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**IDAPA 16
TITLE 03
Chapter 05**

**16.03.05 - RULES GOVERNING ELIGIBILITY FOR
AID TO THE AGED, BLIND AND DISABLED (AABD)**

000. LEGAL AUTHORITY.

The Idaho Department of Health and Welfare, according to Sections 56-201 through 56-233, Idaho Code, did adopt the following rules for the administration of public assistance programs. (1-1-93)

001. POLICY.

It is the policy of the Idaho Department of Health and Welfare, to distribute funds and Medicaid benefits, to needy persons, within the state of Idaho. Funds are distributed according to state and federal laws. (1-1-93)

002. TITLE AND SCOPE.

These rules are known and will be cited as Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 05, "Rules Governing Eligibility for Aid to the Aged, Blind and Disabled (AABD)." These rules provide standards for issuing AABD cash benefits and related Medicaid. (1-1-93)

003. DEFINITIONS.

The following definitions apply to this chapter: (1-1-93)

01. Adult Foster Care Home. An adult foster care home is a family home where an adult lives when he is not able to live in his own home. An adult foster care home client needs family care, help in daily living, protection, security, and encouragement toward independence. An adult foster care home must not serve more than two (2) adults. It must be certified under Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 19, "Rules For Adult Foster Care Homes in Idaho." An exception to the two (2) person limit is made for a 1501 home, as defined in the above-cited rules. An adult foster care home is not a room and board home, adult residential care facility serving more than two (2) adults, nursing home, or institutional facility. (1-1-95)

02. Adult Residential Care Facility. An adult residential care facility is one (1) or more buildings making up a facility or residence. It may be operated on a profit or nonprofit basis, to provide twenty-four (24) hour nonmedical care. The facility must care for three (3) or more persons, eighteen (18) years of age or older, not related to the owner. The persons need personal care or assistance and supervision for daily living activities or for their protection. An adult residential care facility must be licensed by the Department's Facility Standards Program. (1-1-93)

03. AFDC Handbook. Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 01, "Rules Governing Eligibility for Aid to Families with Dependent Children (AFDC)". (7-1-94)

04. Applicant. A person who has applied for public assistance from the Department, and whose application has not been fully processed. (1-1-93)

05. Child. A child is under age eighteen (18), or under twenty-one (21) and attending school. If the child is at least age eighteen (18) he must regularly attend a school, college, university, or vocational or technical training designed to prepare him for gainful employment. A child is not married. A child is not the head of a household. (1-1-93)

06. Department. The Idaho Department of Health and Welfare. (1-1-93)

07. Essential Person. A person of the client's choice whose presence in the household is essential to the participant's well-being. The essential person renders specific services, which must be provided for a client to live at home. (1-1-93)

08. Grant. A money payment in the form of a state warrant paid to a client, a client's guardian, or a protective payee. (1-1-93)

09. Ineligible Child. A child under age twenty-one (21) who does not receive AABD, and lives with the

- AABD client. (1-1-93)
10. Ineligible Parent. A natural or adoptive father or mother, or a stepparent, who does not receive AABD and lives in the same household as a child client. (1-1-93)
11. Ineligible Spouse. A client's husband or wife, living with the client, not receiving AABD is an ineligible spouse. The non-AABD husband or wife, of the parent of a child client, living with the child client and his parent, is an ineligible spouse. (1-1-93)
12. Inmate. A person living in an institution and receiving treatment or services from the institution. The treatment or services must fit the client's needs. A person is not an inmate if he is getting training in a public educational or vocational training institution. A person is not an inmate if he is temporarily in a public institution for an emergency. (1-1-93)
13. Medicaid. The Federally-aided program for medical care (Title XIX, Social Security Act). (1-1-93)
14. Medical Assistance Handbook. Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, "Rules Governing Medical Assistance. (7-1-94)
15. Room and Board. A living arrangement in which the client purchases lodging (room) and meals (board). (7-1-94)
16. School. A grade school, junior high school, high school, junior college, college, university, or vocational or technical training, including the Job Corps Program, designed to fit the trainee for gainful employment. (1-1-93)
17. Working Day. A calendar day when regular office hours are observed by the state of Idaho. (1-1-93)

004. ABBREVIATIONS.

01. AABD. Aid to the Aged, Blind and Disabled. (1-1-93)
02. AB. Aid to the Blind. (1-1-93)
03. AFA. Application for Assistance (HW-0900). (7-1-93)
04. AFDC. Aid to Families with Dependent Children. (1-1-93)
05. AG. Office of the Attorney General, Health and Welfare Division. (1-1-93)
06. APTD. Aid to the Permanently and Totally Disabled. (1-1-93)
07. ASVI. Alien Status Verification Index. (1-1-93)
08. COLA. Cost of Living Adjustment. (1-1-93)
09. CSA. Community Spouse Allowance. (1-1-93)
10. CSNS. Community Spouse Need Standard. (1-1-93)
11. CSRA. Community Spouse Resource Allowance. (1-1-93)
12. DDU. Disability Determinations Unit. (1-1-93)
13. DHW. The Idaho Department of Health and Welfare. (1-1-93)

14. EE. Eligibility Examiner. (1-1-93)
15. EITC. Earned Income Tax Credit. (1-1-93)
16. FMA. Family Member Allowance. (1-1-93)
17. FSI. Federal Spousal Impoverishment. (1-1-93)
18. HCBS. Home and Community Based Services. (1-1-93)
19. HUD. The U.S. Department of Housing and Urban Development. (1-1-93)
20. IEVS. Income and Eligibility Verification System. (1-1-93)
21. IID. Initial Input Document. (1-1-93)
22. IRS. The U.S. Internal Revenue Service. (1-1-93)
23. MA. Medical Assistance. (1-1-93)
24. OAA. Old Age Assistance. (1-1-93)
25. PASS. Plan for Achieving Self-Support. (1-1-93)
26. RSDI. Retirement, Survivors, and Disability Insurance. (1-1-93)
27. SAVE. Systematic Alien Verification for Entitlements. (1-1-93)
28. SSA. Social Security Administration. (1-1-93)
29. SSI. Supplemental Security Income. (1-1-93)
30. SSN. Social Security Number. (1-1-93)
31. UIB. Unemployment Insurance Benefits. (1-1-93)
32. VA. Veterans Administration. (1-1-93)
33. VRS. Vocational Rehabilitation Services, Department of Education. (1-1-93)

005. -- 006. (RESERVED).

007. FEDERAL LAWS.

Within these rules, the following public laws are cited: (1-1-93)

01. Alaska Native Claim Settlement Act. This act is described in 43 USC 1601 through 1628. (1-1-93)
02. Child Nutrition Act of 1966. This act is described in 42 USC 1754, 1757, 1760, 1766, 1771 through 1788, and 5101 through 5106. (1-1-93)
03. Domestic Volunteer Service Act of 1973. This act is described in 5 USC 8332, and 42 USC 3067, 4951 through 4957, 4971 through 4974, 4991, 4992, 5001, 5011, 5012, 5021 through 5023, 5031, 5032, 5041 through 5062, and 5081 through 5085. (1-1-93)
04. Higher Education Amendments of 1968. This act is described in 12 USC 1464; 20 USC 403, 421 through 426, 441 through 455, 462 through 464, 481, 483, 484, 511, 513, 562, 581, 582, 584, 588, 591, 711, 713 through 718, 732, 743, 746, 751, 758, 961, 981, 1001, 1005, 1006, 1021 through 1024, 1031, 1033, 1041, 1051, 1056,

1060 through 1062, 1065 through 1068, 1071 through 1075, 1077, 1078, 1080, 1083 through 1089, 1091, 1101, 1104, 1108 through 1111, 1113 through 1115, 1118, 1119, 1121, 1124, 1125, 1129, 1133 through 1136, 1141 through 1145, 1147 through 1150, and 1176; and 42 USC 2741, 2751 through 2756, and 2809. (1-1-93)

05. Housing Act of 1949. This act is described in 12 USC 24, 84, 1701, 1703, 1709, and 1738; and 42 USC 1401, 1409 through 1411, 1413 through 1416, 1420, 1421, 1430, 1433, 1440 through 1445, 1450 through 1460, 1462, 1463, 1465 through 1469, 1471 through 1490, and 1701. (1-1-93)

06. Housing and Urban Development Act of 1965. This act is described in 12 USC 371, 1464, 1701 through 1703, 1706, 1709, 1710, 1713, 1715, 1717, 1718, 1720, 1721, 1727, 1735, 1739, 1743, 1744, and 1747 through 1750; 15 USC 633, 671, 692 through 694; 20 USC 802 and 803; 38 USC 1804 and 1816; 40 USC 461 and 462; 42 USC 1402, 1410, 1412, 1415, 1421, 1422, 1436, 1451 through 1453, 1455, 1456, 1460, 1465 through 1468, 1471, 1472, 1476, 1481 through 1483, 1485, 1487 through 1490, 1492, 1500, 3071 through 3074, and 3101 through 3108; and 49 USC 1605 and 1608. (1-1-93)

07. Immigration and Nationality Act. This act is described in 8 USC 1101 through 1503; 18 USC 1114, 1429, and 1546; 22 USC 618 and 1446; 31 USC 530; 49 USC 1 and 177; and 50 USC 1952 through 1955 and 1961. (1-1-93)

08. Manpower Development and Training Act of 1962, as amended by the Manpower Act of 1965. This act is described in 42 USC 2571 through 2574, 2581 through 2588, 2601 through 2603, and 2610 through 2628; and 42 USC 2513, 2571 through 2574, 2582, 2583, 2601, 2610 through 2612, 2614 through 2616, 2619, and 2620. (1-1-93)

09. National Housing Act. This act is described in 10 USC 4387; 12 USC 24, 371, 1131, 1422, 1426, 1430, 1431, 1462, 1463, 1701 through 1703, 1705 through 1750, 3604 through 3606, and 3631; 15 USC 609; 41 USC 22; 42 USC 1594 and 1855; 48 USC 723, 724, 1425, and 1426; 49 USC 22; and 50 USC 1830, 1883, and 1909. (1-1-93)

10. National School Lunch Act. This act is described in 42 USC 1751 through 1767, 1769, 1774, and 1874. (1-1-93)

11. Older Americans Act of 1965. This act is described in 42 USC 3001, 3002, 3011 through 3029, 3031 through 3037, 3041 through 3045, and 3051 through 3056. (1-1-93)

12. Rehabilitation Act of 1973. This act is described in 29 USC 701 through 709, 720 through 724, 730 through 732, 740, 741, 750, 760 through 764, 770 through 776, 780 through 787, and 790 through 794. (1-1-93)

13. Tax Reduction Act of 1975, as amended by the Tax Reduction and Simplification Act of 1977. This act is described in 26 USC 1, 3, 11, 12, 21, 42 through 48, 50, 56, 141, 214, 243, 410, 535, 613, 703, 851, 901, 902, 907, 951, 954, 955, 962, 993, 1034, 1551, 1561, 3304, 3402, 6012, 6096, 6201, 6401, 6428, and 6611; 42 USC 402; 5 USC 5520; 15 USC 1673 and 1675; 26 USC 1, 3, 11, 21, 36, 37, 42 through 44, 51 through 53, 56, 63, 67, 105, 141 through 145, 161, 162, 170, 172, 188, 211, 280, 381, 383, 402, 441, 443, 447, 511, 584, 602, 603, 613, 635, 641, 642, 667, 703, 821, 861, 862, 873, 904, 911, 931, 1034, 1211, 1302, 3402, 6012, 6014, 6096, 6212, 6411, 6501, 6504, 6511, 6601, 6611, 6654, and 7651; and 42 USC 652, 654, 658, 659, 661, 662, 6721 through 6724, 6726, 6727, 6735, and 6736. (1-1-93)

14. Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970. This act is described in 42 USC 1415, 2473, 3307, 4601, 4602, 4621 through 4638, and 4651 through 4655; and 49 USC 1606. (1-1-93)

15. United States Housing Act of 1937, as amended by P.L. 92-213. This act is described in 42 USC 1401 through 1417, 1419 through 1422, 1427 through 1430, and 1585. (1-1-93)

008. -- 049. (RESERVED).

