341 - No reapplication is required when regular or irregular lump sum income causes one month of ineligibility.

MS 3345 - Civil Service benefits has been added as a possible source of unearned income. VA CME/UME is excluded as income.

MS 3345 #2 - A note has been added regarding consideration of taxes, insurance, maintenance, etc. for individuals in nursing facilities and ICF/MR facilities, and for TEFRA/Waiver recipients.

MS 3346.2 - The address for the Railroad Retirement Board has been changed.

MS 3346.4 - The address for the Veterans Administration Regional Office has been changed.

MS 3346.5 - A section regarding Civil Service benefits has been added.

MS 3347.1 - The presumed values of in-kind support and maintenance have been updated.

MS 3348.1 - VA A&A benefits for periods 6/1/95 and later will not be applied to the NF vendor payment. Sections have been added Re. VA pensions reduced to $90 and VA CME/UME.

MS 3350.5 - Codes for hospice care have been added. Some changes have been made Re. level of care review date.

MS 3400 - This section has been rewritten. The consideration of VA pension benefits limited to $90 monthly has been added in the computation of the personal needs allowance. Note the changes effective 11/1/95 in #2 and #6. With the exception of bank service charges, fees will no longer be allowed in income trust cases. A $90 PNA will not be given until VA has reduced the pension to $90. Individuals receiving a $90 PNA whose VA benefits have not been reduced to $90 will be given only a $30 PNA at next case change or reevaluation.

MS 3500 - Submit a DCO-730 to Medicaid Eligibility when an individual with an income trust is certified. A DCO-704 may be provided to the facility as notification of a denial.

MS 3500.1 - The maximum number of days in a facility that can be covered by Medicare has been changed from 150 to 100. Also, provisions for the authorization of Medicaid benefits (WASM only) on Medicare approved admissions have been added.

MS 3610 - It is not necessary to complete a full reevaluation of a facility case transferred to another county unless it is time to complete the annual reevaluation.

MS 3620 - Some changes have been made in this section Re. Level of Care Review Date.

MS 3634.1 - The procedure through which counties make case adjustments for LTC periods of ineligibility has been changed.

MS 3637.1 - Submit a DCO-730 to Medicaid Eligibility, Slot 1223, when a recipient with an income trust dies or is discharged.

MS 3650.1 - A DCO-704 may be sent to the facility to notify of case closure.

Inquiries to: Carol McKnight, 682-8259
Terri Wright, 682-8258
Ann Dawson, 682-8254
Boyce Lovett, 682-1562

3000 Guidelines for the Long Term Care Program and Other AABD Categories

3100 General Information

3110 Facilities Which Provide Services

Facilities which provide medically necessary care and services 24 hours per day on a long term basis include private nursing facilities, Benton Services Center, Arkansas Human Development Centers, private intermediate care facilities for the mentally retarded (ICF/MR's), and ICF/MR facilities with both over and under 15 beds.

3120 Services Provided Under Medicaid

In addition to facility vendor payments, all services listed in the pamphlet, "Your Guide to Medicaid Services in Arkansas", are available to individuals under the Long Term Care Program, with the following exception: Individuals in the State Human Development Centers are not eligible for the Prescription Drug Program.

3130 Licensing and Classification of Facilities

To receive vendor payment under the Medicaid Program, a facility must be licensed and certified by the Office of Long Term Care (OLTC), and must execute a provider agreement with the Division of Medical Services.

The OLTC publishes a directory listing all participating facilities. Changes to the directory are issued periodically. The directory and updates are provided to each county office.

3135 Nursing Facility

Section 1919 (a) of the Social Security Act defines a nursing facility as an institution which is primarily engaged in providing:

- Skilled nursing care and related services for residents who require medical or nursing care,
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
- Health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases.

3140 Personal Allowance for Facility Residents

Each recipient in a facility is allowed to retain $30.00 per month from their income for personal expenses. Upon written authorization of a resident, the facility must hold, safeguard and account for the personal funds of the resident deposited with the facility. If the resident's personal funds are in excess of $50.00, the facility must deposit the funds in excess of $50.00 in an interest bearing account (or accounts), separate from any of the facility's operating accounts, that credits all interest earned on the resident's account to his or her account. Resident personal funds may not be commingled with facility funds or with any person's funds other than another resident. The resident's individual financial record must be available on request to the resident or his legal representative.

In addition to the $30 personal needs allowance, ICF/MR clients who have income from employment are allowed to keep up to $100 of their earnings each month for personal needs.

A client with earnings and receiving intermediate care in a nursing facility may also keep up to $100 increased personal needs allowance if the client's physician has stated that a period of employment activity is necessary as a therapeutic or rehabilitative measure. If a client receiving skilled care in a nursing facility becomes employed, the Utilization Review Section of the OLTC should be contacted and requested to reevaluate medical necessity.

Certain SSI recipients whose stay in a nursing facility is not expected to exceed 3 months and who have a home to maintain will be allowed to retain full SSI benefits for personal expenses for three calendar months following the month of entry. The SSI payment, in these instances, will not be considered in eligibility or payment determination (Re. MS 3401).

* A $90 personal needs allowance will be given to a single veteran receiving a VA pension in a facility who has no spouse or dependent children. A $90 allowance will also be given to a surviving spouse of a veteran receiving a VA pension in a facility who has no dependents. The full $90 allowance will be allowed only when VA has reduced the pension to $90. (Re. MS 3348.1). Veterans receiving VA compensation do not qualify for the $90 PNA.

3150 Special Charges to Recipients in Facilities

The facility must inform the patient prior to or at the time of admission or application, and during his stay, of services available in the facility and of related charges, including charges for services not covered by Medicare or the per diem rate. Recipients may be charged only for optional services (services not necessary or consistent with the normal care of the patient). When such services are provided, documentation must be on file with the OLTC. The refusal of a recipient to accept optional services offered by a facility must not effect a decrease or alteration in the services required or necessitated by his condition or otherwise considered as normal care. Inquiries from recipients or family members concerning special charges will be referred to the OLTC.

3160 Nondiscrimination

The Division of County Operations complies with all provisions of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans With Disabilities Act of 1990. All facilities authorized to participate in the LTC program must also comply with these provisions. No person

will be prevented from participation, denied benefits, or otherwise subjected to discrimination based upon race, color, sex, national origin, or disabling condition.

The Division of County Operations has the responsibility of informing applicants and recipients that assistance is provided on a nondiscriminatory basis and of their right to file a complaint with the Division, the Department of Health and Human Services, the Department of Justice, or the United States Civil Rights Commission if they feel they have been discriminated against on the basis of race, color, sex, national origin, or disabling condition.

The OLTC is responsible for securing a statement of compliance from all hospitals and facilities authorized to participate in the Medicaid program, and for assuring that the Statement of Compliance is officially adopted and posted on the premises. The OLTC will also assure that copies of the policy are provided to all employers and staff, and to all referral agencies. The OLTC will conduct annual reviews of facilities to insure compliance with these provisions.

3170 Freedom of Choice

* Residents of nursing and ICF/MR facilities, and AABD recipients whose primary insurance is Medicare, are not required to participate in the Medicaid Primary Care Physician Managed Care Program.

These recipients will have freedom of choice in the selection of facilities, physicians, pharmacies, and other medical providers. The recipient should be informed that payment under the Medicaid program can be made only to medical providers authorized to participate in the Medicaid program. If the recipient wishes to utilize the services of a personal physician or other medical practitioner who does not participate in the Medicaid program, the recipient will be advised that payment cannot be made by the Agency for these services, and that the cost will be his responsibility.

3180 Placement

Relatives or friends of a facility applicant should help in making the selection of a Medicaid certified and licensed facility. Names and addresses of facilities that can provide the appropriate care and services will be given to the patient or his family.

If the applicant is unable to make this choice for himself and if he has no relatives or friends to assist in the decision, the county will assist with the placement. If placement cannot be made, a request for assistance should be made to the OLTC.

3200 Application Process

3210 Initial Application for Facility Payment

An application for facility services may be made by the applicant, his designated representative, next of kin, or person(s) acting responsibly for the individual. Applications should be made in the county where the facility chosen by the individual is located. If an application is made in the applicant's home county before facility entry, but the applicant enters a facility in another county, the application will be denied by input to WIMA, using denial Reason 53. A DCO-700 will then be completed, advising the client or his representative that his application has been sent to the appropriate county. All records will then be

transferred to the county where the facility is located. A new application will not be needed by the receiving county, and the original date of application will be entered in ACES when the application is reregistered.

NOTE: If a period of eligibility has been, or will be, established in a facility in the county of initial application, that county will certify the case for the eligible period before transferring the case to the second county.

Applications may be processed for deceased persons. Application may be made by any person with responsibility for the medical debts of the deceased person.

Application for facility services will be made on Form DCO-777. This form will be completed for all applications for facility vendor payment unless the individual is currently receiving assistance as an AFDC, U-18, or Foster Care (Cat. 91 or 92) recipient. No new application is needed for these categories.

3220 Reapplication for Facility Payment

Reapplication for facility services is made in the same manner as initial applications. Previous records will be reviewed. If the applicant comes from another county where his case was closed, the record will be secured from that county.

3230 Distinction Between Application and Inquiry

Every person has the right to apply for Medicaid. No application or inquiry may be ignored.

The distinction between an application and an inquiry is as follows:

1. An application is the action by which an individual indicates in writing to the Agency his desire to receive services.

2. An inquiry is simply a request for information about eligibility requirements for services. An inquiry may be followed by an application.

3240 Steps in Application Process

3241 Initial Contact

Initial contact may be made in person, by telephone, or by letter. Contact may be made by the applicant, a designated representative, the next of kin, or another person acting responsibly for him. The following tasks will be completed by the county worker during the initial contact:

* 1. Completion of Forms DCO-777 and DCO-727 (except for active AFDC, U-18, or Foster Care, Cat. 91 or 92 recipients). If the applicant or his representative is not present at the initial contact, Forms DCO-777 and DCO-727 may be mailed. The county worker will inform the applicant or his representative that he has not officially made application until the signed DCO-777 is received, and that all correspondence is available in different formats, such as large print;

2. Explanation of the process for determining medical necessity by the Long Term Care-Utilization Control Committee for all facility applicants. If the applicant has not selected a facility, a DCO-703 will be given or mailed to the applicant or his representative for him to take to his

physician. If a Title IV-E or other Foster Care child is placed in an ICF-MR, the facility will mail the DCO-703 to the ES Supervisor of the county where the facility is located. The ES Supervisor will sign the DCO-703, and return the form to the facility for completion;

3. Explanation of the Medicaid program and facility care;

4. Explanation of the SSN enumeration requirement;

5. Explanation of the Agency's responsibility to carry out policy in determining eligibility; of the applicant's responsibility to cooperate in determining eligibility; of the mandatory assignment of rights to medical support/third party liability (Re. 1350); of the obligation to file third party resource claims within a reasonable period of time; of child support enforcement requirements (when applicable); of the information needed to determine eligibility; and of the confidential way in which the Agency treats information;

6. Explanation of the applicant's right to request a hearing if he is dissatisfied with the handling of his case; and

7. Explanation of the Agency time limit for disposing of the application.

3242 Referrals from Arkansas State Hospital and George W. Jackson Center

Persons in the Arkansas State Hospital, Little Rock, or the George W. Jackson Center, Jonesboro, may be eligible for long term care placement under Medicaid. The State Hospital will refer the patient by DHS-3300 to the county office.

If the applicant does not have a guardian or custodian and a need for one is indicated, the Hospital staff will determine need and be responsible for the preparation of necessary documents. If no need is established, the individual's transfer record must indicate "No need for Guardian or Custodian". The Hospital staff will coordinate efforts with the Agency's Office of Chief Counsel for the filing of the documents, when appropriate. Long term care patient referrals will be made by Hospital staff to the county in which placement will be made. It is the responsibility of that county office to mail Form DCO-777 to the applicant or his representative and to process any subsequent application.

The ES Supervisor of the domiciliary county will be responsible for corresponding with the county where the guardian or custodian is located, the county where information indicates possible resources, or the county where relatives may be contacted, as may be required to determine eligibility.

3243 Referrals from Arkansas Human Development Centers

The following procedures apply to those individuals currently in an Arkansas Human Development Center who are referred for assistance:

1. Patient referrals will be made by Center staff to the county office in the county where the patient is domiciled;

2. It is the responsibility of the county office to send Form DCO-777 to the parent or guardian of the child and to process any subsequent application. A new application is not needed for a current recipient of AFDC, U-18, or Foster Care (Cat. 91 or 92). If the Agency has legal responsibility for a Category 96 or 97 Foster Child, Form DCO-777 will be completed by the ES Supervisor, or Family Service Worker in charge of the case, for AB or AD determination.

3. The Center will determine if the Agency has legal custody or guardianship of the child. If custody of a child is vested with the Agency, the DCO-703 will be mailed to the ES Supervisor for signature for release of medical information.

3244 Case Record and Control Card

A case record will be established in the County Office as soon as an application is received. Copies of all documents and correspondence will be placed in this record.

Form DCO-87 (Control Card) will be completed for each application at the time the case record is established.

3245 Entry of Application to WIMA

All applications will be entered into WIMA, with the date of application being the date the application was received in the County Office. The system generated application number will be entered on the DCO-777 by the terminal operator. All formal requests for LTC must be registered.

3247 Denial of Application at Intake

When information presented by the applicant or his representative during initial contact establishes that the applicant is ineligible, the application will be denied at that time. The county worker will complete all tasks required for denial of the application (Re. 3500 #2).

3248 Recording of Applications on Control Sheet

The county worker will maintain a Control Sheet (DCO-88) of all applications assigned to him or her for processing. The worker will list on the Control Sheet:

1. All applications pending at the beginning of the month, arranged by date of application (oldest first), and

2. Applications assigned to the worker during the month in order of receipt.

As applications are completed, the action and the date of completion will be indicated on the DCO-88.

3249 Referral to SSI

All AABD applicants with countable income less than the SSI SPA may be referred to SSA by Form RVI-302 for determination of SSI eligibility. If individuals with countable income of less than the current SSI/SPA ($30.00 for Title XIX facility

residents) allege a disability and apply in the AD category, current disability guidelines will be followed. Information must be sent to MRT if an SSI application is pending (Re. MS 3322). AD applications for these individuals will be approved if found eligible by MRT and if otherwise eligible, when SSA has not yet made a decision on the SSI disability. If SSI disability is later denied, the facility case will be closed (Action Reason 040). If SSI is later approved, facility services may be continued.

Applications for individuals whose countable income is above the current SSI/SPA ($30.00 for Title XIX facilities) will be processed by the County office for AABD eligibility determination (without referral to SSI), including eligibility determination by MRT, if appropriate.

SSA approved individuals with income of less than $50.00 will be eligible for an SSI payment while in a facility. SSA approved individuals with income between $50.00 and the SSI SPA will be eligible for an SSI payment for the month they enter a facility. After they have been in the facility for a full calendar month, the SSI payment will be suspended.

It is not necessary for the County Office to determine whether SSA referrals are later certified or denied for SSI or to report certification for SSI on the DCO-57. This information is communicated to the Office of Information Systems by SSI on the SDX tape, and changes are made automatically.

3250 Securing Information

The county worker will inquire into the circumstances of the applicant in order to ascertain the facts supporting the application and to obtain other information necessary to establish eligibility.

Primary responsibility for obtaining all information necessary to establish eligibility rests with the applicant or his representative. The worker will offer assistance whenever possible.

Collateral information (evidence provided by persons other than the applicant or by written documents) will be obtained when necessary to establish eligibility of the applicant. Collaterals with knowledge of the applicant will be contacted. If necessary, the county worker will use Form DHS-81 (Consent for Release of Information) to secure essential information from a collateral. This form must be signed by the applicant, or by his parent, guardian, or other person acting for the applicant, so that information may be released to the Agency.

The worker will check records or conduct inquiries by correspondence only when information can best be obtained in these ways. Routine record checking or correspondence which will not likely bring forth additional evidence needed to establish eligibility will be avoided.

The worker will protect the rights of the applicant during collateral interviews and will give only the information necessary to enable the person interviewed to understand the need for the information requested.

When an original, photocopy, or certified copy of a document used as evidence is not a permanent part of the case record, it will be necessary for the narrative to contain definitive information as follows:

1. The location of the document, e.g., where or by whom the document is kept, and

2. The pertinent facts contained in the document which establish authenticity (date document was made, where registered or filed, registration or filing identification, serial number).

Conflicting evidence must be resolved.

3251 Time Limit on Disposition of Application

With the exception of an AD application, the county worker will have up to 45 days from the date of application to make disposition by one of the following actions: approval, denial, or withdrawal. The worker will have up to 90 days from the date of application to dispose of AD applications.

3252 Delayed Action on Application

3253 County Office

When action on an application has been delayed by Agency staff, the applicant will be notified by Form DCO-002 of the reason for the delay and of his right to an appeal.

3254 Applicant

If the applicant has been given notice via the DCO-002 to provide information to clear eligibility but fails to do so by the end of the specified time, the application will be denied. If the applicant is having difficulty providing essential information and requests additional time, the county worker will acknowledge the request by sending a second DCO-002 that clearly specifies what information is needed by the end of the extended time period and will assist the applicant in obtaining information, if possible. If the information has not been provided by the end of the extended time period, the application will be denied.

3300 Eligibility Determination

Eligibility determination is the joint responsibility of the applicant, or his representative, and the county worker. The county worker has the responsibility of advising the applicant/representative of the eligibility requirements and for offering assistance whenever possible. The applicant/ representative has the final responsibility for supplying all information necessary to establish eligibility.

3301 Eligibility Requirements

Eligibility requirements for facility services are:

1. Categorical eligibility, and

2. Medical necessity (Re. 3350).

The case record must document that both these requirements have been met before facility services can be authorized.

3310 Establishing Categorical Eligibility

Current recipients of AFDC, U-18, SSI, and Foster Children (Cat. 91 and 92) for whom the Agency has legal responsibility automatically meet the categorical eligibility requirement.

However, if, during the processing of an LTC application, any question regarding the categorical eligibility of these individuals should arise, the question will be resolved with either Agency or SSA personnel before proceeding further with the application. The question and resolution should be documented in the case record.

If the eligibility of an SSI recipient is questionable, a statement will be obtained from SSA (preferably written) to document its awareness and treatment of the eligibility factor. If there appears to be a policy conflict between DCO and SSA, the DCO Medicaid Eligibility Unit will be contacted.

Categorical eligibility for individuals other than AFDC, U-18, SSI, or Foster Children will be determined according to SSI-related AABD facility eligibility criteria as follows:

* 1. Institutional Status - It must be verified that the individual has been institutionalized for 30 consecutive calendar days (an exception to the 30 days is made when death occurs prior to 30 days). Re. MS 3320. The period of 30 days is defined as being from 12:01 a.m. of the day of admission to 12:00 midnight of the 30th day following admission. For example, an individual enters a facility anytime on July 18th. The 30 day count begins at 12:01 a.m. of the morning of July 18th, and ends at midnight of August 16th. Hospitalization will count toward meeting the institutional status requirement if the individual enters a facility on the date of discharge from the hospital. This includes hospitalization at Arkansas State Hospital in Little Rock, and the George W. Jackson Center in Jonesboro. It also applies to individuals who enter an Arkansas institution directly from an out-of-state institution;

2. Categorical Relatedness - In order to meet the requirement of categorical relatedness, the individual must meet one of the following:

   a. Aged - Age 65 or older (Re. 3321);

   b. Blind - Central visual acuity of 20/200 or less in the better eye (with correction) or a limited visual field of 20 degrees or less in the better eye (Re. 3322); or

   c. Disabled - Physical or mental impairment which prevents the individual from doing any substantial gainful work (for a child under age 18, an impairment of comparable severity), and which meets the following criteria:

      (1) has lasted or is expected to last for a continuous period of at least 12 months, or

      (2) is expected to result in death (Re. 3322 or 3322.1, and 3323);

3. Citizenship or Alien Status (Re. MS 3324) - It must be verified that the individual is one of the following:

   a. Citizen of the United States (For Medicaid determinations the U.S. is defined as the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as U.S. citizens);

   b. Alien lawfully admitted for permanent residence;

   c. Alien permanently residing in the United States under color of the law (PRUCOL); or

   d. Certain aliens granted lawful temporary resident status under provisions of the Immigration Reform and Control Act of 1986;

4. Residency - It must be verified that the individual is an Arkansas resident (Re.2200);

5. Resources - Countable resources cannot exceed the following SSI limitations:

	Individual	Couple
1/1/86 - 12/31/86	$1700	$2550
1/1/87 - 12/31/87	$1800	$2700
1/1/88 - 12/31/88	$1900	$2850
1/1/89 - and later	$2000	$3000

Note: The resource standards above apply to all AABD Medicaid categories (the resource standards are doubled for QMBs, SMBs and QDWIs), except when one spouse enters LTC and the other does not (spousal rules at MS 3337-3338 apply) or when both spouses enter LTC. When both spouses enter LTC, the couple's standard will apply for the month of entry, but the resources of each will be compared to the individual standard in the month after entry into LTC (Re. MS 3330.1).

For a married couple in Waiver cases, the couple's standard will apply;

* 6. Income - The individual's gross income cannot exceed the maximum income limit allowed for federal financial participation. The income limit for LTC is three times the SSI payment standard. However, individuals with income over the limit may be eligible if they have established an income trust (Re. MS 3336.9);

7. Assignment of Medical Support (Re. MS 1350);

8. Cooperation with Child Support Enforcement Activities (Re. MS 1355); and

9. Social Security Enumeration (Re. MS 1358).

3320 Verification of Institutional Status

Evidence of institutional status includes any written document, record, etc. from a hospital and/or nursing facility which verifies that the individual was in the hospital and/or nursing facility for 30 consecutive calendar days (Re. 3310).

When an individual cannot meet the institutional status requirement, the application will be denied, unless the individual dies before meeting the 30 day requirement. In that case, certification may be made for the actual days spent in the facility.

* When an individual has met the institutional status requirement of 30 consecutive days, eligibility for facility services will be effective the date of entry into the facility if all other eligibility requirements are met, unless the individual is in an ICF/MR or was subject to PASARR (Re. MS 3420).

Note: The institutional status requirement does not apply to individuals who were certified for SSI, AFDC, U-18, or Foster Care (Cat. 91 or 92) in the month of facility entry.

Individuals who become ineligible for SSI, AFDC, U-18, or Foster Care (Cat. 91 or 92) following the month of LTCF entry, will have their categorical eligibility determined according to SSI-related AABD facility eligibility criteria, with the exception of the institutional status requirement.

3321 Verification of Age

Use primary evidence when possible; if not, use convincing evidence.

1. Primary evidence of age consists of:

   a. Birth certificates recorded before age five, or

   b. Baptismal records established before age five.

2. Convincing Evidence

   a. Social Security record (SS-5 application) established at least five years before the date of application, plus one of the following documents:

      (1) Family Bible or other family records which appear to have been recorded before age 36;
      (2) School and school census records recorded before age 21;
      (3) 1910 Federal census records (a one-year tolerance to support the allegation applies when the record shows the individual's age in completed years and all evidence in file is in substantial agreement);
      (4) 1920 Federal census record;
      (5) Domestic delayed birth certificate recorded before age 55 regardless of the basis;
      (6) State census records for the years 1905 and 1915;
      (7) Insurance policies taken out before age 21;

(8) Arrival records based on the "List of Manifest of Alien Passengers for the U.S. Immigration Officer at Port of Arrival" recorded before age 31;
(9) Newspaper birth announcements; or

b. If there is no Social Security record established at least five years before the date of filing, the following alternative may be used: a marriage record established before age 36 and any document listed in 2.a., items (1) through (9); or

c. If the requirements in 2.b. are not met, any evidence listed in 2.a., items (1) through (9) may be used in combination with two documents as follows:

(1) Insurance policies taken out after age 20;
(2) A child's birth certificate established when parents were over age 30;
(3) Marriage records established after age 35;
(4) Parents' affidavits or driver's license made at least five years before date of filing.

3. Best Evidence

To overcome a material discrepancy in the age of an individual, usually the earliest recorded document is used. (Note: Written documentation is necessary).

4. Proof of Age by Social Security Administration

The County Office will accept SSA date of birth when:

a. It has a State Data Exchange Record on ACES with the date of applicant's birth (i.e. the applicant has received SSI and a record exists on ACES for that eligibility);

b. It has a statement from the local SSA Office stating that SSA has verified date of birth; or

c. It has a WTPY Response verifying date of birth.

* 3322 Verification of Blindness or Disability

Blindness or disability must be established by one of the following means:

1. Receipt of SSI (AB or AD), or receipt of a letter of entitlement to SSI with begin date of entitlement, when the individual has not received the first check. Verify by SSI Award Letter, SSA-1610, "SSI Recipients" printout, or WTPY Response; or

2. Receipt of Social Security based on disability, or receipt of a letter of entitlement to Social Security based on disability, showing a begin date of entitlement, when the individual has not received the first check. Verify by SSA Award Letter, SSA-1610, or WTPY Response;

3. Receipt (or anticipation) of SSI or Social Security Disability based on a disability benefit continuation, when an individual has requested continuation within 10 days of SSA determination that a physical or mental impairment has ceased, has not existed, or is no longer disabling;

4. Nonreceipt of SSI cash benefits for reasons other than disability, but verification of an established disability that is current and continuing; e.g. TEFRA child (Re. 2090); or

5. Blindness or Disability determination by the Medical Review Team. The DCO-109 (Report of Medical Review Team decision) must be filed in the record.

The type of documentation used will be entered into the case narrative and a copy filed in the case records, if available.

3322.1 SSA vs. MRT Disability Decisions

The following disability guidelines will apply to all AD Medicaid applicants where disability is an eligibility factor and disability has not been determined. A disability decision made by SSA on a specific disability is controlling for that disability until the decision is changed by SSA. When DCO makes a disability determination, a later contrary SSA determination will supersede the state determination. If SSA has made a decision that a person is not disabled, that decision is binding on DCO for one year with exceptions noted in 3322.3 below.

3322.2 Referrals to SSA

Because SSA decisions are controlling, any new evidence or allegations relating to previous SSA determinations must be presented to SSA for reconsideration within 60 days of the SSA denial notice. If the decision has not been appealed within 60 days, the individual may still request a reopening of the decision within one year.

Therefore, the Agency must refer to SSA, for reconsideration or reopening of a determination, all applicants who allege new information or evidence which affects previous SSA determinations of "not disabled", except in cases specified in 3322.3 below. When the conditions in 3322.3 are met, counties will be required to make an eligibility determination for Medicaid.

Counties may also refer to SSA, for SSI application, those individuals whose income and resources are below SSI limits, because it would be to their advantage to receive both cash assistance and Medicaid.

3322.3 Applications Which Will Require An MRT Decision

When individuals apply for Medicaid and meet one or more of the conditions below, the DCO-106, DCO-107's and/or DHS-81's, and DCO-108, along with copies of the Social Security Disability or SSI denial letter (if applicable and available) and WTPY, if appropriate, will be submitted to MRT (Re. MS 3323), provided it appears that the other eligibility factors are met.

The Agency will determine eligibility if any one of the following conditions exists:

a. The individual has NOT applied for Social Security Disability or SSI;

b. The individual has been found NOT eligible for Social Security Disability or SSI for reasons other than disability (e.g., income);

c. The individual has applied for Social Security Disability or SSI, and SSA has NOT made a determination;

d. The individual alleges a NEW disabling condition which is different from (or in addition to) the condition considered by SSA in its previous determinations;

e. More than 12 months have elapsed since the most recent Social Security Disability or SSI denial decision, and the individual alleges that the condition upon which SSA made the decision is worse or has changed, and he has not reapplied; or

f. Less than 12 months have elapsed since the most recent Social Security Disability or SSI denial, and the individual alleges that the condition upon which SSA made the decision has changed or deteriorated, AND;

(1) He has asked SSA for a reconsideration or reopening of its previous determination and SSA has refused to consider the new allegations,

OR

(2) The individual no longer meets the non-disability Social Security Disability or SSI requirements (e.g., income).

AD applicants who do not meet a criterion specified above will be denied without further development. The DCO-106 will be used to document the applicant's statements/allegations regarding his disability status.

3322.4 Verification of Social Security Disability or SSI Status

To verify the Social Security Disability or SSI status of an individual the County will:

a. Request from the applicant all denial letters or other correspondence received from SSA. The denial letter is a 2-page letter which states on the 2nd page what disability was alleged and what the SSA determination was.

b. Check the WSSN and WASM Screens to determine whether the individual has an open or closed SSI case.

c. Utilize the WQRY screen if the client does not have a denial letter or other SSA correspondence and the individual is not shown on WASM as an eligible SSI recipient. The WTPY response will usually show the date of Social Security Disability or SSI application, if one has been made within the past year, and the disposition of that

application (sometimes denials are purged from the SSA system in less than a year from application).

The pay status code series beginning with "N"s are the denial codes on WTPY. A brief description of the denial code is included on the query response.

* 3322.5 Dual Applications

When an individual applies for both Medicaid and Social Security Disability or SSI, and the application with SSA is still pending, the county should initiate an MRT determination of disability if the individual appears to meet all other eligibility requirements. The Agency will have 90 days from the date of Medicaid application to make this determination. While an MRT decision is pending, the county worker should check the Social Security Disability or SSI status of the applicant 30 days after the Medicaid application has been made, and again at certification, if found eligible by MRT. If MRT finds that the individual meets the disability requirements and SSA has not yet made a decision, the county may certify the case for Medicaid. To verify that no SSA decision has been made, the WASM screen will be checked, if appropriate, and the individual or authorized representative will be contacted by mail or telephone prior to certification.

Additional case action is indicated as follows:

If application for Social Security Disability is approved first:
- Notify MRT
- Approve Medicaid application (if all other requirements have been met)

If application for SSI is approved first:

- Notify MRT
- Deny Medicaid application, except for LTC, which may be approved for facility payment on WNHU (if all other requirements have been met)

If SSA determines the applicant is NOT disabled:

- Notify MRT
- Deny Medicaid application

* If the county certifies a case based on an MRT disability decision and later learns the individual has been denied by SSA, the Medicaid case will be closed after appropriate notice, unless the recipient appeals the closure. If the appeal is made within the 10-day time frame, the Medicaid case will remain open pending the outcome of the DHS appeals process. In no case, will the Medicaid case remain open pending the outcome of the SSA appeals process, if the recipient has appealed the SSA decision. If an approved Medicaid recipient is approved for SSI, the system will automatically convert the Medicaid case to an SSI category and no further action will be required of the county, except to notify MRT that no future reexamination is required, if appropriate.

* 3323 Procedure for Verification by Medical Review Team

The following procedures will be followed for verification of blindness or disability through the Medical Review Team. The disability onset date will be indicated on the DCO-109.

3323.1 For Blindness

1. The county worker will give the applicant or his representative a DCO-701, Report on Eye Examination, for completion by the ophthalmologist or

optometrist who is to conduct the eye examination. In addition, a self-addressed envelope with the County Office address will be provided for return of the DCO-701 after completion.

2. Upon receipt of the completed DCO-701, the county worker will check it to assure that all items of identifying information are completed. If necessary, the worker will complete the name, address, race, sex, and date of birth blanks on the form before forwarding to MRT. In addition to checking the DCO-701 for completeness, the worker will complete the DCO-108 and attach it to the DCO-701 and forward it to MRT. A notation of the date that the forms are forwarded to MRT will be made in the case narrative.

3323.2 For Disability

1. If the applicant has been a patient in a private or state hospital, a VA hospital, or the University of Arkansas for Medical Sciences within the past year (the past five years for the Arkansas State Hospital or the George W. Jackson Center, Jonesboro), complete Form DHS-81 (Consent for Release of Information). The Medical Review Team will request medical information from these institutions. A separate DHS-81 must be completed for each institution.

2. If the applicant has not been hospitalized within the past year and does not regularly see a physician, Form DCO-107 must be completed. If the applicant has been hospitalized within the past year, Form DCO-107 may also be completed if the applicant chooses to supply medical information in addition to that which can be obtained from the institution by DHS-81. If an applicant goes to a physician regularly, in lieu of another physical examination, a DHS-81 may be used to obtain copies of the records from the physician (no DCO-107 needed).

   The county worker will complete Part 1 of Form DCO-107, when the form is needed. The applicant must sign and date the form in Part 2. The form will then be given to the applicant to take to the medical practitioner of his choice. A stamped envelope addressed to the county office will be provided with the DCO-107. The medical practitioner will complete Part 3 of the form and return the form to the county office.

   If an applicant states he/she does not have the funds for payment of a physician's examination, the applicant should be informed that MRT can arrange and pay for an examination. If the applicant wishes MRT to do this, the worker should report this on the DCO-108 Social Report.

3. Complete Forms DCO-106 and DCO-108 (Social Report). These must be completed for all cases submitted to the Medical Review Team.

4. Attach the following to the completed DCO-108 and DCO-106: DCO-107 and/or DHS-81, and any other medical information which the applicant wishes to provide or which is available in the county office files. Send these to the Medical Review Team.

3323.3 MRT Decision

The Medical Review Team will report the decision regarding physical or mental incapacity to the county office on Form DCO-109.

If the Medica ...v Team finds that the medical information is not adequate to make a decisi ...ther medical/psychiatric/psychological examinations may be recommended b ...edical Review Team at the expense of the Agency.

Arrangements ...ch evaluations will be made by the Medical Review Team only. When medical ...cial evidence has been resubmitted on questioned cases, the Medical Revie... will make a decision as to disability and notify the county office on Form ...109. This decision of the Medical Review Team will be final, subject to the ...lar appeal process, unless a later decision by SSA finds the individual not ...bled.

3323.4 Reapplication Due to Mental or Physical Incapacity

If a reappli... is filed and the case has been closed within the past five years for re... ...ther than disability and the last Form DCO-109 stated, "Re-examination ...cessary" or the date for reexamination has not yet been reached, new ...l and social information will not be submitted to the Medical Review Team. ...e case has been closed for more than five years, new medical and social ... ...tion must be submitted. In all cases of reapplication a DCO-106 will ...mpleted to determine the applicant's SSA disability status.

