0376 OVERVIEW OF MA

0376.05 MANUAL ORGANIZATION

REV:06/1994

Sections 0376 through 0398 of the Manual set forth policies and procedures to determine Medical Assistance eligibility and Medical Assistance payment for services to INSTITUTIONALIZED INDIVIDUALS.

Institutionalized persons in this context refers to individuals who reside in institutional settings, or who receive home and community based services under a Waiver.

The remainder of this section, OVERVIEW OF MA, describes who is considered to be institutionalized for the purpose of determining MA eligibility and the sequence of determinations. This section also lists the terminology for institutionalized persons, the coverage groups and Waiver programs to which they may belong, and services for the relocation of institutionalized individuals;

Section 0378, PRIOR AUTHORIZATION FOR INSTITUTIONALIZED CARE, sets forth the provisions governing prior authorization for institutionalized care, which is a requirement for MA payment of care in certain medical facilities;

Section 0380, RESOURCES GENERALLY, contains general provisions which apply to an institutionalized individual's resources - resource limits, definitions, distinguishing resources from income, determining the countable resources of an institutionalized individual with a community spouse or dependents, resource reduction, and deeming of resources;

Section 0382, EVALUATION OF RESOURCES, sets forth the First Moment of the Month Rule (FOM) and the policies for evaluating specific types of resources;

Section 0384, RESOURCE TRANSFERS, defines resource transfers and when a prohibited transfer may result in a period of ineligibility for MA payment of long term care;

Section 0386, INCOME GENERALLY, contains general provisions which apply to an institutionalized individual's income -- limits, deeming considerations, definitions, and when income is counted;

Section 0388, TREATMENT OF INCOME, describes the various income exclusions and the evaluation of specific types of income such as rental property income and VA payments.

Section 0390, FLEXIBLE TEST OF INCOME, contains the policies governing the spenddown of excess income to achieve Medically Needy eligibility;

Section 0392, POST-ELIGIBILITY TREATMENT OF INCOME, describes how the amount of income that an institutionalized individual must allocate to the cost of his or her care is determined;

Section 0394, SSI-RELATED COVERAGE GROUPS, describes the eligibility requirements and other provisions of the specific SSI- related coverage groups to which an institutionalized individual may belong;

Section 0396, WAIVER PROGRAMS - GENERAL PROVISIONS, contains the eligibility requirements and other common provisions governing home and community-based services;

Section 0398, SPECIFIC WAIVER PROGRAMS, describes the program goals, eligibility requirements, and services of the specific Waiver programs.

0376.10 ELIGIBILITY REQUIREMENTS

REV:01/2002

The rules regarding determinations of eligibility for institutionalized individuals differ from the rules for community residents with respect to:

- Income limits;
- Consideration of the income of an institutionalized individual with a community spouse;
- The procedures utilized in the flexible test of income;
- Evaluation of the resources of an institutionalized individual with a community spouse; and,
- The impact of resource transfers.

In addition to income and resource eligibility, institutionalized applicants for MA must meet the technical and characteristic requirements of the program and require an institutionalized level of care.

The technical requirements for eligibility are:

- o Level of care;
- o Residency;
- o Enumeration;
- o Citizenship/Alienage;
- o Accessing potential income and resources; and,
- o Cooperation in making income/resources available.

An individual must have a characteristic. The characteristics are:

- o Age (65 years or older);
- o Blindness;
- o Disability; and/or,
- o An AFDC-related characteristic.

The Long Term Care Unit within the Division of Medical Services at CO and Long Term Care/Adult Services (LTC/AS) field staff are responsible for determinations involving institutionalized individuals who apply for MA. An institutionalized individual who receives SSI or FIP is automatically Categorically Needy and receives the full scope of services. However, if an eligible institutionalized individual has made a prohibited transfer of resources, the transfer may render the individual ineligible for MA payment of nursing facility care for up to thirty (30) months.

Once eligibility for Medical Assistance and eligibility for payment of nursing facility services is determined, LTC/AS staff evaluate the individual's income to determine the amount the individual must pay toward the cost of care in the institution.

0376.15 CONSIDERED INSTITUTIONALIZED

REV:06/1994

For purposes of determining eligibility for Medical Assistance, the following individuals are considered to be institutionalized from the first day in the medical institution:

- Individuals who receive care, or who are likely to receive care for at least thirty (30) consecutive days in nursing facilities, i.e., Skilled Nursing Facilities, Intermediate Care Facilities (SNF/ICFs), Intermediate Care Facilities for the Mentally Retarded (ICF/MRs), or public medical facilities such as the Eleanor Slater Hospital and Zambarano Hospital;

- Individuals in acute care hospitals who are likely to be in the hospital (or another medical institution) for at least thirty (30) consecutive days, and have applied for nursing or public medical facility placement;

- Individuals in acute care hospitals who are likely to be in the hospital (or other institutional setting) for at least thirty (30) consecutive days, who no longer require acute care and for whom Administratively Necessary Day (AND) payment has been requested by the hospital;

- Individuals who entered the acute care hospital setting from a nursing or public medical facility to receive acute care and who plan to return to a nursing or public medical facility subsequent to the episode of acute care hospitalization.

The following individuals are also considered to be institutionalized for the purpose of determining MA eligibility:

- Individuals who receive home and community-based services under a Waiver; and,

- Children under age eighteen who require an institutional level of care, but who receive services at home (Katie Beckett children).

0376.20 SEQUENCE OF DETERMINATIONS

REV:06/1994

Prior to Medical Assistance payment for the cost of institutional care, it must be determined that the individual requires care in an institutional setting, and that the specific institution is

appropriate for that individual's needs. (See Section 0378, PRIOR AUTHORIZATION FOR INSTITUTIONALIZED CARE).

Three separate financial determinations must be made in order to determine the Medical Assistance benefits for individuals who are institutionalized. The financial determinations are made in the following order:

- First, a determination of eligibility for Medical Assistance as either Categorically or Medically Needy is completed. Because of the broader scope of benefits, a determination of eligibility for the Categorically Needy Program is completed first. If the individual is not eligible as Categorically Needy, a determination of Medically Needy eligibility is completed;

- Second, the impact of resource transfers is evaluated. Eligibility for nursing facility payment (or an equivalent level of care) may be effected by a resource transfer which occurs on or after 10/1/89. (See Section 0384, RESOURCE TRANSFER);

- Third, if eligibility for both Medical Assistance and nursing facility payment exists, the institutionalized individual's income is evaluated to determine how much income must be used to help pay for the cost of care in the nursing facility or public medical facility. The Medical Assistance payment for care in these institutions is reduced by the amount of the institutionalized individual's applied income. This determination is known as the post-eligibility treatment of income. (See Section 0392, POST-ELIGIBILITY TREATMENT OF INCOME).

0376.25 NOTICE OF AGENCY ACTION

REV:06/1994

Each application for Medical Assistance results in a determination of eligibility or ineligibility. If eligible, the scope of services to be provided is determined, i.e. Categorically Needy, Medically Needy, restricted services only for aliens, non payment for nursing facility services due to resource transfers, etc.

Applicants must be notified of agency decisions regarding:

- Medical Assistance eligibility and the effective dates thereof, including the months of eligibility/ineligibility

resulting from the application;

- The scope of services, including eligibility for payment for nursing facility services;
- The amount of income to be applied to the cost of care, and how it was calculated, including the income allocation to the community spouse and/or dependents; and,
- The amount of resources attributed to an institutionalized spouse and to his/her community spouse.

0376.25.05 Timeliness

REV:06/1994

Applicants must receive adequate notice at the time the decisions pertinent to their applications are made. Unless the timely decision time frame has been extended by consent of an individual who is rebutting the presumption of ownership of a joint account, decisions on applications for disabled individuals are made within sixty (60) days. Decisions on applications for all others are made within thirty (30) days.

Recipients must receive adequate and timely (10-day) notice of decisions which result in an adverse action. Adverse actions include closing, reduction in the scope of services, and ineligibility for payment of institutional care services.

0376.25.10 Notice Structure

REV:06/1994

LTC/AS cases frequently require a complex series of decisions relating to eligibility date(s), resource determinations, income to be applied to the cost of care, and allocations to community spouses. A series of attachments supplements the InRHODES system- generated notices of the Medical Assistance program.

The LTC/AS staff utilize the additional special notices:

- Individuals must be notified of the results of the initial determination of total joint resources for couples when the evaluation is conducted in advance of the eligibility determination;

- Applicants must be notified of the attribution of resources between the institutionalized and community spouses at the time of application;

- Applicants must be notified that there may be a period of ineligibility for Medical Assistance as a result of a resource transfer. Recipients must be notified of the period of ineligibility for payment for nursing facility care that results from a prohibited transfer.

0376.30 TERMINOLOGY

REV:06/1994

The following terms, which are listed alphabetically, are used in determining MA eligibility and payment for services:

ADVANCED DETERMINATION OF SPOUSAL SHARE: The determination of the Spousal Share of a couple's Total Joint Resources, conducted prior to the MA application and on the first day of the month in which one member of a couple begins a Continuous Period of Institutionalization.

COMMUNITY SPOUSE: The spouse of an individual in a medical institution whose separation from the institutionalized spouse is due solely to the spouse's institutionalization. For a spousal relationship to exist, there must be a legal marriage under Rhode Island law. A legal marriage may be a ceremonial marriage, or a common-law marriage. For a common-law marriage to exist under Rhode Island law, the following conditions must be met:

- Both parties must be of age;
- Both parties must be otherwise free to marry;
- The parties must hold themselves out to the community to be husband and wife; and,
- The parties must have cohabited at some point.

COMMUNITY SPOUSE RESOURCE ALLOWANCE: The amount of a couple's combined Total Joint Resources which is attributed to the Community Spouse at the time Medical Assistance eligibility is determined for the Institutionalized Spouse.

CONTINUOUS PERIOD OF INSTITUTIONALIZATION: A period of institutionalization which lasts (or is expected to last) at least thirty (30) consecutive days. A continuous period of institutionalization ends when the institutionalized individual is absent from an institutional setting for thirty (30) consecutive days.

DEPENDENT: For purposes of determining the post-eligibility allocation of income, a dependent is defined as:

- The financially dependent minor child of either the institutionalized or community spouse;
- The financially dependent parent of either the institutionalized or community spouse;
- The financially dependent sibling of either the institutionalized individual or the community spouse.

Financial dependency is established if the sibling, parent or child meets the criteria for dependency for federal income tax purposes for either the institutionalized or the community spouse. The dependent must reside with the community spouse in order to receive a dependent's allocation.

INSTITUTIONALIZED SPOUSE: An individual who is in a medical institution and who is married to a spouse who is not in a medical institution or nursing facility.

SPOUSAL SHARE: One half (1/2) of the couple's Total Joint Resources computed as of the beginning of a Continuous Period of Institutionalization. The Spousal Share remains fixed until the institutionalized spouse is determined to be eligible for Medical Assistance, regardless of any changes in the resources of either the institutionalized spouse or the community spouse. At the time of eligibility determination, the Spousal Share is used as one component in the calculation of the Community Spouse Resource Allowance.

TOTAL JOINT RESOURCE: The combined resources of the Community Spouse and the Institutionalized Spouse owned jointly and/or severally, to the extent that either has an ownership interest in the resource(s). Total Joint Resources are normally calculated at two points in the eligibility determination process as follows:

- The first evaluation (referred to as Advance Determination) is conducted as of the first day of the month in which the institutionalized spouse begins a Continuous Period of Institutionalization. The Total Joint Resources are those existing on the first day of the month in which the Continuous Period of Institutionalization begins, regardless of when the evaluation is actually conducted. The Total Joint Resources of the couple (as of the first day of the month in which a continuous period of

institutionalization begins) are divided in half to determine the Spousal Share;

- The second calculation of Total Joint Resources occurs at the point the institutionalized spouse applies for Medical Assistance. At the time of application, as part of the eligibility determination process, the Total Joint Resources of the couple are established as they exist on the first day of the month(s) for which eligibility is being determined.

0376.35 COVERAGE GROUPS

REV:10/1994

The following is a summary listing of the Medical Assistance coverage groups applicable to institutionalized individuals.

Following each listing is a reference to the section where the requirements of that specific coverage group may be found:

- Institutionalized Individuals - SSI Eligible in Community (0394.05)
- Institutionalized Individuals - Not SSI Eligible in Community (0394.10)
- December 1973 Residents of Title XIX Facility (0394.15)
- Continuing Eligibility - Short Term Confinement (0394.20)
- Employed Individuals Receiving SSI Under Section 1619 - Institutionalized in State Operated Facilities (0394.25)
- Institutionalized Individuals AABD Eligible in December, 1973 (0394.30)
- Qualified and Specified Low-Income Medicare Beneficiary (0394.35)
- Qualified Disabled Working Individual (0394.40)
- Disabled Children Receiving Care at Home (Katie Beckett - 0394.45)

Coverage groups also include individuals receiving home and community-based services under one of the following Waiver programs approved by the Health Care Financing Aministration of the U.S. Department of Health and Human Services:

- Home Based Services for the Elderly and Disabled (A&D Waiver) (See section 0398.05)
- Home Based Services for the Mentally Retarded (MR Waiver) (See section 0398.10)
- Home Based Services for the Severely Handicapped (PARI Waiver) (See section 0398.15)
- Home Based Services for Deinstitutionalizing the Elderly (DEA Waiver) (See section 0398.20).

0376.40 RELOCATION OF INSTIT IND

REV:06/1994

The LTC/AS staff has the responsibility to:

- Determine initial and/or continuing eligibility of applicants and/or recipients who reside in a Long Term Care (LTC) facility or who reside in the community under Long Term Care Alternatives (see Section 0396, WAIVER PROGRAMS);
- Provide required medical and social facts to Division of Medical Services for providing care to such recipients; and,
- Report to the LTC/AS Unit Supervisor any questions of quality of care or any indicated deviations from the standards set by the Licensing Authority.

The LTC/AS workers have an ongoing responsibility to provide service to recipients in nursing facilities and individuals receiving home-based services under the Long Term Care Alternatives Program.

Individuals receiving services under Long Term Care Alternatives are Group I and Group II. Group I is active SSI recipients who, as of January 1, 1982, had been previously diverted from entering a nursing facility through Home Maker Services, and meet the financial and non-financial eligibility criteria for Categorically Needy MA. No new beneficiaries may be added to Group I. Group II is individuals who

qualify for nursing facility care, meet the financial and non-financial criteria for Categorically Needy MA and the criteria for Long Term Care Alternatives Program, and who choose home-based services in lieu of institutional care. When home-based care is no longer needed, it is the responsibility of the LTC/AS worker to plan with the recipient concerning his/her discharge from the home.

0376.40.05 Involuntary Relocation

REV:06/1994

The relocation of patients necessitated by the decertification of a nursing or ICF/MR facility for Title XIX funds requires detailed social service planning in order to minimize the disruptive effect of the transfer. The Department will, upon request, provide social services necessary to plan and complete relocation. Every effort must be made to achieve a solid plan based on the patient's individual needs. The planning considers several factors. These factors include nursing facility and ICF/MR vacancies, location of the facility, the patient's medical condition, and proximity to visiting relatives and friends. Relevant planning data should be consolidated from all potential authority, relatives, etc.

The following activities occur:

- The patient and patient's family must be notified in writing immediately as to the status of the facility with respect to decertification. The letter should indicate the inability of DHS to pay for the care thirty days following decertification, and also inform the patient and family that LTC staff will provide service for relocation at any time during the thirty day period that the patient and/or family requests it.

- Since the patient's case record contains all current and pertinent medical and social data, it must be carefully reviewed to identify all factors necessary for a sound relocation plan. If it is determined from this review, from consultation with the patient, the patient's family or attending physician that a change in level of care is appropriate, the LTC/AS supervisor will request that the case be re-evaluated by the DHS Review Team.

- Sufficient casework service will be provided to reduce as much as possible the anxiety level of the patient and assure that the patient understands to his/her capacity the necessity for relocation. Staff must be sensitive to

the potential impact of the relocation on the patient. The patient's attending physician will be notified of the pending relocation and requested to provide information regarding any special medical considerations related to the relocation. Involvement of the patient, and the patient's family is paramount. The significance of the family's involvement in the planning should be emphasized. At least one contact, or as many as necessary to effect the relocation plan, will be made with the patient's family, where available. In most instances where the patient is competent and wishes that the family not be involved, the patient's wish is to be honored.

- Care should be taken to sensitize the staffs at the current and prospective facilities to the seriousness of the impact of relocation. They should be encouraged to provide whatever additional support the patient may require in dealing with the stress of uncertainty about the future.

- The caseworker should prepare the patient by providing as much information about the new facility as the patient needs and/or can absorb. Information may include the prospective facility's policies with respect to personal needs, money, laundry, visiting hours, etc. If brochures or photographs are available, they should be shown to the patient. In those instances where a group of patients from a decertified facility will all be transferring to the same facility, group meetings can be held to answer questions about the new facility.

- To the maximum extent possible, the prospective facility selected should be in close geographical proximity to the decertified facility, to avoid disrupting visiting patterns of the patient's relatives and friends. Every effort will be made to relocate together patients who wish to be placed in the same facility.

- Planning for mentally retarded patients must be coordinated with appropriate MHRH field staff in order to ensure that no disruption of other related special services occurs.

- All activities with respect to relocation, including date, time, place and details for planning must be included in the case record.

- LTC staff will undertake the activities set forth in the preceding bulleted paragraphs before concluding that the patient has knowingly refused to accept relocation planning from LTC staff.

- If medically feasible and if a family member or other appropriate person is available to bring the patient for an on-site visit, it can be very helpful in reducing the patient's anxiety.

- Several appropriate alternatives for transporting patients to the new facility are available. The responsible attending physician should be consulted to determine if the patient requires an ambulance. Voluntary transportation resources in the community should be mobilized, where appropriate, to effect the actual move. Suitable plans for a relative or other appropriate person to transport the patient can be arranged. Unusual problems with transportation should be referred to the Supervisor of LTC services for resolution.

- Appropriate follow-up casework service, after the transfer, is imperative. The social worker must provide whatever support is necessary to ensure adjustment to the new facility.

- Before planning begins, each patient should be notified of the planning process and informed that, if s/he is dissatisfied with any aspect of the contemplated plan, s/he has a right to appeal through the fair hearing process.

0376.40.05.05 Involuntary Relocation Restrictions

REV:06/2000

The Nursing Home Resident Protection Amendments of 1999 prohibit the transfer or discharge of residents from a nursing facility as a result of the facility's voluntary withdrawal from participation in the Medicaid Program.

Individuals residing in a nursing facility on the day before the effective date of the facility's withdrawal from MA participation may not be transferred or discharged as a result of the facility's withdrawal. This includes residents receiving MA benefits at the

time, as well as individuals who are residents but not yet eligible for MA.

To continue receiving MA payments, the nursing facility must comply with all Title XIX nursing facility requirements related to treating patients residing in the facility in effect at the time of its withdrawal from the program.

Involuntary relocation of a resident patient is permitted when the basis for discharge or transfer is:

* to meet the resident's welfare and that welfare cannot be met in the facility;

* the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

* the safety of individuals in the facility is endangered;

* the health of individuals in the facility would otherwise be endangered;

* the resident has failed, after reasonable and appropriate notice, to pay (or have paid by Medicare or Medical Assistance) for a stay at the facility; or

* the facility ceases to operate.

Individuals admitted to the nursing facility on or after the effective date of the facility's withdrawal from the MA program must be provided with notice that:

1) the facility no longer participates in the MA program with respect to that individual; and,

2) the individual may be discharged or transferred if unable to pay the facility's charges even though the individual may have become eligible for MA.

This information must be provided to the individual both verbally and in a prominent manner in writing on a separate page at the time of admission. A written acknowledgment of the receipt of the notice, signed by the individual (and separate from other documents signed by the individual) must be obtained.

0376.40.10 NF Patient Appeal Rights

REV:06/1994

Section 1919 (e) (3) of the Social Security Act requires States to provide appeal hearings for all nursing facility residents who wish to challenge their transfers or discharges. By statute, the appeals process cannot be limited to only Medical Assistance eligible nursing facility residents. Therefore, DHS will conduct administrative hearings for any NF resident who wishes to appeal a transfer or discharge from the facility, whether Medical Assistance or Medicare eligible, or private pay.

0376.40.10.05 Transfer Discharge Criteria

REV:06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- The health of individuals in the facility would otherwise be endangered.

The basis of the transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.10 Documentation Requirements

REV:06/1994

The basis for the transfer or discharge must be documented in the resident's clinical record by the resident's physician if:

- The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

- The health of individuals in the facility would otherwise be endangered;

The basis or transfer or discharge must be documented in the resident's clinical record if the safety of individuals in the facility is endangered.

Each nursing facility must display a notice which identifies the transfer and discharge criteria and informs residents of their appeal rights. The notice should be prominently posted along with the Patient's Bill of Rights.

0376.40.10.15 Pre-Transfer/Discharge Notice

REV:06/1994

Before effecting a transfer or discharge of a resident, a nursing facility must:

- Notify the resident (and, if known, an immediate family member or legal representative of the resident) of the transfer or discharge and of the reasons for the move; and,

- Record the reasons in the resident's clinical record (including any required documentation).

The nursing facility must notify the resident by use of a PRE-TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF) at least thirty (30) days in advance of the resident's transfer or discharge. At the time the patient receives the Pre-Transfer or Pre-Discharge Notice, s/he receives at the same time a NOTICE OF YOUR TRANSFER AND DISCHARGE RIGHTS (DHS-200NF) and a copy of REQUEST FOR A HEARING (DHS-121NF).

Thirty (30) day advance notice is not required under the following circumstances:

- In the event of danger to the safety or health of the

individuals in the facility;

- When the resident's health improves sufficiently to allow a more immediate transfer or discharge;
- Where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs;
- When the resident has not resided in the facility for a period of at least 30 days.

In the case of such exceptions, notice must be given as many days before the date of the move as is practicable, and include:

- The right to appeal the transfer or discharge through the administrative appeals process;
- The name, mailing address, and telephone number of the State long-term care ombudsman.

In the case of residents with developmental disabilities, the pre-transfer or pre-discharge notice must include:

- The mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals.

The resident must request an appeal within thirty (30) days of the date of the pre-transfer/discharge notice.

0376.40.10.20 Adminis Appeals Process

REV:06/1994

The Department of Human Services will conduct administrative hearings for any nursing facility resident who wishes to appeal a transfer or discharge from the facility. The patient or patient's representative may request a hearing by completing Sections I and II of DHS form, REQUEST FOR A HEARING (DHS-121NF). The hearing request form should then be routed promptly to the Department of Human Services, Hearing Office, 600 New London Avenue, Cranston, RI 02920. Upon receipt, the Hearing Office will date stamp the form and send a copy with a letter to the nursing facility instructing the facility to complete Section III and return the form to the Hearing Office within seven (7) days.

The request for a hearing must be submitted within 30 days of the date of the PRE-TRANSFER or PRE-DISCHARGE NOTICE (DHS-100NF). If the

request is submitted within 10 days of the date of the PRE- TRANSFER OR PRE-DISCHARGE NOTICE (DHS-100NF), the patient will remain in the facility pending the decision of the Hearing Officer.

The administrative hearing generally will be conducted at the resident's nursing facility unless otherwise requested by the patient or the patient's representative. Official notice of the hearing is sent to all parties involved at least five (5) days prior to the scheduled hearing date.

0378 INSTITUTIONAL CARE

0378.05 PURPOSE OF PRIOR AUTHORIZATION

REV:08/1998

Prior authorization is required for the Rhode Island Medical Assistance Program to provide payment for the care of Categorically and Medically Needy recipients in certain medical facilities. The purpose of prior authorization is to insure that the individual is placed in a facility appropriate to his/her service needs. Therefore the authorization process includes:

- Evaluating the recipient's needs for institutional care and the type of facility required;
- Screening potential nursing facility candidates for mental illness and mental retardation (PASRR);
- Authorizing Medical Assistance and vendor payments;
- Conducting periodic evaluations of the patient's needs.

0378.05.05 Authorization Responsibilities

REV:08/1998

The district office Long Term Care/Adult Service (LTC/AS) units:

- Determine financial eligibility for MA;
- Determine patient income to be allocated to the cost of institutional care;
- Authorize vendor payments to nursing facilities;
- Assist in the evaluation of medically necessary care;

- Assist in placement of eligible individuals; and,

- Provide social services for applicants and recipients of long term care.

The Office of Medical Review (OMR):

- Establishes the need for nursing facility care by an applicant or recipient prior to authorizing payment; and,

- Ensures that the PASRR Preadmission Screening requirement is completed.

0378.10 TYPES OF FACILITIES

REV:08/1998

The Medical Assistance Program provides payment for the care of MA recipients in the following types of nursing facilities:

- Nursing Facilities (NF)

  A patient qualifies for nursing facility care if s/he requires the services of professional or qualified technical health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, audiologists, or s/he requires assistance with activities of daily living. Activities of daily living include walking, bathing, dressing, feeding and toileting. The facility must provide these services under the supervision of licensed nursing personnel.

- Intermediate Care Facility for the Mentally Retarded (ICF/MR)

  A patient qualifies for an ICF/MR level of care if s/he is mentally retarded, and requires supervision and/or assistance with activities of daily living.

The Medical Assistance Program also provides payment for medically necessary care in the following Public Medical Facility:

- Eleanor Slater Hospital.

Patients in NFs, ICF/MRs, the Public Medical Facility and certain Waiver programs are considered to be institutionalized for purposes of determining eligibility for Medical Assistance. The Medical Assistance payment for institutional care is reduced by the amount of the individual's income after certain allowable expenses are deducted.

0378.15 DETERMINING CARE REQUIREMENTS

REV:08/1998

Procedures for evaluating the type of care required by an individual will vary, depending on whether the individual requests placement from a community setting or while a hospital in-patient.

0378.15.05 Evaluating Needs, Hospital Patients

REV:03/1999

This policy section applies to the following individuals seeking nursing facility placement from a hospital:

- Individuals seeking initial NF placement;
- Individuals who left a NF to enter assisted living, and are now seeking readmission to a NF;
- Individuals who left a nursing facility to return to the community for other than short term social or therapeutic stays, and are now seeking readmission to a NF.

Discharge staff at Rhode Island acute care hospitals have been delegated the authority to make preliminary evaluations of the need for nursing facility care. At the time of discharge to a nursing facility, the hospital social worker or nurse:

- Completes the CP-1 evaluation instrument;
- Sends the original CP-1 and a copy to LTC/Office of Medical Review unit at C.O., along with the PASRR ID screen (See Section 0378.25), a notification of recipient choice (CP-12) and an Inter-agency Referral form;
- Sends a copy of the CP-1, the PASRR forms, and the interagency referral form with the patient to the facility.

Upon approval of the CP-1 evaluation by the Nurse Consultant in the DHS Office of Medical Review (OMR), nursing facility payment is authorized. Copies of the CP-1 and CP-12 are sent to the DHS district office.

Out-of-state hospitals send the PASRR required forms, copies of the medical (72.1) and social worker(70.1) forms, and/or other comprehensive assessments to the DHS Nurse Consultant in the DHS Office of Medical Review. Upon approval, the MA-510 (Authorization for a Level of Care in a Nursing Facility) is completed by the DHS Nurse Consultant and forwarded to the appropriate DHS district office.

When the approved CP-1 or MA-510 is received in the district office, the worker notifies the applicant or recipient of the decision and, if necessary, assists in the placement.

The level of care information is entered to the InRhodes system via the STAT/CARE panel.

Note: MA recipients who have been admitted to the hospital from a nursing facility and are being discharged to the same or another NF are considered to be continuously institutionalized and a new evaluation (CP-1) is not required at the time of their readmission to the NF.

0378.15.10 Evaluating Needs, Community Applicants

REV:08/1998

When a person residing in the community requests direct placement into a nursing facility, the following documentation is assembled by LTC/AS staff and transmitted to the OMR unit at CO:

- A medical evaluation of the applicant by a physician, Form AP-72.1;
- An evaluation completed by the LTC/AS unit social worker establishing the applicant's functional abilities, living arrangements and service needs, Form AP-70.1;
- PASRR ID Screen (MA/PAS-1). (See Section 0378.25);

If an emergency placement is indicated, the worker contacts the LTC/OMR Unit for emergency authorization of nursing facility placement. Otherwise, as soon as the documentation is received by the

LTC/OMR Unit, the Nurse Consultant reviews the evaluations and determines the need for nursing facility care. The decision is transmitted to the LTC/AS staff on Form MA-510, Authorization for Care in a Nursing Facility.

When the MA-510 is received in the district office, the worker notifies the applicant or recipient of the decision and, if necessary, assists in locating a suitable facility. If space is not available, the worker places the individual's name on a waiting list.

The level of care information is entered to the InRHODES system via the STAT/CARE panel.

0378.15.15 Evaluating Needs, ICF-MR Care

REV:08/1998

Caseworkers at the Department of Mental Health, Retardation, and Hospitals are authorized to determine an individual's need for ICF/MR level of care. The caseworker completes the CP-1 form, and forwards it and the PASRR ID Screen to the LTC/OMR Unit at C.O. for review and approval.

The level of care information documented on the CP-1 is entered to the InRHODES system via the STAT/CARE panel.

0378.15.20 Re-Evaluation of Needs

EFF:04/2006

When the Office of Medical Review (OMR) in the Center for Adult Health determines that an individual meets a nursing facility level of care and/or that a full Identification Screen has been received, the OMR Nurse Consultant designates those instances in which the individual’s medical information indicates the possibility of significant functional and/or medical improvement within two (2) months. The OMR maintains all records of pending and completed reviews including all cases requiring future review.

Notification is sent to both the individual, his/her authorized representative and the Nursing Facility by the OMR that a Nursing Facility level of care has been approved, but functional and medical status will be re-reviewed in thirty (30) to sixty (60) days. At the time of the review, the OMR Nurse Consultant must first confirm that the individual remains a resident of the nursing facility. For clients remaining in a nursing facility, the Nurse Consultant reviews

the most recent Minimum Data Set and requests any additional information necessary to make one of the following determinations:

1. The individual no longer meets a nursing facility level of care. In this instance , the Long Term Care Office is notified of the Level of Care denial, and the individual, his/her authorized representative if one has been designated, and the nursing facility are sent a discontinuance notice by the Long Term Care Unit. Any fair hearing appeal requests resulting from this Level of Care discontinuance notice will be defended by the Office of Medical Review.

2. The individual continues to meet a level of care, and no action is required.

0378.20 AUTHORIZATION OF MA PAYMENT

REV:08/1998

Level of care information (and PASRR information for individuals whose authorized level of care is a nursing facility) is entered to InRHODES and maintained via the STAT/CARE panel.

LTC/AS unit staff approve MA eligibility for institutionalized individuals and authorize vendor payments on behalf of the individual via the InRHODES ELIG/AUTH panel, provided a prohibited resource transfer does not prevent Medical Assistance payment for the cost of nursing facility care.

If payment to the nursing facility will be made, the worker determines the amount of the patient's income which must be applied to the cost of nursing facility services. The Medical Assistance payment for care in a nursing facility is reduced by the amount of the patient's applied income. See Section 0392, POST-ELIGIBILITY OF INCOME, for policy regarding allocation of income to the cost of institutional care.

0378.20.05 Payment for Nursing Facility Services

REV:08/1998

Special attention must be paid when a recipient who has Medicare coverage is a resident of a nursing facility. If Medicare coverage is authorized, then Medicare payment for the NF services must be utilized before Medical Assistance payment will be made.

For patients requiring "skilled" services, Federal Medicare helps pay for up to a maximum of 100 days in a participating nursing facility per spell of illness. For persons enrolled in Part A of Medicare, hospital insurance pays for all covered nursing facility services for the first 20 days, if approved. Medically necessary care for the balance of 80 days requires a co-insurance payment. Medical Assistance will pay a recipient's "co-insurance" for approved skilled nursing days if the patient has insufficient income, and no "Medigap" coverage.

0378.20.05.05 Payment to Long Term Care Facilities

REV:08/1998

Each nursing facility has a per diem rate established by the Rate Setting Unit within the Division of Medical Services, determined on the basis of the cost of operating the facility. The payment to the facility is made for all persons authorized to receive service in the facility.

Payment is made for the day of admission to the facility, regardless of the hour, but is not made for the day of discharge, regardless of the hour.

0378.20.05.10 Bed-Hold Days

REV:08/1998

When a patient goes to the hospital or otherwise temporarily leaves a LTC facility, the Agency makes no payment to retain a bed for the patient's return to the facility.

0378.20.10 Notice of Patient Placement or Discharge

REV:08/1998

When a patient has been placed directly from his/her home into a nursing facility, the LTC/AS worker identifies the facility on the AP-510 or CP-1 form, sends one copy of the AP-510 or CP-1 to the facility, and files a remaining copy in the case record.

0378.20.10.05 Facility's Notice of Admission or Discharge

REV:08/1998

Each facility administrator is required to send a Notice of Admission (MA-602) to the appropriate DHS district office LTC unit whenever a recipient is admitted. The Admission Notice contains identifying data

about the person and information pertaining to his/her eligibility for Medicare benefits.

The facility administrator is required to send a Notification of Discharge (MA-603) to the appropriate DHS district office LTC unit when care is no longer required and/or the person is discharged from the facility. Payment is not made to the facility for the day of discharge, regardless of the hour.

0378.20.15 Payment to Other Vendors or Facilities

REV:01/2002

The district office LTC/AS units authorize vendor payments through MMIS to other types of vendors/facilities via InRHODES. Medicare does not provide payment for other than nursing facility services.

0378.25 PREADMISSION SCREEN/RESIDENT REVIEW (PASRR)

REV:01/2002

All new candidates for admission to a nursing facility (NF) must be screened for mental illness and mental retardation prior to admission. The procedure is known as the Preadmission Screening and Resident Review (PASRR).

PASRR has three major purposes which are:

- To assure that all candidates for admission to nursing facilities are properly screened for the existence of mental illness or mental retardation;
- To prevent the inappropriate admission to nursing facilities of patients with mental illness or retardation; and,
- To assure that proper treatment plans for inpatients in nursing facilities who have mental illness or mental retardation are formulated and adjusted when necessary to meet treatment needs.

Medical Assistance cannot authorize a payment to a facility on behalf of a patient if the PASRR screening is not complete.

An individual cannot be admitted to a nursing facility if it is determined by the Level II evaluation process that the individual's

needs for specialized services for mental illness and/or mental retardation cannot be appropriately met in the nursing facility.

0378.25.05 Preadmission Screen - Levels of Evaluation

REV:08/1998

Preadmission screening has two levels of evaluation--the Level I PASRR ID Screen and the Level II evaluation.

0378.25.05.05 PASRR Level I Evaluation - ID Screen

REV:01/2002

Thirty (30) Day ID Screen Exemption

The Level I PASRR process is required on all nursing facility applicants unless the applicant is an individual:

a) who is admitted to a NF directly from a hospital after receiving acute inpatient care at the hospital, AND;

b) who requires NF services for the condition for which the individual received care in the hospital, AND;

c) whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of NF services.

Such individual is EXEMPT from the pre-admission screening aspects of PASRR. It is not necessary to complete either an ID screen or a Level II PASRR on these individuals. Complete page one of the ID screen, including the physician validation section; and return to the Department of Human Services with the appropriate Level of Care determination (i.e., CP-1 or AP-72.1/70.1).

If the patient is found to require longer than 30 days, an ID screen is due on the 25th day after admission. When this ID screen indicates or suggests a serious mental illness, arrangements must be made for an immediate Resident Review (RR).

The PASRR ID Screen is the Level I evaluation instrument to screen for mental illness or mental retardation, and must be completed by a health care professional and signed by a physician for every patient prior to admission to a nursing facility. For patients seeking admission to a nursing facility from a hospital, the PASRR ID Screen accompanies the Interagency Referral Form and the CP-1 for hospital

placements. For individuals seeking placement from the community, the PASRR ID Screen is form MA/PAS-1.

The PASRR evaluation stops at the Level I for those patients who do not have either condition.

The Level II PASRR evaluation process must be completed for individuals who have mental illness or mental retardation UNLESS one of the following three conditions exists:

Delirium - If the individual has delirium to the extent that an accurate diagnosis cannot be made until the delirium clears, or,

Dementia - If the individual has a PRIMARY diagnosis of dementia according to the DSM IV criteria (including Alzheimer's Disease or related disorders) or this individual has a Primary Diagnosis of an illness other than mental illness and a diagnosis of dementia (including Alzheimer's Disease or related disorder); AND a serious mental illness is not a primary problem. The Dementia exemption does not apply for the MR PASRR process.

Respite Care - If the individual is admitted for respite care and is projected to require a stay of less than 30 days.

If the delirium exemption applies, a new ID Screen is required when the delirium clears, but no later than the 30th day after NF admission. In the case of a client who was admitted under the delirium exemption and for whom a psychiatric diagnosis could not be initially determined, an ID Screen is required at the point that the delirium clears. If this identifies or suspects serious mental illness, arrangements should be made for an immediate Resident Review (RR). In all cases, the ID screen and RR are required not later than 30 days after admission. In this case, recommendations for medical and psychiatric follow-up at the nursing facility must be made prior to admission.

If the dementia exemption applies, the name of the physician confirming the diagnosis must be on the ID Screen. Supportive documentation to confirm the diagnosis must be included in the ID Screen evaluation packet. This may include a completed Folstein Mini Mental State or Cognitive Capacity Screening Examination (CCSE) or documentation of symptoms or physical findings to support dementia or

a related disorder. No further Level II screening for Mental Illness is required.

In addition, some individuals who have either or both conditions will have somatic medical needs which indicate a categorical determination of NF level of care.

The entire Level II PASRR evaluation process as described in Section 0378.25.05.10 must be completed for individuals who have mental illness or mental retardation UNLESS one of the following conditions exists:

- The patient is being admitted to the nursing facility for care of a terminal illness, and has a life expectancy of less than six (6) months;

- The patient is being admitted to the nursing facility for care of an illness so severe that active treatment for mental illness or mental retardation is precluded.

If one of the exception conditions exist, a part of the Level II evaluation is necessary prior to nursing facility placement. (As described in Section 0378.25.05.10.)

Completion of the ID Screen ends the PASRR evaluation for those individuals not identified as having mental illness or retardation, and those individuals meeting an exception condition. The following actions must then occur:

- A copy of the completed PASRR ID Screen is submitted to the Office of Medical Review at C.O. along with the CP-1 (or for community placements, the AP-70.1 and AP-72.1).

- The ID screen is forwarded by the hospital, LTC unit or placing agent to the nursing facility when the patient is placed.

0378.25.05.10 PASRR Level II Evaluation

REV:01/2002

Those patients identified by the Level I evaluation as having mental illness or mental retardation and not meeting one of the exception conditions must be further evaluated to assure that nursing facility placement is appropriate. The Level II PASRR evaluation involves completion of a more detailed patient assessment instrument which is

evaluated by staff at the Department of Mental Health, Retardation, and Hospitals (MHRH).

The Division of Integrated Behavioral Health Services (DIBHS) is the state agency charged with making the final determination of whether mental illness exists, and the Division of Developmental Disabilities (DDD) is the state agency responsible for determining if mental retardation exists. DIBHS and DDD also make the final decision regarding placement at a particular facility.

Level II pre-admission requirements must be completed prior to admission unless the individual is admitted under emergency protection services. Individuals who are admitted under emergency protection services must have a PASRR Level II completed within 7 days of admission. In these cases, the nursing facility must have documentation of the need for protective services in addition to the materials required for a routine pre-admission Level II or for an initial Resident Review.

To meet this requirement for an individual identified or suspected of having a serious mental illness, the facility can either forward the pre-admission Level II directly to the DIBHS for a determination, as long as the Level II is not completed by staff of the nursing facility, or, forward the Notification of Need for Resident Review (MA/PAS-3.2) to the Department of Mental Health, Retardation and Hospitals (MHRH), Division of Integrated Behavioral Health Services (DIBHS) and the Department of Health (DOH).

The Level II evaluation procedure varies, depending on the individual's diagnosis. Both procedures described below must be followed for persons diagnosed as having mental illness, mental retardation, or both:

- The Level II evaluation instrument for individuals identified by the ID Screen as having mental illness is the Level II PASRR-MI Evaluation (MA/PAS-2). A copy of the completed MA/PAS-2; along with a copy of MA/PAS-2.1 and MA/PAS-2.2 or equivalent; and a copy of the PASRR ID Screen are forwarded by the MI PASRR contact person to DIBHS for decision;

- The Level II evaluation instrument for individuals identified by the ID Screen as having mental retardation and/or a developmental disability is the PASRR (MR) Level II Data Sheet. The completed Level II Data Sheet and a copy of the PASRR ID Screen are forwarded by the MR PASRR contact person to DDD, along

with any other appropriate documentation, for decision.

Both DDD and DIBHS may require additional evaluation material prior to making a final determination. When a decision on the diagnosis and placement is made, DOH or DDD will notify the referring agent and the Office of Medical Review at C.O.

For Medical Assistance applicants/recipients pending admission to nursing facilities from hospitals, the PASRR ID Screen and any necessary Level II evaluation is completed by hospital staff. If no Level II evaluation is required, a copy of the ID Screen is forwarded to the Office of Medical Review at C.O. along with the CP-1 and Inter-agency Referral form, for evaluation of the type of care required.

If required, a copy of the Level II evaluations, with a copy of the ID Screen, are forwarded directly to the appropriate division of MHRH, as described above.

For Medical Assistance, applicants/recipients pending admission to nursing facilities from community settings, the physician completing the AP-72.1 completes the ID Screen. If no Level II evaluation is needed, LTC/AS staff forward the screening instrument together with the AP-70.1 and AP-72.1 to the Office of Medical Review at C.O. Any necessary Level II evaluations are forwarded directly to the appropriate division of MHRH as described above. When LTC/AS staff receive either the determination notice from DIBHS or the Level II Screen/PASRR (MR) from DDD, the AP-70.1 and AP-72.1 are then forwarded to the Office of Medical Review at C.O. for approval of nursing facility care.

0378.25.05.15 Severe Illness and Serious Mental Illness

REV:01/2002

Severe Illness Categorical Determination of NF Level of Care and Serious Mental Illness

For patients who are admitted for care of a terminal illness with a life expectancy of less than six months and who require NF care or for patients who require care for a severe illness which results in a level of impairment so severe that the individual could not be expected to benefit from specialized services only a part of the Level II PASRR is required.

"Severe illness" includes, but is not limited to: comatose, ventilator dependent, functioning at the brain stem level, chronic obstructive

pulmonary disease, Huntington's disease, Parkinson's disease, amyotrophic lateral sclerosis, and congestive heart failure.

Required PASRR paperwork for individuals with a categorical Determination of Level Of Care for severe or terminal illness is as follows:

a) ID Screen (MA/PAS-1). The ID Screen Update (MA/PAS-1.1) may be used as a supplement to update the ID Screen.

b) Client Notification of PASRR Level II Screen (MA/PAS 1.2)

c) Pages 5 and 6 of PASRR Level II Screen (MA/PAS-2)

d) PASRR Level II Psychiatric Requirements (optional MA/PAS-2.2)

Send the entire PASRR package to the DIBHS prior to discharge for a determination of need for specialized service.

Required documentation to be sent to DHS, Office of Medical Review, 600 New London Avenue, Cranston, RI 02920, for Determination of Level Of Care includes:

- CP-1, an Interagency Form and a completed ID Screen for a patient admitted from a hospital; or,

- 72.1, 70.1 and a completed ID Screen for a patient admitted from the community.

0378.25.05.20 PASRR-MR/DD Process

REV:08/1998

Though PASRR-MR/DD (Mental Retardation/Developmental Disabilities) shares the overall objectives in the description of the PASRR program in general, there are some differences with respect both to the procedure of completing the PASRR process and the nature of the overall focus of the PASRR-MR/DD program as well.

The Division of Developmental Disabilities (DDD) is responsible for the provision of those services which will enhance the quality of life for persons with developmental disabilities as well as for the maximization of their potential for inclusion and participation in community life. The role of PASRR within the framework of services

provided by DDD is to ensure the quality of care of those residing in nursing facilities with the diagnosis of MR/DD and to certify that a nursing facility is the most appropriate and least restrictive residential setting.

With respect to the PASRR-MR/DD process, the following procedural points should be noted. When an I.D. Screen identifies or suggests MR/DD, a complete pre-admission screen includes:

- An Identification Screen, which is completed by the referring agency;
- A PASRR-MR/DD Level II Data Sheet, which is completed by the referring agency and includes the results of cognitive testing and a social history, if available;
- A PASRR-MR/DD Level II Screen - to be completed by the DDD PASRR representative. It should be noted that in order to complete this form, the PASRR representative from the MHRH Division of MR/DD must meet both with the individual who is in need of nursing facility services as well as the referring agent.

If a person should require hospitalization after admission to a nursing facility, a new PASRR will not be needed unless the hospital admission is the result of the person's developmental disability.