050. APPLICANT RIGHTS.

The client has rights protected by federal and state laws and Department rules. The Department must inform clients of their rights during the application process and eligibility reviews. (1-1-93)

01. Right to Apply. Any person has the right to apply for any type of public aid. Applications must be in writing, on forms provided by the Department. (1-1-93)

02. Right to Hearing. The client can request a fair hearing to challenge a Department decision. (1-1-93)

03. Civil Rights. Examiners must respect the rights of the clients under the U.S. and Idaho Constitutions, the Social Security Act, Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, and Federal and State laws. (1-1-93)

051. APPLICATIONS FOR FINANCIAL ASSISTANCE.

The client's application for an AABD money payment is also an application for Medicaid. The client can apply for Medicaid without applying for AABD. (1-1-93)

052. APPLICATION FORMS.

The client must complete the Application for Assistance, (AFA) (HW 0901), and supplement(s) to apply for AABD and AABD-related Medicaid. The form must be completed before an AABD payment or Medicaid can be approved. The AFA must be completed when a client has an open case and wishes to add a program to this case. (7-1-93)

01. Copy of Application. The Department must provide a copy of the completed AFA, and AFA supplement forms when asked for by the client. A copy of pages 1 and 10 of the AFA will be given to the client. (7-1-93)

02. Signatures Required on the Application Forms. The signatures, listed in Subsections 052.02.a. through 052.02.d., under penalty of perjury, must be contained on the AFA and AFA supplements. (7-1-93)

a. Client. The client must sign the application forms. (1-1-93)

b. Client's Spouse. The spouse must sign the application forms if the spouse is living with the client. (1-1-93)

c. Legal Guardian. The legal guardian must sign the application if the client has a legal guardian. Persons with power of attorney to conduct the client's business must sign the application forms. (1-1-93)

d. Representative or Responsible Person. A person acting responsibly for the client must sign the application forms. (1-1-93)

03. Witnessing Signature. The signature on the AFA must be witnessed by a Department employee. The witnessing may be waived in rare instances where a face-to-face interview is not possible. (7-1-93)

04. Signature by Mark. A signature by mark requires two witnesses. The witnesses' signatures must appear on the AFA followed by the word "WITNESS". (7-1-93)

053. CLIENT'S CONSENT.

A client's signature on the AFA is his consent to contact sources for verification. The Examiner must tell the client his signature on the AFA indicates he has made truthful statements in the application. The client's signature allows the Department to make contacts to determine his eligibility for assistance. A client must be allowed to get the proof on his own or withdraw his application. (7-1-93)

054. CORRECTING FORMS.

The client or representative can add, delete, or change any statements on the AFA or Supplements. The client or representative must draw a line through incorrect entries, insert the corrected entry, then initial and date the change. (7-1-93)

055. APPLICATION DATE.

The application date is the date the client brings the AFA (HW 0900) into the Field Office. When the application is mailed, the application date is the postmark date. If the postmark date is not legible, the postal day before the date received will be used. (7-1-93)

056. EFFECTIVE DATE.

The effective date for aid, when all eligibility requirements are met, is the application date. A client who applies for AABD must meet all eligibility factors on the date of his application. Resources are counted on the first (1st) day of the application month. If he is not eligible on this date, the application must be denied. Medicaid eligibility begins as shown in Subsections 056.012 through 056.04. (1-1-93)

01. Normal Eligibility. Medicaid coverage begins on the first (1st) day of the application calendar month. (1-1-93)

02. Retroactive (Backdated) Eligibility. Medicaid benefits are backdated to the first (1st) day of the calendar month, three (3) months before the month of application, if the client was Medicaid eligible during the three (3) month period. If the client is not eligible for Medicaid when he applies, retroactive eligibility must be determined. (1-1-93)

03. Partial Retroactive Eligibility. A client eligible for Medicaid one (1) or more months of the three (3) month retroactive period may request the Department to provide Medicaid benefits for the eligible months. Medicaid must be provided for each eligible month a client received a Medicaid-payable service. (1-1-93)

04. Ineligible Alien. Ineligible alien coverage is restricted to emergency services. Coverage begins when the emergency treatment is required. Coverage ends with the last day emergency treatment is needed. (1-1-93)

057. APPLICATION RULES.

Specific application rules are listed in the following paragraphs. (1-1-93)

01. Representative for Client. A client may be helped by a person or persons of his choice. The person may accompany the client to represent them. (1-1-93)

02. Forms Provided. All forms needed to make an eligibility decision must be given to the client. Forms will contain statements that explain the rules for truthful and complete information. (1-1-93)

03. Help to Complete Application. A client or selected representative may complete the forms in the Field Office or take them home to complete. The Department must provide help when the client states no one is available to help him and he is not capable of completing the form. To avoid conflict of interest, the Examiner who determines eligibility of the case must not complete the forms for the client. (1-1-93)

04. Informing Requirement. The client must be told the application must not be approved until all required forms, information, and documents have been returned to the Field Office. The client must be told failure to provide required material and information will cause the Department to deny the application. (1-1-93)

05. Right to Withdraw Application. The client may withdraw the application at any time before a decision of eligibility is made. (1-1-93)

058. PERSONAL INTERVIEW.

Each applicant for AABD must participate in a face-to-face interview with the Examiner. Questionable statements or partial information must be resolved. A face-to-face interview with the client may be waived when good cause exists. In this case, the client's representative, if one exists, must be interviewed. (7-1-93)

059. -- 068. (RESERVED).

069. SCHEDULING AN APPLICATION INTERVIEW.

When a signed AFA is left at the Field Office, the client must be told an interview must be scheduled to determine if the client is eligible for AABD or Medicaid. The Department must advise the client in writing of the place, date, and time of his interview. The client must be given the address and telephone number of the Field Office. (7-1-93)

070. FAILURE TO KEEP A SCHEDULED APPOINTMENT.

The client must be told, failure to keep his appointment or contact the Field Office to reschedule, will cause the Department to deny the application. If the client does not keep his appointment or contact the Department, the application will be denied thirty (30) days after the application date, or the day after the last scheduled interview, whichever is later. (1-1-93)

071. RESCHEDULING APPOINTMENT.

If a client is unable to keep his scheduled appointment, he must be allowed to reschedule. A client may reschedule his appointment with the Field Office before a decision is made. When a new appointment is agreed upon, the Department must notify the client, in writing if time permits, of the rescheduled place, date, and time. (1-1-93)

072. TIME LIMITS.

Each application will be processed within forty-five (45) days, or, for a disabled applicant, ninety (90) days. The time limit can be extended by events beyond the Department's control. A delay, caused by SSA in determining RSDI or SSI, is not beyond the Department's control, unless the SSA delay is caused by the client. The time limit is counted from the application date to the date the AABD check, Medicaid card, or notice of denial is mailed to the client. The time limit must not be used as a waiting period for acting on an application. The time limit must not be used as the basis for denial of an application. Table 072 lists time limits. (1-1-93)

TABLE 072 - APPLICATION TIME LIMITS

PROGRAM	TIME LIMIT
AABD For Aged Applicant	45 Days
AABD For Disabled Applicant	90 Days
Medicaid For Aged Applicant	45 Days
Medicaid For Disabled Applicant	90 Days

073. APPLICATION PROCESSING ACTIONS.

An application for AABD or Medicaid must be processed in one of the following manners: (1-1-93)

01. Approval. When an Examiner determines the client is eligible for AABD and Medicaid, a Notice of Decision must be mailed to the client. The Notice of Decision must advise the client of his approval for AABD and the amount of his AABD payment. The Notice of Decision must show how the amount of AABD was calculated. (1-1-93)

02. Denial. When an Examiner determines the client is not eligible for AABD or Medicaid, a Notice of Decision must be mailed to the client. The Notice of Decision must give the information listed in the following Subsections 073.02.a. through 073.02.d. (1-1-93)

a. Reason for Ineligibility. The notice must state why the client is not eligible for aid. (1-1-93)

b. Rules. The notice must list the rules supporting the decision. (1-1-93)

c. Date. The notice must list the date of the decision for denial. (1-1-93)

d. Fair Hearing. The notice must give an explanation of the applicant's right to request a fair hearing if he disagrees with the decision. (1-1-93)

03. Withdrawal. A client may request to withdraw his application, either orally or in writing. A Notice of Decision must be mailed to the client telling him the application is denied due to withdrawal. An application abandoned due to the client's failure to keep a scheduled appointment will be considered voluntarily withdrawn. An abandoned application must be denied thirty (30) days after the application date or the day after the last interview, whichever is later. The Notice of Decision must give the information listed in the following Subsections 073.03.a. through 073.03.d. (1-1-93)

a. Withdrawal. The notice must say the application is denied due to the client's withdrawal of the application. (1-1-93)

b. Rules. The notice must list the rules supporting the decision. (1-1-93)

c. Date. The notice must list the date of the decision for denial. (1-1-93)

d. Fair Hearing. The notice must give an explanation of the applicant's right to request a fair hearing if he disagrees with the decision. (1-1-93)

04. Death. Medicaid can be approved, through the date of death, if an AABD applicant dies before eligibility is determined. The applicant must meet all eligibility criteria. AABD checks must not be issued for a deceased client. (1-1-93)

074. CASE RECORD.

All material used to determine eligibility for aid must be placed in the case record. The case record must support the Examiner's decision to approve or deny the application. The case record must contain proof of the client's request for withdrawal of the application. The case record must show whether the request was oral or in writing. The case record must list the date the client requested the withdrawal. (1-1-93)

075. CLIENT ACCESS TO OWN CASE RECORD.

The client can review his case record under the conditions of Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 01, "Rules Governing the Protection and Disclosure of Department Records." The client must not review information in his case record about the nature or status of an investigation, expected to result in criminal prosecution against the client. The names of persons giving information about the client, without his knowledge, must not be disclosed to the client. (1-1-93)

076. REQUIRED VERIFICATION.

Verification is the use of third party data to prove the accuracy of information in the application. Each applicant for AABD or AABD-related Medicaid must prove his eligibility for aid. The applicant must be told in writing of the following: (1-1-93)

01. Required Proof. At the time of application the client must be given a written list of items he must provide to the Department. If the applicant does not furnish all the required proof at the interview, he must be given a written list of items required. The client must be allowed ten (10) calendar days to provide them. The notice must include the action the Department will take if the requested proof is not provided. If an interview is not possible, or if further proof is required later in the application process, the applicant must be given a written list of the items needed and allowed ten (10) calendar days to provide them. (1-1-93)

02. Time Limit for Providing Proof. The client must be told in writing of the time limit to provide proof. The client must be allowed at least ten (10) calendar days to provide the proof. (1-1-93)

03. Unable to Get Proof. The client must be told he may contact the Field Office before the time limit ends, if he is unable to get the proof. The client may request a time limit extension. (1-1-93)

077. EXTENSION OF INFORMATION TIME LIMIT.

If the client is unable to get required information within the time limits, he may request an extension. The client must make the request before the time limit expires. The extension must be granted by the Examiner if the client shows good cause for the delay. The client must be given the new date for providing verification. The client must be told

failure to provide the verification will result in benefit denial. (1-1-93)

078. DEPARTMENT ASSISTANCE.

When a client is unable to get the requested verification, the Department must offer to help the client. (1-1-93)

079. -- 088. (RESERVED).