3323.5 Reexamination of Disability by MRT

When medical ...ocial information indicates that an individual may recover in a year or m... and/or be rehabilitated to the point where he could meet substantial ...ful employment, the Medical Review Team will require reexamination ...ether or not required by MRT, reexamination may be requested by the county ...ice at any time for the aforementioned reasons.

In either cas... t is the responsibility of the county office to initiate the reexam by sub... ...ng current medical and social information (DCO-106, DCO-108A, and DCO-107 a... ... DHS-81) to MRT.

3323.6 Reexamination Required by MRT

When indicated ... the DCO-109, the county office will key the appropriate date to WMLR for f... ...action. The county office will contact the individual in a timely manner ... will allow all necessary medical and social information to reach MRT by t... ...irst of the month of reexam. When the reexam decision is not received in t... ...ounty office by the end of month in which the reexam was required, the ... will remain open pending receipt of the MRT decision.

* 3323.7 Reexamination Resulting from Substantial Gainful Activity

Substantial ga... activity (SGA) is defined as the performance of significant physical and/o... ...al work activities for pay or profit, or in work activities generally perf... for pay or profit.

Countable month... ...rnings are obtained by deducting any employer subsidy and any impairment rel... work expense (not payroll deducts) from the gross income (gross income ...des payment in-kind for the performance of work in lieu of cash). Then, ...rnings are irregular, they will be averaged over the period of months bein... ...sidered to obtain countable monthly earnings.

Employer subsi... the payment of wages that is more than the value of the actual service ...ormed.

If the work is sheltered or if there is marked discrepancy between the amount of pay and the value of services, there exists the strong possibility of a subsidy that requires development of specific evidence.

Sheltered Employment is work performed by handicapped individuals in a protected environment under an institutional program; nonsheltered employment is any work performed by individuals in an unprotected environment.

Impairment Related Work Expenses are items or services needed in order to maintain employment, such as attendant services, prostheses, or other devices. Drugs and medical services are not deductible unless it can be shown they are necessary to control the disability to enable the individual to work. Deductible expenses must be paid for by the individual, and cannot be reimbursable from any source. Legitimate expenses may include installation, repair, or maintenance; the payments may be deducted in one month or prorated over 12 months.

The expenses must be considered "reasonable," i.e. not more than Medicare would allow or than would ordinarily be charged in the individual's community.

The following SGA Earnings Guidelines provide the basis for evaluating whether an individual is engaged in SGA:

1. Countable Earnings of Less Than $300 a Month - When average countable monthly earnings are less than $300 a month, an assumption may be made that the work is not SGA. This assumption may be made for both sheltered and nonsheltered employment; specific evidence does not need to be developed for either sheltered or nonsheltered employment.

2. Countable Earnings of $300 to $500 a Month - When average countable monthly earnings from nonsheltered employment fall within the $300 to $500 a month range, an assumption may be made that the work is not SGA unless:

   a. The work is comparable to that of unimpaired individuals engaged in similar occupations as their means of livelihood; or

   b. The work, although significantly less than that done by unimpaired individuals, is reasonably worth over $500 a month according to pay scales in the community.

   When "a." or "b." occur in a nonsheltered employment situation (or if gross earnings include a subsidy), reexam will be initiated by submitting current medical and social information to MRT.

   When average countable monthly earnings from sheltered employment fall within the $300 to $500 a month range, the work is not ordinarily SGA. However, if earnings include a subsidy, the sheltered worker will also be reexamined by MRT.

3. Countable Earnings of More Than $500 a Month - When average countable monthly earnings are more than $500 a month, an assumption may be made that the work is SGA unless:

- Impairment causes the individual to quit work or reduce employment within a short time (6 months or less) under circumstances that would justify the employment being termed an unsuccessful work attempt. Specific evidence must be developed for both sheltered and nonsheltered employment.

  When there is no subsidy involved in gross pay and when there is no marked discrepancy between the amount of pay and the value of the services, an assumption will be made that pay from employment is fully earned. Action will be taken to close the case as the individual no longer meets the criteria for disability (Re. 3310). Advance notice will be given on the DCO-700.

3324 Verification of Citizenship or Alien Status

1. Evidence of Citizenship - Citizenship may be verified by any document which shows the place of birth. One document is sufficient. A copy of the document used to verify citizenship will be retained in the case file. The document may be the same as that used to verify date of birth. Acceptable evidence of citizenship includes:

   - Birth records,
   - Baptismal or other religious records,
   - Report of Birth Abroad of a Citizen of the U.S. (Form FS-240),
   - Consulate Report of Birth of Certification of Birth (Form I-97), or
   - Naturalization papers.

2. Evidence of Lawful Admission for Permanent Residence - Aliens in this status have been lawfully granted the privilege of residing permanently in the U.S. as immigrants in accordance with the immigration laws, such status not having changed since admission. Acceptable evidence includes:

   - INS Form I-551 or I-151, Alien Registration Receipt card,
   - Form AR-3 and AR-3a (earlier versions of the Form I-551) if endorsed to show lawful admission, or
   - Reentry Permit.

3. Evidence of Permanently Residing Under Color of the Law (PRUCOL) - Aliens residing in the U.S. with the knowledge and permission of the Immigration and Naturalization Service (INS) and whose departure INS does not contemplate enforcing may be considered PRUCOL. Acceptable evidence includes:

   - I-94,
   - I-181,
   - I-210,
   - I-220 B
   - INS letter,
   - Passport properly endorsed,
   - Court order by an immigration judge, or
   - Any proof that an individual entered the U.S. prior to January 1, 1972 and has continuously resided in the U.S. since entry.

4. Evidence of Lawful Temporary/Permanent Resident Status Under the Immigration Reform and Control Act of 1986 (PL 99-603)

PL 99-603 provides that certain illegal aliens who have continuously resided in the U.S. since date of entry may apply for and be granted temporary resident status for a period of time before being granted permanent resident status, if all conditions of eligibility are met. Among those who may apply are:

a. Aliens who entered the U.S. prior to January 1, 1982, and

b. Special agricultural workers (SAW's).

With the exceptions noted below, the aliens who register under PL 99-603 are not eligible for Medicaid for a 5 year period that begins on the date temporary resident status is granted. Medicaid eligibility may be determined for:

- Cubans/Haitians,
- Aged, blind and disabled individuals,
- Children under age 18,
- Pregnant women, or
- Any individual who qualifies for emergency services* (Re. MS 2095 section).

Acceptable evidence includes:

- I-688A - Proof of application only
- I-688 - Temporary resident status
- I-551 or I-151 - Permanent resident status

*Eligibility for emergency Medicaid services only may also be determined for undocumented illegal aliens and for non-immigrants lawfully admitted for a temporary period of time such as students, visitors, etc.

5. Documentation of Status

a. A document currently valid for an indefinite period of time, for at least one year from date of issuance, or for a specified period of time due to conditions in the alien's home country may be acceptable evidence that INS does not contemplate enforcing the alien's departure. However, INS should be contacted for confirmation before certification.

b. A document with an expiration date of less than one year from date of issuance is not proof that INS does not contemplate enforcing departure, and INS should be contacted to verify the alien's status and that there is no plan for deportation of the alien.

c. In all cases, a copy of the alien applicant's documentation will be copied for the Medicaid record, and alien status will be verified by means of SAVE or by completion of Form G-845. The form will be routed to:

* Immigration and Naturalization Service
ATTN: Status Verifier/SAVE
245 Wagner Place, Suite 250
Memphis, TN 38103

3324.1 Declaration of Citizenship or Satisfactory Immigration Status

The Immigration Reform and Control Act (IRCA) of 1986 (P.L. 99-603) requires that, as a condition of an individual's Medicaid eligibility, the individual must declare in writing under penalty of perjury if he is a citizen or national of the United States or, if not, that he is an alien in satisfactory immigration status. This requirement does not affect the existing citizenship and alienage requirement nor does it affect the verification requirements for citizenship or alienage. Therefore, an allegation of U.S. citizenship must still be verified, if questionable, and the immigration status of all aliens must be verified.

Each adult applying for or receiving Medicaid assistance must make his own declaration of citizenship or satisfactory immigration status. The parent or guardian will make the declaration for all unemancipated persons under the age of 18 or otherwise incapacitated for whom medical assistance is requested. A legal guardian may also make the declaration for minors or for individuals otherwise incapacitated.

The application form will serve as the written declaration of citizenship for the applicant and/or any unemancipated persons under the age of 18. Caseworkers should be alert to the proper completion of the question on the application regarding citizenship for each person. As the declaration of citizenship is an eligibility requirement for the individual, the citizenship question on the application form must be answered for each person who will be an eligible in a Medicaid case.

In LTC cases where the applicant/recipient or the applicant/recipient's legal guardian has completed a DCO-777, no further action is necessary. In instances where an authorized representative other than a legal guardian has signed the DCO-777, the applicant/recipient should sign the DCO-9, unless he is physically or mentally incompetent to do so. If the applicant/recipient is unable to sign the DCO-9, then the authorized representative's declaration on the DCO-777 will be accepted as declaration of citizenship.

Once an adult has provided declaration of citizenship or satisfactory immigration status for himself or others, a declaration will not be required again unless an individual loses eligibility. If the individual later reapplies, a new declaration will be obtained.

3330 RESOURCES - AABD

Resources are generally defined as those assets, including both real and personal property, which an individual, or couple, possesses. Resources include all liquid assets as well as those assets which are not presently in liquid form.

In order for assets to be considered as resources, property or an interest in property must have a cash value that is available to the individual upon disposition.

Countable resources will be determined on the first day of the month. When resource eligibility exists at the beginning of a month, it continues for the full month. A resource change that occurs during a month in which resource eligibility exists will not be considered for determination of countable resources until the first of the month following the change.

When an individual is ineligible at the beginning of a month due to excess resources, ineligibility due to resources exists for the full month.

Assets which have been received during the month and considered as income may not also be counted with resources during the same month (unless the income received is given away during the month it is received - Re. MS 3336.6). For example, if an individual had a checking account balance of $1,950 as of June 1, the receipt of a $300.00 SSA check during June would not cause the individual's $2,000 resource limit to be exceeded during June even if the entire check was deposited in the checking account. The individual's resource eligibility would not be affected by the receipt of income during the month. It would only be affected if the income was retained to the extent that it caused the $2,000 limit to be exceeded as of the beginning of July.

SSI lump sum benefits (never counted as income) will be excluded from resource consideration for 6 full months after the month of receipt (Re. MS 3332.3 #6). SSA lump sum payments also have the 6 month resource exclusion, but will count as income in the month of receipt-Re. MS 3341. Interest earned on the excluded funds will be counted as income in the month accrued and, if retained, as a resource in the month following.

Each individual must be advised of how countable resources are determined and how resource changes can affect eligibility.

Requests for Legal Opinions Regarding Resources

A legal opinion from the Office of Chief Counsel (OCC), will be requested when the worker, the ES Supervisor, and the DCO Program Support Specialist are unsure of whether a resource should be considered or disregarded.

If the equity value of the questionable resource, when combined with other resources, appears to exceed the resource limit, OCC will be contacted if:

1. Ownership of the resource is questionable, or

2. The applicant's right to transfer the resource is questionable.

If a legal opinion is needed, a memorandum will be submitted to the Office of Program Planning and Development, P. O. Box 1437, Slot 1220, Little Rock, AR, 72203. The memo will be from the ES Supervisor and will contain a complete description of the circumstances and copies of all pertinent documents.

A copy of any OCC opinion received must be filed in the case record.

NOTE: When an individual is unaware of ownership of an asset, the asset is not counted as a resource. The asset will be counted as income in the month of discovery and as a resource in the months following.

3330.1 Countable Resource Limitations

To be eligible for assistance under AABD categories the countable resources of an aged, blind, or disabled individual or couple may not exceed certain limitations. The countable resource limitations for AABD eligibility are as follows:

	Individual	Couple
1/1/86 - 12/31/86	$1700	$2550
1/1/87 - 12/31/87	$1800	$2700
1/1/88 - 12/31/88	$1900	$2850
1/1/89 - and later	$2000	$3000

Note: The resource standards above apply to all AABD Medicaid categories (the resource standards are doubled for QMBs, SMBs and QDWIs), except when one spouse enters LTC and the other does not (spousal rules at MS 3337-3338 apply) or when both spouses enter LTC. When both spouses enter LTC, the couple's standard will apply for the month of entry, but the resources of each will be compared to the individual standard in the month after entry into LTC.

For a married couple in Waiver cases, the couple's standard will apply.

3330.2 Incapacitation

A person is presumed to possess legal capacity unless declared incapacited by a probate court.

Arkansas Statutes define a person as "incapacitated" when by reason of minority or of impairment due to a disability such as mental illness, mental deficiency, physical illness, chronic use of drugs, or chronic intoxication, he is lacking sufficient understanding or capacity to make or communicate decisions to meet the essential requirements for his health or safety or to manage his estate.

Whenever a person is incapable of caring for himself or his property , a need for a guardian is indicated. A guardian of the estate may be appointed if the person is incapable of managing property, money or his legal affairs. A guardianship of the person is indicated if the person is incapable of taking care of his person.

Normally, the question of incapacitation will not be considered in an eligibility determination. If a person has been adjudicated incapacitated and has had a guardian appointed for him, it will be necessary for the guardian to make application for benefits since the individual does not have that legal power.

If a person's incapacitation has not been determined, it will not be considered in an eligibility determination as long as the person is able to make his wants or application known. If a person has excess resources and a claim is made that his resources are not available due to incapacitation, it will be the responsibility of the person alleging the incapacitation to furnish proof of the incapacitation and to find a person able and willing to serve as guardian of the person and/or estate. The person alleging the incapacitation will be required to provide a medical affidavit attesting to the incapacitation of the individual.

Advance Notice

When the medical statement has been obtained, the county office will inform the person alleged to be incapacitated and the person who has made the allegation that:

1. A period of 120 days will be allowed to find a person who will serve as guardian, to present the guardianship request to probate court, and to finalize the guardianship proceedings;

2. The resources in question will be excluded for 120 days or until the first day of the month following the month in which the court order establishing guardianship is filed, whichever occurs earlier;

3. A copy of the court order establishing guardianship must be given the county office within ten days of filing the order; and that

4. Any LTC payments made on behalf of the person alleged to be incapacitated during the exclusion period will be subject to recovery in accordance with overpayment policy if the probate court fails to find the individual incapacitated or if the person alleging incapacitation fails to initiate and finalize action for the appointment of a guardian within the allotted time.

   If the guardianship has not been finalized within 120 days and if the parties involved maintain that diligent and good faith efforts have been taken to obtain the guardianship, the county office will submit the case record to the Office of Chief Counsel (OCC) along with all related documents and a cover memorandum summarizing the facts and requesting a review to determine if an extension of time is warranted.

   If the written opinion obtained from OCC states that circumstances justify an extension of the 120 day period and specifies the duration of time for the extension, the extension will be granted. If no time extension is found justifiable, the county will proceed as instructed below.

Case Closures

Case closures, when applicable, will be made on the first day of the month following the month in which:

1. The court order establishing guardianship is filed and reported, or

2. The allotted 120 days has ended (when OCC did not grant an extension or when no guardianship action was initiated), or

3. The time extension granted by OCC has expired and guardianship has not been finalized.

Advance notice of closure is not required.

Overpayments

If LTC services have been paid, an overpayment will be written when:

1. The individual was not found to be incapacitated by the court;

2. The person making the allegation failed to initiate action and to establish guardianship within the allotted time, or to finalize guardianship within the OCC extension of time, or

3. OCC did not find an extension of the 120 days was warranted.

No overpayments will be written when the court has found that the individual is incapacitated. A copy of the court order will be obtained by the county office for the case record, and the guardian will be responsible for petitioning the court to dispose of excess resources. A redetermination of LTC eligibility will not be made until disposition of the excess resources has been made.

3331 Real Property

Real property is land, including houses or immovable objects attached permanently to land. It also includes burial plots and crypts.

In order for real property to be a resource, it must be convertible to cash. If the individual has the right, authority, or power to liquidate the property or his share or interest in property, it is considered a resource unless otherwise excluded (Re. MS 3331.5). If a property right cannot be liquidated, it will not be considered a resource.

Certain types of property may have special restrictions, which include the following:

1. Burial Plot - Burial Plots or crypts which are not intended for the use of the applicant/recipient or his immediate family may be a countable resource. If the deed indicates that the contract is irrevocable, the plot or crypt is not a countable resource. If any co-owner refuses to

permit sale of the plot or the burial company requires the individual to move from the state in order to sell the plot, it is not a countable resource. Document the file regarding restrictions with a statement from the co-owner or with a copy of the burial contract, whichever is applicable.

If the deed indicates that the contract is revocable, it is a countable resource. In this case it will be necessary to contact the burial company, etc. (i.e., original seller of the plot) to determine the value of the specific plot. Document the file regarding value with a statement from the burial company, etc.

2. Land Held by a Member of Indian Tribe - Land which is held by an enrolled member of an Indian tribe may be excluded from resources if it cannot be sold or transferred without the permission of other individuals, the tribe, or a Federal Agency. If permission is needed, determine whether it can be obtained. If permission to sell is granted, treat the property as a resource. If permission to sell is not granted, the property is excluded as a resource.

3331.1 Evidence of Ownership

The following official records will be utilized in establishing real property ownership:

1. Assessment Notice
2. Recent Tax Bill
3. Current Mortgage Statement
4. Deed
5. Report of Title Search

Questions of title, ownership, and property interest which cannot be resolved by the county office will be submitted to the Office of Chief Counsel. The memorandum will present the question involved and any relevant facts. Originals or copies of wills, deeds, contracts of purchase, or other documents affecting the property must be attached. If the applicant does not have the necessary documents, he will be advised of his responsibility to obtain them.

3331.2 Forms Of Ownership

1. Fee Simple Ownership - When property is held in fee simple, the owner has sole ownership interest. He alone (or his legal guardian if mentally incompetent) may sell or transfer ownership interest without conditions imposed by others.

2. Shared Ownership - Shared ownership means that ownership interest in property is vested with more than one person. Shared ownership may be by "joint tenancy", "tenancy in common" or, for a married couple, "tenancy by the entirety".

   a. Joint Tenancy -In joint tenancy, each of two or more joint tenants has an equal interest in the whole property for the duration of the tenancy. On the death of one of two joint tenants, the survivor becomes sole owner.

   b. Tenancy-in-Common - In tenancy-in-common, two or more persons have an undivided fractional interest in the whole property for the duration of the tenancy. There is no right to survivorship to a tenancy-in-common.

c. Tenancy-by-the-Entirety - Tenancy-by-the-entirety results when a conveyance is made to a husband and wife, whereupon each becomes possessed of the entire estate, and after death of one, the survivor takes the whole. Real estate owned by a married couple by the entirety is marketable only by consent of both parties. When a marriage has been legally dissolved, former spouses become tenants-in-common of the property, and either person can market his half share, unless conditions in the divorce decree specify otherwise.

3. Life Estates

a. Life Estates - A life estate conveys to an individual or individuals certain rights in property which expire upon the death of the owner or of another person. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his life estate interest. (However, the document establishing the life estate may restrain one or more of the individual's rights.) He can only sell his life estate, and cannot sell any remainder interest.

b. Remainder Interest - When an individual conveys property to another for life (life estate) and to a second person(s) (remainder man) upon the death of the life estate holder, both a life estate interest and a remainder interest have been created in the property. Upon death of the life estate holder, the remainder man will own full title. Several individuals may be designated as remainder men who would hold ownership jointly or in common, as specified by will or deed.

4. Ownership Interest in Unprobated Estate

An individual may have ownership interest in an unprobated estate if he is an heir or relative of the deceased, or has acquired rights on the property due to the death of the deceased, in accordance with a will or state intestacy laws.

5. Dower/Curtesy

State law for dower and curtesy gives a spouse an interest in the other spouse's property. When the deceased leaves no will, dower or curtesy may be claimed. When the deceased leaves a valid will, a widowed spouse can elect to take against the will when he would have a greater right by dower or curtesy than the will provides.

If there are questions regarding the dower or curtesy interest, the Office of Chief Counsel will be contacted, according to procedures established in MS 3330. When requesting an opinion, indicate whether or not there are direct descendents (children, grandchildren, etc.)

6. Rights to Use

An individual may have ownership of certain property rights such as:

a. Mineral Rights - A mineral right is an ownership interest in certain natural resources which are usually obtained from the ground such as coal, sulphur, petroleum, sand, natural gas, etc.

b. Timber Rights - Timber rights permit an individual to cut and remove freestanding trees from property owned by another. A life tenant also has certain timber rights in keeping with good husbandry.

c. Easement - An easement is a property right whereby one has the right to use of the land of another for a special purpose.

d. Leasehold - A leasehold conveys to an individual, at the owner's will and usually for an agreed rent, the control of property for a definite period of time. It does not designate rights of ownership. Leaseholds may be carved out of life estates.

3331.3 Determining Value of Ownership Interest

In determining the equity value (i.e. current market value less encumbrances) of real property, the type of ownership, the number of additional owners, and the individual's actual ownership interest must all be taken into consideration.

1. Fee Simple Ownership (Sole Ownership) - If the individual is the sole owner of property and has the right to dispose of it, the equity value of the property is a countable resource when the property is nonexcludable.

2. Shared Ownership -If the property is jointly owned by two or more individuals, the equity value of the property is charged to the individual in proportion to his ownership interest.

   a. Joint Tenancy - The property's equity value is divided by the number of owners in proportion to the ownership interest of each to determine the individual's ownership interest. When the individual's ownership interest plus other countable resources exceed the resource limit, determine if the individual is free to sell his interest.

      When consent to sell joint tenancy property can be obtained from the other owner(s), the property will be considered a countable resource.

      When it is established (in writing) that consent to sell joint tenancy property cannot be obtained from the other owner(s), the property will not be considered a countable resource.

   b. Tenancy-in-Common - The property's equity value is divided by the number of owners in proportion to the ownership interest of each to determine the individual's ownership interest. The value of the individual's interest will be considered a countable resource, regardless of the other owners' desire to sell.

   c. Tenancy-by-the-Entirety (Applicable to a married couple)

      (1) Married Couple Living Together in the Community - For any month in which a married couple lives together in the community, the total equity value of nonexcludable property held by the couple is a countable resource, whether one or both members of the couple apply for assistance. After the month in which one or both enter a facility, each member of the couple is considered individually as a married couple living apart.

(2) Married Couple Living Apart in LTC - When both members of a "living apart" married couple in LTC are applying for or receiving LTC assistance, half of the equity value of nonexcludable property is a countable resource to each individual.

When only one member of a "living apart" married couple in LTC is applying for or receiving LTC assistance, half of the equity value of the tenancy-by-the-entirety property is a resource to that individual unless he alleges that he cannot obtain consent to sell from the spouse.

When the individual indicates that he wishes to sell his share of the property and indicates that he cannot obtain consent to sell from the spouse, request him to obtain a statement to that effect.

If it is established in writing that the spouse refuses to consent to the sale of the tenancy-by-the-entirety property, it cannot be considered a countable resource to the individual who has applied for LTC.

(3) Married Couple Living Apart - Only One In LTC - If only one member of a married couple is in LTC, the Spousal Impoverishment rules at MS 3337-3338 will apply in determining the attribution of resources to each spouse. The equity value of nonexcludable property will be included in the initial assessment and in the attribution of resources, regardless of the community spouse's consent or refusal to sell.

3. Life Estate or Remainder Interest Held in Nonhome Property

Examine the deed which granted the life estate or remainder interest. If there is a restriction which prevents the life estate holder or remainder holder from disposing of his interest, the value of the life estate or remainder interest is not a countable resource.

If there is no restriction to prevent the disposal of the life estate interest or remainder interest, the following steps will be used to determine its resource value.

a. Determine the value of the nonhome property (Re. MS 3331.4).

b. Select the table immediately following for life estate or remainder interest as appropriate.

c. Find the line for the life estate holder's age as of the last birthday.

d. Multiply the figure in the life estate column or remainder interest column for that age by the current market value of the property to determine the life estate or remainder interest value. Deduct encumbrances owed by the individual to determine net value.

e. The individual or person acting on his behalf will be given the opportunity to rebut the determined value. When the individual elects not to rebut, the value determined in item d. will be used. When the individual elects to rebut, proceed to item f.

f. To rebut the determined value, the individual or person acting on his behalf must secure an evidentiary statement from a knowledgeable source that the market value of the interest held in the property is less than the value determined in item d. When the value determined by the knowledgeable source is less than the value determined in item d, the rebuttal value will be used. (Refer to Note 2.)

NOTE: (1) Life estate and remainder interests which meet the requirements of income producing nonhome property qualify for exclusion as a resource (Re. MS 3331.5).

(2) The knowledgeable source statement for rebuttal should be for the market value of the life or remainder interest only, not the market value of the property itself. The market value of property often has little bearing on the market value of a "life estate" interest.

* 4. Dower/Curtesy

a. Determine the current market value of the property.

b. Find the line in the life estate tables for the individual's age at the last birthday.

c. Multiply the figure beside the individual's age in the life estate table by the current market value of the property.

d. Divide the result of "c" above by 3 to determine the value of the dower or curtesy interest.

Life Estate and Remainder Interest Tables
SOURCE: Section 20.2031-7 of Title 26 of the Code of Federal Regulations

Table - Unisex Life Estate or Remainder Table

Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	.97188	.02812	46	.87863	.12137
1	.98988	.01012	47	.87137	.12863
2	.99017	.00983	48	.86374	.13626
3	.99008	.00992	49	.85578	.14422
4	.98981	.01019	50	.84743	.15257
5	.98938	.01062	51	.83674	.16126
6	.98884	.01116	52	.82969	.17031
7	.98822	.01178	53	.82028	.17972
8	.98748	.01252	54	.81054	.18946
9	.98663	.01337	55	.80046	.19954
10	.98565	.01435	56	.79006	.20994
11	.98453	.01547	57	.77931	.22069
12	.98329	.01671	58	.76822	.23178
13	.98198	.01802	59	.75675	.24325
14	.98066	.01934	60	.74491	.25509
15	.97937	.02063	61	.73267	.26733
16	.97815	.02185	62	.72002	.27998
17	.97700	.02300	63	.70696	.29304
18	.97590	.02410	64	.69352	.30648
19	.97480	.02520	65	.67970	.32030
20	.97365	.02635	66	.66551	.33449
21	.97245	.02755	67	.65098	.34902
22	.97120	.02880	68	.63610	.36390
23	.96986	.03014	69	.62086	.37914
24	.96841	.03159	70	.60522	.39478
25	.96678	.03322	71	.58914	.41086
26	.96495	.03505	72	.57261	.42739
27	.96290	.03710	73	.55571	.44429
28	.96062	.03938	74	.53862	.46138
29	.95813	.04187	75	.52149	.47851
30	.95543	.04457	76	.50441	.49559
31	.95254	.04746	77	.48742	.51258
32	.94942	.05058	78	.47049	.52951
33	.94608	.05392	79	.45357	.54643
34	.94250	.05750	80	.43659	.56341
35	.93868	.06132	81	.41967	.58033
36	.93460	.06540	82	.40295	.59705
37	.93026	.06974	83	.38642	.61358
38	.92567	.07433	84	.36998	.63002
39	.92083	.07917	85	.35359	.64641
40	.91571	.08429	86	.33764	.66236
41	.91030	.08970	87	.32262	.67738
42	.90457	.09543	88	.30859	.69141
43	.89855	.10145	89	.29526	.70474
44	.89221	.10779	90	.28221	.71779
45	.88558	.11442	91	.26955	.73045

Table - Unisex Life Estate or Remainder Table (continued)

Age	Life Estate	Remainder	Age	Life Estate	Remainder
92	.25771	.74229	101	.19532	.80468
93	.24692	.75308	102	.19054	.80946
94	.23728	.76272	103	.18437	.81563
95	.22887	.77113	104	.17856	.82144
96	.22181	.77819	105	.16962	.83038
97	.21550	.78450	106	.15488	.84512
98	.21000	.79000	107	.13409	.86591
99	.20486	.79514	108	.10068	.89932
100	.19975	.80025	109	.04545	.95455

5. Ownership Interest Held In Unprobated Estate

An individual's ownership interest in an unprobated estate is considered to be a resource. When the property cannot be excluded as income producing property and inclusion of it would make the individual's resources exceed the countable resource limitations, ownership must be established.

If ownership cannot be determined, the facts of the ownership interest will be submitted to the Office of Chief Counsel to obtain a legal opinion of the individual's ownership share, if any (Re. MS 3330).

When the individual is determined to have an ownership interest in an unprobated estate, it will be necessary to determine its value through contact with a knowledgeable source. Knowledgeable sources include (by order of priority): real estate broker, the local office of the Farmer's Home Administration (for rural land), the local office of Agricultural Stabilization and Conservation Service (for rural land), County Extension Service, banks, savings and loan associations, mortgage companies, and similar lending institutions, or an official of the local real property tax jurisdiction. The full details of the ownership interest (i.e., the individual's share of the unprobated estate) must be given to the knowledgeable source to obtain an accurate estimate of value. If a free estimate of the value cannot be obtained, it will be the individual's (or his representative's) responsibility to obtain the estimate.

The costs of settling the estate including funeral expenses, payment of mortgages and other debts, attorney fees, etc. will be deducted from the value of the whole estate before determining the individual net interest. A knowledgeable source estimate of these costs will also be used in making this determination, if the actual costs are not known.

Document all findings in the case record.

NOTE: If the consent of others who have an interest in an unprobated estate is required in order to sell an individual's interest in the estate, and the other owners refuse to give consent, then the individual's share is not counted as a resource.

6. Rights To Use

Mineral rights, timber rights, easements or leaseholds may all be countable resources if they have a cash value available to the individual on disposition. However, in many cases, none of the above are saleable and, therefore, would not be a countable resource.

3331.4 Determining Equity Value

Equity value of nonhome real property is determined by deducting outstanding encumbrances (e.g., liens, mortgages, etc.) from the current market value (CMV) of the property. CMV is the amount for which the property can be expected to sell on the open market. The equity value determination of property owned by the individual must be fully documented in the case record.

The individual's allegation of property value is accepted without further verification when the following conditions are met:

- the value would cause total resources to exceed countable resource limitations (Re. 3330.1);
- the individual can dispose of the property; and
- it does not qualify for exclusion.

If these conditions are met, with the exception of alleged value (i.e. the individual is unable to provide an estimate), the county worker will ask if the property would sell for at least the individual/couple's resource limit, as appropriate. If he alleges that it would, the worker will initiate action to deny or close.

When the individual's alleged value does not cause resources to exceed countable resource limitations or result in potential conditional eligibility, determine property value as indicated below:

1. Determine the value based on the tax assessment. Multiply the assessed value (AV) by five. The AV used in this determination will be the current AV on record at the County Assessor's Office in the county where the property is located. If the individual does not have documentation of the current AV, the county worker will contact the County Assessor to obtain the current AV. If the value based on the AV causes ineligibility, the worker will initiate action to deny or close unless the individual wishes to obtain a knowledgeable source estimate to rebut the value. If the value based on the AV allows eligibility, CMV based on knowledgeable source estimate will be determined in accord with item 2.

2. Determine the CMV based on an estimate from a knowledgeable source; the individual will be asked to obtain the estimate. The estimate must be written, signed, and have enough information so the source can be identified. It must be specific as to the point in time for which the estimate is effective. Knowledgeable sources include:

    a. Real estate brokers;

    b. Local office of the Farmer's Home Administration (for rural land);

    c. Local office of the Agricultural Stabilization and Conservation Service (for rural land);

    d. Banks, savings and loan associations, mortgage companies, and similar lending institutions;

    e. County Agricultural Extension Service (for rural land);

    f. Local newspaper real estate ads, "multiple listing" publications, etc.

    NOTE: When there is a difference between the assessed value and the CMV based on a knowledgeable source estimate, the knowledgeable source estimate will be used.

Although it is the individual's responsibility to obtain an estimate, the county worker will assist when necessary. If requested, the worker will attempt to obtain a free estimate.

If the CMV of nonexcludable property (based on the knowledgeable source estimate), when combined with other countable resources, causes ineligibility, the county worker will initiate action to deny or close. If the CMV allows eligibility, the worker will proceed with the determination. The worker may request/secure additional knowledgeable source estimates of value when necessary to clear property values. When multiple estimates are secured, the highest estimate will be used.

Net equity in nonhome real property is a countable resource unless it is excludable as income producing property. Refer to MS 3331.5 #2 to determine if the property is excludable.

3331.5 Real Property Exclusions

The following resource items qualify for special exclusions from resources when specific conditions are met.

1. Home

The "home" is excluded as the principal place of residence as long as it is occupied by the individual, his spouse, or "dependent relative"; or, if unoccupied, as long as the individual states his intent to return to the home.

a. The "home" is any shelter in which the individual (or spouse with whom the individual lives) has an ownership interest (e.g., title or life estate), and which is used by the individual (or spouse) as his principal place of residence. The home may be either real or personal property, fixed or mobile, and located on land or water. The home includes all contiguous land and the buildings located on such land. Only one home can be considered the principal place of residence and qualify for exclusion.

Farm or other business assets located on the home property (e.g., tractors, trailers, cars, other equipment, inventory, seed, livestock, etc.) cannot be included under the home property exclusion. These assets are considered personal property and will be included with countable resources unless they can qualify for exclusion under MS 3331.5 #2 and MS 3332.3, #4.

NOTE: Livestock is defined as any animal(s) kept for use or profit. Livestock includes poultry, catfish, minnows, worms, crickets, etc.

b. A "dependent relative" is defined as a son, daughter, grandson, granddaughter, stepson, stepdaughter, in-law, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, stepsister, or cousin who is dependent on the recipient's home for shelter. Dependency may be verified by the recipient's declaration or by contact with collateral sources knowledgeable of the

circumstances. Actual documentation of relationship is not required unless relationship is questionable (i.e. doubt has been raised due to contact with collaterals, etc.).

Absence from the Home - Absence from the home does not affect the home exclusion, as long as the individual intends to return to his home (this exclusion may be given to all AABD applicants/recipients who are away from home but intend to return to their home). See below for consideration to be given to an out-of-state home.