EXEMPTION

There are certain exemptions on the I.D. Screen, that dispense with the need for a Level II PASRR evaluation (see Section 0378.25.05.05). The dementia exemption does not pertain to the MR/DD PASRR process. A Level II Screen will be necessary for individuals who have this diagnosis.

0378.25.10 RESIDENT REVIEW (PASRR)

REV:01/2002

When there is a significant change in a resident's physical or mental condition, nursing facilities (NFs) must make a clinical judgement whether the change in the resident's condition warrants a Resident Review (RR).

Formerly, nursing facilities were responsible for arranging for an annual review of their residents with Serious Mental Illness (SMI) or with Mental Retardation/Developmental Disabilities (MR/DD) to assure that a resident had been properly diagnosed regarding the presence of

mental illness and/or mental retardation, and to assure that active treatment needs were being met if either condition were present. Congress amended Section 1919(e)(7)(B) of the Social Security Act to rather require that Resident Reviews (RRs) be conducted promptly after a nursing facility has notified the state authority that a resident has had a "significant change in condition" affecting their physical or mental status.

The change from an annual review to a review upon a "significant change in condition" provides the flexibility to time evaluations and determinations when they are needed. However, RRs are still required by MHRH with certain conditions.

MR/DD Resident Review

If there is a question of a significant change in a resident's physical or mental status, the nursing facility is instructed to contact the MHRH Division of DD PASRR representative to determine if a resident review is necessary.

Given the nature of DDD services, significant change has other considerations in addition to a change in an individual's physical or mental status. The purpose of the PASRR MR/DD program is to assure the quality of care of persons with developmental disabilities who reside in nursing facilities. In addition, the program ascertains that nursing facility care is necessary as well as the choice of the resident. Less restrictive residential options, if appropriate, are offered for consideration. Resident reviews are warranted in order to ensure quality care as well as to determine the need for residential alternatives.

Resident reviews for MR/DD individuals are conducted on a periodic basis. The PASRR MR/DD representative will contact the nursing facility and make arrangements for visitation and consultation. It is the responsibility of the nursing facility to complete the PASRR Level II Resident Assessment Form prior to the visit.

0378.25.10.05 Treatment Needs Indicate Significant Change

REV:08/1998

Treatment is geared to help a resident meet his/her highest practicable level, improve when possible, and prevent avoidable decline.

Treatment needs which may indicate the need for a Level II Resident Review (RR) are listed below.

- o 1 to 1 monitoring;
- o 15 minute checks;
- o Close patient observation, e.g., in the hallway or by the nurses station;
- o Medication holiday which requires 1 to 1, 15 minute checks or close monitoring;
- o Intensive medication review;
- o PRN medication titration monitoring;
- o Introduction or increase in usage of psychotropic medication for behavior control;
- o Introduction or usage of restraints for behavior control;
- o Treatment plan includes repeated use of PRN psychotropic medication and/or restraints for behavior control;
- o Significant incidence of abusive behavior (such as: sexually inappropriate behavior, assault, suicide attempt);
- o Intensive involvement of nursing facility or mental health professional staff to maintain a behavior plan.

0378.25.10.10 Health Status Areas of Significant Change

REV:08/1998

Significant change usually contains the following conditions:

1. The change is not self-limiting. Self-limiting is defined as:
    - o a change confined to a particular clinical area;
    - o a transient change where intervention(s) are appropriate and timely.

2. There is a major change in more than one area of the Resident's Health Status. Examples of classifications of the Resident's Health Status include:

    - o Communication
    - o Cognition
    - o Behavior
    - o Mood
    - o Physical Symptomology
    - o Activities of Daily Living (ADLs)

    This may include more than one change within a particular classification.

3. An interdisciplinary review and/or a revision of the care plan is required.

0378.25.10.15 Significant Change, Level II Resident Review

REV:08/1998

The following describes some, but is not inclusive of all, situations that may require a Resident Review for a significant change in condition.

1. Person does not stabilize, improve, or return to baseline within the expected time frame despite implementation of mental health treatment as identified on previous PASRR.

2. A resident with MI may benefit from mental health services when there is a significant change in physical condition such as:

    - Deteriorating physical condition.
    - Significant unplanned weight loss, e.g., 5% in the past 30 days or 10% in the past 180 days.
    - Significant deterioration in two (2) or more of the following areas: ADLs, communication, cognitive ability or continence.

- Deterioration in mood or behavior when daily problems arise and relationships become problematic, if staff conclude that these conditions in the resident's psychosocial status are not likely to improve without staff intervention.

- Significant overall deterioration of resident's condition.

3. NF readmission when a substantial change in the resident's condition has not responded to hospitalization or has developed after hospitalization. A Resident Assessment (RA) is required within 14 days along with a revision of the treatment plan within 7 days of the RA. An evaluation of the need for a resident review would be indicated if the resident does not respond to treatment within 21 days of readmission provided that the change in condition has a bearing on his or her mental health needs.

4. Improvement in behavior, mood or functional status to the extent that the plan of care no longer addresses the needs of the resident and the resident may be more appropriate for another community setting.

0378.25.10.20 Other Conditions Indicating Need for RR

REV:01/2002

Other conditions which may indicate a need for a Resident Review (RR) when the ID Screen identifies or suspects serious mental illness are identified below.

1. Any person with either:

    a. a newly-suspected diagnosis of "Serious Mental Illness" (SMI); or,

    b. a recurrence of a Serious Mental Illness in an individual whose last PASRR may or may not have specifically identified the individual as having a SMI.

    Complete form MA/PAS-3.2 and forward to DIBHS and DOH within a maximum of 21 days.

2. A Department of Health (DOH) review of "Nursing Facility Patient to Patient Abuse Report" or a Department of Elderly

Affairs (DEA) Nursing Facility Ombudsman identifies suspected mental illness or a significant change in condition.

3. An MHRH or DOH request for revaluation.

4. Any change in condition when a pre-admission 30-day exemption no longer applies.

5. Any change in condition where a terminal or severe illness exemption no longer applies.

6. Any change in condition where a respite admission is expected to be longer than 30 days.

7. When a delirium condition clears, following a delirium exemption lasting not longer than 30 days.

8. A PASRR Level II is required within 7 days of admission for patients who are admitted under emergency protection services. In these cases, the nursing facility must have documentation of the need for protective services in addition to the materials required for a routine pre-admission Level II or for an initial Resident Review (RR).

To meet this requirement, the facility can either forward the pre-admission Level II directly to the DIBHS for a determination, as long as the Level II is not completed by staff of the nursing facility, or, forward the Notification of Need for Resident Review (MA/PAS-3.2) to the Department of Mental Health, Retardation and Hospitals (MHRH), Division of Integrated Behavioral Health Services (DIBHS) and the Department of Health (DOH).

0378.25.10.25 Summary of Assessment Activities

REV:01/2002

A nursing facility is required to initiate treatment to meet immediate needs and begin a comprehensive reassessment when there is a significant change in a resident's condition. Treatment is geared to help the resident meet his/her highest practicable level, improve when possible and prevent avoidable decline.

The nursing facility is responsible for:

- completing a comprehensive assessment by the 14th day

after noting a significant change;

- revising the care plan based on the reassessment within 7 days after its completion;

- assuring that active treatment needs, if any are identified, are met;

- concurrently making a clinical judgement, based on the person's response to treatment and current treatment needs, on whether the change in the resident's physical or mental condition warrants a Resident Review (RR) by the State within this 21-day time period.

If the facility decides that a State RR might be necessary, the nursing facility must complete:

- a PASRR Level I, "RI DEPARTMENT OF HUMAN SERVICES ID SCREEN UPDATE FOR MI AND MR" (MA/PAS-1.1).

If a "serious mental illness" (SMI) is identified or suspected as a result of the PASRR screen, the nursing facility must also:

- complete a "NOTIFICATION OF NEED FOR RESIDENT REVIEW" (MA/PAS-3.2); and,

- forward a copy of the MA/PAS-3.2 to the State Division of Integrated Behavioral Health Services (DIBHS) and the Department of Health (DOH).

0378.25.10.30 Department of Health Notified of Need for RR

REV:08/1998

Upon receipt of a "Notification of Need for Resident Review" (MA/PAS-3.2), the Department of Mental Health, Retardation and Hospitals (MHRH) is responsible for determining the need for:

- additional information updates in collaboration with the Department of Health (DOH);

- an immediate full Resident Review (RR);

- a delayed RR; or,

- an abbreviated RR; and,

- notifying the nursing facility accordingly.

0378.25.10.35 Client in Crisis

REV:01/2002

In addition to the Resident Review (RR), an intensified level of psychiatric services may be indicated. If, however, a client is in a crisis situation that needs more care than the nursing facility can provide, it is the nursing facility's responsibility to transfer the client to a more appropriate setting. The receiving facility sends a notification of need for Resident Review (MA/PAS-3.2) to the DIBHS and DOH and the Resident Review (RR) is conducted in the receiving nursing facility.

0378.25.10.40 Conditions Requiring an Annual Review

REV:08/1998

Conditions which require at least an annual Resident Review (RR) when the ID Screen identifies or suspects "Serious Mental Illness" (SMI) are:

1. Any usage of physical restraints for symptoms of an SMI.

2. Residents with SMI whose condition has not changed since the last PASRR and whose psychiatric condition exhibits frequent fluctuation, is not responsive to, or counter-indicates traditional treatments. These residents may be significantly withdrawn or have frequent episodes of symptoms or behaviors that require Nursing Facility (NF) psychiatric services. These symptoms related to a "Serious Mental Illness" may include episodes of continued use of psychotropic PRNs for behavior control; episodes of extensive supportive treatment for significant disruptions; and episodes of cyclical mental illness manifesting themselves as episodic periods of screaming, demanding, intrusive, or aggressive behavior, which result in intensive or ongoing need for NF psychiatric services.

   This requirement for a PASRR on an annual basis is differentiated from the requirement for an immediate PASRR for a significant change in condition in that the client's symptoms are well established, predictable cyclical patterns of clinical signs and symptoms associated with a previously diagnosed condition which was described on a previous PASRR. In addition, the treatment plan documents appropriate

treatment and this condition is appropriately managed with ongoing NF psychiatric services. The condition is not severe enough to require specialized services.

3. Residents who have made a competent decision to refuse treatment and have not had a recent significant deterioration in condition. Although these residents refuse treatment, they may significantly benefit from additional medical or psychiatric services.

   This requirement for a PASRR on an annual basis is differentiated from the requirement for an immediate PASRR for a significant change in condition in that the condition is appropriately managed with ongoing NF psychiatric services. A previous PASRR along with the current treatment plan documents appropriate follow-up treatment. However, it is likely that increased mental health or medical services may significantly improve the quality of life.

0378.25.10.45 Quality Assurance Survey Program

REV:08/1998

A quality assurance survey program is geared to assure the quality of services for nursing facility (NF) residents with mental illness. A survey of 10-100% of residents previously determined to have or suspected of having, a "Serious Mental Illness" will review the MDS Assessment, Plan of Care and services provided. The program will provide consultation and limited technical assistance aimed to assure that treatment is geared to reduce psychiatric symptoms and behaviors, improve level of functioning, and prevent regression and loss of functioning.

This may include:

a) Survey of MDS assessments, treatment plans and need for additional Resident Assessment Instruments for any Significant Change in Condition. Review for appropriateness and timeliness.

b) Survey the implementation of treatment recommendations identified in previous Preadmission Screening and Resident Review (PASRR) evaluation.

c) Survey of treatment regarding:

   o Provision of opportunity for client choice and

self-management.

- Participation of all relevant staff in implementation of an individualized treatment plan.

- Implementation of habilitation services in formal and informal settings across disciplines to support the achievement of objectives in the plan of care.

d) Review of policy, procedures and standards for treatment provision.

0380 RESOURCES GENERALLY

0380.05 RESOURCE LIMITS

REV:06/1994

For MA Resource eligibility to exist, the institutionalized individual's countable resources cannot exceed the following basic limits:

- For Categorically Needy eligibility - $2000

- For Medically Needy eligibility - $4000

The evaluation of resources of an institutionalized individual with a community spouse first determines:

- The total joint resources of a couple;

- The spousal share of resources; and,

- The community spouse resource allowance.

The computation of the community spouse resource allowance is based on the couple's total joint resources and the spousal share of those resources as of the first moment of the month in which the period of continuous institutionalization begins.

Except for the community spouse resource allowance, the total joint resources of a married couple with an institutionalized spouse are deemed available to the institutionalized spouse for purposes of MA eligibility.

Each determination of eligibility (new, reopening or redetermination) requires a review of resources, which includes sending three bank

statements (AP-91). Resources are also reviewed at the time of a reported change, or when information is received which indicates a change has occurred, or that unreported resources may exist (Income Eligibility Verification System match, etc.).

Resources must be verified by a review of documents related to the resource, with copies of the documentation kept for the case file.

0380.10 RESOURCE DEFINITIONS

REV:06/1994

A RESOURCE is either real or personal property which the applicant/recipient can use (either directly or by sale or conversion) to provide for his/her basic needs for food, clothing, shelter or medical care. Third Party Resources for medical care, such as health insurance, are not countable resources in eligibility determinations.

- o REAL PROPERTY is land and generally whatever is erected or growing upon or attached to land. Real property also includes any interest in land. Examples of real property and interests in land include a lot with or without a house, a life estate, a remainder estate, mineral rights, easements, and leaseholds;

- o PERSONAL PROPERTY in a broad sense is everything that is subject to ownership that is not real property. It includes tangible and intangible personal property.

  - TANGIBLE PERSONAL PROPERTY includes movable and tangible things such as animals, furniture, automobiles, jewelry, boats, and merchandise.

  - INTANGIBLE PERSONAL PROPERTY includes such rights as stock, bonds, savings accounts, checking accounts, certificates or deposit, cash, and promissory notes.

Resources are further defined based upon whether they are countable or excluded in the process of determining eligibility for Medical Assistance.

- o COUNTABLE RESOURCE: A resource, whether real or personal property, that is counted toward a resource limit. Countable resources are available to the recipient, and are not excluded;

- o EXCLUDED RESOURCE: A resource that is not counted toward

the resource limit because of a specific exclusion in policy. Some resources are totally excluded regardless of value (e.g. the home of a recipient, or an automobile used for transportation for medical care); some resources are excluded to the extent they do not exceed a specific threshold amount (e.g. life insurance face value limit). See Section 0382, EVALUATION OF RESOURCES.

Other definitions pertaining to the evaluation of an institutionalized individual's countable resources are set forth below.

TOTAL JOINT RESOURCES is the combined resources of the community spouse and the institutionalized spouse, to the extent that either has an ownership interest in the resources. Total joint resources are normally calculated at two points in the eligibility determination process - 1) Advance Determination when the institutionalized spouse begins a continuous period of institutionalization, and 2) at the time of application for MA (total joint resources as they exist on the first day of the month for which eligibility is being determined).

SPOUSAL SHARE is one-half (1/2) of the couple's Total Joint Resources computed as of the beginning of a continuous period of institutionalization. The spousal share remains fixed until the institutionalized spouse is determined eligible for MA, regardless of any changes in the resources of the institutionalized spouse or the community spouse. At the time of MA eligibility determination, the spousal share is used as one component in the calculation of the community spouse resource allowance.

COMMUNITY SPOUSE RESOURCE ALLOWANCE is the amount of a couple's total joint resources which is attributed to the community spouse at the time Medical Assistance eligibility is determined for the institutionalized spouse.

A RESOURCE TRANSFER is the conveyance of right, title, or interest in either real or personal property from one person to another.

The conveyance may be by sale, gift, or other process.

COMPENSATION/CONSIDERATION is all real and/or personal property, or any other right or item of value that is received by an applicant/recipient pursuant to a binding contract in exchange for a resource. The recipient may receive the consideration or compensation prior to, at the time of, or after the transfer.

Items of value that serve as consideration or compensation include money, food, shelter, services, stocks, bonds, etc.

FAIR MARKET VALUE (FMV) of property (real and personal) is the amount for which the property can be expected to sell on the open market in the geographic area involved and under existing economic conditions at the time of the determination.

EQUITY VALUE is the FMV less the amount of any legal encumbrances.

UNCOMPENSATED VALUE (UV) is the equity value of a transferred resource minus the amount of compensation/consideration received by the applicant/recipient in exchange for the resource.

THE HOME is an individual's principle place of residence. An individual may possess many houses but only one home.

0380.15 DIFFER/RESOURCES FROM INCOME

REV:06/1994

Resources are items such as property, cash, bank accounts, other financial instruments, real estate, buildings, etc. that are owned by or available to individuals. Resources must be distinguished from income. The general rule is: A RESOURCE is that which is owned at the beginning of the month. INCOME is that which is received during the month. Income that is not spent within the month in which it is received becomes a resource at the beginning of the next month.

0380.20 CONVERSION/SALE OF A RESOURCE

REV:06/1994

A resource that is converted from one form to another does not result in income to the individual. A previously excluded resource may become a countable resource if converted into another form (e.g. an excluded auto is sold for $400 in cash. The cash received becomes a countable resource - not income). Conversely, a countable resource may become excluded (e.g. an excludable auto is purchased with $400 in cash), but in no event does income result from the transaction.

EXAMPLE: Mr. Bush is receiving MA benefits. He owned a home in which he lived valued at $25,000. The home was an excluded resource. He sold his home to a niece for $15,000 on 10/5/89 because he could no longer maintain the home. His only other resource is a savings account for $1,000. His countable resources are now $15,000 (the actual value received) plus $1,000 (other nonexcludable resource) for a total of $16,000. His resources exceed the Medically Needy limit, and he is no longer eligible for MA. The fact that the sale was for

less than the FMV is irrelevant as long as he lives in a community setting, however, the agency representative records the date of the transfer, and other pertinent information about the transfer on the DHS-2 and InRHODES Statement of Need Transfer Panel. The uncompensated value of the transfer may render him ineligible for payment for nursing facility services should he become institutionalized at a later date (See Section 0384, RESOURCE TRANSFERS).

0380.25 REPLACEMENT OF A RESOURCE

REV:06/1994

When an individual sells a home and the proceeds are used to purchase a new home within three months, the money obtained from the sale of the home cannot be considered a resource.

Cash (e.g. an insurance settlement) received for the purpose of repairing or replacing an excluded resource that is lost, damaged, or stolen is excluded as a resource for a period of nine months with an additional nine-month extension for good cause. Similarly, in-kind replacement of a lost, damaged, or stolen excluded resource is also an excluded resource.

0380.30 AVAILABILITY OF A RESOURCE

REV:06/1994

In order to be countable in the determination of Medical Assistance eligibility, a resource must be available to the individual. The individual must be able to use the resource to provide food, shelter, clothing, or convert it into a form in which it can be used to meet needs:

- A resource is considered to be available both when actually available, and when the applicant has the legal ability to make such sum available for support and maintenance;
- Resources are not available when a legal impediment exists which precludes the applicant from making the resource available for support, maintenance or medical care.

Applicants/Recipients are required, as a condition of eligibility, to cooperate with the Department in making resources available. See Section 0308, COOPERATION REQUIREMENTS.

0380.35 EXCLUDED RESOURCES

REV:06/1994

In determining eligibility for both Categorically Needy and Medically Needy Medical Assistance for an institutionalized individual, the following resources, subject to certain rules discussed in Section 0382, EVALUATION OF RESOURCES, are EXCLUDED:

- THE HOME AND ASSOCIATED LAND;
- HOUSEHOLD GOODS AND PERSONAL EFFECTS, regardless of value;
- ONE AUTOMOBILE, regardless of value;
- LIFE INSURANCE with a face value less than $1,500 for Categorically Needy, less than $4,000 for Medically Needy;
- BURIAL SPACES;
- IRREVOCABLE BURIAL CONTRACTS OR TRUSTS;
- FUNDS SET ASIDE FOR BURIAL, up to a maximum of $1,500;
- RETROACTIVE RSDI AND SSI BENEFITS, for a limited period;
- RESOURCES NECESSARY FOR SELF EMPLOYMENT;
- RESOURCES DESIGNATED BY SSA FOR A PLAN OF SELF SUPPORT for a blind or disabled individual;
- RESOURCES EXCLUDED BY SPECIFIC STATUTES.

0380.40 COUNTABLE RESOUR, INSTIT SPOUS

REV:06/1994

The evaluation of resources of an institutionalized spouse with a community spouse first determines:

- The total joint resources of the couple; then,
- The spousal share of the resources; and,
- The community spouse resource allowance.

The computation of the community spouse resource allowance is based on the couple's total joint resources at the beginning of the period of continuous institutionalization.

The total joint resources of the married couple with an institutionalized spouse are deemed available to the institutionalized spouse for the purpose of eligibility determination.

0380.40.05 Total Joint Resources

REV:06/1994

The total joint resources of an institutionalized spouse and community spouse are ALWAYS EVALUATED AS OF THE FIRST OF THE MONTH IN WHICH A CONTINUOUS PERIOD OF INSTITUTIONALIZATION BEGINS, regardless of the actual date on which the evaluation is conducted.

The total joint resources are equal to the combined resources of the couple, regardless of whether they are owned partly or wholly by either spouse. The evaluation of specific resources follows the policies set forth in Section 0382.

The procedures for evaluating total joint resources differ depending on whether the initial evaluation is conducted in advance of a Medical Assistance application at the individual's request (Advance Determination), or is conducted as part of a Medical Assistance application.

0380.40.05.05 Advance Determination

REV:06/1994

The LTC/AS unit conducts evaluations of total joint resources when requested by an institutionalized or community spouse in advance of a Medical Assistance application. When a request for an Advance Determination is received, the LTC/AS unit forwards a packet containing the MA-2 and MA-2a to the requesting spouse. The completed forms are returned to the LTC/AS unit with supporting documentation which includes a copy of the couple's most recent income tax returns.

Upon receipt of the MA-2, a file/case number is assigned.

If all relevant documentation is provided, the LTC/AS unit determines the total joint resources and spousal share. If the information provided is not sufficient for a determination, the LTC/AS unit

requests that the additional information be provided within a reasonable period of time.

Within 45 days of receipt of a completed MA-2 and all relevant supporting documentation, both spouses are notified of the results of the advance determination of total joint resources and spousal share via an MA-3.

All documents related to the advance determination of the total joint resources are retained in the district office case record until:

- A Medical Assistance application is filed; or,
- The institutionalized spouse ends the continuous period of institutionalization by residing outside the institutional setting for at least thirty consecutive days; or,
- The death of one spouse.

At the time of Medical Assistance application, the file is used as the Medical Assistance case record.

0380.40.05.10 Determination at Time of Appl

REV:06/1994

When a Medical Assistance application is filed by an institutionalized individual with a community spouse, the LTC unit determines if an advance determination has been completed. If so, the file is requested from the LTC/AS unit which conducted the initial determination.

If an advance determination has not been completed, the LTC/AS worker conducts both the evaluation of total joint resources as of the time of institutionalization, and the determination of total joint resources as they exist at the time of application.

The determination of total joint resources at the beginning of the period of institutionalization is needed to calculate the spousal share and the community spouse resource allowance. The determination of total joint resources at the time of the MA application is needed to determine the countable resources of the institutionalized spouse. (The countable resources of the institutionalized spouse, for purposes of MA resource eligibility, is the couple's joint total resources at the time of application LESS the community spouse resource allowance).

0380.40.10 Spousal Share

REV:06/1994

The spousal share is equal to one-half of the value of the couple's total joint resources as of the beginning of a period of continuous institutionalization. The value of the spousal share remains fixed at the value computed as of the beginning of the period of continuous institutionalization, regardless of changes in resources which may occur between the beginning period of institutionalization and the time of the MA eligibility determination.

0380.40.15 Community Spouse Resource Allowance

REV:01/2006

The community spouse resource allowance, to the extent such resources are available, is equal to the greater of:

- $19,908; or,
- The spousal share, up to a maximum of $99,540.

0380.40.20 Community Spouse Resource Allowance Examples

REV:01/2006

BRADLEY Example:

Mr. Bradley becomes institutionalized on October 20, 2004. His community spouse requests an initial evaluation of total joint resources and the spousal share. The initial evaluation results in a finding that the Bradley's have total joint resources (as of 10/1/04) in the amount of $200,000 (joint bank accounts of $95,000, stocks owned solely by Mrs. Bradley of $82,000 and non-home real estate, vacant land, owned solely by Mr. Bradley with a Fair Market Value of $23,000). The spousal share is $100,000. The Bradley's are apprised via MA-3 of these findings.

An application for Medical Assistance is not filed for 22 months, until July 29, 2006.

A second evaluation of total joint resources is conducted to establish total joint resources as of the month of application.

As of the first moment of July, 2006, total joint resources amount to $128,000 (non-home real estate with an appreciated value of $31,000;

Mrs. Bradley's stock with an appreciated value of $87,000; joint bank account of $10,000).

Although the spousal share is $100,000, the community spouse resource allowance for Mrs. Bradley is capped at $99,540 (the greater of $19,908 or the spousal share up to a maximum of $99,540). Mr. Bradley's countable resources are $32,900 and he is ineligible for Medical Assistance.

JONES Example:

Mrs. Jones, age 74, applies for Medical Assistance on April 20, 2006. She became institutionalized on November 3,2005 when she was placed in an NF directly from her community residence.

Neither she nor her community spouse requested an evaluation of total joint resources at that time. To establish Mrs. Jones' countable resources for eligibility determination purposes, two evaluations of total joint resources are completed. The first to determine total joint resources as of the first moment of the month of institutionalization, November 1,2005 (so that the spousal share can be established); the second to determine total joint resources as of the first of the moment of April, 2006 (so that the community spouse resource allowance for Mr. Jones, and thus Mrs. Jones' countable resources can be determined).

As of November 1, 2005, Mr. and Mrs. Jones' total joint resources are determined to be $39,000 (consisting of joint checking and savings accounts totaling $7,500 and jointly held stocks with a fair market value of $31,500). The spousal share is consequently $19,500.

As of April 1, 2006, the total joint resources of the Jones' amounted to $24,500 (joint bank accounts of $5,500, and jointly held stocks with a fair market value of $19,000, the value decreased as a result of a decline in share price and liquidation of some shares to help pay for costs of care). Mrs. Jones' countable resources amount to $5,000 (total joint resources at the time of application) less the community spouse resource allowance (the greater of $19,908 or the spousal share up to $99,540: $24,500 - $19,908 = $4,592). Mrs. Jones would be ineligible for the month of April, except that $2,500 was paid toward the cost of care for April on April 15th. This documented allowable expenditure reduces excess resources to within the limit. Based on resources, Mrs. Jones is eligible effective April 1st. She is otherwise eligible, and is certified for Medical Assistance effective April 1. She has already paid for her institutional care for the month of April, however, so no vendor payment can be made for the month of April.

In May of 2006 Mr. and Mrs. Jones separate the funds in their accounts to reflect the above attribution of resources. On June 10th, Mrs. Jones receives an inheritance of $50,000. The resource is hers alone - none is attributed to Mr. Jones. Mrs. Jones is determined ineligible for Medical Assistance effective July 1.

SMITH Example:

Mr. Smith, age 79, is placed in an NF on June 15, 2006, subsequent to a hospitalization which began on February 24, 2006.

He required acute care hospitalization from February 24th through March 28th, was on Administratively Necessary Days from March 29th through the end of his hospital stay. He applies for Medical Assistance on April 20th, from the hospital, while pending placement. His continuous period of institutionalization begins February 24th. The retroactive period encompasses the day that begins a continuous period of institutionalization, and medical expenses for which Medical Assistance is requested have been incurred in that retroactive month. Consequently, only one evaluation of total joint resources is conducted to determine the spousal share and countable resources. The LTC/AS worker evaluates the resources of Mr. Smith and his community spouse as of the first moment of February. The total joint resources are $19,108 comprised entirely of a checking and savings account owned solely by Mr. Smith). The spousal share is $9,910. Mr. Smith's countable resources as of February 1st are $800(total joint resources of $19,108 less the community spouse resource allowance $19,908 {the greater of $19,908 or the spousal share}).

Mr. Smith is otherwise eligible, and is certified for Medical Assistance beginning February 1, 2006.

0380.40.25 Segregating the Resources

REV:01/1996

The total joint resources of the couple should be divided as soon as practicable to segregate in the community spouse's name the funds permitted as a community spouse resource allowance.

Resources transferred to the community spouse in order to segregate the funds permitted as a community spouse resource allowance are exempt from the rules pertaining to transfer of resources set forth in Section 0384.

Any resource acquired by the community spouse after the month in which an institutionalized spouse is determined to be eligible will not be deemed available to the institutionalized individual.

Conversely, any resource acquired by the institutionalized spouse in the month after the determination of eligibility is fully countable, and cannot be transferred to the community spouse as part of the community spouse resource allowance.

Resources transferred by an individual to a community spouse under a court order are also exempt from the rules pertaining to transfer of resources in Section 0384.

0380.40.30 Assign Rights, 3rd Party Resou

REV:06/1994

Under Rhode Island law, rights to spousal support are automatically assigned to the Department of Human Services upon application for and receipt of Medical Assistance. In the event the community spouse does not make the couple's joint resources (less the community spouse resource allowance) available to the institutionalized spouse, the institutionalized spouse is not determined to be ineligible on the basis of such resources. When a community spouse has refused to make resources available, and eligibility has been established, the Department is empowered to take action to obtain said resources to reimburse DHS for the cost of medical care paid for on behalf of the institutionalized spouse.

The institutionalized spouse is required, as a condition of eligibility, to assist DHS in the process of obtaining such support from the community spouse.

Resources obtained as a result of action taken against the community spouse that are in excess of the incurred cost of institutional care are distributed to the institutionalized spouse, and are considered to be countable resources of the institutionalized spouse.

0380.40.35 Fair Hearing

REV:06/1994

If either the institutionalized spouse or the community spouse is dissatisfied with the spousal share of the joint resources, the attribution of resources, or the determination of the community spouse resource allowance, and if an application for Medical Assistance has been made on behalf of the institutionalized spouse, the dissatisfied spouse is entitled to a fair hearing.

Section 1924 (e) (2) (C) of the Social Security Act provides State Hearing Officers authority to raise the community spouse resource allowance (CSRA) under certain circumstances. If either the community spouse or the institutionalized spouse establishes that the community spouse resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, an amount adequate to provide such a minimum monthly maintenance needs allowance (under the post-eligibility formula) shall be substituted for the current community spouse resource allowance. In determining how much more income must be generated by the additional resources in order to raise the community spouse's income to the minimum maintenance allowance, the Hearing Officer considers the community spouse's existing income. Existing income for this purpose includes the monthly income allowance which the institutionalized spouse has made available to the community spouse under the post-eligibility formula. There can be no substitution for the current community spouse resource allowance if the institutionalized spouse does not actually make a monthly income allowance available to the community spouse under the post- eligibility formula.

The additional resource(s) above the CSRA which may be protected under this section of the Social Security Act must be income producing. To be protected, the income producing resource must be providing a reasonable rate of return.

The hearing must be held within thirty days of receipt by the agency of a written request for a hearing.

0380.45 RESOURCE REDUCTION

REV:06/1994

If an applicant or recipient is found to be ineligible due to excess countable resources as of the first moment of the month, s/he is notified that eligibility does not exist via the InRHODES Eligibility Notice. Included with the Notice is a description of the possibility of resource reduction (form MA-6).

An applicant whose countable resources exceed the basic resource limitation may establish eligibility on the basis of resources if:

- S/he incurs (or has incurred) outstanding allowable medical bills or other allowable expenses that equal or exceed his/her excess resources; AND,

- S/he reduces the excess resources to the appropriate

resource limit by actually paying the allowable expenses or fees, and submitting verification thereof within thirty days of the date of the rejection or closing notice. Both the expenditure of the resource and submission of verification of the expenditure and the reduced resource must occur within the thirty day time period.

The bills used to establish eligibility cannot be incurred earlier than the first day of the third month prior to the date of an application that is eventually approved. Allowable bills, which the applicant has paid and used to reduce resources, may not be the same bills that have been used to meet an income spenddown.

The agency representative must see the bills that have been actually paid in order to verify that resources have been properly reduced.

0380.45.05 Date of Eligibility

REV:06/1994

An individual who reduces resources and is otherwise eligible will be eligible as of the date the incurred allowable expenses equaled or exceeded the amount of his or her excess assets, subject to verification that the excess resource was actually expended on the allowable expense. In no event shall the first day of eligibility be earlier than the first day of the month of application.

Although an applicant may reduce excess resources by paying an allowable expense that was incurred up to the first day of the third month prior to the date of an application, an applicant cannot establish eligibility by resource reduction in the retroactive period.

The applicant will be required to verify that:

- S/he incurred the necessary amount of expenses; and,
- His or her excess resources were reduced to the allowable resource limit by expenditure of the excess resource on the allowed expense.

0380.45.10 Allowable Expenses

REV:04/2001

Only certain expenses may be used to establish eligibility by reduction of excess resources. These expenses are as follows:

- Medical expenses that would be allowed under the policy on the Flexible Test of Income. See Section 0390, FLEXIBLE TEST OF INCOME.

- Certain fees required for: a) an individual to make income or resources available; or b) an incompetent individual, who needs a court-appointed guardian, to access or consent to necessary medical treatment, including applying for Medical Assistance. Only the fees indicated in Sections 0380.45.10.05 through 0380.45.10.15 are allowable under this provision.

0380.45.10.05 Guardian/Conservatorship Costs

REV:04/2001

Applicants who have court-appointed guardians or conservators are generally required to pay court-approved guardian/conservator's fees. Such fees include but are not limited to court filing fees, the cost of a Probate Bond, court-approved guardianship/conservatorship fees, and court-approved legal fees.

Allowable court-approved expenses not covered by other sources for items listed in Section 0380.45.10, subject to the Rhode Island Supreme Court approved fee schedule (currently $30 per hour under "Executive Order" Number 95-01), may be considered.

When such guardianship fees have been approved by Probate Courts, related guardian ad litem fees not exceeding $250 may also be recognized. The applicant must submit a copy of the Probate Court Order and any supporting documentation, including an itemized bill for allowable guardianship expenses.

The case is referred to the Office of Legal Counsel by the Long Term Care Administrator (or his designee) for a decision on the amount of the allowable deduction. The referral must contain a brief description of the case, a copy of the Probate Court Order, an itemized bill from the guardian, and any other supporting documentation submitted by the applicant. The total amount allowed must be reasonable and shall be based on the hours approved by the particular Probate Court for items listed in 0380.45.10 at the rate of compensation paid for guardians ad litem in Family Court as specified in the then-current Rhode Island Supreme Court Executive Order on fee schedules.

0380.45.10.10 Legal Fees

REV:06/1994

Individuals who incur legal fees resulting from legal action to obtain income or resources for their support may expend excess resources to pay such fees.

0380.45.10.15 Tax Assessments

REV:06/1994

Individuals ordered by the Internal Revenue Service, the Rhode Island Division of Taxation, or other State or municipal taxing authority to pay income taxes may expend excess resources to pay the taxes.

0380.45.15 Examples of Resource Reduction

REV:01/2006

The following are hypothetical cases involving resource reductions:

- MR. M files an application on 7/21. As of 7/1, he has a savings account of $3075 and an automobile with a countable value of $975, for a total of $4,050. On 7/10, he withdrew $125 from the bank for automobile repairs, reducing his resources to $3,925. He is ineligible as of 7/1 and the change in resources during July does not affect his INELIGIBILITY. He has no allowable expenses on which to expend the excess resource. He remains ineligible in July. He may be eligible in August if his countable resources are $4,000 or less on 8/1.

- MR. E is a Categorically Needy individual who does not receive SSI. As of 3/1, he had a $2,000 life insurance policy with a cash surrender value of $800, a savings account valued at $900 and an excluded automobile, for a total of $1,700. On 3/5, he sold his automobile for $1,000 and deposited the money in his savings account. His countable resources then amounted to $2,700 (the sale of the car is considered a "converted" resource) and that is the amount he had as of 4/1. The increase in his resources does not affect his ELIGIBILITY for March. He is ineligible as Categorically Needy for April, and is notified that he is Medically Needy. He has no allowable expenses on which he can expend excess

resources. He will remain Medically Needy until the month following the month his resources are reduced to $2,000 or less; i.e., he is not Categorically Needy for as long as the excess resources are retained and THROUGH the month that his resources are reduced to within the resource limit.

- MS. D applies for recertification on 5/1. She had $3,700 in her savings account. On 5/3, she received a $660 RSDI check which was directly deposited in her savings account. She is eligible for the month of May since the $660 is income in the month of receipt. However, she retains the $660, and consequently exceeds the resource limit for June 1, with total resources of $4,360. She is notified on 6/2 that she is ineligible due to excess resources, and her case is closed effective June 13th. On June 20th, she enters the hospital. Her Medicare deductible is $952 (the Part A deductible as of January 1, 2006). She opts to reduce her resources by expending $360 on the outstanding deductible for the hospital bill. She re-establishes eligibility effective June 20th.

- MS. I applies for recertification on 7/20. She had $3,975 in her savings account as of 7/1. On 7/31, $43 in interest was added to her account, for a total of $4,017. She is ELIGIBLE in July. As of 8/1, the interest is a cash resource and she is INELIGIBLE for August. She has no allowable expenses incurred or outstanding in August on which she can expend excess resources. On August 10th, she reduces her resources to below $4,000 by purchase of a pair of shoes. She will NOT REGAIN eligibility for the month of August even though her resources are again within the resource limit. The earliest she CAN REGAIN ELIGIBILITY is September 1, if her resources are within allowable limits as of the first moment of that month.

- MR. C applied on July 15th for help with a hospital bill of $12,000 incurred between June 2nd and June 15th. He had total countable resources of $6,485 on June 1st. He paid $2,000 on June 29th toward the bill from his cash resources, leaving countable resources of $4,485 on July 1st. He was notified on July 30th that he was ineligible due to excess resources, and that he could reduce resources to establish eligibility. He expended an additional $500 toward the hospital bill on August

20th. He presented verification of the expenditure and the reduced resources on August 25th, and was determined to be eligible effective July 1st in the ongoing period. He was ineligible for copayment of the balance of the hospital bill from June, because June is a retroactive month.

- MR. D has resources of $6,500 on the first of July. He incurs allowable medical expenses of $8,000 during a hospitalization from July 5th through July 20th. He applies for Medical Assistance on July 29th. He is rejected on August 10th due to excess resources and is apprised of the ability to reduce resources to establish eligibility. On August 20th, he purchases an excludable automobile for $3,000, reducing his countable resources to $3,500. He does NOT establish eligibility for July or August. He reapplies in September, has countable resources within the limit, and is otherwise eligible. He is accepted effective September 1st.

- MRS. P has resources of $10,000 on August 1. She is hospitalized August 10th, incurring a bill of $22,000 between August 10th and August 17th. She files an application for Medical Assistance on August 30th. On September 12th, she is determined ineligible due to excess resources and notified of the possibility that she could reduce resources to become eligible. On September 15th, she paid $6,000 toward the hospital bill. She was subsequently certified eligible effective August 10th.

0382 EVALUATION OF RESOURCES

0382.05 FIRST MOMENT OF THE MONTH RULE

REV:06/1994

Countable resources are determined as of the FIRST MOMENT OF THE MONTH (FOM). The determination is based on the resources the individuals own, their value, and whether or not they are excluded as of the first moment of the month. The FOM rule establishes a point in time at which to value resources; what a person owns in countable resources can change during a month but the change is always effective with the following month's resource determination.

The kinds of changes that can occur are:

- CHANGES IN VALUE OF EXISTING RESOURCES

  The value of an existing resource may increase or decrease. For example, the value of a share of stock may decrease by $30 or increase by $20.

- DISPOSITION OR ACQUISITION OF RESOURCES

  An individual may dispose of an existing resource (e.g., close a savings account and purchase an item) or may acquire a new resource (e.g., an inheritance which is subject to the income-counting rules in the month of receipt).

- CHANGE IN EXCLUSION STATUS OF EXISTING RESOURCES

  An individual may replace an excluded resource with one that is not excluded (e.g., sell an excluded automobile for nonexcluded cash) or vice versa (use nonexcluded cash to purchase an excluded automobile). Similarly, a time-limited exclusion (such as the period for exclusion of retroactive Title II benefits) may expire.

Changes such as SSI, SSA, and Lump Sums do not effect the countable value of resources in the month in which they occur. Any change does not effect countable resources until the first moment of the following month.

If countable resources exceed the limit as of the first moment of a month, the recipient is not eligible for that month, unless the resources are reduced by expenditure on certain allowable expenses, see Section 0380.45, RESOURCE REDUCTION.

Resources are evaluated using the methodologies set forth in the remainder of Section 0382 for the various types of resources. Each type of resource has its own unique deductions, exclusions, and methods for evaluation to determine its countable value. If not otherwise indicated, the countable value of a resource is the equity value (fair market value less legal encumbrances).

Once the countable value of each resource (after the appropriate exclusions/deductions) is determined, the countable values of all resources (including deemed resources) are added together to determine the total countable resources for the institutionalized individual.

0382.10 REAL ESTATE

REV:03/2004

The policies and procedures set forth in the following sections will be used to determine Medical Assistance eligibility and Medical Assistance payments for services to INSTITUTIONALIZED INDIVIDUALS.

The equity value of real property owned by an individual that is neither excluded as the home nor determined unavailable is a countable resource.

Real property may consist of land, buildings, and objects permanently attached to the land, (including "mobile" homes permanently sited). Real property includes the value of certain interests in real estate such as life estates, mineral rights, easements, life leaseholds.

0382.10.05 Home and Associated Land Excl

REV:03/2004

Effective March 1, 2004, DHS policy is revised to clarify application of the home exclusion for residential real estate property.

Definitions

For the purposes of this section, the following definitions apply:

--APPLICANT: New applicants for Medical Assistance as well as current recipients at any point in which eligibility is redetermined.

--DEPENDENT CHILD: An unmarried child of the applicant and/or the applicant's spouse who is dependent upon the applicant and/or the spouse for financial support, and is either under eighteen (18) years of age; or over eighteen (18) years of age and living with a disability which began before age twenty-two (22).

--HOME: Any residential property in which the applicant and/or applicant's spouse possess an ownership interest that also serves as the principal place of residence of the applicant and/or, in the instances specified in this section, the applicant's spouse or dependent child. A home may be a fixed or mobile residential property.

A cooperative or condominium apartment, townhouse, mobile house, and houseboat are all examples of residential properties that may serve as homes. An applicant and spouse may have an ownership interest in several residential properties, but only one (1) shall be considered a home for the purposes of this section.

--HOME EXCLUSION: The treatment of a residential property as a non-countable resource when the property serves as the home of an applicant/spouse as specified in this section. Regardless of whether one or both spouses in the household are applicants, only one residential property is considered to be a home, and as such, is treated as an excluded resource for the purposes of determining MA eligibility.

--INTENT TO RETURN: An expression indicating that it is the applicant's plan to live in the home used as the principal place of residence after a temporary absence. The intent to return home is subjective rather than objective and, as such, must be expressed by the applicant or an authorized representative of the applicant in the form of a signed, written statement.

--OWNERSHIP INTEREST: The individual holds sole or joint legal title to the residential property or is a party to a legal covenant establishing property ownership, such as a life estate.

--PRINCIPAL PLACE OF RESIDENCE: The residential property where the applicant, and/or in the instances specified in this section, a spouse or a dependent child lives the majority of the time during the year. For example, one hundred and eighty-three (183) days in the previous twelve (12) months.

--RESIDENT OF RHODE ISLAND: The applicant has an intent to stay in the state permanently or for an indefinite period, in accordance with the provisions set forth in Section 0106.05 through 0106.25 of the DHS Code of Administrative Rules.

--TEMPORARY ABSENCE: A limited period of time in which the applicant is residing away from home for reasons essential to personal welfare (e.g. protective

or rehabilitative services), related to medical or social needs (e.g. hospitalization or nursing home care), or over which the applicant has no direct control.

Application of the Home Exclusion

The home of an institutionalized applicant is an excluded resource, if it is located in Rhode Island, and the applicant expresses an intent to return to the home. If the applicant does not maintain a Rhode Island home, the home exclusion applies to the principal place of residence of the community spouse or a dependent child.

The value of any land/building contiguous to the home is also excluded.

0382.10.05.05 Home and Associated Land Defin

REV:06/1994

Home and Associated Land Definition - The home exclusion applies to any land which appertains to the home and other buildings located on such land. To appertain to the home, the real property must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others.

Where real property adjoins the plot on which the home is located and has contact with that plot, it does not matter if there is more than one document of ownership (e.g., separate deeds). It also does not matter that the home was obtained at a different time from the rest of the real property, or that the holdings may be assessed and taxed separately. In considering whether real property appertains to the home plot, easements or public rights of way (e.g., streets, roads, utility lines) which run through or by the land and separate the land from the home plot or from the rest of the land are not considered. Watercourses, such as streams and rivers, do not separate land, but are included in the term "land." Land parcels which are adjoined side-to-side, corner-to-corner, or in any other fashion are considered to appertain to each other.