089. FAILURE TO PROVIDE PROOF.

The application must be denied if proof is not provided within ten (10) calendar days of the written request, and good cause for failure to provide the proof is not given by the applicant. The failure to provide proof will result in denied benefits for failure to cooperate. If the tenth (10th) day falls on a weekend or holiday, the client must be allowed until the close of the next working day to provide the proof. (1-1-93)

090. APPLICATIONS FOR MEDICAID.

The Department must examine the potential eligibility of the client for all Medicaid coverage groups when a client applies for Medicaid. (1-1-93)

091. SOCIAL SECURITY NUMBER (SSN) USAGE.

The Department must tell the client Social Security Numbers (SSN) will be used for any person whose income and resources are used to determine eligibility and benefit amount. The SSN will be used to get proof of income from the Department of Employment (DOE), the SSA, and the IRS. (1-1-93)

092. INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS).

IEVS is an exchange of information with state and federal agencies to verify income and information needed to determine eligibility. The Department must inform the client his SSN will be used to get income verification from the Department of Employment (DOE), the (SSA), and the IRS. IEVS information available before eligibility is determined must be used. Case actions, based on IEVS information received after approval, must be completed within forty-five (45) days from the date the IEVS information is received. Information received from SSA, and Unemployment Insurance Benefits information from DOE, can be used without further proof. Information received from IRS or wage file information from DOE must be verified through other sources, before it can be used. Table 092 shows IEVS data verification requirements.

TABLE 092 - IEVS ADDITIONAL VERIFICATION REQUIREMENTS

DATA TYPE	DATA SOURCE	ADDITIONAL VERIFICATION REQUIRED?
Wage File	Wage file data from the Department of Employment (DOE) in Idaho or sources from another state.	YES
Unemployment Insurance Benefits	Unemployment Insurance Benefit (UIB) data from the DOE in Idaho or sources from another state.	NO
Self- Employment Earnings	Beneficiary Earnings Exchange Record (BEER) data about self-employment earnings.	YES
RSDI Benefits	Retirement income data from the Social Security Administration (SSA). Accessed through the Benefit Data Exchange (BENDEX).	NO
SSI Benefits	Benefit and other eligibility-related data available from SSA under RSDI disability (Title II) and SSI (Title XVI) of the Social Security Act. Accessed through the State Data Exchange (SDX).	NO
Interest Income	Unearned income data from the Internal Revenue Service (IRS).	YES
SSN Verification	Social Security number (SSN) verification from SSA. Verified by NUMIDENT or SSA-verified federal or federally-assisted benefit program.	NO

DATA TYPE	DATA SOURCE	ADDITIONAL VERIFICATION REQUIRED?
State Public Assistance	State run Medicaid and SSI state supplement programs such as AABD.	NO
Immigration Status	Immigration status verification from INS records. Accessed through the Systematic Verification for Alien Entitlements (SAVE).	NO

(1-1-93)

093. OUT OF STATE APPLICANTS.

A client who is receiving an AABD payment from another state must not receive AABD in Idaho until the client moves to Idaho and the payment has ended in the other state. A client may receive Medicaid in Idaho before AABD or Medicaid is closed in another state, if the client meets all other Medicaid criteria. AABD payments received from another state are unearned income in determining Medicaid eligibility. The out-of-state medical coverage is a third party resource. Idaho residents temporarily out of the state, and not receiving aid, may apply for aid in Idaho.

(1-1-93)

094. APPLICANTS WHO MOVE.

If an applicant reports he will be moving to an area served by another Field Office, the case record must be sent to the new Field Office.

(1-1-93)

095. SELECTION OF BENEFITS.

A client must not receive AABD and or Federally-funded Foster Care payments at the same time. If a child is eligible for AABD and another type of aid, the client must be told the benefits for each program. The client, or representative, must elect the type of benefit he wishes to receive.

(1-1-93)

01. Selection of Benefits. The caretaker relative, guardian, or person acting responsibly for a client, must choose the type of aid payment when the client can qualify for more than one (1) aid program.

(1-1-93)

02. When the Department has custody of a child, the social services worker supervising the child's placement, must choose whether the child will receive AABD, SSI, AFDC, or Federally-funded Foster Care payments when the child is eligible for more than one (1) benefit.

(1-1-93)

03. Concurrent Benefit Payee. An AABD, SSI, or AFDC participant can be the payee of an AABD grant for a child.

(1-1-93)

096. -- 099. (RESERVED).

100. NONFINANCIAL CRITERIA DEFINITION.

Nonfinancial criteria are conditions of eligibility, other than income or resources, the client must meet before AABD or Medicaid can be allowed.

(1-1-93)

101. RESIDENCY.

The client must be voluntarily living in Idaho and have no immediate intention of leaving. A client has "no immediate intention of leaving" if he plans to stay in Idaho, at least until his AABD or Medicaid eligibility is determined. The length of time a person has lived in Idaho does not affect residency for AABD. The cash aid an Idaho resident gets from another state must be counted as income for Medicaid.

(7-1-93)

102. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.

The client must be a citizen or national of the United States or an eligible alien. The client must provide proof of citizenship or alien status. The client or legal guardian must sign a declaration, under penalty of perjury, attesting to his citizenship or alien status.

(1-1-93)

01. Eligible Aliens. An eligible alien is a legal alien, admitted to the United States for permanent residence. An eligible alien is a person lawfully living in the United States, under the color of the law. (1-1-93)

02. Verifying Alien Status. Alien status claimed by a client must be verified, through the INS automated Alien Status Verification Index (ASVI). If INS reports the alien's status cannot be verified through ASVI, secondary proof is required. Secondary proof is required before AABD can be denied, reduced, or stopped based on alien status. (1-1-93)

103. NEW VERIFICATION OF LEGAL NON-CITIZEN STATUS.

Alien status must be verified again if the client reapplies after the expiration date on the INS document verified with SAVE. Alien status must be verified again if the case record does not contain proof of status through SAVE. (1-1-93)

104. VERIFICATION FOR ALL PROGRAMS.

Proof of alien status with SAVE for Medicaid, AFDC, AABD, or Food Stamps is proof for all programs. The SAVE verification must be in the case record. (1-1-93)

105. SOCIAL SECURITY NUMBER.

To qualify for AABD payments, the client must provide his SSN. The client must provide all SSNs if he has more than one (1). AABD must not be denied, delayed, or stopped if the SSN has been applied for, but not issued, by the SSA. (1-1-93)

01. Department Help to Get SSN. The Department must help the client apply for an SSN. (1-1-93)

02. SSN Verification. All SSNs must be verified by the SSA. An SSN is verified when it is provided directly to the Department by the SSA. (1-1-93)

106. TEMPORARY ABSENCE.

A client may be temporarily absent from his home and still receive AABD. Temporary absence includes the following: (1-1-93)

01. Absent Client Intends to Return Home in One (1) Month. A client is temporarily absent if he intends to return home within one (1) month. The intent to return home must be verified for AABD benefits to continue. If the client intends to return within one (1) month, but is absent longer, due to circumstances beyond his control, the absence is temporary. (1-1-93)

02. Child Attending School. Temporary absence may exceed one (1) month for a child attending school or vocational training. If the child attends summer school, he may remain at school during summer vacation and get AABD benefits. (1-1-93)

03. Client in Hospital. Temporary absence may exceed one (1) month, when the client is in a medical institution, hospital, or nursing home. The client must intend to return home to be temporarily absent. (1-1-93)

107. INSTITUTIONAL STATUS.

An institution provides treatment, services, food, and shelter to four (4) or more people, not related to the owner. A client living in an ineligible institution an entire calendar month is not eligible for AABD, unless he qualifies for the institution payment exception. (1-1-93)

01. Eligible institutions for AABD and Medicaid are defined in the following Subsections 107.01.a. through 107.01.f.iv. of these rules. (1-1-93)

a. Medical Institution. A medical institution, including a hospital, nursing care facility, or an intermediate care facility for the mentally retarded is an eligible institution. The Adolescent Treatment Unit of State Hospital South in Blackfoot, Idaho is an eligible institution for children receiving inpatient psychiatric services. A medical institution provides medical care. It is authorized to do so under State law. It has adequate staff, equipment, and facilities to manage patient needs on a continuing basis. A client is not eligible for AABD if he is a resident of a medical institution the full month. (7-1-94)

b. Child Care Institution. A non-profit private child care institution is an eligible institution. A public child care institution with no more than twenty-five (25) beds is an eligible institution. A child care institution must be licensed or approved by the Department. A detention facility for delinquent children is not a child care institution. (1-1-93)

c. Child Care IMD. A child care institution for mental diseases (IMD) is an eligible institution if it has sixteen (16) beds or less. (1-1-93)

d. Community Residence. A community residence is a facility providing food, shelter, and services beyond food and shelter to residents. A privately operated community residence is an eligible institution. A publicly operated community residence serving no more than sixteen (16) residents is an eligible institution. (1-1-93)

e. Community Residence Exception. The Community Restorium in Bonners Ferry, Idaho, is an eligible institution even though more than sixteen (16) residents are served. (1-1-93)

f. Public Institution. A public institution is under government responsibility or control. The following are eligible public institutions. (1-1-93)

i. Medical institutions. (1-1-93)

ii. Intermediate care facilities. (1-1-93)

iii. A publicly operated community residence serving no more than sixteen (16) residents. (1-1-93)

iv. A child care institution for children in foster care. (1-1-93)

02. Ineligible Institution. Ineligible institutions for AABD and Medicaid are defined in the following Subsections 107.02.a. through 107.02.c. of these rules. (1-1-93)

a. Public Institution. Public institutions are ineligible institutions unless listed in the Subsections 107.01.a. through 107.01.f. of these rules. (1-1-93)

b. Institution for Mental Diseases. An institution for mental diseases is not an eligible institution unless listed in the Subsections 107.01.a. through 107.01.f. of these rules. A facility is an institution for mental diseases if it is maintained primarily for the care and treatment of persons with mental diseases. (7-1-94)

c. Institution for Tuberculosis. An institution for tuberculosis is an ineligible institution. A facility is an institution for tuberculosis if it is maintained primarily for the care and treatment of persons with tuberculosis. (1-1-93)

d. Correctional Institution. A correctional institution is an ineligible institution. A correctional institution is a facility for prisoners, persons detained pending disposition of charges, or held under court order as material witnesses or juveniles. (7-1-96)

108. RESIDENT OF AN INSTITUTION.

A resident must live in the institution. The person is a resident if he or anyone pays for his food, shelter, and other services in the institution. Residents of institutions are listed in Subsections 108.01 through 108.04. (1-1-93)

01. Born In Institution. A person born in an institution and living there for the rest of the month, is a resident of an institution. (1-1-93)

02. Dies In Institution. A person living in an institution at the first of the month, and dying there, is a resident of an institution. (1-1-93)

03. Transferred to Institution. A person transferred from one institution to another, is a resident of an institution. (1-1-93)

04. Temporary Absence. A person temporarily absent from an institution, for not more than fourteen (14) consecutive days, is a resident of an institution. (1-1-93)

109. NOT A RESIDENT OF AN INSTITUTION.

Persons not a resident of an institution are listed in Subsections 109.01 through 109.04 of these rules. (7-1-96)

01. Education Resident. If the person is in the institution to get educational or vocational training he is not a resident. This includes an ineligible institution, part of which is an educational or vocational training facility with an approved program. Educational or vocational training is a recognized program, to teach knowledge or skills preparing a person for gainful employment. This does not include programs limited to teaching basic life skills, such as eating and dressing. (1-1-93)

02. Temporary Resident. A person in an institution, for a temporary period pending other arrangements, is not a resident of an institution. A temporary resident may be entitled to receive AABD payments. (1-1-93)