Occupied Home - Intent to return is irrelevant if the home is occupied by a dependent relative at any time while the individual is residing in a medical institution. As long as the dependent relative resides in the home, it will be excluded.

Unoccupied Home - When an individual enters a facility and leaves his home unoccupied, his/her statement of intent to return to that home will be sufficient to allow exclusion of the home. The case record should be documented with a signed statement that identifies the reason for his/her being away from home, and if he/she intends to return.

Accept the statement of intent without challenge unless the statement is self-contradictory (e.g., the individual states his intent to return, but also states he will talk to a realtor about listing the home for sale). When the statement is self-contradictory and does not make the intent clear, or the individual's actions are contradictory to his statement, obtain clarification from a secondary source, such as a physician, relative, or other person in a position to know.

* If after 12 months the individual with an unoccupied home remains institutionalized, the county worker will again obtain the individual's statement regarding his intent to return home. The home exclusion will continue as long as the individual intends to return.

The individual's statement of intent to return should be documented at 12-month intervals as long as the individual remains institutionalized and as long as the home remains unoccupied by a dependent relative.

NOTE: Statements concerning intent to return, allegation of dependency, and/or principal place of residence may be accepted from individuals who have the authority to act on behalf of the applicant/recipient when the applicant/recipient is incapable of providing the information.

If, at any time, it is established conclusively that the individual has no intent to return home (e.g., the home has been listed with a local realtor), the home will no longer be exempt from resource consideration. Effective the first day of the month following the month in which it is determined that the home is no longer the principal place of residence, the individual's equity in the home will be a countable resource.

Out-of-State Home

The out-of-state home of an individual who enters the state with the intent to reside permanently or for an indefinite period of time will not be excluded as the principal place of residence unless the home is occupied by a spouse or dependent relative.

Transfer of the Home - If an individual transfers his home for less than fair market value while institutionalized, refer to 3334.2, 3334.8, 3335.2 and 3335.4 for treatment.

Rental of the Home - If the home is rented while an individual is institutionalized, it may continue to qualify as the principal place of residence and be excluded from resources as long as the individual intends to return.

The intent to return will be documented at 12-month intervals as long as the individual remains institutionalized.

Replacement of a Home

When an excluded home is sold and the intent is to purchase another home, the proceeds from sale of the original home may be excluded from resources if they are used or obligated to purchase the substitute home by the last day of the third full month following the month of receipt of the funds. If the home is not replaced during this period, then the proceeds will be counted as a resource beginning with the month following the month they were received.

Interest earned on the funds is not excluded, but will be treated as income in the month accrued, and as a resource in the month following.

The home replacement period begins in the month following the month in which the proceeds are received. However, if the funds were received prior to application, the replacement period begins the month of application.

The proceeds of a home sale will be the net payments received after deducting all encumbrances and sale expenses. All of the net proceeds must be used (or legally obligated) by the end of the exclusion period on the costs of the purchase and occupancy of the substitute home. Allowable costs may include the down payment (even if made before sale of the original home), loan fees and points, moving expenses, repairs or replacements to structure or fixtures, and mortgage payments prior to occupancy. The exclusion does not apply to that portion of the proceeds in excess of the funds used on the substitute home, i.e. if all of the proceeds from the sale of a home are not applied to the substitute home, the unused (unapplied) funds will be counted as a resource beginning with the month following the month they were received.

The intent to replace an excluded home must be documented by a signed statement from the individual or his representative. (For home replacement due to disaster, Re. MS 3333 #4.)

Installment Sales Contract in Home Replacement

If an excluded home is sold, the seller has an installment sales contract for payment of the property, and all funds (down payment and periodic payments) are reinvested in the purchase of a replacement home, the CMV of the sales contract may be excluded from resources. In order for the exclusion to apply, the down payment and each installment payment must be applied to the purchase of the replacement home within 3 calendar months of the date each payment is received (i.e., by the end of the last day of the third month after the month in which the proceeds are received).

The portion of any payment which is interest on the principal is counted as unearned income.

If an individual does not use the monies received as payments on the replacement home, the CMV of the sales contract and any payments made will count as resources in the month following the month of receipt of the contract.

If an individual ceases to use the installment payments to purchase the replacement home, any retained payments and the CMV of the contract will be considered countable resources in the month after the month of receipt of the first payment not used as intended within 3 months.

SSI Recipients in a Facility - The Social Security Administration will determine when the home becomes a countable resource for SSI recipients (i.e. those receiving reduced SSI benefits while in a facility). Vendor payments and Medicaid eligibility will continue as long as the individual remains eligible for SSI, unless the individual has made a prohibited resource transfer (which would result in only vendor payment ineligibility) or the county discovers a disqualifying resource unknown to SSA (which would result in ineligibility for both vendor payment and the Medicaid card).

* 2. NonHome Income Producing Property

There are three categories of nonhome income producing property which may be excluded from resources.

Any excluded property must be in current use or, if not in use for a reason which the individual cannot control, it must be expected that the usage will be resumed. Resumption of the use must be within 12 months of last use. The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition.

a. PROPERTY WITH EQUITY UP TO $6000 EXCLUDED IF PRODUCING A 6 PERCENT ANNUAL RATE OF RETURN

This exclusion applies ONLY to AABD applicants/recipients in facilities, medically needy categories, and QMB/SMB categories who have an interest in mineral or timber rights, rented farmland, rented dwellings, etc., when the income from their property interest is not considered their principal means of livelihood or support and they are not considered to be conducting a trade or business. The exclusion does not apply to SSI recipients or QDWIs.

Up to $6000 equity may be excluded from the property described above if it is producing at least a 6 percent annual return on the amount of equity excluded. Any equity remaining after the exclusion is given will be included with other countable resources. For example, a mobile home on nonhome land with total combined equity value of $7000 is being rented for $60 month/$720 year. Six percent of $6000 is $360. Since the annual return ($720) is greater than 6 percent of $6000, $6000 of the equity value of this property may be excluded from resources. The remaining $1000 equity must be counted as a resource.

If an individual has more than one nonhome income producing property interest, the total equity value excluded cannot exceed $6000, and the rate of return must equal at least 6 percent of the excluded equity for each activity.

If the property is not excludable because the annual return is less than 6 percent of the excluded equity value, the total equity value of the property is a countable resource.

b. PROPERTY EXCLUDED REGARDLESS OF VALUE OR RATE OF RETURN

When nonhome real or personal property is used in a trade or business essential to self support (including personal property used by an employee for employment), the total equity value of the property may be excluded from resources.

A trade or business is defined as the principal commercial or mercantile self employment work activity in which one engages regularly and from which one derives his/her principal livelihood. An individual residing in a long term care facility is not ordinarily involved in a business which involves regular work activity that is the primary source of income.

All of the liquid resources used in the operation of a trade or business may also be excluded as property essential to self support.

Some examples of property used for self support are land and equipment used for farming; land, a building and equipment used for a dry cleaning establishment; or the land and multiple mobile homes being operated as a mobile home park business. Examples of property used by an employee to maintain employment are tools, safety equipment, uniforms, etc.

The most recent tax return available may be used to verify current use of the property as a trade or business enterprise. If a tax return is not available, other means of verification such as purchase receipts, bank statements, proof of payments, etc., can be used.

The profit/loss shown on an income tax return is irrelevant in determining whether the individual is conducting a trade or business or whether the value of the property will be excluded from resources.

c. PROPERTY WITH UP TO $6000 EXCLUDED REGARDLESS OF RATE OF RETURN

Up to $6000 of the equity of nonhome, nonbusiness real or personal property used to produce goods or services essential to daily living may be excluded from resources. There is no rate of return requirement. If the equity value exceeds $6000, only $6000 may be excluded; the remaining equity is a countable resource.

Some examples of the above exclusion are the land used for gardening or for grazing livestock when the product (vegetable or meat) is used only for personal consumption by the applicant/client and his household members. Equipment, such as a tractor or fishing boat, used in the production of food solely for home consumption may also be excluded. However, an automobile or truck may not be excluded under these provisions.

The current market value (obtain from a knowledgeable source) and the value of the individual's equity in the property must be verified in order to determine what portion of the equity value, if any, must be counted as a resource.

Only one $6,000 exclusion may be given under this policy that allows a $6000 exclusion regardless of rate of return.

3332 Personal Property

Personal property is property other than real property, consisting primarily of liquid assets.

Personal property which is accessible to the individual, or of which the individual is free to dispose, is a countable resource unless it meets the criteria for exclusion as specified under MS 3332.3.

3332.1 Forms of Ownership

Generally, ownership of personal property can be in the same form as that of real property (Re. MS 3331.2).

3332.2 Determining Value of Personal Property

Listed below are various types of commonly held assets which are countable resources. The listing also describes how their resource value is determined.

Verification of countable resources is required.

1. Cash - Cash consists of money which is on hand in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for United States issue. (Coin collections, however, are not considered to be cash, even though they are a resource. Their value is based on collectors value which is determined by contact with a knowledgeable source.)

   Cash on hand includes amounts that the individual has on his person, amounts that he has at home, and amounts being held for him elsewhere.

   The total amount of cash on hand (excluding amounts which were received during the month and counted as income) is a countable resource. The individual's allegation of actual cash on hand is accepted as verification.

2. Checking or Savings Accounts - Assets of an individually held checking or savings account (including patient funds accounts managed by a facility for an individual) will be considered a resource to the individual when he has unrestricted access to the account. The assets of a jointly held account are presumed to be fully available to an eligible individual when he is the only party to the account eligible for assistance. However, when all parties to a jointly held account are receiving or have applied for assistance under the same program, the assets of the account are presumed to be divided equally among the eligibles who have access to the account.

   An otherwise eligible individual, who is a joint account holder with unrestricted access to the account, will be offered an opportunity to rebut the presumption. To rebut the presumption of full or partial ownership, the individual must provide all of the following evidence within 30 days:

   a. A written statement by the individual giving his allegation regarding ownership of the funds for the applicable period, the reason for establishing the joint account, who made deposits to and withdrawals from the account, how withdrawals were spent, etc.;

b. corroborating written statements from the other account holders; and

c. proof of the change in the account designation removing the individual's name from the account (if he has no ownership), or restricting his access to the funds in the account.

The County Office will provide assistance in obtaining the evidence only when the individual is unable to do so.

If the co-holder of a joint account is incapacitated or a minor, it will not be necessary to obtain a corroborating statement from that individual. When this occurs, obtain a corroborating statement from a third party who has knowledge of the circumstances surrounding the establishment of the joint account. If there is no third party, make the rebuttal determination without a corroborating statement. Document the case record with an explanation as to why no corroborating statement was obtained.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the funds (if any).

If the individual elects not to rebut the presumption, obtain a written statement from the individual which documents his election.

If the individual elects not to rebut, does not provide a rebuttal within the allotted time, or does not provide all of the required evidence, the presumed ownership interest will be used in his eligibility determination. When the individual is a joint account holder with an ineligible, any interest payments or deposits made to the account will be considered unearned income in his eligibility determination. When the individual is a joint account holder with an eligible, any interest payments will be divided equally among the holders but deposits by one will not be considered income to the other.

If the individual submits all required evidence within the allotted time, determine his ownership interest (if any) and document the findings in the case record. The actual ownership interest (i.e. the interest determined by rebuttal) will be used in his eligibility determination. When the individual has successfully rebutted ownership of all or a portion of the funds in a joint account, deposits by the other holder(s) will not be counted as income and interest payments will be charged in proportion to his ownership interest (if any).

If the value of a joint account will cause the individual to be ineligible because he is the only party to the account eligible for Medicaid, he must be advised of the reason for his ineligibility. Any questions that the individual may have regarding the effect of specific actions that he may take concerning the account will be answered.

Verification of a checking account balance is made by examining the checkbook record and the bank statement covering the month before application or reevaluation, or written contact with the financial institution. Checks written and forwarded or delivered for payment prior to the first of a month but not cleared by the first day of the month will be deducted from the account balance.

Verification of a savings account balance is made by examining the passbook and/or bank statement or by written contact with the financial institution.

Verification of a patient fund account balance will be secured by contact with the facility.

If there is any question as to the accuracy of the passbook or checkbook record, secure a DHS-81, Consent for Release of Information, and request a written verification from the financial institution.

3. Certificates of Deposit - Certificates of deposit or time deposits are contracts between an individual and financial institutions whereby the individual deposits funds for a specified period of time in the form of a certificate of deposit, savings certificate, etc. In return, the financial institution agrees to pay the individual a higher interest rate than the maximum permissible passbook rate.

   To be considered a resource, funds invested in the time deposit must be available to the individual. Generally, funds in a time deposit can be withdrawn prior to maturity with interest penalties imposed. The value of a time deposit as a resource is the net amount an individual would receive after imposition of penalties for early withdrawal.

   If by examination of the certificate it cannot be determined whether the funds can be withdrawn, or if the resource value cannot be determined, contact with the financial institution where the funds are deposited will be necessary. The case file will be documented as to the resource value of time deposits and the method used to determine value.

4. Promissory Notes - A promissory note is a written unconditional promise signed by a person who promises to pay a specified sum of money at a specified time or on demand to a person, company, corporation, or institution on the note.

   Promissory notes may be discounted and sold, unless the terms of the note prevent it. If the terms of the note prevent its sale, it is not considered to be a resource.

   Discounting refers to the interest deducted in advance by one who buys, or lends money on a bill or exchange or promissory note. For example, a bank may be willing to pay $450 for a $500 promissory note which is due in one year's time.

   When the individual owns a promissory note which he could sell or discount, it is considered to be a resource in the amount for which it could be sold or discounted.

   If by examination of the promissory note, it cannot be determined whether the promissory note is saleable, or its value cannot be determined, contact with a local bank or lending institution will be necessary. The bank may wish to examine the note before making a determination. When this is required, the individual or person acting on his behalf should personally submit the note to the bank for examination. When the note is determined not to be saleable until maturity, its value is not a countable resource until that time.

   The cash payments received on a nonsaleable promissory note are counted in full as unearned income.

   The cash payments received on a saleable promissory note, which is considered to be a resource, are treated as follows: (1) payment which

represents payment on principal is considered as a resource; (2) payment which represents payment on interest is considered to be unearned income. An amortization schedule may be necessary to determine interest income.

Case narrative documentation will be made to indicate a note's resource value and how it was determined.

5. Mortgage - A mortgage is a pledge of a particular property to a creditor as security for the payment of a debt (or the performance of some other obligation) within a prescribed time period.

Generally, a mortgage can be sold or discounted like a promissory note.

Determination of the value and saleability of a mortgage is made in the same manner used for promissory notes.

6. Stock - Shares of stock represent ownership in a corporation. Stock value is determined by the closing price at the time of application or redetermination.

Individuals who own stock must provide either the stock certificate for verification of ownership or a copy of the most recent account statement, if the stock is held by a securities firm.

Verification of stock value may be made by consulting the financial section of a newspaper for stock that is listed on either the New York or American Stock Exchange. Closing price is used. For stock not listed on either exchange that is traded "over the counter", the "bid" price for the stock is used to determine market value. If "bid" prices for "over the counter" stock are not listed in the newspaper, contact will be made with a local securities firm to verify value. Documentation of ownership and value will be entered in the case narrative.

7. Stock in Close Corporation - Stock held in a corporation wholly owned by one or more board members requires complete development to determine resource value.

The value of stock in a close corporation which has elected not to trade its stock publicly is determined by subtracting the liabilities of the corporation from its assets and dividing the resulting net assets by the number of stock shares outstanding.

Net assets of the corporation must be determined by examination of the corporate tax return for the most recent taxable year. The individual who owns stock in a close corporation must provide information necessary to determine its resource value.

8. Stock in Alaskan Native Corporation - Shares of stock held in an Alaskan Native regional or village corporation are excluded from resources.

9. Mutual Fund Shares - A mutual fund is a company that buys and sells securities and other property with funds obtained from its shareholders.

Value determinations for mutual fund shares follows the procedure used in determining the value of stock.

10. Municipal, Corporate, and Government Bonds - A bond is a written agreement to pay a sum of money at a future specified date. Even though a bond must

- It is used to obtain medical treatment for a specific or regular medical problem, or
- It is necessary for employment, or
- It is specially equipped for use by a handicapped individual, or
- It is necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the value of the automobile exceeds $4500 and it is not excludable based on its use, the value in excess of $4500 will be included with countable resources.

NOTE: If an individual in a facility has a spouse living in the community, they will be allowed one vehicle, regardless of value.

When the above general exclusion has been given to an automobile, a second automobile can be excluded only if it is essential to the means of self-support of an individual or couple. If a second vehicle is normally used in the operation of a trade or business and if the first excluded vehicle cannot also fulfill the self-support function, then the second vehicle may be excluded from counting toward the resource limitation.

The equity value of all nonexcludable automobiles will be included with countable resources.

Development

(1). Determination of Current Market Value - The determination of value for foreign and domestic passenger cars will be based on use of the "average wholesale value" listed in the NADA Official Used Car Guide, for listed automobiles. The determination of value for trucks, passenger cars, and other vehicles not listed in the NADA Official Used Car Guide will be based on the county personal property tax assessed value (20% rate) multiplied times 5, or contact with a knowledgeable source (e.g., auto dealers, truck dealers, auto insurance companies, etc.).

The NADA Official Used Car Guide is distributed by the Agency twice a year. When using the NADA Official Used Car Guide, use the edition current for the point in time determination. Determine the average trade-in or wholesale value for the auto as listed in the NADA Official Used Car Guide. If the value of the auto is not material to the eligibility determination (i.e., it is excluded or its countable resource value does not affect eligibility when combined with other countable resources), no further determination of exact value is necessary. If, however, the value of the auto is material (affects eligibility), further determination is necessary because the average wholesale value for all domestic cars includes air conditioning and sometimes other options and, if the applicant/recipient's auto does not have the standard

options, their wholesale value is deductible. The option valuations are listed with each model in the NADA Official Used Car Guide.

Normally, vehicles too old to be listed in the NADA Official Used Car Guide can be assumed to be worth under $4500. However, the value of an automobile of obvious value such as a Jaguar, Mercedes-Benz, Rolls Royce, Cadillac, Lincoln, Corvette, antique auto, or customized auto will be determined even when it is too old to be listed in the NADA Official Used Car Guide. These may be verified by use of the tax assessment method or by contact with a knowledgeable source.

When contacting a knowledgeable source, an estimate of the wholesale value will be requested. In all value determinations, it is essential to obtain a complete and accurate description of the vehicle being evaluated. Document the case narrative as to determined values and the means used to make the value determinations (including the name and address of dealers used in knowledgeable source contact).

(2). Application of General Exclusion - If the value of an auto is not more than $4500, it is excludable without further determination. If the value exceeds $4500, it is necessary to determine whether it can be given exclusion on the basis of obtaining medical treatment, of being used as transportation in connection with work, of being specially equipped for use by a handicapped member of the household, or of being required to perform essential daily activities due to climate, terrain, or of distance, etc.

(a). Exclusion based on use to obtain medical treatment In the case of an obvious illness or handicap, assume that the automobile is used to obtain specific or regular medical treatment. Document the file with a narrative as to the nature of the illness or handicap and the exclusion of the automobile. If there is no obvious illness or handicap, verify frequency of use of the auto by obtaining medical appointment cards, evidence of past treatment (bills for services, physician fees, prescription drugs, etc.), or contact with treatment sources. It must be established that the automobile is used at least 4 times per year to obtain medical treatment or prescription drugs. Document the file as to the exclusion and evidence used. This exclusion is made whether the use is for the applicant/recipient or a member of the immediate family living in the household.

(b). Exclusion based on use in connection with employment An automobile used by the applicant/recipient, spouse, or other member of the immediate family living in the household as transportation to and from work is excluded regardless of value. The development of income from work activity of a spouse or person whose income is deemed is sufficient to document the exclusion. If the auto is used by

another member of the household, a signed statement from that person is acceptable evidence. Narrate the exclusionary status and reason in the case record.

(c). Exclusion of an auto specially equipped for a handicapped individual - An automobile specially equipped for use by a handicapped individual in the household (either as a passenger or as an operator) is excluded, regardless of value. Accept the individual's statement explaining the nature of the modification to the vehicle as verification. Narrate the exclusion in the case record.

(d). Exclusion based on climate, terrain, etc. that requires transportation to perform essential daily activities - If climate, terrain, distance, or similar factors requires a vehicle to perform essential daily activities, the vehicle may be totally excluded, even if its value is over $4500. The reason for exclusion should be narrated in the case record.

If the value of the automobile exceeds $4500 and it is not excludable based on its use, consider excess value above $4500 as a countable resource. Do not deduct encumbrances.

Generally, only one automobile is excludable. If the second auto does not qualify for exclusion (i.e. essential for self support), its equity value (current market value less encumbrances) is considered to be a countable resource. No more than two autos can be excluded. If any additional autos are owned, their equity value is considered to be a countable resource.

If a family has two or more automobiles and only one is excludable based on its value/use, the exclusion will be given to the automobile with the highest equity value.

(3). Applicant Disagrees with Determined Value - If the applicant disagrees with the value determined for an automobile which is material to the case (affects eligibility), he will be afforded the opportunity to provide two knowledgeable source statements to establish a different value. These appraisals will be at the applicant's own expense. It should be explained to the applicant that the agency is not bound to honor the appraisals. However, the agency will recheck any provided appraisals for accuracy and, if they are accurate, establish a value based on the appraisals.

2. Life Insurance Policies

a. An individual is allowed to own policies with a combined face value of $1500 or less without consideration of cash surrender value (CSV).

b. Only policies that have CSV are considered against the $1500 limit. These include Whole Life, Straight Life, Endowment, Limited Payment Life, etc.

c. Policies without CSV are not counted as resources.

Development - When the combined face value of policies with CSV owned by the individual is equal to or less than $1500, there is no resource to be considered. However, the face value must be considered in determining excluded burial funds (Re. 3332.3, 5, b, (1).

When the combined face value of policies with CSV owned by the individual exceeds $1500, the CSV of the policies must be determined and counted as a resource. If the individual alleges that the insurance policies are intended to cover burial expenses, the CSV of such policies may be designated as a burial fund (Re. 3332.3, 5, b, (4).

Most Whole Life policies come with a CSV chart which can be used to determine value. If the CSV cannot be determined from a chart provided with the policy or other available evidence, secure an DHS-81 from the client, and contact the insurance company to determine value. Any outstanding loans made against a policy's CSV will be deducted.

3. Household Goods and Personal Effects

a. $2000 exclusion (normally the value is assumed to be less than $2000); or
b. If the individual alleges that a single item is worth $500 or more, verify the value of the item and assume remaining items to be valued at $1000.

Development - If the individual does not allege a single item to be worth more than $500, no further development is necessary.

If the individual alleges that a single item such as an antique is worth more than $500, the value of the item must be verified through a knowledgeable source-in this case an antique dealer. A description of the property's age, type, and condition should be given to the dealer. If it is verified that the property is worth more than $500, the actual value of the item is added to the value of the remaining household goods and personal effects ($1000), and any amount above the $2000 limit is considered as a countable resource.

4. Income Producing Nonhome Property (Personal Property)

For the consideration of personal property used in conjunction with a trade or business, with employment, or with production of goods or services essential to daily activities, refer to MS 3331.5 #2.

5. Burial Spaces and Funds

a. Burial Spaces

The term "burial space", as used here, applies to conventional gravesites, crypts, mausoleums, urns, vaults, caskets, and other repositories which are customarily and traditionally used for the remains of deceased persons.

The value of burial spaces for the individual, his spouse or any member of the individual's immediate family will be excluded from resources. The term "immediate family", as used here, applies to the individual's children (minor and adult), including adopted children

and stepchildren, his brothers, sisters, parents (natural or adoptive), and the spouse of those individuals. Dependency or living in the same household are not factors.

If a burial space item is included in a contract or policy which accrues interest, the interest retained is excluded from both income and resources as it increases the value of the excluded burial space. This exclusion is in addition to the burial fund exclusions specified in item "b". below.

If a burial contract or policy (item "b" below) separately identifies a burial space from the other items in the contract or policy, the amount for the burial space may be allowed in addition to the $1500 burial fund exclusion. For example, an individual has a $2700 burial contract which lists $900 for the casket and $400 for the gravesite. A total of $1300 may be excluded from resources under the burial space exclusion. The remaining $1400 will be applied to the $1500 burial fund exclusion.

b. Burial Funds and Other Burial Arrangements

Burial funds are defined as revocable burial contracts, burial trusts, other burial arrangements, cash accounts, or other financial instruments (documents which have a definite cash value) clearly designated for burial expenses. Property other than listed above will not be considered "burial funds."

The individual and his spouse can have an exclusion of $1500 each of funds specifically set aside for their burial arrangements. This exclusion is in addition to the burial space exclusion.

It <u>is</u> required that burial funds be kept in an account separate from other nonexcluded funds. Burial funds and other funds may not be commingled in the same account.

Interest earned on excluded burial funds are excluded from income and resources, if left to accumulate and become a part of the burial fund.

* If burial funds are comingled with other nonburial funds, all of the funds will be counted as a resource, and no exclusion of burial funds will be allowed. When an applicant agrees to (and does) separate his commingled funds, eligibility may begin effective the date of entry into a facility, if the individual is otherwise eligible.

If any excluded funds, or accumulated interest, set aside for burial expenses are used for a purpose other than the burial arrangements of the individual or his spouse for whom the funds were set aside, the amount used will be considered unearned income in the month in which it was accessed, and a resource (to the extent retained) in the following month.

The most common type of burial funds and burial arrangements are shown below, and must be considered in the order given in their application to the $1,500 burial exclusion.

(1) <u>Life Insurance Policies, other than those specifically designated for burial</u> (See Item #3) - The total face value of all insurance policies on the life of an individual owned by

the individual (or spouse) will reduce the $1500 burial exclusion if the cash surrender value of those policies was excluded in determining eligibility (MS 3332.3 #2). If the total face value of policies considered here is $1500, no further exclusions are allowed.

NOTE: Life insurance policies with no cash surrender value will be totally disregarded as both resources and burial funds.

(2) Irrevocable Contracts - Burial Association policies (membership through a funeral home) and some prepaid burial contracts (including those funded by deferred annuity and insurance policies) are considered irrevocable and are not treated as a resource, regardless of the value. Groups that issue prepaid burial contracts must have a permit to sell from the Arkansas Securities Department, and the contract must be written on an approved Securities Department form. Irrevocable trusts that have been established by the applicant/client or representative which are payable only upon death to a specified funeral home for burial of the client shall not be considered an irrevocable contract under this section unless the funeral home designated under the arrangement is licensed by the Arkansas Securities Department to sell prepaid burial contracts.

* All prepaid burial contracts, including those funded through annuities and life insurance policies which are irrevocably assigned to a funeral home, must include an itemized list of specified services and merchandise to be provided by the funeral home at the death of the individual. Each item on the list must show a value of the service or merchandise. The total value of the itemized services and merchandise must equal the cash payment made to purchase the arrangement. Any amounts itemized as "miscellaneous" or other unspecified services will not qualify for exclusion. Such amounts will be included with the amount paid for unspecified services and merchandise, and the total will be subject to a transfer of assets penalty (see 5d below).

The local funeral home may be able to advise the county if a contract is irrevocable, if the county cannot make this determination by reading the policy. Irrevocable contracts will be counted toward the $1500 burial exclusion.

If face values of insurance policies in Item (1) are less than $1500, then the value(s) of irrevocable contracts in Item (2) will be applied toward the $1500 exclusion. If a combination of insurance (with face value less than $1500) and irrevocable contracts equals $1500 or more, no further burial exclusions will be allowed, and any combined amount in excess of $1500 will be totally disregarded.

(3) Revocable Contracts -

(a) Some Prepaid Burial Contracts may be revocable and, if the $1500 burial exclusion limit has been reached by the preceding funds in Item #1 or #2, the value of the revocable contract will be treated as a resource. If the limit has not been reached, the value of the

revocable contract will be used to reduce the $1500 exclusion, with any amount over $1500 considered a resource.

(b) An insured burial contract is a burial arrangement covered by a life insurance policy. These policies are normally considered revocable. If the $1500 burial exclusion limit has been reached by the preceding funds, the total cash surrender value of the burial insurance policy will be treated as a resource. If the limit has not been reached, the cash surrender value will be used to reduce the $1500 exclusion, with any cash surrender value over $1500 considered a resource.

(4) Cash, Checking, Savings Accounts, or Other Funds - If these funds are specifically designated as burial funds (by the client's written statement in case record), they may be used to reduce the $1500 burial exclusion. If the $1500 limit has been reached by funds in Items (1), (2), and (3), then the cash funds in Item (4) will be considered as a resource. If the limit has not been reached, then the cash funds may be used to reduce the $1500 exclusion, with any amount remaining to be treated as a resource. The cash surrender value of life insurance policies (Re. 3332.3 #2), if designated for burial, may also be used to reduce the $1500 exclusion.

Contracts or Policies Purchased/Owned by Others - Some contracts or policies are purchased and owned by individuals who are not the applicant/client, but they designate the applicant/client, as beneficiary. These contracts/policies are not considered a resource to the applicant/client; however

(a) Irrevocable contracts/policies owned by other individuals will count against the $1500 exclusion, but

(b) Revocable contracts/policies owned by other individuals will not count in the $1500 exclusion.

The above rule does not apply when the purchaser/owner declares the contract/policy was purchased with the applicant/client funds.

Ownership can usually be determined by reading the policy/ contract. If the buyer's name shown is not the applicant/client, then the policy/contract is owned by someone other than the applicant/client.

* c. Out-of-State Burial Arrangements

Some burial arrangements with out-of-state funeral homes may be excluded from resources. If it is verified that the arrangement is irrevocable, the value of the arrangement will not be countable. If questionable, contact Medicaid Eligibility, Slot 1223.

* d. Transfer of Assets Penalty Applicable to Irrevocable Burial Funds

RULE FOR APPLICATIONS APPROVED 11/1/95 AND LATER

Transfer of Funds to Funeral Homes - If the value of the merchandise and services itemized in a prepaid irrevocable funeral plan is equal to the payment made for the plan (or to the value of the life insurance or annuity irrevocably assigned to the funeral home as payment for the plan), it can be assumed that the individual has purchased a funeral for fair market value. If the value of the itemized merchandise and services is less than the payment, a period of ineligibility will be imposed for an uncompensated transfer. For example, if an individual pays $15,000 to a funeral director but the contract specifies only $5000 worth of merchandise and services, there is a $10,000 uncompensated transfer for which a period of ineligibility will be imposed.

* Transfer of Funds to a Trust, Certificate of Deposit or Other Instrument Designated for Burial - If an individual has a revocable trust, certificate of deposit or other instrument and the fund is designated only for burial, any amount over the $1500 burial fund limit is a countable resource. If the fund is irrevocable, the amount over $1500 is also a countable resource. (Re. MS 3336.8 #4). If the trust, CD, etc., is irrevocably assigned to a funeral home, a penalty for transfer of resources will be applied unless there is an agreement with the funeral home (which must be licensed by the Arkansas Securities Commission to sell prepaid burial contracts) to provide specified services and merchandise equal in value to the fund.

6. Any SSI or SSA retroactive payments that were due for one (1) or more prior months will be excluded from countable resources according to the schedule below. This rule is applicable to an eligible individual, an ineligible spouse, and/or any other persons whose resources are subject to deeming. (Interest accruing to the lump sum funds is not excludable).

Any SSA or SSI retroactive payments received on or after October 1, 1984, through September 30, 1987, will be excluded for six (6) months, beginning in the month after receipt of the funds.

SSA or SSI retroactive payments received on or after October 1, 1987, through September 30, 1989, will be excluded for nine (9) months.

SSA or SSI retroactive payments received on or after October 1, 1989, will be excluded for six (6) months.

Once the money is spent, the exclusion does not apply to countable resources that were purchased with the money, even if the 6 or 9 months have not expired.

3333 Treatment of Resource Changes

1. Increase in Value of Existing Resource

The increase in value of an existing resource (such as a value increase in stock) is not considered to be income when it occurs. Value increases in resources are included with resources the month following the increase.

2. Receipt of New Resource

The receipt of a new resource such as a cash gift is considered to be income for the month of receipt and, if retained, as a resource in the month following receipt.

3. Conversion of Resource

Conversion of a resource from one form to another (cash to property or vice versa, etc.) can affect resource eligibility in the month following the change. For example, the conversion of an excludable automobile to nonexcludable assets by sale or trade could cause the countable resource limitation to be exceeded the month following the change.

4. Repair/Replacement of Lost, Damaged or Stolen Resources

Cash or in-kind payments received from any source for repair or replacement of lost, damaged or stolen resources are not counted as income, and are not considered countable resources until the month after 9 full months from the date of receipt. Any interest that accrues to these funds is also excluded from income and resource consideration for the 9 month period. The cash payments and interest should be maintained separate from other liquid resources. Cash received for personal injury or other purposes is not excluded from income and resources.

If the excluded cash is used to purchase a nonexcludable resource during the 9 month period, the resource will be evaluated according to the applicable resource rules.

When circumstances prevent the repair/replacement of the resource during the 9 month exclusion, a reasonable extension not to exceed 9 additional months may be granted, provided:

a. it can be documented that a reasonable effort to repair/replace was made (at least 2 providers should be contacted for documentation), and

b. the individual still intends to repair/replace the resource.

Change of intent to repair/replace is irrelevant during the 9 month exclusion but, if during an extension of the exclusion the individual's intent to repair/replace is changed, the funds and all of the accrued interest will become fully countable as a resource on the first day of the month following the month of changed intent.

When the exclusion period (and extension, if applicable) has expired and the individual has not repaired/replaced the resource, the cash funds and interest will be a countable resource the first day of the month following the month of expiration.

If the payment has been in-kind support and maintenance (e.g., an individual has been furnished shelter because his home was destroyed by fire and the individual decides not to replace the home), the in-kind support will be considered income in the month following the end of the 9 month period or, if an extension was granted, in the month following the month of changed intent.

5. Proceeds of Loan

Proceeds of a loan which is subject to repayment are not income to the individual; however, unused loan proceeds accrued into the month following their receipt become a countable resource.