If some indication arises that a portion of the property is separated from the home property and does not appertain to the home, the extent of the home property as provided is determined.

Where there is no indication that the plot on which the home is located is separated from other real property, nothing further is needed.

If any of the individual's property is not contiguous with the home plot, the extent of the home property is documented. A copy of the tax assessment bill, title, deed, or other pertinent documents that the individual has in his/her possession is placed in the case record. A description of the property situation and whether all the land appertains to the home is obtained. If the individual cannot provide this evidence or the evidence is insufficient, the agency representative contacts the local tax jurisdiction regarding the property boundaries and records the information.

If the property on which the home is located is recorded as a single holding and treated as a single holding for tax assessment purposes, the agency representative treats the property as a single piece of property to which the home plot is adjoined by the rest of the land. If there has been subdividing of the original holding but the residue is treated as a single holding for tax assessment purposes, the same assumption applies.

If two or more holdings, including one or more homes, are reported to be a combined property and are treated as two or more holdings for recording and tax assessment purposes, the agency representative obtains a description of the holdings and their relationship to one another. A sufficient description is a sketch which shows the locations of the boundaries and the shelter used as a home in relation to the boundaries. The agency representative obtains the description by direct observation of the property or from the public records. If the description is by an individual, the description is recorded on the property sheet.

Where it is determined that land owned by the individual does not appertain to the home plot, such land and any buildings on it cannot be part of the home exclusion.

0382.10.05.10 Multiple Residences

REV:03/2004

When an applicant with an ownership interest in multiple residential properties has not lived in any one for the majority of the time during the preceding twelve (12) months, the home exclusion is applied to the state residential property identified as the applicant's address on one of the following, in order of preference:

1. A valid Rhode Island driver's license;

2. The most recent voter registration form;

3. A government check or electronic deposit receipt (e.g., Social Security, SSI, State Treasury) issued within the last sixty (60) days; or

4. The most recent U.S. federal income tax return submitted by, or on behalf, of the applicant.

The home remains excluded during the applicant's temporary absence if the applicant expresses an intent to return to the home; or the applicant's spouse/dependent child resides in the home.

All other residential properties in which the applicant or the applicant's spouse maintain an ownership interest shall be treated as countable resources, in accordance with Section 0308.10.

0382.10.05.15 Out-of-State Residences

REV:03/2004

To be eligible for Medical Assistance, an applicant must be a Rhode Island resident and, as such, have an intent to stay in the state permanently or for an indefinite period. Accordingly, an applicant who has expressed the intent to return to an out-of-state residential property shall not be considered a Rhode Island resident for the purposes of determining eligibility for Medical Assistance.

When an applicant owns residential properties both in and out-of-state, the home exclusion may only be applied to the property located in Rhode Island. The value of out-of-state residential property is a countable resource, even if it is the principal place of residence of the applicant's spouse/dependent child, as long as the applicant maintains an ownership interest in a Rhode Island residential property.

If the applicant does not own real property in Rhode Island, but lives and intends to remain in the state, the home exclusion may be applied to an out-of-state residential property if, and only if, it is the principal place of residence of the applicant's spouse or dependent child.

An out-of-state residential property may otherwise only be deemed temporarily excluded when it is determined that:

- There is a legal impediment to the sale of the property due to joint ownership (as specified in Sections 0356.10.10, 0356.10.10.05, 0382.10.10, and 0382.10.10.05); or

O The property is an unavailable resource as defined in Sections 0356.10.10.10, and 0382.10.10.10.

0382.10.05.20 Temporary Absence and Intent to Return

REV:03/2004

The home may be excluded during an applicant's temporary absence (e.g., due to hospitalization or nursing home care) when both of the following conditions are met:

O The applicant intends to return to the home; and

O The home is located in Rhode Island.

Initial Application

At the time of initial application, a signed statement (Form MA-400) must be submitted to DHS indicating when the applicant left the home and whether the applicant intends to return to the home. If a community spouse or a dependent child continues to live in the home during the applicant's temporary absence, the value of the home is not counted as a resource regardless of whether the applicant has expressed an intent to return to the home.

The statement indicating the applicant intends to return to the home shall remain valid from the date it is received by DHS until eligibility is redetermined unless the temporary absence ends first, or, as is specified in Sections 0382.10.05.25 and 0382.10.05.30, the applicant acts in a manner that indicates an intent to the contrary.

Redetermination of Eligibility

At the time eligibility is redetermined, whether due to recertification or a change in other eligibility factors, the department shall verify whether there has been a change in the intent to return to the excluded home. Providing all other eligibility requirements have been met, the home shall remain excluded if the applicant continues to express an intent to return at that time.

0382.10.05.25 Contrary Acts

REV:03/2004

If the department learns at anytime that the applicant is acting in a manner that is inconsistent with the statement expressing an intent to return, the home may be treated as a countable resource. For example, an applicant who has taken the steps required to sell or transfer ownership interest in an excluded home is acting in a manner that is contrary to an intent to return, as it is defined in this section. If, upon review of the applicant's actions, it is determined that such acts are sufficient to invalidate an expression of the intent to return, the department shall provide the applicant with timely and adequate notice of the decision to treat the home as a countable resource.

0382.10.05.30 Diminished Capacity

REV:03/2004

In the event that the department finds that the applicant's capacity to express a clear intent to return to the home is diminished, as evidenced by a legal judgement of incompetence, or a documented mental or medical condition, an authorized representative of the applicant may submit a sworn affidavit, indicating an intent to return on the behalf of the applicant.

For the purposes of this section, an authorized representative of the applicant is any of the following:

- The person who completed and signed the application for Medical Assistance for the incapacitated applicant, providing the person is not an employee or representative of an institution or organization with a fiduciary interest in the care of the applicant (e.g. nursing home/assisted living employee, hospital worker, etc.);
- The applicant's spouse, child, parent, sibling, or legal guardian; or
- An individual who meets the criteria established in RIGL Section 5-37.3-3 (The Confidentiality of Health Care Information Act).

0382.10.05.35 Limitations

REV:03/2004

Although an applicant may own several residential properties either alone or in conjunction with others, only one shall be considered a

home and, as such, may be treated as an excluded resource at any given point in time. Even in situations in which both spouses in the household are applicants, the value of only one home may be excluded.

When the applicant and the applicant's spouse/dependent child make conflicting claims over which residential property is subject to the home exclusion, the following decision rules shall apply:

- If the applicant and applicant's spouse live in separate residential properties in Rhode Island, in which they share equal ownership, the home exclusion applies to the residential property where the applicant(s) lived at the time the Department received the application. If both applicants apply on the same day, the applicants must agree in writing which home is to be excluded. If no agreement can be reached, the home exclusion shall be applied to the residential property with the greatest value.

- If, at the time eligibility is redetermined, an applicant who is temporarily absent expresses an intent to return to a residential property other than the one excluded at the time the initial application was made, the residential property may only be excluded if it is located in Rhode Island and is the home- i.e. principal place of residence - of the applicant's spouse or dependent child. However, the value of the residential property excluded at the time of initial application shall be treated as a countable resource.

0382.10.10 Legal Imped to Real Est Sale

REV:06/1994

Other persons, in addition to an applicant and spouse (if any), may share in ownership of property in which the individual, spouse, or child is not living. If so, the property is considered to be unavailable if the individual or couple is not legally free to dispose of the property because the other owner(s) will not consent to sell. Notwithstanding the above, the applicant/recipient must make every effort to sell their equity share of that real estate.

An unavailable resource is not countable in the eligibility determination.

0382.10.10.05 Types of Ownership of Real Estate

REV:06/1994

Whether the applicant is free to dispose of his/her share depends on the type of ownership. The agency representative should examine the deed to determine the type of ownership. The following types of ownership are the most common.

- JOINT TENANTS

  JOINT TENANCY is when two or more persons own the property. (The property may be either real property or personal property). Upon the death of any Joint Tenant, title automatically vests in the surviving Joint Tenants without the necessity of a Probate proceeding. While alive, any Joint Tenant can convey his/her interest to a third person. After such a conveyance, the new parties own the property as Tenants in Common (see below).

- TENANTS IN COMMON

  TENANCY IN COMMON is when two or more persons own the property with no right of survivorship between them. Upon the death of any owner, that owner's interest in the property will pass under the deceased's will or, in the absence of a will, under the applicable laws of intestacy. While alive, any Tenant-in-Common can convey his/her interest to a third person.

- TENANTS BY THE ENTIRETY

  Only a husband and wife can hold property as Tenants by the Entirety. It is the most common form of ownership for married couples who own property together. Like a Joint Tenant, the survivor will automatically own the property upon the death of one spouse. Unlike a Joint Tenant, however, both Tenants by the Entirety must join in any deed of an interest in the property. Property owned by a husband and wife under a Tenancy by the Entirety cannot be sold without the consent of both spouses. In the event a spouse refuses to dispose of the property, it is excluded as a resource of the applicant/recipient.

The agency representative obtains documents (usually a copy of the deed) to establish the nature of the shared ownership.

It is presumed that an individual who owns an interest in property as a Joint Tenant or Tenant in Common is free to sell his/her ownership interest without the consent or signature of the other owner(s). If the property is not otherwise excludable, the applicant's proportional share of the equity value of the property is counted toward the resource limit. (Unless stated otherwise in the deed, the applicant's proportional share of ownership is the ratio of 1 to the total number of owners.)

It is presumed that a Tenant by the Entirety is NOT able to liquidate his/her interest without the consent of the other owner.

The individual's share of the resource is NOT countable, pending the individual's action to make the resource available for his/her support.

0382.10.10.10 Docu Non-Avail of Real Est

REV:06/1994

When the individual claims that s/he is unable to liquidate a real property resource, s/he must provide documentation from a competent authority (e.g. real estate broker, attorney) that s/he cannot sell the property. The agency representative refers the case to the Office of Legal Counsel for a decision as to whether the property can be liquidated.

All cases in which real estate is determined to be not countable under these provisions must be referred to the Office of Legal Counsel for review. As a CONDITION OF ELIGIBILITY, an applicant/recipient must take all reasonable actions to liquidate the resource. The Office of Legal Counsel determines what actions are reasonable based on review of each particular situation.

0382.15 INTANGIBLE PERSONAL PROPERTY

REV:06/1994

Intangible personal property includes those resources which are in cash or payable in cash on demand, and financial instruments convertible into cash. The most common types of intangible personal property are savings accounts, checking accounts, NOW accounts, certificates of deposit, money market accounts, stocks, bonds, and mutual funds.

Other intangible resources include promissory notes, loans which may not be secured by promissory notes, and mortgages. Such personal property is always a countable resource, except as excludable under this section.

0382.15.05 Cash

REV:06/1994

Cash is money on hand or available in the form of currency or coins. Foreign currency or coins are cash to the extent that they can be exchanged for U.S.-issued currency. Cash on hand is always counted as a resource except when it is a business resource necessary to the operation of a trade or business that is excluded as necessary for self-support.

The applicant's statement of the amount of cash on hand is acceptable without verification, unless the amount could impact the applicant's eligibility.

0382.15.10 Checking and Savings Accounts

REV:06/1994

The terms checking/savings accounts include any and all accounts, certificates, money market or broker's funds and instruments or devices having the general characteristics commonly associated in the community with checking and savings accounts. The countable resource from such accounts is the amount that the individual/deemor can withdraw, subject to the policy below.

A penalty for early withdrawal of the funds in a time deposit does not prevent the resource from being countable. If there is a penalty for early withdrawal of funds, the penalty amount is deducted from the balance of the account in determining the countable resource.

In determining the amount of money in, or the existence of, a bank account at least three bank statements (AP-91) are sent. One is sent to the bank where the individual has or had an account. The others are sent to the banking institutions most likely to have been used by the individual considering the location of home and/or employment. If the statement(s) shows deposit and withdrawal activity or cash flow inconsistent with the applicant's/ recipient's alleged financial situation during 30 months prior to application or while receiving assistance, the agency representative determines if funds were transferred to another individual and/or whether such funds are still available to the applicant/recipient.

0382.15.10.05 Availability of Funds

REV:06/1994

Funds maintained in checking or savings accounts are usually payable on demand. An individual should be able to withdraw money from a checking account on the same day (s)he presents a check.

Funds can usually be withdrawn from a savings account the same day the request is made.

However, some unusual circumstances may occur which prevent the immediate withdrawal of money, and may result in the resource being unavailable. For example, if there is a joint account with only one individual having authority to withdraw money and that individual dies, a prolonged period may elapse before the surviving owner can withdraw the money.

Certain time deposits (e.g. savings certificates or certificates of deposit) may not be legally available to the applicant/deemor until a specific point in time. If so, the policy in Section 0380.30 regarding availability of resources is applied to determine if the resource is not countable until the maturity of the certificate.

0382.15.10.10 Joint Checking and Savings

REV:06/1994

Whenever the applicant is a joint account holder who has unrestricted access to the funds in the account, ALL of the funds in the account are PRESUMED to be the resources of the applicant or deemor. The applicant or deemor will be offered the opportunity to submit evidence in rebuttal of this presumption. A successful rebuttal will result in finding that the funds (or a portion of the funds) in the joint account are not owned by the applicant or the deemor and , therefore, are not the resources of the applicant.

0382.15.10.15 Presump of Owner, One Account

REV:06/1994

When only one holder of a joint account is an applicant who has unrestricted access to the funds in the account, explain to the applicant that ALL of the funds in the account are presumed to be the applicant's. This presumption is made regardless of the source of the funds.

0382.15.10.20 Presump of Owner, Two or More

REV:06/1994

When two or more eligible individuals or applicants (with or without ineligible individuals) are holders of the same joint account and each has unrestricted access to the funds in the account, the agency representative explains the presumption that each eligible individual or applicant owns an EQUAL SHARE of the total funds in the account. This presumption is made regardless of the source of the funds.

0382.15.10.25 Presump of Owner, Joint Account

REV:06/1994

The presumption of ownership which apply to applicants who are joint account holders also apply to deemors who are joint account holders. When a deemor is a joint account holder with an applicant and each has unrestricted access to the funds in the account, ALL of the funds in the account are presumed to be the applicant's resources. If two or more applicants are joint account holders with a deemor, then each eligible applicant owns an equal share of the total funds in the account. If two deemors, who are not considered parents, hold a joint account, "divide" the funds EQUALLY between them for deeming purposes.

0382.15.10.30 Determining Access to Funds

REV:06/1994

The determination of accessibility depends upon the LEGAL STRUCTURE of the account. Where an applicant is a joint holder of a bank account and is legally able to withdraw funds from that account, (s)he is considered to have UNRESTRICTED ACCESS to the funds.

It is possible to have ownership interest in a bank account but have RESTRICTED ACCESS to the funds. An example of language which restricts access is: "In trust for John Jones and Mary Smith, subject to the sole order of John Jones, balance at death of either to belong to the survivor." In this example, only John Jones has unrestricted access. When it is clearly established that all funds in an account are legally accessible to the applicant only in the event of the death of the co-owner, the applicant's access to the funds is restricted and the funds are not a countable resource. Regardless of whether the applicant has unrestricted access to the resources of an individual whose resources must be DEEMED, the funds in the account are deemable resources to the applicant.

If unrestricted access is an issue which cannot be resolved with the evidence on hand, the agency representative requests the financial institution to provide additional information. This may include the

exact language used in the document which established the account, a description of any legal restrictions on the individual's access to the funds, etc.

If there is a legal impediment to the access to funds which may be owned by the recipient, see policy on availability of resources, Section 0380.30.

0382.15.10.35 Rebuttal of Presumpt of Owner

REV:06/1994

There may be a situation where an individual has unrestricted access to the funds in a joint account but does NOT consider himself/herself an owner of the funds (either fully or partially).

For example, the individual may allege that all of the funds in the account are deposited by other account holder(s). The individual may declare that (s)he has never withdrawn funds from the account or, withdrawals were made, the funds were used for or given to the other account holder(s); i.e., the applicant acts as agent for the other acount holder(s).

0382.15.10.40 Rebuttal Procedures

REV:06/1994

When a joint account is alleged or discovered during the applicant process, the agency representative explains the applicable ownership presumption to the applicants or deemors.

If the applicant disagrees with the presumption of ownership, the agency representative provides an explanation of the rebuttal procedure. If the individual chooses not to rebut the presumption of ownership, the resource determination proceeds in the usual manner.

If the individual wishes to rebut the presumption, the agency representative explains to the individual that all of the necessary rebuttal evidence must be submitted within thirty days.

An additional thirty day period is granted if the applicant establishes good cause for his or her inability to provide the necessary documentation within the initial thirty day period.

IF the required information is not provided, the presumption of ownership issued to determine the value of resources.

Once the rebuttal evidence is submitted, the Resource Unit at the DHS Central office determines who owns the funds in the joint account and documents the findings for the record.

If the applicant is ineligible due to any other factor of eligibility (such as excess income) or if a successful rebuttal would not change a determination of ineligibility due to other excess resources, it would then be necessary to initiate the rebuttal procedure.

0382.15.10.45 Evidence for a Success Rebut

REV:06/1994

In order for an applicant/recipient to rebut successfully the presumption of full or partial ownership, ALL of the following evidence is required:

- A statement by the applicant or deemor on an AP-92 containing the penalty clause, giving his/her allegation regarding ownership of the funds, the reason for establishing the joint account, the date the account was made joint, the source of the funds, who made deposits and the source of the deposits, who made withdrawals from the account, how the withdrawals were spent, whose Social Security number was on the account; and,

- Corroborating statements (on form AP-92A) from other account holder(s); and,

- Submittal of the original and revised (if any) account records showing that the change above was made. Photocopies are necessary for the record; and,

- The AP-92 from the applicant and the AP-92A(s) from the joint account holder(s) must provide the information needed to establish that none of the funds, or only a portion of the funds, are owned by the applicant. The applicant must submit all available documentary evidence to support the statements in the AP-92 and AP-92A(s). The evidence should, if available, include a financial institution record, or other source document. A source document is a passbook or other document which shows deposits, withdrawals, and interest for the period for which ownership is being rebutted. The documentary evidence should support the allegations of ownership, and should not contradict the statements on the AP-92 and AP-92A.

It is the applicant's or deemor's responsibility to provide the required evidence. The district office provides assistance in obtaining the evidence only when the individual is unable to do so.

If the applicant alleges that there is no documentary evidence available, s/he must submit evidence to substantiate the allegation. If the rebuttal is successful, a new account must be established in the name of the applicant which contains only the applicant's funds, or a change must be made in the account designation which removes the applicant's name from the account, or restricts the applicant's access to the funds in the account.

0382.15.10.50 Minor/Incompetent Co-Holder

REV:06/1994

If either the applicant or the co-holder of the joint account is incompetent or a minor, it is necessary to obtain a corroborating statement from that individual. That person's incompetency or age may be the reason why the applicant is listed as a joint account holder. In this event, the agency representative obtains 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, the agency representative makes a rebuttal determination without a corroborating statement.

The decision is documented with an explanation why no corroborating statement was obtained. The agency representative determines if the rebuttal is successful.

The rebuttal process may result in determinations showing the applicant owned varying dollar amounts for prior periods.

0382.15.15 Stocks, Bonds, Like Securities

REV:06/1994

Securities may include stocks, bonds, and other securities held individually, or as shares in a mutual fund.

0382.15.15.05 Stocks

REV:06/1994

A STOCK is a negotiable instrument which represents ownership in a corporation. Most stocks are assigned a certain value, known as "par value". Par value, which in many cases is only one dollar, has no significance or correlation to the actual market value of stock.

The value of stock is normally determined by the demand for it when it is bought or sold on one of the stock exchanges or on the "over- the-counter" market. The value of stock frequently varies significantly. The daily fluctuating prices of most stocks are listed on the New York Stock Exchange, the American Stock Exchange or on the "over-the-counter" market. There are also several regional exchanges located in large cities which list stocks not shown on the major exchanges. Many newspapers publish the closing prices for stocks listed on the New York and American Exchanges.

The value of the stock should be determined through one of the listings after verifying the identity of the stock and number of shares held.

0382.15.15.10 Municipal and Corporate Bonds

REV:06/1994

A BOND is not cash but a promise to pay cash to the holder (bearer) of the bond. The term "bond" signifies an obligation in writing to pay a sum of money at a future specified date, usually to the bearer. It is a negotiable instrument and is transferable. The term "bond" is commonly understood in financial circles to be the obligation of a state, its sub-divisions (counties, districts or municipalities) or private corporations. These entities issue municipal or corporate bonds to raise money for improvement projects.

To redeem a municipal or corporate bond for its stated value, it must be held until the specified date of maturity. However, if a person wants to cash in a bond before its maturity date, the current cash value is determined by the market for such bonds, which is similar to stocks. If there is a great demand for certain bonds, the market value may be more than its face value; or less, if there is little or no demand. The bond's current market value may be substantially less than the face value. The current market value of a bond can be determined in the same manner as stocks.

When an individual requests that his/her municipal or corporate bond(s) be sold, it takes about 7 to 10 work-days from the day the brokerage firm completes the transaction to the time the seller receives the proceeds from the sale.

0382.15.15.15 U.S. Savings Bonds

REV:06/1994

U. S. Savings Bonds are backed by the Federal Government. There are several series of U.S. Savings Bonds, which normally can be quickly converted into cash at local banks. However, some bonds must be held at least 60 days from the date of issue before they can be converted into cash, and others must be held for a minimum of 6 months before they can be liquidated. During the period in which the bonds cannot be liquidated, they are not available, and are not countable resources. U.S. Savings Bonds are usually registered in the name of the owner (the name shown on the face of the bond) and are redeemed by the owner completing a form on the back of the bond.

When it is necessary to establish the value of a U.S. Savings Bond, the date of issue on the face of the bond is controlling. The bond's value depends on the time elapsed from the date of issue.

Although many U.S. Savings Bonds have a table of values on the reverse of the bond, this table is often inaccurate since the interest rate may have changed since the bond was issued. Contact a bank for documentation of a U.S. Savings Bond's current value.

0382.15.15.20 Mutual Funds

REV:06/1994

A Mutual Fund is a company that buys and sell securities and other investments as its primary business. Shares in mutual funds represent ownership in the investments held by the fund. The value of the mutual fund shares varies with market conditions. The current value of the shares of many funds is published in the financial section of newspapers. If the current value of the fund is not published, it must be obtained from a broker, or from the fund itself. Most mutual fund shares may be liquidated on demand.

0382.15.15.25 Presump of Owner and Rebuttal

REV:06/1994

Jointly-held financial instruments described in Sections 0382.15.15.05 through 0382.15.15.20 above are subject to the same presumptions of ownership share as for real estate, e.g. the applicant is presumed to own his/her proportional share of the resource. For example, if the applicant owns shares of stock jointly with a sibling, the applicant is presumed to own half the stocks. This presumption is subject to the rebuttal procedure set forth in Sections 0382.15.10.10.25 through 0382.15.10.10.40.

0382.15.20 Promissory Notes, Loans and Mortgag

REV:06/1994

In some financial transactions, the applicant may be the lender who is the person to whom money is owed. This section sets forth the policy for considering transactions or agreements in which the applicant is the lender, or the person to whom money is owed.

Section 0382.15.25 provides policy when the applicant is the borrower, and receives the proceeds of a loan.

Types of instruments in which the applicant may be the LENDER are:

- PROMISSORY NOTES

  A PROMISSORY NOTE is a written agreement signed by a person who promises to pay a specific sum of money at a specified time, or on demand, to the person or organization named on the note as holder. The note may be secured by real estate (a mortgage), or a security agreement on personal property (chattel mortgage). A promissory note held by an individual is a resource of the individual.

- LOANS

  A LOAN is a transaction in which one party advances money (or other property) to another party who promises to repay the amount of the loan in full within his/her lifetime, with or without interest. The loan agreement may be oral or written. When an applicant has loaned money to another, the loan is a resource to the applicant, subject to the policy regarding its negotiability, valuation and salability set forth in the following sections.

0382.15.20.05 Negotiability of Instruments

REV:06/1994

Promissory notes, mortgages, and loan agreements generally may be sold or discounted. For example, a bank may be willing to pay $450 for a $500 promissory note due in one year's time. Promissory notes, mortgages, and loans are negotiable if the owner (lender) has the legal right to sell the instrument, or has an interest in the instrument which can be converted into cash. Examination of the instrument establishes negotiability. Negotiable instruments are countable resources. Questions regarding negotiability are referred to the Office of Legal Counsel for review. Instruments determined to

be non-negotiable by the Office of Legal Counsel are considered unavailable resources.

0382.15.20.10 Valuation

REV:06/1994

Once negotiability is established, the instrument is considered a resource in the amount of the outstanding principal balance, unless the individual can furnish evidence from a reliable source which shows that the instrument is worth a lesser amount. Reliable sources include banks, other financial institutions, real estate brokers, private investors, etc.

0382.15.20.15 Salability

REV:06/1994

If the individual is unable to sell or liquidate the resource because no market exists, the resource is considered to be unavailable, and is not countable. To establish unavailability, the individual must present:

- Evidence showing that the instrument was offered for sale for example, newspaper advertisement; and,
- Statements from two different reliable sources stating that, in their opinion, the instrument cannot be sold, and the reason(s).

The case must be referred by memo to the Assistant Administrator for a determination regarding availability, who will consult with the Office of Legal Counsel, as necessary.

0382.15.20.20 Treat of Count/Non-Count Instr

REV:06/1994

If the instrument is determined to be a non-countable resource, the entire amount of any payments on the loan are considered to be unearned income. If the instrument is a countable resource, the principal portion of each payment is considered to be a converted resource; the interest portion is unearned income.

0382.15.25 Proceeds of a Loan

REV:06/1994

The policy set forth in this section pertains when the applicant is the BORROWER, and receives the proceeds of a loan.

When the applicant is the borrower, the proceeds of a bona fide loan which requires repayment by the applicant are not income or resources in the month of receipt, but become a countable resource if retained beyond that month. If the loan is not bona fide, the proceeds are countable as unearned income when received.

For a loan to be considered bona fide, the terms of the loan must be legally binding on the borrower under State law.

0382.15.25.05 Commercial Loans

REV:06/1994

Loans granted by organizations that are in the lending business (such as banks, finance companies, and credit unions) are considered to be bona fide. There will be a formal written contract between the organization and the borrower which specifies the promise to pay a sum on a certain date, or when certain circumstances are met.

0382.15.25.10 Informal Loans

REV:06/1994

Loans which are negotiated between individuals may be less formal, even unwritten. A bona fide loan may exist without a written contract. The loan need not be secured by specific items of collateral.

A loan agreement (oral or written) must include all the following to be considered bona fide:

- The borrower's acknowledgement of an obligation to repay (with or without interest); and,
- A timetable and plan of repayment; and,
- The borrower's express intent to repay the loan by pledging real or personal property or anticipated income. It is not necessary that the loan be secured by real or personal property. It is necessary that the borrower express intent to repay the loan when funds become available in the future and indicate that s/he will begin repaying the loan when s/he receives future anticipated

income.

If the agreement is oral, statements are obtained from all parties to the loan, and any witnesses to the transaction. The agency representative evaluates the statements to determine if the loan is bona fide.

All documents relating to informal loans are photocopied and retained in the case record. Questionable situations are referred by memo through LTC/AS to the Office of Legal Counsel for review.

All available documentation is attached to the memo.

0382.15.30 Retirement Funds

REV:06/1994

Retirement funds are annuities or work related plans for providing income when employment ends (such as a pension, disability or retirement plan administered by an employer or union), or funds held in Individual Retirement Accounts (IRA'S), or plans for self- employed individuals, sometimes referred to as Keogh plans.

An applicant who owns a retirement fund must apply for the benefits of such fund or liquidate the fund. However, the applicant is not required to terminate active employment in order to make a retirement fund available. If the applicant must terminate employment in order to receive benefits from the retirement fund, the fund is not a countable resource.

If the applicant is eligible for periodic retirement benefits (monthly, quarterly payment, etc.), the retirement fund is not a resource, but the payments from the fund are unearned income when received.

If an applicant owns a retirement fund and is not eligible for periodic payments, but has the option of withdrawing the funds, the retirement fund is counted as a resource. The resource is the amount the applicant can actually withdraw from the account. If there is a penalty assessed for early withdrawal, the resource is the amount available after these penalties are deducted. If taxes are owed on the funds, any taxes due are NOT deducted in determining the value of the retirement fund.

0382.15.35 Annuities

REV:12/2000

An annuity is an investment of funds from which an individual is paid or promised regular payments over a lifetime or a fixed period of time. Generally an annuity is established with a lump sum of money which is paid to a bank, insurance company, or other entity.

A deferred annuity is one under which payments begin at some date to be specified in the future. Once an individual selects a periodic payment option (frequency, amount and duration of payments), the annuity has been annuitized.

An annuity may guarantee periodic payments for a stated period (termed period certain) or guarantee periodic payments for the remainder of the life of the individual, without regard to how long the individual lives (termed life annuity).

When determining eligibility for MA, COUNT AS AN AVAILABLE RESOURCE:

The cash value of an annuity which can be surrendered or "cashed in." The cash value is equal to the amount of money used to establish the annuity, plus any earnings, minus any earlier withdrawals and surrender fees. No consideration in determining cash value is given for income tax withheld or tax penalties for early withdrawal.

Annuity contracts that do not allow for cash surrender but instead allow the owner to sell the annuity on the open market are assignable. Annuity contracts that are silent regarding assignability are presumed to be assignable. Assignable annuities are countable resources. The countable value of the resource is equal to the outstanding principal balance, unless the individual can furnish evidence from a reliable source which shows that the annuity is worth a lesser amount. Reliable sources include banks, other financial institutions, insurance companies, brokers, viatical settlement companies, etc.

COUNT AS AVAILABLE INCOME:

Payments made to the individual from an annuity are counted as unearned income.

TRANSFER OF ASSET PROVISIONS FOR INSTITUTIONALIZED INDIVIDUALS MAY APPLY WHEN:

A non-cashable, non-assignable annuity was purchased by the individual (or the individual's spouse) within thirty-six

(36) months immediately prior to or anytime after the date the individual was both institutionalized and applied for MA. In this case, a determination must be made as to whether its purchase constitutes a transfer of assets for less than fair market value.

To be considered a valid transfer for fair market value, an annuity must:

* provide regular payments, in both frequency and amount, to or for the sole benefit of the individual; and,

* be actuarially sound. Scheduled payments must return at least the principal within the number of years of expected life remaining for the individual. Life expectancy tables compiled from information by the Office of the Actuary of the Social Security Administration and published by the Health Care Financing Administration (HCFA) for this purpose are used to determine the number of years of expected life remaining for an individual.

If based on life expectancy tables complied by the Social Security Administration's Office of the Actuary and published by HCFA, the individual is not expected to live longer than the guaranteed period of the annuity, the annuity is not actuarially sound, and a transfer of assets for less than fair market value has taken place. The transfer is considered to have taken place at the time the annuity was purchased. The uncompensated value of the transfer is based on the amount projected to be paid beyond the individual's reasonable life expectancy. (See Section 0384-Resource Transfers)

Cases involving annuities are referred by field staff to the LTC Administrator for evaluation. The agency representative forwards a copy of the annuity document, including date of purchase to the LTC Administrator.

The LTC Administrator consults, as needed, with the Office of Legal Counsel, and determines:

* whether the annuity is an available or unavailable resource;

* the countable amount of the resource (i.e., the cash surrender value and/or negotiable value of the annuity); and,

* whether a transfer of assets for less than fair market value has occurred as well as and the amount of the uncompensated value and date of the transfer.

EXAMPLE 1:

Mr. Jones, age 65, purchases a $10,000 annuity. The annuity makes regular monthly payments of $100 per month over the course of 10 years. The annuity is not assignable and has no provision for cash surrender.

Because the annuity has no cash surrender or saleable value, it is not a countable resource.

The monthly payments are countable as unearned income both in the determination of MA eligibility and in the post-eligibility process.

Mr. Jones life expectancy according to the table is 14.96. Payments scheduled over his life expectancy total $17,952. ($1,200 per year x 14.96 years = $17,952). He is expected to: 1)live longer than the guaranteed payment period of 10 years; and, 2) receive payments totally at least the amount invested over that period. Thus the annuity is actuarially sound and no transfer of assets for less than fair market value has taken place.

EXAMPLE 2:

Mr. Smith, age 80, purchases the same $10,000 annuity which pays $100 per month over 10 years. However, his life expectancy is only 6.98 years. Thus a payout of just under three years is considered a transfer of assets for less than fair market value. That amount is subject to a penalty if the annuity was purchased within thirty-six months prior to the date Mr. Smith was both institutionalized and applied for MA.

EXAMPLE 3:

Mr. Fisher, age 88, purchases a $25,000 annuity six months prior to entering a nursing facility and

applying for MA. The annuity pays him $200 per month for "life." The annuity has no cash value and is not assignable. His nephew is named beneficiary and will receive a lump sum or periodic payment upon Mr. Fisher's death.

The monthly payments to Mr. Fisher are counted as unearned income both in eligibility and post-eligibility determinations.

Mr. Fisher's life expectancy according to the table is 4.34 years. Paying $2400 per year ($200/month), the annuity payments over the term of his expected life (4.34 years) total $10,416. Since the scheduled payments do not return at least the principal invested during Mr. Fisher's expected life, a transfer of assets for less than fair market value has occurred. The amount of the uncompensated value of the transfer is equal to the amount invested ($25,000) minus the amount scheduled to be paid during his expected life ($10,416). $25,000 - $10,416 = $14,584.
A transfer of assets penalty is assessed based on an uncompensated transfer of $14,584 made on the date the annuity was purchased.

EXAMPLE 4:

Mrs. Findlay, age 65, purchases a $10,000 annuity on January 1st. Under the terms of the contract, she has the right to cancel and receive the full amount of $10,000 back within ninety (90) days of the purchase. She applies for MA on February 15th.

Because the annuity provides for a $10,000 cash surrender at the time of MA application, this amount is added to Mrs. Findlay's countable resources. Her MA application is denied.

0382.15.35.05 Life Expectancy Tables

REV:12/2000

LIFE EXPECTANCY TABLES
TO BE USED WHEN EVALUATING ANNUITIES

Male Life	Female Life	Male Life	Female Life

Age	Exp.	Exp.	Age	Exp.	Expectancy
0	71.80	78.79	30	44.06	50.15
1	71.53	78.42	31	43.15	49.19
2	70.58	77.48	32	42.24	48.23
3	69.62	76.51	33	41.33	47.27
4	68.65	75.54	34	40.23	46.31
5	67.67	74.56	35	39.52	45.35
6	66.69	73.57	36	38.62	44.40
7	65.71	72.59	37	37.73	43.45
8	64.73	71.60	38	36.83	42.50
9	63.74	70.61	39	35.94	41.55
10	62.75	69.62	40	35.05	40.61
11	61.76	68.63	41	34.15	39.66
12	60.78	67.64	42	33.26	38.72
13	59.79	66.65	43	32.37	37.78
14	58.82	65.67	44	31.49	36.85
15	57.85	64.68	45	30.61	35.92
16	56.91	63.71	46	29.74	35.00
17	55.97	62.74	47	28.88	34.08
18	55.05	61.77	48	28.02	33.17
19	54.13	60.80	49	27.17	32.27
20	53.21	59.83	50	26.32	31.37
21	52.29	58.86	51	25.48	30.48
22	51.38	57.89	52	24.65	29.60
23	50.46	56.92	53	23.82	28.72
24	49.55	55.95	54	23.01	28.86
25	48.63	54.98	55	22.21	27.00
26	47.72	54.02	56	21.43	26.15
27	46.80	53.05	57	20.66	25.31
28	45.88	52.08	58	19.90	24.48
29	44.97	51.12	59	19.15	23.67
60	18.42	22.86	95	2.90	3.36
61	17.70	22.06	96	2.74	3.16
62	16.69	21.27	97	2.60	2.97
63	16.30	20.49	98	2.47	2.80
64	15.62	19.72	99	2.34	2.64
65	14.96	18.96	100	2.22	2.48
66	14.32	18.21	101	2.11	2.34
67	13.70	17.48	102	1.99	2.20

68	13.09	16.76	103	1.89	2.06
69	12.50	16.04	104	1.78	1.93
70	11.92	15.35	105	1.68	1.81
71	11.35	14.66	106	1.59	1.69
72	10.80	13.99	107	1.50	1.58
73	10.27	13.33	108	1.41	1.48
74	9.27	12.68	109	1.33	1.38
75	9.24	12.05	110	1.25	1.28
76	8.76	11.43	111	1.17	1.19
77	8.29	10.83	112	1.10	1.10
78	7.83	10.24	113	1.02	1.02
79	7.40	9.67	114	0.96	0.96
80	6.98	9.11			
81	6.59	8.58			
82	6.21	8.06			
83	5.85	7.56			
84	5.51	7.08			
85	5.19	6.63			
86	4.89	6.20			
87	4.61	5.79			
88	4.34	5.41			
89	4.09	5.05			
90	3.86	4.71			
91	3.64	4.40			
92	3.43	4.11			
93	3.24	3.84			
94	3.06	3.59			

0382.20 LIFE INSURANCE

REV:06/1994

Life insurance that is owned by the applicant (or deemor) is a resource which is evaluated according to the face value threshold limits set forth in Section 0382.20.15. Policies on the applicant's life owned by others are not countable unless deeming policies apply. However, regardless of ownership, all policies on the individual's life are recorded in the case file for use in the event a subsequent request for assistance with burial expenses is made.

0382.20.05 Types of Policies

REV:06/1994

A life insurance policy can be either a GROUP or INDIVIDUAL policy.

Group insurance policies generally have no cash surrender value.

Group policies are usually issued through a company or organization insuring the participating employees or members and perhaps their families. The group policy may be paid partially by the employer.

This is not counted as a resource. The individual policy is paid for entirely by the owner of the policy.

Individual policies include policies having no cash surrender value (term insurance) and those having a cash surrender value (ordinary life, limited payment life, or endowment).

0382.20.10 Life Insurance Terminology

REV:06/1994

FACE VALUE is the amount for which a policy is written, or the benefit amount. For example, a $10,000 insurance policy has a face value of $10,000.

CASH SURRENDER VALUE -- As the premiums of certain life (not term insurance) policies are paid over time, a cash value accumulates in the policy. The cash surrender value is the amount of cash which may be advanced to the policy owner when the policy is surrendered according to the conditions stipulated in the policy.

A TERM INSURANCE POLICY is a contract of temporary protection. The insured pays relatively small premiums for a limited number of years, and the company agrees to pay the face amount of the policy only if the insured should die within the time specified in the policy. If the insured outlives the period, he receives nothing.

It is a temporary protection. USUALLY A TERM INSURANCE POLICY HAS NO CASH SURRENDER VALUE and is not counted as a resource.

AN ORDINARY LIFE (known as whole or straight) policy is a contract for which the insured pays the premium during his life time or to age one hundred (unless purchased by a single premium or by letting dividends accumulate). The company pays the face value of the policy to the beneficiary upon the death of the insured. THIS POLICY HAS A CASH SURRENDER VALUE, usually after the second year.

The policy combines protection and savings with the emphasis on protection for the whole life.

A LIMITED PAYMENT LIFE POLICY is a contract for which the insured makes payments for a definite number of years (20 or 30) after which no more payments are required. The policy remains in force for life and affords the same protection as an ordinary life policy. THE POLICY HAS A CASH SURRENDER VALUE.

AN ENDOWMENT INSURANCE promises payment upon death of the insured within a specified period or upon his survival to the end of a specified period. AN ENDOWMENT HAS A CASH SURRENDER VALUE.

INSURED PERSON - The insured person shown on the policy identifies the person whose life is insured. The $1,500 ($4,000 for Medically Needy) face value exclusion applies to all policies on each insured person which are owned by the applicant (individual or couple).

The exclusion applies to policies the applicant holds on his life, the life of a family member, or the life of any other person.

Where the face value exclusion is exceeded on one insured person, this does not affect its application to policies on another insured person.

JOINT POLICIES generally cover a man and wife, often with whole life for the husband and term for the wife.

FAMILY POLICIES cover each family member on one policy. They are sometimes a combination of whole life for the father and term for the mother and children.

OWNER OF THE POLICY - The owner of the policy is the only person who can receive the proceeds under the cash surrender provisions of the policy. If the applicant is the insured person, but not the owner, the value of the policy does not count as his/her resource unless deeming policy applies. Conversely, if another individual is the insured person, but the applicant is the owner, the value of the policy counts as his/her resource (subject to the $1,500/$4,000 face value exclusion). If the consent of another person is needed to cash in a policy, and consent cannot be obtained after a reasonable effort, the insurance policy is excluded.

0382.20.15 Policy and Procedure for Evaluation

REV:06/1994

STEP 1: Determine the face value of each insurance policy on the individual as listed on the application. Total the face values of all policies owned by the individual or couple, or in a deeming situation, policies owned by a spouse or parent. If the total face value of all the policies is less than the appropriate face value threshold for exclusion ($1,500 for Categorically Needy determinations, $4,000 for Medically Needy), no further determination is needed. There is no countable resource from life insurance. If the total exceeds the appropriate face value threshold limit, all the policies must be reviewed further.

STEP 2: Exclude all policies that do not have a cash surrender value (e.g., group insurance, term insurance). Sum up the face values of all remaining policies to determine the total face value of all policies which do have a cash surrender value. If the total face value is now less than the appropriate limit, there is no countable resource from life insurance.

STEP 3: If the total face value still exceeds the appropriate face value threshold limit, determine the total cash surrender value of all policies. The total cash surrender value of all policies counts toward the basic resource limit.

Staff should note that the tables of values accompanying many policies may be inaccurate due to the existence of a loan on the policy, or due to changes in the rate at which the policy gains value. The cash surrender value of each policy should be obtained directly from the issuing insurance company.

STEP 4: Retain copies of all policies and relevant documents for the case record.

If countable resources exceed the appropriate basic resource limit, due in whole or in part to the countable value of life insurance, the individual/couple is ineligible and may pursue one of the following options:

- Cash in a policy to bring the resource within the limit;
- Spend down the cash amount by which the resource exceeds the eligibility limit of combined cash, stocks, bonds and personal property;
- Adjust the insurance to bring it within the eligibility limit;
- Determine eligibility for a Burial Funds Set-Aside

(Section 0382.45); or,

- Elect to retain the resources and the case will be rejected/closed.

0382.20.20 Policies Owned by Spouses

REV:06/1994

Policies owned separately by a husband and wife on the same person (e.g., a child), must be evaluated together, (e.g., the husband and wife may each hold a policy on a child with a face value of $1,000). Since the COMBINED total face value exceeds the $1,500 Categorically Needy face value limit, the entire cash surrender value of both policies counts as a resource in the Categorically Needy determination. CONVERSELY, BECAUSE THE COMBINED FACE VALUES ARE LESS THAN THE $4,000 MEDICALLY NEEDY FACE VALUE LIMIT, THERE IS NO COUNTABLE RESOURCE IN A MEDICALLY NEEDY DETERMINATION.

0382.25 HOUSEHOLD AND PERSONAL EFFECTS

REV:06/1994

Household goods and personal effects are excluded if their total current market value does not exceed the following threshold values:

- For Categorically Needy eligibility $2,000;

- For Medically Needy eligibility $5,000.

An applicant's household goods and personal effects are excludable unless there is strong evidence that their value is exceptional or unusual. For the purpose of determining the total joint resources of a couple, the spousal share of resources, the community spousal resource allowance, and MA eligibility for an institutionalized individual with a community spouse, all household goods and personal effects are excluded, regardless of value.

Household appliances, furniture, carpeting, drapes, utensils, garden equipment, etc. are essential for the care and maintenance of the premises to support an adequate standard of health or the normal life comforts. Clothing, hobbies of reasonable value, jewelry, family heirlooms, and other effects typically restricted to the use of one individual are also essential to maintaining a reasonable living standard.

0382.25.05 Items of Exceptional Value

REV:06/1994

When there is evidence that the applicant possesses household or personal items of unusual or exceptional value, there shall be verification that such item is a resource by establishing the fair market value (FMV) for it. Items of unusual value are those not essential to the physical health and safety, or items not normally used to maintain an adequate standard of comfort and convenience for the household.

Recreational boats, expensive jewelry (one wedding ring and one engagement ring are always excluded), art objects, or valuable collections are luxury items of unusual value and represent resources that can, along with other countable resources, exceed the resource limit for eligibility.

In such cases, a FMV is established for each such item and the amount is added to the $1,000. The $2,000 exclusion is subtracted.

(Do not include excluded items in this computation.) If there is a balance which, when added to other countable resources, would exceed the basic resource limit and render the individual/couple ineligible, it is then necessary to establish the equity value of the items and recompute in the same manner, as above. If the total equity value of household goods and personal property computed as above is in excess of the tangible personal property limit ($2,000, for Categorically Needy determinations, or $5,000 for Medically Needy determinations), the value in excess of the tangible personal property limit is a resource countable toward the appropriate basic resource limit.