03. New or Leaving Resident. An applicant entering or leaving an institution, during the month of application for AABD, is not a resident of an institution. (7-1-96)

04. Correctional Institution. A person released from a correctional institution for care in a medical institution, not expected to return to the correctional institution, is not a resident of a correctional institution. (7-1-96)

110. PATIENT IN AN INSTITUTION.

A person receiving room, board, and professional services in an institution for tuberculosis, or an institution for mental diseases, is a patient there. The institution stay must be on a continuous twenty-four (24) hour basis. (1-1-93)

111. WHO IS NOT A PATIENT.

A person on conditional release from an institution for mental diseases is not a patient in the institution. (1-1-93)

112. INSTITUTION ELIGIBILITY EXCEPTION.

A client may get AABD payments in an ineligible institution or a medical institution. The client must meet one (1) of the conditions listed in Subsections 112.01 through 112.01.c. (1-1-93)

01. AABD Eligibility in Ineligible Institutions. (1-1-93)

a. First Month in Institution. An AABD client can get an AABD payment for the month he entered the institution. Eligibility for the entry month applies to the following residents. (1-1-93)

i. Resident of a public institution. (1-1-93)

ii. Patient in a medical institution. (1-1-93)

iii. Patient in an institution for tuberculosis. (1-1-93)

iv. Patient in an institution for mental diseases. (1-1-93)

b. Temporary Institution Stay. An AABD client can get up to three (3) month's AABD payment during a temporary stay in an institution. A client entering a public medical or psychiatric institution, a hospital, a nursing facility, or an ICF/MR may continue to get AABD payments. The payments may continue up to three (3) months if the following conditions are met. (1-1-93)

i. The Department is informed of the institutional stay. (1-1-93)

ii. A physician certifies the client's stay is not likely to exceed three (3) full months. (1-1-93)

iii. A signed statement from the client or a responsible party showing the client's need to continue to maintain and pay for the place he intends to return to live. (1-1-93)

c. The Department must receive the preceding data no later than the ninetieth (90th) full day of confinement, or the release date, whichever is first. (1-1-93)

02. Conditions for Temporary AABD in Institutions. Special conditions for AABD when a client is in an institution are listed in the following Subsections 112.02.a. through 112.02.e. (1-1-93)

a. Living Arrangement. The AABD grant is paid based on the client's living arrangement the month before the first (1st) month in the institution. Changes in living arrangement costs must be used to determine continuing eligibility for AABD and AABD grant amount. (1-1-93)

b. Client Becomes Ineligible. The client becomes ineligible for AABD during his temporary institutional stay, his AABD payment must be ended after proper notice. (1-1-93)

c. AABD Status. A client must get AABD for the month he enters the institution to receive continued AABD payments. (1-1-93)

d. Counting Three (3) Full Months. A full month is a month the client is in the institution every day of the month. If the client enters after the first (1st) day of a month, the month of entry is not included in the three (3) full months. If the client is discharged before the last day of the month, the month of discharge is not included in the three (3) full months. (1-1-93)

e. SSI Benefits. If SSA decides a client's SSI benefit will continue while the client is in the institution, AABD payments can also continue. (1-1-93)

113. -- 115. (RESERVED).

116. CLIENT'S GUARDIAN FOR PUBLIC AID.

A guardian for public aid manages the AABD payment, for a client not able to do so. A guardian can be appointed for a client who has no friend or relative to help manage his AABD payment. A client's guardian for public aid must be court appointed. (1-1-93)

117. NEED FOR GUARDIAN FOR PUBLIC AID.

The need for a guardian to manage the client's AABD payment must be documented in the case record. A client's physical disability, advanced age, or unwise use of his AABD payments are not proof the client cannot manage his money. (1-1-93)

118. RESPONSIBILITIES OF CLIENT'S GUARDIAN.

The guardian must provide a true and accurate account of payments he makes for the AABD client. The report must be made to the Department at least once every six (6) months. The report must include a listing of items bought and expenses paid. The report must include receipts and the date of all payments. Accounting includes, but is not limited to, the following items listed in Subsections 118.01 and 118.02. (1-1-93)

01. Purchases. (1-1-93)

a. Purchase of food and other items normally purchased at a grocery store. (1-1-93)

b. Purchase of prescription medicines not covered by Medicaid. Purchase of over-the-counter vitamins, pain relievers, bandages and other drugstore items. (1-1-93)

c. Purchase of clothing, shoes, and furnishings. (1-1-93)

d. Purchase of furniture and appliances. (1-1-93)

02. Expenses. (1-1-93)

a. Payment for housing. (1-1-93)

- b. Payment for fuel, electricity, water, trash collection, sewer fees, insurance premiums, and irrigation. (1-1-93)
 - c. Payment for emergencies, such as home repairs. (1-1-93)
 - d. Cash given to the client for his personal use. (1-1-93)
- 119. GUARDIAN APPOINTMENT.**
The Department must petition the District Court to appoint a guardian if one is needed. (1-1-93)
- 120. -- 129. (RESERVED).**
- 130. CONSENT FOR GUARDIAN FOR PUBLIC AID.**
The Department must obtain the consent of the client's nearest relative, friend, or caretaker. (1-1-93)
- 131. SELECTION OF GUARDIAN FOR PUBLIC AID.**
The Department must advise the District Court if the client wants to select a guardian. If the client does not select a guardian, the Department must select a capable and trustworthy person. The guardian must be acceptable to the client and his nearest relative, friend, or caretaker. The guardian must serve without pay. The guardian must agree, in writing, to give true and accurate accounts of AABD payments spent, to the District Court and the Department. (1-1-93)
- 132. PETITION FOR GUARDIAN FOR PUBLIC AID.**
The Department must file the petition for appointment of guardian for public aid with the District Court. The nearest relative, friend, or caretaker must consent to the petition. (1-1-93)
- 133. AABD PAYMENTS AND GUARDIAN FOR PUBLIC AID.**
The client's AABD checks will be written to the guardian and the client. (1-1-93)
- 134. ENDING GUARDIANSHIP FOR PUBLIC AID.**
If a client no longer needs a guardian for public aid, the Department must petition the District Court to end the guardianship. The Department must remove the former guardian's name from the client's AABD checks. (1-1-93)
- 135. ADMINISTRATOR FOR PUBLIC AID FOR DECEASED CLIENT.**
An administrator for public aid for a deceased client's AABD funds can be appointed by the court. AABD checks, delivered before the death of the client, must be spent by the administrator to pay bills owed by the client's estate. AABD checks delivered after the client's death are the property of the state of Idaho. (1-1-93)
- 136. ESTATE IN PROBATE.**
An AABD check received by a client before his death is disbursed as part of the client's estate if it is probated. The probate administrator must spend the AABD check under his oath of administration. The Department must take no action on how the AABD check is spent. The probate administrator must provide a receipt for any AABD checks delivered before the client's death. (1-1-93)
- 137. ESTATE NOT IN PROBATE.**
When the deceased client's estate does not require probate, the AABD check can be spent only by the court appointed to administrator for public aid. The AABD check can only be spent to meet the needs of the client, or his dependents, for the month the check was paid. If a client had no debts for himself, or his dependents, the administrator must return the AABD check to the Department. (1-1-93)
- 138. APPOINTMENT OF ADMINISTRATOR.**
To appoint an administrator for public aid, the Department must petition the appropriate District Court. (1-1-93)
- 139. CONSENT FOR APPOINTMENT OF ADMINISTRATOR.**
The Department must get written consent of the deceased client's nearest relative, friend, caretaker or guardian to have an administrator appointed. (1-1-93)

140. -- 149. (RESERVED).

150. SELECTION OF ADMINISTRATOR.

A capable and trustworthy person must be selected to act as the administrator. The person selected must be acceptable to the deceased client's nearest relatives, friend, guardian, or caretaker. The administrator for public aid must serve without pay. He must agree to give the District Court and the Department a true and accurate account of payments. (1-1-93)

151. PETITION AND APPOINTMENT.

The Department must file its petition for appointment of administrator and the written consent with the District Court. (1-1-93)

152. ADMINISTRATOR REPORTING.

The administrator for public aid must provide a true and accurate account of payments made for the deceased AABD client. The report must include a listing of items purchased and expenses paid. The report must be made to the Department and the District Court. (1-1-93)

153. -- 155. (RESERVED).

156. AABD FOR THE AGED.

To qualify for AABD for the aged, a person must be age sixty-five (65) or older. The client must prove his age with a copy of his birth certificate, if available. If a copy of his birth certificate is not available, he must provide one (1) of the documents listed in the following Subsections 156.01 through 156.07 to prove his age. (1-1-93)

01. SSA. SSA records with the client's age. (1-1-93)
02. Public Record. School, church, marriage, military, employment, or state or federal census records with the client's age. (1-1-93)
03. Policy. Insurance policies with the client's age. (1-1-93)
04. Child's Birth Certificate. Birth certificate of client's child with client's age. (1-1-93)
05. Passport. Passport or naturalization papers with the client's age. (1-1-93)
06. Bible. Family Bible or other family records with the client's age. (1-1-93)
07. Other. Other proof of age if none of the documents listed above is available. (1-1-93)

157. AABD FOR THE DISABLED.

To qualify for AABD for the blind or disabled, a person must meet the definition of blindness or disability used by the SSA for RSDI and SSI benefits. Blindness and disability will be referred to as disability or disabled in this section. (1-1-93)

01. Disabled RSDI or SSI Recipient. A client meets the AABD disability requirement if he is entitled to receive either RSDI benefits or SSI benefits because of his disability. (1-1-93)
02. SSA Decision for Disabled. A decision a person is disabled, made by the SSA for RSDI or SSI, is binding on the Department. A decision a person is not disabled, made by the SSA for RSDI or SSI, is binding on the Department unless:
 - a. The client states his disabling condition is different from, or in addition to, his condition considered by SSA, and the client has not reapplied for SSI; or (1-1-93)
 - b. More than twelve (12) months have passed since the SSA made a final determination the client was not disabled, and the client states his condition has changed or become worse since that final determination, and the

client has not reapplied for SSI. (1-1-93)

03. Referral to SSA for Disability Decision. A client applying for AABD cash aid, who has income below the SSI level, must be referred to the SSA for a disability decision. A client who states he has new information or evidence about a prior SSA decision of ineligibility based on disability, must be referred to the SSA for a disability decision. (1-1-93)

04. Department Decision for Disabled. The Department must decide if a client meets the SSA definition of disability when the client is not eligible for, has not applied for, or is not receiving AABD cash aid, RSDI or SSI. The Department must decide disability if the SSA disability decision is not binding on the Department. (1-1-93)

05. Medicaid Continuation Right. A client meets the AABD disability requirement if he was receiving Medicaid, SSA decided he was no longer disabled, he is appealing the SSA decision with the SSA, and the SSA decision on his appeal is not final. (1-1-93)

06. Appeal and Review for Disabled. The client may appeal a finding he does not meet the SSA disability standards. If the client appeals the finding, the Department must review the finding. Results of the review must be sent to the Department's hearing officer. (1-1-93)

07. Grandfathered Client for Aid to The Permanently and Totally Disabled (APTD) or Aid to the Blind (AB). A client is disabled if he meets all current requirements for eligibility, except disability or blindness, and was eligible as disabled in December 1973, continues to meet the disability requirement in effect in December 1973, and the other eligibility requirements. (1-1-93)

158. -- 199. (RESERVED).