6. Proceeds from Sale of Resource

Proceeds from the sale of a resource are not income to the individual. Proceeds from the sale of a resource are countable for resource determination the month following their receipt if retained by the individual.

3334 TRANSFER OF ASSETS - HISTORY AND REFERENCES

Treatment of asset transfers for less than fair market value made by an applicant/recipient, his/her eligible spouse, or their representative are governed by the date of transfer, the institutional or waiver status of the applicant/recipient, and whether the transfer was to the applicant/recipient's spouse.

Prior to 9/1/81 - there was no applicable transfer of assets policy for Medicaid applicants/recipients.

9/1/81 through 6/30/88 (through 9/30/89 for Spouses) - Applicable transfer policy for all Medicaid applicants/ recipients is found at MS 3334.1 through MS 3334.9.2.

7/1/88 and later - There is no policy (i.e., there is no penalty for uncompensated transfers) for non-institutionalized and non-Waiver Medicaid applicants/ recipients.

7/1/88 (10/1/89 for Spouses) through 8/10/93 - Transfer policy for institutionalized and Waiver applicants/recipients is found at MS 3335 - MS 3335.3. Also refer to related policy for institutionalized/community spouses at MS 3337 - MS 3338.12 effective 10/1/89 and later.

8/11/93 and later - Transfer policy for institutionalized and Waiver applicants/ recipients is found at MS 3336 - MS 3336.15.

Refer to chart at MS 3335.4.

3334.1 Transfer of Resources - General

Transfers of assets (including the establishment of or placement into a trust) made by an applicant/recipient, his/her eligible spouse, or a representative acting on their behalf must be verified and evaluated to determine:

whether the transfer is validly irrevocable;

whether any interest remains legally available to the individual or is declared by the current legal owner(s) to be available; and

whether an asset was transferred for less than fair market value within the applicable look back period preceding the month of application/ redetermination.

When it is determined that an applicant/recipient, his/her eligible spouse, or representative has the authority or ability to revoke the transfer and regain the transferred interest, the value of such interest will be included with countable assets.

When it is determined that an applicant/recipient or his/her eligible spouse has remaining interest or ownership in a transferred asset, the value of such interest will be included with countable assets.

When it is determined that an applicant/recipient, his/her eligible spouse, or their representative has transferred an asset at less than fair market value within the applicable look back period prior to application, the transfer will be presumed to be for the purpose of establishing eligibility, and the amount of uncompensated value from the transfer(s) and the period of time the uncompensated

value will be included with countable assets will be determined. Transfer(s) of assets presumed to be for the purpose of establishing eligibility will be subject to rebuttal (Re. MS 3334.6 and MS 3334.7) and, in some cases, subject to exclusion based on other circumstances.

NOTE: The above guidelines apply not only to an applicant/recipient or his/her eligible spouse but also to any fiduciary or individual legally authorized to act on their behalf, such as holder of power of attorney, parent of a minor child, guardian, etc. The guidelines also apply to other persons acting on behalf of the applicant/recipient or eligible spouse, e.g., an ineligible spouse.

3334.2 Documentation of Resource Transfers

Each individual who is subject to a penalty for uncompensated transfers and who applies for Medicaid September 1, 1981 or later, must complete Form DCO-727, Disposal of Assets Disclosure, in conjunction with his/her application for assistance (including applications completed at reevaluations). The county worker will explain to each applicant/recipient (or to his/her representative) that transfers of any assets within the applicable look back period must be disclosed as a part of the eligibility determination.

Reported property transfers will be documented by copy of bill of sale, title transaction, deed, business records, receipts, account statements, etc. A signed statement from the receiving party of the transaction may also serve as evidence. The applicant/recipient or person acting on his behalf must provide necessary documentation to verify the transfer, but the county worker will give assistance when necessary.

In addition to documenting the actual transfer, when a transfer has been made by an applicant/recipient, his/her eligible spouse, or another joint owner or account holder, etc., and fair market value compensation was not received, the worker must complete an Asset Inquiry, Form DCO-778, and forward it to the individual who received ownership of the asset. This inquiry is completed to document current ownership of the asset, the purpose of the transfer, and any expected compensation. If a complete Asset Inquiry Form cannot be obtained the worker should attempt to gather the information through other means, e.g., direct from the client, etc. Assistance cannot be denied solely on the basis of not being able to obtain a completed Asset Inquiry Form.

3334.3 Determination of Uncompensated Value and Period of Consideration

The uncompensated value from an asset transfer is the difference between the fair market value of the asset at the time of transfer (Re. MS 3331-3331.5 for real property and MS 3332-3332.3 for personal property) and the value of compensation received for the asset (Re. MS 3334.4).

The period of time that the uncompensated value from a resource transfer is considered is determined by dividing the uncompensated value by the amount specified for the period of time in which the transfer was made. The result will be the number of months that an individual will be ineligible for Medicaid. For example, the value of a transfer made between 9/1/81 and 6/30/88 will be divided by $1000. If $30,000 has been transferred, the period of ineligibility will be 30 months ($30,000 divided by $1000 = 30).

The period of ineligibility due to the uncompensated value of an income transfer is determined according to MS 3336.11. Amounts of uncompensated value and their periods of consideration may be affected by the receipt of compensation at a later time. Refer to MS 3334.8 for treatment.

NOTE: This section does not apply to individuals who applied and/or were receiving assistance prior to 9-1-81, for whom the agency determined eligibility, and who have remained continuously eligible.

When eligibility was determined by SSA for SSI prior to 9/1/81, and eligibility has not been determined by this agency, the date that the individual applies with this agency (e.g. for nursing facility services) will determine which transfer policy is applicable.

3334.4 Determining Value of Compensation Received

The value of compensation received is based on the agreement and expectation of the parties at the time of transfer. For example, if the purchaser agreed to pay the individual $10,000 in 10 installments of $1,000 each, the compensation is valued at $10,000 regardless of the amount of any payment(s) actually received at the time of application or redetermination.

The value of compensation is the gross amount paid or to be paid in a tangible form (such as cash, real or personal property) by the purchaser (the value is not reduced by expenses attributed to a sale). When compensation is equal to or greater than the value of the asset transferred, the transfer will not be considered uncompensated. However, any balance of resources from the transaction will be counted toward the resource limit.

* NOTE: A transfer for love and consideration is not considered a transfer for fair market value. It is presumed that services provided for free at the time were intended to be provided without compensation. Therefore, any transfer for care or services provided for free is a transfer of assets for less than fair market value.

When uncompensated value exists, proceed to 3334.5.

3334.5 Notifying Individual of Established Uncompensated Value

When uncompensated value is established, the individual must be advised of that fact before the application or redetermination is completed. The individual will be informed by letter (Form DCO-732) that he transferred an asset at less than fair market value and that the uncompensated value will result in a period of ineligibility unless he can provide convincing evidence that the action was exclusively for some purpose other than establishing eligibility. A copy of the letter will be filed in the case record.

If the individual does not respond to the letter within 15 days, it will be assumed that he does not wish to rebut the presumption that the transfer was for the purpose of establishing eligibility.

3334.6 Rebuttal of Presumption That Resources Were Transferred to Establish Eligibility

When an individual elects to rebut the presumption that the asset was transferred to establish eligibility, he will be informed that it is his responsibility to present convincing evidence that the asset was transferred exclusively for some other purpose.

The individual's statement concerning the circumstances of the transfer will be obtained and should include (but need not be limited to) the following points:

1. Purpose of transfer of asset,

2. Attempts to transfer asset at FMV,

3. Reasons for accepting less than FMV for the asset,

4. Means of or plans for supporting himself after the transfer, and

5. Relationship, if any, to the person(s) to whom the asset was transferred.

The individual will be required to submit any pertinent documentary evidence (e.g., legal documents, realtor agreements, relevant correspondence, etc.).

The individual's statement of purpose for transfer of the asset and any documentary evidence provided will be evaluated to determine if the transfer was exclusively for some purpose other than establishing Medicaid eligibility. After securing the statement and evidence, proceed to 3334.7.

3334.7 Factors Which Indicate Transfer Exclusively for Some Other Purpose

The presence of one or more of the following factors may indicate that assets were transferred exclusively for some purpose other than establishing eligibility:

1. The occurrence after transfer of the asset of:

   a. Unexpected (traumatic) onset of disability, or

   b. Unexpected loss of other assets which would have precluded eligibility at the time the asset was transferred, or

   c. Unexpected loss of income which would have precluded eligibility at the time the asset was transferred.

2. The asset (if retained) would not have caused total assets to exceed the asset limit at the time of transfer.

   (Example: An individual who has a car worth $1500 and $300 in a checking account gives away the car. No period of ineligibility will be imposed, because the value of the car would not have made him ineligible had he kept it. THIS EXCEPTION DOES NOT APPLY TO A HOME; IF A HOME IS GIVEN AWAY, THE EQUITY VALUE WILL BE COUNTED AS AN UNCOMPENSATED TRANSFER unless one of the exceptions may be applied (e.g., it is transferred to a spouse).

3. The transfer was court ordered for the purpose of satisfying an obligation in existence at the time of that transfer.

If the individual indicates that he had another purpose for transferring the asset but protection of the asset against use for medical or nursing home expenses was a factor in transferring it, the presumption that it was transferred to establish eligibility is not rebutted.

3334.8 Reacquisition of/or Additional Compensation Received on Resource Transfer at Less Than FMV

Return of Transferred Assets - If transferred assets are returned to the individual who transferred them, no period of ineligibility will be imposed, i.e., the transfer will be considered as if it had never occurred. However, an individual who regains transferred assets may not be eligible for a period of time due to the value of the assets. If only a portion of the transferred assets are returned, a period of ineligibility will be calculated based on the value of the assets not returned and will begin with the date of transfer of the first transferred asset not returned.

The receipt of additional compensation for an asset which was transferred at less than fair market value reduces the consideration of uncompensated value for that asset by the amount of additional compensation received. The additional compensation received plus remaining uncompensated value (if any) will be counted with the value of the other assets of the individual.

3334.9 TRANSFER OF RESOURCES EFFECTIVE 9/1/81 THROUGH 6/30/88 (THROUGH 9/30/89 FOR INTERSPOUSAL TRANSFERS)

All Medicaid applicants and recipients for the period shown above are subject to penalty for transfer of assets for less than fair market value.

3334.9.1 Determination of Uncompensated Value and Period of Consideration

The value of uncompensated transfers occurring within 24 months prior to the month of application/redetermination will be divided by $1000 to determine the number of months of ineligibility for all Medicaid services. Any remainder will count as an additional month. For example, an uncompensated transfer of $41,500 divided by $1000 equals 41.5 months, or 42 months of ineligibility. The first month of ineligibility will be the month following the month of transfer.

3334.9.2 Exceptions to the Period of Ineligibility Due to Transfer of a Home for Less than Fair Market Value

The transfer at less than fair market value of the home of an individual who is an inpatient in a medical institution will not cause him to be ineligible if:

1. A medical statement is obtained and documented in the case record that the individual can reasonably be expected to be discharged from the medical institution and to return to that home (Refer to 3331.5 #1 for definition of a "home"). The medical statement should be obtained in writing from the individual's physician, and the statement may be used to justify this exception to ineligibility for an indefinite period of time (Form DCO-779 will be used for this documentation).

2. Title to the home was transferred to the individual's spouse; or to the individual's child who is under age 21; or to his (her) child age 21 or over who is blind or permanently and totally disabled, as determined by SSA.

3. Documentation can be made to the Agency that the individual or his representative intended to dispose of the home either at fair market value, or for other valuable consideration.

4. The Agency determines that denial of eligibility due to home transfer for less than FMV would work an undue hardship upon the individual. If the

individual is otherwise income and resource eligible, and if it can be documented that no family member or other person will be responsible for his medical needs while in a medical institution (Form DCO-778), the Agency may conclude that imposing a period of ineligibility would constitute an undue hardship.

3334.9.3 Related Policy

Refer to MS 3334.1 - 3334.8 for policy related to transfers from 9/1/81 through 6/30/88 (through 9/30/89 for interspousal transfers).

3335 TRANSFER OF RESOURCES EFFECTIVE 7/1/88 THROUGH 8/10/93 (EFFECTIVE 10/1/89 FOR SPOUSES)

THIS SECTION (3335 - 3335.4) APPLIES TO TRANSFERS MADE 7/1/88 THROUGH 8/10/93, AND TO INTERSPOUSAL TRANSFERS MADE 10/1/89 THROUGH 8/10/93. SEE MS 3337 - 3338.12 FOR ADDITIONAL TRANSFER RULES FOR SPOUSES EFFECTIVE 10/1/89 AND LATER.

This section applies to all resources transferred for less than FMV by, or on behalf of, institutionalized and waiver individuals from 7/1/88 through 8/10/93 and to interspousal transfers occurring from 10/1/89 through 8/10/93.

For the purposes of this policy, an institutionalized individual is an individual who is an inpatient of a medical institution and nursing facility (or nursing facility only) for a period of at least 30 days. The term nursing facility includes all licensed nursing facilities and ICF/MR facilities. A Waiver recipient is an individual who is certified by the Agency for services under a Home and Community Based Waiver Services Program.

Examples: A) Ms. A entered a NF from her home on December 1 and remained through December 31. Ms. A became institutionalized on December 31; therefore, resource transfers must be considered. B) Mr. B was hospitalized on January 6, and was admitted to a NF on January 20. Mr. B remained in the institution through February 5. Mr. B became institutionalized on February 5 and resource transfers must be considered. C) Ms. C entered a NF from her home on May 1. She left the LTCF on May 30, a stay of 29 days. Ms. C was not institutionalized and resource transfers are not considered. D) Mr. D entered a hospital on June 2. He went back home on July 2. Mr. D was not institutionalized, because he never entered a NF. Therefore, resource transfers are not considered. E) Ms. E transferred property after 7/1/88, and has received SSI since that time. She applies for waiver services one year after the transfer; resource transfers must be considered.

No period of ineligibility can be imposed on a non-institutionalized or non-waiver applicant/recipient who transferred, or whose representative transferred, resources for less than FMV on 7/1/88 or later.

SSI recipients who transfer property for less than FMV on or after 7/1/88 will not be penalized unless they become institutionalized or apply for Waiver services. SSA will provide information to the agency regarding any uncompensated transfers made by SSI applicants/recipients after 7/1/88. If an SSI recipient becomes institutionalized or applies for Waiver services, this policy (3335-3335.4) will apply.

The SSI transfer information reported to Central Office by SSA will be keyed to ACES on the WRTR screen by Central Office staff. Counties will access this screen to check for SSI transfers when processing a NF or waiver application or reevaluation of an SSI recipient or former SSI recipient. If an asset transfer

is displayed on WRTR the county must determine if a period of ineligibility is to be applied and, if so, report the penalty to the local SSA office.

3335.1 Determination of Uncompensated Value and Period of Ineligibility

A period of ineligibility will be imposed upon an institutionalized or Waiver individual, if the institutionalized or Waiver individual, his/her spouse, or representative disposed of resources for less than FMV as specified below:

1. If the individual was a Medicaid recipient on the date of institutionalization or entry into a Waiver program (Re. MS 3335), a period of ineligibility will be imposed if such transfer occurred during or after the 30 month period immediately before the individual became institutionalized or entered a Waiver program (if the transfer occurred prior to 7/1/88, or prior to 10/1/89 for interspousal transfers, see MS 3334.9.1 for calculation of period of ineligibility).

2. If the individual was not a Medicaid recipient on the date of institutionalization or application for Waiver services (RE. MS 3335), a period of ineligibility will be imposed if a transfer for less than FMV occurred during or after the 30 month period immediately prior to his application (if the transfer occurred prior to 7/1/88, or prior to 10/1/89 for interspousal transfers, see MS 3334.9.1 for calculation of period of ineligibility).

The period of ineligibility will not apply if the transfer can be excluded under the provisions in 3335.2.

The length of the period of ineligibility will be the lesser of:

a. 30 months, or

b. a number of months equal to the total uncompensated value of the transferred resources (the difference between the FMV of the resources at the time of transfer and the value of compensation received for the resources) divided by $1500.00. Any remainder from the division will be dropped.

Example: A $15,500 uncompensated transfer would result in 10 months of ineligibility ($15,500 divided by $1500 equals 10, with $500 remaining. The $500 would be disregarded, and would not count for an additional month of ineligibility.

Upon determination of uncompensated transfer, the institutionalized or Waiver individual will be notified via DCO-732 (Re. MS 3334.5) specifying the period of ineligibility.

NOTE: For uncompensated transfers made 7/1/88 or later, the period of ineligibility will begin in the same month that the transfer was made, NOT in the month following the month of transfer;

AND

When uncompensated transfers are made 7/1/88 or later and an individual applies for nursing facility or Waiver services, that individual will not be eligible for a vendor payment or Waiver services until the period of ineligibility has expired. An individual in a nursing facility WILL be eligible to receive a Medicaid card during the period of ineligibility, provided he/she is otherwise

eligible. However, an individual who has applied for Waiver Services will NOT be eligible for a Medicaid card only, unless that individual is found eligible in some category other than a Waiver category.

3335.2 Exceptions to (the period of) Ineligibility Due to Transfer of a Resource for Less than FMV

No period of ineligibility for uncompensated transfer will be imposed upon an institutionalized or Waiver individual, as specified in 3335.1, to the extent that:

1. The resource transferred was a home, and title to the home was transferred to:

   a. the community spouse of the individual (Re. MS 3337.1)

   b. a child of the institutionalized or Waiver individual who is under age 21 or who is blind or disabled (as determined by SSI or MRT);

   c. a son or daughter (other than a child under 21, or a blind/disabled child) of the institutionalized or Waiver individual who resided in the home for at least two years before the applicant was admitted to the medical institution, Waiver program, or nursing facility, and who provided care which enabled the institutionalized individual to remain at home during that period; or

   d. a sibling of an institutionalized or Waiver individual who has an equity interest in the home and who resided in the home for at least one year before the applicant was admitted to the medical institution, Waiver program, or nursing facility;

2. The resources were transferred to a community spouse (or to another for the sole benefit of the community spouse) or to a blind or permanently and totally disabled child (as determined by SSI or MRT). See MS 3337.4 - MS 3337.7 for limits on transfers to community spouses;

3. A satisfactory showing is made that the individual intended to dispose of the resources at FMV or for other valuable consideration, or that the resources were transferred exclusively for a purpose other than to qualify for medical assistance (the procedures for rebuttal of the presumption that resources were transferred to establish eligibility in 3334.6 are applicable);

* 4. It is determined that denial of eligibility would work an undue hardship. Undue hardship exists if each condition below is met:

   a. counting uncompensated value would make an individual ineligible;

   b. lack of assistance would deprive the individual of food, shelter, and care determined to be medically necessary;

   c. the individual's total assets are not great enough to pay for facility care for a month; and

   d. the resource(s) cannot be recovered from the individual(s) to whom the resource(s) was transferred without compensation due to loss, destruction, theft, or other extraordinary circumstance.

Undue hardship does not exist when applying the transfer provisions merely would cause the individual inconvenience, or would restrict his lifestyle without putting him at risk of serious deprivation.

3335.3 Other Policy Related to Resource Transfers Made 7/1/88 Through 8/10/93 (For Interspousal Transfers, 10/1/89 Through 8/10/93)

For transfers by individuals who applied and transferred property for the periods above, see MS 3334.1 through 3334.8, MS 3335.4, and MS 3337-3338.2.

PROPERTY TRANSFER CHART

MS 3335.4

PROPERTY TRANSFER CHART

TRANSFER DATE	TYPE OF COVERAGE NEEDED	TRANSFER POLICY APPLICABLE	LOOK FOR UV
I. NON-SPOUSAL TRANSFERS			
BEFORE 7/1/88	LTC	3334.1 - 3334.9.3	YES
BEFORE 7/1/88	NON-LTC	3334.1 - 3334.9.3	YES
ON/AFTER 7/1/88	LTC/WAIVER	3335 - 3336.15	YES
ON/AFTER 7/1/88	NON-LTC/NON-WAIVER	3335 - 3335.3	NO
II. INTER-SPOUSAL TRANSFERS			
BEFORE 10/1/89	LTC	3334.1 - 3334.9.3	YES
BEFORE 10/1/89	NON-LTC	3334.1 - 3334.9.3	YES
ON/AFTER 10/1/89	LTC	3335 - 3338.12	NO**
ON/AFTER 10/1/89	NON-LTC	3335 - 3338.12	NO

** No period of ineligibility for uncompensated transfer will be imposed on an IS as long as the spouse who is not institutionalized does not transfer resource(s) to another for less than FMV. If a noninstitutionalized spouse transfers property to another, refer to MS 3335.1 or MS 3336.9 for determination of a period of ineligibility for the IS.

3336 TRANSFER OF ASSETS MADE 8/11/93 OR LATER

THIS SECTION APPLIES TO TRANSFERS MADE ON OR AFTER 8/11/93 BY ALL ,SING FACILITY AND WAIVER MEDICAID APPLICANTS AND RECIPIENTS AND THEIR SPOU , AS MANDATED BY THE OMNIBUS BUDGET RECONCILIATION ACT (OBRA) OF 1993.

TRANSFERS OCCURRING PRIOR TO 8/11/93 SHALL BE GOVERNED BY THE RULES AT MS 334.9 or MS 3335.

Individuals and/or their spouses who transfer assets without compensat for less than fair market value on or after 8/11/93 will be ineligible for sing facility vendor payments (or, in the case of Waiver applicants, ineligi for all Medicaid benefits) for a period of time as specified at MS 3336.9 and .10 below. The penalties shall be applied to both institutionalized individ and noninstitutionalized Waiver individuals who have transferred assets and w pply for Medicaid assistance.

When it is determined that an applicant/recipient, the spouse of the app nt/ recipient, or someone acting on behalf of the applicant/recipie has transferred assets at less than fair market value in the 36 months pr to application or redetermination, it will be presumed that the transfer wa made for the purpose of establishing eligibility. Transfers of assets presume made for the purpose of establishing eligibility will be subject to rebuttal (Re. MS 3334.6 and 3334.7).

3336.1 Assets Defined

Assets are defined as all income (Re. MS 3340 - 3348.1) and resources (Re. MS 3330 - 3333) of an individual and of the individual's spouse, includin any income and resources to which they are entitled to but do not receive becau e of action by:

1. the individual or the individual's spouse;

2. a person with legal authority to act in place of or on behalf of the individual or spouse, including a court or administrative body; or

3. any person, including any court or administrative body, acting at the direction or upon the request of the individual or spouse.

3336.2 The Look Back Date

The look back date will be 36 months from the date on which an individual is both in an institution and has applied for medical assistance or, in the case of a Waiver individual, from the date on which the individual applies for Waiver assistance.

The 36 month look back date is effective with enactment of OBRA, 1993, for transfers occurring 8/11/93 and later. However, county workers cannot begin asking "Have you transferred assets in the past 36 months?" until 36 months have passed since enactment of OBRA, 1993. Therefore, the following dates will be utilized in investigating transfers by NF and Waiver applicants/recipients:

8/11/93 through 2/10/96 - Inquire about transfers in the last 30 mont s

2/11/96 through 8/10/96 - Inquire about transfers made 8/11/93 or later

8/11/96 and later - Inquire about transfers in the last 36 months.

If an institutionalized or Waiver individual is not eligible when he first applies for assistance and later reapplies, the county worker will ask about transfers in the appropriate look back period from the date of the second application, or the dates of subsequent applications if not eligible at the second application.

3336.3 Income Transfers and Failure to Apply For Benefits

As the definition of assets includes income to which an individual is entitled but does not receive, a penalty for transfer must be considered when, for example, an individual takes action to:

1. irrevocably waive pension income; or

2. waive an inheritance.

Federal regulations require that, as a condition of eligibility, an individual must take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which he is entitled. These benefits include, but are not limited to, veterans' compensation and pensions, OASDI benefits, railroad retirement benefits, and unemployment compensation. If an individual fails through inaction to access any benefits to which he is entitled, he will not be eligible for Medicaid.

3336.4 When an Ineligible Spouse Gives Away Income

No penalty will be imposed on an institutionalized spouse (IS) if the individual's community spouse (CS) gives away income belonging to the CS or fails to access CS income, since the CS's income is not counted toward the IS's eligibility nor in the budget for vendor payment. However, if a CS takes such action, no payment will be made from the income of the eligible IS's income to compensate the CS for the income not received. For example, an eligible facility resident agrees to give his spouse $300 of his monthly income and is allowed to give her this amount under the provisions of MS 3338.3 and the DCO-712. The facility resident's spouse has elected to give an elderly sister $100 of her monthly income. An additional $100 of the NF resident's income cannot be given to his spouse ($400 total) to bring her income back up to the level it would have been had she not given $100 to her sister.

If the ineligible spouse of a Waiver applicant/recipient has given away income or refused to access income to which that spouse was entitled, no penalty will be imposed on the Waiver applicant/recipient, since the ineligible spouse's income has no affect on a Waiver applicant/recipient's eligibility.

However, if an ineligible CS later enters a facility or requests Waiver services, the CS will be penalized for the income he/she has given away.

3336.5 Spousal Transfers

If an IS transfers resources or income to the CS in amounts greater than the amounts allowed by the spousal rules (Re. MS 3337-3338.12), no period of ineligibility will be imposed on the IS. However, the assets will still be considered available in the eligibility determination of the IS.

3336.6 Income Received and Transferred in Same Month

If funds are received AND transferred in the same month, the funds are treated as income in the month received and also treated as a resource in that month when considering transfer of assets. The month in which the funds are transferred will be the first month of the penalty period.

When income is received and retained by an individual, it is considered income in the month received and considered a countable resource on the first of the following month.

3336.7 Ownership Held in Common With Others

When assets are held by an individual in common with another person or persons in joint tenancy, tenancy in common or other similar arrangements, the asset (or portion of the asset) shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of such asset. For example, Mrs. White adds her daughter's name to a bank account. Adding a name to an asset in itself does not necessarily constitute a transfer because, in this case, Mrs. White still has full access to her money. However, the daughter later withdraws the money. The withdrawal shall be viewed as if Mrs. White had directly transferred the money to her daughter, and a period of ineligibility will be imposed on Mrs. White if she applies for facility or Waiver assistance.

If in the case of joint tenancy property ownership where an individual cannot access his interest in property due to the refusal of the other owners to give consent to sell the property, it should be determined when the joint tenancy ownership was established. For example, during the look back period an individual had full ownership of 10 acres of land but, prior to entering a facility, deeded the property to himself and two brothers as joint owners who will not consider sale of the property. In this situation, a transfer of assets should be considered, because an action occurred which eliminated or reduced the owner's access to an asset.

If, on the other hand, the joint tenancy ownership has existed for a period of time longer than the look back period, a transfer of assets will not be considered and the applicant's interest in the property will not be considered an asset if the other owners will not consider sale of the property.

When a transfer was made in the look back period by a joint owner which reduces or eliminates an individual's ownership or control of an asset, the individual will be given the right to rebut the presumption of ownership of joint accounts, if applicable (Re. MS 3332.2), and to rebut the presumption that assets were transferred to establish eligibility (Re. MS 3334.6 and 3334.7).

3336.8 Transfers to Trusts and Annuities

TRUSTS ESTABLISHED PRIOR TO 8/11/93

1. State Law

All transfers to trusts established on or before August 10, 1993, are governed by the terms of Act 1228 of 1993 and by federal law in #2 below. Act 1228 of 1993 provides as follows:

"Trust" means a trust, or similar legal device, established other than by will by an individual or an individual's spouse under which the individual may be a beneficiary of all or part of the payments from the trust, and the distribution of such payments is determined by one (1) or more trustees or other fiduciaries who are permitted to exercise any discretion with respect to the distribution to the individual, and shall include trusts, conservatorships, and estates created pursuant to the administration of a guardianship.

"Grantor" means the individual, institution or entity that established, created or funded the trust and shall also include fiduciaries as 1) defined by Arkansas Code §28-69-201 and third parties as contemplated by 2) Arkansas Code §20-77-301, et seq.

A provision in a trust, other than a testamentary trust, which limits the availability of, or provides directly or indirectly for the suspension, termination or diversion of the principal, income or beneficial interest of either the grantor or the grantor's spouse in the event that the grantor or grantor's spouse should apply for medical assistance or require medical, hospital or nursing care or long term custodial, nursing or medical care shall be void as against the public policy of the State of Arkansas, without regard to the irrevocability of the trust or the purpose for which the trust was created and without regard to whether the trust was created pursuant to court order.

* 2. Federal Law

The following federal policy was applicable to trusts established prior to 8/11/93.

a. Trust Established by the Client or Spouse - Medicaid Qualifying Trust

A Medicaid Qualifying Trust is a trust or "similar legal device" established by an individual (or his spouse) who is the beneficiary of the trust and who gives a trustee any discretion for use of the trust fund.

A "similar legal device" is defined as an arrangement, instrument, or other device which does not qualify as a trust under state law, but which has other characteristics of a trust (e.g., escrow account, savings account, pension fund, investment account or other account managed by a custodian, guardian or other individual with a fiduciary obligation). Any such legal device described above will also be considered a Medicaid Qualifying Trust.

If an individual is not legally competent and a trust is established for the individual by a guardian or legal representative (including

a parent for a child), using the individual's assets, the trust will be treated as having been established by the individual, since he could not do it for himself.

With a Medicaid Qualifying Trust, consider as a resource to the beneficiary (for eligibility purposes) the maximum amount that a trustee could disburse if he exercised his full discretion allowed under the terms of the trust. This amount is deemed available to the individual, whether or not the distribution is actually made. The amount actually distributed by a trustee is counted as income (if paid from the current monthly interest) or a resource (if paid from the principal or from past months' accumulated interest). This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an ICF/MR facility.

(1) If Client is Trustee - If the client is trustee of a trust established by himself or his spouse, consider the trust assets as a resource if he has legal authority to revoke or dissolve the trust, or use the assets for the benefit of himself or his spouse.

(2) If Appointed Trustee with Full Discretion - If the client is beneficiary of a trust with an appointed trustee who has full discretion for use of trust funds for the client's benefit, consider the trust assets as a resource to the client.

(3) If Appointed Trustee With Limited Discretion

If the appointed trustee has limited discretion, the assets will be considered available to the maximum extent allowed by the trust, whether they are distributed or not.

Examples:

(a) The trust allows only a monthly payment of $300. This will be income in the month available, whether paid or not, and, if not paid, or used, will be a resource in the month(s) following.

(b) The trust allows only payment of interest earned on the principal. This will also be considered income in the month available, whether paid or not, and, if not paid or used, will be a resource in the month(s) following.

(c) If trust limits invasion of the principal to "care and maintenance" of the client, the monthly amount required for "care and maintenance" will be considered as an available resource for such care.

b. Trust Established by Other(s) for client

(1) Consideration of Trust Principal - If the applicant, as beneficiary of the trust, has no access to the trust principal, it is not considered a resource to him. If the trust agreement provides for regular payments from the principal to the beneficiary, they are considered to be income in the month of their receipt and, if retained, to be a resource in the month(s) following.

When the beneficiary of the trust has direct access to the principal of a trust it is considered as a resource, and withdrawals are not considered as income.

(2) Consideration of Interest Income from Trust Principal - When the beneficiary has legal access to the income from the trust principal, it is considered to be income as it becomes available, whether used or not. If not used, the amount will become a resource in the month(s) following its availability.

When the beneficiary has no right to the interest income from the trust principal and it is added to the principal, it is not income to the beneficiary, and only the trust payments made to the beneficiary are considered to be income. If retained, the payment(s) will be considered a resource in the month(s) following.

If the trustee exercises authority over the use of trust payments, the payments are still considered to be income to the beneficiary whether received direct or "in-kind".

TRUSTS ESTABLISHED 8/11/93 AND LATER

1. General Provisions

All transfers to trusts established August 11, 1993, or later are governed by the terms of OBRA 1993 which, as federal law, supersedes Act 1228 and other applicable policy previously considered.

The consideration of trusts established August 11, 1993, or later is as follows:

a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust, other than by will:

(1) the individual;
(2) the individual's spouse;
(3) a person, including any court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
(4) a person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

b. If the corpus of a trust includes assets of an individual and assets of any other person(s), the provisions of this section shall apply to the portion of the trust attributable to the assets of the individual.

c. Subject to No. 5 below, this section shall apply without regard to:

(1) the purpose for which a trust is established;
(2) whether the trustees have or exercise any discretion under the trust;
(3) any restrictions on when or whether distributions may be made from the trust; or
(4) any restrictions on the use of distributions from the trust.

2. The Look Back Period

The look back date to inquire about the establishment of a trust will be 60 months (5 years) from the date on which an individual is both in and institution and has applied for medical assistance or, in the case of a Waiver individual, from the date on which the individual applies for Waiver assistance.

The 60 month look back date is effective with enactment of OBRA of 1993 for transfers to a trust occurring 8/11/93 and later. However, county workers cannot begin asking "Have you transferred assets to a trust in the past 60 months?" until 60 months have passed since enactment of OBRA of 1993. Therefore, the following dates will be used in inquiring about transfers to trusts by NF and Waiver applicants/recipients:

8/11/93 through 2/10/96	-	Inquire about transfers to trusts in the last 30 months
2/11/96 through 8/10/98	-	Inquire about transfers to trusts since 8/11/93
8/11/98 and later	-	Inquire about transfers to trusts in the last 60 months.

3. Consideration of Revocable Trusts

a. The corpus of the trust is considered available to the individual;
b. Payments from the trust to or for the benefit of the individual are considered income to the individual, and
c. Any other payments from the trust (e.g., to another individual) will be treated as a transfer of assets.

4. Consideration of Irrevocable Trusts

a. If the trust permits payments, under any circumstances, to or for the benefit of the individual, the portion of the corpus from which payment to the individual could be made (or the income on the corpus from which payment to the individual could be made) shall be considered a resource available to the individual; and payments actually made from that portion of the corpus or income

(1) to or for the benefit of the individual shall be considered income of the individual, and
(2) for any other purpose, shall be considered a transfer of assets by the individual; and

b. Any portion of the corpus of a trust from which, or any income on the corpus from which, no payment could under any circumstances be made to or for the benefit of the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be a transfer of assets. The value of such trust shall be determined by including the amount of any payments made from such portion of the trust after such date.