0382.30 AUTOMOBILE(S)

REV:06/1994

An automobile is any vehicle which is used to provide necessary transportation, such as passenger automobiles, trucks, boats and special vehicles (e.g., snowmobiles, animals or animal-drawn vehicles).

0382.30.05 Exclusion Based on Use

REV:06/1994

One automobile (motor vehicle) will be TOTALLY EXCLUDED regardless of value if (for the individual or member of the individual's household):

- It is necessary for employment; or,
- It is necessary to get to medical treatment for a specific or regular medical problem (used at least four times a year to receive treatment or to pick up prescribed medication for a specific medical problem); or,
- It is modified for operation by or for transportation of a handicapped person.

0382.30.10 Threshold Exclusion

REV:06/1994

If no automobile (motor vehicle) is excluded based on use, one automobile is excluded from counting as a resource to the extent its NADA book value does not exceed a threshold of $4,500. If the automobile exceeds the $4,500 threshold, the amount in EXCESS of $4,500 is counted toward the basic resource limit. EQUITY VALUE IS NOT USED IN APPLYING THIS PROVISION. HOWEVER, THE LOWEST NADA VALUE ASSIGNED TO THE TYPE OF AUTOMOBILE IS USED, MINUS THE AMOUNT ALLOWED FOR ANY EQUIPMENT THE AUTOMOBILE DOES NOT HAVE.

0382.30.15 Additional Vehicles

REV:06/1994

The EQUITY VALUE of any additional automobiles or motor vehicles is counted toward the basic resource limit.

0382.35 BURIAL SPACES

REV:06/1994

Burial space owned by the individual intended for use by the individual, his/her spouse or another member of the individual's immediate family is excluded from resources.

Burial space owned by an individual from whom resources are deemed to an applicant is excluded if the burial space is intended for use by the individual, the individual's spouse or another member of the individual's immediate family.

0382.35.05 Definitions

REV:06/1994

The following definitions apply to determinations regarding burial spaces:

- BURIAL SPACE

  Burial spaces are conventional gravesites, crypts, mausoleums, urns or other repositories which are customarily and traditionally used for the remains of deceased individuals.

- IMMEDIATE FAMILY

  Immediate family includes an individual's minor and adult children, stepchildren, adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those individuals.

  Dependency and living-in-the-same household are not factors. Immediate family DOES NOT INCLUDE the members of an ineligible spouse's family unless they meet this definition.

0382.35.10 Examples of Burial Space Eval

REV:06/1994

EXAMPLE: Mary Jackson is applying for Medical Assistance. She owns three gravesites which she states are intended for the use of herself, her daughter and her daughter's future husband. Two of the gravesites are excluded. One cannot be excluded because it is intended for the use of an individual (her daughter's future husband) who is not currently a member of Mary Jackson's immediate family.

EXAMPLE: Bob Sullivan is applying for Medical Assistance. His resources are deemed to include those of his wife, Alice Sullivan, who owns four burial spaces. Alice Sullivan states that the burial spaces are intended for use by herself, Bob, John Sullivan (Bob's brother) and Frances Gates (Alice's sister). Three of the burial spaces are excluded. One cannot be because it is intended for the use of Frances Gates who is not a member of Bob's immediate family.

0382.40 IRREVOC BURIAL CONTRACTS, TRUSTS

REV:06/1994

Funds in an IRREVOCABLE agreement which are available only for burial are excluded from countable resources. These are:

- Funds which are held in an irrevocable burial contract, or irrevocable burial trust; or,

- An amount in an irrevocable trust specifically identified for burial expenses.

When, prior to application, an individual has an irrevocable contract or trust, the funds are not considered as a countable resource. To determine revocability or irrevocability, the contract or trust must be evaluated. A photocopy must be filed in the record.

0382.40.05 Id a Revocable Contract/Trust

REV:06/1994

A burial arrangement that may be liquidated by the mutual consent of the buyer (the individual) and the seller (the funeral director) is considered revocable unless the seller refuses to consent to liquidation. A statement of the seller's willingness or unwillingness to liquidate the arrangement is obtained and a copy placed in the record. If the seller is willing to liquidate, the arrangement is considered revocable; if the seller is unwilling to liquidate, the arrangement is considered irrevocable.

Any questions regarding revocability will be sent in writing through the Assistant Administrator in Long Term Care, with appropriate documentation, who will consult with the Office of Legal Counsel, as necessary.

If the contract or trust is revocable, it may be considered as "funds set aside for burial" or cash, depending on the amount of other resources. If the contract or trust is irrevocable, then the amount allowed as "funds set aside for burial" must be reduced by the amount held in the irrevocable burial arrangement.

0382.40.10 Post-Elig Burial Agreement

REV:06/1994

After eligibility has been established, an individual who wishes to do so may place some or all of his/her resources, that are within the resource limit, in an irrevocable burial arrangement without affecting eligibility.

0382.45 FUNDS SET ASIDE FOR BURIAL

REV:06/1994

In addition to cash which may be retained under the appropriate basic resource limit, the applicant is permitted to set aside up to $1,500 in a separately identifiable fund for burial purposes. Funds can include a revocable burial contract, burial trust or any separately identifiable resource. If the conditions set forth below are met, the set-aside amount is excluded from resources.

The maximum amount which may be excluded from resources as a burial set aside is $1,500 for both Categorically Needy and Medically Needy determinations. The maximum excludable set aside amount is reduced by amounts held in irrevocable burial contracts and certain insurance policies, as specified below. At each application it is necessary to learn whether any funds are set aside for burial of the eligible individual or the eligible individual's spouse. If there are no such funds, no special procedures are required.

0382.45.05 Comput Burial Set-Aside Funds

REV:06/1994

If the applicant has funds set aside for burial, the amount which is excluded from resources is determined in the following manner:

- Start with the maximum of $1,500 for an individual and $1,500 for the spouse.

  Funds can include a revocable burial contract, burial trust or any separately identifiable resource.

- Reduce the maximums by the FACE VALUE of any non-term life insurance policies ON THE INDIVIDUAL'S LIFE, owned by the individual or the spouse, if the cash surrender values of the policies were excluded in determining countable resources according to policy in section 0382.20, Life Insurance. For Categorically Needy individuals, this means the total face values of such non-term life insurance policies which have cash surrender values and the total face values are $1,500 or less. For Medically Needy individuals, this means the total face values of such non-term life insurance policies which have cash surrender values and the total face values are $4,000 or less. (The face amounts of term life insurance or other life insurance on the individual's life, owned by his/her spouse, which have no

cash surrender values, have no affect on the amount that can be set aside for burial).

- o Reduce the balance further by the amount held by each individual in an irrevocable burial arrangement as defined in 0382.40.

- o When both of these resources have been deducted from the $1,500 limit, any remaining balance may be set aside in a burial fund which meets the following requirements.

  The funds must be:

  - Separately identifiable and not combined with other funds or resources which are not set aside for burial. If they are combined, they must be restructured into separate accounts with separate account numbers within the month of application, if eligibility is to exist for that month.

  - Clearly designated as set aside for burial. If the funds are not so designated, the funds may be excluded if the individual states that he/she intends to use the funds for burial and submits, within 30 days of application, a statement (AP-5.2) and documentary evidence that the funds have been designated as set aside for burial. Where the funds are set aside in a bank account, it is necessary to obtain a copy of the account to verify the existence and amount of the "set-aside" account. The designation that the funds are for burial need not be indicated on the account since banks will not normally allow the designation.

- o Obtain a statement (AP-5.2) from each individual and/or deemor regarding the revocable burial agreement, trust and/or fund set aside for burial. The statement must be dated and must include the amount, account number (if applicable) and other pertinent information in each such arrangement. If a contract or trust, the statement should be fastened to the record copy of the contract or trust.

  Once excluded from resources, any increase in the value of excluded burial funds due to interest on such funds which was left to accumulate, or appreciation of such funds which occurred after the date of first eligibility,

is excluded.

Once a burial set-aside is excluded in whole or in part from resources, the excluded funds may not be used for any purpose other than burial expenses. An individual with set-aside must be advised that if the excluded set aside funds are used for any purpose other than burial, the amount used must be counted as income.

Eligibility will need to be redetermined (including this additional income) for the period during which the income was used. Any question of fraud should be referred in accordance with Section 107.

0382.45.10 Burial Set-Aside Examples

REV:06/1994

The following examples assume that the funds are separately identifiable and clearly designated for burial, and that the individuals possess only the resources indicated.

- An individual has $1,900 in cash, no life insurance and $1,500 in an account set aside for burial. S(he) has countable resources of $1,900 and is resource-eligible as Categorically Needy.

  Example:

Max. Possible Set-Aside	$1,500
Insurance excluded previously	- 0
	$1,500
Irrevocable Contract	- 0
Allowable Set-Aside	$1,500

- An individual has $2,000 in cash, $1,500 set aside for burial and a term insurance policy on his/her life with face value of $7,000. The face amount of this insurance policy does not affect the amount available (or set aside) and thus this individual has countable resources of $2,000, and is eligible as Categorically Needy.

  Example:

Max. Possible Set-Aside	$1,500
Insurance excluded previously	- 0

	$1,500
Irrevocable Contract	- 0
Allowable Set-Aside	$1,500

- An individual has cash of $3,900, no insurance, an irrevocable burial contract of $1,500, and $1,500 set-aside. The excludable set aside amount is determined by reducing the maximum possible excludable set aside of $1,500 by the $1,500 in the irrevocable contract. There is no excludable set-aside amount. Therefore, the individual has countable resources of $5,400 and is ineligible both as Categorically Needy and Medically Needy.

  Example:

Max. Possible Set-Aside	$1,500
Insurance excluded previously	- 0
	$1,500
Irrevocable Contract	-1,500
Excludable Set-Aside	0

- An individual has a bank account of $1,900 and life insurance with a face value of $2,000, cash surrender value of $1,500. In a Categorically Needy determination, the total cash resources are $3,400 ($1,900 bank account plus $1,500 cash value of overthreshold insurance), and the individual would be ineligible.* However, the individual states that s(he) plans to use $1,500 in the bank account as a set-aside for burial and submits an AP-5.2 and evidence of restructured bank accounts within 30 days. In this instance, the individual would be eligible since the cash surrender value of the insurance plus the $400 remaining in the original account is within the Categorically Needy resource limit. The bank account containing the burial funds qualifies as an excludable set-aside as long as the funds remain untouched.

  Example:

Max. Possible Set-Aside	$1,500
Insurance excluded previously	- 0
	$1,500
Irrevocable Contract	- 0

Allowable Set-Aside	$1,500

The set-aside can be either a portion of the bank account or the insurance.

* Note that in a Medically Needy determination, the life insurance face value is less than the $4,000 threshold. As a result, the cash value of the life insurance policy is excluded. The $4,000 face value reduces the permissible set-aside to zero.

- An individual has $1,500 in a bank account, non-term life insurance with a face value of $500 and non-home property valued at $800. The individual states that the property is to augment the insurance for burial.

Example:

Maximum Set-aside	$1,500
Insurance excluded previously	-500
	$1,000
Irrevocable Contract	-0
Allowable Set-Aside	$1,000

The non-home property is an allowable set-aside. The individual is eligible once the statement regarding the set-aside is completed.

0382.50 TRUSTS

REV:12/2000

A trust is an arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or certain designated beneficiaries.

When an applicant or recipient is a party to a trust, the trust must be reviewed to determine if it has an impact on the individual's eligibility for MA. Trusts and portions of trusts may be treated as available income, available resources or as a transfer of assets for less than fair market value. Trusts are referred to the LTC Administrator for evaluation.

Trusts established prior to 8/11/93, called Medical Assistance Qualifying Trusts, are treated under provisions contained in 0382.50.05 and 0382.50.05.05.

Trusts established on or after 8/11/93 are evaluated in accordance with provisions contained in 0382.50.10

Exceptions to trust provisions are contained in 0382.50.25.

The following definitions apply in general to trusts created other than by will:

A TRUST is any arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or other designated beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by will. If the trust includes assets of the individual and other person(s), this policy applies only to the portion of the trust attributable to the individual. A trust must be valid under Rhode Island law.

A REVOCABLE TRUST is one which:

- under RI law can be revoked by the grantor;
- provides for modification or termination by a court; or,
- terminates if some action is taken by the grantor.

AN IRREVOCABLE TRUST is one which cannot, in any way, be revoked by the grantor.

THE GRANTOR/SETTLOR is the person who creates a trust. For purposes of this policy the term grantor/settlor includes:

- the individual;
- the individual's spouse;
- A person, including a court or administrative body, with legal authority to act on behalf of the individual or the individual's spouse; and,
- A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

THE BENEFICIARY/GRANTEE is the person(s) for whose benefit the trust exists. In some cases, the person creating the

trust (the trustor) is named as one of the beneficiaries.

THE TRUSTEE is the person or entity (such as a bank or insurance company) that holds and manages a trust, and has fiduciary responsibilities. In most cases, trustees do not have the legal right to use the trust fund for their own benefit.

THE TRUSTEE'S DISCRETION is the power the terms of the trust grant expressly to the trustee to use judgement as to when and/or how to handle trust income and/or principal. Not all trusts grant discretion to a trustee.

THE TRUST PRINCIPAL is the property or funds placed in trust by the trustor who set up the trust.

TRUST INCOME is the amount earned by trust property. Trust income may take various forms, such as interest, dividends, or rent. Trust income may also be called trust earnings.

A TRUST DOCUMENT is the legal document setting forth the terms of the trust.

0382.50.05 Trusts Established Prior to 8/11/93

REV:12/2000

A trust, or similar legal device, is called a MEDICAL ASSISTANCE QUALIFYING TRUST when it:

- was established prior to 8/11/93 by the individual, the individual's spouse or legal guardian, or the individual's legal representative acting on his/her behalf;
- was established through a method other than a will;
- names the individual as a beneficiary;
- gives a trustee any discretion to disburse funds from the trust to or for the benefit of the individual; and
- was created for a purpose other than to qualify for MA.

Medical Assistance Qualifying Trusts may be irrevocable or revocable. There are no "use" limits on the funds in a Medical Assistance Qualifying Trust; trusts established by the individual to pay for special needs (e.g., medical, rehabilitative, or educational) may be considered MA Qualifying Trusts insofar as they meet the criteria above.

However, if a beneficiary of a trust is a mentally retarded individual who resides in an Intermediate Care Facility for the Mentally Retarded, that individual's trust is NOT considered a Medical Assistance Qualifying Trust, provided the trust or initial trust decree was established prior to April 7, 1986, and is solely for the benefit of that mentally retarded individual.

Legal instruments such as trusts are almost always drafted by an attorney. It is the grantor (beneficiary) himself who actually establishes or creates the trust when he signs or executes it.

0382.50.05.05 Eval an MA Qualifying Trust

REV:12/2000

In the determination of financial eligibility and in the post-eligibility treatment of income, count as AVAILABLE to the applicant the maximum amount which the trustee(s) may distribute from a Medical Assistance Qualifying Trust. The maximum amount is the amount that the trustee could disburse if (s)he exercised his/her full discretion under the terms of the trust.

Distributions are considered available to the individual establishing the trust whether or not the distributions are actually made or the trustee(s) exercise their authority under the trust.

The amount from the trust that is deemed to be available as a RESOURCE to the beneficiary is the maximum amount that could have been distributed to the beneficiary from the PRINCIPAL of the trust under the terms of the trust, provided the trustee exercised his full discretion under the terms of the trust to distribute the maximum amount to the beneficiary.

The amount from the trust that is deemed to be available as INCOME to the beneficiary is the maximum amount that could have been distributed to the beneficiary from the INCOME of the trust under terms of the trust, provided the trustee exercised his full discretion under the terms of the trust to distribute the maximum amount to the beneficiary.

The maximum distributable amounts deemed available include only those amounts which CAN be but are not distributed from either the income (interest) or principal of the trust. Amounts which are actually distributed to the beneficiary for any purpose, including amounts to pay for the beneficiary's health, personal and other maintenance needs, are treated as income and/or resources, depending on whether the distribution was made from the income or principal of the trust.

0382.50.10 Trusts Established On Or After 8/11/93

REV:12/2000

The following provisions apply to TRUSTS ESTABLISHED BY THE INDIVIDUAL (as defined below) OTHER THAN BY WILL ON OR AFTER 8/11/93. These rules apply without regard to:

- the purpose for which the trust was established;
- whether the trustees have or exercise any discretion under the trust;
- any restriction on when or whether distribution can be made from the trust; or
- any restriction on the use of distributions from the trust.

The term individual includes: the individual; the individual's spouse; any person, including a court or administrative body, with legal authority to act on behalf of the individual or the individual's spouse; and any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse. A trust must be valid under RI law.

I. REVOCABLE TRUSTS

A revocable trust is a trust which under RI law can be revoked by the grantor. A trust which provides for modification or termination by a court is considered to be revocable since the grantor can petition the court to terminate the trust. A trust which is called irrevocable but which terminates if some action is taken by the grantor is also a revocable trust. For example, a trust may require the trustee to terminate a trust and disburse funds to the individual if the individual leaves a nursing facility. This would be considered to be a revocable trust.

Revocable trusts are treated as follows:

* The entire corpus of the trust is treated as a countable RESOURCE;

* Payments made from the trust to or for the benefit of the individual are counted as available INCOME;

* Any other payments made from the trust are considered to be a TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE and are subject to a TRANSFER PENALTY as provided Section 0384 when payment was made within sixty (60) months immediately prior to or anytime after the individual was both institutionalized and applied for MA.

* The home or former home of the individual held in a revocable trust established on or after December 1, 2000 is a countable resource. Where the home is an asset of the trust, it is not subject to the exclusion provision contained in 0382.10.05.

EXAMPLE: Mr. Baker establishes a revocable trust with $100,000 on March 1, 2000. He enters a nursing facility on November 15, 2003 and applies for MA on August 15, 2004. Each month the trustee disburses $100 as an allowance to Mr. Baker and $500 to a property management firm for upkeep on his home. On June 15, 2000, the trustee gives $50,000 from the trust to Mr. Baker's brother, leaving $50,000 in the trust.

In this example, the $100 personal allowance and the $500 for upkeep of the home count as unearned income each month to Mr. Baker. Because the trust is revocable, the entire value of the corpus, $50,000, is considered a countable resource to Mr. Baker.

The giveaway is treated as a transfer of assets for less than fair market value. Because the trust is revocable, the look back period for such transfers is sixty (60) months. Since the transfer occurred (June 15, 2000) within 60 months immediately prior to the date in which Mr. Baker was both institutionalized and applied for MA (August 15, 2004), a penalty under the transfer of assets provisions is imposed. The penalty period begins June 1, 2000, (the first of the month in which transfer occurred). The length of the penalty period, during which payment for Mr. Bakers nursing facility care is denied, is based on the amount of the uncompensated transfer ($50,000), divided by the average monthly cost of private nursing facility care. (See Sections 0384.15-0384.45 for Transfer of Assets rules.)

II. IRREVOCABLE TRUSTS

An irrevocable trust is one which cannot, in any way, be revoked by the grantor. Irrevocable trusts are treated as follows:

* Payments from trust income or principal which are made to or for the benefit of the individual are treated as INCOME to the individual;

* Portions of the principal which COULD BE PAID to or for the benefit of individual are treated as an available RESOURCE;

* Payments from income or principal which under the trust could have been made to or for the benefit of the individual, but are instead made to someone else and not for the benefit of the individual are treated as a TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE and are subject to a penalty if made with thirty-six (36) months immediately prior to or anytime after the month the individual was both institutionalized and applied for MA.

* Portions of the trust which CANNOT UNDER ANY CIRCUMSTANCES BE PAID to or for the benefit of the individual are treated as a TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE and are subject to a penalty if made within sixty (60) months immediately prior to or anytime after the month individual was both institutionalized and applied for MA.

* The home or former home of the individual held in an irrevocable trust established on or after December 1, 2000 is not subject to the intent to return exclusion provision contained in 0382.10.05.

For portions of trusts which are treated as a transfer, the date of the transfer is considered to be the date the trust was established or, if later, the date which payment to the individual was foreclosed. The uncompensated value of the transfer can be no less that its value on the date of transfer.

When additional funds are added to a trust, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds were added to that portion of the trust.

EXAMPLE 1: Mr. Baker establishes an irrevocable trust with $100,000 on March 1, 2000. He enters a nursing facility on November 15, 2003 and applies for MA on August 15, 2004. Each month the trustee disburses

$100 as an allowance to Mr. Baker and $500 to a property management firm for upkeep on his home. On June 15, 2000 the trustee gives $50,000 from the trust to Mr.

Baker's brother, leaving $50,000 in the trust. The trustee has discretion to disburse the entire principal and all income from the trust to anyone, including the grantor.

> The $100 personal allowance and $500 for home upkeep are countable income to Mr. Baker. The amount left after the giveaway is a countable resource to Mr. Baker since there are circumstances under which payment of this amount COULD BE MADE to Mr. Baker.
>
> The $50,000 gift to Mr. Baker's brother is treated as a TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE. However, the look back period in this situation is only 36 months. Since the transfer occurred (June 15, 2000) more than 36 months prior to the date Mr. Baker was both institutionalized and applied for MA (August 15, 2004), no penalty for transfer is imposed.

EXAMPLE 2: Mrs. Jones places her home in an irrevocable trust on December 1, 2000. The property does not produce income. On July 15, 2002, she is admitted to a nursing facility (NF) and applies for MA. Under the trust provisions, no payments can be made to Mrs. Jones.

> The equity value of her home is considered to be a transfer of assets for less than fair market value. The transfer is considered to have taken place on December 1, 2000, the date the trust was established. Because under the trust agreement no payment can be made to Mrs. Jones, the look back period is sixty (60) months. Since the transfer did occur (December 1, 2000) within sixty (60) months prior to the date Mrs. Jones was institutionalized and applied for MA (July 15, 2002), a penalty is imposed beginning December 1, 2000. During this penalty period, payment of long term care services is denied. The length of the penalty period is calculated by dividing the equity value of the home by the average cost of care to a private patient in a NF.

EXAMPLE 3: Mrs. Carothers establishes an irrevocable trust on December 1, 2000 with $1. On March 1, 2001, she places her home in the trust. The property does not produce income. Under the trust provisions, no distributions can be made to or for Mrs.

Carothers. On July 1, 2003, she is admitted to a nursing facility and applies for MA.

The equity value of her home is considered to be a transfer of assets for less than fair market vale. The transfer is considered to have taken place on March 1, 2001, the date the home was placed in the trust. As in example 2, the look back period is sixty (60) months. Since the transfer occurred within sixty (60) months prior to the date Mrs. Carothers was institutionalized and applied for MA, a penalty is imposed beginning March 1, 2001. The length of the penalty period is calculated by dividing the equity value of the home by the average cost of care to a private patient in a nursing facility.

0382.50.15 Trust Evaluation Process

REV:12/2000

When field staff encounter a trust, the individual must provide a copy of the trust document or other device, and relevant documents to verify the value of any investments and distributions that have been made by the trustee. A memorandum, along with copies of the trust document and all documentation, is forwarded to the LTC Administrator for a determination of: a) the amount of countable income and/or resources; and b) the date and amount of any prohibited transfer of assets. Copies are retained in the case record. The Office of Legal Counsel is available for consultation with the Administrator to aid in establishment of the countable resource amount. The countable income/resource amount is added to other countable income/resources to determine eligibility. The imposition of a penalty related to a prohibited transfer is calculated based on the date of the transfer and the uncompensated value of the transfer.

0382.50.20 Exceptions to Trust Provisions

REV:12/2000

The following trusts receive special treatment in the determination of eligibility for MA. No transfer of assets is considered to have taken place as a result of establishing the trust. The income and resources considered available to the individual are ONLY those made available by the trust.

1. SPECIAL NEEDS TRUST, defined as a trust which

   - contains the assets of an individual under age 65 who is disabled (as defined by the SSI program);

- o was established as a trust for the sole benefit of the individual by a parent, grandparent, legal guardian or court; and,

- o provides that upon the death of the individual, the State will receive all amounts remaining in the trust, up to an amount equal to the total MA payments made on behalf of the individual.

The trust may contain assets of individuals other than the disabled individual.

This exemption remains once the individual turns age 65 as long as there are no changes in the terms of the trust once the individual attains age 65. Any assets added to the trust as of age 65 are not subject to this exemption.

AND

2. POOLED TRUST, defined as a trust that contains the assets of a disabled individual and meets the following conditions:

- o The trust is established and managed by a non-profit association;

- o A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools the funds in these accounts;

- O Accounts in the trust are established solely for the benefit of the disabled individual by the individual, parent, grandparent, legal guardian or by a court; and,

- o To the extent that any amounts remaining in the beneficiary's account upon his/her death are not retained by the trust, the trust pays to the State the amount remaining in the account, up to the total amount of Medical Assistance paid on behalf of the individual.

0382.50.25 Claims of Undue Hardship

REV:12/2000

Trust provisions shall be waived if application of those provisions would cause the individual undue hardship. Undue hardship exits when:

1) Application of trust or transfer of asset provisions would deprive the individual of medical care to the

extent that his/her life or health would be endangered or would deprive the individual of food, shelter, clothing or other necessities of life; AND

2) All appropriate attempts to retrieve the prohibited transfer have been exhausted; AND

3) The nursing facility has notified the individual of its intent to initiate discharge or the agency providing essential services under a home and community based waiver has notified the individual of its intent to discontinue such services for reasons of non-payment; AND,

4) No less costly non-institutional alternative is available to meet the individual's needs.

Undue hardship does not exist when application of the trust provisions merely causes inconvenience or restricts lifestyle but would not put him/her at risk of serious deprivation.

When eligibility for Medical Assistance has been denied due to imposition of trust provisions, the individual may claim undue hardship. The individual must submit a written request and any supporting documentation. The individual's request for consideration of undue hardship does not limit his or her right to appeal denial of eligibility for reasons other than hardship.

Claims of undue hardship are forwarded to the Long Term Care Administrator for evaluation. The LTC Administrator may instruct the agency representative to obtain documentation from the individual which can include but is not limited to the following:

- A statement from the attorney, if one was involved;
- Verification of medical insurance coverage and statements from medical providers relative to usage not covered by said insurance;
- A statement from the trustee and/or transferee.

The LTC Administrator, in consultation with the Office of Legal Counsel, determines whether undue hardship exists. The individual is provided written notification of the Department's decision, along with appeal rights, within sixty (60) days of the Department's receipt of the request.

0382.55 LIFE ESTATE

REV:06/1994

A life estate is a legal procedure giving a person certain rights in a property for his/her lifetime. Usually a life estate conveys the property to one party (the life estate holder) for life and to a second party (remainderman) when the life estate expires. The holder of the life estate agreement is entitled to all of the income produced by the property unless the life estate specifies otherwise. The agreement which creates a life estate is a will, a deed or some other legal instrument.

When considering a life estate it is necessary to distinguish between the physical property and the life estate. The physical property has one value and the life estate has another, separate value. The value of the life estate is based on the equity value of the property and the age of the life estate holder.

The life estate holder may use the property as his home for the rest of his life, or he may rent the property or sell his interest.

A primary obligation of the life estate holder is to preserve the property in the same condition as when s/he received it so that, at his/her death, it will pass to the remainderman in much the same condition.

The remainderman has an ownership interest in the physical property but s/he cannot possess or use the property until termination of the life estate. Unless restricted by the life estate agreement, the remainderman can sell his/her interest in the property before the life estate expires.

0382.55.05 Life Estate Exclusions

REV:06/1994

A life estate in real property is excluded if the property is the applicant's home (and the applicant intends to return to the home) or is the primary residence of the LTCF resident's spouse, minor child or disabled child of any age.

A life estate may be excluded if the life estate cannot be sold.

If the life estate cannot be sold, then the value is not available to the applicant and it is excluded on that basis.

The salability of the life estate must be reviewed at each redetermination.

0382.55.10 Eval Life Est/Remainder Interest

REV:06/1994

The value of a life estate or remainder interest is based on the equity value of the real property and the mortality table.

To determine the value of a life estate, the Office of LTC will:

- Determine the EQUITY VALUE of the real property by subtracting any encumbrances from the Fair Market Value;
- Round the age of the estate holder to the nearest year;
- Consult the Life Estate and Remainder Interest Tables which provide the value of a life estate and the value of a remainder estate at any given age. Multiply the equity value of the real property by the appropriate figure from the Life Estate and Remainder Interest Tables.

0382.55.15 Resource Transfer

REV:06/1994

When an individual owns real estate and establishes a life estate for himself or herself in the property, the individual has transferred an asset, the remainder interest. These transfers are handled the same way as any other transfer of real property. The value of the transfer is the remainder interest in the life estate.

The remainder interest is the equity value of the property minus the value of the life estate.

0382.60 RSDI AND SSI RETRO PAYMENTS

REV:06/1994

An RSDI or SSI retroactive payment due for one (1) or more prior months is excluded from resources for six (6) months following the month of receipt.

This exclusion applies to retroactive payments received by the individual, the individual's spouse and/or any other individual whose income is deemed to the individual (or spouse).

RSDI benefits are regularly paid for the prior month. Therefore, a retroactive RSDI payment is one made for a month that is TWO (2) OR MORE MONTHS PRIOR TO THE MONTH OF PAYMENT.

This exclusion applies to retroactive payments only if they remain in the form of cash or identifiable funds; this exclusion does not apply once the retroactive payment has been converted to any other form.

If a resource is excluded under this policy, the case record must clearly indicate the resource, its amount and the period of the exclusion. If the excluded resource in conjunction with other resources would render the individual ineligible for MA, the redetermination must be scheduled for the month prior to the month in which the period of exclusion ends.

Although excluded from resources, retroactive RSDI benefits are COUNTABLE unearned income in the month received. As such, they are included in the calculation of income, and the calculation of the excess income under the flexible test policy. Such benefits are also included in the calculation of monthly income to be applied to the cost of care of a recipient in an LTC facility, or the cost of services received under a Waiver.

0382.65 RESOURCES FPR SELF-EMPLOYMENT

REV:06/1994

Resources essential to the recipient's (or deemor's) means of self support are excluded from countable resources if the property is currently used to produce income, or will be used to produce income within one year, such as the boat of a shell fisherman during the winter. Such resources are the tools and equipment necessary for and normally used in the operation of a trade or business, or for an employee to perform his/her job. For example, the boat of a commercial fisherman, the tools of a plumber or mechanic, the automobile of a cabdriver, etc. are excluded.

0382.70 PLAN FOR ACHIEV SELF-SUPPORT

REV:06/1994

When a blind or disabled individual has a specific plan approved by the Social Security Administration (SSA) for achieving self-support (PASS), resources (and income) necessary for accomplishing the objective of the plan are excluded from countable resources.

To document the exclusion, the applicant must provide a copy of the approved plan, or, with the applicant's permission, a copy must be obtained from SSA.

0382.75 RESOURCES EXCLUDED BY STATUTE

REV:06/1994

The statutory exclusion of resources retained from such benefits obtains so long as the resource is maintained in a separate and identifiable account, and not commingled with other, countable resources. Except as noted below or in the policy on specific types of resources (e.g. burial set-asides), interest or dividends paid on the excluded resource are NOT excluded from counting as income, or if retained, as resources.

0382.75.05 Disaster Assistance

REV:06/1994

Disaster Assistance provided under a federal statute pursuant to a Presidential declaration of a disaster, which is excluded from income, is also excluded from resources for a period of nine (9) months from the date of receipt. In addition, INTEREST EARNED ON SUCH FUNDS IS ALSO EXCLUDED from income and resources for a period of nine months. The exclusions may be continued for one additional nine month period if circumstances beyond the control of the recipient make it impossible for him/her to use the funds for the purpose intended within the first period.

0382.75.10 German Reparation Payments

REV:06/1994

As a result of the court case Grunfeder v. Heckler (9th Cir. 1984) and section 4715 of OBRA '90, German Reparation Payments are not counted for any Medical Assistance Program purpose. German Reparation Payments are disregarded in Medical Assistance eligibility determinations and in the post-eligibility process, and payments retained beyond the month of receipt are excluded from resources.

0382.75.15 Agent Orange Settlement Pay

REV:06/1994

OBRA '89 provides that Agent Orange Settlement Payments paid from a trust fund set up, pursuant to the Agent Orange product liability

settlement, by manufacturers of a chemical defoliant used by the U.S. military in Vietnam are excluded from income and resources for veterans or their survivors.

0382.75.20 Burial Spaces, Accru Income

REV:06/1994

OBRA '89 provides that interest earned on the value of agreements representing the purchase of burial spaces (provided that the burial spaces are excluded from resources and provided that the interest is left to accrue) is excluded from income and resources in eligibility determinations.

The intent of the statute is that interest left to accumulate together with the excluded value of the burial space should not be counted as income or resources because it is not intended to be used for the purchase of food, clothing, or shelter (the criteria used to define countable income).

0382.75.25 Restit Pay to Japanese, Aleut

REV:06/1994

Public Law 100-83 provides for the U. S. Government to make individual restitution payments to certain Japanese-Americans and Aleuts who were relocated or interned during World War II. In certain instances, payments on behalf of deceased individuals will be made to survivors. The payments will be $20,000 to Japanese- Americans, and $12,000 to Aleuts. Payments made under this law are not to be considered resources (or income) for Medical Assistance purposes.

The recipient should have documentation of the amount of the payment. If documentation is not available, or a potential recipient wishes to inquire about eligibility for benefits, s/he may write to:

Office of Redress Administration
U. S. Dept. of Justice
P. O. Box 66260
Washington, D. C. 20035-6260

0384 RESOURCE TRANSFERS

0384.05 LEGAL BASIS

REV:12/2000

The Omnibus Budget Reconciliation Act (OBRA) of 1993 provides a penalty for institutionalized individuals who on or after 8/11/93, transfer or have transferred assets for less than fair market value. Asset transfers are examined for potential penalty when the transfer took place within thirty six (36) months prior to or anytime after the date the individual was both institutionalized and applied for MA.

Under OBRA provisions, trusts and/or portions of trusts established on or after 8/11/93 are in some cases treated as a transfer of assets and subject to a penalty. Asset transfers involving a trust are examined for potential penalty when the transfer took place within sixty (60) months prior to or anytime after the date the individual was both institutionalized and applied for MA. In the event that application of the transfer rules and the trust rules result in an individual being subject to a transfer penalty twice for actions involving the same resource, the trust rules supersede the transfer rules in determining eligibility.(See Section 0382 for detailed information about Trusts.)

The penalty is a period of RESTRICTED MA ELIGIBILITY during which payment for Long Term Care Services is denied. Long Term Care Services include nursing facility services, Intermediate Care Facility Services for the Mentally Retarded, administratively necessary days in a hospital, and home and community based waiver services.

The Medicare Catastrophic Coverage Act of 1988 provides a penalty for institutionalized individuals who transferred resources for less than fair market value prior to 8/11/93. The maximum penalty period for resources transferred for less than fair market value prior to 8/11/93 is 30 months.

0384.10 IND INELIG FOR NF PAYMENT

REV:12/2000

Unless exempt, transfers of assets (income and resources) made for less than fair market value by an institutionalized individual (or the community spouse - if made prior to the establishment of the applicant's MA/LTC eligibility) are subject to a penalty if the transfer was made:

- within thirty six (36) months immediately prior to or

anytime after the date the individual was both institutionalized AND applied for MA; (This time period is referred to as the look-back period.) OR,

- o if the transfer involves a trust, within a sixty (60) month look back period immediately prior to or anytime after the date the individual was both institutionalized AND applied for MA.

If the individual has multiple periods of institutionalization and/or applications, the look back period starts with the first date on which the individual was both institutionalized and applied for MA.

The PENALTY is a period of INELIGIBILITY FOR PAYMENT OF LONG TERM CARE SERVICES for an otherwise eligible individual.

For calculations of penalty periods, see Section 0384.20.

For exempt transfers and exceptions to penalty periods, see Section 0384.35.

0384.15 RESOURCE TRANSFER DEFINITIONS

REV:03/2004

For purposes of evaluating transfers of assets, the following definitions apply:

- o INSTITUTIONALIZED INDIVIDUAL

  An inpatient of a Nursing Facility, an inpatient of a medical institution for whom payment is based on a level of care provided in a NF, an inpatient of an ICF for the Mentally Retarded, and/or a home and community based waiver recipient.

- o ASSETS

  All income and resources of the individual or the individual's spouse that would be countable in the determination of Medical Assistance eligibility for an SSI-related individual; and,

  The home (and associated land) of an institutionalized individual.

This includes any income and resources to which the individual or his/her spouse is entitled but does not receive because of action taken by:

- the individual or his/her spouse;
- a person, including a court or administrative body, with legal authority to act in place of the individual or his/her spouse; or
- any person, including any court or administrative body, acting at the direction or upon the request of the individual or his/her spouse.

o TRANSFER

The conveyance of right, title, or interest in either real or personal property from one person to another by sale, gift, or other process.

The gift or assignment of income from one person to another. Disposal of a lump sum payment before it can be counted as a resource can be an example of a transfer of income.

Transfers made by an individual include transfers made by:

- the individual;
- his/her spouse;
- any person, including a court or administrative body, with legal authority to act on behalf of the individual or his/her spouse; or,
- any person, including a court or administrative body, acting at the direction or upon the request of the individual or his/her spouse.

o COMPENSATION/CONSIDERATION

All real and/or personal property (money, food, shelter, services, stocks, bonds, etc.) that is received by an applicant/recipient pursuant to a binding contract in exchange for an asset either prior to, at the time of, or after the transfer.

o FAIR MARKET VALUE (FMV)

The amount for which the property (real and personal) can be expected to sell on the open market in the geographic area involved and under existing economic conditions at the time of transfer.

- UNCOMPENSATED VALUE (UV)

  The equity value (fair market value less any outstanding loans, mortgages or other encumbrances) minus the value of any compensation /consideration received by the applicant/recipient in exchange for the asset.

- LONG TERM CARE SERVICES

  Services provided to individuals in Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, as an inpatient in a medical institution for whom payment is based on a level of care provided in a NF, and under Home and Community Based Waivers and Administratively Necessary Days.

- PENALTY PERIOD

  The period of time during which payment for Long Term Care services is denied. The number of months in a penalty period (P) is equal to the total uncompensated value (UV) of prohibited transfers made by the institutionalized individual (or spouse if made prior to establishment of individual's MA/LTC eligibility) during the 36 month period immediately prior to the date of institutionalization (or if later the date of MA application) divided by the average monthly cost of a private patient in a NF at the time of application.

  $$P = UV/C$$

- PROHIBITED TRANSFER

  Transfer of an asset for less than fair market value by an individual (or spouse if made prior to establishment of individual's MA/LTC eligibility) which was made within thirty-six (36) months (or sixty (60) months for some transfers involving trusts) prior to or anytime after the date the individual was both institutionalized and applied for MA.

O FOR THE SOLE BENEFIT OF

A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a blind or disabled individual, when the transfer is established using a written agreement that legally binds the parties and clearly expresses that the transfer is for the spouse, blind or disabled child, or blind or disabled individual only, and that no one else can benefit from the assets transferred. Without this agreement, a transfer cannot be determined to be for the sole benefit of the individual.

0384.20 PENALTY PERIOD FOR PAYMENT OF LTC SERVICES

REV:03/2006

The penalty for an otherwise eligible institutionalized individual who transfers assets for less than fair market value is a period of INELIGIBILITY FOR PAYMENT OF LONG TERM CARE SERVICES. The following provisions apply in determining the penalty period for a prohibited transfer:

o THE PENALTY PERIOD FOR A PROHIBITED TRANSFER

To calculate the penalty period (P) for a prohibited transfer, divide the amount of the uncompensated value (UV) of the transfer by the average monthly cost (C) for private payment in a nursing facility.

P =UV/C

Currently, the average monthly cost for private payment in a nursing facility is $6,826 per month.

When more than one prohibited transfer occurs during the same month, the uncompensated values of all prohibited transfers made during the month are totaled, then divided by the average monthly private payment for an individual in a nursing facility.

The penalty period begins on the first day of the month in which the transfer was made and runs continuously from the penalty date regardless of whether the individual remains in or leaves the institution (or waiver program). Thus, if an individual leaves the NF, the penalty period nevertheless continues until the end of the calculated period.

Penalty periods are imposed for full months only; penalty periods of less than one month are not imposed.

There is no maximum length to the penalty period. However, no penalty is imposed for resources transferred more than 36 months (60 months for transfers involving trusts) prior to the date the individual was both institutionalized and applied for MA.

EXAMPLE 1:

As a token of her love and affection, Mrs. Jones gives $12,000 to each of her ten grandchildren in January. She enters a nursing facility in March and applies for MA in December of the same year.

Since the transfers were uncompensated and were made within 36 months prior to the date of MA application (which in this case is later than the date of institutionalization), a penalty period applies. The total uncompensated value of all prohibited transfers made in the month is $120,000.

That amount is divided by the average monthly cost of NF services, $6,826, to arrive at the length of the penalty period.

120,000/6,826 = 17.58 = 17 full months

The penalty period is eighteen (17) months.

It begins on January 1st, the first of the month in which transfer was made. It continues for a total of eighteen (17) full months.

EXAMPLE 2:

Mrs. Swanson transfers her home with a fair market value of $300,000 to her sister (who lives with her but has no equity position in the home) for no consideration on January 31, 2003. On November 1, 2003 she enters a NF and applies for MA.

The transfer occurred within thirty-six (36) months of the date Mrs. Swanson was both institutionalized and applied for MA, and it was made for less than fair market value. The penalty period is calculated by dividing the amount of the uncompensated transfer ($300,000) by the average monthly cost of NF services ($6,826).

$300,000/6,826 = 43.95 = 43 full months

The penalty period is forty-three (43) months.

It begins on January 1, 2003, the first of the month in which transfer was made and continues through July 30, 2006.

EXAMPLE 3:

Mr. Edwards makes an uncompensated transfer of $300,000 to his nephew on January 1, 1998. In January 2000, he is admitted to a nursing facility. On February 2, 2001 he applies for MA.

No penalty period applies. The transfer for less than fair market value was made more than 36 months prior to the date of MA application.

O MULTIPLE TRANSFERS WITH OVERLAPPING PENALTY PERIODS

When assets have been transferred in amounts and/or frequency that make the calculated penalty periods overlap, a single penalty period is imposed. This penalty period begins on the first of the month in which the first prohibited transfer was made and is calculated as follows:

FIRST, add the total of the uncompensated value of all assets transferred;

THEN, divide the sum by the average private pay cost of NF care.

THIS PRODUCES a single penalty period that begins on the first day of the month in which the first transfer was made.

EXAMPLE:

Mr. Smith transfers $14,000 in January, $14,000 in February and $14,000 in March, all uncompensated. In April of the same year he enters a NF and applies for MA.

Since all were uncompensated and made within 36 months prior to the date Mr. Smith was both institutionalized and applied for MA, a penalty applies for each transfer.

Calculated as separate transfers, the penalty period for the first transfer would be (14,000/6,826 = 2.05 months = 2 full months) two months, January and February. Likewise the penalty period for the second would be February and March; and for the third, March and April.

Because the penalty periods overlap when calculated separately, a single penalty period must be re-calculated by adding the uncompensated value of all three transfers ($42,000) and dividing that total by the average private pay NF cost ($6,826).

42,000/6,826 = 6.15 = 6 full months

This yields a single penalty period of six (6) months, which runs from January 1st (the first of the month in which the first prohibited transfer occurred), and continues for six (6) months, through June 30th.

O MULTIPLE TRANSFERS WITH NO OVERLAPPING PENALTY PERIODS

When multiple prohibited transfers are made in such a way that penalty periods do not overlap, each transfer is treated as a separate event with its own penalty period. Each separate penalty period is calculated by dividing the total amount of the uncompensated value of the transfer by the average monthly NF cost for a private patient.

Each separate penalty period begins on the first of the month in which transfer occurred.

EXAMPLE:

Mrs. Roland transfers $7,000 in January, $14,000 in March, and $21,000 in June, all uncompensated. She enters a NF and applies for MA on July 1st of the same year.

Since all transfers were uncompensated and made within 36 months of the date Mrs. Roland was both institutionalized and applied for MA, a penalty period applies for each transfer.

Each separate penalty period is obtained by dividing the amount of the uncompensated value (UV) of the transfer by the average monthly cost of private NF care (C). Assuming an average monthly cost of $6,826, the penalty period for the first transfer is (7,000/6,826 = 1.03 = 1) one full month. It begins on the first of the month in which transfer was made, January 1st and continues until the end of the month, January 31st. The second penalty period is two months (14,000/6,826 = 2.05 = 2), beginning on the first of March and continuing until the end of April. The third penalty period is three months (21,000/6,826 = 3.08 = 3), beginning on the first of June and continuing until the end of August.

Eligibility for payment of LTC services is denied for the months of July and August.