200. RESOURCES DEFINED.

Resources are cash, personal property, and real property. A client, or spouse, must have the right, authority, or power to convert the resource to cash. The client must have the legal right to use the resource for support and maintenance. (1-1-93)

201. RESOURCE LIMIT.

Countable resources must be two thousand dollars (\$2,000) or less, for a person to be AABD eligible. An AABD client and an AABD spouse must have countable resources of three thousand dollars (\$3,000) or less to be AABD eligible. (1-1-93)

202. RESOURCES AND CHANGE IN MARITAL STATUS.

A change in marital status changes the resource limit. The resource limit change is effective the month after married clients begin living separately. The resource limit change is effective the month after individual clients are married, divorced, separated, or one (1) spouse dies. (1-1-93)

203. (RESERVED).

204. FACTORS MAKING PROPERTY A RESOURCE.

Property of any kind, including cash, can be a resource in a month, if, as of the first (1st) moment of the month, it meets all criteria listed in the following Subsections 204.01 through 204.03. (1-1-93)

01. Ownership Interest. A client must have ownership interest in property for it to be counted as a resource. Property is not a resource if the client does not own a portion or all of the property. (1-1-93)

02. Legal Right to Spend or Convert Property. A client must have a legal right to spend or convert property to cash. Property is not a resource if the owner lacks the legal right to spend or convert property into cash. Physical possession of property is not needed if the owner has the legal ability to spend or convert the property to cash. (1-1-93)

a. Access Via an Agent. A client has the right to spend or convert property, even though it must be

through an agent, a representative payee, or guardian. (1-1-93)

b. Access only Via Litigation. Property is not a resource if there is a legal bar to sale of property. A client is not required to undertake litigation to sell or access property. The property is not a resource in a month if a legal bar exists the first (1st) moment of that month. (1-1-93)

c. Access Via Petition - Conservatorship. A conservatorship protects the client's ownership interest in funds. If the account can be used for the client's support and maintenance, the account is a resource. Absent evidence to the contrary, the account is available for support and maintenance and must be counted as a resource. The resource is available even if the client's agent must petition the court to withdraw funds for the client's care. (1-1-93)

03. Legal Ability to Use for Support. Property is not a resource if it can not legally be used for the owner's support and maintenance. (1-1-93)

205. RESOURCES COUNTED FIRST MOMENT OF MONTH.

Resources are counted the first (1st) moment of each calendar month and apply to the entire month. Resource changes have no effect until the first (1st) moment of the next month. (1-1-93)

206. COUNTING RESOURCES AND INCOME.

Items must not be counted as income and resources in the same month. Items received in cash or in-kind during a month are counted as income. Items held past the month received are counted as resources. (1-1-93)

207. RESOURCES DURING CHANGE-OF-PAYEE.

Resources are available during a change in payee or guardian. Unused funds, or other property, are resources while a bank or paying agency holds the funds during a change in payee. (1-1-93)

208. PROPERTY AS A RESOURCE OR INCOME.

When a client receives property as a gift or inheritance, the property is counted as income the month received. The property remaining is a resource the month following receipt. (1-1-93)

209. LIQUID RESOURCES.

Liquid resources are resources in cash or resources convertible to cash within twenty (20) working days. (1-1-93)

210. NONLIQUID RESOURCES.

Nonliquid resources are any resources, not in the form of cash, which cannot be converted to cash within twenty (20) workdays. (1-1-93)

211. EQUITY VALUE OF RESOURCES.

Equity value is the current market value of a resource minus any encumbrance on it. The current market value is the price the resource can be expected to sell for, on the open market, in the geographic area involved. An encumbrance is a legally binding debt against property. The encumbrance on the property does not prevent the property owner from selling to a third party. (1-1-93)

212. TYPES OF REAL OR PERSONAL PROPERTY OWNERSHIP.

Types of real or personal property ownership are listed in the following Subsections 212.01 through 212.05. (1-1-93)

01. Sole Ownership. Sole ownership of real or personal property means only one person may sell, transfer, or otherwise dispose of the property. (1-1-93)

02. Shared Ownership. Shared ownership of real or personal property means two or more people own it. (1-1-93)

03. Fee Simple Ownership. Fee simple ownership, which relates only to real property, is completely free of conditions imposed by others. (1-1-93)

04. Less Than Fee Simple Ownership. A life estate interest is ownership of limited duration. Equitable ownership can occur when a client does not have legal title to property. (1-1-93)

05. Property Rights Without Ownership. A leasehold conveys a time-limited control of property but not ownership. An incorporeal interest in property is a right to use the property but not to own it or sell it. (1-1-93)

213. SHARED OWNERSHIP RULE.

Except for checking and savings accounts and time deposits, the Department assumes each owner of shared property owns only his fractional interest in the property. The total value of the property is divided among the owners, in direct proportion to the ownership share held by each. Shared ownership rules are defined in the following Subsections 213.01 through 213.04. (1-1-93)

01. Joint Checking/Savings Accounts and Time Deposits. For a joint checking or savings account or a jointly-owned time deposit, assume all the funds in the account belong to the client, or in equal shares if there is more than one (1) client. (1-1-93)

02. Tenancy-In-Common. In tenancy-in-common, two (2) or more persons each has an undivided fractional interest in the whole property, for the duration of the tenancy. The interests are not necessarily equal. One (1) owner may sell, transfer, or otherwise dispose of his share of the property without permission of the other owners, but cannot take these actions with respect to the entire property. When a tenant-in-common dies, the surviving tenant has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, the deceased's interest passes to his estate or heirs. (1-1-93)

03. Joint Tenancy. In joint tenancy, each of two (2) or more persons has equal ownership interest and possession of the whole property for the duration of the tenancy. In effect, each owner owns all the property. Upon the death of one (1) of only two (2) joint tenants, the survivor becomes sole owner. On the death of one (1) of three (3) or more joint tenants, the survivors become joint tenants of the entire interest. (1-1-93)

04. Tenancy By The Entirety. A tenancy by the entirety can exist only between a married couple. The wife and husband own the entire property. The property can be sold only with the consent of both parties. If a marriage has been legally dissolved, the former spouses become tenants-in-common. One can sell his share without consent of the other. Upon the death of one (1) tenant by the entirety, the survivor takes the whole. (1-1-93)

214. DEEMING RESOURCES.

In addition to resources of a client, the resources of certain other persons are deemed available to the client. Deeming of resources occurs only from a spouse to a client, from a parent or spouse of a parent to a child client, from an essential person to a client, or from a sponsor to an alien client. Resource deeming is determined by the client's circumstances the first moment of the month. Subsections 214.01 through 214.04.c. list persons, other than the client, whose resources are counted as the client's. (1-1-93)

01. Spouse of Adult Client. If a client lives with a spouse, the resources of a client include those of the spouse. The resource limit is for a couple, if the spouse was a member of the household as of the first (1st) moment of the benefit month. (1-1-93)

a. The couple resource limit applies and both persons countable resources are considered. (1-1-93)

b. Pension funds the ineligible spouse has on deposit are excluded. Pension funds are held in an individual retirement account (IRA) or in work related pension plans. This includes KEOGH plans for self employed persons. (1-1-93)

c. Only one (1) home is excluded under the home exclusion. (1-1-93)

d. Only one (1) special-purpose vehicle is excluded under the vehicle exclusion. (1-1-93)

e. Only one (1) vehicle is excluded up to four thousand five hundred dollars (\$4,500) of the current market value. (1-1-93)

f. The household goods and personal effects of both spouses must combined in determining the two thousand dollar (\$2,000) value. (1-1-93)

g. Governmental retroactive cash payments to the client's ineligible spouse for medical or social services the spouse provided to the client, are excluded from resources for one (1) month. A retroactive payment is a payment made in a month after the month it was due. (7-1-93)

02. Resources of Parent(s) of Child Under Age Eighteen (18). If a child client, under age eighteen (18), is living with his parent or the spouse of his parent, their resources must be deemed to the child. Resources exceeding the single person resource limit are deemed to the child, if the child lives with one (1) parent. Resources exceeding the couple limit are deemed to the child, if the child lives with both parents. A stepparent's resources are not deemed to the child for Medicaid eligibility. A stepparent's resources are deemed to the child for AABD grant amount. Resources and exclusions of the child client, and the parent and spouse of the parent, are computed separately, with the following limited exclusions: (7-1-94)

a. Only one (1) home is excluded under the home exclusion. (1-1-93)

b. Only one (1) special-purpose vehicle is excluded under the vehicle exclusion. (1-1-93)

c. Only one (1) vehicle is excluded up to the four thousand five hundred dollar (\$4,500) current market value. (1-1-93)

d. Two thousand dollars (\$2,000), household goods and personal effects owned by the child are not counted. Two thousand dollars (\$2,000), household goods and personal effects owned by the parent and the parent's spouse are not counted. (1-1-93)

e. If more than one (1) child client lives in the household, the deemed resources are divided and deemed equally to the child clients. (1-1-93)

f. Resources of a stepparent are not deemed to the child for a child's Medicaid eligibility. (1-1-93)

g. Deeming from parent to child stops the month after the month of the child's eighteenth (18th) birthday, even if the child lives in his parent's household. (1-1-93)

h. Governmental retroactive cash payments to the client's ineligible parent for medical or social services the parent provided to the client, are excluded from resources for one (1) month. A retroactive payment is a payment made in a month after the month it was due. (7-1-93)

03. Resources of Essential Person of Client. If a client lives with an essential person, the resources of the essential person must be deemed to the client. The essential person's countable resources are combined with the client's countable resources. (1-1-93)

a. If the essential person is not the client's spouse, the single person resource limit is used. (1-1-93)

b. If the essential person is the client's ineligible spouse, the couple resource limit is used. (1-1-93)

04. Resources of Sponsor of Alien. An alien's resources includes those of his sponsor and of the sponsor's spouse, for five (5) years following an alien's admission into the U.S. for permanent residence. A sponsor's resources are not deemed to the alien for Medicaid eligibility. A sponsor's resources are deemed to the alien for AABD grant amount. (7-1-94)

a. If the sponsor does not have a spouse living with him, the sponsor's countable resources over the single person resource limit are deemed to the alien client. (1-1-93)

b. If the sponsor's spouse lives with him, the sponsor couple's resources over the couple resource limit are deemed to the alien client. (1-1-93)

c. If a person sponsors two (2) or more alien clients, the sponsor's deemed resources are divided and deemed equally to the alien clients. (1-1-93)

215. HOUSEHOLD FOR RESOURCE COMPUTATIONS.

For resource computations, a household is defined by its living arrangement. Clients in a household can live in a home owned or being purchased, the private household of another, rented housing, a board and room home, or a semi-independent group residential facility. Clients living in an institution are not a household. (1-1-93)

216. INCREASE IN VALUE OF RESOURCES.

An increase in the value of resources is counted the first (1st) moment of the following month. Resource value increases when a client replaces an excluded resource with a counted resource. (1-1-93)

217. DECREASE IN VALUE OF RESOURCES.

A decrease in the value of resources is counted the first (1st) moment of the following month. The resource value decreases when a client spends a resource to pay bills. Resource value decreases when a client replaces a counted resource with an excluded resource. (1-1-93)

218. UNKNOWN RESOURCES.

An asset is not a resource if the client is unaware of his ownership. The asset is a resource the month after discovery. (1-1-93)

219. -- 220. (RESERVED).