5. Trusts Not Considered an Available Asset

A trust will not be considered an available asset to an individual if it meets the criteria of one of the 3 trusts described below:

a. A trust containing the assets of an individual under age 65 who is disabled, as determined by SSI or MRT, and which has been established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court, if the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual;

b. A trust (Re. MS 3336.9) established for the benefit of an individual receiving Social Security and other pension:

(1) if the trust is composed ONLY of pension, Social Security, and other income to the individual (and accumulated income in the trust),
(2) if the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual subsequent to establishment of the trust, and
(3) as long as the state provides facility services to individuals in institutions under the federal income level (3 times the SSI payment level) but does not provide the same assistance to medically needy individuals.

c. A trust containing the assets of an individual who is disabled, as determined by SSI or MRT, that meets the following conditions:

(1) The trust is established and managed by a non-profit association;
(2) A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts;
(3) Accounts in the trust are established solely for the benefit of disabled individuals (who are determined disabled by SSI or MRT, including individuals age 65 and older) by the parent, grandparent, or legal guardian of such individuals, or by a court; and
(4) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays the state from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

6. Hardship

If it is determined that denial of eligibility due to the transfer of assets into a trust would work an undue hardship on an individual, the hardship provisions at MS 3335.2, #4 may be applied.

7. Inquiries to the Office of Chief Counsel

When a county worker becomes aware of the existence of a trust or of the transfer of assets into a trust, whether made by an individual, spouse, court of law, etc., the trust document along with other pertinent documents and a cover memorandum giving all information available will be sent to the Office of Program Planning and Development, P. O. Box 1437, Slot 1220, Little Rock, AR 72203, with a request for review by the Office of Chief Counsel.

3336.9 Income Trusts

1. Terms and Other Conditions

The trust must be irrevocable. It can be terminated or amended only by mutual agreement between DHS and the trustee.

The trust may be used to establish Medicaid eligibility only for individuals determined to be medically in need of nursing facility care.

The trust must have been established on or after August 11, 1993.

The trust can only be funded from Social Security, pension and other income payable to an individual, and income earned by the fund. If assets other than income, such as real or personal property, are placed in the trust, the individual cannot be eligible for facility services under the income trust provisions.

The trust must contain a provision that all assets remaining in the trust at the individual's death will be transferred to DHS up to an amount equal to medical payments made by DHS on behalf of the individual subsequent to establishment of the trust.

If an individual with a trust prepared in a state other than Arkansas has received Medicaid benefits in that other state, the trust will not qualify the individual for Medicaid in Arkansas, as Arkansas DHS will have no claim on the remainder of the trust at the death of the individual.

2. Consideration of Income

* Only individuals with gross monthly countable income (excluding VA A & A and CME/UME) which exceeds the federal cap (3 times the SSI payment for an individual living in his own home - $1374 in 1995) but whose total gross income does not exceed the maximum rate (the skilled care rate for a 31 day month in a NF) may establish eligibility through income trusts. The skilled care rate for a 31 day month is $2116 from 7/1/94 through 6/30/95. The 31 day skilled care rate from 7/1/95 through 6/30/96 is $2198. After eligibility has been established, annual cost-of-living increases that cause the individuals income to exceed the maximum skilled care rate will not affect eligibility.

All of an individual's income must be placed in the trust.

Income received by an individual and placed in the trust, or an individual's income paid to the trust by direct deposit, is not countable income for eligibility purposes. Income which is received directly by an individual must be transferred to the trust immediately upon receipt.

* The income (other than income accumulated by the trust) must be income payable to the applicant/recipient, and the income must first be received by the applicant/recipient before being placed in the trust. If an applicant/recipient assigns the right to receive any or all of the income to the trust, the income assigned is no longer considered income to the applicant/recipient under SSI rules. Such an assignment will be considered a disqualifying transfer. However, for purposes of this section, if an applicant/recipient authorizes the income to be paid into the trust by direct deposit from the payor, the direct deposit will not be considered an assignment (disqualifying transfer).

If in any month the income is not placed in the trust, the individual is not eligible in that month.

The income must be placed into and maintained in a single trust account.

If an individual receives income on an irregular basis, (such as royalty or farm rental income, or lump sum payments such as SSA retroactive benefits) the income must be placed into the trust when it is received.

If an individual receives income paid jointly to him and another person(s), the facility resident's share of the income must be separated from the other owner(s) share(s) before depositing his share in the trust account. No income belonging to any other individual may be placed in the income trust of a Medicaid recipient.

3. Request for Eligibility Determination

Individuals with income above the federal cap who inquire regarding Medicaid eligibility in a facility will be given information regarding eligibility limits under the income trust provisions along with a resource assessment (Re. MS 3337.3) if requested. Individuals with excess resources cannot establish eligibility through an income trust.

4. Application for Benefits

At application for facility care, the applicant, representative, guardian or other person responsible for the application, must inform the county worker of the existence of an income trust, or that such a trust is to be established, and must provide the worker with a copy of the trust document.

An application will not be held longer than 45 days to permit the finalization of an income trust. If all eligibility requirements have been met with the exception of income in excess of the federal cap and the trust has not been finalized within 45 days since the date of application, the application will be denied and the individual or responsible party will be informed that reapplication may be made when the trust agreement is finalized.

5. Review by the Office of Chief Counsel

Prior to certification of eligibility, the county worker must submit the trust document to the Office of Program Planning and Development, Slot 1220, for review by the Office of Chief Counsel (OCC), to obtain an opinion that the trust document meets the requirements of a valid income trust in Arkansas.

* 6. Fees and Other Disbursements

CASES CERTIFIED PRIOR TO 11/1/95

A monthly fee may be paid out of the trust for the services of the trustee. A fee greater than the prevailing institutional charge may not be paid to an individual who is serving as trustee.

Other allowable disbursements from the trust may include monthly bank service charges, preparation of income tax returns for the trust, income taxes owed by the trust, and attorney's fees for preparation of the trust.

Trusts certified prior to 11/1/95 may continue to allow these distributions, as initially established. HOWEVER, NO INCREASES OVER THE INITIAL AMOUNTS ESTABLISHED WILL BE ALLOWED.

CASES CERTIFIED 11/1/95 AND LATER

Effective for cases certified for services 11/1/95 and later, fees for trustees (including trustee fees for banks), preparation of income tax returns and attorneys WILL NOT BE ALLOWED AS DISTRIBUTIONS FROM INCOME TRUSTS. THE ONLY FEES ALLOWED WILL BE THE BANK SERVICE CHARGES FOR MAINTAINING THE BANK ACCOUNT.

7. Trustee Responsibilities

A trustee may serve without bond or supervision of any court.

Prior to any distribution from the trust, the trustee must notify the county worker responsible for the case of any fees, income taxes or other payments which must be made from the trust before these disbursements can be made, and the advance notice must be made no later than the month which precedes the month in which the disbursements will be made.

No disbursements of any kind can be made by the trustee until the trustee has been provided a current Post Eligibility Income Worksheet, DCO-712, completed by the county worker in charge of the case.

Any disbursements made that are not for the benefit of the recipient, the community spouse or other dependents, as specified on the DCO-712, will be considered a transfer of resources and a period of ineligibility will be applied.

Payments must be made from the trust each month, during the first week of the month, and only in the amounts specified on the DCO-712. The payments must be made directly to the designated recipient, i.e., to the recipient or responsible person for the personal needs allowance (PNA); to the community spouse and/or dependent(s) for their allowances; to the recipient or responsible party for the recipient's noncovered medical expenses; and to the facility for the patient's share of cost.

While an individual is receiving Medicaid benefits in a facility, no disbursements other than those specified on the DCO-712 may be made.

The trust records shall be open to inspection and for copying by DHS, and periodic reporting may be required at the discretion of DHS.

If the trustee becomes aware of any change in circumstances which will affect the recipient's eligibility or the amounts being distributed monthly from the trust, the trustee shall be responsible for notifying the county worker of such changes. Changes to be reported include income changes, increase or decrease of cost of noncovered medical expenses, recipient dies or leaves the facility, community spouse enters a facility, etc.

The trustee must notify the county worker if in any month the funds are not disbursed according to the DCO-712 or if the balance in the trust account exceeds the maximum allowed as specified in Number 11 below so that the worker can adjust the facility payment(s) for the month(s) in which the vendor payment is affected.

8. Post Eligibility Consideration of Income

The total net countable income of an individual will be included in the post eligibility consideration. Net income will be calculated as for all other Medicaid eligible individuals in the post eligibility process.

For example, an individual has $1500 net countable monthly income. For post eligibility purposes, the calculations will begin with $1500. The $30 PNA, the spousal/dependent allowances (if applicable, but not in amounts greater than the maximum allowed on the DCO-712), and noncovered medical expenses of the recipient will be deducted. The balance remaining must then be applied to the individual's cost of care in the facility.

The county worker will be responsible for providing the trustee and the recipient or his representative with a copy of the DCO-712 at initial certification and each time it is necessary to make a revision in the post eligibility budget due to income changes or other changes such as those made on the DCO-712 mandated by the spousal laws.

9. Begin Date of Eligibility

Eligibility for facility care shall not be retroactive to the month which precedes the month of establishment of the trust. Eligibility may begin on the first day of the month in which the trust is established, provided that the individual's income has been placed in the trust that month, that no funds have been disbursed from the trust prior to certification during that month and that the individual is otherwise eligible. If funds have been disbursed from the trust during the month of establishment of the trust and prior to authorization of disbursements by the DCO-712, eligibility cannot begin until the first of the month following the month of establishment of the trust.

It must be verified prior to beginning eligibility that the individual's income has been placed in the trust.

10. Certification Procedures

After opening a case on WASM, the income MUST be entered on WNHU. If entered on WASM first, the system will not accept it. Any income in excess of the current federal cap ($1374 in 1995) must be entered in the VA A&A Field. This will allow the system to disregard the amount over the federal cap for eligibility purposes and count it in determining patient liability.

First enter the SSA income in the SSA income Field so that the COLA adjustment can be made annually. Then enter other types of income in the appropriate fields, up to a combined total (including the SSA) which equals the current federal cap.

Example: An individual with $1440 income has $860 SSA and $580 private retirement benefits. Enter $860 in the SSA Field, $514 in the OTHUNE Field, type "O", ($860 and $514 are equal to the federal cap of $1374 in 1995) and $66 (the income in excess of $1374) in the VA A&A Field.

Counties must also complete the DCO-730 at certification and send the form to Medical Eligibility, Income Support Section, P. O. Box 1437, Slot 1223, Little Rock, AR, 72203. Two copies of the form must be kept in the county office, one in the recipient's case record and the other in a central file in alpha order with the DCO-730s completed for other facility recipients certified under these procedures.

The face sheet of the recipient's record (DCO-86) and/or DCO-87 should be marked in red with a "T" in the upper right hand corner so that the case can be easily identified as an income trust case.

11. Penalty for Transfer of Assets

There is no penalty for transfer of income into an income trust fund. However, if the balance of the trust at the end of any month (excluding any deposits which represent income for the following month and any spousal/ dependent/noncovered medical expenses amounts specified on the DCO-712 which were not disbursed for the month) exceeds $1700, the individual will not be eligible again for facility care until the first of the month after the month in which the balance in the trust has been spent down for the benefit of the facility resident. During any such month(s) of ineligibility the spousal, dependent, and noncovered medical allowances may be paid according to the DCO-712, and Medicaid benefits other than the facility vendor payment will be continued.

Example: In October a county worker learns that an income trust had a $3400 balance at the end of the preceding month which included a $700 SSA check deposited the last day of September, representing payment for October. The trustee failed to make any disbursements for September, including $300 to the community spouse and $200 for noncovered medical expenses. When the October SSA check and the non-payments for September are subtracted from $3400 ($3400 - $700 - $300 - $200 = $2200), the remainder is greater than $1700. Therefore, the individual is not eligible for vendor payment in September, and the payment will be stopped for that month on WNHU.

For any such month(s) of ineligibility, the worker will send a DCO-700 notice of adverse action to the recipient or representative, and a copy of the notice to the trustee.

12. Medicare and Other Third Party Payments

If in any month or part of a month a patient is in a Medicare bed or has other third party coverage which lessens or eliminates the obligation of the trustee to pay the facility for the patient's share of cost as computed on the DCO-712, the funds which would have been paid to the facility in that month shall remain in the trust and may not be disbursed for reasons other than for the recipient's medical care for which there is no other third party liability.

If a trustee has made the patient's share of vendor payment at the first of a month and later is reimbursed the funds from the facility due to payments from other third party coverage, the reimbursement must be returned immediately to the trust. If the facility does not make the refund to the trustee, i.e., places the payment(s) in the patient's facility account, the funds placed in the account will be countable toward the $2000 resource limit.

13. Changes

If an individual leaves a facility for a therapeutic home visit (up to 14 days) or for a hospital visit (up to 5 days), Medicaid benefits and vendor payment will continue, and the trustee will make disbursements in that month as specified on the DCO-712.

* If an individual has not returned to the facility after 14 days home visit or after 5 days hospitalization, Medicaid will no longer pay the vendor payment, and the individual will be responsible for arrangements with the facility. Medicaid benefits other than the vendor payment may continue unless a formal notice of discharge is sent to the DHS County Office via DCO-702 (and the recipient has not entered, nor is it anticipated that he will enter, another facility). During any such period of extended home visit or hospitalization when Medicaid is not paying the facility vendor payment, the trustee may continue to disburse the spousal/dependent/ noncovered medical expenses as specified on the DCO-712 and may disburse funds from the trust for medical expenses of the recipient which are not specified on the DCO-712 and not covered by Medicaid or other insurance.

The county worker must determine the residence of a recipient when receiving a DCO-702, notice of discharge from a facility, because facilities may erroneously send discharge notices when an individual has been hospitalized for more than 5 days. A facility may also correctly send notice of discharge when an individual has been transferred directly from one facility to another, from a hospital to a second facility, or from a therapeutic home visit to a second facility. In any of the above situations, the case should not be closed and Medicaid benefits should not be terminated.

If an individual improves to the extent that he is able to return home and is deemed unlikely to need continuing care in a facility according to written medical statement, the Medicaid case must be closed on WNHU and WASM. However, the trust must be maintained according to the terms of the trust, i.e., the individual's income must continue to go into the trust, no other individual's income may be put into the trust, etc. Disburse-

ments may be made only for medical care, food, clothing, and shelter for the individual.

14. Changes in Community Spouse or Dependent Status

If a community spouse or dependent who has been receiving a monthly income allowance from the facility resident enters a facility, has an income change, divorces the recipient or dies, the worker in charge of the case must be notified immediately by the recipient, representative, trustee or other responsible party. No additional disbursements for the spouse or dependent can be made until the worker has revised the DCO-712 and provided the trustee with a copy.

15. Reevaluations

In addition to the required verification of other eligibility factors at annual reevaluation, the county worker will verify and document that the individual's income has been placed in the trust and disburse-ments made as required since the last reevaluation. This may be done by viewing bank statements, or other trustee records that may be available.

16. Case Closures

When a Medicaid case is closed due to permanent discharge from a facility, out-of-state move, or death, the DCO-730 must again be submitted, with the closure section completed, to Medical Eligibility, Income Support Section, P.O. Box 1437, Slot 1223, Little Rock, AR 72203. Counties should retain two copies, one for the case record and the other for the DCO-730 central file.

Do not submit the form with closure information if a case is temporarily closed for excess resources, excess income in the trust, or for other reasons.

17. Termination of the Trust

Upon the death of the individual, no further disbursements may be made from the trust until the trustee has notified OCC and received instructions regarding termination of the trust.

3336.10 Determination of Uncompensated Value and Period of Ineligibility for RESOURCE Transfers

The number of months of ineligibility for facility/Waiver services will be determined by dividing the uncompensated value of all resources transferred by the individual or spouse on or after the look back date by 1700. There is no cap on the total number of months of ineligibility (Example: a $250,000 transfer divided by 1700 equals 147.06 months of ineligibility). Any fraction remaining after dividing the total uncompensated value by 1700 will be dropped. The period of ineligibility will begin on the first day of the first month during which assets were transferred.

* Multiple Transfers Made That Do Not Result in Overlapping Penalties - If an individual has made multiple transfers that do not result in overlapping penalty periods, a separate penalty period will be assigned to each transfer. For example, a penalty period for a $3400 transfer made in December will expire at the end of January. A second transfer of $5000 made in February results in a

penalty period that expires at the end of March. A $10,000 transfer in June results in a 5 month penalty period which ends in October. If the individual making these transfers applies in June, he will not be eligible until November 1st. The first two penalty periods will have expired, but the $10,000 transfer penalty will still be in effect.

* Multiple Transfers Made That Do Result in Overlapping Penalties - The sum total of all transfers made will be divided by $1700 to determine the period of ineligibility.

For example, an individual gives away $8000 in May, $10,000 in June, $12,000 in July, and $4000 in August. He applies for assistance in August. The total value of uncompensated transfers ($34,000) will be divided by 1700, resulting in a penalty of 20 months.

If an individual has made transfers both prior to 8/11/93 and 8/11/93 or later, the rules governing transfers at the time the transfers occurred will be applied to each transfer. For example, an individual gave $10,000 away in 7/93, and an additional $10,000 in 10/93. The July transfer will result in a 6 month penalty ($10,000 divided by 1500 equals 6 months), or a period of ineligibility from July through December. The October transfer will result in a 5 month penalty ($10,000 divided by 1700 equals 5 months). In this case, although the penalty periods overlap, the additional penalty will be added on to the original penalty, extending from January, 1994, through May, 1994.

* Penalty for Transfer to Annuities - If an applicant with an annuity has not yet annuitized (i.e., started receiving regular payments) and the annuity is revocable, the principal of the annuity is a countable resource. If annuity payments have begun and the contract is irrevocable, the number of years of payout of the annuity must equal the number of years of expected life remaining for the individual, based on the life expectancy tables at MS 3336.17. If the payout years are greater than the life expectancy years, a transfer of assets for less than fair market value has been made.

For example, a male at age 65 purchases a $10,000 annuity that will be paid over the course of 10 years. Since his life expectancy according to the table is 14.45 years, he can expect to recover the full amount of his investment. However, a male at age 80 has a life expectancy of only 7.04 years. If he purchases a $10,000 annuity to be paid over the course of 10 years, the payout of the annuity for approximately three years is considered a transfer of assets for less than fair market value and the amount is subject to penalty, beginning with the first month in which the contract is annuitized. To determine the penalty, subtract the total payout for 7.04 years from $10,000. Divide the difference by $1700 to determine the number of months of ineligibility.

If an annuity is made irrevocable and there will be no payout during the life of the annuitant, the full purchase price of the annuity is subject to a penalty for transfer of assets.

3336.11 Determination of Uncompensated Value and Period of Ineligibility When INCOME Has Been Diverted

When income has been given away, the period of ineligibility will be determined according to the amount of income not received, based on the life expectancy of the individual who is being penalized.

For example, an individual with income $300 over the NF income limit irrevocably revokes his company pension of $400. The life expectancy tables at MS 3336.17

will be utilized to determine the period of ineligibility. If he is age 76, for example, when he enters a NF and gives away his right to income, his life expectancy is 8.70 years. The income he elected not to receive is valued at $41,760 ($400 monthly x 12 months x 8.70 years). The $41,760 will be divided by 1700, resulting in a penalty of 24 months, beginning in the month he gave up his right to the income.

The above penalty does not apply in the case of an eligible IS who is allowed to give part or all of his income to a CS according to the methodology at MS 3338.3 and on the DCO-712.

3336.12 Penalty to Impose When Transfer Occurs 8/11/93 Through 9/30/93

If an individual has transferred assets during the period of 8/11/93 through 9/30/93, the period of ineligibility will begin in August or September, 1993, but the agency will not be allowed to withhold vendor payments until October 1, 1993, for transfers occurring during these two months. For example, if $30,000 was transferred 8/16/93, a penalty period of 17 months will be imposed ($30,000 divided by 1700) and the first month of the 17 month count will be August, 1993. However, vendor payment cannot be withheld until October 1, 1993, which, in effect, will require the state to pay the facility vendor payment from 8/16/93 through 9/30/93 if the individual is in the facility on 8/16/93, has made application on or after that date, and is otherwise eligible for services. The case would then have to be closed effective 9/30/93, as the individual is not eligible beginning 10/1/93, and the individual would not be eligible for the remaining 15 months of the penalty period.

3336.13 Apportionment of Penalty for Spouses

If the spouse of an individual has transferred resources without compensation which results in a period of ineligibility for an individual, the period of ineligibility will be apportioned between spouses if the spouse otherwise becomes eligible for medical assistance.

For example, a CS of an institutionalized individual has transferred resources valued at $17,000, which results in a period of 10 months of ineligibility for the IS ($17,000 divided by 1700 equals 10). Two months after the transfer, the CS must also enter the nursing home and she meets all the eligibility requirements for Medicaid assistance. The remaining 8 month period of ineligibility will be divided between spouses, leaving only 4 months of ineligibility remaining for the spouse first institutionalized and giving 4 months of the penalty to the spouse who entered last, thus allowing both to become eligible in 4 months.

If a penalty has been apportioned between two institutionalized spouses and one spouse dies, the penalty period for the surviving spouse will be extended. For example, an institutionalized couple is under a penalty period of five months each from January through May. One of the spouses dies in March. The remaining penalty months of April and May for the deceased spouse will be added to the surviving spouses's penalty, causing that spouse to be ineligible for services through June and July.

When an IS under a penalty dies or goes home, the CS of that individual later enters a facility and the penalty period of the IS has not yet expired, the CS entering the facility will inherit the remainder of the penalty previously imposed. Example: An individual under a 12-month penalty imposed January through December of a year dies in July. The surviving spouse enters a NF in September. The remaining months of the penalty (September through December) will be imposed on the surviving spouse.

The above rules will also apply if one member of a couple is an IS and under a penalty and the CS applies for Waiver services, or if both members of a couple are requesting Waiver services, and one is under a penalty previously imposed.

3336.14 Penalty Continues Without Interruption Until Expiration

If an institutionalized resident under a transfer penalty leaves the institution, the penalty period will continue to run. If the individual later reenters an institution and reapplies for Medicaid, the worker will not only inquire about transfers in the appropriate look back period from the date of reapplication, but will also check the case record to determine the length of the penalty previously imposed and whether or not that penalty has expired. The break in institutional status does not eliminate or disrupt a penalty previously imposed.

For example, an individual who transferred $75,000 was penalized from receiving services for 44 months. After 3 months in an institution, the individual is able to return home for a period of 3 months before it again becomes necessary to enter a NF. The previously imposed period of ineligibility will continue (44 months less the 6 months which have elapsed since the penalty began) and the individual will remain ineligible for NF services until the full 44 months have passed.

If he reapplies, for example, when 38 of the 44-month period has elapsed and the county worker inquires about transfers in the 36-month look back period, the $75,000 transfer would have occurred more than 36 months prior to this reapplication. However, the original penalty imposed (44 months) will continue to expiration before eligibility can be considered. If the individual has made additional transfers in the 36-month look back period, an additional penalty period will be imposed.

Even though the penalty for facility/Waiver services continues until expiration, an individual living in the community may still be found eligible for Medicaid in another category, such as QMB, AD-MN, etc.

NOTE: In order to track the periods of ineligibility, when an applicant is denied due to transfer of resources, the worker will complete Form DCO-723, Report of Resource Transfer, and route the form to the Medicaid Eligibility Unit, P. O. Box 1437, Slot 1223, Little Rock, AR, 72203. The Medicaid Eligibility Unit will key the transfer information to WRTR so that, if the individual later applies in another county, workers can determine whether a previously imposed penalty is still in effect.

3336.15 Exceptions to the Period of Ineligibility

A period of ineligibility shall not be calculated according to MS 3336.10 or MS 3336.11 and imposed on an individual if:

1. The asset transferred was a home, and title to the home was given to:

   a. the individual's spouse;

   b. a child of the individual who is under age 21, or who is blind or disabled (as determined by SSA or MRT);

   c. a child of the individual (other than a child described in " b" above) who lived in the home for at least two years immediately before the individual became institutionalized and who provided care to the

individual which allowed the individual to remain at home rather than enter an institution; or

d. a sibling of the individual who has an equity interest in the home and who was residing in the home for at least one year immediately before the individual entered an institution;

2. The assets were transferred:

a. to the individual's spouse or to another for the sole benefit* of the individual's spouse;

b. from the individual's spouse to another for the sole benefit of the individual's spouse;

c. to the individual's blind or disabled child (as determined by SSA or MRT) solely for the benefit of that child, or to a trust, described at MS 3336.8, solely for the benefit of that child; or

d. a trust (including a trust described at MS 3336.8) established solely for the benefit of an individual under 65 years of age who is disabled (as determined by SSI or MRT).

3. The individual intended to dispose of the assets either at fair market value or for other valuable consideration, the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or all assets transferred for less than fair market value have been returned to the individual, or

4. Denial of eligibility would work an undue hardship as defined at MS 3335.2, #4.

* Sole benefit" means that it will benefit that individual only and that no other individual will derive benefit from the transferred asset during the lifetime of the individual to whom the asset was transferred. There must be a legal document executed to establish the transfer and evidence of "sole benefit", and it must be established that the transferred asset will have some immediately measurable monetary value which will benefit the spouse or child, e.g., a CD or other instrument which produces income, land or rental property which produces income, etc.

3336.16 Related Policy

Other applicable sections of policy which apply to transfers made 8/11/93 and later are MS 3334.1 through 3334.8; MS 3335.4, and MS 3337 through 3338.2.

* 3336.17 Life Expectancy Tables

Life Expectancy Tables SOURCE: SSA, Office of the Actuary

(1) Table 1 - Male

Age	Average Number of Years of Life Remaining
0	70.83
10	61.98
20	52.43
30	43.31
40	34.11
50	25.11
60	17.77
61	17.07
62	16.39
63	15.72
64	15.07
65	14.45
66	13.84
67	13.26
68	12.70
69	12.15
70	11.61
71	11.09
72	10.59
73	10.09
74	9.61
75	9.15
76	8.70
77	8.26
78	7.84
79	7.43
80	7.04
81	6.65
82	6.28
83	5.92
84	5.59
85	5.27
86	4.97
87	4.69
88	4.43
89	4.19
90	3.96
100	2.42
110	1.54

(2) Table 2 - Female

Age	Average Number of Years of Life Remaining
0	78.30
10	69.33
20	59.55
30	49.88
40	40.29
50	31.16
60	22.72
61	21.93
62	21.15
63	20.38
64	19.62
65	18.87
66	18.13
67	17.41
68	16.70
69	15.99
70	15.30
71	14.62
72	13.95
73	13.29
74	12.65
75	12.02
76	11.40
77	10.79
78	10.21
79	9.64
80	9.09
81	8.56
82	8.05
83	7.56
84	7.09
85	6.64
86	6.21
87	5.80
88	5.41
89	5.05
90	4.71
100	2.60
110	1.54

3337 Treatment of Income and Resources for Certain Institutionalized Spouses

Effective September 30, 1989, the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P. L. 100-360) requires special treatment of the income and resources of institutionalized individuals who are legally married to spouses living in the community. No comparable treatment of income and resources is required for noninstitutionalized individuals or for institutionalized individuals who do not have a spouse living in the community. If there are changes in the marital status or other changes (e.g., - the spouses divorce or the institutionalized spouse returns home), the rules do not apply in the month following the month of change.

Except as specified in MS 3337-3338.12, this section does not affect the determination of what constitutes income or resources, or the methodology and standards used to determine or evaluate income or resources.

3337.1 Definitions

In MS 3337-3338.12, the following definitions apply.

Institutionalized Spouse (IS) - an individual who is an inpatient in a medical institution or nursing facility, who remains (or appears likely to remain) in the institution or facility for 30 consecutive days, and who is legally married to a spouse who is not in a medical institution or nursing facility. The marriage must be verified and documented.

Community Spouse (CS) - the legal spouse (of the IS) who is not institutionalized.

Medical Institution - an institution (hospital) where care equivalent to that in a nursing facility is provided. Days in a medical institution may be considered a part of the continuous period of institutionalization when an individual enters a nursing facility directly from the medical institution. (If confined to a medical institution only, consider Medically Needy coverage - the spousal rules will not apply).

Nursing Facility - a facility which offers both skilled and intermediate nursing care, and ICF/MR facilities.

* Likely to Remain - With medical documentation (physician's statement, hospital records, etc.) that the patient is "likely to remain" in the institution and/or facility for a period of 30 days, the rules may be applied and the individual may be certified, if the individual is otherwise eligible, before a period of 30 days has passed. If the case was opened and the patient does not remain institutionalized 30 days, no penalty will be imposed on the patient (nor on the county by Quality Control) if there is "likely to remain" documentation in the case record. "Likely to remain" applies ONLY to individuals in facilities with community spouses. Single individuals must meet the 30 day institutionalization requirement.

Dependent Family Member - includes minor (under age 18) or dependent (age 18 or over) children, dependent parents, or dependent siblings (including half-brothers and half-sisters) of the IS or CS who live in the home of the CS. To qualify as a dependent, an individual must be claimed on the income tax return of the IS or CS as a dependent, which must be verified by viewing the tax return.

Initial Assessment - an evaluation of resources and computation of the spousal share of resources at the beginning of the first continuous period of institutionalization (this does not apply if entry into LTC was prior to 9/30/89). Compute on DCO-710.

Continuous Period of Institutionalization - a period of residence in a medical institution and/or nursing facility of at least 30 consecutive days (therapeutic visits will be allowed).

Beginning of a Period of Institutionalization - date of entry into a medical or nursing facility.

Community Spouse Maximum Resources (CSMR) - the total amount of resources which may be considered available to the CS; this amount includes resources held solely by the CS (in which the IS has no ownership interest) and the Community Spouse Resource Allowance. Compute on DCO-713.

Community Spouse Resource Allowance (CSRA) - the maximum amount of the IS's resources which may be transferred to the CS or to another for the sole benefit of the CS. Compute on DCO-713.

Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA) - the total income that the CS needs for his/her support. This amount may not exceed the limit shown on the DCO-712.

Community Spouse Monthly Income Allowance (CSMIA) - the maximum amount that an IS may contribute toward the support of the CS. Compute on DCO-712.

Family Member Allowance (FMA) - the amount of income an IS can give to a dependent family member other than the CS. Compute on DCO-712.

3337.2 Resources

The rule for treatment of resources specified in MS 3337.2 - MS 3337.13 are effective October 1, 1989, and apply ONLY to institutionalized spouses who begin continuous periods of institutionalization on or after September 30, 1989.

Resource eligibility for an IS whose period of institutionalization began prior to September 30, 1989, will be determined according to the policy in effect at that time.

3337.3 Initial Assessment

Upon application for LTC, or upon request by the IS, CS, or representative, the county worker will promptly assess and document the total value of countable resources (less exclusions specified in MS 3331.5 and MS 3332.3, except that no limit will be imposed on the value of the home, household goods and one vehicle) to the extent that either the IS or the CS or both hold an ownership interest, as of the date on which the first continuous period of institutionalization begins.

The purpose of the initial assessment is to record the total amount of resources held by both the IS and CS at the time of entry into LTC and to compute a spousal share of the total resources for the CS, which will be a protected amount and will remain constant as long as there is an IS/CS situation (Re. MS 3337.7).

The IS, CS, or representative will be responsible for providing relevant documentation of the composition and value of all resources held by the couple as of the beginning of the first period of institutionalization. The county worker will assist in obtaining such documentation when requested. The assessment will be completed promptly, and in all cases within 45 days, unless pending receipt of information from the requesting party or a third party (bank, insurance company, etc.). An DCO-002 will be given or sent to the requesting party to inform the party that the information should be provided as soon as possible but within 45 days and that the assessment cannot be completed until the information is provided.

If the request was for an assessment only, no further action is required by the county until the information has been provided.

At the time of the assessment, Form DCO-710 will be completed to reflect all countable resources held by either the CS or IS, or both, at the beginning of the first period of institutionalization. The total value of these resources and the spousal share (equal to one-half of the total value) will be entered on the DCO-710. The resources owned solely by the CS will also be totaled on the form.

The worker will provide a copy of the DCO-710 to each spouse, or representative, and retain the original, regardless of whether an application for LTC is made at that time. Only an applicant or applicant's spouse will have appeal rights if there is disagreement with the attribution of assets on the form. A person requesting only an assessment has no right to appeal if an application has not been made.

If application has been made, the DCO-710 will become a part of the case record. If no application has been made, the DCO-710 will be kept by the county in an alphabetical file for future reference if the individual later makes application. (e.g., - An individual enters LTC and makes application on September 30, 1995, and an assessment of resources made on October 1, 1995, results in an ineligibility determination. A reapplication is made two years later, after two years of continuous residence in LTC. The county must look at assets held at the beginning of that first continuous period of institutionalization, i.e., September 30, 1995. Reference to a form on file will be preferable to reconstructing the assets held two years earlier. If the applicant left LTC at any time during the two year period but returned to LTC, the county will use the assessment of resources made at the time of first entry in determining eligibility).

3337.4 Resource Eligibility

At the time of application, all resources held by either the IS or CS shall be considered available to the IS to the extent that the resources exceed the Community Spouse Maximum Resources (CSMR), the maximum resources that are considered available to the CS.

When application has been made, or upon request of either spouse or representative, the worker will compute the CSMR and the Community Spouse Resource Allowance (CSRA), and will determine resource eligibility on the DCO-713.

The CSRA is computed to determine the amount of the IS's resources which may be transferred to the CS. Resources of the IS may be transferred for less than fair market value to the CS (or to another for the sole benefit of the CS) only to the extent allowed by the CSRA. For rules regarding transfer by the IS, refer to MS 3337.10 - 3337.11.

3337.5 CSMR and CSRA Computation

The Community Spouse Maximum Resources (CSMR - the maximum amount of resources that a CS is allowed to retain) and the Community Spouse Resource Allowance (CSRA - the amount of resources that an IS may transfer to the CS in order to give the CS the maximum allowed) are computed on Form DCO-713.

By following the instructions on the DCO-713, the CSMR, Line 2 of the form, and the CSRA, Line 4 of the form may be computed.