O TRANSFERS BY THE SPOUSE

When a transfer by the spouse results in a penalty period for the institutionalized individual, and the spouse later becomes institutionalized and applies for MA payment of long term care services, the penalty period remaining is apportioned equally between the spouses. If both spouses are institutionalized in the same month the period of ineligibility is divided equally between them. When one spouse is no longer subject to a penalty, any remaining penalty is then imposed on the remaining institutionalized individual.

O TRANSFERS OF INCOME

When lump sum income is transferred (e.g., a stock dividend check is given to another person in the month in which it is received by the individual), a penalty period is calculated based on the value of the lump sum payment and the date transfer was made.

When a stream of income has been transferred, a penalty period is calculated for each income payment that is periodically transferred.

When the right to a stream of income is transferred, a penalty period is calculated based on the total amount of income expected to be transferred during the individual's lifetime, based on life-expectancy tables established by the Social Security Administration's Office of the Actuary.

0384.35 EXCEPTIONS TO PERIOD OF INELIG

REV:12/2000

A penalty period is not imposed when:

- The asset was transferred for fair market value;
- The transferred resource was the individual's HOME and title to the home was transferred to:
  - the individual's spouse;
  - a child of the individual who is under the age of 21, or is blind, or permanently and totally disabled (as evidenced by receipt of SSI or RSDI benefits, or as defined in Section 0352.15);
  - a sibling of the individual who has an equity interest in the home and who resided in the home

for at least one year immediately prior to the institutionalization of the individual;

- a son or daughter of the individual who:

  * was residing in the home for at least two years prior to the parent's institutionalization; and,

  * can demonstrate that s/he provided care to the parent which prevented the parent from entering an institution for the two year period.

o The asset (other than a home, see above) was transferred to:

  - the spouse, or to another for the sole benefit of the spouse, or from the spouse to another for the sole benefit of the spouse;

  - the individual's child who is blind or permanently and totally disabled, or to another for the sole benefit of such child, or to a trust established for the sole benefit of such child;

  - a trust established for the sole benefit of an individual who is under the age of 65 and permanently and totally disabled (as defined in Section 0352.15);

o The individual can prove his/her intention was to receive fair market value or other valuable compensation/consideration;

o The individual can prove the transfer was exclusively for some purpose other than to qualify for Medical Assistance;

o Denial of payment for LTC services would work an undue hardship;

o The asset is returned to the individual.

0384.40 RESPONSIBILITIES

REV:12/2000

Field staff responsibilities pertaining to transfer of assets are the following:

FIRST

The agency representative is responsible to explain the policy on transferred assets and how it may affect eligibility for nursing facility payment, and assist the applicant in determining what documentation is relevant and how such documentation is generally obtained.

SECOND

Exceptions to the penalty period which involve transfer of an individual's home to his/her spouse, child under 21, or blind or disabled child are referred with relevant documentation to the casework supervisor for review.

All other exceptions should be referred to the Long Term Care Administrator or his designee, who will consult with the Legal Counsel as necessary.

Any and all documents relative to the transferred resource and its fair market value, such as bills of sale, deeds, purchasing agreements, and compensation received must be provided by the applicant as a part of the application process.

THIRD

Transfers of assets for less than FMV are presumed to be for the purpose of establishing eligibility for nursing facility payment. The applicant can rebut the presumption by making a satisfactory showing that the transfer was for some other purpose.

If the applicant/recipient wishes to rebut the presumption, the agency representative shall explain that it is the applicant/recipient's responsibility to make a satisfactory showing that the assets were transferred exclusively (i.e., only) for some other reason. The information furnished by the applicant/recipient should cover, but need not be limited to, the following factors:

- The purpose for transferring the asset;

- The attempts to dispose of the asset for FMV;
- The reasons for accepting less than FMV;
- The applicant/recipient's relationship, if any, to the person(s) to whom the asset was transferred;

The applicant/recipient should be assisted in obtaining information to rebut the presumption when necessary; however, the burden of proof rests with the applicant/recipient.

FOURTH

Once the LTC Administrator determines that an asset was transferred for less than fair market value and the resultant uncompensated value, the agency representative will determine the period of ineligibility for nursing facility payment.

FIFTH

The agency representative is responsible to inform the applicant of the outcome of the review conducted by LTC Administrator, and the period of ineligibility, if any. The individual must be notified of the decisions, and his/her right to appeal.

SIXTH

If the individual is either eligible for Medical Assistance or pending spenddown, but is determined to have a period of ineligibility for payment of LTC services due to the transfer, the penalty period information is recorded on the InRHODES Transfer Panel. Eligibility or pending spenddown status for Medical Assistance is approved, and the case is transferred to the appropriate MA unit.

The responsibilities of the LTC Administrator are:

FIRST

Determine the fair market value (FMV) of the transferred asset based on the documentation forwarded by field staff.

SECOND

Determine the uncompensated value, if any, by subtracting the value of any compensation/consideration received from the equity value.

THIRD

Evaluate the individual's rebuttal of the agency's presumption that resources were transferred in order to become eligible for nursing facility payments, and consult with the Office of Legal Counsel, as necessary.

FOURTH

Evaluate claims of undue hardship.

0384.45 REBUT OF PRESUMP OF PROH TRANS

REV:12/2000

An individual may rebut the agency's presumption that assets were transferred in order to become eligible for nursing facility payments.

The presence of one or more factors may indicate that the asset was transferred exclusively for some purpose other than establishing eligibility for nursing facility payments.

These factors are:

- A traumatic onset (e.g. traffic accident) of disability or blindness after transfer of the resource.

  If the applicant/recipient states that AFTER the transfer s(he) experienced a traumatic onset of disability which could not have been foreseen at the time of transfer, and which resulted in the inability to provide for his/her own support, consider the applicant's/recipient's age, medical history, and medical condition at the time of transfer as well as his/her financial situation. Was the applicant/recipient in good health at the time of the transfer and spending a minimal amount on medically related costs such as insurance, routine doctor visits, etc.? Did the applicant/recipient have sufficient income and/or resources to meet his/her medical needs, as well as basic living expenses, as they existed at the time of the transfer and as they could be foreseen over the next 36 months?

The applicant/recipient may submit whatever medical documentation s(he) wishes to substantiate his/her claim.

- Inability to dispose of the asset for fair market value.

  The applicant/recipient must provide evidence of attempts to dispose of the asset for fair market value, as well as evidence to support the value at which the asset was disposed.

- Diagnosis of previously undetected disabling condition;

- Unexpected loss of other resources (including deemed resources) which would have precluded MA eligibility;

- Unexpected loss of income (including deemed income) which would have precluded MA eligibility;

- Total countable resources that would have been below the resource limit at all times from the month of transfer through the present month even if the transferred resource had been retained;

- Court-ordered transfer.

0384.45.05 Claims of Undue Hardship

REV:12/2000

A transfer penalty shall be waived if imposition of the penalty would cause the individual undue hardship. The entire penalty period or a portion of the penalty period shall be waived when:

1) Imposition of the penalty period would deprive the individual of medical care to the extent that his/her life or health would be endangered or would deprive the individual of food, shelter, clothing or other necessities of life; AND

2) All appropriate attempts to retrieve the transferred asset have been exhausted; AND

3) The nursing facility has notified the individual of its intent to initiate discharge or the agency providing

essential services under a home and community based waiver has notified the individual of its intent to discontinue such services for reasons of non-payment; AND

4) No less costly non-institutional alternative is available to meet the individual's needs.

Undue hardship does not exist when application of the transfer provisions merely causes inconvenience or restricts lifestyle but would not put him/her at risk of serious deprivation.

When eligibility for payment of long term care services has been denied due to imposition of a transfer of assets penalty, the individual may claim undue hardship. The individual must submit a written request and any supporting documentation. A request for consideration of undue hardship does not limit the individual's right to appeal a denial of eligibility for reasons other than hardship.

Claims of undue hardship are forwarded to the Long Term Care Administrator for evaluation. The LTC Administrator may instruct the agency representative to obtain documentation from the individual which can include but not be limited to the following:

- A statement from the attorney, if one was involved;
- Verification of medical insurance coverage and statements from medical providers relative to usage not covered by said insurance;
- A statement from the transferee relative to his/her financial position;
- Resource documents such as a deed, bank book, etc. to verify the existence and structure of the jointly held resource;
- A statement from the other owner(s) of the jointly held resource relative to the reason for and circumstances of the transfer.

The LTC Administrator, in consultation with the Office of Legal Counsel, determines whether undue hardship applies. Written notification of the Department's decision regarding undue hardship, along with appeal rights, is provided to the individual within sixty (60) days of the Department's receipt of the request.

0384.45.10 Example of Rebuttal

REV:06/1994

Edward Johnson owned a farm free and clear. Mr. Johnson and his son had farmed the property for a number of years. Age 58 and healthy, Mr. Johnson decided to seek another line of work. He transferred one-half interest in the farm to his son in October 1989. The Fair Market Value at the time of the one-half interest was $120,000. In April of 1990, Mr. Johnson was injured in an auto accident, and became institutionalized.

He applied for Medical Assistance, and was found eligible, but ineligible for payment of the institutional care services. He submitted evidence substantiating the circumstances. Upon review of the rebuttal material, it was established that the resource transfer was exclusively for a purpose other than to qualify for Medical Assistance. He became eligible for payment of his institutional care.

0384.50 SSI RECIPIENTS

REV:06/1994

Resource transfers do not impact Medical Assistance or SSI eligibility determinations. Individuals may be eligible for Medical Assistance-only or SSI and Medical Assistance while at home or while in an institution, without regard to resource transfers.

However, once institutionalized, all Medical Assistance recipients are subject to the policies contained in this section regarding resource transfers.

The Social Security Administration (SSA) questions SSI recipients regarding transferred resources at the time of application and redetermination for SSI benefits. SSA maintains a record of those SSI recipients who have transferred resources which is transmitted to the Long Term Care Unit at Central Office on a regular basis.

This LTC Unit in turn sends the information to the appropriate LTC field office.

Prior to authorizing a vendor payment to a nursing facility, the Long Term Care field office screens the list of alleged transferers to ascertain that the individual in question has not disclosed a resource transfer to SSA. In the event that this screening indicates that the applicant has transferred a resource, the case is referred to the LTC/AS district office for review and evaluation of the impact of the transfer on eligibility for nursing facility payment.

0386 INCOME GENERALLY

0386.05 INCOME STANDARDS - INSTITUTIONAL/WAIVER

REV:03/2006

INDIVIDUAL/COUPLE INCOME STANDARDS

The following standards are used to determine income eligibility for an institutionalized individual or a waiver individual.

Income eligibility will exist if the individual's or couple's countable monthly income does not exceed the appropriate limit for the unit size.

O Categorically Needy Income Limits;

O Medically Needy Monthly Income Limits;

O 2006 Federal Poverty Level Income Guidelines (for Qualified Medicare Beneficiaries, Specified Low Income Medicare Beneficiaries and Qualified Disabled and Working Individuals).

CATEGORICALLY NEEDY NET MONTHLY INCOME LIMITS
FOR INSTITUTIONALIZED INDIVIDUALS

	INDIVIDUAL	COUPLE
Living in a Nursing Facility or ICF-MR Facility	$ 1,809.00	N/A
Institutionalized Individual eligible for the Federal and State Supplement	50.00	100.00

By Federal Law, to be eligible as Categorically Needy while living in a Nursing Facility or an ICF-MR Facility, an individual's gross income cannot exceed 300% of the Federal SSI level of payment for an individual. This is the FEDERAL CAP which is $1,809.00 effective 01/01/06.

MEDICALLY NEEDY MONTHLY INCOME LIMITS

1 Person	$ 717	5 Persons	$1,200
2 Persons	758	6 Persons	1,358
3 Persons	942	7 Persons	1,492

4 Persons	1,075	8 Persons	1,642

Family size includes an unborn; if medical documentation shows multiple births are expected, add as documented.

2006 FEDERAL POVERTY LEVEL MONTHLY INCOME GUIDELINES

100% OF POVERTY LEVEL INCOME GUIDELINES FOR QUALIFIED MEDICARE BENEFICIARIES (QMB's).

INDIVIDUAL	$ 816.67
COUPLE	$1,100.00

120% OF POVERTY LEVEL INCOME GUIDELINES FOR SPECIFIED LOW-INCOME MEDICARE BENEFICIARIES (SLMB's).

INDIVIDUAL	$ 980.00
COUPLE	$1,320.00

135% of FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR QUALIFIED INDIVIDUALS (QI-1)

INDIVIDUAL	$1,102.50
COUPLE	$1,485.00

200% OF POVERTY LEVEL INCOME GUIDELINES FOR QUALIFIED DISABLED AND WORKING INDIVIDUALS (QDWI's).

INDIVIDUAL	$1,633.33
COUPLE	$2,200.00

0386.10 TREATMENT OF INCOME

REV:06/1994

Section 0366 sets forth the treatment of income rules for spouse to spouse deeming of income when both members of a couple live together in the community, and when an ineligible parent lives in the same household with an eligible child under 18. DEEMING STATUS IS CHANGED WHEN AN ELIGIBLE INDIVIDUAL BECOMES INSTITUTIONALIZED.

If an eligible individual moves into a medical facility, deeming stops for the purpose of determining MA eligibility effective with the month following the month of separation.

Eligibility determinations for persons applying for or receiving services under a Waiver are conducted AS IF THE PERSON WERE ACTUALLY INSTITUTIONALIZED. This means that deeming of spousal/parental income does NOT apply after the month of separation due to institutionalization.

0386.15 RECIPIENT INCOME APPLIED TO COST OF CARE

REV:01/1996

If the institutionalized individual is eligible for MA, either as Categorically Needy or Medically Needy, and Medical Assistance payment is requested for the individual's institutional care expenses, a determination is made regarding the amount of income the institutionalized individual must allocate to his/her cost of share.

0386.20 INCOME DEFINITIONS

REV:06/1994

Income is anything received in cash or in-kind that can be used to meet the needs for food, clothing or shelter. In-kind income is not cash, but is actually food, clothing, or shelter, or something the individual can use to get one of these. Earned and unearned income is considered when determining an individual's and couple's financial eligibility.

0386.20.05 Earned Income

REV:06/1994

Earned income may be in cash or in-kind and consists of the following types of payments:

- Wages;
- Net earnings from self employment;
- Payments or refunds of earned income tax credits;
- Payments for services performed in a sheltered workshop or work activity.

Earned income is counted as earned income when received (or would have been received except that the applicant/recipient decided to postpone receipt) rather than when earned. This recognizes that the time between earning and receiving income sometimes is long.

In a program based on the current need, the relevant time is when income is received.

0386.20.10 Unearned Income

REV:06/1994

Unearned income is defined as all income that is not earned income whether cash or in-kind. Some types of unearned income are:

- Deemed income;
- Income from legally liable relatives;
- Workers' Compensation;
- Annuities, pensions, and other periodic payments;
- Alimony and support payments;
- Dividends, interests and royalties;
- Rents;
- Benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient;
- Prizes and awards;
- In-kind support and maintenance (ISM);
- Life insurance proceeds; and,
- Gifts and inheritances.

0386.20.15 Forms of Income

REV:06/1994

Income, whether earned or unearned, may be received in either of two forms, cash and in-kind.

- Cash includes currency, checks, money orders, or electronic funds transfers (EFT), such as:

- social security checks;

- unemployment compensation checks; and,

- payroll checks or currency.

o In-kind includes noncash items such as:

- real property;

- food;

- clothing; and,

- noncash wages (e.g., room and board as compensation for employment).

0386.20.20 Living in Own Household, Defin

REV:06/1994

The following is a list of individuals living in their own households:

o An individual (or living-with spouse or any person whose income is deemed to the individual) who has an ownership interest or a life estate interest in the home;

o An individual (or living-with spouse or any person whose income is deemed to the individual) who is liable to the landlord/landlady for payment of any part of the rental charges;

o An individual who is in a noninstitutional care situation;

o An individual who lives in an all-public assistance household; or,

o An individual who pays at least a pro rata share of household operating expenses, AND

- is living with someone other than a spouse and/or child(ren) and/or someone whose income is deemable to such individual, AND

- is eating meals which s/he did not purchase separately.

0386.20.20.05 Proof of Pro Rata Share

REV:06/1994

If the applicant claims that s/he is contributing to the household, his/her pro rata share is established by averaging the monthly household operating expenses over the past 12 months and dividing by the number of persons in the household, regardless of age. If exact figures are unavailable, a reasonable estimate is used, considering current expenses and seasons of the year.

The household expenses to be considered, provided someone outside the household does NOT pay for them, are:

- o Real Property Taxes
- o Water
- o Sewer
- o Heating Fuel
- o Garbage Removal
- o Gas
- o Food
- o Electricity
- o Rental Payments
- o Mortgage (including property insurance)

0386.20.20.10 Documentation of Sharing

REV:06/1994

The applicant must submit evidence of sharing. This includes bills and receipts which establish the household expenses, and canceled checks or money order receipts which establish the applicant's contributions. When such evidence is not available, statements from the applicant and the person who owns or rents the household are accepted. Copies of all supporting documents are retained in the case record.

The applicant must be advised to retain future bills/receipts in the event a redetermination is required because changes occur, or because s/he wants to rebut one or more of the amounts used in determining the household expenses.

When a change does occur, it is only necessary to determine what is affected by the change. For example, if the only change is in household composition, only the food expense will increase or decrease. If the individual's contribution has decreased, a determination must be made that the lower contribution still constitutes a pro rata share.

0386.25 WHEN INCOME IS COUNTED

REV:06/1994

Generally, income is counted at the EARLIEST of the following points:

- When it is received; or,
- When it is credited to an individual's account; or,
- When it is set aside for his/her use.

Income is determined monthly and counted in the month it is received.

Occasionally, a regular periodic payment (e.g., wages, title II, or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, the funds are considered to be income in the normal month of receipt.

0388 TREATMENT OF INCOME

0388.05 EARNED/UNEARNED INCOME EXCLUS

REV:06/1994

Certain exclusions apply only to EARNED income, some apply only to UNEARNED income and a few apply to BOTH earned and unearned income.

The following exclusions apply to both earned and unearned income:

- Infrequent and irregular income exclusions;
- $20 per month General Income Exclusion;
- PASS Exclusion.

0388.05.05 Infrequent/Irregular Income Exclusion

REV:06/1994

Income which is received infrequently and irregularly is excluded provided the total income of such exclusion does not exceed:

- $10/month of earned income; and/or,
- $20/month of unearned income.

An individual receives income on an INFREQUENT basis if s/he receives it no more than once in a calendar quarter from a single source. An individual receives income on an IRREGULAR basis if s/he could not reasonably expect to receive it.

This exclusion can apply to both earned and unearned income in the same month provided the total of each does not exceed the allowed limits. Thus it is possible to exclude as much as $30 in a month under this provision.

0388.05.10 $20/Month General Income Disregard

REV:04/1995

The first $20 per month of unearned income is deducted from income. The $20 is applied to earned income only if the $20 cannot be applied to unearned income. The dollar amount of this exclusion is not increased when an eligible individual and eligible spouse both have income. An eligible couple receives one $20 exclusion per month.

0388.05.15 PASS Exclusions

REV:06/1994

Income, whether earned or unearned, of a blind or disabled recipient may be excluded if such income is needed to fulfill a Plan for Achieving Self-Support (PASS).

This exclusion does not apply to a blind or disabled individual age 65 or older, unless s/he was receiving SSI or State disability or blind payments for the month before s/he reached age 65.

0388.10 EARNED INCOME EXCLUSIONS

REV:06/1994

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income. Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

0388.10.05 $65 and 1/2 Earned Income Exclusion

REV:06/1994

If the applicant or spouse is employed, earned income of $65/month plus one-half (1/2) of the balance is excluded. When both eligible

spouses are employed, this exclusion is applied to only one earned income.

0388.10.10 Impairment Related Work Expenses

REV:06/1994

Impairment related work expenses are deducted provided:

- The individual is under age 65 and disabled (but not blind), or received SSI as a disabled individual (or received disability payments under a former State plan) for the month before attaining age 65; and,
- The severity of the impairment requires the individual to purchase or rent items and services in order to work; and,
- The expense is reasonable; and,
- The cost is paid in cash (including checks, money orders, credit cards and/or charge cards) by the individual and is not reimbursable from another source (e.g. Medicare, private insurance); and,
- The payment is made in a month the individual receives earned income for a month in which s/he both worked and received the services or used the item, or the individual is working but makes a payment before the earned income is received.

The determination of the amount of the allowable work expense is an off-line evaluation. The allowable work expense is deducted from gross income.

0388.10.15 Blind Work Expenses

REV:06/1994

The following expenses related to a blind individual's employment are excluded:

- TRANSPORTATION EXPENSES: Bus, cab fare, instructions for use of cane; cost/upkeep of guide dog; private automobile.
- JOB PERFORMANCE: Braille instruction; child care costs;

equipment needed on job (e.g. for homebound work); instructions in grammar (if work related); licenses; lunch; prosthesis needed for work even though not related to blindness; optical aids; reader; safety shoes; income (federal, state, local) taxes; FICA taxes; self-employment taxes; translation of material into braille; uniforms and care of them; union dues; wheelchair if necessary due to other disability.

- JOB IMPROVEMENT: Computer program training, key punch training, stenotype instructions for blind typist. Further expenses are disregarded if the individual has an approved plan for self support. The amounts must be reasonable and not exceed the earned income of the blind individual or a blind spouse.

The determination of the amount of the allowable work expense is an off-line evaluation. The allowable work expense is deducted from gross income.

0388.10.20 Earned Income Tax Credit Exclusion

REV:06/1994

The earned income tax credit (EITC) is a special tax credit which reduces the Federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from the employer or as a refund from the IRS.

Income from any EITC received January 1, 1991 or later is excluded, regardless of the tax year involved.

0388.10.25 Child Student Earned Income Exclusion

REV:06/1994

For a blind or disabled child who is a student regularly attending school, up to $400/month of earned income (but not more than $1620 in a calendar year) is excluded.

The exclusion is applied only to the child's income. The child must be under age 22 and regularly attending school. Regularly attending school means the child was a student in at least one month of the current calendar quarter, or expects to attend school for at least one month in the next calendar quarter.

0388.15 TREATMENT OF UNEARNED INCOME

REV:06/1994

Exclusions never reduce unearned income below zero. Except for the $20 general unearned income exclusion, no other unused unearned income exclusion may be applied to earned income.

0388.15.05 Distinguishing IBON and ABON

REV:06/1994

Income Based On Need (IBON) is assistance provided under a program which uses income as a factor of eligibility and is funded wholly or partially by the Federal government or a non-government agency (e.g. Catholic Charities or the Salvation Army) for the purpose of meeting basic needs.

Income Based on Need is COUNTED as income dollar for dollar UNLESS it is totally excluded by statute (e.g. Food Stamps) or excluded under PASS.

Assistance Based On Need (ABON) is assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a State. (If a program uses income to determine payment amount but not eligibility, it is not ABON.) Assistance Based on Need is EXCLUDED from income. (Note that State supplementary payments made to refugees are considered to be ABON even if the Federal government reimburses the State).

In short, ABON is excluded from income and IBON is counted as income dollar for dollar unless excluded under PASS or by statute.

0388.15.10 AFDC Under a PASS

REV:06/1994

AFDC payments under a PASS are excluded. However, AFDC payments are based on need; and, unless excluded under a PASS, are counted dollar for dollar as income. The $20 general income exclusion does not apply to this income.

AFDC makes a payment to family unit rather than to an individual.

The payment is frequently referred to as a grant. An individual who meets the eligibility requirements for AFDC and SSI may choose the program under which s/he prefers to receive benefits. However, if the

individual receives SSI, s/he may no longer be included in the AFDC grant.

0388.15.15 Foster Care Payments

REV:06/1994

An individual is considered to be in foster care when:

- A public or private (nonprofit) agency places an individual under a specific placement program; and,
- The placement is in a home or a facility which is licensed or otherwise approved by the State to provide care; and,
- The placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

Foster care payments made to the provider of foster care is not income to the provider.

0388.15.15.05 Effects of Foster Care Payments

REV:06/1994

Foster Care payments made under Title IV-E are federally funded income based on need (IBON) to the child in care. This income is not subject to the $20 general exclusion. The total payment is counted dollar for dollar.

Foster Care payments involving funds provided under Title IV-B or Title XX of the Social Security Act are social services and are excluded from the foster child's income.

0388.15.20 Adoption Assistance

REV:06/1994

Adoption Assistance Programs provide payments and/or services for children for whom unassisted adoption is unlikely because of age, ethnic background, physical, mental, or emotional disability etc.

The income of either the adopting parent, the adopted child or both may have been considered in determining the amount of the adoption assistance.

Adoption assistance provided by States under Title IV-E of the Social Security Act involves Federal funds and is needs-based.

Under IV-E there is no income test for the adopting parents. The law requires that the child, to be eligible for federally funded foster care must be AFDC or SSI eligible (but not necessarily receiving AFDC or SSI) at the time adoption proceedings are initiated, and meet the additional criterion of special needs. Adoption assistance cash payments made to adoptive parents under Title IV-E are federally funded income based on need (IBON) to the adopted child. This income is not subject to the $20 general exclusion and is counted dollar for dollar.

0388.15.25 Support Payments

REV:06/1994

Alimony and support payments are cash or in-kind contributions to meet some or all of a person's need for food, clothing or shelter.

Support payments may be made voluntarily or because of a court order. Alimony is an allowance made by the court from the funds of one spouse to the other spouse in connection with a suit for legal separation or divorce.

Alimony, spousal and other adult support payments are unearned income to the parent.

Child support payments are unearned income to the child. However, one-third of a child support payment made to or for an eligible child by an absent parent is excluded.

A parent is considered absent if the parent and the child do not reside in the same household. If there are brief periods of living together, the parent is considered absent if the child remains independent or under the care and control of another person, agency or institution, or is living in the home of another unless the parent retains parental control and responsibility.

A parent is not considered absent if he is away due to employment (except for military service), intends to resume living with the child, and retains parental responsibility and control.

0388.15.30 Grants, Scholarships, Fellowship

REV:06/1994

Grants, scholarships, and fellowships are amounts paid by private, nonprofit agencies, the U.S. Government, instrumentalities or agencies of the U.S., State and local governments and private concerns to enable qualified individuals to further their education and training or research work.

Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses is excluded from income. This exclusion does not apply to any portion set aside or actually used for food, clothing or shelter.

Allowable expenses include carfare, stationery supplies, and impairment related expenses necessary to attend school or perform schoolwork. Allowable fees include laboratory fees, student activity fees, etc.

0388.15.35 Student Loans

REV:06/1994

Federal funds or insurance are provided for educational programs at middle school, secondary school, undergraduate and graduate levels under Title IV of the Higher Education Act and student assistant programs of the Bureau of Indian Affairs.

Any grant, scholarship or loan to an undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education is excluded from income and resources.

Any portion of student financial assistance for attendance costs received from a program funded in whole or in part under Title IV of the Higher Education Act of 1965 or under BIA Student Assistance Programs is excluded from income and resources.

Attendance costs are:

- Tuition and fees normally assessed a student carrying the same academic workload (as determined by the institution) required of all students in the same course of study;
- Allowances for books, supplies, transportation and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

0388.15.40 Interest Earned on Burial Fund

REV:06/1994

Interest earned on the value of excluded burial funds is excluded from income (and resources) if left to accumulate in the burial fund.

Interest earned on agreements representing the purchase of an excluded burial space is excluded from income (and resources) if left to accumulate.

THIS INCOME EXCLUSION APPLIES ONLY IF THE BURIAL FUND OR SPACE PURCHASE AGREEMENT IS EXCLUDED AT THE TIME THE INTEREST IS PAID.

Appreciation in value and the interest must be left to accumulate to be excluded from income. If not left to accumulate (e.g. paid directly to the individual, spouse or parent), the receipt of the interest may result in countable income.

0388.15.45 Gifts of Domestic Travel Tkts

REV:06/1994

The value of a ticket for domestic travel received by an individual (or spouse) is excluded from income and, if retained, is not a resource if:

- The ticket is received as a gift; and,
- The ticket is not converted to cash.

0388.15.50 Death Benefits

REV:06/1994

A death benefit is something received as the result of another's death.

Examples of death benefits are:

- Proceeds of a life insurance policy received due to the death of the insured;
- Lump sum death benefit from SSA;
- Railroad Retirement burial benefits;

- o VA burial benefits;
- o Inheritances in cash or in-kind;
- o Cash or in-kind gifts given by relatives, friends or a community group to "help out" with expenses related to the death.

NOTE: Recurring survivor benefits such as those received under Title II, private pension programs etc. are not death benefits.

Death benefits are excluded to the extent the beneficiary paid the expenses of the deceased's last illness and burial expenses.

Last illness and burial expenses include:

- o Related hospital and medical expenses;
- o Funeral, burial plot and internment expenses;
- o Other related expenses.

0388.15.55 Home Energy Assistance Payment

REV:06/1994

Home energy or support and maintenance assistance is excluded if it is certified in writing by the appropriate State agency to be both based on need and:

- o Provided in-kind by a private nonprofit agency; or,
- o Provided in cash or in kind by a supplier of home heating oil or gas, a utility company providing home energy, or a municipal utility providing home energy.

State certification may be in the form of an individual certification of a particular case, or a "blanket" certification of a program or organization.

The exclusion applies to assistance provided for:

- o An SSI applicant/recipient;
- o A member of the SSI applicant/recipient's household; or,

- An SSI applicant/recipient's spouse, parent(s), sponsor (sponsor's spouse) or essential person.

0388.15.60 Disaster Assistance

REV:06/1994

At the request of a State governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and local governments, and federal assistance is needed.

Assistance provided to the victims of a presidentially-declared disaster area includes assistance from:

- Federal programs and agencies;
- Joint Federal and State programs;
- State or local government programs;
- Private organizations (e.g. the Red Cross).

The value of support and maintenance in cash or in-kind is excluded from countable income if:

- The individual lived in a household maintained as the home at the time the disaster occurred in the area; and,
- The President declared the area a Federal disaster area; and,
- The individual stopped living in the home because of the disaster and began to receive support and maintenance within 30 days after the catastrophe; and,
- The individual receives support and maintenance while living in a residential facility maintained by another person. A residential facility is to be interpreted broadly, to mean a private household, a shelter, or any other temporary housing arrangement as a result of the disaster.

0388.15.65 Federal Housing Assistance

REV:06/1994

The Federal Government provides many forms of housing assistance through the Office of Housing and Urban Development (HUD) and the Farmers' Home Administration. The forms of housing assistance include:

- Subsidized housing (e.g. public housing, reduced rent, cash towards utilities etc.);
- Loans for renovations;
- Loans for construction, improvement, or replacement of farm homes and other buildings;
- Mortgage or investment insurance;
- Guaranteed loans and mortgages.

This assistance may be provided directly by the Federal Government or through other entities such as local housing authorities, nonprofit organizations etc.

The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

- The United States Housing Act of 1937;
- The National Housing Act;
- Section 101 of the Housing and Urban Development Act of 1965;
- Title V of the Housing Act of 1949; or,
- Section 202(h) of the Housing Act of 1959.

0388.15.70 Food Programs with Fed Involve

REV:06/1994

Food and assistance provided by the following Federal programs are excluded from income (and resources):

- Food Stamp Program;
- School Lunch program;
- Child Nutrition programs;

- Nutrition Programs for Older Americans.

The following may be assumed to have Federal involvement and to be excludable under Federal statutes:

- Meals and milk provided at reduced rates or free to children in schools and service facilities such as day care centers, recreational facilities or recreation centers;

- Meals provided for free or at reduced rates to senior citizens by a center or project under the auspices of a State or local government or nonprofit program for the aging;

- U.S.D.A. food commodities distributed by any program;

- Food stamps and cash which has been verified as the value of the food stamps provided in lieu of the stamps;

- WIC distributions to pregnant women and children.

0388.15.75 Refugee Cash Assistance

REV:06/1994

Refugee Cash Assistance, Cuban and Haitian Cash Assistance, and federally reimbursed general assistance payments to refugees may be excluded under a PASS.

If not excluded under a PASS, it is federally funded income based on need (IBON) and counted dollar for dollar as income. The $20 general income exclusion does not apply to this income.

0388.15.80 Relocation Assistance

REV:06/1994

Relocation assistance is provided to persons displaced by projects which acquire real property. Relocation assistance provided to persons displaced by any Federal, federally-assisted, State, State-assisted or locally assisted project is excluded.

The following types of relocation assistance may be provided:

- Moving expenses;

- Reimbursement for losses of tangible property;
- Expenses of looking for a business or farm;
- Displacement allowance;
- Amounts required to replace a dwelling over the acquisition cost for the prior dwelling to the project or agency;
- Compensation for increased interest cost and other debt service costs of a replacement dwelling (if encumbered by a mortgage);
- Expenses for closing costs (but not prepaid expenses) on replacement dwelling;
- Rental expenses for displaced tenants;
- Amounts for downpayments on replacement housing for tenants who decide to buy;
- Mortgage insurance through Federal Programs with Waiver or requirements of age, physical condition, or personal characteristics etc., which borrowers must usually meet; and,
- Direct provision of replacement housing (as a last resort).

0388.15.85 Certain Reparation Payments

REV:06/1994

Reparation payments which are excluded from income are:

- Reparation payments received from the Federal Republic of Germany;
- Austrian social insurance payments based in whole or in part on wage credits granted under the Austrian General Social Insurance Act;
- Restitution payments made by the U.S. Government to individual Japanese Americans (or if deceased, their survivors) and Aleuts who were interned or relocated during World War II;

- Agent Orange settlement payments.

0388.15.90 Miscellaneous Exclusions

REV:06/1994

The following sources of unearned income are excluded from countable income when determining MA eligibility for individuals and couples:

- Victim Compensation Payment which is any payment received from a fund established by a State to aid victims of crime;

- Home Produce which is consumed by the individual or the individual's household; and,

- Refund of Taxes Paid on Real Property or Food.

0388.15.95 Non-SSA Statutory Exclusions

REV:06/1994

Many Federal statutes in addition to the Social Security Act provide assistance or benefits for individuals and specify that the assistance or benefit will not be considered in deciding eligibility for SSI. These statutes are listed and placed in categories according to the kind of income or assistance they provide. The list gives the name of the Federal statute (where possible), the public law number, and the citation. Each item briefly describes what the statute provides that will not reduce or eliminate an SSI payment.

FOOD

- Value of food coupons under the Food Stamp Act of 1977, section 1301 of Pub. L. 95-113 (91 Stat. 968, 7 U.S.C. 2017(b)).

- Value of federally donated foods distributed under section 32 of Pub. L. 74-320 (49 Stat. 774) or section 416 of the Agriculture Act of 1949 (63 Stat. 1058, 7 CFR 250.6(e)(9)).

- Value of free or reduced price food for women and children under the

    - (1) Child Nutrition Act of 1966, section 11(b) of

Pub. L. 89-642 (80 Stat. 889, 42 U.S.C. 1780(b)) and section 17 of that Act as added by Pub. L. 92-433 (86 Stat. 729, 42 U.S. C. 1786); and,

- (2) National School Lunch Act, section 13(h)(3), as amended by section 3 of Pub. L. 90-302 (82 Stat. 119, 42 U.S.C. 1761(h)(3)).

HOUSING AND UTILITIES

- Assistance to prevent fuel cut-offs and to promote energy efficiency under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program as authorized by section 222(a)(5) of the Economic Opportunity Act of 1964, as amended by section 5(d)(1) of Pub. L. No. 93-644 and section 5(a)(2) of Pub. L. 95-568 (88 Stat. 2294 as amended, 42 U.S.C. 2809(a)(5)).

- Fuel assistance payments and allowances under the Home Energy Assistance Act of 1980, section 313(c)(1) of Pub. L. 96-223 (94 Stat. 299, 42 U.S.C. 8612(c)(1)).

- Value of any assistance paid with respect to a dwelling unit under

  - (1) The United States Housing Act of 1937;

  - (2) The National Housing Act;

  - (3) Section 101 of the Housing and Urban Development Act of 1965; or,

  - (4) Title V of the Housing Act of 1949.

  Note: This exclusion applies to a sponsor's income only if the alien is living in the housing unit for which the sponsor receives the housing assistance.

- Payments for relocating, made to persons displaced by Federal or federally assisted programs which acquire real property, under section 216 of Pub. L. 91-646, the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (84 Stat. 1902, 42 U.S.C. 4636).

EDUCATION AND EMPLOYMENT

- Grants or loans to undergraduate students made or insured under programs administered by the Secretary of Education under section 507 of the Higher Education Amendments of 1968, Pub. L. 90-575 (82 Stat. 1063).

- Any wages, allowances, or reimbursement for transportation and attendant care costs, unless excepted on a case-by-case basis, when received by an eligible handicapped individual employed in a project under title VI of the Rehabilitation Act of 1973 as added by title II of Pub. L. 95-602 (92 Stat. 2992, 29 U.S.C. 795(b)(c)).

NATIVE AMERICANS

- Revenues from the Alaska Native Fund paid under section 21(a) of the Alaska Native Claims Settlement Act, Pub. L. No. 92-203 (85 Stat. 713, 43 U.S.C. 1620(a).

  Note: This exclusion does not apply in deeming income from sponsors to aliens.

- Indian tribes - Distribution of per capita judgment funds to members of

  - (1) The Blackfeet and Gros Ventre Tribes under section 4 of Pub. L. No. 92-254 (86 Stat. 265, 25 U.S.C. 1264) and under section 6 of Pub. L. No. 97-408(96 Stat. 2036);

  - (2) The Papago Tribe of Arizona Indians under section 8(d) of Pub. L. No. 97-408 (96 Stat. 2038);

  - (3) The Grand River Bank of Ottawa Indians in Indian Claims Commission docket numbered 40-K under section 6 of Pub. L. No. 94-540 (90 Stat. 2504);

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

  - (4) Tribes or groups under section 7 of Pub. L. No. 93-134 (87 Stat. 468, 25 U.S.C. 1407);

    Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the

sponsor's household.

- (5) The Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation as authorized by section 2 of Pub. L. No. 95-433 (92 State. 1047, 25 U.S.C. 609c-1);

- (6) The Wyandot Tribe of Indians under section 6 of Pub. L. No. 97-371 (96 Stat. 1814, 42 U.S. C. 1305);

- (7) The Shawnee Tribe of Indians under section 7 of Pub. L. No. 97-372 (96 Stat. 1816, 42 U.S.C. 1305);

- (8) The Indians of the Miami Tribe of Oklahoma and Indiana under section 7 of Pub. L. 97-376 (96 Stat. 1829, 42 U.S. C. 1305);

- (9) The Clallam Tribe of Indians under section 6 of Pub. L. 97-402 (96 Stat. 2021);

- (10) The Pembina Chippewa Indians under section 9 of Pub. L. No. 97-403 (96 Stat. 2025);

- (11) The Confederated Tribes of the Warm Springs Reservation under section 4 of Pub. L. No. 97-436 (96 Stat. 2284);

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (12) The Red Lake Band of Chippewa Indians under section 3 of Pub. L. No. 98-123 (97 Stat. 816); and

- (13) The Assiniboine Tribe of Fort Peck Montana under section 5 of Pub. L. No. 98-124 (97 Stat. 818, 42 U.S.C. 1305) and the Assiniboine Tribe of Fort Belknap under section 5 of Pub. L. No. 98-124 (97 Stat. 818, 42 U.S.C. (1305) and section 6 of Pub. L. No. 97-408 (96 Stat. 2036).

o Receipts from land held in trust by the Federal government and distributed to members of certain Indian tribes under section 6 of Pub. L. No. 94-114 (89 Stat. 579).

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

- (1) The Pueblo of Santa Ana Indians of New Mexico under section 6 of Pub. L. No. 95-498 (92 Stat. 1677, 42 U.S.C. 1305);

- (2) The Pueblo of Zia Indians of New Mexico under section 6 of Pub. L. No. 95-499 (92 Stat. 1680, 42 U.S.C. 1305); and

- (3) The Shoshone and Arapahoe Tribes of the Wind River Reservation of Wyoming under section 2 of Pub. L. No. 98-64 (97 Stat. 365, 25 U.S.C. 117).

o Revenues from the Maine Indian Claims Settlement Fund and the Maine Indian Land Acquisition Fund paid under section 5 of the Maine Indian Claims Settlement Act of 1980, Pub. L. No. 96-420 (94 Stat. 1796, 25 U.S.C. 1728(c)).

Note: This exclusion applies to the income of sponsors of aliens only if the alien lives in the sponsor's household.

OTHER

o Compensation provided volunteers in the foster grandparents program and other similar programs, unless determined by the Director of the Action Agency to constitute the minimum wage, under sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973 (87 Stat. 409, 413), as amended by Pub. L. No. 96-143; (93 Stat. 1077); 42 U.S.C. 5044(g) and 5058).

Note: This exclusion does not apply to the income of sponsors of aliens.

o Any assistance to an individual (other than wages or salaries) under the Older Americans Act of 1965, as amended by section 102(h)(1) of Pub. L. 95-478 (92 Stat. 1515, 42 U.S.C. 3020a).

0388.20 RENTAL PROPERTY INCOME

REV:06/1994

If the applicant reports income from property, the AP-759 is completed and signed by the applicant. For individuals and couples (SSI-related), net income from rental property or roomer/boarders is normally unearned income. (In rare instances in which an individual makes his/her living in the real estate or boarding home business, the rental income may be earned income. Any questions regarding classification of rental income are referred by memorandum to the Regional Manager).

0388.20.05 Rental Inc, Ind Lives in Prop

REV:06/1994

If the applicant/recipient owns and lives in a multiple family dwelling, the agency representative must pro-rate the allowable expenses based on the number of rental units.

Allowable expenses are:

- Interest payment on the mortgage(s);
- Insurance;
- Taxes;
- Water and sewer charges and assessments;
- Utilities provided to the tenant as part of the rent and billed to the applicant for the building as a whole.

To determine the countable UNEARNED income from rental property which is also the home of the applicant:

- The monthly rental income from all units is totaled;
- The expenses that the client incurs for the building as a whole are determined;
- All expenses are converted to monthly amounts and totaled. The allowable expenses on the basis of the number of rental units to the number of dwelling units in the building are pro-rated. For example, an applicant renting one unit in a two-family house may deduct one-half of the allowable expenses; an applicant occupying a

three-family house may deduct two-thirds of the allowable expenses;

- The cost of the tenant's utilities, if billed to and paid by the applicant separately from the applicant's own utilities are determined and may be deducted in full;

- The allowable deductions from the rental income are totaled to determine the countable unearned income.

0388.20.10 Rental Inc, Prop is Not Home

REV:06/1994

The property must first be evaluated as a resource. The value of the property combined with the value of other resources must not exceed the resource limit. If the resources are within the limit, all the allowable expenses are deducted from the gross rental income to determine the countable rental income of the applicant/recipient.

Allowable expenses are:

- Interest payments on the mortgage(s);

- Insurance;

- Taxes;

- Water and sewer charges and assessments.

0388.20.15 Roomer or Roomer/Boarder Inc

REV:06/1994

ROOMER INCOME

An individual may rent one or more rooms of his/her single family home or apartment. If the applicant/recipient has roomer income, allowable expenses are pro-rated based on the number of rented rooms to the total number of rooms in the house. Bathrooms, unfinished attics and basements do not count in determining total rooms. For example, if a house with six rooms has one room rented, one-sixth of the allowable expenses are deducted from the gross roomer income. The balance after deduction of the pro-rated expenses is countable unearned income.

ROOMER/BOARDER

The applicant/recipient may provide meals in addition to lodging.

If so, the allowable expenses which are deducted from the roomer/boarder income may include the cost of providing food. To reflect the added cost of providing food, the Food Stamp Program "Maximum Food Stamp Allotment" amount is deducted for the number of roomer/boarders. (See Food Stamp Manual, Sec. 1038).

0388.25 VA PAYMENTS

REV:06/1994

The Department of Veterans Affairs (VA) has numerous programs which make payments to Supplemental Security Income (SSI) recipients and their families. For SSI purposes, treatment of those VA payments depends on the nature of the payments.

The most common types of payments and their treatment is the following:

- VA PENSION PAYMENTS are income based on need and the $20 general income exclusion does not apply;

- VA COMPENSATION PAYMENTS, which are made on the basis of a service-connected disability or death, are unearned income subject to the $20 general income exclusion if made to the veteran, spouse, child or widow(er). VA compensation payments made to a surviving parent of a veteran are federally funded income based on need and the $20 general income exclusion does not apply;

- VA AID AND ATTENDANCE ALLOWANCES, which are paid to veterans, spouses of disabled veterans and surviving spouses in regular need of the aid and attendance of another person, or who are housebound, is excluded. This allowance is combined with the individual's pension or compensation payment;

- VA EDUCATIONAL BENEFITS are provided under a number of different programs, including vocational rehabilitation. Payments made as part of a VA program of vocational rehabilitation is excluded. Any VA educational benefit or portion of such a payment which is funded by the government, and is not part of a program of vocational education, is unearned income.