221. EXCLUDED RESOURCES.

Some resources do not count against the limit because they are excluded. Sections 222 through 292 describe resources and exclusion conditions. (1-1-93)

222. VEHICLES.

An automobile is any vehicle used for transportation. It includes cars, trucks, boats, snowmobiles, animal-drawn vehicles, and animals. The average trade-in value, in the most recently published NADA guide, is the current market value of an automobile. (1-1-93)

01. Vehicle Exclusion Regardless of Value. Vehicles owned by the client, or by a person with resources deemed to the client, may be excluded. One (1) vehicle is excluded, regardless of value if it is defined in Subsections 222.01.a. through 222.01.d. If more than one (1) automobile is owned, the exclusion applies in the manner most advantageous to the client. (1-1-93)

a. Employment. The vehicle is excluded if it is necessary for employment. (1-1-93)

b. Medical Problem. The vehicle is excluded if it is necessary for the treatment of a specific or regular medical problem. (1-1-93)

c. Handicapped. The vehicle is excluded if it is modified for operation by, or the transportation of, a handicapped person. (1-1-93)

d. Essential Daily Activities. The vehicle is excluded if it is necessary, because of climate, terrain, distance or similar factors, for the performance of essential daily activities. (1-1-93)

02. Alternate Vehicle Exclusion. If no vehicle is excluded regardless of value, one (1) vehicle is excluded up to a value of four thousand five hundred dollars (\$4,500). If the current market value exceeds four thousand five hundred dollars (\$4,500), the excess value counts as a resource. Current market value, not equity value, is used for this exclusion. (1-1-93)

03. Other Automobiles Not Excluded. The equity value of any other automobiles a client owns, not wholly or partly excluded, and not excluded under another rule, is a resource. (1-1-93)

223. BURIAL FUNDS EXCLUDED FROM RESOURCE LIMIT.

Burial funds up to one thousand five hundred dollars (\$1,500), set aside for the burial expenses of the client, are excluded from resources. One thousand five hundred dollars (\$1,500), set aside for the burial expenses of the client's spouse, are excluded from resources. This exclusion is separate from the burial space exclusion. The burial funds exclusion may include funds paid on burial spaces not excluded. Burial fund exclusion ends, if the client buys excluded life insurance or an irrevocable burial contract, to the extent it offsets the exclusion. An irrevocable burial trust is subject to different treatment for Medicaid than for AABD cash assistance. See Sections 691, 693, 705, and 706 for Medicaid treatment of an irrevocable burial trust. (1-1-96)T

01. **Burial Funds Defined.** Burial funds are used to prepare a body for burial. Burial funds are used for any services before burial. Expenses for burial include transportation of the body, embalming, cremation, flowers, clothing, and services of the funeral director and staff. (1-1-93)

02. **Burial Fund Restrictions.** Burial funds must be clearly designated for the client's or spouse's burial, cremation, or other burial-related expenses. Items used to bury the remains, such as the casket and burial space, do not fall under this exclusion. (1-1-93)

03. **Burial Fund Exclusion Reduced By Life Insurance.** The burial fund exclusion is reduced by the face value of any excluded life insurance policy on the client. Term life insurance with no cash value does not reduce the burial fund exclusion. The burial fund exclusion is reduced by any amount held in an irrevocable burial trust, burial contract, or other irrevocable plan for the client's burial expenses. The burial fund exclusion is not reduced, when the policy or contract is for an excluded burial space. (1-1-95)

04. **Face Value of Burial Insurance Not Counted.** Burial insurance is a contract. The proceeds of the insurance can only be used for the insured person's burial expenses. The face value of burial insurance policies must not be counted toward the one thousand five hundred dollar (\$1,500) limit, when computing the total face value of life insurance policies a client owns on each insured person. (1-1-93)

05. **Increases In Amount of Excluded Burial Funds.** Once the amount of designated burial funds equals one thousand five hundred dollars (\$1,500), including any reduction, the only additions to the amount excluded under the burial funds provision are appreciation and interest. Until one thousand five hundred dollars (\$1,500), including any reduction has been reached, additional amounts can be excluded under the burial funds provision, if the client designates them for burial expenses. Interest on excluded burial funds is not included in computing the one thousand five hundred dollars (\$1,500) maximum. (1-1-93)

06. **Burial Funds Must Be Kept Separate From Assets Not Burial Related.** To be excluded, burial funds must be kept separate from assets not burial related. Burial funds may be commingled with burial-related assets. Burial-related assets are burial funds, excluded and not excluded, and burial spaces including burial space purchase agreements. If burial funds are commingled with assets not burial related, the exclusion does not apply. (1-1-93)

07. **Burial Funds Remain Designated.** Once a fund is designated, it remains a burial fund until eligibility ends. Burial fund exclusion ends if the burial funds are used for another purpose. (1-1-93)

08. **Penalty For Misusing Burial Funds.** If the client does not get SSI, burial funds used for another purpose lose the exclusion. An overpayment must be recovered. If the client gets SSI, and is penalized by SSA because he used excluded burial funds for another purpose, his AABD payment must not be increased to compensate the SSA penalty. (1-1-93)

09. **Deeming Factors For Burial Funds.** The burial funds exclusion applies to deemed resources, designated as set aside for the burial expenses of the client or spouse. The deemor must be the client's spouse or parent. (1-1-93)

10. **Designation of Burial Funds.** Burial funds must be designated by a burial fund document, or a signed statement. A signed statement designating resources as set aside for burial must show all information listed in this Section. (1-1-93)

a. **The value of the burial funds.** (1-1-93)

- b. The owner of the burial funds. (1-1-93)
- c. The person for whom the burial the funds are set aside. (1-1-93)
- d. The form(s) in which the resources are held (burial contract, bank account, etc.). (1-1-93)
- e. The date the client first considered the funds set aside for the burial of the person specified. (1-1-93)
11. **Date of Intent to Designate Burial Funds.** The date the client claims he first set funds aside for burial will be accepted, unless there is evidence the funds were used and replaced after that date. Burial funds can be designated retroactively, back to the first day of the month the client intended the funds to be set aside. The client must confirm the designation in writing. (1-1-93)
12. **Effective Date of Exclusion of Burial Funds.** The exclusion is effective the month following the month the funds were set aside. The exclusion is effective the month of filing for the exclusion, if the funds were set aside before that month. (1-1-93)
13. **Designating Life Insurance as a Burial Fund.** The client can designate a countable life insurance policy as a burial fund. The client typically designates the policy, rather than the cash surrender value. The cash surrender value of a policy is payable only during the lifetime of the client, and cannot be used to bury the client. The cash surrender value is counted as the resource value of a life insurance policy. The cash surrender value is applied toward the burial fund limit when computing countable resources. When designating insurance as a burial fund, the client can also designate any dividends, on the life insurance policy, as a burial fund. Dividends are a separate resource and not considered as an increase in the cash surrender value. Dividends must be designated as burial funds separate from the life insurance policy. (1-1-93)
14. **Prepaid Burial Contracts.** A prepaid burial contract is an agreement. The buyer pays in advance for a burial. The seller agrees to furnish the burial upon the death of the buyer, or other designated individual. If a burial contract is revocable or salable, and any conditions for its liquidation do not present a significant hardship, it is a resource. Any portion of the contract for the purchase of burial spaces may be excluded, regardless of value. Some or all of any remaining value of the contract, may be excluded as burial funds. (1-1-93)
15. **Prepaid Burial Contract Is Not a Resource.** If a burial contract cannot be revoked, and cannot be sold without significant hardship, it is not a resource. Any burial fund portion of the contract reduces the one thousand five hundred dollar (\$1,500) burial funds exclusion. Any burial space portion of the contract has no effect on the burial funds exclusion. (1-1-93)
16. **Burial Insurance and Burial Trusts.** Prepaid burial contracts do not include burial insurance or burial trusts. If a client contracts burial services and the provider puts the funds in trust, this is a purchase and not a transfer of funds for a burial contract. (1-1-93)
17. **Conditions For Liquidation of Burial Contract.** A prepaid burial contract, even when revocable, may have conditions on its liquidation or revocation. If significant hardship exists, the contract is not a resource. Significant hardship may result from the conditions required for selling or revoking a contract. Significant hardship is an unrealistic demand on the buyer, such as having to move out of state. The Department makes the hardship determination. The hardship determination must be documented in the case file. If a condition creating hardship, or some other obstacle to liquidation, is not evident on the face of the contract, it is revocable or salable and counted as a resource. The burden is on the client to provide evidence to the contrary. (1-1-93)
18. **Value of Burial Contract as a Resource.** If a burial contract is a resource, its value is the amount payable to the owner upon revocation. If the contract is not revocable but is salable, its value is the cash market value. (1-1-93)
19. **Single-Purpose Contracts For Burial Expenses.** A single-purpose contract for burial expenses must include only services counted as burial funds. This contract is subject to, or reduces the amount of, the burial funds

exclusion. (1-1-93)

20. Life Insurance Funded Burial Contracts. A life insurance funded burial contract involves a client purchasing a life insurance policy on his own life. The client then makes a revokable or irrevocable assignment of the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract. The life insurance funded burial contracts are not burial insurance. Proceeds of a life insurance policy are the face value of the policy, plus any additions payable at maturity or death. This does not include dividends, cash surrender value, or interest. The burial contract, without the insurance policy assigned to fund it, has no resource value. The contract is not salable. It is a part of a larger arrangement involving life insurance assigned to another party as payment for contract goods and services. The value of the burial arrangement is the value of the life insurance policy. (1-1-93)

21. Life Insurance Dividends For Burial Contract. Life insurance policy dividends, as part of the value of the policy or the burial contract, are separate, counted resources. Dividends must be designated to qualify for the burial funds exclusion. If ownership of the life insurance policy has been irrevocably assigned, the dividend accumulations are also assigned. (1-1-93)

224. CONTRACTS FOR BOTH BURIAL SPACES AND BURIAL EXPENSES.

If a combined burial space and burial expense contract states which portion is revocable and which is not, the statement is accepted by the Department. If the contract states only the burial space purchase is irrevocable, the burial funds portion is revocable. The burial funds portion is subject to the burial funds exclusion. The amount paid for spaces and services in a combined contract, purchased in installments, is burial funds if the contract does not entitle the client to the spaces and services until paid in full. The amount paid for spaces and services in a combined contract, purchased in installments, is burial funds if the contract relieves the seller of the obligation to provide the spaces and services listed at the price listed until the contract is paid in full. Once the contract has been paid in full, the space and funds exclusions apply. (1-1-93)

225. BURIAL SPACE OR PLOT EXCLUSION.

A burial space, or agreement for the purchase of a burial space, held for the burial of the client, spouse, or other member of his immediate family is an excluded resource, regardless of value. Immediate family includes the client's spouse, his natural or adoptive parents and his natural, adoptive or step sisters, brothers, children, and their spouses. The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion. (1-1-93)

01. Burial Space Definition. A burial space is a burial plot, grave site, crypt, mausoleum, casket, urn, niche, or other repository normally used for the deceased's remains. The burial space includes reasonable improvements or additions to burial spaces. These include, but are not limited to, vaults, headstones, markers or plaques, burial containers for caskets, and arrangements to open and close the grave. A contract for care and maintenance of the grave site, sometimes referred to as endowment or perpetual care, can be excluded as a burial space. (1-1-93)

02. Burial Space Contracts. The burial space is an excluded resource if the contract lists all the burial spaces. The contract must include a value for each space or the total value of all the spaces. The contract must state no further payment is required. (1-1-93)

03. Multiple Burial Containers Not Excluded. A cemetery lot and a casket may be excluded for the same person. A casket and an urn must not be excluded for the same person. (1-1-93)

04. Spaces Held By Deemors Excluded. Spaces held by deemors, for the burial of a client, spouse, and any member of the client's immediate family are excluded. Spaces held by an alien sponsor, or essential person, for his own burial are excluded only if the sponsor is a member of the client's immediately family. (1-1-93)

05. Agreement to Purchase a Burial Space. An agreement to purchase a burial space is a contract with a burial provider. The contract is for a burial space held for the client or a member of his immediate family. If the relative's relationship to the client is by marriage only, the marriage must be in effect to apply the burial space exclusion. (1-1-93)

06. Burial Space Held For a Client. A burial space is held for a client when someone has title to, or owns, a burial space for the client. A burial space is held for a client, when a contract is made with a funeral service company for spaces for the client's burial. Until the purchase price is paid in full, a burial space is not held for a client under an installment sales contract, if the client does not own the space, does not have the right to use the space, and the seller is not obligated to provide the space. Until all payments are made on the contract, the amounts paid are burial funds. (1-1-93)

226. -- 231. (RESERVED).