MCCA of 1988 set a maximum amount (the dollar amount shown in Section 1, #1 of the DCO-713) that a CS was allowed to keep under the law, and also allowed states to set a minimum amount (the dollar amount shown in Section 1, #2 of the DCO-713) that a CS could keep. These amounts are subject to change by the Consumer Price Index and will be changed annually on the DCO-713.

The total amount of resources that a CS is allowed to retain depends on the total amount of combined resources that a couple has and also on the current minimum state standard and the current maximum standard set by law.

RESOURCE RULE

If total combined resources are equal to or less than the state minimum standard, the CS may keep all.

If total combined resources are between the state minimum standard and twice the state minimum standard, the CS may keep an amount equal to the state minimum standard.

If total combined resources are in an amount of twice the state standard up to twice the maximum standard, the CS may retain one-half of all resources.

If total combined resources are greater than twice the maximum standard, the CS may still keep only the maximum standard allowed by law.

The CSRA may only be changed by a hearing officer (Re. MS 3337.9 and MS 3338.7) or by a court order.

3337.6 Determining Resources of the IS After CSRA Computation

To determine the IS's resource eligibility, Part II of the DCO-713 will be utilized. If the amount in Line 7 exceeds the one person resource level, the IS is ineligible and the application will be denied.

If the amount in Line 7 is at or under the one person resource level, the IS will be considered resource eligible for the month of determination.

When determined eligible, it will be necessary for the IS or representative (guardian or power of attorney) to sign the statement on the reverse side of the DCO-713, agreeing to transfer the described property to the CS. If the IS or representative refuses to sign, then the combined resources will be considered fully available to him/her and the IS will not be resource eligible at that time.

A copy of the DCO-713 will be provided to each spouse upon determination of eligibility, or to the spouse requesting the CSRA and eligibility determination, if a request by either spouse is made prior to application.

The DCO-713 will be retained by the County as a part of the case record, if application was made. If no application was made, a copy will be kept in a County file for reference if application is made in the future.

3337.7 Spousal Protected Amount (CSMR)

When resources exceed the limits, the IS will be ineligible until combined countable resources are reduced to the greater of the following:

1. The state standard plus the one person resource amount for the IS;

2. The spousal share (one-half of the total resources, as computed at the beginning of the continuous period of institutionalization) plus the one person resource amount for the IS;

3. Court ordered spousal share plus the one person resource amount for the IS; or

4. Spousal allowance determined necessary by a hearing officer plus the one person resource amount for the IS.

Example: A couple's combined countable resources at the beginning of the first continuous period of institutionalization are $140,000; the spousal share is $70,000, the CSMR, which is the protected amount, and there is not a court order. At the time of application the combined countable resources are $90,000. (These dollar amounts are used for purposes of illustration only.)

Deduct from current combined countable resources ($90,000) the greater of the following:

$70,000, the spousal share (protected amount), or

$14,000, the state standard

($90,000 less $70,000 equals $20,000)

The remaining $20,000 is a countable resource used to determine eligibility of the IS, and the IS is not eligible. However, if the couple's combined resources are later reduced to $72,000, the IS will be resource eligible (protected amount of $70,000 for the CS plus $2000 for the IS).

If after the time of initial assessment ($140,000/$70,000 spousal share) and first application, there is a break in institutionalization, the initial assessment will be used at the time of reentry to redetermine eligibility for the IS. The $70,000 protected amount from the first assessment is still a protected amount for the CS, and a new amount need not be calculated.

Example: The IS above left LTC for 60 days and then reenters. The couple has combined countable resources of $65,000 at reentry; the spousal share earlier computed was $70,000. Since total combined resources are now only $65,000, which is less than the spousal share, all of the resources may be attributed to the CS, and the IS is eligible for LTC.

3337.8 Retroactive Eligibility

* Retroactive eligibility may be given under these rules, provided all eligibility requirements are met. For example, application is made January 1, 1995, after entry into LTC on October 1, 1994. The assessment of resources owned by the couple as of October 1, 1994, will be made and, if eligible, the case may be opened retroactively to October 1, 1994).

3337.9 Appeal Rights - Changing the CSRA

The CSRA may be changed by court order, or may be changed by the Agency in the following three instances:

1. By a hearing officer, when either the IS or CS establishes that income generated from the CSRA will be inadequate to meet the minimum monthly maintenance needs allowance (CSMNA) as computed on the DCO-712 due to exceptional circumstances resulting in significant financial duress (Re. MS 3338.7). There will be NO substitute CSRA made by a hearing officer when an IS does not make a living allowance (CSMIA) available to the CS.

2. By a hearing officer who confirms the allegation by either spouse that the initial determination was incorrect, or

3. By the county when it is determined that inaccurate information was provided and used in determining the CSMR.

Refer to MS 3338.7 for additional information on Appeals and Hearings.

3337.10 Rules for Transfer by the IS

Effective October 1, 1989, if the IS (who has entered 9/30/89 or later) or a representative acting on his/her behalf, transfers resources (in an amount less than or equal to the CSRA) for less than FMV on or after October 1, 1989, to the CS, or to another for the sole benefit of the CS, no period of ineligibility will be applied to the IS.

If resources are transferred by the IS for less than FMV on or after October 1, 1989, to anyone other than the CS, or to another but not for the sole benefit of the CS, a period of ineligibility will be applied according to the resource transfer provisions in effect at the time of the transfer. The period of ineligibility will apply to the vendor payment only. If the IS is otherwise eligible, he/she may be given eligibility for a Medicaid card ONLY. Prohibited transfers for uncompensated value will not affect eligibility for the Medicaid card.

3337.11 Time Period for Transfer of CSRA to Community Spouse

The IS will be encouraged to transfer the CSRA to the CS as soon as possible. He/she will be given a period of 12 months (from the date the notice of approval is completed) to transfer the property in the amount of the CSRA to the CS.

If the transfer has not been made by the end of the 12 month period, the case will be closed, and the IS will not be eligible in the 13th month. No penalty will be applied, i.e., no overpayment will be written if the CSRA transfer was not made.

3337.12 Rules for Transfer by the CS

* If a spouse transfers property to his/her spouse before or after LTC entry and the receiving spouse transfers it to a third party for uncompensated value, a period of ineligibility will be imposed on the IS. The transfer will be treated as if the IS had transferred directly to the third party. For example, a man transfers his home and land worth $40,000 to his wife on 11/1/94. His wife gives the property to her nephew without compensation on 3/1/95, and the man enters LTC on 4/1/95. An assessment will be made at application, and the County will inquire about transfers. A period of ineligibility will be imposed on the IS, beginning 3/1/95.

3337.13 Consideration of Resources After Eligibility is Determined

During the continuous period in which an IS is in an institution and after the month that the IS is determined eligible for LTC, any resources owned solely by the CS which were considered available to the IS at determination of eligibility (i.e., any resources of the CS which exceeded the CSMR, and were considered available to the IS at determination of eligibility) will not be considered available following the month of eligibility determination. Resources will be considered available to each spouse according to actual ownership of those resources, except that the period for transfer specified in MS 3337.11 will be allowed.

3338 Income Eligibility Determination for the IS

The rules for treatment of income apply to all spouses who are in an institution on or after September 30, 1989. If a case was certified prior to September 30, 1989, the new income rules will be applied at reevaluation, case change or upon request of the IS, CS, or representative. If an application is pending September 30, 1989, the new rules will apply.

* Income eligibility for the IS will be determined in general following the procedures in MS 3340 - MS 3349. Gross income of the IS cannot exceed the current LTC income limit in determining eligibility, unless an income trust has been established. Income of the CS will not be deemed to the IS in any month or partial month of institutionalization. If an IS is receiving full SSI payment for the first three months of institutionalization, the SSI payment will be disregarded as income.

3338.1 Consideration of Income

After the IS has been determined to be resource eligible for Long Term Care, income of the IS and CS will be considered as follows:

1. Income Not From A Trust:

   a. Income received solely in the name of either spouse will be considered income only to that spouse;

b. If payment of income is made in the names of both the IS and CS, half will be considered available to the CS and half to the IS;

c. If payment of income is made in the names of the IS and/or the CS and another person, the income will be considered available to each spouse in proportion to each spouse's interest. If payment is made with respect to both spouses, and no such interest is specified, one half of the joint interest will be considered available to each spouse.

2. Income From A Trust:

Income from a trust will be considered available to each spouse as provided by the trust or, in the absence of a specific provision in the trust, according to the rules in 1., a. - c., above. If the IS or CS established the trust, refer to MS 3336.8 for consideration of income from the trust.

3. Income Through Property With No Instrument Establishing Ownership:

When income is from property which has no instrument establishing ownership (Example: unprobated, income-producing heir property), one half of the income will be considered to be available to the IS and one-half to the CS.

3338.2 Rebutting Consideration of Income

The county worker will advise the applicant or representative of the income that will be considered in the gross income test of the IS.
If the IS or representative disagrees with the treatment of ownership interest in income (other than from a trust) required by MS 3338.1, the IS or the representative will be given the opportunity to rebut the presumption of ownership. In order to successfully rebut the presumption of full or partial ownership, he/she must provide the following within 30 days of the date on the DCO-712:

1. A written, signed statement by the IS giving his/her allegation regarding ownership, the reason for the applicant's receipt of the income or for his/her name appearing as an owner on the payment of the income;

2. Corroborating, signed statements from the other owner(s);

3. A change in the instrument of ownership removing the IS's name from the instrument or a change which redirects the income to the actual owner(s); and

4. Copies of the original and revised documents reflecting the change in 3.

A successful rebuttal will result in a finding that supports the individual's allegation regarding ownership of the income.

If the individual elects not to rebut the consideration of ownership interest, obtain a written statement from the individual which documents his/her election.

If the individual elects not to rebut, does not provide a rebuttal within the allotted time, or does not provide all of the required evidence, the income produced from the presumed ownership interest will be used in his/her eligibility determination.

If the individual submits all required evidence within the allotted time, the individual's ownership interest will be determined and the findings documented in the case record. The income from the actual ownership interest (i.e., the interest determined by the rebuttal) will be used in the eligibility determination.

When the individual has successfully rebutted ownership of all or a portion of the income, income payments will be considered available to the IS in proportion to his/her interest (if any).

* NOTE: This section does not apply to federal, state or other entitlements, pensions or retirement benefits. For example, ownership of a $600 Social Security income entitlement for an IS cannot be rebutted.

3338.3 Determination of Nursing Home Net Income

After determination of resource eligibility and the post-eligibility consideration of income (or upon request by the IS, CS, or their representative), the Nursing Home Net Income, Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA), Community Spouse Monthly Income Allowance (CSMIA), and any Family Member Allowances (FMA) will be computed on Form DCO-712. Amounts will be rounded to the nearest dollar (Round 50¢ up). These amounts will be deducted from the IS's gross income, in the following order:

1. The $30.00 personal needs allowance.

2. The Community Spouse Monthly Income Allowance (CSMIA), which is determined by:

   a. Computing The Excess Shelter Allowance in Section 3a of the DCO-712. Total shelter costs may include

      (1) Rent or mortgage, including principal and interest;

      (2) Prorated taxes and insurance, including personal property taxes and insurance on household contents if paid yearly;

      (3) Condominium or cooperative fee, including maintenance charges; and

      (4) The standard utility allowance.

      Shelter costs must be verified. Utilities need not be verified.

      Note: Do not add the standard utility allowance in computation if utilities are included in rent or if someone else is paying the utilities. If only partial utilities are included in rent (Ex. - water), the full utility allowance may be used.

   b. Computing the Community Spouse Minimum Monthly Maintenance Needs Allowance (CSMNA) by adding the amount shown in 3b of the DCO-712 to the Excess Shelter Allowance. The total CSMNA amount may not exceed the maximum indicated on the Form DCO - 712 (the maximum will be adjusted annually according to the Consumer Price Index).

   * c. Computing the Community Spouse Monthly Income Allowance (CSMIA) by subtracting the CS's gross income from the CSMNA (VA A&A and CME/UME are not countable income to the CS).

The CSMIA will only be deducted to the extent contributed by the IS. If the IS contributes an amount less than the computed CSMIA, only the actual amount contributed will be deducted from the IS's gross income; i.e., the actual contributions will be deducted instead of the computed CSMIA (Re. MS 3338.5). An IS may not contribute more than the CSMIA unless under a court order, or unless a hearing officer has determined the CS needs income greater than the CSMNA (Re. MS 3338.7).

If a court orders the IS to contribute a larger amount for the support of the CS, then the amount of support ordered by the court will be used instead of the CSMIA. Any amount ordered by a court will be not subject to the limit on the CSMNA.

3. A Family Member Allowance (FMA) for each dependent family member.

The FMA is computed for each dependent family member by deducting the family member's income from the amount shown in Section 4 of the DCO-712 and by dividing the result by 3.

The FMA will only be deducted from the IS's income to the extent that it is actually contributed by the IS. If the IS contributes an amount less than the FMA, only the actual amount contributed will be deducted from the IS's gross income, i.e., the actual contribution will be deducted instead of the computed FMA (Re. MS 3338.4).

A CS who is an SSI recipient, or who has children receiving SSI, will have the right to choose whether or not to accept a CSMIA or FMA. It should be explained to the CS that the result of accepting an allowance may be reduction or termination of SSI benefits and Medicaid. A dependent family member receiving SSI (parent or sibling of the IS) will also be given the same choice.

* 4. Monthly noncoverable medical expenses of all facility recipients which are not subject to payment by a third party (including Medicaid). The medical expenses must be verified as currently due and unpaid. Future anticipated expenses may be used when it is verified that these expenses have occurred with regularity in the past and will continue to occur with regularity in the future.

When there is a contract between an applicant and a medical provider and regular payments on a medical bill are being made, the monthly payment will be deducted as a noncoverable medical expense. When there is no contract, the monthly amount of the medical expense being paid may be deducted, with verification that regular payments are being made.

Deduction of medical expenses is not allowed for nursing facility and ICF/MR residents for items and services included in the state's Reimbursement Cost Manual as allowable cost items (items the facility will provide). Examples of these include wheelchairs, canes, crutches, walkers, ambulance services or enrollment fees for ambulance services (unless there is not a Medicaid enrolled ambulance provider in the area), other transportation services, over-the-counter pain killers, antacids, laxatives, cough syrups, suppositories, anti-diarrhea medication, diapers, bandaids, bandages, peroxide, antiseptics, etc. Facilities are required to provide these items and services at no additional charge to the recipient.

An income offset for the purchase of eyeglasses, contact lenses, hearing aids, prostheses, and dentures can be made only if the following procedure is followed:

1. The items must be prescribed by a physician or other licensed medical practitioner.
2. The items must be a part of the recipient's plan of care. It must be determined by the facility interdisciplinary team that the recipient's quality of life will be enhanced and that he or she is able to utilize the item(s).
3. The request must be approved by the facility's Quality Assessment and Assurance Committee.
4. The cost of the item(s) must be determined.
5. The recipient or authorized representative must provide the county office with verification of the above. The recipient or authorized representative must not make the purchase or pay the medical bill until the county has made an adjustment to the patient liability.

Other allowable medical expenses (if not subject to payment by a third party) include: health insurance premiums, deductibles, and coinsurance; prescription drugs not in the Medicaid formulary; physician, hospital, and dental charges; etc. These are not subject to approval through the facility's Quality Assessment and Assurance Committee. However, prior to making the purchase or paying the bill, the recipient or authorized representative must provide the county office with proof that the item or items were prescribed by a physician or other licensed medical practitioner, and with proof of the cost.

* Deduction from income for cosmetic and elective procedures (e.g., face lifts or liposuction) will not be allowed from the income of a facility recipient. Other expenses not allowed are the premiums for insurance which pays cash to a recipient when medical expenses have been incurred and Medicare premiums deducted from SSA payments prior to buy-in. The only allowable medical deductions will be the recipient's noncovered medical expenses. Medical expenses of family members cannot be deducted from facility income.

* Note: As of January 1, 1990, there is no monthly limit on the number of prescription drugs for facility recipients receiving vendor payment, as long as the prescribed medicine is within the Medicaid formulary. Medicaid facility recipients who are not certified for vendor payment are limited to three prescriptions per month.

Medical expenses can be of three types:

a. Monthly - Expenses incurred regularly each month such as prescription drugs, doctor visits, and medical supplies;

b. Nonmonthly - Expenses which are not incurred monthly but are incurred periodically, such as quarterly doctor visits and prescription drugs purchased every other month;

c. One-time - Expenses incurred such as hospital bills.

If the county worker is unable to determine within a fair degree of certainty what the non-covered medical expenses will be, then no medical expenses will be deducted from the income.

The remaining income (if any) is the net income which will be applied to the client's cost of care.

If all of the IS's gross income is depleted at any step in the computation, the amount applied to the LTC vendor payment will be $0.

After the DCO-712 is completed, a copy of the DCO-712 will be provided to each spouse. If the form is completed prior to application, at the request of either spouse, the Form DCO-712 will only be provided to the spouse making the request.

3338.4 Option To Estimate Net Income

County offices may elect to estimate for a period not to exceed six months any or all of the following: the income of the IS, the spousal and family member maintenance allowances, and the medical expenses. The six month projection will show reasonable income and expenses, based on the six month period immediately preceding the projection and may be preferable when income or living/medical expenses fluctuate.

3338.5 Verification or Refusal of Contributions

Prior to certification of the IS, the IS or representative must complete and sign the statement on the reverse of the DCO-712 to indicate that the IS plans to contribute the CSMIA and the FMA specified on the front of the DCO-712, during the period of institutionalization.

If the DCO-712 is not completed and signed, no allowances for the CS or other family members will be used in determining Nursing Home Net Income. The CSMIA and FMA will only be deducted to the extent actually contributed by the IS.

If the CS does not want to accept the contribution from the IS, the CS should decline the income by completing the appropriate section on the DCO-712.

3338.6 Quality Control Errors

The amount computed as net income to be applied to the vendor payment will be subject to Quality Control error.

If a contribution or medical expense is deducted from gross income and the IS is not actually meeting the contribution or expense, this will be an understated liability and a dollar error.

If the contribution (or full contribution) or medical expense is not being deducted from the income, and the IS has agreed to pay the contribution, or has incurred a medical expense, this will be an overstated liability but no dollar error.

3338.7 Appeals and Hearings

If either spouse is dissatisfied with the determination of:

* the CS's monthly income allowance,
* the amount of monthly income otherwise available to the CS,
* the computation of the spousal share of resources,
* the attribution of resources, or
* the CS's resource allowance,

such spouse is entitled to a hearing, if application has been made on behalf of the IS.

Any hearing regarding the determination of the CS's resource allowance shall be held within 30 days of the date of the request for the hearing.

REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE

If it is established that the CS needs income above the level provided by the minimum monthly maintenance needs allowance (CSMNA) due to exceptional circumstances resulting in significant financial duress, a greater allowance may be substituted by a hearing officer, but only to the extent the IS is willing to make the IS's income available to the CS.

"Exceptional circumstances resulting in extreme financial duress" are defined as circumstances other than those taken into account in establishing the maintenance standards for the CS, such as unreimbursed medical expenses or household repair and maintenance for which the income allowance calculated by the Service Representative on the DCO-712, along with the CS's income, is inadequate to pay.

If an income allowance greater than the one calculated by the county worker on the DCO-712 is granted by a hearing officer, the greater amount cannot exceed the current maximum, as shown on the DCO-712. For example, in 1993 the maximum CSMNA is $1769. A CS's CSMNA computed on the DCO-712, based on rent and utilities, is $1400. The CS's income is $800 a month, and the IS is allowed to give the CS $600 per month, giving the CS a total of $1400. The CS establishes that her monthly expenses are $1800, due to exceptional circumstances. A hearing officer may allow the IS to give the remainder of the IS's income, if any, to the CS (excluding the $30 PNA). If the IS has $369 additional income, it may be given to the CS to bring the CS's income up to the maximum CSMNA ($800 + $600 + $369 = $1769, the maximum allowed). No additional amount can be granted to raise the CS's total income to $1800, because $1800 is over the maximum.

REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE

If an IS is willing to contribute all of the IS's monthly income (less the $30 PNA) to the CS and the CS still does not have enough monthly income to raise the income to meet the needs of a CS when financial duress exists, a hearing officer may change the CS's resource allowance to bring the CS's income up to the maximum CSMNA. Any additional resources attributed to the CS must be income producing, otherwise the resources would not serve to increase the CS's income. In determining an increased resource allowance, no resources can be transferred which, along with the CS's other income (including the income from the IS) would generate total income to the CS in an amount greater than the current maximum CSMNA limit shown on the DCO-712.

If a greater CSMIA is awarded by a hearing officer due to extreme financial duress, the county may:

- Request the hearing officer to reopen and review the case when the county has reason to believe the exceptional circumstances no longer exist;

- Have the hearing officer schedule future hearings to review the circumstances and determine if financial duress still exists; and

- Monitor the case(s) to assure that exceptional circumstances still exist, and make adjustments when indicated.

3338.8 Certification

The procedures in MS 3400 will be followed in certifying the applicant for facility services. The sum of the CSMIA, FMA, and noncovered medical expenses will be entered in the Protected Maintenance Field of WNHU. The amount of the IS's income remaining after deduction of all allowances (the sum of the CSMIA, FMA, noncovered medical expenses, and the personal needs allowance) will be entered in the Nursing Home Net Income field.

Each Form DCO-86 and EMS-87 for IS's who have a CS will be marked in red in the upper right corner to assist in identifying these cases.

3338.9 Changes

The IS, CS, representative, and family members will be advised to report any changes in income, shelter costs, or medical expenses while the IS remains in the facility. Any of these changes will affect the amount that the IS is required to contribute toward the facility vendor payment.

The county office will not be required to make monthly adjustments to the net income. If the county has elected to project income and expenses for a period of six months (Re. MS 3338.4), the case will be flagged through WALR or DCO-87 for a net income adjustment, if necessary, at the end of the six month period. Adjustments must be made sooner than six months if changes are expected or reported.

A full reevaluation (completed DCO-777, etc.) will not be necessary at the six month review. Only changes in income, shelter costs, and expenses will be reverified, if reported as changed, and a new DCO-712 will be completed.

When the IS, CS, or individuals receiving an FMA are affected by the annual Cost of Living Adjustment made by SSA, the SSA income amount of each individual whose needs are included in the calculation of the Nursing Home Net Income Amount must be recomputed to determine if the allowance or the net income changes.

Each time the CSMIA, FMA, noncoverable medical expense deduction, or Nursing Home Net Income is adjusted, the reverse side of the DCO-712 will be completed and signed by the IS or representative, declaring that the IS intends to provide the CSMIA and FMA for the support of the CS and family members (or that the CS refuses to take the allowance). The CSMIA and FMA will only be deducted to the extent contributed by the IS.

Each time a DCO-712 is completed, a copy of the DCO-712 will be provided to each spouse.

3338.10 Retroactive Adjustments

When the county discovers that the income of an IS, CS, or other family member has changed, that the maintenance needs of the CS have changed, or that uncovered medical expenses have changed (any change that affects the net income applied to the cost of facility services), the retroactive fields of WNHU will be used to adjust the net income for retroactive periods.

3338.11 NonRecurring Lump Sums

If nonrecurring lump sums are received, or anticipated, they will be treated according to policy at MS 3341.

3338.12 Reevaluations

Regular case reevaluations will be made yearly. At each reevaluation, the amount of the CSMNA, CSMIA, and FMA will be recomputed on Form DCO-712. In order for the CSMIA, FMA and medical expense deductions to continue, the recipient and the CS will be required to reverify the amounts of income, shelter expenses, and medical expenses which are being considered in the computation of the facility net income. If this information is not provided at reevaluation, the deductions will not be allowed.

The DCO-712 must be signed by the IS or representative at reevaluation, and a copy of the form must be given to both the IS and CS.

3340 INCOME

Income is defined as the receipt of assets by an individual in cash or in-kind (Re. MS 3347) during the month. To be considered as income, the assets received must be something of value received by the individual for his own use and benefit in providing the basic requirements of food, clothing, and shelter. Lump sum or one time payments are considered as income for the month of their receipt.

Income may be received in cash (including checks, money orders, etc.) or in-kind (including items such as rent, free food, etc.) The cash value of items received in-kind must be determined. The value of infrequently and irregularly received items such as small gifts of clothing will not be considered as income.

3341 Income Evaluation

Determination of income eligibility will be based on an applicant/recipient's monthly income. The recipient's gross monthly income will be compared to the monthly income eligibility standard to make this determination. (Exclude VA Aid and Attendance and CME/UME in this computation).

Income which is received on a basis other than monthly (annually, semi-annually, etc.) will be considered as income for the month of receipt only. (Do not count dividends received from insurance policies as income in eligibility determinations). Amounts carried over into the following month will be considered as resources. Nonmonthly income receipts will be treated as follows:

* 1. Regularly Received Nonmonthly Income - When income that will affect eligibility is regularly received by the individual in an established amount and at a set time, the worker will begin processing case adjustment in the month prior to the receipt of the income. The worker will notify (via the DCO-700) the recipient or person acting on his behalf of case adjustment at least ten days prior to the month in which the income is to be received. If the increased income will result in only one month of ineligibility, the case may be reinstated effective the first day of the month following the month of ineligibility, without taking a new application. Advance notice to the client will state that the case is being suspended for a month and that it will be reinstated the following month without action from the client, provided the client is still resource eligible. To adjust the case for a month of ineligibility: (1) In the month prior to the month of ineligibility, key the last day of the current month as the Med. End Date on WASM, with action type "O" (The case will remain open on WASM). On WNHU, key the last day of the current month as in NH Elig. Stop Date, with action type "NC". (2) During the month of ineligibility (or later), and after verifying resource eligibility, key to WASM as the Med. Begin Date the first day of the month following the month of ineligibility and zero out the Med End Date, using action type "O". On WNHU, reopen the case as if it were a new certification, with the first day of the month following the month of ineligibility as the NH Elig. Start Date, using action type "NA". (3) If the individual is not resource eligible in the month following receipt of the lump sum, send an advance notice of closure due to excess resources, and state that a new application will be required to reopen the case. The case may then be closed on WASM.

   If the anticipated income is in an amount great enough that is likely to result in two or more months of ineligibility, the client will be informed

in the advance notice that the case will be closed and that a new application will be required to reopen the case.

Anticipated income changes that will not result in case closure may be entered in WNHU no earlier than the month prior to the month of receipt of the income. The vendor payment adjustment will then be made by the Medicaid claims processing agent (Re. DCOUM 3723 for procedure). The client or his representative should be notified of his increased vendor payment responsibility by DCO-700 at least ten days prior to input of the change.

2. Irregularly Received Nonmonthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The ten day advance notice of intended action will be given before effecting any case closures or income adjustments. All income adjustments or closures will be made effective the first day of the month in which the income is received (Re. DCOUM 3722, 3723, and 3724). The recipient or person acting on his behalf must be fully advised by DCO-700 of the amount of his vendor payment responsibility in these cases. Every effort should be made to anticipate nonmonthly income receipts so that advance action can be taken as specified under #1.

* As with regularly received nonmonthly income, if benefits will be terminated for only one month for receipt of irregular nonmonthly income, a new application will not be required and the client will be so advised. Closures of two or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at MS 3332.3 #6. SSA lump sum payments will be counted as income in the month of receipt, but will be given the appropriate resource exclusion. Interest earned on these excluded funds will be counted as income in the month accrued and as a resource, if retained, in the month(s) following.

* When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month. (Re. MS 3634.1 for procedures).

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer account. The frequency with which interest is computed is immaterial in determining when the income is received (e.g., a bank may compute interest daily, but credit an account only monthly or quarterly).

Interest and dividends will be considered in both eligibility and net income determinations. An individual will not be allowed to retain interest and dividends for personal needs in addition to the monthly personal needs allowance.

In determining initial eligibility and at subsequent reevaluations, the latest interest/dividend statement (two if paid quarterly, at least three

if paid monthly) will be used to determine the countable monthly amount. If small interest/dividend amounts paid monthly or quarterly fluctuate slightly, counties may average and use the the average amount until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change. Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

The county worker will provide the client (or authorized representative) with an explanation regarding the consideration of interest/dividend income in the eligibility and net income determinations. Since the monthly interest/dividend amount will be combined with other income before the $30 monthly allowance for personal needs is considered, the recipient will not receive the full month $30 monthly allowance unless he withdraws his interest/dividends as paid.

NOTE: Interest income (and recipient earned income) of State Human Development Centers and Benton Services Center clients will be used in determining initial eligibility, but will not be considered in determining net income. All recipient earnings and interest income will be reported by these facilities in their semi-annual cost reports, and the full amount will be deducted by Central Office at the time of retrospective cost settlement.

Interest income (and recipient earned income) of clients in 10 bed ICF/MR facilities are counted in BOTH initial and posteligibility determinations, as semi-annual cost reporting is not done for these facilities.

3342 Consideration of Ineligible Spouse/Parent(s) Income after Initial Eligibility Has Been Established

After initial eligibility has been established, income of the noninstitutionalized ineligible spouse/parent(s) may be considered available to the eligible spouse/child in a facility only to the extent that it is voluntarily contributed either to the eligible spouse/child in a facility or directly to the facility for partial vendor payment.

The ineligible spouse/parent(s) is not required to make a contribution to the eligible spouse/child in a facility or to the facility and may, in fact, choose to make no contributions.

If, however, the ineligible spouse/parent(s) indicates that he will voluntarily contribute any income, determine whether the contribution is made directly to the eligible person in the facility or directly to the facility for partial vendor payment.

DCO-712 Contributions made directly to the eligible person in the facility will be considered as unearned income both in determination of eligibility and in determining the net income to be applied to the vendor payment.

Contributions made directly to the facility as partial vendor payment will only be considered for client share of the facility vendor payment, and will not be considered for recipient eligibility. The payment made by the ineligible spouse/parent(s) must be for covered services under the LTC program to be considered available to apply toward the vendor payment. Payments made by the ineligible spouse/parent(s) for special charges or additional services and items not covered by the facility vendor payment will not be considered. This includes payments made by the family of the facility recipient to the facility for the cost of a private room.

in the advance notice that the case will be closed and that a new application will be required to reopen the case.

Anticipated income changes that will not result in case closure may be entered in WNHU no earlier than the month prior to the month of receipt of the income. The vendor payment adjustment will then be made by the Medicaid claims processing agent (Re. DCOUM 3723 for procedure). The client or his representative should be notified of his increased vendor payment responsibility by DCO-700 at least ten days prior to input of the change.

2. Irregularly Received Nonmonthly Income - When the recipient receives income on an unpredictable basis and in unpredictable amounts, income adjustments and ineligibility resulting from its inclusion in the budget will not be processed until after its receipt. The ten day advance notice of intended action will be given before effecting any case closures or income adjustments. All income adjustments or closures will be made effective the first day of the month in which the income is received (Re. DCOUM 3722, 3723, and 3724). The recipient or person acting on his behalf must be fully advised by DCO-700 of the amount of his vendor payment responsibility in these cases. Every effort should be made to anticipate nonmonthly income receipts so that advance action can be taken as specified under #1.

* As with regularly received nonmonthly income, if benefits will be terminated for only one month for receipt of irregular nonmonthly income, a new application will not be required and the client will be so advised. Closures of two or more months will require a new application.

3. SSI/SSA Lump Sum Benefits - SSI lump sum payments will not be counted as income in the month of receipt and will be given a resource exclusion according to the schedule at MS 3332.3 #6. SSA lump sum payments will be counted as income in the month of receipt, but will be given the appropriate resource exclusion. Interest earned on these excluded funds will be counted as income in the month accrued and as a resource, if retained, in the month(s) following.

* When SSA lump sum benefits result in income ineligibility, the case will be suspended in the month of receipt of the lump sum. A new application will not be required to reopen the case in the following month. (Re. MS 3634.1 for procedures).

4. Interest and Dividend Income - Interest and dividends on checking and savings accounts, certificates of deposit, etc. represent a return on an investment or a loan of money, and are considered unearned income when credited to an account. Interest and dividends are considered credited to an account when a financial institution normally reports the income to the customer account. The frequency with which interest is computed is immaterial in determining when the income is received (e.g., a bank may compute interest daily, but credit an account only monthly or quarterly).

Interest and dividends will be considered in both eligibility and net income determinations. An individual will not be allowed to retain interest and dividends for personal needs in addition to the monthly personal needs allowance.

In determining initial eligibility and at subsequent reevaluations, the latest interest/dividend statement (two if paid quarterly, at least three

if paid monthly) will be used to determine the countable monthly amount. If small interest/dividend amounts paid monthly or quarterly fluctuate slightly, counties may average and use the the average amount until the next scheduled reevaluation, unless an adjustment is necessary sooner due to a reported change. Interest/dividends credited or paid annually will be counted as income in the month of credit or receipt.

The county worker will provide the client (or authorized representative) with an explanation regarding the consideration of interest/dividend income in the eligibility and net income determinations. Since the monthly interest/dividend amount will be combined with other income before the $30 monthly allowance for personal needs is considered, the recipient will not receive the full month $30 monthly allowance unless he withdraws his interest/dividends as paid.

NOTE: Interest income (and recipient earned income) of State Human Development Centers and Benton Services Center clients will be used in determining initial eligibility, but will not be considered in determining net income. All recipient earnings and interest income will be reported by these facilities in their semi-annual cost reports, and the full amount will be deducted by Central Office at the time of retrospective cost settlement.

Interest income (and recipient earned income) of clients in 10 bed ICF/MR facilities are counted in BOTH initial and posteligibility determinations, as semi-annual cost reporting is not done for these facilities.

3342 Consideration of Ineligible Spouse/Parent(s) Income after Initial Eligibility Has Been Established

After initial eligibility has been established, income of the noninstitutionalized ineligible spouse/parent(s) may be considered available to the eligible spouse/child in a facility only to the extent that it is voluntarily contributed either to the eligible spouse/child in a facility or directly to the facility for partial vendor payment.

The ineligible spouse/parent(s) is not required to make a contribution to the eligible spouse/child in a facility or to the facility and may, in fact, choose to make no contributions.