Some VA educational assistance programs are "contributory". The money is contributed to an educational fund and the government matches the money when it is withdrawn while the veteran is pursuing an education. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contributions is a conversion of a resource and is not income.

- VA CLOTHING ALLOWANCES related to the use of a prosthetic or orthopedic appliance, payable in August of each year to a veteran with a service connected disability, is excluded.

0390 FLEXIBLE TEST OF INCOME

0390.05 USE OF EXCESS INCOME

REV:06/1994

An institutionalized individual who meets the other eligibility requirements, but has income in excess of the Medically Needy income limits may be eligible for Medical Assistance in accordance with the Flexible Test of Income.

During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

0390.10 DETERMINE SPENDDOWN LIABILITY

REV:01/2000

CATEGORICALLY NEEDY

To be eligible as Categorically Needy, the gross income of an institutionalized individual (who is not an SSI recipient or receiving 1619(b) benefits) may not exceed the FEDERAL CAP set forth in Section 0386.05.

MEDICALLY NEEDY

An applicant who has countable income less than or equal to the Medically Needy Income Limit (MNIL) is eligible as Medically Needy, without regard to the cost of medical services.

If countable income is greater than the Medically Needy Income Limit, a flexible-test calculation must be completed. The flex-test BUDGET PERIOD IS ONE MONTH for institutionalized individuals. (Although the

budget period is one month, the APPLICATION PERIOD is the same as for other institutionalized individuals. A NEW APPLICATION IS NOT NEEDED FOR EACH MONTH.) The flex-test calculation is as follows:

From the applicant's monthly gross income, first deduct the $20 general disregard (from unearned income first), then any other applicable disregards ($65 and 1/2 the balance of wages, etc.) Compare the countable income to the MNIL for an individual set forth in Section 0386.05. If income exceeds the MNIL, deduct the MNIL from the countable income. The balance is the monthly excess income.

From the monthly excess income, deduct the PROJECTED cost of institutional care over the month, if any. The projected cost of institutional services is the number of days of institutional care (not covered by Medicare) multiplied by the PRIVATE per diem rate. If the excess income is absorbed, the applicant is eligible for Medical Assistance for the month. If the excess income is not absorbed, then deduct the documented monthly cost of medicare and other medical insurance premiums, then the documented cost of incurred medical expenses (including coinsurance liabilities) for the month in question. If, after the previous deductions, a balance of excess income remains, the individual is ineligible because of excess income. The balance of excess income becomes the flex-test spend down liability for the month. The individual does not become eligible until and unless s/he incurs costs for OTHER non-covered medical services which equal or exceed the remaining balance of income.

If, after the deduction of projected institutional expenses and incurred medical expenses, the individual still has excess income, s/he is ineligible. S/he must be notified that eligibility does not exist and notified in writing of the amount of excess income which must be absorbed each month in order to establish eligibility.

If eligibility is established for a month, the individual must be so notified. At the same time, if the case is being certified for the current month only, written notification is sent to notify the client of the closing.

If Medical Assistance payment is requested for an individual's institutional care expenses, the post-eligibility treatment of income described in Section 0392 must be followed to apply the individual's income to

the cost of the institutional care. Those medical expenses actually INCURRED (not projected) for services in the current month that are used to establish flex-test eligibility are deducted from income before applying income to the cost of care

If the institutionalized individual is eligible for MA, either as Categorically Needy or Medically Needy, go to the discussion of Resource Transfers in Section 384. If not eligible for MA, the applicant must be notified in writing that eligibility does not exist.

0390.10.05 When Eligibility Begins

REV:06/1994

The date of eligibility is the actual day of the month on which the applicant incurs a medical expense which reduces income to the income standard. THEREFORE, THE DATE OF ELIGIBILITY IS THE DAY THAT THE MEDICAL SERVICE IS PROVIDED AND NOT THE DATE OF THE BILLING, which may be a later date. The expense is incurred on the day of the service.

When an incurred medical expense is a hospital bill, the date of eligibility is the first day of hospitalization. An AP-758 is required to establish the amount of the hospital bill for which the individual is liable. The individual's liability is his/her excess income on the first day of hospitalization, providing there is no expense subsequently incurred which reduces such excess income to a lesser amount.

0390.15 RECOGNIZED MED/REMEDIAL CARE

REV:06/1994

Care which is not being provided within the MA scope of services and which may be used to offset excess income includes:

- Adult Day Care;
- Respite Care; and,
- Home Health Aide/Homemaker Services.

0390.15.05 Adult Day Care

REV:06/1994

The cost of adult day care services may be used to offset a flexible-test spenddown liability. In order to be considered a cost of "medical or remedial care", these conditions must be met:

- The service must have been rendered by a provider agency approved by the Department of Elderly Affairs (DEA); and,

- The service was required to assist an individual, who because of severe disability related to age or chronic illness, encountered special problems resulting in physical and/or social isolation detrimental to his/her well-being, or required close monitoring and supervision for health reasons.

0390.15.10 Respite Care

REV:06/1994

The cost of respite care may be used to offset a flexible-test spenddown liability if the applicant receives overnight respite care at a licensed nursing facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).

0390.15.15 Home Health Aide/Homemaker Ser

REV:06/1994

The cost of Home Health Aide services or Homemaker services may be used to offset a flexible-test spenddown liability under certain circumstances. In order to be considered a cost of "medical or remedial care", the following three conditions must be met:

- The service must have been rendered by an agency licensed by the Rhode Island Department of Health, and recognized as a service provider by DHS under the Homemaker Program (see Section 0530.35 for list); and,

- At least a portion of the service provided each month MUST be for personal care services (assistance with bathing, dressing, grooming, etc.). If the applicant does not (or did not) receive assistance with personal care during a month, no part of that month's cost of service may be used to offset the flexible-test spenddown liability; and,

If the foregoing three criteria are met, eligibility staff may recognize, without further review, the cost of up to 65 hours per month in Home Health Aide/Homemaker services to offset a flexible-

test spenddown liability. Deductions in excess of this amount must be approved in writing by the Nurse/Consultant for Homemaker Services located at 111 Fountain Street, Providence. The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the agency representative, a copy of the individual's Plan of Service obtained from the provider agency, and a copy of the physician's certification of need for services. The Nurse/Consultant reviews the material to determine the extent to which the costs of service in excess of 65 hours per month may be recognized as a deduction from excess income. Only the cost of substantive services may be allowed as a deduction from excess income.

0390.20 DEDUCT LOANS TO PAY MED BILLS

REV:06/1994

A loan can be an incurred health care expense and, in some circumstances, may be applied against the CURRENT spenddown liability when the applicant has a CURRENT obligation under the loan. The objective of the policy is to allow the recipient to use his or her liability to the lender in place of his or her liability to the provider. However, since the applicant may apply only the amount that would have been deducted had the provider's bill been used, the deduction of interest paid or payable on the loan is precluded.

A loan that is taken out in the current eligibility period to pay a health care provider for services rendered in the same period (or, in the case of a new application, for services rendered in the month of application or within the three preceding months) may be applied against the spenddown liability for the current period IN PLACE OF the provider's bill. (The loan expense and the provider's bill may not BOTH be applied against the spenddown liability).

A loan taken out in the current period or a preceding period to pay a provider's bill incurred in a preceding period may be applied against current spenddown liability to the extent of any unpaid balance in certain cases. Current principal payments and any remaining unpaid principal balance on the loan may be applied against the spenddown liability to the extent that:

- The proceeds from the loan WERE actually used to pay the provider's bill (i.e., the loan payments are not deductible until after the proceeds have been paid to the provider); and,

- Neither the provider's charges nor the loan payments and the unpaid balance were previously applied against

spenddown liability or deducted from income.

Loan proceeds that will not be used until after the current eligibility period may not be applied against the spenddown liability in the current period because only loan proceeds THAT HAVE BEEN USED to pay for health care expenses may be applied.

However, such proceeds could be used against any spenddown liability for the subsequent period in which they actually are used.

This policy gives the recipient the relief intended by the spenddown (i.e., application of the remaining liability for old medical expenses against the person's spenddown liability). The policy does not change the treatment of old bills that remain unpaid -- i.e., they are still deductible in the spenddown to the extent that a current liability continues to exist and the bills have not been previously deducted.

0392 POST-ELIGIBILITY TREATMENT OF INCOME

0392.05 OVERVIEW

REV:06/1994

Institutionalized Medical Assistance recipients are required to apply their income toward the cost of institutional care. Once Categorically Needy or Medically Needy eligibility has been established, and the applicant has been determined eligible for payment of institutional care services, a determination is made of the amount of income that the institutionalized individual must allocate to the cost of care.

The individual may protect certain prescribed amounts of income for specific needs. ONLY the prescribed amounts for the specific purposes may be protected. ALL of the institutionalized individual's remaining income must be used to reduce the Medical Assistance payment for institutional care. The applicant's income, protected amounts, and allocation to the cost of care are computed on a monthly basis.

The policy in this section applies to individuals who reside in Nursing Facilities and Public Medical Facilities. See Section 0396 for the specific post-eligibility policies which apply to individuals who receive home and community based services under a Waiver. For eligibility determination purposes, children receiving Medical Assistance under the "Katie Beckett" provisions are considered to be institutionalized. However, "Katie Beckett" eligible children are not subject to the post-eligibility process since only regular covered medical services are provided.

0392.10 INCOME FOR POST-ELIG PURPOSES

REV:03/1995

There are differences between the definition of income for determining MA financial eligibility and the definition of income for post-eligibility purposes. In the post-eligibility process, income means all income that is defined to be part of the client's gross income when determining financial eligibility.

The income disregards which were excluded in the eligibility determination process are added back as countable income in the post-eligibility process.

Generally, certain types of income that are paid to a client for medical or social services and are excluded in determining financial eligibility are counted as income in the post- eligibility process. However, Aid and Attendance (A&A) benefits or benefits for unusual medical expenses (UME) paid by the VA, are excluded in determining financial eligibility and are also excluded as income in the post-eligibility process.

Likewise, SSI benefits are not considered to be income in the MA eligibility process and are "invisible" (not countable) in the post-eligibility treatment of income as well.

0392.10.05 Income Ownership

REV:06/1994

During any month in which an institutionalized spouse is in the institution, except with respect to trust property as provided below, no income of the community spouse shall be deemed available to the institutionalized spouse.

In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined to be eligible for Medical Assistance, the following rules apply, regardless of any state laws relating to community property or the division of marital property:

NON-TRUST PROPERTY

Non-trust property is all property not subject to a trust. The caseworker reviews the instruments, if any, which provides

the income and applies its specific provisions regarding payment and availability of income. If the instrument providing the income lacks specific provisions relating to payment and availability of income, the following provisions apply:

- If payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

- If payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them;

- If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to that spouse's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.

EXAMPLE: Mrs. Sousa, an institutionalized spouse, and Mr. Sousa, her community spouse, own a four-unit tenement house (that is Mr. Sousa's home) jointly with their son. Each has a 1/3 interest in the property, and the rental payments are made jointly to all three. After a pro-rata share of the operating expenses (in this case, 75%) is deducted from the gross rental income, they have rental income from the tenement in the amount of $600 monthly. The income considered available to each is $200 monthly.

In the case of income not from a trust in which there is no instrument establishing ownership, subject to Section 0392.10.05.05, one-half of the joint interest shall be considered available to the institutionalized spouse and one-half to the community spouse.

TRUST PROPERTY

In the case of a trust, income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust:

- If payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

- If payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them;

- If payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest. If payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse.

0392.10.05.05 Rebutting Income Ownership

REV:06/1994

The rules set forth in Section 0392.10.05 regarding non-trust property may be superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under that section.

0392.15 INC APPLIED TO COST OF CARE

REV:06/1994

For each month in which Medical Assistance is requested to pay for the individual's institutional care, the individual must contribute his/her income to pay for institutional services, deducting only certain allowable amounts. The individual's income remaining after allowable deductions is paid to the institution as his/her contribution to the cost of the institutional care. Such income is known as APPLIED INCOME. The Medical Assistance payment to the institution is reduced by the applied income amount.

The calculation of applied income starts with the individual's gross income, which includes the deduction and disregard amounts which were subtracted from gross income in the determination of eligibility. To determine applied income, certain allowable deductions are subtracted

from the recipient's gross income. The deductions, and the order in which they are subtracted from the recipient's gross income are:

- Personal Needs Deduction (Regular) or $90 Reduced Pension Deduction;
- Personal Needs Deduction (Expanded);
- Personal Needs Deduction (Guardian and Legal);
- Community Spouse Allowance;
- Community Dependent Allowance;
- Medical Insurance Premiums;
- Medical/Remedial Items;
- Home Maintenance Deduction;
- First/Last Month Institutionalization Expenses.

0392.15.05 Pers Needs Deduct/$90 Pension

REV:07/1999

This deduction is a Personal Needs Deduction which is normally $50 per month, but may be larger for certain individuals with greater needs.

Beginning with benefits payable June 1, 1991 and continuing until September 30, 1997, VA improved pensions payable to certain institutionalized veterans (those with neither spouse nor children, and who are eligible for Medical Assistance) are limited to $90 per month. This reduced pension amount is protected and can be used to meet the veteran's needs while in the institution. The Veterans' Benefits Act of 1992 extended the application of the law that limits VA pensions to $90 per month and bars Medical Assistance from counting the amount in the post-eligibility process to include surviving spouses with no children on the same basis that it applies to veterans. Therefore, for personal needs, a veteran or a surviving spouse of a veteran, with no children, receiving a reduced pension is entitled to the greater of the $50 Personal Needs Allowance or, the $90 pension protected amount. In the post-elig added to the individual's other income. From the total income, subtract $90 for the veteran's personal needs.

0392.15.10 Person Needs Deduct, Expanded

REV:07/1999

Certain institutionalized individuals have higher than normal personal needs which result from their employment, and which allow them a personal needs deduction greater than the normal $50.

This higher personal needs deduction can be retained from the GROSS earned income of certain institutionalized individuals who are employed in public or private employment, or in sheltered workshops. The employment and the retention of earned income must be therapeutic. To be considered therapeutic, the employment must be part of a written plan to encourage the individual to attain his/her highest level of independence. For these individuals, an ADDITIONAL $85 plus one-half (1/2) the remainder of earned income per month may be protected for personal needs. The maximum expended personal needs allowance will vary with the amount of earnings, but can never exceed $400 ($50 + $85 + ($265 maximum) = $400).

0392.15.10.05 Pers Needs Deduct, Employ Ind

REV:07/1999

Example:

For an institutionalized applicant with monthly unearned income and earnings, the calculation of the personal needs deduction is as follows:

From UNEARNED INCOME first, subtract $50 basic personal needs;

From EARNINGS only, subtract $85;

Then, subtract 1/2 of the remaining balance of EARNINGS (up to a maximum of $265). The personal needs allowance is:

$	50	Basic personal needs allowance
+	85	Additional personal needs allowance
+	XX	Variable capped additional personal needs allowance
		Total Personal Needs Allowance

The Total Personal Needs Allowance CANNOT EXCEED $400.

0392.15.15 Pers Needs Deduct, Guard/Legal

REV:04/2001

An increased personal needs deduction is allowed for institutionalized individuals who incur certain fees.

Expenses which may result in an additional personal needs deduction under this provision are:

- Guardianship/Conservatorship Costs as provided in Section 0392.15.15.05;
- Legal Fees as provided in 0392.15.15.10;
- Tax Assessments as provided in Section 0392.15.15.15.

If specified criteria are met, the individual may retain income, in the form of an increased personal needs deduction, to meet the allowed expense(s).

0392.15.15.05 Guardian/Conservator Costs

REV:04/2001

Individuals who have court-appointed guardians or conservators are allowed to retain income in the form of an additional Personal Needs Deduction to pay for certain court-approved guardian/conservator's fees or court-ordered fees relating to the guardianship/conservatorship. Such fees include but are not limited to:

- Court filing fees;
- The cost of a Probate Bond;
- Court-approved guardianship/conservatorship fees; and,
- Court-approved legal fees.

To be considered, the expense must be required for the individual to make income or resources available, or in the case of an incompetent individual who needs a court-appointed guardian, required to access or consent to necessary medical treatment (including applying for Medical Assistance). The individual must submit a copy of the Probate Court Order and any supporting documentation, including an itemized bill for allowable guardianship/conservatorship expenses, to the Department.

Such cases are referred to the Office of Legal Counsel by the Administrator of Long Term Care (or his designee). The referral must contain a brief description of the case, a copy of the Probate Court Order, an itemized bill from the guardian, and any other supporting documentation submitted by the individual.

The Office of Legal Counsel may consider as deductions reasonable court-approved expenses (not covered by other sources) listed above, subject to the Rhode Island Supreme Court approved fee schedule (currently $30 per hour for guardians under "Executive Order" Number 95-01). When such guardianship fees have been approved by the Probate Courts, related guardian ad litem fees not exceeding $250 may also be recognized.

The total amount allowed must be reasonable shall be based the hours approved by the particular Probate Court for items as provided above at the rate of compensation paid for guardians ad litem in Family Court as specified in the then-current Rhode Island Supreme Court Executive Order on fee schedules.

Monthly deductions of up to one hundred twenty five dollars ($125) may be allowed for guardianship expenses. Monthly deductions up to one hundred twenty five dollars ($125) may also be allowed for related legal fees. An additional deduction from income of up to two hundred fifty dollars ($250) is recognized for allowable expenses related to a guardian-ad-litem during the month in which the individual pays the expense.

0392.15.15.10 Legal Fees

REV:06/1994

Individuals who incur legal fees resulting from legal action to obtain income or resources for their support may retain income in the form of an additional Personal Needs Deduction to pay such fees. The maximum which may be deducted from income is the LESSER of the actual fee, or one third of the settlement amount.

0392.15.15.15 Tax Assessments

REV:06/1994

Individuals ordered by the Internal Revenue Service, the Rhode Island Division of Taxation, or other State or municipal taxing authority to pay income taxes may retain income to pay the taxes.

0392.15.20 Community Spouse Allocation

REV:01/2006

If the institutionalized individual has a community spouse, the individual may wish to allot an amount to the community spouse for his/her support. The amount of the community spouse allocation is based on the income already available to the community spouse. Thus, the calculation of this allocation is preceded by a determination of the community spouse's income.

If the institutionalized individual has a community spouse and other community dependents, s/he may choose to bypass the community spouse and allocate only to his/her dependents.

The maximum amount that may be taken from an institutionalized individual's income for the support of a spouse and dependents in the community is $2,488.50 per month, except:

- In the case of a court order for spousal support; or,
- In the case of a court order or a finding by an administrative hearing.

The allocation to community spouse is based upon the gross income otherwise available to the community spouse. The income of the community spouse is determined in the same manner as gross income for purposes of eligibility determination. No disregards or deductions are applied to the community spouse's gross income in determining the allocation from the institutionalized spouse.

If the amount made available to the community spouse by the institutionalized spouse is less than the allowed calculation, the allocation is the amount actually made available to the community spouse.

0392.15.20.05 Calculation of Community Spouse Allocation

REV:07/2005

The calculation of the community spouse allowance considers the following:

- The community spouse's gross income; and,
- The spouse allowance which consists of two parts, the basic allowance and the excess shelter allowance.

The BASIC ALLOWANCE to a community spouse with no other income is $1,604 per month.

An EXCESS SHELTER ALLOWANCE is added to the basic spouse allowance if the community spouse's shelter expenses exceed $482 per month.

0392.15.20.10 Excess Shelter Allowance

REV:07/2005

The excess shelter allowance is the amount by which the community spouse's shelter expenses exceed $482 monthly. Only shelter expenses relating to the community spouse's principal place of residence may be used to calculate the excess shelter allowance.

Shelter expenses are defined as and limited to:

- Rent;
- Mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge;
- A STANDARD UTILITY ALLOWANCE of $357 per month, regardless of the actual utility costs, IF utility costs are incurred by the community spouse.

If the total allowable monthly shelter expenses are less than $482, there is no excess shelter allowance. The amount of shelter costs that EXCEEDS $482 is the excess shelter allowance.

0392.15.25 Dependent's Allocation with Community Spouse

REV:07/2005

Other family members of the institutionalized individual who live with the community spouse are also entitled to an allowance from the institutionalized individual. The dependent's allowance, when the dependent is living with the community spouse, is IN ADDITION to any spouse allowance, and MUST BE ALLOWED AS A DEDUCTION WHETHER OR NOT IT IS MADE AVAILABLE TO THE DEPENDENT(S) BY THE INSTITUTIONALIZED INDIVIDUAL.

To qualify for this dependent's allowance, the relative must live with the community spouse and must be:

- A minor (less than 18 years old) dependent child of

either the institutionalized or the community spouse;

- O A dependent parent of either spouse;

- O A dependent sibling of either spouse (including an adoptive sibling or sibling of half blood).

Family members living with a community spouse for whom a dependent's allowance is sought must be determined to be financially dependent on the institutionalized individual. A family member is dependent if s/he is (or could be) claimed as a tax dependent of either the institutionalized spouse or the community spouse.

If the above criteria are met, the allowance for each dependent is calculated as follows:

- O The allowance for a dependent with no income is $535 per month.

- O If the dependent has income, his/her gross monthly income is deducted from the basic allowance of $1,604. The difference between $1,604 and the dependent's monthly income is DIVIDED BY 3. The divisor 3 is a constant value in this computation. The QUOTIENT is the MONTHLY DEPENDENT'S ALLOWANCE FOR THAT PARTICULAR DEPENDENT.

EXAMPLE: Mr. Rostenkowski, a disabled institutionalized individual, has a wife and two minor children at home, John, age 16, and Dan Jr., age 10. The rent for their home is $500/month including H & U giving an excess shelter allowance of $18 ($500 - $482 = $18/month). He collects a gross RSDI benefit of $927 monthly for himself, and dependent's benefits of $309 per month EACH for his wife and children. In addition to the RSDI benefit, he collects a veteran's pension of $1,400 per month for himself alone.

Mr. Rostenkowski's wife is entitled to an allocation of $1,313 per month, calculated as follows:

Basic Allowance	$1,604.00
Excess Shelter Allowance	+ 18.00
Spouse Allowance	$1,622.00
Less Spouse's Income	- 309.00

MONTHLY ALLOCATION FROM THE INSTITUTIONALIZED INDIVIDUAL TO

THE COMMUNITY SPOUSE: $1,313.00

The RSDI benefit for each dependent child is considered to be the income of that child. EACH child is entitled to a dependent's allowance of $432 per month, calculated as follows:

Basic Allowance	$1,604.00
Less the dependent's income	- 309.00
Difference	$1,295.00

$1,295 divided by constant value 3 = $432/MONTH for EACH child.

MONTHLY ALLOCATION FROM THE INSTITUTIONALIZED INDIVIDUAL TO DEPENDENTS LIVING WITH THE COMMUNITY SPOUSE: $432 x 2 = $864

0392.15.25.05 Depend Allocat/No Comm Spouse

REV:07/1999

Dependent family members of the institutionalized individual, WHEN THERE IS NO COMMUNITY SPOUSE, are entitled to an allowance from the institutionalized individual based on the Medically Needy Income Unit. To qualify for this dependent's allowance, the relative must be:

- A minor (less than 18 years old) dependent child;
- A dependent parent;
- A dependent sibling (including an adoptive sibling or sibling of half blood).

Family member(s) for whom a dependent's allowance is sought must be determined to be financially dependent on the institutionalized individual. A family member is dependent if s/he is (or could be) claimed as a tax dependent.

The basic allowance for a dependent without a community spouse is equal to medically needy income limit for an individual, less any income of the dependent. If there is more than one dependent, the Medically Needy Income Limit for the family size is used.

0392.15.30 Fair Hearing

REV:06/1994

If either the institutionalized spouse or the community spouse is dissatisfied with a determination of the community spouse monthly income allowance or the amount of income otherwise available to the community spouse, such spouse is entitled to a hearing. In addition, if either spouse establishes that due to exceptional circumstances resulting in significant financial duress, the community spouse requires additional income, the hearing officer may order an allocation to provide such additional income as is necessary.

0392.15.35 Medical Insrance Premiums

REV:06/1994

The deduction is the total of premiums paid for medical insurance coverage identified on the InRHODES system STAT/INSU or STAT/MEDI panels. If the institutionalized individual's Medicare premium is being paid by the State, it is not allowed as a deduction.

0392.15.40 Medical/Remedial Care Costs

REV:06/1994

The deduction consists of the cost of medical or remedial care recognized under state law but not covered under the Medical Assistance scope of services. This includes the cost of such items as chiropractic services, hearing aids for the Medically Needy, and certain ambulance services. Medical/remedial items which may be included in this deduction from the institutionalized individual's gross income are identified on the STAT/MEDX panel.

0392.15.45 Allocation for Home Mainten

REV:07/1999

If the institutionalized individual has no spouse living at home, and a physician has certified that s/he is likely to return home within six months, an amount can be allocated for the maintenance of the home. This deduction cannot exceed the Medically Needy Income Limit for one, nor can the amount be allocated for more than six months in any continuous period of institutionalization.

An institutionalized individual may not allocate income for both HOME maintenance and for the support of dependents at home.

The dollar amount per month that the individual is allowed to pay for expenses of the home are identified on the InRHODES system STATEMENT OF NEED/ HOME, RENT, and UTIL panels.

Expenses that can be deducted from the income are:

- Rent or mortgage;
- Taxes;
- Insurance;
- Special assessments and water bill.

THE MONTHLY TOTAL ALLOCATED CAN NOT EXCEED THE MONTHLY MEDICALLY NEEDY INCOME LIMIT FOR AN INDIVIDUAL. (See Section 0386.05)

0392.15.50 1st/Last Months of Instit Exp

REV:06/1994

In determining the amount of income to be protected for the needs of an institutionalized individual WITHOUT a community dependent, the fact that a patient who is institutionalized for less than a full month will have out-of-institution expenses is recognized. In fact, the likelihood is great that an individual entering an institution during the middle of the month will have already expended his/her personal income for ONGOING EXPENSES.

This deduction is the amount of extra expenses allowed during partial months of institutionalization for an individual with no community spouse or dependents. It is manually entered and maintained in the InRHODES system by the Long Term Care worker.

Evidence of an on-going expense can be either a receipt for payment or a bill that is due. An UNPAID BILL need not be for the month of admission or the month of discharge from the facility; an overdue bill is still an ongoing expense for which the individual is liable. However, a RECEIPT must be for an expense incurred for the month of admission and/or the month of discharge from the facility. (These concepts comport with the policy on spenddown.)

Copies of receipts and/or bills are inserted in the case record.

0392.20 MA PAYMENT FOR INSTITUTIONAL CARE

REV:07/2005

An allocation for the support of the community spouse and/or dependents, and the deduction allowed for medical insurance may only be subtracted from the recipient's income to the extent that the income is actually made available for the purpose intended.

For example, a community spouse may be entitled to an allowance of $950, but if the institutionalized spouse only provides $700 to the community spouse in the month of January, only $700 is deducted from the institutionalized spouse's income as the spousal allowance in the post-eligibility process for January.

After the appropriate deductions have been subtracted from the institutionalized individual's income, the remaining balance of the income is applied to the cost of institutional care. The monthly Medical Assistance payment to the medical institution is reduced by the applied income amount. Following the previously cited example (Sec.0392.15.25), set forth below are the final calculations of the amount the recipient is responsible to pay toward the cost of care in the institution.

ROSTENKOWSKI EXAMPLE:

Mr. Rostenkowski's Income	$2,327.00
Personal Needs Allowance	- 50.00
Spousal Allocation	-1,313.00
Dependent's Allowance	- 864.00
Medicare Premium	- 66.60
Income Applied to the Cost of Institutional Care	$ 33.40

0392.25 INSTITUTIONALIZED SSI REC

REV:07/1999

Recipients of SSI are automatically Categorically Needy Medical Assistance recipients. If the applicant is eligible for payment of institutional care services (s/he has not incurred a period of ineligibility by a resource transfer), LTC/AS staff determine the applicant's income to be applied to the cost of care in the institution. The SSI payment itself (and the State Supplement, if any) is excluded from consideration in the post-eligibility allocation of income to the cost of institutional care.

ALL OTHER INCOME of the SSI recipient is considered in the monthly income allocation from the first month of confinement in a Long-Term Ca

There are two groups of SSI recipients for whom the post-eligibility al are:

- Community SSI recipients whose SSI benefits continue during inpatient confinement; and,
- Employed individuals receiving SSI under Section 1619 who are institutionalized.

0392.25.05 3 Month Continu of SSI Benef

REV:06/1994

The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for the continuation of full SSI benefits for up to three months to individuals who enter medical facilities, including acute care hospitals and Nursing Facilities, but who intend to return to their community residences within ninety days. Retention of full SSI benefits is intended to allow these individuals to maintain their community residences while temporarily confined to a hospital or Long-Term Care facility. To be eligible for continued SSI benefits, three conditions must be met:

- A physician must certify in writing that the individual's medical confinement is not expected to exceed ninety days; and,
- The individual must certify in writing that s/he needs the SSI benefit to maintain the home; and,
- Documents attesting to the above conditions must be received by SSA not later than ten days after the end of the month in which the individual entered the institution.

0392.25.05.05 Processing Continuation Benef

REV:06/1994

SSI recipients eligible for continuing SSI benefits may enter a LTC facility from a hospital or may request placement directly from home.

- SSI Recipient Entering an LTC Facility From a Hospital

The Long-Term Care/Adult Services (LTC/AS) worker obtains an application and supporting documentation in the normal manner in order to determine the income to be applied to the cost of care, to determine eligibility for MA if SSI is terminated prior to discharge, and to determine if a prohibited resource transfer has been made. The worker communicates with the Social Security Administration via the RI-DHS-SSA-1 to advise SSA of the recipient's entry into a LTC facility.

o SSI Recipient Requesting Placement Directly From Home

The LTC/AS worker obtains an application and supporting documentation in order to determine income to be applied to the cost of care, to determine eligibility for MA if SSI terminates prior to discharge, and to determine if a prohibited resource transfer has been made. The worker effecting the placement informs the individual of the availability of extended SSI benefits. If the individual intends to return home and medical evidence indicates that the individual will be able to do so within ninety days, the LTC/AS worker obtains a statement from the individual's doctor that indicates when the individual's return home is anticipated. The worker also obtains a signed statement from the individual which states that the SSI benefit is needed to maintain the home for his/her return. When the individual is placed, the RI-DHS-SSA-1 is sent, as above, to notify SSA of the placement. A copy of the doctor's statement and the individual's statement are sent to SSA along with the RI-DHS-SSA-1. These documents must be received by SSI before the tenth day of the month following the month of institutionalization for SSA to continue full SSI benefits.

o Termination or Reduction of SSI

If an SSI recipient remains institutionalized beyond the time limit, the SSI payment is terminated or reduced to the $30 level. LTC/AS assumes responsibility for eligibility determinations for those individuals who no longer receive an SSI payment.

o Allocation of Income to the Cost of Care

The SSI payment is excluded from the individual's gross income when calculating income to be applied to the cost of care.

0392.25.10 Employ/Instit SSA 1619 (B) Rec

REV:06/1994

Section 1619 of the Social Security Act provides for special SSI payments for disabled persons who are working. Persons who received SSI payments under Section 1619 of the Social Security Act in the month prior to institutionalization may receive two months of continued SSI benefits when admitted to:

- Eleanor Slater Hospital;
- Zambarano Hospital.

The LTC/AS worker, as part of the normal intake process, secures an application and supporting documents from the individual. The worker determines if an individual admitted to one of the institutions listed above is a member of this group by communicating with the Social Security Administration via form RI- DHS-SSA-1. If so, the allocation of income to the cost of care EXCLUDES the SSI payment from the individual's gross income.

0392.30 SPECIAL SITUATIONS

REV:01/2002

Some situations produce unusual results in the three-step sequence of financial determinations, especially in months in which the recipient is Medical Assistance-eligible for only a partial month, or in those circumstances in which the individual is Medical Assistance-eligible based on a flexible-test income calculation which includes projected institutional care expenses.

Example A:

Step 1. Mrs. Stark, widowed with no dependents, has been institutionalized since 1985. She has exhausted her resources paying for nursing facility care, and is resource eligible. She has gross income of $4,870 per month. After the $20.00 disregard, her countable income is $4,850/monthly, leaving her with a monthly income of $3,208.33 in excess of the Medically Needy Income limit ($4,850 - $641.67 = $3,208.33). After deduction of allowable medical insurance premiums (SMI), her flex-test spenddown liability is $3,154.33 per month ($3,208.33 - $54 = $3,154.33). The private pay rate in the nursing facility is $175 per day ($5,250/mo). The projected institutional

expense of $5,250 exceeds the spenddown liability, therefore Mrs. Stark is ELIGIBLE for Medical Assistance for the full month. Proceed to step 2 to evaluate eligibility for a vendor payment.

Step 2. She has not transferred any resources that would preclude Medical Assistance payment for the nursing facility services. Proceed to step 3.

Step 3. The post-eligibility treatment of income results in no vendor payment being made to the facility. From her gross income of $4,870, Mrs. Stark is allowed to protect $50 for personal needs, and $54 for her SMI premium. Her income applied to the cost of nursing facility care is $4,766 per month ($4,870 - $50 - $54 = $4,706). The Medical Assistance per diem rate for the facility in which Mrs. Stark resides is $120.00 per day ($3,600/mo.). Her applied income exceeds the Medical Assistance rate for care in the facility, and thus no vendor payment can be made to the nursing facility.

Example B:

Step 1. Mr. Bradley is an institutionalized individual with a spouse and two minor children in the community. He has gross income of $5,400 per month, comprised of a $900 monthly RSDI benefit, and a $4,500 private pension. His countable income for Medical Assistance eligibility determination purposes is $5,380. His income in excess of the Medically Needy income limit is $4,738.33 ($5,380 - 641.67 = $4,738.33). His spenddown liability is $4,684.33 ($4,738.33 - $54 {SMI} = $4,684.33). He has no other incurred medical expenses. The private cost of care in the institution in which he is placed is $140 per day ($4200/mo).

Because his projected institutional care costs combined with his incurred medical expenses do not absorb his excess income, he is not eligible for Medical Assistance. Because he is not eligible for Medical Assistance, there is no post-eligib were eligible for Medical Assistance, the post-eligibility process would have provided for an allowance for his spouse and dependent children. Because he is not eligible for Medical Assistance, the post-eligibility treatment of income never comes into play. There is no equivalent spouse/dependent allowance methodology in the eligibility determination process.

Example C:

Step 1. Mr. Dingell is an institutionalized individual with a community spouse who lives in a subsidized apartment for the elderly. Mr. Dingell's resources consist only of his Personal Needs Account of $145.00 at the nursing facility. His income consists solely of a gross RSDI benefit of $996.00. The income of the community spouse consists solely of her gross RSDI benefit of $560.00 per month. Mr. Dingell is Categorically Needy by virtue of having resources and income less than the Categorically Needy limits for an institutionalized individual. Proceed to Step 2.

Step 2. Mr. Dingell has not transferred any resources, and thus has incurred no penalty period for nursing facility payment. Proceed to step 3.

Step 3. The post eligibility process results in zero income being applied to the cost of care. The amount allocated to Mrs. Dingell from Mr. Dingell's income is $892/mo. ($1452.00 - 560.00 = $892.00. There is no excess shelter allowance because Mrs. Dingell pays no utility expenses, and her total shelter cost in subsidized housing amounts to a monthly rental payment of $161). From Mr. Dingell's gross income of $996.00 is deducted the personal needs deduction of $50.00, then the spousal allocation of $892.00, then the SMI Premium of $54.00, leaving nothing to be applied to the cost of care in the nursing facility.

Example D:

Mrs. Bentson is an institutionalized individual with a community spouse. She entered a Nursing Facility from her home on the 11th of the month. She has resources between the Categorically Needy and Medically Needy limits, and has income from RSDI benefits of $1051.00 gross per month. Her community spouse is 59 years old, has no RSDI, but collects TDI of $581 monthly. He has shelter costs of $225/month for rent, which includes heat and utilities. Mrs. Bentson has Medicare Part A coverage and Medicare is to pay for her first 20 days in the nursing facility.

Step 1. Mrs. Bentson has countable income of $1031.00 per month, and an excess income of $389.33. After deduction of her monthly SMI premium of $54.00, her spenddown liability is $335.33. Because Medicare pays for her care in the Nursing Facility for the remainder of the month, she has no cost of institutional care, and is not eligible for Medical Assistance based on projected institutional care costs.

During the second week of the month, she incurs expenses for prescriptions of $122. Her spenddown liability decreases to $213.33. She has no further medical expenses that month, and never becomes eligible for Medical Assistance during the month. There is no post-eligibility treatment of income for that month, and no income specifically allocated to the support of Mr. Bentson in the month. Since she has no obligation to pay for any services other than her prescriptions, she may choose to make funds available to her spouse.

EXAMPLE E:

During the second FULL month of Mrs. Bentson's institutionalization, she incurs the cost of her Nursing Facility care and her spenddown liability for the month is met. Her projected institutional expenses render her eligible for Medical Assistance for the full month. She is certified for Medical Assistance from the first day of the month. In the post-eligibility process, she retains $50 for Personal Needs, an allocation to support Mr. Bentson of $871, and an amount to pay her Medicare premium of $54. Her contribution to the cost of her care is $56.

0394 SSI-RELATED COVERAGE GROUPS

0394.05 INSTIT IND, SSI ELIG IN COMM

REV:01/2002

This coverage group consists of individuals in a medical or nursing facility who would be eligible for SSI if living in the community. This includes individuals with sufficient income to meet personal needs while in the facility, but not enough income to meet their needs outside the community according to SSI and State Supplement Standards.

0394.10 INSTIT IND, NOT SSI ELIG IN COM

REV:01/2002

This coverage group consists of individuals in a medical or nursing facility who would not be eligible for SSI if s/he were living in the community. While in the facility these individuals are MA eligible under a special income level for institutionalized individuals (the Federal Cap). The resources of institutionalized persons in this coverage group must be within SSI limits.

0394.15 12/73 RES OF TITLE XIX FACILIT

REV:06/1994

This coverage group (InRHODES Category Code 18) consists of individuals who were eligible for AABD as residents or inpatients of Title XIX facilities or were, on the basis of need for institutional care, considered to be eligible for AABD in the month of December, 1973. The Title XIX facilities are the Eleanor Slater Hospital and Zambarano Hospital.

Eligibility for Medical Assistance continues for these individuals as long as they:

- Remain residents of the Title XIX facilities; and,
- Meet the eligibility conditions of AABD as of December, 1973; and,
- Are in need of institutionalized care.

Due to the small number of individuals in this coverage group, this category will be entered to InRHODES by the Eligibility Technician using the InRHODES manual determination command (MANL).

0394.20 CONTIN SSI ELIG, SHORT CONFINE

REV:01/2002

This coverage group consists of SSI recipients who enter medical facilities, including acute care hospitals and Nursing facilities, and who intend to return to their community residences within ninety (90) days. The Omnibus Budget Reconciliation Act (OBRA) of 1987 provides for the continuation of full SSI benefits for up to three months. The intent of the OBRA provision is to allow individuals to retain their community residences while temporarily confined to a hospital or Long Term Care facility.

The eligibility requirements for continued SSI benefits are:

- A physician must certify in writing that the individual's medical confinement is not expected to exceed ninety (90) days; and,
- The individual must certify in writing that s/he needs the benefit to maintain the home; and,
- Documents attesting to the above conditions must be

received by the SSA not later than ten (10) days after the end of the month in which the individual entered the hospital.

0394.25 EMPLOYED IND, SSI BY 1619 (B)

REV:01/2002

This coverage group consists of disabled persons who are working and who receive special SSI payments under Section 1619b of the Social Security Act. Individuals who received SSI payments in the month prior to institutionalization receive two (2) months of continued benefits when admitted to:

- Eleanor Slater Hospital;
- Zambarano Hospital.

0394.30 INSTIT IND, AABD ELIG IN 12/73

REV:01/2002

This coverage group consists of individuals who, whether or not they actually received cash assistance in December, 1973 satisfy the following criteria:

- Eligibility for cash assistance in December, 1973 because they were blind or disabled under the State's approved AABD plan; and,

- For each consecutive month after December, 1973, continued eligibility based on the December, 1973 conditions of blindness or disability, and the other conditions of the plan in effect in December, 1973; and,

- Income and resources within current SSI standards.

0394.35 DISABLED CHILD-KATIE BECKETT

REV:01/2002

This coverage group consists of certain disabled children under the age of eighteen (18) who are living at home and who would qualify for Medical Assistance if in a medical institution.

"Katie Beckett" coverage requires that the child meet special eligibility conditions in addition to financial eligibility.

A child under 18 years of age who is living at home but who is in need of the level of care provided in a hospital, Nursing Facility, or Intermediate Care Facility for Mental Retardation, has his/her Medical Assistance financial eligibility determined as if s/he were actually institutionalized. ONLY THE CHILD'S OWN INCOME AND RESOURCES ARE USED IN THE DETERMINATION OF FINANCIAL ELIGIBILITY. THE INCOME AND RESOURCES OF THE CHILD'S PARENTS ARE NOT DEEMED TO BE AVAILABLE TO THE CHILD. A "Katie Beckett" child is deemed Categorically Needy for the full scope of medical services. The purpose of "Katie Beckett" coverage is to make Medical Assistance for home care available to children who might otherwise be disqualified due to the parents' income.

0394.35.05 Special Elig Conditions

REV:09/2003

To be eligible for Katie Beckett coverage, it must be determined that:

- The child requires the level of care provided in a hospital, a Nursing Facility, or an ICF-MR. The LTC/AS worker must assure that a completed assessment of the child's needs is sent to the Center for Child and Family Health (CCFH). This unit has the responsibility of determining the level of care and disability status for the child and the specific time frame for re-evaluation.

- The level of care provided at home is appropriate for the child;

- The estimated cost to Medical Assistance for providing the appropriate level of care at home does not exceed the cost to Medical Assistance for providing care in an institutional setting.

If the child meets these special eligibility conditions and is otherwise eligible, the Long Term Care worker authorizes medical coverage. Children eligible for MA under this coverage group may be enrolled in a Rite Care Health Plan in accordance with provisions contained in Section 0348, if they are not otherwise covered by a third party health insurance plan.

0394.35.10 Instit, Home Cost Comparison

REV:06/1994

The estimated cost to MA of providing care for the child at home cannot exceed the estimated cost to MA of providing care in an institution.

To make this determination, the LTC/AS worker compares the gross monthly cost for the required level of care (hospital, NF, or ICF- MR, as appropriate) to the total gross monthly cost for allowed home care services), using the Waivered Services Panel in the InRHODES eligibility function.

0394.35.10.05 Allowed Home Care Services

REV:09/2003

Allowed home care services are:

- Certified home health agency services, including skilled nursing; physical, speech and occupational therapy and home health aid services; and,
- Purchase or rental of durable medical equipment;
- Home based therapeutic services; and,
- Minor assistive devices, minor home modifications, and other special equipment.

Certain services may be provided by school systems for school age children, by family members and/or by volunteers and are not to be considered in estimating the cost of care at home. It should be noted, however, that for school age children these services are the legal responsibility of the school system.

0394.35.10.10 Determ Costs of Instit Care

REV:06/1994

The LTC worker enters the applicable type of institutional care on the Waivered Services (SERV) Panel and refers to the table of institutional costs maintained by the InRHODES system. The worker uses the SERV Panel which determines if the costs of services required to provide an appropriate level of care in the home are within the costs of care in the appropriate institution.

If eligible, there is no income applied to the cost of services.

The child is allowed to retain all income for community living expenses.

If the total estimated cost of care in the home is less than the total estimated cost of care in the appropriate institution, the child meets this special condition and, if otherwise eligible, is eligible for the full scope of MA benefits.

If the total estimated cost of services required to allow the child to be cared for at home exceeds the cost of institutional care, the child is ineligible, even if the child meets all other eligibility requirements.

0394.35.15 Financial Eligibility Requirements

REV:01/2000

To establish financial eligibility for "Katie Beckett" coverage, it is necessary to determine that if the child were in a medical institution s/he would be eligible for Medical Assistance, as either Categorically Needy or Medically Needy. Under the law, if the child meets the "Katie Beckett" requirements, s/he, for MA purposes only, is deemed to be receiving an SSI cash payment, and is therefore CATEGORICALLY NEEDY.

Only the income and resources of the child are considered. Any payment provided under Title XX or other federal, state or local government programs for in-home supportive services is excluded from income.