232. HOUSEHOLD GOODS DEFINITION.

Household goods are items of personal property normally found in the home. The items must be used for maintenance, use, and occupancy of the home. Household goods include, but are not limited to, furniture, appliances, television sets, carpets, cooking and eating utensils, and dishes. (1-1-93)

233. PERSONAL EFFECTS DEFINITION.

Personal effects are items worn or carried by a client, or items having an intimate relation to the client. They include, but are not limited to, clothing, jewelry, personal care items, and prosthetic devices. Personal effects include educational or recreational items such as books, musical instruments, or hobby materials. (1-1-93)

234. PERSONAL PROPERTY DEFINITION.

Personal property is any property not real property. Personal property includes cash, jewelry, household goods, tools, life insurance policies, and automobiles. (1-1-93)

235. FULLY EXCLUDED HOUSEHOLD GOODS AND PERSONAL EFFECTS.

One (1) wedding ring and one (1) engagement ring, per client, are excluded regardless of value. Prosthetic devices, wheelchairs, hospital beds, dialysis machines, and items required by a person's physical condition are excluded, regardless of value. The items required by the client's physical condition must not be used primarily by other members of the household. (1-1-93)

236. EXCLUDED HOUSEHOLD GOODS AND PERSONAL EFFECTS.

Two thousand dollars (\$2,000) equity value of household goods and personal effects is not counted toward the resource limit. Fully excluded items are not counted as part of the equity value. Equity value more than two thousand dollars (\$2,000) is counted toward the resource limit. The client's statement of value must be used to establish the value of household goods and personal effects. (1-1-93)

237. REAL PROPERTY DEFINITION.

Real property is land, including buildings or immovable objects attached permanently to the land. Real property is counted as a resource unless excluded. (1-1-93)

01. Fee Simple Real Property Ownership. Fee simple ownership is complete legal title to real property. The fee simple owner has absolute control of the property during his lifetime. Upon his death, property held in fee simple can pass to the owner's heirs. Fee simple ownership may exist with jointly or solely owned property. (1-1-93)

02. Equitable Real Property Ownership. Equitable ownership exists without legal title to property. It can exist when another party has legal title, or when no one has legal title. (1-1-93)

03. Real Property Life Estate. A life estate gives persons property rights during their lifetimes. A life estate owner owns the property only for the duration of the life estate. A life estate is a form of legal ownership. It is created through a deed or will or by operation of law. Unless the will or deed places restrictions on the life estate owner, the owner has the right to possess, use, and obtain profits from the property. If there are no restrictions, the owner may sell his life estate interest. A life estate in home property is an excluded resource. A "remainderman" is a person with ownership interest in the property, who cannot possess and use the property until the life estate has ended. The owner can sell only his interest in the life estate. The life estate owner cannot sell the interest of the remainderman. A life estate can give property to one (1) person for life (life estate owner) and to one (1) or more remaindermen at the end of the life estate. Unless restricted, the remainderman is free to sell his interest in the property, even before the life estate ends. (1-1-93)

04. Leasehold as Life Estate. A leasehold is not ownership. It gives a client use and possession of property for a precise term at an agreed rent. Any lease for life must be reviewed by the Department for resource value. (1-1-93)

05. Incorporeal Interests as Resources. Several types of real property rights are called incorporeal interests. They do not convey ownership of the physical property itself. They convey the right to use property but not to possess it. These rights encompass mineral and timber rights and easements. Incorporeal interests must be evaluated as resources. (1-1-93)

238. HOME EXCLUDED AS RESOURCE.

A client's home, regardless of value, is an excluded resource. (1-1-93)

01. Home Definition. A client's home is property he owns, serving as his principal place of residence. It includes the house, the land where the house is located, and related buildings on the land. A home may be either real or personal property, fixed or mobile, and located on land or water. A home includes, but is not limited to, houses, cooperative and condominium apartments, mobile homes, motor homes, and houseboats. (1-1-93)

02. Principal Place of Residence. A client's principal place of residence is the place the client considers his principal home. If the client is absent from his home, it is still his principal place of residence, if he intends to return. The client, or person acting for him, must state, in writing, he intends to return. The principal place of residence can be real or personal property. The principal place of residence can be fixed or mobile. The principal place of residence can be located on land or water. If a client leaves his home to live in an institution, and states his intent to return to his home when he leaves the institution, the home remains his principal place of residence. (1-1-93)

03. Client Owns the Land But Not the Shelter. For purposes of excluding the land where the shelter is located, the client does not need to own the shelter itself. (1-1-93)

04. Home Ownership. A client may gain an ownership interest in his home by making mortgage payments, making or paying for additions to a shelter, or making improvements to a shelter. (1-1-93)

05. Adjoining Property Exclusion. The home exclusion applies to the plot of land where the home is located and any land that adjoins it. Land adjoins the home plot if it is not completely separated by land owned by someone other than the client or spouse. Easements and public rights of way do not separate other land from the home plot. The home exclusion applies to all buildings on excluded land. (1-1-93)

06. Property No Longer the Principal Place of Residence. Property ceases to be the principal place of residence the date the client, having left it, does not intend to return. On this date, the property is no longer excluded as the home. If the property is not excluded under another rule, it must be counted as a resource the first (1st) moment of the following month. Absence from the home does not change the status of the home as an excluded resource, so long as the client intends to return home. The client's signed statement of intent to return is accepted, unless it is self-contradictory. If the client leaves the home, without the intent to return, the property remains an excluded resource only if the client's spouse or dependent relative continues to live there. The property is exempted if sale of the property would cause undue hardship. (1-1-93)

239. SALE OF EXCLUDED HOME AND REPLACEMENT.

When a client sells an excluded home, the proceeds of the sale are excluded resources, if the client plans to buy another excluded home within three (3) full calendar months. (1-1-93)

01. Installment Sales Contract. If the client receives resources under an installment contract, the contract is an excluded resource if the client uses the entire amount to buy another excluded home. The principal of an installment payment the client receives is an excluded resource if the client uses the payment toward purchase of the excluded home. The client must buy the other excluded home, or use the installment payment toward the excluded home, within three (3) full calendar months of receiving payment. (7-1-96)

02. Proceeds From Sale of an Excluded Home. If the client is paid in a lump sum, the proceeds are the net amount paid to the seller. If the client is paid in installments, the proceeds are the down payment and any

following payments less interest. (1-1-93)

03. Allowable Uses of Proceeds From Sale of Excluded Home. The use of proceeds to buy another excluded home, includes purchase costs of the home. Purchase costs include, but are not limited to, the down payment, settlement costs, loan processing fees and points, moving expenses, and mortgage payments. Purchase costs include necessary repairs to the new home, known and documented before occupancy. (1-1-93)

04. Timely Use of Proceeds From Sale of Excluded Home. Proceeds from the sale of an excluded home must be used to replace the home within three (3) full calendar months. Three (3) calendar months means by midnight the last day of the third month, after the month the proceeds are received. This exclusion includes obligating the proceeds by contract. (1-1-93)

05. Lump Sum Home Replacement Proceeds Not Used Timely. The exclusion of the unused home replacement funds will be revoked retroactively, to the date of their receipt, if the funds are not used within the time limits. If the client is not eligible, AABD payments for the three (3) month period are an overpayment. (1-1-93)

06. Home Replacement Installment Payment Not Used Timely. The exclusion of the installment contract, and any unused portion of installment payments, must be revoked retroactively to the date the unused proceeds were received, if a home replacement installment payment is not used within the time limits. If the client is not eligible, AABD payments for the three (3) month period are an overpayment. (1-1-93)

07. Reinstatement of Home Replacement Exclusion After It Is Revoked. The exclusion of an installment contract, once revoked, must be reinstated if the client uses the entire principal portion of a subsequent installment payment to purchase another excluded home. The home must be purchased within three (3) full calendar months of receiving the installment payment. Reinstatement of the exclusion is effective the date the client signs a new statement of intent. The new exclusion affects the resources determination for the next month. (1-1-93)

240. REPLACEMENT OF EXCLUDED RESOURCES.

Cash and in-kind payments for replacement or repair of lost, damaged, or stolen excluded resources, are excluded resources for nine (9) months from the date received. This exclusion can be extended for cash receipts, up to an additional nine (9) months. The extension can be made if, for the first nine (9) months, circumstances beyond the client's control prevent repair or replacement of the lost, damaged or stolen property and keep the client from contracting for repair or replacement. Interest earned by funds excluded under this provision is excluded from resources. The interest is excluded only for the period the funds are excluded from resources. This exclusion applies to funds received for the purchase of temporary housing. (1-1-93)

241. UNDUE HARDSHIP EXCLUSION FROM SALE OF JOINTLY-OWNED REAL PROPERTY.

A client's ownership interest, in jointly-owned real property, is an excluded resource, as long as sale of the property will cause undue hardship to a co-owner. Undue hardship results if a co-owner uses the property as his principal place of residence, would have to move if the property were sold, and has no other readily available housing. (1-1-93)

242. PROPERTY RIGHTS WITHOUT ABILITY TO SELL.

A client may have rights to property, without having the right to sell the property. The client may have the ability to sell the right to use, or possess, the property. If the client does not have the right to sell the property, it is not a resource. (1-1-93)

243. RESTRICTED ALLOTTED INDIAN LANDS EXCLUDED.

Restricted allotted land, owned by a client who is of Indian descent from a federally recognized Indian tribe, is an excluded resource if the client cannot sell, transfer or otherwise dispose of it without permission from other clients, his tribe or an agency of the Federal Government. (1-1-93)

244. RESOURCES ASSOCIATED WITH PROPERTY.

Resources associated with real property are listed in Subsections 244.01 through 244.06. The resources are counted as real property. (1-1-93)

01. Mineral Rights. Mineral rights are ownership interest in natural resources such as coal, oil, or natural gas, normally extracted from the ground. A client can have a mineral right resource without real property

ownership. (1-1-93)

02. Timber Rights. Timber rights permit one party to cut and remove freestanding trees from the property of another party. A client can have a timber right resource without real property ownership. (1-1-93)

03. Easements. An easement gives one party the right to use the land of another party for a special purpose. (1-1-93)

04. Leaseholds. A leasehold gives one party control over certain property of another party for a specified period. A lease for life can create a life estate. (1-1-93)

05. Water Rights. Water rights give the owner of river front or shore front property the right to access and use the adjacent water. (1-1-93)

06. Remainder Interests. When the owner of property gives it to one party in the form of a life estate, and selects a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property. (1-1-93)

07. Sale of Natural Resources. An outright sale of timber, minerals and other natural resources by the owner of the land or by the owner of rights to use the land is conversion of a resource. The proceeds are a resource, not income. (7-1-93)

245. RESOURCES ESSENTIAL FOR SELF-SUPPORT EXCLUDED.

Resources are excluded as essential to self-support, if they fall into one (1) of three (3) categories. The first (1st) category is property excluded regardless of value or rate of return. The second (2nd) category is property excluded up to six thousand dollars (\$6,000) equity, regardless of rate of return. The third (3rd) category is property excluded up to six thousand dollars (\$6,000) equity, if it produces a six percent (6%) rate of return. Resources excluded under this rule must be in current use in the type of activity described. If not in current use, there must be a reasonable expectation the required use will resume. Liquid resources are not property essential to self support, unless used as part of a trade or business. (1-1-93)