If, however, the ineligible spouse/parent(s) indicates that he will voluntarily contribute any income, determine whether the contribution is made directly to the eligible person in the facility or directly to the facility for partial vendor payment.

Contributions made directly to the eligible person in the facility will be considered as unearned income both in determination of eligibility and in determining the net income to be applied to the vendor payment.

Contributions made directly to the facility as partial vendor payment will only be considered for client share of the facility vendor payment, and will not be considered for recipient eligibility. The payment made by the ineligible spouse/parent(s) must be for covered services under the LTC program to be considered available to apply toward the vendor payment. Payments made by the ineligible spouse/parent(s) for special charges or additional services and items not covered by the facility vendor payment will not be considered. This includes payments made by the family of the facility recipient to the facility for the cost of a private room.

Each ineligible spouse/parent will be advised that income contributions may be made on a voluntary basis to the eligible spouse/child in a facility or to the facility, and of the different ways that the contribution may be considered if one is made. The decision of whether to contribute or not contribute is left to the ineligible spouse/parent(s) to make, and no suggestions or recommendations of action will be given to him. Any questions that the ineligible spouse/parent(s) has regarding the affects of a specific action will be answered.

Nonvoluntary contributions can only be effected by court order, and only considered when actually paid by the ineligible spouse/parent(s). The eligible person in a facility is not required to seek support from the ineligible spouse/parent(s) to remain eligible for facility Care.

3343 Determination and Verification of Earnings from Employment

The monthly gross amount of any earnings from employment will be determined. Monthly gross income is determined by the actual earnings received (or to be received) during the month of application or reevaluation, whether paid weekly, biweekly, semimonthly, or monthly. In cases where 5 pay periods during the month of application result in ineligibility, the application will not be denied (if otherwise eligible) but will be considered for eligibility in the following month when there will be only 4 pay periods. In ongoing cases where earnings are biweekly, the cases will be flagged (by DCO-88 or WALR) to make income adjustments on WNHU during the months when 5 paychecks are to be received.

If the earnings fluctuate, the worker will determine, by averaging or other means, an amount which fairly reflects the income actually currently available to the applicant on a monthly basis. The case narrative will clearly reflect the manner in which the income was determined and the justification for considering it a fair reflection of the actual, current income available to the applicant.

Verification of earnings from employment will be by check stubs, pay slips, or collateral contact with the employer. Sufficient verification must be obtained so that the actual income of the employee can be determined. The worker will not automatically assume that one check stub accurately reflects earnings for an entire month. The latest month's verification will be required. If a person is paid weekly, then the latest 4 (or 5) consecutive check stubs will be required. If the person is paid every other week or twice a month, then the latest two check stubs will be required, and if paid monthly, then the latest check stub will be required. If the client does not have the required verification, then verification from the employer will be required.

EXCEPTION: For cases in which applicant/recipient has just begun employment and a month's verification is not available, the Service Representative will compute the income from the best information available. In this instance the case will be flagged for a redetermination of earnings in the following month using full verification procedures.

3343.1 Earnings of ICF/MR Facility Residents

Residents of ICF/MR facilities who have earned income may be given a disregard of up to $100 of their monthly earnings, in addition to the $30 personal needs allowance. The same disregard may also be given to nursing facility residents with earnings who receive intermediate care, provided there is documentation

that a physician has prescribed employment activity as a therapeutic or rehabilitative measure. If a nursing home resident receiving skilled care reports earnings, the Utilization Control Committee of the OLTC should be contacted and requested to reevaluate medical necessity.

All nursing facility and ICF/MR residents must first pass the gross income test, with no disregards allowed. If found eligible, the consideration of earnings will be as follows.

1. Human Development Centers and Benton Services Center

A semi-annual retrospective cost accounting of the earned income (and interest income) of residents of the Human Development Centers (Booneville, Jonesboro, Alexander, Conway, Warren, and Arkadelphia) and the Benton Services Center is processed by Central Office. When residents of these facilities with earned income have passed the gross income test for eligibility, only unearned income will be considered in determining the net income to be applied to the vendor payment. The earned income will not be considered.

2. Ten Bed ICF/MR Facilities

There is no retrospective cost accounting for residents of 10 bed ICF/MR facilities. Therefore, their earnings must be taken into consideration for both eligibility and net income determinations. If residents pass the gross income eligibility test, their earnings will be included in the net income determination. In determining the net income to be applied toward the vendor payment, first subtract the mandatory deductions (e.g., federal and state income taxes) from gross income and, from the remaining earned income, up to an additional $100 for personal needs. Refer to MS 3400 for consideration of earnings at certification.

3. Fluctuating Earnings

If the earnings of ICF/MR facility residents fluctuate, they may be averaged (MS 3343), provided the facility administrator will agree to report to the county:

a. every 6 months, when the earnings are fairly stable, or

b. More frequently if the client loses employment or changes jobs, or earnings in any month rise more than $15 above the computed average.

3344 Determination and Verification of Earnings from Farm, Business or Self-Employment

Generally, it is necessary for the self-employed individual to estimate current income based on a projection from the tax return filed for the previous year and from current records kept in the regular course of business.

Because of the fluctuating nature of income receipts and self-employment expenses, current estimates for net income from self-employment will be based on the entire taxable year.

3344.1 Determining Amount of Net Earnings from Self-Employment

The amount of net earnings from self-employment is not always ascertainable from business records. If this is the case, use the first of the following

methods that is likely to give the most accurate estimate of current and future net earnings which may be allocated on a monthly basis.

1. When the individual has been carrying on the same trade or business for some time, his net earnings from self-employment have been fairly constant from year-to-year, and he anticipates no change or gives no satisfactory explanation of why the net earnings for current and future months would be substantially different from what it has been in the past, the estimate of earnings for his current taxable year should be the same as his net profit last year. His monthly income should be determined as one-twelfth of his net profit as shown on his tax return for the preceding year.

2. When the individual is engaged in the same business that he had the preceding taxable year and he anticipates no change or can give no reason why the net earnings for current and future months would be substantially different from what it has been in the past, determine the ratio between his net profit and gross receipts for the last year (e.g. net profit of $1,200 for $6,000 gross income, or 20%). Determine from his records the actual gross receipts for the current taxable year and project it for the remainder of the year (e.g. $4,000 in current year's receipts for the first 6 months gives an assumed gross of $8,000 for entire year). Apply the previously determined gross-net ratio (e.g. 20% of $8,000 is $1,600) and the resulting estimated net profit would be allocated equally into each month of the taxable year. This method would not be suitable for a business which is seasonal or has income peaks at certain times of the year.

3. Have the self-employed individual supply a profit and loss statement or other business records for his taxable year to date so that a net profit can be projected for the year and allocated monthly.

4. Use the individual's best estimate based on his business records.

5. Consideration may be given to the individual's explanation as to why he believes his estimated net earnings for the current year will be substantially different from the information on his tax returns for past years or his business records for past periods. Some examples of satisfactory explanations include business loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other such catastrophic event which can be documented. Obtain documentation for the records (newspaper accounts, police reports, medical reports, etc.). With documentation, a lower estimate may be accepted.

After the estimated net income from self-employment has been determined, explain to the individual how it has been determined and the effect it has on eligibility. Advise the individual that he may appeal if he disputes the estimates, or that he may request a change or reapply if new evidence becomes available.

If the allocated amounts of income result in ineligibility, explain to the individual that he may reapply if his remaining current year receipts or expenses or a new accounting of his net earnings from self-employment result in lower net earnings.

If the individual is eligible for assistance, advise him that any substantial variation of net earnings should be reported promptly with appropriate

evidence, so that overpayments and underpayments can be prevented. Explain also that he must provide a copy of the federal tax return as it becomes available.

When one of the methods under items 3, 4 and 5 has been used to determine net earnings, advise the individual that he should maintain monthly records of his ongoing receipts and expenditures until the federal tax return is available so that substantial variations of income can be identified and reported immediately to avoid erroneous eligibility.

3344.2 Unstated Income

Unstated income is income not reported or otherwise accounted for, but known to exist because living expenses exceed the income that has been reported.

An applicant, recipient or person whose income is subject to deeming may have unstated income.

The amount of unstated income to be considered as unearned income in determining eligibility is the difference between the declared monthly income and the monthly living expenses.

3344.3 When to Develop Unstated Income

When an individual's stated income does not appear adequate to cover living expenses, it will be necessary to develop unstated income, unless there is a reasonable explanation to account for the difference; e.g., savings have been used or bills have not been paid.

If the previous year's income tax return of an individual engaging in self-employment activity shows "0" or only a small amount of net income, living expenses and unstated income must be explored.

3344.4 Development of Living Expenses

When development of living expenses is required due to unstated income, explain to the individual what information will be needed to develop living expenses and why it is needed. Consider the living expenses of each and every member of the self-employed individual's household, and explain that all expenses must be considered. It is essential that a complete disclosure be obtained.

The following guide should be used in developing living expenses:

1. Prepare on a separate narrative sheet(s) a topical breakdown of pertinent monthly living expenses such as:

    a. Shelter or Living Quarters Cost (rents, taxes, mortgage payments, heating expenses, utility expenses, water expenses, sewer expenses, garbage collection expenses, etc.).

    b. Clothing and Upkeep.

    c. Medical Expense not reimbursed by Insurance (doctor bills, dentist bills, drugs, health insurance premiums, etc.).

    d. Transportation (car loan payments, insurance premiums, gasoline, tires, oil, mass transportation fares, etc.).

e. Food, Meals and Household Supplies (groceries, cleaning supplies, restaurant meals, etc.).

f. Credit Purchases and Loans (furniture bill payments, finance company payments, etc.).

g. Other (life insurance premiums, legal services, traffic fines, cigarettes, alcoholic beverages, etc.).

2. The reported living expenses will be considered as expenses in the actual time periods in which the expenses were paid by members of the household. Take into account the tendency to overlook expenses. Avoid averaging out of expenses between different months unless the monthly living expense total would be distorted if they were not averaged. If averaging is used, make explanation of the reason on the narrative sheet.

3. Add the following statement to the narrative sheet(s) of living expenses: "I agree that this is a fair statement of monthly household living expenses".

4. Obtain the signature of the self-employed individual. If the self-employed individual does not provide the information, obtain the signature of the individual who does, and explain why the self-employed individual cannot or will not sign the statement.

3344.5 Determination of Unstated Income

1. Reported Income - Reported income may include net earnings from self-employment and income from other sources, including cash or in-kind income. The amount of reported income for a month is determined by adding to the allocated monthly portion of net income from self-employment, the amount of other monthly income for the self-employed individual and any other individual who is an applicant or whose income is being deemed to the applicant, or who is an ineligible child taken into account because of deeming of income.

   Reported income is the aggregate of unearned and earned income of the following people living together as one household.

   a. Applicant(s)

   b. Individual(s) whose income is deemed to the applicant; and

   c. Ineligible children, if any, who would be taken into account in computing the amount of deemed income where there is a deeming situation.

2. Computation of Unstated Income:

   a. Applicant is self-employed - When an applicant or both applicants in a household (in the case of a couple) are self-employed, the computation of unstated unearned income, if any, requires that the amount of reported monthly income be subtracted from the amount of monthly living expenses, and the result, if greater than zero, be added to the amount of total unearned income of the applicant(s). Such income would be treated as other unearned income in the application.

EXAMPLE: The applicant reports earned income consisting of $100 per month net earnings from self-employment. The spouse, also an applicant, reports a pension of $100 per month. Living expenses are developed and total $400 per month. The total family income of $200 is subtracted from the $400 monthly living expenses, leaving $200 that will be counted as unstated unearned income for the couple to be divided as $100.00 for each member of the couple.

b. Individual whose income is deemed as self-employed - When the self-employed individual(s) in a household with an applicant is an ineligible spouse or parent, the computation of unstated unearned income (reported income subtracted from living expenses) increases the amount of unearned income of the self-employed individual. The effect of the unstated unearned income on the applicant depends on the deeming computation. Refer to MS 2110 for SSI Retroactive Medicaid determinations, and MS 7400-7440 for AABD Medically Needy Determinations.

3. Providing an Opportunity to Explain - When unstated unearned income is determined, discuss the matter with the individual and provide the individual with an opportunity to explain how living expenses are met. If the stated living expenses include obligations which do not represent actual expenditures (because bills are not being paid), adjust the amount of living expenses after obtaining a second (adjusted) statement of living expenses. If there are loans which account for the money used to pay living expenses, obtain a statement of specifics of the loan(s) and verify the loan transaction(s). Verified proceeds from loans received and used for living expenses can be subtracted from the amount of unstated unearned income left after subtracting reported income from living expenses. The use of resources may also be used to explain how living expenses are met.

4. Notice of Determination - When unstated unearned income is counted, explain on the notice of decision (DCO-700) that an inclusion of unstated income was made based on a comparison of living expenses with reported income because of excess living expenses.

3345 Sources of Unearned Income

The following are possible sources of unearned income:

* 1. Pensions, annuities, insurance benefits, Social Security, Railroad Retirement, Veterans' Benefits (exclude V.A. Aide and Attendance and CME/UME payments. Re. MS 3348.1), Civil Service, military allotments, Teachers' Retirement, State Retirement, Workmen's Compensation, Miners' Pension, and Black Lung benefits.

* 2. Payments received for the rental of rooms, apartments, dwelling units, buildings, or land. If paid regularly, taxes, insurance, interest on loans, and the expense of upkeep may be deducted.

NOTE: In Waiver and TEFRA cases, the deductions are not given for eligibility determinations. In nursing facility and ICF/MR cases, the deductions are not given in the initial OR posteligibility determinations, and neither for home nor for nonhome rental properties.

3. Interest, dividends, and income from capital investments, insurance policies, etc.

4. Royalty income from oil, gas or other mineral leases.

5. Regular payments from estates, trust funds (Re. MS 3332.2, #13), or other personal property which cannot be converted into cash because of legal provisions.

6. Child support payments.

7. Regular contributions from organizations, churches, friends, relatives, or social agencies.

8. Income or support and maintenance received in-kind.

3346 Determination and Verification of Unearned Income

The monthly amount of unearned income must be determined, verified, and included in the budget. Verification will normally be by documentary evidence obtained from the source of the income. Another means of verification may be used if it clearly establishes the source and amount of the income.

In addition, if the applicant or recipient is potentially eligible for any benefit, he will be required to apply for it and to accept the benefit if found eligible. Verification of his application for such benefits will be included in the case record. Once the applicant has applied for the benefit, his application or reevaluation may be completed, if he is otherwise eligible. The DCO-87 will be held current pending decision on his application for the benefit. If the applicant refuses to apply within 30 days of his application for any benefit for which he may be eligible, his application will be denied (or case closed).

3346.1 Social Security Benefits

Social Security benefits are paid upon retirement, disability, or death of a covered wage earner. Retirement benefits are payable at age 62.

Social Security disability benefits are payable at any age. A wife or widow is eligible at age 60, disabled widows at age 50. A wife or widow is eligible at any age if there are minor children of the wage earner living in their home. Children are covered until age 18, or until age 19, if attending school, and an individual may receive a child benefit at any age if incapacitated prior to age 21. All unmarried children of a wage earner are covered, even though the wage earner and the mother of the children were later separated or divorced. Illegitimate children may be covered if the wage earner can be established as the parent.

* Social Security benefits will be verified by BENDEX, WTPY response, SSA-1610, or by award letters. WQRY will be keyed at any time to verify benefits when there is an indication that the applicant may be eligible for Social Security benefits at "initial eligibility" determinations and when other sources of verification are not available; and to clear discrepancies between amounts reported and BENDEX.

3346.1.1 Voluntary Reduction of Benefits

The withholding from Title II benefits by SSA for the recovery of SSI overpayments is voluntary on the part of the overpaid SSI recipient. The money withheld from this cross-program adjustment will be considered as available income for the institutionalized individual's contribution toward his cost of care.

Individuals who have agreed to the Title II reduction will not have sufficient income to pay their share of the cost of institutional care. Since the individual remains liable for the cost of institutional care, the county office will inform the individual of the possible adverse consequences of choosing cross-program adjustments while residing in a Title XIX nursing home, and of his right to revoke the agreement.

Note: The withholding from Title II benefits by SSA for the recovery of SSA overpayments is not voluntary on the part of the overpaid SSA recipient. The money withheld from this adjustment will not be considered as available income for the institutionalized individual's contribution toward his cost of care.

3346.2 Railroad Retirement Benefits

Railroad Retirement Benefits are paid to individuals and spouses covered under the Railroad Retirement Act. An individual may receive both Railroad Retirement and Social Security, if covered under both programs, and the wife of a Railroad Retirement beneficiary may receive a wife's benefit while drawing Social Security.

* Information on Railroad Retirement Benefits may be secured from:

U.S. Railroad Retirement Board
Three Financial Centre
900 S. Shackleford, Suite 513
Little Rock, AR 72211

3346.3 Military Allowances or Allotments

If the applicant has a son, daughter, or spouse in the Armed Services, the Service Representative will explore the possibility of obtaining an allotment.

The address of the Army Finance Center is: Army Finance Support Agency
Indianapolis, Indiana 46492

The address of the Navy Finance Center is: Navy Finance Center
Federal Office Building
Cleveland, Ohio 44199

The address of the Air Force Finance Center is: Air Force Finance Center
3800 York Street
Denver, Colorado 80205

3346.4 Veterans Benefits

If the applicant is a veteran, or the wife, widow, child, or other dependent of a veteran, full exploration will be made of potential eligibility for Veterans Benefits. Only the portion of the VA Benefit attributable to the veteran/surviving spouse will be counted as his/her income. The dependent's portion of the VA Benefit will be counted as income to the dependent(s). It will be necessary to determine the portion of the VA Benefit that is attributable to the applicant/recipient. Veterans, widows and other surviving dependents eligible for higher benefit payments under the Veteran's Pension Improvement Act must agree to apply for and accept those benefits. Information on Veterans' Benefits should be requested on Form DCO-52 from:

VA Regional Office
Building 65, Fort Roots
North Little Rock, Arkansas 72205

County Office workers will not attempt to represent veterans or dependents in filing claims. Such persons should be referred to Service Officers of the local American Legion Post, County Offices, Veterans Administration Contact Offices, or the Veterans' Service Office, American Legion Arkansas Department, 1415 West 7th, Little Rock, Arkansas.

* 3346.5 Civil Service Benefits

Civil Service Benefits are paid to individuals and to surviving spouses of individuals who retired from civilian government jobs (e.g., Internal Revenue Service, Postal Service, etc.). These benefits include regular retirement and disability retirement.

Information on Civil Service Benefits may be secured from:

U.S. Office of Personnel Management
Retirement Operations Center
Boyers, PA 16017

3347 In-Kind Support and Maintenance and Other In-Kind Income

There are two types of unearned in-kind income: in-kind support and maintenance, and other in-kind income.

1. In-Kind Support and Maintenance

When an individual receives an item of food, clothing, or shelter outright, or when someone else pays for (or makes a payment on) food, clothing, or shelter for the individual, the individual receives in-kind support and maintenance (ISM). Generally, ISM is counted when the individual has use of the food, clothing, or shelter item. Mortgage payments made by a third party on the home where the individual resides will be considered ISM; or an individual living rent free (or making only token payments) in the home of another is considered to be receiving ISM.

2. Other In-Kind Income

When an individual receives something outright (other than food, clothing, or shelter) which can be sold or converted to cash, the individual receives other in-kind income. Other in-kind income is counted when received. The use of a car is not considered other in-kind income, as it cannot be sold or converted to cash. However, if the individual is given a car outright, it is considered other in-kind income in the month received, unless the car (or other item) would be a partially or totally excluded nonliquid resource if retained into the month following the month of receipt.

Someone else's payments to a vendor on behalf of the individual (other than ISM), even if it increases equity value, is not considered unearned in-kind income. However, the equity value is considered in the determination of total resources. For example, car payments for an individual are not other in-kind income, even though the equity value increases; but the equity value may be counted as a resource. Premium payments made for an individual on health insurance, life insurance, credit life, or credit disability insurance are not counted as other in-kind income (There is no equity value increase in these examples). However, the cash surrender value of a life insurance policy may be counted as a resource (Re. MS 3332.3 #2).

Cash payments which are made directly to an individual are counted in full as unearned income. This would be true even if the cash payment is given to the individual for the purpose of his meeting a basic need.

NOTE: In-kind support and in-kind income are not considered in Long Term Care, Waiver or TEFRA determinations.

3347.1 Valuation of In-kind Income and In-kind Support and Maintenance

The value of other in-kind income is determined by its current market value. The value of in-kind support and maintenance is determined by presumed value. The presumed value of in-kind support and maintenance is based on one third of SSI standard payment amount plus $20.00.

Presumed values of in-kind support and maintenance are as follows:

Effective Dates	Individual	Couple
1/1/92 - 12/31/92	$160.66	$231.00
1/1/93 - 12/31/93	$164.66	$237.33
1/1/94 - 12/31/94	$168.66	$243.00
1/1/95 - 12/31/95	$172.66	$249.00

Individuals receiving in-kind support and maintenance always have the right to rebut the presumed value and must be advised of this right.

To rebut the presumed value:

1. The actual cash value of the in-kind support and/or maintenance must be established. For example, if the individual is receiving free room and board, living in the household of another, determine the actual cost necessary to maintain the household. Include mortgage payments, utilities, real estate taxes, insurance, and food for all members. Expenses should be verified by receipts. Determine the individual's prorata share by dividing the actual monthly cost by the number of individuals living in the household. This will be the actual cost figure. If the individual purchases his own food, do not include this cost in determining the monthly household expenses.

   If the individual lives rent-free in the home of another or makes only token payments for rent compared to the value received, establish the rental value of the home. This can be established by securing a statement from the owner or through obtaining a verbal estimate from a rental agency. The payment made by the individual in return for in-kind support and maintenance is deducted as stated under step 2.

   If a third party makes payments on behalf of the individual for basic needs items such as rent, consider the actual amount paid as the cash value.

2. Any cash contributed by the individual(s) in return for in-kind support and/or maintenance received is subtracted directly from the established cash value (never the presumed value).

3. If the net amount derived is lower than the presumed value, the presumption is rebutted, and the net figure would be considered as unearned income.

4. If the actual net cash value of in-kind support and maintenance exceeds the presumed value, the presumed value is counted as unearned income.

3347.2 Third Party Payments Excluded as In-Kind Support and Maintenance

1. In-Kind payments made in lieu of cash wages are not considered as in-kind support and maintenance except when paid to agricultural or domestic employees.

   In-kind payments made in lieu of cash wages to other types of employees are considered to be earned income instead of in-kind support and maintenance.

2. The value of support and maintenance provided in a nonmedical nonprofit retirement home or similar facility which does not receive full payment from the individual or which receives subsidy payments from a nonprofit organization is not considered as in-kind income of the individual.

   The value of support and maintenance in such facilities is considered as in-kind support and maintenance for individuals who have acquired rights to life care in the facility by turning over all of their assets to the home or through membership in a fraternal group or union.

   The value of support and maintenance provided in public or private nonprofit institutions for educational or vocational training is considered as income of the individual.

3. Support and maintenance provided during a medical confinement and paid to a medical provider by a third party is excluded from income for eligibility determinations. This could be in a hospital or facility.

   Third party payments made directly to a facility as payment for items covered by the facility vendor payment will be considered as income in the computation of the patient's share of the vendor payment. If third party payments are made to cover special charges or additional services and items not covered by the LTC program, they will not be considered as income.

4. The value of support and maintenance provided by a private for profit nonmedical retirement home or similar facility which does not receive third party payments on behalf of an individual is not considered as income of the individual.

   The value of support and maintenance in such facilities is considered if third party payments are being made on behalf of the individual.

5. Occasional in-kind items of little value (not exceeding $20.00 in a month) are excluded when they are received irregularly or infrequently.

3348 Supplemental Security Income Exclusions

When the State's income limitation for LTC or Waiver services is at the Federal maximum (three times the SSI payment limit for an individual in his own home), SSI income exclusions are not allowable. The individual's gross income will be compared to the LTC or Waiver income limitation, and no SSI exclusions will be used in the eligibility determination or when computing the recipient's share of the facility vendor payment.

When the State's income limitation for AABD Medicaid categories other than LTC or Waiver is below the Federal maximum, SSI exclusions are allowable for the purpose of determining initial and continuing eligibility.

The following exclusions are allowed by SSI in determination of countable income (in order of application).

1. Refund on real property taxes, food taxes or income taxes.

2. Assistance based on need (State Supplementation of SSI, Interim General Assistance).

3. The tuition and fees portion of grants, scholarships, and fellowships.

4. Home produce for personal consumption.

5. Irregular income or infrequent income which:

   a. Cannot be predicted with any regularity;

   b. Is received less than twice per year; and

   c. Does not exceed $10.00 per month earned income or $20.00 per month unearned income.

   Income exceeding these amounts is considered in full.

6. The full amount of foster care payments made to an adult individual or eligible spouse.

7. One third of child support payments as income to a child.

8. Up to $400 a month of Student Earned Income for a student enrolled in an educational institution attending a course of study preparatory for gainful work. Maximum exclusion of $1,620 per calendar year of Student Earned Income.

9. $20.00 monthly may be excluded from any income not based on need (Per individual or per each couple determination), but

   a. Is not allowed from VA pension or payments made by Bureau of Indian Affairs, and is

   b. Always applied to unearned income first, the balance, if any, is then applied to earned income.

10. $65.00 plus 1/2 of the remainder of monthly earned income.

11. Income to cover work expenses for the blind (FICA, federal withholding, state income tax, transportation, lunches, expenses for a seeing eye dog, etc.)

12. Income to fulfill a self-support plan for blind or disabled recipients. (Approved plan through Rehabilitation Services).

13. Home Energy Assistance and Support and Maintenance Assistance provided by private non-profit organization, state or federal government body, a supplier of home heating oil or gas, or a municipal utility providing home energy.

14. Support and Maintenance and other assistance received as a result of a presidentially declared disaster.

15. Agent Orange Settlement Payments (also excluded from resources).

3348.1 Assets Disregarded as Income

The following receipts of assets are disregarded as income in entirety:

1. Credit disability insurance payments made on home or automobile loans.

2. Personal services performed for the individual (mowing grass, house cleaning, etc.).

Screening and Annual Resident Review (PASARR) requirements for determination of appropriate placement prior to entering a nursing facility. Persons requiring pre-admission evaluations for mental retardation or mental illness shall not be eligible for Medicaid reimbursement of nursing facility services prior to the date that a determination is made (the PASARR effective date on the DCO-704), unless emergency admission has been prior authorized by the Office of Long Term Care PASARR Coordinator or Utilization Control Committee.

ICF/MR applicants are exempt from PASARR evaluation, but they are not eligible for services prior to the decision date on the DCO-704.

* 3350.5 County Office Procedures

When the patient is determined to be in need of facility care, he will be assigned a classification based on his required level of care. The assigned classification will appear on the DCO-704. The classifications assigned are: Skilled Care (S), Intermediate Care I (A), Intermediate Care II (B), Intermediate Care III (C), and Developmentally Disabled (D). The "D" classification will apply to patients in ICF-MR only.

Individuals found to be in need of facility care may also choose to receive hospice services. For new approvals, the county office will receive a DCO-704 from the Utilization Control Committee which will indicate if the individual has elected hospice care. The classifications assigned to these individuals are: Hospice Skilled (J), Hospice Intermediate I (K), Hospice Intermediate II (L), or Hospice Intermediate III (M).

The level of care (classification) and the level of care begin date must be entered into WNHU, after the case has been opened on WASM (Re. MS 3500, DCOUM 3624). If a review date is shown on the DCO-704, the date will be entered on WNHU. If no review date is given on the DCO-704, zeroes will be entered in the LVC Review Date Field on WNHU.

Facility payment may not begin prior to the level of care begin date. On WNHU, the level of care begin date must equal the nursing home eligibility start date. If the level of care begin date is prior to the nursing home eligibility start date, the nursing home eligibility start date will be input for the level of care begin date on WNHU.

If the nursing home eligibility start date, determined by the county, is prior to the level of care begin date, the level of care begin date will be input for the nursing home eligibility start date. However, in no case will an ICF/MR case be certified with an eligibility start date which precedes the decision date on the DCO-704 (or PASSAR date for PASARR cases).

When a level of care review date is indicated on the DCO-704, the level of care review date must be a future date when the case is opened unless the case is added with a NH eligibility start and stop date for a fixed period. If the level of care review date is not a future date when a case is to be added on WNHU, a later DCO-704 must be requested from the OLTC Utilization Control Committee. When Utilization Control completes another level of care review prior to county request and/or certification of a case, the later EMS-704 will be automatically forwarded to the county office.

Once the level of care, the level of care begin date, and the level of care review date, when appropriate, have been entered in WNHU at certification, the county office will not make any later changes to these fields. Any changes in the level of care, decision date, and review date will be processed centrally by OLTC and the Medicaid claims processing agent.

* If a Medicaid recipient in a facility elects hospice care after a case has been certified by the county with a level of care code S, A, B, C, or D, the code will be system changed by OLTC, and the county will not be involved.

The county office is responsible for completing part III of the DCO-704 and distributing the DCO-704 to the appropriate parties at the time facility eligibility is authorized via the DCO-57 or DCO-765.

3351 Prompt Notice of Skilled Care Classifications

In any case that the county office cannot complete certification action promptly after the receipt of an DCO-704 which indicates a skilled care classification, the Service Representative will provide a machine copy of the DCO-704 to the facility where the patient is residing. This copy will be annotated with the following information at the top of the form:

"Information Copy for Utilization Control Requirements Only" and the name of the facility.

3352 Appeal of Utilization Control Committee Action

There are two types of appeal in the Utilization Control process:

1. Admission/Continued Stay Not Medically Necessary - The Utilization Control Committee will request comments and opinions from the attending physician in each case where admission/continued stay is determined not to be medically necessary. However, if the committee's decision is that continued stay is not medically necessary, this decision is final. The committee will make notification to the attending physician, the facility administrator and the county office when it has been determined that continued stay in a facility is not medically necessary.

   If the county office has a pending application, it will be denied (MS 3500).

   If the recipient has an active case, the County Office will provide advance notice of closure to the recipient and next of kin (when possible) by form DCO-700 and, at the end of the notice period, close the facility case by submitting a DCO-57 and/or DCO-765 with appropriate entries for data entry.

2. Reclassification - If the administrator and attending physician are not in agreement with the assigned level of care, they may appeal the decision within ten (10) days of receipt of Form DCO-704 (for applicants) or review report from OLTC by writing the Administrator, Utilization Control Committee, OLTC. The appeal should indicate why a reevaluation is being requested. It may be signed by the administrator or physician. The reviewing physician(s) in the OLTC will consider this information and, if warranted, the applicant/recipient will be reclassified. During the period of appeal, the facility will be paid at the rate of the latest classification. If the classification is changed by virtue of the appeal, payment adjustment will be made to the date of the previous classification.

3400 Determination of Net Income

When categorical eligibility and medical necessity have been established, the county worker will determine the amount of the individual's income that will be applied to the cost of care. Section 3 of the DCO-707 (and the DCO-712 when there is a CS) is used for the determination.

Using Section 3 of the DCO-707, determine the income to be applied to the cost of care as follows:

* 1. Total Earned and Unearned Income

In Section 3, enter all income of the recipient by type and amount, with the following exception:

State Human Development Centers (HDC) and Benton Services Center (BSC) residents - Do not enter the earned income and interest income. A semi-annual cost accounting will be made by these facilities which will take this income into consideration.

Enter the unearned income of all recipients. Exclude VA Aid and Attendance payments and VA CME/UME, along with the interest income of HDC and BSC residents.

From the earned income of all recipients (exclude earned income of HDC and BSC residents) deduct the actual mandatory deductions and work related expenses from gross earnings. From the earnings of 10 bed ICF/MR residents, up to an additional $100 may be deducted from earned income as a personal needs allowance.

Total the unearned income and the net earned income and enter on Line 4.

* 2. Fees for Income Trusts

For individuals whose cases were certified prior to November 1, 1995, deduct the fees which were approved - trustee fees, attorney fees, monthly bank services and preparation of income tax returns. Cases certified November 1, 1995, and later may have deducted ONLY the monthly service charges for maintaining the bank account.

* 3. Personal Needs Allowance

a. Subtract a $30 personal needs allowance for most facility residents.

b. Single veterans and spouses of single veterans with no dependents whose VA pensions have been reduced to $90 will be given the full $90 as a personal needs allowance. They will not be given an additional $30. **EFFECTIVE 11/1/95, the $90 PNA will NOT BE GIVEN to any individual whose VA pension has not been reduced to $90 by VA.** If VA reduces a pension to $90, an income adjustment will be made on WNHU.

c. For 10 bed ICF/MR residents with earned income, $30 may be given as a personal needs allowance, in addition to a disregard of earned income up to $100. The maximum disregard in these facilities for personal needs is $130.

Effective 11/1/1995, it will NOT be the responsibility of the county to attempt to identify individuals who may be eligible for a $90 PNA or to

allow a $90 PNA when the VA benefits have not been reduced to $90. If a single veteran or surviving spouse of a veteran with no dependents is receiving VA pension and the benefits have not been reduced to $90 at certification, only a $30 PNA will be given. The case will later be adjusted if the county learns that the pension has been reduced to $90.

Individuals previously given $90 PNA and still receiving the full VA pension amount will be reduced to a $30 PNA at next case change or reevaluation after appropriate notice. They may be instructed to contact the Veterans Administration if they believe they are entitled to a $90 reduced pension.

If the individual has no spouse and/or dependents or noncovered medical expenses, this will be the only allowance given to arrive at net income. If the individual has dependent children only (no spouse), proceed to step 4 below before arriving at net income. If the individual has a spouse or a spouse and other dependents living in the community, refer to MS 3338.3.

4. Protected Maintenance Allowance from NF Eligibles Income for Dependent Children When There Is No Spouse in the Home. In certain cases, an allowance may be given from the eligible individual's income for the protected maintenance of dependent children living in the home, when there is no spouse in the home.

Eligibility for the individual in a facility must be established before consideration is given for protected maintenance. If there are dependent (under 18) children, the combined income of the children must be less than the Medically Needy Income Level for the appropriate number of children in the household (MS 7610) to qualify for protected maintenance.