The LTC/AS worker determines if the child would be financially eligible for Medical Assistance if institutionalized. An institutionalized child is financially eligible for Medical Assistance if s/he is in one of the following groups:

- If s/he would be eligible for SSI if institutionalized, i.e., has resources within the SSI limit of $2,000, and income LESS THAN $70.00 MONTHLY. These individuals receive cash SSI payments even when they are institutionalized and are therefore Categorically Needy;

- If s/he had resources within the $2,000 limit and income of at least $70.00 but NOT MORE THAN THE Federal Cap set forth in Section 0386.05. These individuals lose their SSI cash payment when they are institutionalized because their gross personal income

is $70 or more per month. However, because their income is less than the Federal Cap they remain eligible for Medical Assistance as Categorically Needy;

- o If s/he has with resources less than the Medically Needy resource level of $4,000 and income less than the cost of care in the institution. These individuals are eligible as Medically Needy.

The income and resources of the parents are not considered in the determination of eligibility, and are not used to reduce the cost of Medical Assistance services.

0396 WAIVER PROGRAMS, PROVISIONS

0396.05 OVERVIEW OF WAIVER PROGRAMS

REV:12/2000

Many individuals who require the level of care provided in an institutional setting may be able to receive such services at home. Programs that provide home and community-based services to persons who would otherwise require institutional care require special waivers of the normal Medical Assistance rules. These waiver programs must be approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

Home and community-based services are a humane, cost-effective, and generally preferable way of providing institutional levels of care to eligible individuals. The Department of Human Services provides Home and Community Based Services to eligible aged and disabled individuals under a Waiver program operated by the Long Term Care/Adult Services unit (see Section 0398.05).

DHS also operates Waiver programs in conjunction with other agencies to serve the needs of certain target populations. These jointly operated programs are the following:

- o The Department of Mental Health, Retardation and Hospitals (MHRH) program for developmentally disabled individuals ("MR Waiver" - see Section 0398.10);
- o People Actively Reaching Independence (PARI) program for very severely disabled individuals ("PARI Waiver" - see Section 0398.15);
- o The Department of Elderly Affairs (DEA) program for individuals in the community or seeking to return home from nursing facilities ("DEA Waiver" - see Section

0398.20);

- The Department of Elderly Affairs (DEA) program for aged and disabled individuals in specified Residential Care/Assisted Living Facilities ("Assisted Living Waiver" - see Section 0398.30).

DHS Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of financial eligibility for Medical Assistance for all waiver recipients. Since categorically needy individuals receive a greater scope of services, waiver recipients must be determined to be eligible as categorically needy whenever possible.

Case Managers at MHRH, DEA, and PARI assist in the determination of eligibility for the Waiver Programs by forwarding information to the DHS LTC/AS unit, and by communicating directly with their applicants and recipients regarding eligibility and income allocation matters.

The Waiver programs differ in:

- Target populations;
- Special home and community-based services provided to eligible recipients;
- Eligibility level required for participation (Categorically Needy or Medically Needy); and,
- Procedures.

This section contains the policies that generally pertain to all waiver programs, including determinations of eligibility, post-eligibility treatment of income, and determinations of cost-effectiveness. Exceptions are listed, where applicable, in the following sections specific to each waiver program.

0396.10 DETERMINATION OF ELIGIBILITY

REV:12/2000

Eligibility determinations conducted for individuals applying for or receiving services under a Waiver program are conducted AS IF THE INDIVIDUAL WERE ACTUALLY INSTITUTIONALIZED. Policies contained in Sections 0376 through 0392 are generally applicable to individuals applying for Medical Assistance eligibility and services under a Waiver program. This means that:

- Deeming of spousal resources and/or income does not apply after the month of separation due to institutionalization;

- Deeming of parental income and/or resources does not apply to a child under 18 after the month in which the child is determined to be separated due to institutionalization;

- All transfers of assets made within thirty-six (36) months prior to, or anytime after, the individual applies for services under the waiver program must be evaluated under transfer provisions contained in Section 0384. Trusts established within sixty (60) months immediately prior to, or anytime after, the individual applies for services under the waiver program must be evaluated under trust and transfer provisions contained in Section 0382. Resource transfers may render an individual ineligible for payment of Waiver-specific services.

0396.10.05 Who May Be Eligible

REV:12/2000

Individuals potentially eligible for Waiver programs include SSI recipients and non-SSI recipients.

SSI RECIPIENTS

SSI recipients (and former SSI recipients who are determined eligible for Medical Assistance by SSA under section 1619(b)) are automatically eligible for Categorically Needy Medical Assistance and thus potentially eligible for Waiver services unless the individual has transferred an asset with a resulting uncompensated value. See Section 0384 for specific information about the penalties related to transfer of assets, and Section 0382 for information about trusts and portions of trusts which are treated as a transfer of assets.

SSA transmits a list of individuals who have transferred resources to the LTC Unit at CO. These transfers must be evaluated when a request for Waiver services is made.

NON-SSI RECIPIENTS

Eligibility for non-SSI recipients is determined as if the applicant were entering or in an institutional setting. The applicant must meet

the technical, characteristic, and financial requirements of the Medical Assistance program.

0396.10.10 Technical Elig Requirements

REV:06/1994

Technical Requirements which must be met are:

- Level of care;
- Residency;
- Enumeration;
- Citizenship/Alienage;
- Assessing potential income and resources;
- Cooperation in making resources/income available;
- Transfer of assets.

0396.10.10.05 Institutional Level of Care

REV:06/1994

In order for an individual to be eligible for home-based services under a Waiver, s/he must require the level of care provided in an institutional setting. Case Managers recommend the appropriate level of institutional care for each Waiver applicant, subject to the review and approval of the Long Term Care Unit at CO.

The instruments for establishing the appropriate level of care are the CP-1 and the CP-1.1. Policy and criteria for establishing levels of care are found in Section 0378, PRIOR AUTHORIZATION.

Each Waiver program's targeted population is a specific subset of the overall population requiring institutional services. The appropriate level of care for eligibility varies with each Waiver program.

0396.10.15 Characteristic Requirements

REV:06/1994

The characteristic requirements are those of the SSI program: Age (65 years or older); Blindness; or Disability. Only aged individuals can

be served under the Waiver Program for Deinstitutionalizing the Elderly (DEA Waiver).

0396.10.20 Financial Requirements

REV:12/2000

For CATEGORICALLY NEEDY eligibility to exist, the applicant's resources must be within the Categorically Needy limits set forth in Section 0380, and the applicant's GROSS income must not exceed the Federal Cap set forth in Section 0386.05.

The Waiver Programs requiring Categorically Needy eligibility are:

- Waiver for Aged and Disabled Individuals (Section 0398.05); and;
- Waiver Program for Aged and Disabled Individuals in Assisted Living (Assisted Living Waiver) (Section 0398.30).

For MEDICALLY NEEDY eligibility to exist, the individual's resources may not exceed the Medically Needy resource limits set forth in Section 0380. The applicant's COUNTABLE income must be less than the Medically Needy income limit for an individual set forth in Section 0386.05; OR the individual must incur each month allowable medical expenses (including the anticipated cost of Waiver services) which exceed the amount of the individual's monthly income which is over the Medically Needy Income Limit.

The Waiver Programs in which an individual may be either Categorically Needy or Medically Needy are:

- Waiver Program for the Severely Handicapped (PARI Waiver) (Section 0398.15);
- Waiver Program for Aged Individuals (DEA Waiver) (Section 0398.20);
- Waiver Program for Developmentally Disabled Individuals (Section 0398.10).

0396.10.25.05 Cost Neutrality Requirement

REV:05/2002

The DHS Center for Adult Health is responsible for reviewing and approving the aggregate cost neutrality of each waiver program on an

annual basis. To meet cost neutrality, the average per capita expenditures under a waiver cannot exceed one hundred percent (100%) of the average per capita expenditures for the appropriate level(s) of care that would have been made in that year had the waiver not been granted.

0396.10.25.10 Cost Neutrality - Level of Care Costs

REV:03/2006

The average monthly costs to Medical Assistance by level of care are:

O	Nursing Facilities	$ 5,082.00
O	Intermediate Care Facilities for the Developmentally Disabled (ICF-MR)	$16,047.95
o	Hospitals	$20,655.00

0396.15 Average Cost of Care

REV:06/1994

The post-eligibility treatment of income applies to those individuals who are:

- o Categorically Needy by virtue of having resources within the Categorically Needy limits, and income within the Federal Cap; and,
- o Medically Needy.

SSI RECIPIENTS: SSI recipients, and individuals receiving Categorically Needy Medical Assistance by virtue of 1619(b) status are NOT subject to the post-eligibility process. The SSI payment itself is invisible in the allocation process, and for Waiver program recipients who are also SSI recipients, NONE of the other income of an SSI recipient is subject to the post-eligibility process.

DHS Long Term Care/Adult Service (LTC/AS) units are responsible for determinations and redeterminations of the post-eligibility allocation of patient income to the cost of Waiver services for all Waiver services recipients who are subject to the post-eligibility process. The calculation starts with the individual's full, gross income, including amounts which were disregarded in the determination of eligibility. For purposes of the post-eligibility process, income means all amounts that are available to the individual that would be

defined to be part of the applicant's gross income in the determination of MA financial eligibility

0396.15.05 POST-ELIG TREATMENT OF INCOME

REV:03/2006

The following is a list of allowable deductions in the order they are to be deducted:

o Maintenance Needs Allowance

The Maintenance Needs Allowance is eight hundred thirty six dollars and sixty-seven cents ($836.67) per month. This amount is in lieu of the Personal Needs Deduction and the Home Maintenance Deduction available to other institutionalized (non-Waiver) individuals.

For employed individuals eligible under the Waiver for the Developmentally Disabled (Section 0398.10), the Maintenance Needs Allowance is equal to eight hundred thirty six dollars and sixty-seven cents ($836.67) plus all gross earned income per month, an amount not to exceed the federal cap. To qualify for this expanded Maintenance Needs Allowance, the individual's employment must be in accordance with the plan of care.

O Spouse/Dependent Allowance

This deduction is an allowance for the support of a spouse and any dependents. The basic allowance for a spouse is equal to the monthly medically needy income limit for an individual, less any income of the spouse.

If there are also dependent children to be supported, the Medically Needy Income Limit for the number of children is used.

O Medical Insurance Premiums

This deduction is insurance premiums paid by the individual, such as Medicare, SMI, and medigap policies such as Blue Cross and Plan 65. This information will have been previously entered and identified on the STAT/INSU and STAT/MEDI panels.

O Allowable Costs Incurred for Medical or Remedial Care

This deduction is reasonable costs for medical services recognized under state law but not covered in the scope of the Medical Assistance Program. Examples of such items would be hearing aids, chiropractic

expenses, or ambulance charges. These items are entered on the InRHODES Medical Expense (MEDX) Panel.

Any balance of income remaining after these expenses are deducted is allocated toward cost of home-based services according to the plan worked out with the Case Manager.

0396.15.10 Allowable Income Deductions

REV:06/1994

Beginning with the second (2nd) month in which the individual receives services, income is allocated toward the cost of home- based services in the manner indicated below. The LTC/AS staff will calculate costs for individuals receiving services under the Aged and Disabled Waiver. The LTC/AS staff will review and approve CP-3 and CP-4 forms submitted by Case Managers from other agencies on each individual.

0396.15.10.05 Calculation of Income Allocation

REV:03/2006

From the full gross income of a single individual the following amounts are deducted in order:

- Maintenance Needs Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care

Any balance of income remaining after these expenses are deducted is allocated toward the cost of home-based services according to the plan developed with the Case Manager.

EXAMPLE: Mr. Alonzo applies, is found eligible to receive home based services, and is Categorically Needy with income under the Federal Cap. He lives alone. His sole income from RSDI is $934 per month. He has Medicare, but no other health insurance. His monthly allocation to the cost of services is as follows:

RSDI Benefit	$934.00
Maintenance Needs	- 836.67
Balance	97.33
Medicare Premium	- 88.50
Income Allocation	$ 8.83

*NOTE: To qualify as Medically Needy, an individual must have income within the Medically Needy income limit or incur allowable medical expenses (including the anticipated cost of Waiver services) which exceed the amount of the individual's monthly income which is over the Medically Needy Income Limit.

0396.15.10.10 Individual With Community Spouse/Dependent

REV:03/2006

When an eligible individual lives with a spouse (or a parent in the case of a child with an ineligible parent), the individual is considered to be a single individual. The spouse's (or parent's) income is not considered in determining the amount the individual must pay for the cost of services.

Deduct from the applicant's full, gross income the following amounts, in the order presented:

- Maintenance Needs Allowance
- Spousal and Dependent Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care

EXAMPLE: Mrs. Quackenbush has been found eligible for home-based services as a Categorically Needy individual with income under the Federal Cap. She has income from RSDI of $789.60, and a private pension of $449.80, for a total income of $1,239.40 monthly. Her husband has income of $515.60 from RSDI. Each has Medicare and pays an SMI premium of $88.50 monthly. Each also has Blue Cross Plan 65 at a monthly cost of $82.85. Mrs. Quackenbush's monthly income allocation is as follows:

Total Gross Income		$1,239.40
Maintenance Needs	-	836.67
Spouse Allowance	-	201.40*
Mrs. Q's premiums	-	171.35
Income Applied to the Cost of Services	$	29.98

*The Spouse allowance is calculated as follows: MNIL $717.00 less Mr.Q's gross income of $515.60 results in a spousal allowance of

$201.40. Note that the gross amount of Mr.Q's income is deducted from the MNIL. There is no recognition of Mr.Q's medical insurance premiums.

0396.15.10.15 MA Payment for Waiver Service

REV:06/1994

The Waiver services recipient is responsible to pay the income allocation toward cost of home-based services according to the plan worked out with the Case Manager.

The Medical Assistance payment for Waiver services is reduced by the amount of the income allocation each month.

0396.20 FORMS UNIQUE TO WAIVER PROG

REV:06/1994

Listed below are several of the forms used in more than one Waiver program, the programs for which each is used, and a description of their use. Specific procedures are found in the policies relating to each Waiver program.

0396.20.05 Patient Assesment Form

REV:06/1994

The CP-1 and CP-1.1 may be completed only by staff trained in the use of these forms, and delegated the responsibility for recommending the appropriate care. Case Managers for all Waiver programs have been delegated this responsibility. The CP-1 cover sheet is used as an authorizing document to establish the need for NF care for services under a Waiver. The original and one copy of page 1 are sent to the LTC Unit, Division of Medical Services at Central Office for review and approval.l One copy is retained in the case record.

0396.20.10 AND Activity Log

REV:06/1994

The CP-2 is used in the aged and disabled Waiver. It is the chronological log of the Case Manager's activity for each individual receiving services under the Waiver. The form is retained in the case record. All contacts (face-to-face, telephone, or mail) with the individual, family, provider or others should be entered briefly. A column is provided on the right side of the sheet for appropriate file instructions.

0396.20.15 AND Worksheet

REV:06/1994

The CP-3 worksheet (see the InRHODES SERV panel) is designed to help the Case Manager compile the monthly cost of the individual plan of care. Informal providers of service need not be listed on the CP-3. The service costs calculated on the CP-3 are for Homemaker Services, Adult Day Care Services, Home Health Aide Services, Minor Modifications to the Home, and Minor Assistive Devices.

COLUMN 1:

Each deficit identified in the assessment should be specified.

For example, "cooking main meal weekdays," or "laundry."

COLUMN 2:

The type of provider whose service will compensate for the identified deficit rather than specific agency is entered here.

For example, "Homemaker Services," or "Day Care Services."

COLUMN 3:

Enter the number of hours per day for Homemaker Services required to complete the task. This column is used only for Homemaker Services.

COLUMN 4:

Enter the number of days per week the service will be delivered.

This column is used for Homemaker Services, Day Care Services and Home Health Services paid by Medical Assistance.

COLUMN 5:

Enter the unit cost of the service. Provider rates will be found on the CP-20. For minor modification in the home and minor assistive devices, (including the installation charge for PERS), divide the total cost by 12 and add to the dividend the monthly cost of PERS, if provided. Enter the total in column #6.

COLUMN 6:

Enter the monthly cost of each service and total the monthly cost for all services. Enter this figure on the CP-4, line 11.

0396.20.20 Case Mngr Financial Worksheet

REV:06/1994

LINE 1:

Enter the consumer's total monthly gross income, excluding only the SSI payment, and the amount of the SMI premium, if any.

LINES 2-8:

Calculate exactly as if the individual were in a nursing facility.

Instructions for the allocation of income toward the cost of a nursing facility are in DHS MANUAL, Sec. 0396.

LINE 9:

Enter the average gross monthly cost of care in a nursing facility.

This amount is updated each year, and is found in DHS MANUAL, Sec.

0394.

LINE 10:

Subtract line 8 from line 9.

LINE 11:

Enter the consumer's total monthly gross income, excluding only the SSI payment and the amount of the SMI premium, if any.

LINE 12:

Enter the Medically Needy Income Limit (MNIL) for ONE for the consumer's maintenance needs. See Sec. 301.3.

LINE 13:

Enter the amount of any medical insurance premiums paid by the consumer (other than SMI).

LINE 14:

Enter the amount necessary for the support of a spouse who lives with the consumer. This is the MNIL for ONE less the spouse's gross income. If dependent children under 18 are present in the home, this

amount is the MNIL for the total number of dependents to be supported (including the spouse), less any gross income of the dependents.

LINE 15:

Enter the cost of medical or therapeutic services provided for under state law but not covered by Medical Assistance (e.g., chiropractic services).

LINE 16:

Add lines 12, 13, 14 and 15.

LINE 17:

Subtract line 16 from line 11. If eligible, this is the amount for which the consumer will be responsible.

LINE 18:

Enter the total cost of Waiver services from the CP-3, or the Master Authorization form, as appropriate.

LINE 19:

Subtract line 17 from line 18.

The cost to Medical Assistance for home based services cannot exceed the cost of care in a Nursing Facility.

0398 SPECIFIC WAIVER PROGRAMS

0398.05 HOME-BASED FOR ELDER/DISABLED

REV:06/1994

Since July, 1982, under a Waiver approved by the Health Care Financing Administration (HCFA), DHS has operated a program to divert elderly and disabled individuals from entering a Nursing Facility (NF). This Waiver program provides to eligible participants an array of home-based services which are equal to or less than the cost of institutional care. o be eligible for Waiver services, individuals must be Categorically Needy and meet the requirements of the Long Term Care Alternatives Program.

The program is designed to supplement the existing scope of services already provided by Medical Assistance, Federal Medicare, other State

and local programs, and "informal" caretakers such as relatives, friends and neighbors.

0398.05.05 Waiver Services

REV:06/1994

The additional MA services provided under the Waiver are:

- Case MANAGEMENT SERVICES - a broad coordinating function which authorizes, arranges, and monitors home-based services. Case management services are provided by LTC Social Service staff.

- HOMEMAKER/PERSONAL CARE SERVICES - defined in Section 0530 of the DHS Policy Manual.

- ADULT DAY CARE - defined in Section 0514 of the DHS Policy Manual.

- MINOR MODIFICATIONS TO THE HOME - such as portable wheel chair ramps, grab bars, modifications to tubs and toilets.

- MINOR ASSISTIVE SERVICES - such as cooking and eating aids, grooming aids, and other devices which assist in the Minor Assistive Services may include payment for the installation fee and monthly monitoring fee of a Personal Emergency Response System (PERS). The PERS is an in-home, twenty-four hour electronic alarm system which allows a functionally impaired housebound individual to signal a central switchboard in the event of an emergency.

  This service is limited to high risk, physically vulnerable individuals who must live alone or spend prolonged periods of time alone, and who have the mental capacity to understand the purpose of PERS and to use it properly.

  Minor Assistive services requires prior authorization via an MA-505 by the individual's physician, evaluation of the individual by the LTC Case Manager and service provider (usually the hospital discharging the patient), and is subject to the approval of the Chief of Pharmacy Services in the Division of Medical Services.

The additional services provided under the Waiver are meant to fill remaining gaps in service, not to substitute for existing services for which the individual is eligible. For example, many of the individuals served under the Waiver may be entitled to Medicare-home-health aide or rehabilitation specialists such as a physical therapist. Thus, the home-based service plan written by the Case Manager would not include services already available through other programs such as Medicare.

0398.05.10 Target Population

REV:06/1994

Under the Waiver, two groups of beneficiaries receive services.

They are Categorically Needy SSI Recipients (Group I) and Newly Diverted Individuals (Group II).

- Group I - Categorically Needy SSI Recipients

  Group I is active SSI recipients who, as of January 1, 1982, had been previously diverted from entering a NF through the use of Homemaker Services, and meet the financial and non-financial eligibility criteria for Categorically Needy MA. No new beneficiaries may be added to this group.

- Group II - Newly Diverted

  Group II is individuals who qualify for NF care and meet the financial and non-financial eligibility criteria for Categorically Needy MA.

0398.05.15 Eligibility Determination

REV:06/1994

Initial eligibility for Group II individuals is determined by the appropriate Long Term Care (LTC) staff as if the individual were entering a nursing facility. If the individual meets the MA technical and characteristic requirements, has income and resources within Categorically Needy limits, and meets the criteria for the Long Term Care Alternatives Program, s/he may choose home care services in lieu of institutional care. If so, the Case Manager in the LTC Unit will be responsible for the case.

TRANSFER OF GROUP I CASES TO THE LTC UNIT

There are two situations in which Group I cases are transferred to the LTC Unit. A previously diverted Group I individual loses SSI eligibility, or a Group I case requires minor modifications to the Home, or Minor Assistive Devices.

- Group I Individual Loses SSI Eligibility

  When a previously diverted Group I individual loses SSI eligibility, the Adult Services worker refers the case to the appropriate LTC unit and eligibility is determined as for an individual in Group II. The individual must have an aged, blind or disabled characteristic, have income within the Federal Cap and resources within the Categorically Needy limits. In addition to meeting MA eligibility requirements, the individual must meet the criteria for the Long Term Care Alternatives Program and choose home care services in lieu of institutional care.

  When the determination of eligibility is completed, the social worker is notified. If the individual is ineligible, the social worker discontinues Homemaker Services and/or Adult Day Care Services. IF the individual is eligible under the Waiver, the Case Manager assumes responsibility for the case.

- Active Group I cases requires Modifications to Home or Minor Assistive Devices.

  If a currently active Group I case requires Minor Modifications to the Home, or Minor Assistive Devices, the case responsibility is transferred to the appropriate LTC/AS Unit.

0398.05.20 Redetermination

REV:06/1994

GROUP II - NEWLY DIVERTED

Redetermination of financial eligibility is conducted at least annually for Group II Waiver service recipients, or when there is a change in circumstances which would affect eligibility. The redetermination is completed by the LTC Unit of the Case Manager servicing the case. Waiver-eligible individuals with a spouse are considered to be living separately, as if in a nursing facility or medical institution. Resources of the spouse are considered as if the individual were applying for care in a medical institution.

GROUP I - PREVIOUSLY DIVERTED

Redetermination of financial eligibility is conducted by the SSA, concurrently with the SSI determination. When a previously diverted case requires redetermination of need for services, the case will continue to be handled by the Adult Services worker with current responsibility for the case. Current procedures apply, except that the CP-1 and CP-1.1 are sent to the Homemaker Review Office in lieu of an HS-1 and HS-2. One copy of the CP-1 is forwarded from the Homemaker Review Office to the LTC Unit at CO.

0398.05.25 Case Management Function

REV:06/1994

In addition to determining eligibility, and the level of care required, DHS Case Mangers coordinate the array of home-based services. Case Mangers will:

- Plan alternative services;
- Arrange and authorize services;
- Monitor and adjust the service mix; and,
- Reassess to determine eligibility and need for services under the Waiver, including need for a Nursing Facility level of Care.

0398.05.30 Planning Alternative Services

REV:06/1994

The hospital Social Service staff identify likely candidates for home-based services under the Waiver. Potential candidates are Categorically Needy MA patients who qualify for SNF/ICF Care and express an interest in receiving those services in the community rather than a facility. The hospital social worker completes the CP-1 and CP-1.1 and notifies the DHS Case Manager.

Hospital Social Services Staff apprise each candidate of the availability of services either in an institutional setting or in a home-based setting under the Waiver program. Each recipient's choice is documented by a signed form, CP-12. The CP-12 is retained in the LTC/AS case record.

The DHS Case Manager carries out the following sequence of functions:

- The Case Manager meets (within one workday of notice when possible) with the hospital discharge team to design a care plan which compensates for all deficits identified on the CP-1 and CP-1.1. The Case Manager completes the CP-4 in order to ascertain the maximum amount available for home -based services under the Waiver. (CP-4, line 10).

- The service plan agreed to by the DHS Case Manager and the hospital discharge team is recorded by the Case Manager on the CP-3.

- The Case Manager discusses the Preliminary Care Plan with the patient and family and negotiates modifications.

- The Case Manager completes line 11-19 of the CP-4 to ensure that the planned services to not exceed the amount on line 10.

- When the plan is agreed to by the patient and family, the Case Manager completes the Individual Plan of Care (CP-5). The Case Manager discusses the allocation of the individual's income toward the cost of home-based services, and helps the individual select providers, when there is a choice.

- The Case Manager notifies the individual of his/her eligibility and the amount (if any) of contribution toward the cost of care by sending a CP-7.

- Before authorizing and arranging services, the Case Manager completes Forms CP-1, CP-1.1 or 70.1 or 72.1 as appropriate, and obtains a Level of Care from the LTC Unit at DHS Central Office, CP-3, CP-4, CP-5, and CP-99. The Case Manager will verify that the client has completed a CP-12.

0398.05.30.05 Planning Alt Services - Comm

REV:06/1994

The LTC/AS staff identify likely candidates for home-based services under the Waiver. Potential candidates are Categorically Needy MA individuals who qualify for NF care and express an interest in receiving these services in the home rather than in a facility.

LTC/AS staff apprise each candidate of the availability of services in either an institutional setting or in a home-based setting under the Waiver program. Each recipient's choice is documented by a signed form, CP-12. The CP-12 is retained in the LTC/AS case record.

The LTC/AS worker (Case Manager) carries out the following sequence of functions:

- The LTC/AS worker (Case Manager) forwards a completed 72.1 and 70.1 to the Medical Review office at CO. The level of care will be issued on a MA 510 and sent to LTC/AS.
- The LTC/AS worker (Case Manager), in concert with the candidate, designs a care plan which compensates for the deficits identified. The Case Manager completes the CP-4 in order to ascertain the maximum amount available for home-based services under the Waiver (CP-4, line 10).
- The service plan agreed to by the Case Manager and the candidate is recorded by the Case Manager on the CP-3.
- The Case Manager discusses the Preliminary Care Plan with the candidate and family and negotiates modifications.
- The Case Manager completes lines 11-19 of the CP-4 to ensure that the planned services do not exceed the amount on line 10.
- When the plan is agreed to by the candidate and family, the Case Manager completes the Individual Plan of Care (CP-5). The Case Manager discusses the allocation of the individual's income toward the cost of home-based services and helps the individual select providers, when there is a choice.
- The Case Manager notifies the individual of his/her eligibility and the amount (if any) of contribution to the cost of care by sending a CP-7.
- Before authorizing and arranging services, the Case Manager completes forms CP-3, CP-4, CP-5, and CP-99.

As part of the Case Management function, the Case Manager arranges and authorizes a variety of services, including

- Homemaker/Personal Care Services;
- Adult Care Services;
- Devices to Adapt the Home Environment and Minor Assistive Devices; and,
- Other Services.

0398.05.30.15 Homemaker/Personal Care Serv

REV:06/1994

To arrange Homemaker/Personal Care services, the Case Manager telephones the provider selected to discuss the Service Plan and the beginning date of services. The provider is informed of the total amount of service to be purchased, and what share, if any, the recipient is responsible to pay directly.

The service recipient's share of the payment must be allocated to the first hours of service delivered in a provider/payroll period (four weeks). For example, thirty hours of service per payroll period are authorized and the recipient is responsible to pay for ten hours (form CP-4, line 19) and Medical Assistance is responsible to pay for twenty hours of services. In the event the provider delivers only twenty five hours of service, the recipient is still responsible for ten hours, and Medical Assistance is responsible for fifteen hours.

Homemaker Services are authorized on form HS-3. Four copies are completed. The original is sent to the Family and Adult Services Fiscal Unit at Central Office, one copy is sent to the provider, one copy to the recipient, and one copy is kept in the case record.

When the plan for service(s) is finalized, the individual is notified of his/her elgigibilty and the amount of his/her contribution toward cost of care by a CP-7. Copies of the CP-5, Individual Plan for Care and the appropriate authorization form, HS-3, is also sent.

The provider receives a copy of the Individual Plan of Care (CP- 5) and a copy of the Authorisation for Homemaker Services (HS-3).

0398.05.30.20 Adult Day Care Services

REV:06/1994

The Case Manager monitors the provision of home-based service at least once weekly for the first four weeks. If possible, the Case Manager should avoid modifying the service plan during the first thirty days to allow sufficient time for proper adjustment by the individual, family and providers.

All contacts with the recipient, family or providers are entered in the Activity Log (CP-2).

- The Case Manager is responsible to maintain appropriate contact with providers of home-based service.

  The Case Manager learns the amount and duration of Home Health Services to be delivered under federal Medicare by contacting the visiting nurse who is responsible for completing the home assessment.

  The Case Manager and the visiting nurse should discuss the total service plan to assure the adequacy and compatibility of the various services.

- The Case Manager will visit the recipient at home within thirty days following the start of Waiver services to reassess the service needs and to make appropriate adjustments in the service mix.

0398.05.30.25 Dev for Home/Minor Assist Dev

REV:06/1994

Certain durable medical equipment can be provided when it is necessary as part of a total care plan to prevent institutionalization. These are:

- Devices to adapt the home environment, such as portable ramps, grab bars and devices for adapting tubs and toilets. Installation is included in the purchase price and modifications requiring more than incidental construction are excluded; and,

- Minor assistive devices, such as grooming, eating and cooking aids and Personal Emergency Response Systems (PERS).

Provision of these items requires prior authorization from the Chief of Pharmacy Services in the Division of Medical Services.

The Chief of Pharmacy Services may be consulted if the Case Manager is not certain which vendors provide the required items.

If time is important, the Chief of Pharmacy Services can grant verbal authorization.

The process will be facilitated if a physical/occupational therapist participates on the hospital discharge team for patients who may require these items.

The Case Manager contacts the vendor who completes an MA-505.

For, PERS, in addition to the MA-505 completed by the physician and the service provider, the LTC/AS Case Manager must evaluate the individual's suitability for the service. Factors to be considered are the individual's diagnosis, living arrangements, and physical and mental ability to use the PERS equipment properly. A memo detailing the evaluation accompanies the MA-505 to the Chief of Pharmacy Services. Once prior authorization has been received, the Case Manager calls the vendor to arrange delivery and/or installation.

0398.05.30.30 Arranging Other Services

REV:06/1994

The Case Manager should be familiar with the entire range of other services which may be brought to bear on existing deficits.

This includes the services provided under Medicare and Medical Assistance as well as those funded by other Federal, State, local or private sources. The Case Manger assists the individual in arranging these services.

Examples of services which may be used to complete the Individual Plan of Care are:

- Social services - from Family and Adult Services or other providers;
- Meals-on-Wheels;
- Transportation - from Senior Citizens Transportation (SCT) or informal providers;
- Recreational activities - senior citizens, church groups, service clubs;
- Universal services - beauticians or barbers who can

serve the handicapped, legal services, financial advisors, consumer advisors, etc.

0398.05.30.35 Monitoring Home-Based Service

REV:06/1994

The Case Manager monitors the provision of home-based service at least once weekly for the first four weeks. If possible, the Case Manager should avoid modifying the service plan during the first thirty days to allow sufficient time for proper adjustment by the individual, family and providers.

All contacts with the recipient, family or providers are entered in the Activity Log (CP-2).

- The Case Manager is responsible to maintain appropriate contact with providers of home-based service.

  The Case Manager learns the amount and duration of Home Health Services to be delivered under federal Medicare by contacting the visiting nurse who is responsible for completing the home assessment.

  The Case Manager and the visiting nurse should discuss the total service plan to assure the adequacy and compatibility of the various services.

- The Case Manager will visit the recipient at home within thirty days following the start of Waiver services to reassess the service needs and to make appropriate adjustments in the service mix.

0398.05.30.40 Reassessing Rec Elig and Need

REV:06/1994

Reassessments of levels of care are completed at least every six months, or by the date indicated on the CP-1/MA510.

Redeterminations of eligibility for the Waiver Program are conducted annually, or more often, as appropriate.

To reassess the level of care, both the CP-1 and CP-1.1 are completed:

- Completion of the CP-1 assures that the individual continues to reqire the level of services provided in the nursing facility which is an eligibility requirement of the Waiver Program;

- o Completion of the CP-1.1documents changes in the individual's functional ability so that the service plan can be modified accordingly.

The original and one copy of Page 1 of CP-1 are sent to the Medical Review Office at Central Office and a copy is kept in the record.

0398.10 HOME-BASED FOR MENTAL RETARDED

REV:06/1994

Since July, 1983, the Department of Human Services (DHS), in conjunction with the Department of Mental Health, Retardation and Hospitals (MHRH), has offered a program to provide home and community-based services to mentally retarded individuals who would normally receive such services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). The program is operated under a Waiver approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services. The Waiver allows the program to deviate from certain MA rules pertaining to eligibility determination and services provided to eligible recipients. This program supplements the existing scope of services already provided under Medical Assistance (MA) and by other programs and service providers. The program has become informally known as the MR Waiver Program.

The goals of the program are:

- o To reduce and prevent unnecessary institutionalization by providing home and community-based services to eligible mentally retarded MA recipients; and,

- o To provide the services at a cost less or equal to the cost of institutionalization.

0398.10.05 Target Population

REV:11/1994

The program is intended to reach individuals who are (or would be if institutionalized) Categorically Needy or Medically Needy Medical Assistance recipients; and,

1) have requested Waiver services in lieu of admission to an ICF/MR facility, and are determined by MHRH to be at risk of institutionalization; or,

2) are residents of an ICF/MR who will return to the

community with services under the Waiver.

MHRH Case Managers identify potential candidates from the population of ICF/MR residents and at risk applicants described in Section 0398.10.20.05 below. The Case Manager at MHRH recommends the candidate for ICF/MR level of care by forwarding a CP-1 to the Medical Review Office. At the same time, for non-SSI recipients, an application and supporting documents are obtained by the MHRH Case Manager, and forwarded to the appropriate LTC/AS district office of DHS for a Determination of Eligibility (DOE).

0398.10.10 Waiver Services

REV:11/1994

Individuals eligible under the Waiver receive the Medical Assistance scope of services provided to Categorically Needy individuals or Medically Needy individuals, as appropriate. In addition to the normal services, an array of special services is provided under the Waiver. The services are selected, arranged, authorized, re-mixed, monitored, and re-authorized by the Case Manager. In some cases, the individual is required to pay a part of the cost of the special Waiver services.

The special services provided under the Waiver are:

- o CASE MANAGEMENT

  The coordination of the array of home-based services by Department of Retardation/Developmental Disabilities (DOR/DD) Case Managers who:

  - Establish and update an individual plan of care;
  - Arrange and authorize services;
  - Monitor and adjust the service mix;
  - Reassess the recipient's need for services and for ICF/MR level of care.

- o SPECIALIZED HOMEMAKER SERVICES

  Household management and personal care services provided by licensed mental retardation agencies.

- o FAMILY LIVING ARRANGEMENTS

Household management in foster care homes. The individual's own income pays for room and board. The Waiver provides payment for services needed beyond room and board.

- HOMEMAKER SERVICES/PERSONAL CARE SERVICES

  General household duties such as cleaning, meal preparation, laundry, and personal care services (see Sec. 0530) provided when the normal provider (usually the relative with whom the recipient lives) is unavailable.

- HOMEMAKER/LPN SERVICES

  The monitoring of a complex or unstable medical condition such as frequent pneumonia, skin prone to breakdown, or cerebral palsy, beyond the level which can be furnished by a homemaker/personal care provider. In addition, patients must require mechanical and/or physiologic supports such as tracheotomy, colostomy, or catheter care. The service requires prior administrative approval at the level of Chief Caseworker Supervisor or above in DOR/DD.

- RESPITE SERVICES

  Temporary, care-giving services in the absence of the caretaker relative.

- EARLY INTERVENTION

  The provision of developmental activities to infants and toddlers with a developmental disability and the guidance and training offered to their parents.

- MINOR ASSISTIVE DEVICES

  Items such as grooming, eating, and cooking aids provided as part of a total case plan to prevent institutionalization.

- MINOR MODIFICATIONS TO THE HOME

  Minor modification to the home, such as ramps, grab bars, toilet modifications, etc. to enable the recipient who also has a physical handicap to use

toilet facilities and be mobile.

Specific details of the Case Manager's functions are contained in the MHRH Division of Retardation's SOCIAL SERVICE MANUAL.

0398.10.15 DHS Responsibilities

REV:11/1994

Long-Term Care/Adult Services (LTC/AS) Units conduct determinations and redeterminations of Categorically Needy or Medically Needy eligibility for MA. The LTC/AS units also calculate the amount of a recipient's income to be allocated to the cost of care (if any) and communicate the results of these determinations to individuals through the Case Managers at DOR/DD. The LTC/AS staff authorizes vendor payments for Specialized Homemaker Services. The Long-Term Care Unit at Central Office has the responsibility to review and approve/deny the level-of-care recommendations completed by DOR/DD.

0398.10.15.05 Deter. MA Eligibility, Non-SSI Recipient

REV:11/1994

Long-Term Care/Adult Services (LTC/AS) Units conduct determinations and redeterminations of Categorically Needy or Medically Needy eligibility for individuals considered for this program. Eligibility is determined by the appropriate LTC Staff as if the individual were entering an LTC facility. The individual must meet the normal citizenship/alienage, residency, enumeration, and disability requirements. For Categorically Needy eligibility, the individual must have resources within the Categorically Needy limits, and have monthly income less than the Federal Cap, as adjusted each January. For Medically Needy eligibility, the individual must have income and resources within the Medically Needy limits.

The cost of services to be provided under the Waiver must be less than the average cost of institutional care. All standard resource and income verification procedures must be completed (including sending of AP-91s).

Form CP-31 is completed to notify the recipient (in care of the DOR/DD Case Manager)of the decision. The original and one copy are sent to the DOR/DD Case Manager. The third copy is retained in the case file.

In addition, a CP-30 is completed to apprise MHRH of the eligibility decision and amount (if any) of income to be applied to the cost of services. One copy is retained for the DHS case file.

If the case is REJECTED, an AP-167M is completed in duplicate.

The original is sent to the recipient, (in care of the DOR/DD Case Manager) along with the CP-30, and the copy is retained for the DHS case file.

The DHS case file is the MA eligibility record. It is maintained in the LTC/AS field office. It contains all documents relating to the determination of financial eligibility. In addition, the CP-1 received via the Office of Medical Review at Central Office, copies of CP-30s and notices sent to recipients are retained in the case file.

For cases determined to be Categorically Needy by virtue of receipt of SSI, LTC/AS maintains a case file which contains the CP-1 forms which have been routed through and approved/denied by the Office of Medical Review at Central Office and documents relating to assessments of resource transfers, if any.

0398.10.15.10 Inc Alloc, Non-SSI Recip

REV:06/1994

Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients determined eligible for Categorically Needy Medical Assistance by SSA under 1619(B)) is allocated to the cost of Waiver services. For others, once eligibility is determined, the individual's income is reviewed to determine the monthly amount (if any) that s/he must pay toward the cost of special Waiver services.

Staff of the LTC/AS Unit utilize the CP-30 to inform the Case Manager at MHRH and the Business Manager of the Division of Medical Services of the recipient's monthly income allocated to the cost of Waiver services. LTC/AS staff used the CP-31 to notify the recipient (in care of the DOR/DD Case Manager) of the amount allocated to the cost of services.

0398.10.15.15 Redetermination of Elig

REV:06/1994

The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

The individual and Case Manager at MHRH are notified of any changes in eligibility status or allocation of income.

0398.10.20 MHRH Responsibility

REV:11/1994

Unlike the Long Term Care Alternatives Waiver Program for the Elderly and Disabled described in Section 0398.05, the case management function rests with staff in DOR/DD.

The case management function does not include determination of Medical Assistance eligibility or allocation of income.

The DOR/DD case management responsibilities include:

- Identifying potential Waiver services recipients;
- Determining need for ICF/MR level of care;
- Ascertaining the status of MA Categorically Needy or Medically Needy eligibility;
- Evaluating the cost-effectiveness of Waiver services;
- Ascertaining amount of income to be applied to cost of Waiver services;
- Coordinating home-based services.

0398.10.20.05 Point of Entry

REV:11/1994

Case Managers apprise potential recipients of the availability of Waiver services.

Potential recipients are:

- Categorically Needy or Medically Needy individuals who reside in ICF/MR facilities;
- Individuals who have requested services in lieu of admission to an ICF/MR and who are at risk of institutionalization because of one or more of the following conditions:
  - Individual living with only one family member;
  - Individual living with parents or family members over age 60;
  - Certain severely/profoundly retarded or developmentally disabled individuals, i.e. persons

requiring total care;

- Persons with severe behavior problems requiring specific behavior interventions more than once an hour.

0398.10.20.10 ICF/MR Level of Care

REV:06/1994

The Case Manager at MHRH Division of Retardation and Developmental Disabilities has responsibility to obtain information and evaluate an individual to determine if s/he requires the level-of-care provided in an Intermediate Care Facility/Mentally Retarded facility. If the evaluation indicates that the candidate requires an ICF/MR level of care, form CP-1 is completed by the Case Manager recommending the ICF/MR level of care. The "Waiver" block at the top of the CP-1 is checked, and the form is forwarded to the Long Term Care Unit at Central Office for review and approval. All CP-1 forms are reviewed and approved by the Long Term Care Unit.

0398.10.20.15 Medical Assistance Eligibility Status

REV:11/1994

Prior to providing services under the MR Waiver program, and at each reassessment, the Case Manager must ascertain that the applicant is eligible for Medical Assistance. The procedures vary as outlined below.

o SSI RECIPIENTS

SSI recipients are Categorically Needy for MA. Active SSI status must be verified at intake and reassessment. The LTC Unit has the responsibility to determine if a resource transfer exists that will impinge on Medical Assistance eligibility or eligibility for payment of nursing facility services or MR facility services.

o NON-SSI RECIPIENTS

All other individuals are referred to DHS LTC/AS by the Case Manager for a determination of eligibility for MA. The procedures vary depending on whether or not the individual is receiving Social Security Disability Insurance Benefits (DIB).

If the candidate RECEIVES disability benefits, the Case Manager forwards a completed and signed DHS-1, DHS-2

and CP-30 to the appropriate LTC/AS district office.

If the candidate DOES NOT receive DIB, the Case Manager obtains a form AP-72.1 from the candidate's physician, and completes form AP-70.1 containing social information and functional abilities. Both forms are forwarded, along with the CP-1 (see above), to the Office of Medical Review at CO. The application for Medical Assistance is sent to the appropriate LTC/AS district office.

The LTC/AS district office notifies the Case Manager of the eligibility decision by return CP-30. LTC/AS also routes notices to recipients in care of the DOR/DD Case Manager.

0398.10.20.20 Cost-Effective of Waiver Serv

REV:06/1994

Home and community-based services provided to an individual as an alternative to institutional care must be cost-effective. The cost to Medical Assistance for providing Waiver services to an individual cannot exceed the average cost to provide in an institutional setting.

0398.10.20.25 Inc, Cost of Waiver Services

REV:06/1994

The Case Manager provides the LTC/AS district office with accurate income information, via the CP-30, whenever there is a change in an individual's income, so that LTC/AS can accurately determine income to be applied to the cost of Waiver services.

0398.15 HOME BASED FOR SEVER HANDICAPP

REV:06/1994

The Department of Human Services, in conjunction with People Actively Reaching Independence (PARI) offers a program of home and community-based services to quadriplegics who would normally require the services of a Nursing Facility (NF). The program is operated under a Waiver approved by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

The Waiver allows the program to deviate from certain MA rules pertaining to eligibility determination and services provided to eligible recipients. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare and other programs and services.

The program is informally known as the PCA Waiver Program.

The goals of the program are:

- To reduce unnecessary institutionalization by providing specialized home and community-based services to qualified quadriplegic MA recipients; and,
- To provide the services at a cost which is less than or equal to the cost of institutional care.

As the single state agency responsible for the MA program, DHS retains administrative responsibility.

0398.15.05 Target Population

REV:06/1994

The program is designed to assist quadriplegic individuals who are MA eligible (or would be if institutionalized) and:

- Require the level of care provided in a Skilled Nursing or Intermediate Care Facility (SN/ICF);
- Are at least 18 years old;
- Are medically stable and free from life threatening conditions;
- Have demonstrated the ability and competence to direct their own care; and,
- Require home-based services which are no more costly than institutional services.

0398.15.10 Waiver Services

REV:06/1994

Waiver services recipients receive the normal scope of Medical Assistance services. In addition to the normal MA services, three special service are provided under the Waiver. In some cases, the individual may bear a portion of the cost of the Waiver services.

Waiver services are:

- CASE MANAGEMENT

Case management refers to the identification, authorization and coordination of Waiver services provided to the recipient. Case management begins with the evaluation of the individual's needs and the development of a plan of care. The Case Manager arranges for and authorizes the services, and monitors their provision. Adjustments in the service mix are made based on periodic reassessments.

o CONSUMER PREPARATION

The recipient is extensively prepared for conducting medical self care and Activities of Daily Living. The preparation includes management training (personal care attendant management, time management and fiscal management).

A baseline of skill areas is established during the intake assessment process. Any deficits are addressed in the recipient's plan as training needs. The pre-requisite skills in medical self care and Activities of Daily Living are:

bowel movement	transfers
bladder management	home safety
proper nutrition	homemaking skills
medical emergencies	skin care
bathing	medications
equipment use	

Once all medical and Activities of Daily Living prerequisite skills are established, management training based on identified needs is initiated.

o PERSONAL CARE ATTENDANTS (PCAs)

A Personal Care Attendant (PCA) is a person who performs tasks for the handicapped individual which the individual is unable to perform for himself. A PCA also does things it would take the individual an exceptionally long time to do alone. The assistance provided by the PCA enables the individual to live more independently. The handicapped individual hires the PCA and is the employer. The duties of the attendant vary, depending upon the nature of the individual's disability and daily schedule.

PCA services differ from more traditional services because the program recipient is supervising his/her own care on a daily basis. There are numerous safeguards built into this service delivery system to assure that the handicapped recipient is qualified and competent to use this service. The individual must demonstrate a comprehensive knowledge of his/her care needs and the procedures for instructing someone in addressing these needs. To this end, much care is devoted to preparing the individual for this responsibility. This preparation, plus regular monitoring visits by the Case Manager, assures that the basic health and safety needs are being met.

0398.15.15 DHS Responsibilities

REV:01/2000

The DHS Long Term Care/Adult Services (LTC/AS) Unit determines eligibility and calculates the recipient's income to be allocated to the cost of care (if any). These determinations are communicated to the recipients and Case Managers at PARI.

Vocational Rehabilitation monitors the billing process to assure accurate payment of bills for Waiver services. The Long Term Care Unit at Central Office has the responsibility to review and approve the level of care assessments completed by PARI.

Specific DHS responsibilities related to the Waiver are:

- DETERMINATION OF ELIGIBILITY FOR MEDICAL ASSISTANCE

  SSI recipients are Categorically Needy recipients of Medical Assistance. LTC/AS must determine if the SSI recipient has transferred resources. If no resource transfer has been made, no further determination of MA eligibility (or income allocation) is required.

  For those individuals who are non-SSI recipients, LTC/AS staff have responsibility to process applications forwarded by PARI. Individuals who are receiving MA via one of the ESS District Offices may be referred by PARI. These cases are transferred "active" to the appropriate LTC/AS office for determination of eligibility for Waiver services.

  Eligibility determinations for applicants of Waiver services are conducted as if the applicant were

institutionalized. A recipient who meets the technical and characteristic requirements, has resources within the Categorically Needy limits and income under the Federal Cap (See Section 0386.05), is certified as Categorically Needy. If the recipient's income or resources exceed the Categorically Needy limits, s/he may be Medically Needy if resources are within the Medically Needy resource limits, and monthly income is less than the cost of all medical services.

o REDETERMINATION OF ELIGIBILITY

The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

o MAINTENANCE OF DHS CASE FILE

For non-SSI recipients, the DHS case file is the MA eligibility record. It is maintained in the LTC/AS field office and contains all documents relating to the determination of financial eligibility and income allocated to the cost of care. In addition, the CP-1 received via the Long Term Care Unit at Central Office and copies of the CP-40's, the CP-12, and notices to recipients are retained in the case file.

For those individuals who are Categorically Needy by virtue of receipt of SSI, LTC/AS maintains a case file of the CP-1 forms which have been routed through and approved by the Long-Term Care Unit at Central Office, any documents relating to the evaluation of resource transfers, and the CP-12 to document the recipient's choice of services.

o ALLOCATION OF INCOME TO THE COST OF WAIVER SERVICES

Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients who are Categorically Needy under 1619(b) of the Social Security Act) may be allocated to offset the cost of Waiver services. For other recipients of Waiver services, once eligibility is determined, the recipient's income is reviewed to determine the monthly amount, if any, the recipient must pay toward the cost of Waiver services.

0398.15.20 Voc Rehab Responsibilities

REV:06/1994

The responsibility of Vocational Rehabilitation (VR) is to monitor the claims for payment received from PARI Case Managers to assure that appropriate payments are made based on proper documentation.

VR also assures that the MA payment is reduced by the amount of the recipient's income allocation, if any.

Vocational Rehabilitation evaluates and monitors Waiver activity.

VR maintains a folder for each recipient containing the PCA service plan, assessment report and summary of identified services. As part of its monitoring activities, VR crosschecks bills for service submitted by PARI with the service plan prior to payment.

Every six months, VR staff review a random sample of PARI case records to determine that procedures and documentation standards are followed.

A master Authorization Form, maintained by the Case Manager, is forwarded to VR with a copy maintained in individual case records at the Center for Independent Living. The form is used by VR to control the payment, case by case, to the Center for Independent Living.

0398.15.25 PARI Responsibilities

REV:06/1994

The case management function rests with PARI. The case management function does not include determination of MA eligibility or allocation of income.

Specific PARI responsibilities are:

POINT OF ENTRY IDENTIFICATION

PARI staff identifies potential candidates in the target population to assure that the essential program criteria are met. The PARI Case Manager evaluates the abilities and needs of the candidate and establishes a comprehensive care plan which assures the candidate's needs are met.

DETERMINING NEED FOR NURSING FACILITY LEVEL OF CARE

The Case Manager at PARI has responsibility for evaluating the applicant's need for a level of care provided in a Nursing Facility. If the evaluation indicates the individual requires nursing facility

care, the Case Manager completes form CP-1 and forwards it to the Long Term Care Unit at Central Office where it is reviewed and approved.

CONFIRMING MA ELIGIBILITY STATUS

Prior to providing services under the Waiver program, and at each reassessment, the Case Manager must confirm that the candidate is eligible for Medical Assistance and has an active case number. The procedures vary, depending on whether or not the individual is an SSI recipient.

SSI Recipients

SSI recipients are normally Categorically Needy for MA. Active SSI status must be verified by contact with LTC/AS at intake and reassessment. The LTC/AS unit establishes that the individual has not transferred resources which would render him/her ineligible for medical assistance payment of Waiver services.

Non SSI Recipients

Waiver candidates who are not SSI recipients are referred by the Case Manager to LTC/AS for a determination of eligibility for MA.

If the candidate is currently receiving Social Security Disability Insurance benefits (DIB), the Case Manager forwards a completed and signed DHS-1 and DHS-2, three AP-91s and CP-40 to the appropriate LTC/AS district office. If the candidate does not receive DIB, at initial application the Case Manager obtains a form AP-72.1 from the individual's physician, and completes form AP-70.1 indicating the individual's social information and functional abilities. The completed forms, with the CP-1, are transmitted to the LTC Unit at Central Office, from where the application is sent to the appropriate LTC/AS district office. The LTC/AS district office notifies the Case Manager of the eligibility decision.

Case Management

The Case Manger is the "hub" of all assessments and services to the individual. This DEA staff person establishes and maintains the individual plan of care and subsequently monitors the provision of services to assure individual needs are met. The monitoring ensures that the health and welfare of the recipient is protected.

Specifically, the Case Manager will:

Establish and update an individual plan of care. The Case Manager evaluates the candidate's needs in the Activities of Daily Living, such as dressing, bathing, toileting, feeding etc. S/he also evaluates home maintenance needs, such as cleaning, shopping, laundry etc. A plan of care is designed which provides for the candidate's unmet needs and specifies the case management, individual preparation and personal care attendant services to be provided. The candidate and the Case Manager agree on the care plan.

Make a preliminary evaluation (using CP-4) of the cost- effectiveness of Waiver services and the individual's income to be allocated to the cost of services;

Apprise each individual in writing of the availability of services in either an institutional setting or in a home-based setting under the Waiver. The individual's choice is recorded on the CP-12A, signed and forwarded to the LTC/AS for filing in the MA record;

Arrange and authorize service;

Reassess the individual's need for SN/NF care at least every six months;

Coordinate with the individual, LTC/AS and VR the allocation of the individual's income to be applied to the cost of Waiver services.

0398.20 HOME-BASED FOR DEINSTIT ELDER

REV:06/1994

Pursuant to Rhode Island General Laws 40-66-4, the Department of Human Services (DHS) and the Department of Elderly Affairs (DEA) jointly operate a program to allow certain institutionalized Medical Assistance recipients to return home with the provision of home-based services. The program is operated under a Waiver approved by the Health Care Financing Administration of the U.S.

Department of Health and Human Services. The Waiver allows the program to deviate from certain MA rules pertaining to eligibility determination and services provided to eligible recipients. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare and other programs and services.

The goals of the program are:

- To reduce unnecessary institutionalization by providing

home and community-based services to elderly individuals who reside in Nursing Facilities so that the recipient is able to return to the community; and,

- To provide the services at a cost which is less than or equal to the cost of institutional care.

0398.20.05 Target Population

REV:06/1994

The program is designed to assist individuals who are:

- Over 65 years of age and receive Medical Assistance (as Categorically Needy or Medically Needy);
- Require the level of care provided in a Nursing facility;
- Reside in a Nursing Facility at the point of application and are, with home-based services, potential candidates for discharge to the home where they will be homebound.

Case Managers at DEA identify candidates for the program from the population of Nursing Facility residents.

0398.20.10 Waiver Services

REV:06/1994

Waiver services recipients receive the normal scope of Medical Assistance services. In addition to the normal MA services, five special services are provided under the Waiver. Waiver services are provided only in a home setting. In some cases, the recipient may bear a portion of the cost of the Waiver services.

Waiver services are:

- Case Management

  Case management refers to the identification, authorization and coordination of Waiver services provided to the recipient. Case management begins with the evaluation of the individual's needs and the development of a individual plan of care. The Case Manager arranges for and authorizes the services, and monitors their provision. Adjustments in the service mix are made based on periodic reassessments of the recipient's need for services;

- Homemaker/Personal Care Services as defined in Section 0530 of the DHS Policy Manual;

- Adult Day Care as defined in Section 0514 of the DHS Policy Manual;

- Minor Modifications to the Home

  Minor modifications to the home include such items as portable wheel chair ramps, grab bars, modifications to tubs and toilets.

- Minor Assistive Services

  Minor assistive services are services such as cooking and eating aids, grooming aids and other devices which assist in the Activities of Daily Living.

  Minor assistive services may include payment of the installation and monthly monitoring fee of a Personal Emergency Response System (PERS). The PERS is an in-home, twenty-four hour electronic alarm system which allows a functionally impaired homebound individual to signal a central switchboard in the event of an emergency. This service is limited to those individuals who are at high risk, physically vulnerable, who must live alone or spend prolonged periods of time alone. In addition, the recipient must be capable of understanding the purpose of the PERS and using it properly.

  This service requires prior authorization by the individual's physician via the MA 505, evaluation by the LTC Case Manager and service provider (usually the hospital discharging the patient) and is subject to approval by the Chief of Pharmacy Services in the Division of Medical Services.

0398.20.15 DHS Responsibilities

REV:01/2000

The DHS Long Term Care/Adult Services (LTC/AS) Unit determines eligibility and calculates the recipient's income to be allocated to the cost of care (if any). These determinations are communicated to the individuals and Case Managers at DEA. The Long Term Care Unit at Central Office has the responsibility to review and approve the level of care assessments completed by DEA. Specific responsibilities include:

o Determinations of Eligibility for Medical Assistance

SSI recipients are Categorically Needy recipients of Medical Assistance. LTC/AS must determine if the SSI recipient has transferred resources. If no resource transfer has been made, no further determination of eligibility (or income allocation) is required.

For those individuals who will not be SSI recipients while living at home, the LTC/AS Unit is responsible for eligibility determinations and redeterminations.

- LTC/AS staff will process new and recertification applications forwarded by DEA. Individuals applying for this program may already be Medical Assistance eligible as determined by the appropriate LTC/AS Unit, or automatically eligible as an SSI recipient. Individuals may receive services under this program as Categorically or Medically Needy.

  Eligibility determinations are conducted as if the candidates were institutionalized. An applicant who meets the technical and characteristic requirements, has resources within the Categorically Needy limits and income under the Federal Cap (See Section 0386.05), is certified as Categorically Needy. If the individual's income or resources exceed the Categorically Needy limits, s/he may be Medically Needy if resources are within the Medically Needy resource limits, and monthly income is less than the cost of all medical services.

- Recipients who are certified for MA receive a Notice of Eligibility. Individuals who are rejected or closed on Medical assistance are notified in the usual manner. The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

o Maintenance of DHS Case Files

The MA eligibility record that was established for the individual while s/he was institutionalized continues

to be the MA eligibility record for the Waiver program. It is maintained in the LTC/AS field office and contains all documents relating to the determination of financial eligibility and income allocated to the cost of care.

- Allocation of Income to the Cost of Waiver Services

  Once eligibility has been determined, the DEA Case Manager calculates the individual's income to be applied to the cost of care, using forms CP-3 and CP-4. The completed forms are forwarded to the appropriate LTC/AS unit for review and approval.

- Review of Cost Effectiveness and Income Allocation

  The LTC/AS worker receives the completed CP-3, CP-4, CP-5A and CP-7A from DEA. S/he reviews and approves the DEA case manager's preliminary calculations of the cost effectiveness of Waiver services and the income to be applied to the cost of care. If approved, the LTC/AS worker countersigns the CP-7A and sends it and the CP-5A to the individual. If corrections are needed, the LTC/AS worker consults with the DEA Case Manager to make the necessary changes prior to notifying the individual.

0398.20.20 DEA Responsibilities

REV:06/1994

The case management function rests with DEA. The case management function does not include determination of MA eligibility.

Specific DEA responsibilities are:

- Point of Entry Identification

  DEA staff identifies potential candidates in the target population of aged MA recipients residing in Nursing Facilities. The DEA Case Manager evaluates the abilities and needs of the candidate and establishes a comprehensive care plan on Form CP-5A. The patient's attending physician must approve the plan to discharge the patient and provide home-based services.

- Confirming MA Eligibility Status

Prior to providing services under the Waiver program, and at each reassessment, the Case Manager must confirm that the candidate is eligible for Medical Assistance and has an active case number. This is done by direct contact/referral to the LTC/As unit.

- Preliminary Calculation of Cost Effectiveness and Allocation of Income

  The Case Manager at DEA completes a preliminary calculation of the cost effectiveness of program services, and the amount of income to be allocated to the cost of care. These determinations are subject to review and approval by the LTC/As Unit. Once the individual plan of care is completed, forms CP-3 and CP-4 are completed. The CP-3 worksheet is designed to assist the Case Manager to compile the monthly cost of the Individual's Plan of care. The CP-4 worksheet is used by the Case Manager to calculate the cost effectiveness of Waiver services compared to institutional services, the maximum amount that can be paid by Medical Assistance for Waiver services and the amount the individual must contribute.

- Notification to Individuals Accepted into the Program.

  Individuals accepted into the Program are notified by the Case Manager and the LTC/AS worker by use of form CP-A. The CP-7A also apprises the individual of the amount of his/her income which must be contributed to the cost of care. Enclosed with the CP-7A is form CP-5A, the Individual's Plan of care. The forms are completed by the DEA Case Manager. The original and one copy are forwarded to the LTC/AS district office along with completed CP-3 and CP-4 for review and approval. If approved, the LTC/AS worker countersigns the CP-7A and sends the CP-7A and CP-5A to the individual.

- Case Management

  The case manger is the "hub" of all assessments and services to the recipient. This DEA staff person establishes and maintains the individual plan of care and subsequently monitors the provision of services to assure the individual's needs are met. The monitoring ensures that the health and welfare of the individual is protected.

Specifically, the Case Manager will:

- make a preliminary evaluation (using CP-4) of the cost- effectiveness of Waiver services and income to be allocated to the cost of services;

- secure an information release form signed by the candidate allowing DEA and DHS to share information regarding the candidate;

- apprise each candidate in writing of the availability of services in either an institutional setting or in a home-based setting under the Waiver. The candidate's choice is recorded on the CP-12A, forwarded to the LTC/AS for filing in the MA record with a copy retained by PARI for the individual's record;

- reassess the recipient's need for NF care at least every six months;

- coordinate with the individual and LTC/AS the allocation of the individual's income to be applied to the cost of services.

o Redetermining Need for Nursing facility Care

The Case Manager at DEA has responsibility for re-evaluating every six months the recipient's need for a Nursing Facility level of care. To remain eligible for the Waiver services, the individual must continue to require an institutional level of care. If the evaluation indicates nursing facility care is required, the Case Manager completes form CP-1 and forwards it to the Long Term Care Unit at Central Office where it is reviewed and approved.

0398.30.05 Assisted Living Waiver Program

REV:12/2000

Pursuant to R.I.G.L. 42-66.8, the Department of Human Services (DHS) received approval from the Health Care Financing Administration (HCFA) to administer a home and community-based waiver for up to two hundred (200) elderly and disabled individuals residing in Assisted Living Facilities. Initiated through the combined efforts of DHS, DEA, and the Rhode Island Housing and Mortgage Finance Corporation (RIHMFC),

this innovative waiver not only utilizes existing facilities but, for the first time, develops and provides publicly financed housing units for assisted living purposes for frail elderly and disabled individuals.

The purpose of the Assisted Living Waiver program is to provide home and community-based services to eligible elderly and disabled individuals in qualified assisted living facilities as an alternative to nursing facility care at a cost which is less than or equal to the cost of institutional care.

0398.30.10 Target Population

REV:12/2000

The program is designed to assist individuals who:

- are over the age of sixty-five (65) or disabled;
- receive SSI or meet the categorically needy MA eligibility requirements for an institutionalized individual (income within the Federal Cap);
- require the level of care provided in a nursing facility; and,
- reside or have the opportunity to reside in an Assisted Living Facility.

0398.30.15 Waiver Services

REV:12/2000

In addition to the normal scope of categorically needy services, the following special services are provided under the waiver:

- Case Management Services

  Services which assist individuals in gaining access to needed waiver, MA, and any necessary medical, social, or educational services. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care. In addition, they are responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

- Specialized Medical Equipment and Supplies

  Includes devices, controls, or appliances specified in the plan of care, which enable individuals to increase the ability to perform activities of daily living (ADLs), or to perceive, control or communicate in the environment in which they live.

  Also includes items necessary for life support, ancillary supplies and equipment necessary to proper functioning of such items, and durable and non-durable medical equipment not available to MA eligible individuals except as provided under this waiver. Items which are not of direct medical or remedial benefit to the individual are excluded. All items must meet applicable standards of manufacture, design and installation.

- Assisted Living Services: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed community care facility in conjunction with residing in the facility. This service includes 24 hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security.

  Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to such arrangement) which must contain bedrooms and toilet facilities. The consumer has a right to privacy. Care must be furnished in a way which fosters the independence of each individual to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

  Also included are medication administration and transportation specified in the plan of care.

  MA payments for assisted living services are not made for room and board, items of comfort or convenience, or

the costs of facility maintenance, upkeep and improvement, twenty four (24) hour skilled care or supervision.

0398.30.20 Facility Certification Standards

REV:12/2000

In addition to meeting all requirements of Rhode Island's assisted living licensing regulations, a facility must meet the following criteria in order to participate as a provider under this waiver:

- o Affordability

  Providers must agree to make available up to 20% of their units to low-income and/or MA waiver individuals subject to demand and availability. Facilities with less than 20% low income/waiver occupancy are required to retain residents who exhaust their resources and convert from private pay to SSI/MA waiver status.

- o Design Guidelines

  The architectural design of the facility should create a residential setting that emphasizes a "home-like" environment while providing for a supportive service infrastructure.

- o Occupancy requirements

  Facilities must provide for single occupancy units with private bath and toilet. Double occupancy may be allowed in the case of consumer choice, i.e., spouses or siblings, upon approval of the Department of Elderly Affairs.

- o Service Requirements

  Each facility must provide at a minimum a service package as follows:

  1. Direct assistance to residents with at least two (2) activities of daily living (ADLS) by a Certified Nursing Assistant (CNA) and including but not limited to assistance with bathing, continence, dressing, ambulation, toileting, eating and transfers.

2. Assistance with housekeeping, medication management (with M-1 licensure), linen services, laundry services (including personal laundry, exclusive of dry cleaning), and such transportation services as may be specified in the plan of care.

3. A program of social and recreational activities.

4. Twenty-four (24)hour on-site staff adequate to meet scheduled or unpredictable needs in a way that promotes dignity and independence while maintaining provider supervision, safety, and security.

o Participation Requirements

Owners of existing assisted living facilities who wish to participate in the Assisted Living Waiver Program must meet the standards stated above. The physical plant, financial capacity, adequacy of services, and commitment to servicing low-income individuals will be evaluated prior to approval of participation in the program.

0398.30.25 DHS Responsibilities

REV:12/2000

The DHS Center for Adult Health has the responsibility to review and approve or deny the level of care assessments completed by DEA.

The Center for Adult Health has the responsibility for:

* initial determinations and annual redeterminations of MA eligibility;

* review and approval of DEA's calculation of the recipient's income to be allocated to the cost of waiver services (if any);

* related InRhodes approval/denial;

* notification of agency action in accordance with 0376.25; and,

* maintenance of the DHS case file.

0398.30.30 DEA Responsibilities

REV:12/2000

The case management function rests with DEA and may be performed by DEA or agency staff under contract to DEA. The case management function does not include determination of MA eligibility.

Specific DEA responsibilities are:

1. POINT OF ENTRY IDENTIFICATION

   DEA staff or DEA contracted staff identifies potential candidates in the target population of aged and disabled individuals residing in or seeking to reside in Assisted Living Facilities. Individuals may be referred to the waiver program by family, friends, facility staff, community based social service agencies, the LTC Ombudsman or through self-referral.

   The case manager contacts the appropriate LTC office and, when necessary, assists the individual in completing an application for Medical Assistance/LTC. The application is then forwarded to the appropriate LTC office for determination of eligibility.

2. CONFIRMING MA ELIGIBILITY STATUS

   Prior to providing services under the waiver program, and at each reassessment, the case manager contacts the LTC unit and confirms that the individual is eligible for Medical Assistance and has an active case number.

3. PRELIMINARY CALCULATION OF COST-EFFECTIVENESS AND CALCULATION OF INCOME ALLOCATION TO COST OF CARE:

   The case manager completes a preliminary calculation of the cost effectiveness of program services, and the amount of income to be allocated to the cost of care. These determinations are subject to review and approval by the LTC unit. Once the individual plan of care is completed, forms CP-3 and CP-4 are completed by the case manager. The CP-3 worksheet is designed to assist the case manager in calculating the monthly cost of the individual's plan of care. The CP-4 worksheet is used by the case manager to calculate the cost effectiveness of waiver services compared

to institutional services, the maximum amount that can be paid by Medical Assistance for waiver services, and the amount the individual must contribute towards the cost of care.

4. NOTIFICATION TO INDIVIDUALS ACCEPTED INTO THE PROGRAM

The CP-7A is used to notify individuals of acceptance into the program and to indicate the amount of any income which must be contributed to the cost of care. Enclosed with the CP-7A is form CP-5A, the Individual's plan of care. The forms are completed by the case manager. The original forms and one copy of each are forwarded to the appropriate LTC office along with the completed CP-3 and CP-4 for review and approval. If approved, the LTC worker countersigns the CP-7A and sends the CP-7A and CP-5A, along with forms used to request a hearing (AP-121 and 121A), to the individual.

5. CASE MANAGEMENT

The case manager evaluates and monitors the abilities and needs of the candidate and develops an individual written plan of care based upon the functional assessment used by DEA to measure the abilities, deficits and environmental modifications required. The informal supports that are available for each individual are incorporated into the plan. DEA's recommended plan of care is recorded on the CP-1 and forwarded to the DHS Office of Medical Review for approval. OMR's approval is recorded on the CP-1, and copies of the completed form are returned to DEA and the LTC office for incorporation into the case record.

The plan of care contains at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each services. A copy is retained in individual's record at both DEA and DHS for a minimum period of three (3) years.

Specifically, the case manager:

- makes a preliminary evaluation, using the CP-4, of the cost-effectiveness of waiver services and income to be allocated to the cost of services;

- secures an information release form signed by the candidate allowing DEA and DHS to share information regarding the candidate;

- o apprises each candidate in writing of the availability of services in either an institutional or in a community assisted living setting under the waiver. The candidate's choice is recorded on the CP-12A, forwarded to the LTC unit for filing in the case record with a copy retained by DEA for the individual's record;

- o assesses, reassesses and updates the recipient's plan of care at least every twelve (12) months to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability;

- o monitors the provision of services included in the individual's plan of care; and,

- o coordinates with the individual, the LTC unit, and the assisted living facility the allocation of the individual's income to be applied to the cost of care.

6. REASSESSMENT OF NEED FOR NURSING FACILITY CARE

The case manager has the responsibility for re-evaluating the recipient's need for a nursing facility level of care at least every twelve (12) months. To remain eligible for the program, the individual must continue to require a nursing facility level of care. If reassessment indicates nursing facility care is required, the case manager completes and forwards form CP-1 to the Center for Adult Health, Long Term Care Unit at Central Office, where it is reviewed and approved.

0398.30.35 Eligibility Determinations

REV:12/2000

To receive services under this waiver program, the aged or disabled individual must receive SSI or be eligible as a categorically needy institutionalized individual (income must be within the Federal Cap), reside in or have the opportunity to reside in an Assisted Living Facility meeting the certification requirements in Section 0398.30.20, and require a Nursing Facility level of care.

The DEA case manager assists the individual in completing the application and related forms needed to apply for Medical Assistance Waiver Services, and forwards the completed forms to the appropriate LTC office.

Individuals applying for this program may already be eligible for Medical Assistance as determined by the LTC Unit or a community MA unit, or automatically eligible as an SSI recipient. A new application is not required when a DHS-2 has been completed within the past twelve (12) months and the individual is still within a current certification period. In this case, the current case file may be used, together with any additional required documentation (e.g., information relating to trusts and transfers of resources), to determine eligibility for the program.

Eligibility determinations and redeterminations are conducted by appropriate Long Term Care (LTC) staff as if the individual were institutionalized. An applicant must meet the technical and characteristic requirements, have resources within the Categorically Needy limits and income under the Federal Cap in order to qualify.

When the individual has a community spouse, resources are evaluated in accordance with spousal impoverishment rules contained in Section 0380.40 - 0380.40.35. In the application of spousal impoverishment rules to waiver applicants or recipients, all Section 0380 references to institutionalized spouses and continuous periods of institutionalization include individuals receiving assisted living waiver services in lieu of institutional services.

Any transfer of assets must be evaluated in accordance with policy in Section 0384. The look-back period for evaluating transfers of assets is calculated from date the individual began receiving assisted living waiver services or the date of MA application, whichever is later.

Individuals are provided with written notice of eligibility or ineligibility in the usual manner. The LTC unit conducts redeterminations of eligibility each year, unless a change is anticipated sooner.

Individuals are required to report changes in circumstances, such as changes in income or resources, which could affect eligibility.

Maintenance of Case Files

The LTC unit is responsible for maintenance of both the electronic (InRhodes) and paper case file, which contains all documents and information relating to the determination of financial eligibility and income allocated to the cost of care.

Allocation of Income to the Cost of Care

Once eligibility has been determined the DEA Case Manager calculates the individual's income to be applied to the cost of care, using forms CP-3 and CP-4. The completed forms are forwarded to the appropriate LTC unit for review and approval.

Review of Cost-Effectiveness and Income Allocation

The LTC worker receives the completed CP-3, CP-4, CP-5A, and CP-7A from DEA. The LTC worker is responsible for review and approval of the DEA case manager's preliminary calculations of the cost effectiveness of Waiver services and the income to be applied to the cost of care. If approved, the LTC worker countersigns the CP-7A and sends it and the CP-5A to the individual. If corrections are needed, the LTC worker consults with the DEA Case Manager to make the necessary changes prior to notifying the individual.

0398.30.40 Allocation of Income to Cost of Care

REV:12/2000

All individuals receiving services under this waiver program are subject to the post-eligibility treatment of income and allocation of income to cost of waiver services. This includes those individuals receiving the enhanced SSI payment for Residential Care/Assisted Living, providing however that no part of the SSI Federal Benefit Rate (FBR) is allocated to the cost of waiver services.

The individual's income is allocated toward the cost of waiver services as follows:

FOR A SINGLE INDIVIDUAL

From the full gross income of a single individual the following amounts are deducted in the following order:

- Personal/Maintenance Needs Allowance

  An amount equal to the facility's charge for room and board plus a $100 personal needs allowance, the combined total not to exceed the SSI standard for an individual in residential care/assisted living (See Section 0402.05).

  The individual is allowed to retain $100 for personal needs, and is then responsible for paying the facility's charge for room and board.

- Medical Insurance Premium

- Allowable Costs Incurred for Medical or Remedial Care

FOR AN INDIVIDUAL WITH A COMMUNITY SPOUSE AND/OR DEPENDENTS

From the gross income of the individual the following amounts are deducted in the following order:

- Maintenance Needs Allowance - as above

- Spouse/Dependent Allowance

  An amount of income may be allocated for the support of the community spouse in accordance with policy contained in 0392.15.20 - 0392.15.20.10. The community spouse may reside either with the individual in the assisted living unit or in the community.

  An additional amount of income may be allocated for support of other dependent family members who live with the community spouse following provisions contained in 0392.15.25.

  When there is no community spouse, an amount of income may be allocated for the support of dependent family members in accordance with Section 0392.15.25.05.

- Medical Insurance Premium

- Allowable Costs Incurred for Medical or Remedial Care

Any balance of income remaining after these expenses are deducted is allocated toward the cost of the waiver services. Note that the

individual is responsible for paying the facility's charge for room and board.

0398.35.05 Habilitative Waiver Program

REV:05/2002

The Department of Human Services received permission from the Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA) to administer a home and community based waiver for up to twenty-five individuals who require daily habilitative and/or ongoing skilled nursing services to a degree that would be otherwise provided in a hospital, and who do not qualify for the home and community based waiver for people with Developmental Disabilities.

The purpose of the Habilitative Waiver is to provide intensive home and community-based services to eligible elderly and disabled adults residing in a community setting as an alternative to hospital care at a cost that is equal to or less than the cost of institutional care. For purposes of this waiver, hospital level of care is defined as a need for daily habilitative and/or ongoing skilled nursing services that cannot be adequately and/or appropriately provided in a nursing facility. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare and other programs and services.

0398.35.10 Target Population

REV:05/2002

The program is designed to assist individuals age eighteen (18) and older who:

- meet the MA requirement for disability or age (65 or older);
- meet the categorically needy or medically needy MA eligibility requirements for an institutionalized individual;
- require the level of care provided in a hospital; and
- do not meet developmental disability criteria. For purposes of this policy section, an individual is considered to meet developmental disability criteria if found to be developmentally disabled prior to age twenty-one (21) by the RI Department of Mental Health Retardation and Hospitals (MHRH) pursuant to R.I.G.L. 40.1-21-6.1.

0398.35.15 Waiver Services

REV:05/2002

In addition to the full scope of services provided to the Categorically Needy or Medically Needy, as appropriate, the following special services are available under the waiver:

o Case Management Services

Provided by PARI Independent Living Center, these services are any that assist individuals in gaining access to needed waiver, MA, and any necessary medical, social, or educational services. Case managers initiate and oversee the process of assessment and reassessment of the individual's level of care, and development and review of plans of care. The Center for Adult Health is responsible for approving all levels of care and plans of care. The case manager is responsible for monitoring provision of services and appropriateness of approved plans of care, and submitting revisions, as needed to the Center for Adult Health.

o Residential Habilitation

Assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Residential Habilitation does not include the costs of room and board. Residential Habilitation Providers must be licensed with the Department of Mental Health, Retardation and Hospitals to be qualified to provide residential habilitation services under this waiver program.

o Day Habilitation

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which take place in a non-residential setting, separate from the home or facility in which the individual resides. Day Habilitation Providers must be licensed with the Department of MHRH to be qualified to provide day habilitation services under this waiver program.

o Supported Employment Services

Paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Any person using this waiver service must be ineligible for an equivalent service funded by the DHS Office of Rehabilitation Services.

- Environmental Accessibility Adaptations
  Physical adaptations to the home, required by the individual's plan of care, which are required to ensure the health, welfare and safety of the individual, or which enable the individual to function more independently within the home, and without which, the individual would require institutionalization. Environmental Accessibility Adaptations are subject to approval for medical necessity by the Center for Adult Health.

- Specialized Medical Equipment and Supplies

  Specialized medical equipment and supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Specialized medical equipment and supplies are subject to approval for medical necessity by the Center for Adult Health.

- Personal Emergency Response Systems (PERS)

  PERS is an electronic device, which enables individuals to secure help in an emergency. PERS services are restricted to individuals who live alone, or are alone for significant parts of the day, and have no regular care giver for extended periods of time, and who would otherwise require extensive routine supervision. Individuals can only receive this service from Center for Adult Health qualified PERS providers.

- Private Duty Nursing

  Individual and continuous care provided by licensed nurses (Registered Nurses and/or Licensed Practical Nurses) with Physician orders within the scope of Rhode Island licensing guidelines. These services are provided only in an individual's home by Home Care or Home Nursing Care Agencies

licensed with the RI Department of Health.

o Rehabilitation Services

Physical, Occupational, and Speech Therapy services may be provided with a physician's orders by Rhode Island Department of Health licensed Outpatient Rehabilitation Centers. These services supplement Home Health and Outpatient Hospital Clinic rehabilitation services already available under the Rhode Island State Plan when the individual requires a specialized rehabilitation service not available from a Home Health or Outpatient Hospital provider. The Center for Adult Health will approve rehabilitation services under the waiver as part of the plan of care.

0398.35.20 DHS Responsibilities

REV:05/2002

The DHS Long Term Care (LTC) Unit is responsible for determining MA eligibility and approving the amount of the recipient's income to be allocated to the cost of care. These determinations are communicated to the recipients and Case Managers at PARI.

The DHS Center for Adult Health has the responsibility for reviewing and approving level of care assessments and plans of care completed by PARI.

Specific DHS responsibilities related to the waiver are:

o DETERMINATION OF ELIGIBILITY FOR MEDICAL ASSISTANCE

LTC workers have responsibility for processing applications forwarded by PARI and for determining eligibility for waiver services both for new MA applicants and current SSI or MA-only recipients.

A new DHS-2 is not required if one was completed within the past twelve (12) months, and the individual is within a current certification period. In this case, the current case file is used, together with documentation of any new or additional information (e.g., information relating to transfers of assets) needed to determine eligibility for the program.

Eligibility determinations for applicants of the Waiver Program are conducted as if the applicant were

institutionalized. Any transfers of assets must be evaluated in accordance with policy contained in Section 0384. A recipient who meets the technical and characteristic requirements, has resources within the Categorically Needy limits and income under the Federal Cap (see section 0386.05), is certified as Categorically Needy. Individuals are certified as low income (equivalent to categorically needy) when income is at or below one hundred percent (100%) of the federal poverty level and resources are within the Medically Needy resource limits. If the individual's resources are within the Medically Needy resource limit, s/he may be Medically Needy if resources are within the Medically Needy resource limits, and monthly income is less than the cost of all medical services.

o REDETERMINATION OF ELIGIBILITY

The LTC unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

o MAINTENANCE OF THE DHS CASE FILE

The DHS InRhodes and paper case files are the MA eligibility record. Case files are maintained in the LTC office and contain all documents relating to the determination of financial eligibility and income allocated to the cost of care. In addition, the CP-1 and plan of care received via the Center for Adult Health, and copies of the CP-40's, the CP-12, and notices to recipients are retained in case files.

o ALLOCATION OF INCOME TO THE COST OF WAIVER SERVICES

Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients who are Categorically Needy under 1619(b) of the Social Security Act) may be allocated to offset the cost of Waiver services. For other recipients of Waiver services, once eligibility is determined, the recipient's income is reviewed to determine the monthly amount, if any, the recipient must pay toward the cost of Waiver services.

The LTC worker is responsible for reviewing and approving the calculation of the individual's income to be applied to the cost of care.

o APPROVING LEVELS OF CARE AND PLANS OF CARE

The Center for Adult Health will review and approve all Levels of Care and Plans of Care prior to the Plans of Care being implemented. In the event of an urgent situation, the Center can give a verbal authorization.

o CALCULATING AGGREGATE COST NEUTRALITY

The Center for Adult Health will review and assure aggregate cost neutrality on an annual basis.

0398.35.25 PARI Responsibilities

REV:05/2002

The case management function rests with PARI. The case management function does not include any determination of MA eligibility or post eligibility treatment of income.

Specific PARI responsibilities are:

o POINT OF ENTRY IDENTIFICATION

PARI staff takes referrals and identifies potential candidates in the target population to assure that the essential program criteria are met. The PARI Case Manager evaluates the abilities and needs of the candidate and works with the individual to develop a comprehensive plan of care that assures the candidate's needs are met. The PARI Case Manager is responsible for submitting the Plan of Care to the Center for Adult Health Office for approval.

o ASSESSING NEED FOR HOSPITAL LEVEL OF CARE

The case manager at PARI has responsibility for evaluating the applicant's need for a level of care provided in a hospital. If the evaluation indicates the individual requires hospital level care, the Case Manager completes form CP-1 and forwards it to the Center for Adult Health. Records of evaluations and reevaluations of level of care are maintained by case managers at PARI and at DHS.

When an individual is determined to be likely to require a hospital level of care, the individual is informed of any feasible alternatives available under this waiver, and given the choice of either institutional or home and community based services.

o CONFIRMING MA ELIGIBILITY STATUS

Prior to providing services under the waiver program, and at each reassessment, the Case Manager must confirm that the candidate is eligible for the waiver.

o CASE MANAGEMENT

The Case Manager is the "hub" of all assessments and services to the individual. The PARI staff person is responsible for the development and implementation of approved plans of care and subsequently monitors the provision of services to assure that individual needs are met. The monitoring assures that the health and welfare of the recipient is protected. The case manager will meet with the individual at least one time each quarter to monitor provision of services.

Specifically, the Case Manager will:

1. Develop and update an individual plan of care. The Case Manager evaluates the candidate's needs in order to reside in the community, designs a plan of care with the candidate that addresses these unmet needs. The plan of care will specify the provider, goals, amount, and duration of any waiver service to be provided. The plans of care must be submitted to and approved by the Center for Adult Health prior to implementation. Copies of the plans of care must be retained by case managers for a period of at least three (3) years.

2. Notify the Center for Adult Health of cases whose plans of care could exceed cost neutrality;

3. Apprise each individual in writing of the availability of services in either an institutional setting or in a community-based setting under the waiver. The individual's choice is recorded on the CP-12A, signed and forwarded to the LTC for filing in the MA record;

4. Arrange authorized services;

5. Reassess the individual's need for hospital level care at least every twelve months;

6. Coordinate with the individual, LTC/AS, and providers of services the allocation of the individual's income

to be applied to the cost of Waiver services.

0398.40 PERSONALCHOICE PROGRAM

0398.40.05 OVERVIEW
EFF:03/2006

The Department of Human Services (DHS) offers a program (commonly referred to as the PersonalChoice Program) of participant-directed home and community-based services to people with disabilities (who are at least eighteen (18) years of age) or who are aged (sixty five (65) years and over) who would normally require the services of a Nursing Facility (NF). The program is operated under a Waiver approved by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services.

The waiver allows the program to waive service comparability. The services of this program supplement the existing scope of services already provided by Medical Assistance, Medicare, and other programs and services.

0398.40.10 GOALS
EFF:03/2006

The goals of the program are:

- To reduce unnecessary institutionalization by providing specialized home and community-based services to qualified Medical Assistance recipients; and,

- To provide the services at an aggregate cost which is less than or equal to the cost of institutional care.

As the single state agency responsible for the Medical Assistance Program, DHS retains administrative responsibility for the PersonalChoice Program.

0398.40.15 ELIGIBILITY CRITERIA
EFF:03/2006

The PersonalChoice Program is designed to assist individuals who are either aged (age sixty five (65) years and older) or have a disability and are at least eighteen (18) years old who are Medical Assistance eligible (or would be if institutionalized) and who:

- Require the level of care provided in a Nursing Facility

- Are eligible as Categorically or Medically Needy

- Have demonstrated the ability and competence to direct their own care or have a qualified designated representative to direct care;

0398.40.20 SERVICES
EFF:03/2006

Waiver services recipients receive the normal scope of Medical Assistance services. In addition to the normal Medical Assistance services, eight (8) special services are provided under the Waiver. In some cases, the individual may be responsible for a portion of the cost of the Waiver services.

Waiver services are:

- SERVICE ADVISEMENT

  The Service Advisor team consisting of the Advisor, an RN and Mobility Specialist focus on empowering participants to define and direct their own personal assistance needs and services. The Service Advisor guides and supports, rather than directs and manages, the participant through the service planning and delivery process.

- FISCAL INTERMEDIARY SERVICES

  Fiscal Intermediary services are designed to assist the participant in allocating funds as outlined in the Individual Service and Spending Plan and to facilitate employment of personal assistance staff by the participant.

- PERSONAL CARE ASSISTANCE

  Personal Care Assistance services provide direct support, in the home or community, to individuals in performing tasks that due to disability they are functionally unable

to complete independently, based on the Individual Service and Spending Plan.

- PARTICIPANT DIRECTED GOODS AND SERVICES

  Participant Directed Goods and Services are services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the Individual Service and Spending Plan (including improving and maintaining the individual's opportunities for full membership in the community).

- HOME MODIFICATIONS

  Equipment and/or adaptations to an individual's residence to enable the individual to remain in his/her home or place of residence, and ensure safety, security, and accessibility.

- HOME DELIVERED MEALS

  The provision of a meal delivered to the waiver recipient's residence.

- PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

  PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency.

- SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

  Specialized Equipment and Supplies are devices, controls, or appliances specified in the Individual Service and Spending Plan, which enables the participant to improve their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

0398.40.25 ELIGIBILITY DETERMINATIONS
EFF:03/2006

The DHS Long Term Care/Adult Services (LTC/AS) Unit determines eligibility and calculates the recipient's income to be allocated (if any) to the cost of care. Neither the SSI payment itself nor any of the other income of an SSI recipient (or former SSI recipients who are Categorically Needy under 1619(b) of the Social Security Act) may be allocated to offset the cost of Waiver services. For other recipients of Waiver services, once eligibility is determined, the recipient's income is reviewed to determine the monthly amount, if any, that the recipient must pay toward the cost of Waiver services.

Eligibility determinations for applicants of Waiver services are conducted as if the applicant were institutionalized.

0398.40.30 CONFIRMING MA ELIGIBILITY STATUS

EFF:03/2006

Prior to providing services under the Waiver program, and at each reassessment, the Service Advisement agency and Fiscal Intermediary agency must confirm that the candidate is eligible for Medical Assistance and has an active case number by utilizing the Recipient Eligibility Verification System (REVS).

0398.40.35 REDETERMINATION OF ELIGIBILITY

EFF:03/2006

The LTC/AS Unit conducts redeterminations of eligibility in the normal manner each year, unless a change is anticipated sooner.

0398.40.40 DETERMINING NEED FOR NURSING FACILITY LEVEL OF CARE

Eff:03/2006

Service Advisement Agency Responsibilities:

The Service Advisement agency has responsibility for evaluating the applicant's need for a level of care provided in a Nursing Facility. If the evaluation indicates the individual requires nursing facility care, the Service Advisement agency completes form CP-1 and forwards it to the Long Term Care Unit at Central Office where it is reviewed and approved.

DHS Responsibilities:

The Office of Medical Review in the Center for Adult Health has the responsibility to review and approve the level of care. In order to ensure that only federally allowable waiver costs are allowed, and whenever any subsequent changes to that plan are made, the Center for Adult Health program staff shall review and approve each participant's service plan prior to the participant receiving Waiver services. Once the plan is approved, DHS will forward it to the appropriate Service Advisement agency and Fiscal Intermediary agency.

0398.40.45 SERVICE ADVISEMENT AGENCY RESPONSIBILITIES

EFF:03/2006

The Service Advisor shall conduct all assessments and assist the participant in developing an individual service plan and shall forward the plan to DHS/CAH for review and approval.

The Service Advisor is the "hub" of all assessments and services to the individual. The Service Advisement agency staff person establishes and maintains the individual service plan and subsequently monitors the provision of services to assure that individual needs are met. The monitoring ensures that the health and welfare of the recipient are protected.

0398.40.50 CASE MANAGEMENT

EFF:03/2006

The case management function rests with the Service Advisement agency. The case management function does not include determination of Medical Assistance eligibility or allocation of income.