In addition to meeting the stated income limitations, the countable resources of the dependent children must be within the AABD resource limitations to qualify for protected maintenance. Actual amounts allowed for protected maintenance are determined as follows:

a. Determine the children's maintenance level (i.e. appropriate MNIL for the children);

b. Total any income that the children may have. If the total gross income equals or is greater than the maintenance level established in a., then no protected maintenance from the individual's income will be allowed. If the children's income total is less than their maintenance level, their total gross income will be subtracted from their maintenance level to arrive at the amount that will be given from the individual's income for protected maintenance. Example: Two dependent children each have $75 monthly income; their total income ($150) is subtracted from the 2 person MNIL of $216.66, leaving $66.66.

c. Deduct the figure derived from step b. ($66.66) from the individual's income. If there are no noncovered medical expenses, this net income will be entered in Section 3 of the DCO-707 and will be applied to the cost of facility care. The amount allowed for protected maintenance must be entered on the DCO-57 (In this example, $66.66). If there are noncovered medical expenses, see step 5 below.

5. Noncovered Medical Expenses

After deduction of the personal needs allowance and a maintenance allowance (if any), the total of noncovered medical expenses (for the facility recipient only) will be entered on the DCO-707. For noncovered medical expenses allowable as deductions, refer to MS 3338.3 #4. The remaining amount, after all allowable deductions, is the net income that the individual will be expected to apply to the cost of care.

6. Net Income

When ready to certify a case, a total of the excluded earnings (up to $100), income trust fees (when applicable), maintenance allowance(s), and noncovered medical expenses (if any) will be entered in the PROT MAIN Field of the DCO-57 or DCO-765. The net amount remaining will also be entered on the DCO-57 or DCO-765. The actual vendor payment will be determined centrally by the Medicaid claims processing agent, based on the net income that has been entered by the County Office.

VA PENSIONS REDUCED TO $90

* For active cases, ONLY after the VA pension benefit has been reduced by VA to $90, $90 will be entered on WASM in the VA PENSION field. On WNHU, $60 will be entered in the PROTECTED MAINT. field (plus any additional amount considered for noncovered medical expenses). The system will automatically exclude the $30 PNA so that a total of $90 will be given to the veteran or surviving spouse.

3401 Treatment of Extended SSI Benefits for Institutionalized Recipients

Effective 7/1/88, those SSI recipients entering a medical or nursing facility:

- who have a home to maintain, and
- who obtain a medical statement for SSA to document that the medical confinement will not exceed 3 calendar months after the month of entry to the facility

will be allowed to retain their full SSI benefits for a period up to 3 full months. No extension beyond the 3 months will be allowed.

When aware of the extension of SSI benefits for facility applicant/recipients, the county office will totally disregard the SSI benefits for determination of facility eligibility and vendor payment. If the applicant/recipient has income from any other source (e.g. VA, SSA, RR Retirement, etc.), that income will be included in the facility budget.

At certification of facility applicants receiving the full SSI benefit (who have no other income), only the $30.00 personal needs allowance will be entered on the DCO-57 (WNHU) and the remaining income will be disregarded.

When certifying recipients with a combination of SSI and other income, all of the SSI benefit will be disregarded. The other income will be entered in the budget section of the DCO-57 (WASM) and DCO-765 (WNHU). The $30.00 personal needs allowance will be deducted from the countable income, and the remaining income will be entered as NH Net Income (patient liability) on the DCO-57 or DCO-765 (WNHU).

If the SSI recipient's stay in the facility actually exceeds three months, no adjustment in the budget will be required, as it remains correct.

3410 Authorization of Services

Facility services will be authorized on the DCO-57 or DCO-765, except for current recipients of AFDC, Foster Care (Cat. 91 or 92) and U-18. AFDC and U-18 recipients must be changed to Special Needs only (Re. FA 2385.1) and, if they remain eligible, facility services will be authorized on the DCO-765. For Foster Care cases, the DCFS worker should enter any necessary changes to the status of the Foster Care case before authorization of facility services on the DCO-765.

3420 Effective Eligibility Dates for LTC and ICF/MR Services

The effective date of eligibility of an applicant for LTC and services in an ICF-MR depends on three factors:

1. Date of Entry - The individual's date of entry into a participating facility is indicated on the DCO-702 which is completed by the facility and forwarded to both the Office of Long Term Care and the county office for initial certification. Vendor payments cannot begin prior to the individual's date of entry into a facility.

2. Date of Medical Necessity - Medical necessity is determined by the Office of Long Term Care. The medical necessity decision is transmitted to the county office and the facility by the DCO-704 which classifies the patient for a specific level of care. If an DCO-704 is received by the county office on an applicant which classifies him/her for a specific level of care, medical necessity exists to the date of the individual's entry, or to the date of application if the patient was accepted as private pay only until the application for Medicaid was made. However, if the patient is in an ICF/MR facility or was subject to PASARR, medical necessity begins on the DCO-704 decision date for ICF/MR or PASARR date for PASARR residents, and Medicaid and vendor payment cannot begin prior to this date.

3. Date of Categorical Eligibility - Categorical eligibility for facility care and services under the AABD criteria can be established to begin three months prior to the date of application, provided all eligibility conditions are met. If categorical eligibility is established by receipt of SSI, AFDC, Foster Care (Cat. 91 or 92) or U-18, the date to begin vendor payment is not governed by the three month retroactive eligibility limitation as applied under the AABD eligibility criteria. Even though categorical eligibility may be established prior to application, however, the begin date for Medicaid and vendor payment cannot be prior to the decision date on the DCO-704 for ICF/MR applicants or PASSAR date for individuals subject to PASARR.

Authorization of services cannot be made until all three factors have been met.

3500 Disposition of Application

The Service Representative will take the following actions to complete an application for facility care and services:

1. Approval

   a. Complete and sign the DCO-57 and/or DCO-765 to submit for data entry. The Medicaid case will be opened on WASM prior to authorizing services on WNHU (Re. DCOUM 3600 and 3700) Exception:

      For SSI and income trust cases cases opened on WASM, income data will be entered on WNHU prior to updating on WASM. For open or closed SSI cases with addresses in another county, the certifying county will change the county code on WASM at certification. For closed SSI cases only, the correct address may also be entered at certification.

   b. The net income entered will be the net income as determined in MS 3400.

   c. The level of care, the level of care decision date (begin date) and the level of care review date, if applicable, will be entered as determined in MS 3350.

   d. Action Type NA will be entered on WNHU (NF for fixed eligibility).

   e. Notify the applicant of approval.

   f. Complete and route the DCO-704.

   g. Code the DCO-87 for reevaluation and/or the next anticipated change.

   h. Indicate approval and date on the DCO-88.

* i. If a case is approved with an income trust, complete and submit a DCO-730 to Medicaid Eligibility at Slot 1223.

2. Denial or Withdrawal

   a. For withdrawal only, obtain a signed written statement from the applicant requesting withdrawal.

   b. Record information pertinent to the denial in the case narrative.

   c. Indicate denial and date on the DCO-88.

   d. Notify the applicant of denial.

* e. An informational copy of the DCO-704 may be provided to the facility as notification of the denial.

   f. Complete denial data on first page of DCO-777, and submit for data entry on WIMA.

3. Transfer to NH in Another County

   If an eligible applicant transfers to a facility in another county before certification is completed, the county office where application was made will:

a. Complete the certification (Re. MS 3500 #1)

b. Transfer the case on WASM and WNHU to the county where the recipient now resides (Re. EMSUM 3726).

* 3500.1 Certification of Patients Approved for Medicare

When Medicare approves individuals for skilled nursing care/extended care, the facility receives reimbursement in the form of Medicare per diem and Medicaid coinsurance (if applicable) for up to 100 days, provided the individual continues to meet Medicare criteria.

Applications for Medicare approved admissions will be processed in the same manner as applications for non-Medicare approved admissions, except that nursing home services will not be authorized on WNHU until Medicare benefits have been exhausted. Medicaid for Medicare eligible individuals will be authorized on WASM, however, so that all other Medicaid covered services may be paid. For example, Medicare pays 100% of facility expenses for only 20 days. After this time, the individual becomes liable for coinsurance, which cannot be paid by Medicaid until the case is opened on WASM.

The monthly Medicare per diem amount will not be considered when determining income eligibility, but it will be treated as a third party resource to be applied to the cost of care in a facility.

When Medicare approves an individual for skilled nursing care, the facility should notify the county office of the Medicare admission via the DCO-702.

If at some point the individual fails to meet Medicare criteria or exhausts his benefits, Medicare will stop payment. The facility will notify the county office of the change in status via the DCO-702. On the day following termination of Medicare benefits, the Service Representative may authorize facility services on WNHU to be effective on that date, provided the individual continues to meet all LTC requirements.

3600 Continuing Eligibility

Reevaluation of facility cases to determine continuing eligibility is required periodically by the county office for all categories of LTC. Once a case has been certified, the county office responsibilities will be limited to completing regularly scheduled reevaluations, making retroactive and current income adjustments on WNHU, transferring cases, and effecting closures due to death, discharge or other eligibility factors.

3610 Reevaluation of Eligibility

* The time period for review of facility cases will vary according to the category, as shown below. All facility cases, regardless of category, must be reviewed within 30 days of receipt by the receiving county when a case transfer has been made to assure continuing eligibility. However, a new application and full reevaluation is not required unless it is time for the annual reevaluation.

3611 AFDC, Foster Care (Cat. 91 or 92) and U-18 Cases

* These cases will be reevaluated every six months. Eligibility will be redetermined according to the current eligibility criteria for the category. Form DCO-95 will be completed (DCO-98 for Cat. 92, IV-E foster children), along with other required forms.

* 3613 SSI

These facility cases will be reevaluated every twelve months. Form DCO-777 and all other required forms will be completed. Categorical eligibility is established if the individual continues to receive SSI payment.

3614 AA, AB, and AD

These cases will be reevaluated every twelve months. Form DCO-777 and all other required forms will be completed, and eligibility will be redetermined according to the current AABD criteria. NOTE: If the individual has a spouse and/or other dependents in the community and fluctuating noncovered medical expenses, a partial reevaluation will be completed every 6 months, if the county has elected to estimate net income (Re. MS 3338.4).

3615 Completion of Reevaluation

Upon determination of continuing eligibility, the DCO-57 will be completed for data entry into WASM. An "O" action will be shown along with worker number, date of completion of review, and any changes.

WNHU update will be made only if there have been changes in income, NH county or NH number. If income has changed, NL must be entered as the Action Type on WNHU.

If an income change was not previously reported, the retroactive income with start and stop dates will be entered in the retroactive payment section of the DCO-765 or DCO-57 for WNHU update. If the last income change is the current income, however, this change will be entered as a current change with an income start date effective the month the new amount was received (i.e., do not use a retroactive field).

The DCO-87 will be coded for next anticipated change/reevaluation, and the DCO-88 will be marked to show the reevaluation was completed.

3620 Utilization Control

* The Utilization Control Committee of the Office of Long Term Care will periodically review and redetermine patient classification and necessity for continued stay in a facility when required. Classification and medical necessity reviews will be made only for individuals whose medical condition changes and for those admitted for convalescent care.

When the need for continued stay in a facility has been determined to be medically necessary, a new review date is assigned and the approval/patient classification is valid through that date. The county office will not receive notice of change in classification, unless a change in medical necessity will require case closure, or transfer to another facility. The change in classification (if any), the decision date, and the new review date will be system entered by OLTC.

When the county office is notified by DCO-702 from a facility that an individual has entered another facility prior to the scheduled review date, the county office will complete a blank DCO-704 (Re. 3637.7) to advise the receiving facility of the scheduled review date, if any, and the current level of care.

3621 Changes in Classification

When the Utilization Control Committee finds that reclassification of a recipient is warranted, the Office of Long Term Care will provide the findings of the committee to the facility and to the claims processing agent who will make the adjustment to the vendor payments.

3622 Continued Stay in a Facility Not Medically Necessary

When continued stay in a facility is determined not to be medically necessary, the Office of Long Term Care will notify the attending physician, the facility administrator, and the county office by letter. Recipients determined not in need of facility services will be allowed thirty (30) calendar days continued LTC eligibility to arrange for relocation.

The county office will:

1. Provide advance notice of discontinuance of services to the recipient or legal guardian and next of kin (when possible), giving the nature and effective date of the proposed action.

2. Close the LTC case by submitting a DCO-57 and/or DCO-765 for data entry with appropriate entries.

3623 Appeal of Utilization Control Action

Reclassification may be appealed by the facility administrator and attending physician using the same procedure provided for the appeal of the initial classification (MS. 3351).

3625 Continued Stay in a Facility Not Medically Necessary (PASARR)

When continued stay in a facility is determined not to be necessary due to PASARR evaluation, the Office of Long Term Care will notify the recipient or his legal guardian and the facility administrator by letter. The county office will be provided a copy of the recipient/guardian letter of such notifications. Recipients determined not in need of facility services will be allowed thirty (30) calendar days continued LTC eligibility to arrange for relocation.

The county office will:

1. Provide advance notice of discontinuance of services to the recipient or legal guardian and next of kin (when possible), giving the nature and effective date of the proposed action.

2. Close the LTC case by submitting a DCO-57 and/or DCO-765 for data entry with appropriate entries.

3630 Change of Status

The recipient or his representative is responsible for reporting to the county office within 10 days any change which might affect his eligibility for assistance.

The county office will complete appropriate case actions as soon as possible following discovery of a change. When the county office becomes aware of a change, a prompt investigation will be made to assure that appropriate case actions are completed timely.

Other types of recipient changes of status may occur as the result of action taken by the Office of Long Term Care. These actions are specified in different policy sections of this manual.

3631 Advance Notice for Terminations of Assistance

When the county office proposes to terminate Long Term Care assistance for a recipient, advance notice must be mailed to the recipient on Form DCO-700.

The advance notice given on Form DCO-700 must be mailed to the recipient at least ten (10) days prior to the effective date of action unless probable fraud is indicated. Where probable fraud exists, five (5) days prior notice is required. The notice given on the DCO-700 must include a statement of the action the Agency intends to take, the effective date of the action, the reason(s) for the action, the manual policy reference(s) supporting the action, an explanation of the person's right to request a hearing, and an explanation of the circumstances under which assistance is continued if a hearing is requested (Hearing rights are preprinted on the DCO-700).

If a hearing is requested within the advance notice period, the county worker will forward a copy of the DCO-700 with the DCO-1200 and the Hearing File to Central Office Appeals and Hearing and delay action pending outcome of the appeal. If a hearing is not requested within the advance notice period, action will be taken by the Service Representative on the date indicated on the DCO-700.

3632 Advance Notice for Reduction of Assistance

When the recipient's net income increases, advance notice of his increased liability for facility services and of the effective date of change will be given on Form DCO-700. No action will be taken by the county worker before the 10 day advance notice period expires, in order to allow the applicant an opportunity to request a hearing. If a hearing is not requested, the income change will be system entered.

The recipient and/or his representative will be advised of the amount of personal allowance money that he is entitled to keep from monthly income and of his payment obligation to the facility for his care. In addition to prompt reporting when income changes, the recipient will be advised to pay any increased amounts of income to the facility as part of his share of vendor payment, and to keep only the approved amount for a monthly personal needs allowance.

When recipient income has increased, and the increased amount has been paid to the facility, the change in income will be entered on the DCO-765 for data entry, with the new amount effective the first day of the month of change. An informational copy of Form DCO-704 will be provided to the facility by the county office to show the new patient liability and the effective date. When making changes to the recipient income only, do not change the NH Eligibility Start Date.

If the increased recipient income has not been paid to the facility, the income adjustment will be effective the first day of the month of discovery. An over-

payment report will be submitted on the DCO-51 if the recipient has received more than $5.00/month in excess personal needs allowance funds. An informational copy of the DCO-704 will be completed for the facility as previously described.

3633 When Advance Notice is Not Required

Advance notice is not required when:

1. The Agency has factual information confirming the death of a recipient.

2. The Agency receives a clear written statement signed by the recipient that he no longer wishes assistance or that gives information which requires termination or reduction of assistance, and the recipient has indicated in writing that he understands the consequences of supplying such information.

3. The recipient has been admitted or committed to a tax supported institution and is not eligible for continued Medicaid assistance.

   (Note: Individuals age 65 or older and under age 21 may continue to qualify for Medicaid while receiving inpatient psychiatric care from the Arkansas State Hospital, Little Rock or the George W. Jackson Center in Jonesboro. Refer to MS 3637.5 for specific information.)

4. The recipient's whereabouts are unknown and Agency mail directed to him has been returned by the Post Office indicating no forwarding address.

5. A recipient has been accepted for assistance in a new jurisdiction (State) and that fact has been established by the county office.

6. A change in the level of medical care is prescribed by the recipient's physician.

7. A special allowance by the Office of Chief Counsel (exclusion of assets, etc.) granted for a specific period is terminated and the recipient has been informed in writing at the time of initiation that the allowance will automatically terminate at the end of a specific period.

8. Agency action does not propose to discontinue, terminate, or reduce assistance.

3634 Acquisition of Additional Income and Resources

The acquisition of additional income and resources by a recipient will be verified in the same manner used for determination of initial eligibility. Necessary income adjustments or closures will be entered on Form DCO-57 and/or DCO-765 to be submitted for data entry. Advance notice will be given when required for terminations of assistance or increased vendor payment liability.

Refer to: MS 3330 through MS 3339.8 for specific information regarding resource evaluations and changes, etc.; MS 3340 through 3348.1 for specific information regarding income treatment; MS 3349 for specific information regarding the preliminary budget for income eligibility; and MS 3400 for specific information regarding the net income determination (or MS 3338.3 when there is a CS).

3634.1 Case Adjustments for Lump Sum Payments in Prior Months

* When a County Office learns that a recipient received lump sum benefits in a prior month which caused ineligibility for the month of receipt only, it will not be necessary to close the case if the recipient regained eligibility the month following the receipt of the lump sum. If the recipient has lost eligibility for more than one month, then the case will be closed and a new application will be required.

Example: The County Office learns in March 1995 that the recipient received a lump sum payment in January 1995 which caused ineligibility due to excess income but, in February 1995, the recipient's income and resources were below the limits again. The case will not be closed and a new application will not be required because the recipient regained eligibility the month following receipt of the lump sum.

Case adjustments in this situation will be made as follows:

1. Case Adjustment for LTC Ineligibility Period - To adjust the case for the month of ineligibility, an entry should be made in the Retro Income Changes Field (C1 Field, etc.) on WNHU for the month of ineligibility. The county should key the start date as the first day of the month the client was income ineligible, and the stop date as the last day of the month the client was ineligible. The income amount keyed should be the total income received in the month, or one dollar more than the maximum skilled care rate ($2198 in 1995), whichever is greater.

2. No System Case Adjustment is needed for Medicaid categories other than LTC.

3. Overpayments - Overpayment reports for LTC and other Medicaid categories will be submitted to recover any Medicaid payments made during the month of ineligibility (Re. MS 8000). If the facility has retained the lump sum benefits, no overpayment is required to recoup the vendor payments.

When the county has advance knowledge of lump sum payments (e.g., land rent paid annually) that will result in one month of ineligibility, procedures at MS 3341 #1 will be followed, advance notice given, and the case adjusted at the appropriate time.

3635 Completion of Changes, DCO-57 Data Entry Form

The county office will complete Form DCO-57 and/or DCO-765 for data entry to effect necessary case actions and adjustments. The Office of Information Systems will provide Form DCO-57 to the county office for each active case.

If the county office does not have an DCO-57 to effect a case change, the form may be requested on WTUR (Re. DCOUM Appendix C, Screen Summaries).

NOTE: When making income adjustments, do not change the NH Eligibility Start Date on the DCO-57.

3636 Absences from Long Term Care Facilities

All facilities are required to report to the county office certain recipient absences from the facility on Form DCO-702. Absences will be reported for death, discharge, and transfer. Overnight home visits and hospitalizations will not be reported. Admissions to the Arkansas State Hospital (Little Rock) and the George W. Jackson Center (Jonesboro) will be reported as discharges (Re. MS 3637.5).

3637 County Office Responsibilities Following Report of Absence on Form DCO-702

3637.1 Death or Discharge

Upon receipt of Form DCO-702 from the facility reporting the death or discharge of a recipient, the county office will initiate action to close the recipient's case. Advance notice is not required for closure due to death. The county office will:

1. Complete Form DCO-700 (or send system generated DCO-55) to notify the recipient or his next of kin of the case closure or intended case closure and reason for action;

2. Complete Form DCO-57 and/or DCO-765 for data entry to stop facility services on WNHU and to close on WASM (SSI cases will not be closed on WASM);

* 3. Submit a DCO-730 to Medicaid Eligibility Unit, Slot 1223, if the recipient received benefits under an income trust; and

4. Provide assistance to the next of kin in securing a deceased recipient's personal allowance funds and property (if assistance is requested).

3637.2 Home Visits

A recipient receiving long term care services has the right to make overnight home visits whenever he desires, provided they are consistent with his required level of care and his attending physician's orders. This includes authorized home visits during the 30 days in which institutional status is achieved.

The Office of Long Term Care is responsible for monitoring recipient home visits and their consistency with the patient's required level of care. For example, a skilled care patient who makes overnight home visits might require reclassification action by Long Term Care.

Long Term Care services may continue during a recipient's absence due to therapeutic home visit without regard to the cumulative number of days absence during a calendar year. However, a 14 consecutive day limit is placed on each home visit for payment purposes.

Home visits of less than 14 days will <u>not</u> be reported by facilities to the county office. The date left counts as the first day of absence. For home visits which exceed 14 consecutive days, facilities will report the date left and a discharge on the 15th consecutive day of absence on the DCO-702. If the recipient is expected to return to the facility within 90 days of the date left, the facility will also indicate "code 88" by the discharge date on the DCO-702.

When there is no indication that the recipient is expected to return to the facility, the county office will initiate action to close the case as described under MS 3637.1.

When there is an indication that the recipient is expected to return to the facility ("code 88 indicated on the DCO-702), the county office will take action as follows:

1. AABD No Grant

   a. Complete Form DCO-700 to provide advance notice of Medicaid closure.

   b. Complete Form DCO-57 at the end of notice period for WNHU entry to show the Stop Date effective the 15th day of absence and to close on WASM for termination of Medicaid (Reason 88).

2. SSI Recipients

   a. Advance notice by DCO-700 is not required since their Medicaid status is based on receipt of SSI rather than LTC assistance.

   b. Complete Form DCO-57 to show a Stop Date effective the 15th day of absence for WNHU entry. SSI cases will not be keyed for closure on WASM.

   Cases suspended or closed using this procedure can be reactivated without new application if the recipient returns to the facility within 90 days of the date left on home visit (Re. MS 3637.3).

   If the reevaluation falls due during the period of suspension, it will not be completed until the client reenters the facility.

   If the AABD No Grant or SSI recipient does not reenter the facility within 90 days, the case record will be placed in closed files. A new application will be required to reopen the case.

3637.3 Procedure for Reactivating a Suspension Case

When a recipient returns from an extended home visit, the facility will notify the county office of his return on Form DCO-702. To reactivate the suspended or closed case, the County Office will:

1. AABD No Grant

   a. Verify institutional status.

   b. Complete reevaluation, if due, and enter completion date on DCO-57.

   c. Verify current income.

   d. Verify patient classification, the level of care decision date, and a future level of care review date, if applicable, by requesting DCO-704 from OLTC, if a current DCO-704 is not on file.

   e. Complete DCO-57, using Action type B, Reason 95 for reopen of Medicaid on WASM and to reopen facility services on WNHU with the NH county, NH number, patient classification, level of care decision date, level of care review date, if applicable, NH eligibility start date, NH net income, income start date, and any budget changes entered. The Action Type NA will be entered in Field 80 of the DCO-57.

2. SSI Recipients

   a. Complete reevaluation, if due, and enter completion date on DCO-57.

b. Verify current income.

c. Verify patient classification, level of care decision date and a future level of care review date, if applicable, by requesting DCO-704 from OLTC if a current DCO-704 is not on file.

d. Complete DCO-57 to reopen facility Services on WNHU with the NH County, NH Number, patient classification, level of care decision date, level of care review date, if applicable, NH eligibility start date, NH net income, income start date and any budget changes entered. Update WNHU prior to WASM. Action Type NA will be entered in Field 80 of the DCO-57.

3637.4 Hospitalization

Hospitalizations will not be reported to the county office (Exception: State Hospital admissions. Re. 3637.5) by the facility, but will be reported to the claims processing agency for payment adjustments.

If a recipient dies during hospitalization, is discharged to his home or elsewhere from the hospital, or reenters another facility following hospitalization, the facility will report to the county on Form DCO-702 for appropriate county office action (Re. MS 3637.1).

Any terminations due to death or discharge will be made effective the date of death or discharge. The number of hospital days for which the facility will be reimbursed is a determination of the claims processing agent. In all instances of termination following hospitalization, the Stop Date field on the DCO-765 should coincide with the date of death or discharge shown on the DCO-702.

If the county office is notified of a transfer from the hospital to another facility, the county office will not stop services in the Stop Date field on the DCO-765. Re. DCOUM 3726 for transfer procedures.

3637.5 Hospitalization at the Arkansas State Hospital (Little Rock) or the George W. Jackson Center (Jonesboro)

All admissions to the Arkansas State Hospital (Little Rock) and the George W. Jackson Center (Jonesboro) will be reported as a discharge by the facility on the DCO-702 to the county office.

In all cases of reported recipient absence to the State Hospital or the George W. Jackson Center, facility services will be discontinued effective the date the recipient left the facility and will remain suspended until the recipient returns to the facility.

Cases of recipients who are absent to the State Hospital or the George W. Jackson Center will be suspended and be maintained in the county of last facility residence for up to 60 days. For those recipients who return to the facility within 60 days, facility services will be restarted effective the date of reentry. Cases of recipients who do not return to the facility within 60 days will be either closed or transferred to the county of domiciliary residence.

Even though nursing home services may not continue, recipients under age 21 and recipients age 65 or over may qualify for continued Medicaid assistance while at the State Hospital under the same eligibility criteria used for Long Term Care Services eligibility. Recipients aged 21 through age 64 will not qualify for continued Medicaid while at the State Hospital.

Procedures for suspending cases of recipients who have been admitted to the State Hospital are contained in the following paragraphs.

3637.6 Procedures for Suspension of Cases-State Hospital and George W. Jackson Center

The procedure used to suspend a case during a recipient's absence to the State Hospital and the George W. Jackson Center depends on the recipient's aid category and whether continued Medicaid assistance is authorized. Two procedures are employed to account for differences between cases. They are specified by categories according to age.

1. AABD and U-18, AFDC and Foster Care (Cat. 91 or 92), under Age 21 or Age 65 and older, and all SSI Cases. These recipients under age 21 or age 65 or over are eligible for continued Medicaid assistance while receiving inpatient psychiatric care at the State Hospital or George W. Jackson Center. In order to continue Medicaid assistance to these individuals without a disruption of eligibility, the county office will:

   a. Complete the DCO-765 to stop nursing home services on WNHU effective the date the recipient left the facility.

   b. Notify the State Hospital or the George W. Jackson Center by interagency memorandum of the recipient's continued Medicaid eligibility including the recipient's name, his ten-digit Medicaid ID #, his aid category (AA, AB, AD, U-18, AFDC, Foster Care, or SSI), his residence county, D.O.B., SSN, Medicare Claim # and/or other health insurer, facility left, and date he left the facility. Address correspondence to: Director, Social Work Dept., AR State Hospital, 4313 W. Markham, Little Rock, AR 72201; or George W. Jackson Center, 2920 McClellan Drive, Jonesboro, AR 72401.

   c. Maintain the case record in the county of last facility residence until notice is received from the State Hospital by DHS-3300 of readmission to long term care or of other action, or until 60 days of continuous hospitalization.

   d. For recipients who return to long term care prior to 60 days continuous hospitalization, Little Rock or Jonesboro, restart LTC services by completion of DCO-765 for data entry to WNHU, showing the eligibility start date as the date of readmission. The level of care, level of care decision date, and level of care review date, if applicable, as shown on WNHU will be entered, along with current net income, NH county, and NH number. If the level of care review date has passed, a new EMS-704 is required. If the patient is readmitted to a facility other than the one left, the address will be changed on WASM, and the case record transferred on WNHU to the county where the facility is located (Re. MS 3637.7). (Addresses will not be changed for SSI recipients).

   e. Case records of recipients who remain at the State Hospitals for more than 60 days will be transferred to Pulaski South or Craighead County, and the recipient's address will be changed on WASM to that of the appropriate State Hospital. A new DCO-704 will be required before Long Term Care Services can be restarted when the recipient has been hospitalized for more than 60 days and subsequently reenters long term care.

If a recipient is discharged from a State Hospital and does not return to long term care or becomes ineligible for assistance for any other reason, the county office will initiate action to terminate assistance. Advance notice will be given on Form DCO-700 where required.

SSI recipients are included in this section because the Agency cannot terminate their Medicaid status. If termination of Medicaid is required, it will be received from SSA through the State Data Exchange (SDX).

2. AB and AD No Grant Recipients (Age 21 through 64): Recipients age 21 through 64 are not eligible for continued Medicaid assistance while in the State Hospital. All aspects of the suspense procedure described above, including notification of the State Hospital of case status and maintenance of the case record in the county of last facility residence, remain the same with the following exceptions:

a. Submit a DCO-57 with a "Stop Date" effective the date the recipient left the facility, and complete a "Close" action, using Reason 88.

b. Notify the recipient via Form DCO-700 of the case closure due to admission to a public institution.

c. If the recipient returns to a facility before 60 days absence, complete DCO-57, using action type B, Reason 95 for reopen of Medicaid and complete WNHU information by entering level of care, decision date, review date, when appropriate, start date, NH number, net income, and start date.

d. If the recipient does not reenter a facility within 60 days, the case will be placed in closed files. A new application will be required to reopen the case.

3637.7 Transfer

Upon receipt of an DCO-702 from a facility indicating a transfer of a patient from one facility to another, the Service Representative will:

1. Complete form DCO-57 to show "Other" action and address change for data entry on WASM, and to show NH number and NH county (if different) on WNHU. (See note) Do not enter NH Eligibility Start or Stop Dates on WNHU with a transfer action.

2. Complete Sections I, II (Date to be Reviewed, only), and III of a blank DCO-704, mail the original to the receiving facility and file a copy in the case record.

3. Transfer the case record if the receiving facility is in a different county.

A patient may not be transferred from one facility to another within a chain of facilities without approval of the patient (or his responsible relative or guardian where necessary) and the approval of the Office of Long Term Care.

Note: For transfer of SSI cases from one facility to another, no address change will be entered on WASM, but the NH number and NH county (if different) will be entered on WNHU.

2. County Office

Upon receipt of written notification that an agreement will be cancelled and relocation action will be implemented, the county office will:

a. Give priority attention to all relocation actions.

b. Identify all recipients in the facility.

c. Provide the Office of Long Term Care with a list of applicants who reside in the facility but who are not yet certified.

d. Provide casework services to recipients and families. This will include:

(1). Interviewing recipients and families to explain the reason for relocation, obtain a preference for a new facility or area of the state and match the preference facility or area against vacancy lists.

(2). Contacting the new facility and setting a date for receiving recipients. Request the new facility to provide transportation, if available. If not, request local Area Agency on Aging to provide transportation. If unsuccessful in either case, request transportation assistance from the Central Office, Office of Long Term Care.

(3). Insuring that ambulance service is provided when indicated by OLTC.

e. Insure that the sending facility submits a discharge on Form DCO-702 for each recipient.

f. Complete Form DCO-765 or DCO-57 to submit to the data entry for transfer of each recipient (Re. MS 3637.7).

g. Transfer case records to the county office of the receiving county, if applicable.

h. Submit a report of completed action to the Assistant Director, Office of Long Term Care (Re. DCO-768).

i. If relocation is declined, insure that the recipient, a family member, or responsible person, specifies in writing that he does not desire relocation to another facility (Re. DCO-767).

j. Use Form DCO-700 to advise all recipients, family, or responsible person(s) declining relocation to another facility that long term care payment will be discontinued.

k. After advance notice period, take immediate action to close those cases of clients who decline relocation, and submit appropriate documents to the terminal operator and recipients.

l. Contact all recipients who are out of the facility because of hospitalization or home leave to ascertain their relocation preferences. Contact the attending physician for hospitalized recipients and obtain his approval for discussing relocation actions

prior to talking with the recipient. If the attending physician recommends against discussing this action until a later time, follow-up actions will be insured at a later date. Request the hospital to give notice prior to discharging the recipient or when the recipient expires.

m. Priority will be given to hospitalized recipients for relocation in the local area.

3. The Facility

The facility will be requested to provide maximum assistance to include the following:

a. Provide full cooperation with all Agency personnel.

b. Make available all records to Agency personnel.

c. Transfer personal belongings and allowances with each recipient.

d. Provide the receiving facilities a copy of the most recent DCO-704, and a discharge plan for each recipient.

e. Insure maximum assistance is provided in all relocation actions.

f. Insure that all Agency recipients are identified and relocated in an orderly and timely manner.

g. Submit a DCO-702 for each recipient to the county office and Office of Long Term Care, Central Office.

h. Within seven (7) days after the last recipient has been relocated, submit a final adjustment form to show all recipients (relocated, deceased, hospitalized, or on home leave during the 30-day relocation period).

3650 Closure

A case will be closed:

1. Upon the written request of the recipient.

2. Upon notice from another state that the recipient is being certified for assistance in that state.

3. When the county office has factual information that a recipient fails to meet any eligibility requirement.

4. When a recipient has failed to furnish requested information, or comply with other Agency procedures necessary to establish his eligibility after specific written notice (DCO-700) that he must do so.

3650.1 To Close Case:

1. Record pertinent information in case narrative.

2. Give advance notice (DCO-700), if required.

3. Complete DCO-57 for data entry to stop facility services on WNHU and to close on WASM (Exception: SSI cases will not be closed on WASM).

* 4. An informational copy of Form DCO-704 may be provided to the facility indicating the last date of Medicaid coverage and/or facility payment.

5. File the case record in closed file.