01. Essential Property Current Use Rule. Property, including property used by a client as an employee, must be in current use in the type of activity that qualifies it as essential to be excluded as essential to self-support. Current use is evaluated on a monthly basis. Property not in current use can be excluded as essential to self-support only if it has been in use, and there is a reasonable expectation the use will resume. Resumption of use must be expected within twelve (12) months of last use. The twelve (12) month period can be extended for an additional twelve (12) months if the lack of use is due to a disabling condition. (1-1-93)

02. No Intent To Resume Activity For Self-Support. If the client does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use. (1-1-93)

03. Change of Intent. The exclusion of property, because the client intends to resume self-support activity, ends on the date the client no longer intends to resume the activity. Unless excluded under another rule, the property is a counted resource the following month. (1-1-93)

04. Property Excluded Regardless of Value or Rate of Return. Subsections 245.04.a. through 245.04.c. lists requirements for property exclusion regardless of value or rate of return. (1-1-93)

a. Trade or business property. Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return. (1-1-93)

b. Government permits. Government permits represent authority granted by a government agency to engage in income producing activity. Examples are commercial fishing permits granted by a State Commerce Commission and tobacco crop allotments issued by the U.S. Department of Agriculture. (1-1-93)

c. Personal property used by employee. Personal property used by an employee for work is excluded from resources. Excluded items include tools, safety equipment, uniforms, and reference books. (1-1-93)

05. Property Excluded Up to Six Thousand Dollars (\$6,000) Equity, Regardless of Rate of Return. Property not used for business but essential to self-support can be real or personal property. It must produce goods or services essential to daily activities. The property must be used to grow produce or livestock solely for the client's home consumption. A vehicle, such as a garden tractor, used solely in a nonbusiness self-support activity, is not counted as a resource. The exclusion does not include any vehicle that qualifies as an automobile. Equity value over six thousand dollars (\$6,000) is counted as a resource. (1-1-93)

06. Property Excluded Up to Six Thousand Dollars (\$6,000) Equity, if It Produces a Six Percent (6%) Rate of Return. Subsections 245.06.a. through 245.06.e. list requirements for property exclusion up to six thousand dollars (\$6,000) equity if it produces a six percent (6%) of rate of return. (1-1-93)

a. Current use exclusion. Essential property is excluded up to six thousand dollars (\$6,000) equity if it produces a six percent (6%) rate of return. Up to six thousand dollars (\$6,000) of the equity value of income producing property, not used in a business, can be excluded from resources. The property must produce a net annual return equal to at least six percent (6%) of the excluded equity. Any property equity value in excess of six thousand dollars (\$6,000) is not excluded under this rule. (1-1-93)

b. More than one (1) income producing property. If a client owns more than one (1) piece of income producing property, the six percent (6%) return requirement applies to each. The six thousand dollars (\$6,000) equity value limit applies to the total equity value of all the properties meeting the six percent (6%) return requirement. If all properties meet the six percent (6%) test, but the total equity value exceeds six thousand dollars (\$6,000), the portion of the total equity value in excess of six thousand dollars (\$6,000) is not excluded. (1-1-93)

c. Current use exclusion rate of return less than six percent (6%). The current use exclusion can apply if the property produces less than a six percent (6%) return. The lower return must be for reasons beyond the client's control such as crop failure or illness. There must be a reasonable expectation the property will again produce a six percent (6%) return. If the property is not expected to again produce a six percent (6%) return, the equity value is not excluded under this rule. (1-1-93)

d. Earnings decline beyond client's control. If the earnings decline is for reasons beyond the client's control, up to twenty-four (24) months can be allowed for the property to resume producing a six percent (6%) return. The twenty-four (24) month period begins with the first (1st) day of the tax year, following the one in which the return dropped to below six percent (6%). (1-1-93)

e. Ending the current use exclusion. If evidence shows the earnings decline is for reasons beyond the client's control, the client has up to twenty-four (24) months from the end of the tax year, in which the earnings went below six percent (6%), to meet the six percent (6%) requirement. If the property still is not producing a six percent (6%) return at the end of the twenty-four (24) month extension, the resource exclusion must end the month following the month in which the twenty-four (24) month period ends. (1-1-93)

246. RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT (PASS) EXCLUDED.

PASS allows blind and disabled clients to set aside income and resources necessary for the achievement of its goals. Resources set aside as part of an approved PASS are excluded. The PASS disregard must not be applied to resources unless the client would be ineligible due to excess resources. To disregard resources, the PASS must show how resources the client has or will receive under the plan, will be used to obtain the PASS goal. The PASS must show how the disregarded resources will be identified from the client's other resources. The PASS must list items or activities requiring savings or purchases and the amounts the client anticipates saving or spending. The PASS must show a specific target date to achieve the objective. (1-1-93)

247. -- 255. (RESERVED).

256. RETROACTIVE SSI AND AABD BENEFITS.

Retroactive SSI and AABD benefits are issued in any month after the calendar month for which they are paid. SSI or AABD benefits for January, issued in February, would be counted as retroactive. (1-1-93)

257. RETROACTIVE RSDI BENEFITS.

Retroactive RSDI benefits are issued more than a month after the calendar month for which they are paid. RSDI benefits for January issued in February are not retroactive, but RSDI benefits for January issued in March would be counted as retroactive. (1-1-93)

258. SIX-MONTH EXCLUSION OF RETROACTIVE AABD, SSI AND RSDI BENEFITS.

The unspent portion of retroactive AABD, SSI and RSDI benefits is excluded from resources. The exclusion lasts for six (6) calendar months, following the month the client receives the benefits. Interest earned by funds excluded under this rule is not excluded from income. (1-1-93)

259. GERMAN REPARATIONS PAYMENTS EXCLUDED.

Unspent German reparations payments are excluded from resources. German reparations payments are made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution, or German Restitution Act. These payments may be made periodically or in a lump sum. Interest earned by German reparations payments saved by the client is not excluded from income by this rule. (1-1-93)

260. FEDERAL DISASTER ASSISTANCE EXCLUDED.

Unspent assistance received under The Disaster Relief and Emergency Assistance Act of 1974 (Public Law 930-288) is excluded from resources. Unspent assistance received under Federal statute because of a major disaster, declared by the President of the United States, is excluded from resources. To be excluded from resources under this rule, the funds in question must be excluded from income. Interest earned on funds excluded under this rule is excluded from income and from resources. This exclusion does not apply to funds received because of personal injury. (1-1-93)

261. CASH TO PURCHASE MEDICAL OR SOCIAL SERVICES EXCLUDED.

Cash paid by a recognized medical or social services program, for the client to purchase medical or social services, is not a resource for one (1) calendar month following receipt. The cash must not be repayment for a bill already paid. (1-1-93)

262. AGENT ORANGE SETTLEMENT PAYMENTS EXCLUDED.

Unspent Agent Orange settlement payments are excluded from resources. Interest earned by unspent Agent Orange settlement payments is excluded from resources, but not from income. (1-1-93)

263. STOCK IN ALASKA REGIONAL OR VILLAGE CORPORATIONS EXCLUDED.

Stock held by Alaska natives in regional or village corporations is inalienable for a twenty (20) year period under Sections 7(h) and 8(c) of the Alaska Native Claims Settlement Act. Until the period expires on January 1, 1992, the stock is not a resource because its ownership is not transferable. After that time, the stock is an excluded resource. (1-1-93)

264. VICTIMS' COMPENSATION PAYMENTS EXCLUDED.

Unspent payments, from a fund set up by a state to aid victims of crime, are excluded from resources for nine (9) months. The client must prove the payment was compensation for expenses incurred, or losses suffered, as the result of crime. Interest earned on unspent victims' compensation payments is not excluded from income or resources by this rule. (1-1-93)

265. AUSTRIAN SOCIAL INSURANCE PAYMENTS EXCLUDED.

Austrian General Social Insurance Act payments based, in whole or part, on wage credits granted under paragraphs 500 through 506 of the Act, are excluded from resources. (1-1-93)

266. RADIATION EXPOSURE COMPENSATION ACT PAYMENTS EXCLUDED.

Payments made under the Radiation Exposure Compensation Act (P.L. 101-426) are excluded from resources. (1-1-93)

267. STATE OR LOCAL RELOCATION ASSISTANCE PAYMENTS EXCLUDED.

Unspent relocation assistance payments, from a state or local government, received through April, 1994 are excluded from resources, for nine (9) months. The last month this resource exclusion applies is April, 1994. Payments received in August, 1990 through April, 1991 can be excluded from resources under this rule beginning May, 1991, but only

for the months left in the nine (9) month period, after the month of receipt. Payments received after July 1993 cannot be excluded under this rule for the full nine (9) month period, but only through April 1994. Interest earned on unspent relocation assistance payments is not excluded from income or resources. (1-1-93)

268. TAX ADVANCES AND REFUNDS RELATED TO EARNED INCOME TAX CREDITS EXCLUDED.

An unspent Federal tax refund, or payment made by an employer, related to Earned Income Tax Credits (EITCs) is excluded from resources, for the month, following the month, the refund or payment is received. Interest earned on unspent tax refunds related to EITCs is not excluded from income or resources. (1-1-93)

269. IDENTIFYING EXCLUDED FUNDS COMMINGLED WITH FUNDS NOT EXCLUDED.

Excluded funds must be identified to remain excluded. Excluded funds do not need to be kept physically apart from other funds, except for burial funds. When withdrawals are made from an account with commingled funds in it, the Department assumes funds not excluded are withdrawn first. This leaves as much of the excluded funds in the account as possible. (1-1-93)

01. Effect of Account Transactions. If excluded funds are withdrawn, the excluded funds left in the account can be added to, but only by funds under the same exclusion, and any excluded interest. (1-1-93)

02. Interest on Excluded Funds. If interest on excluded funds is excluded, the percentage of excluded interest is the same as the percentage of excluded funds in the account. The percentage is calculated at the time interest is posted. The excluded interest is added to the excluded funds in the account. (1-1-93)

270. -- 275. (RESERVED).

276. TRUST AS RESOURCE.

A trust is a right of property given by a trustor or grantor. The trustee holds legal title to trust property and manages it for the beneficiary. The beneficiary does not have legal title but does have an equitable ownership interest. (1-1-93)

01. Trust Funds and Resources Rule. A trust is a resource to a client legally empowered to revoke the trust, and use the principal for his own support and maintenance. The client's ability to revoke a trust depends on the terms of the trust agreement and State law. If a trust is not revocable, the trust is not a resource. The trust is a resource to anyone who can revoke the trust and access the principal, whether or not he actually does so. Payments from the principal are not income. They are the conversion of a resource. (1-1-93)

02. Trust Components. Subsections 276.02.a. through 276.02.f. list components and terms associated with trusts. (1-1-93)

a. Trustee. A trustee is a person holding legal title to property for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for his own benefit. (1-1-93)

b. Trust Beneficiary. A trust beneficiary is a person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it. (1-1-93)

c. Trustor/Grantor. A trustor or grantor is a person who creates a trust. (1-1-93)

d. Totten Trust. A Totten trust is a trust in which a trustor makes himself trustee of his own funds for the benefit of another. The trustor or trustee can revoke a Totten trust at any time. If the trustor or trustee dies without revoking the trust, the principal reverts to the beneficiary. (1-1-93)

e. Trust Principle. The trust principle is the amount placed in trust by the trustor, plus any trust earnings paid into the trust and left to accumulate. (1-1-93)

f. Trust Earnings. Trust earnings are amounts earned by trust property. They may be interest, dividends, royalties, or rents. These earnings are unearned income to the person legally able to use them for personal support and maintenance. (1-1-93)

277. RETIREMENT OR PENSION FUNDS DEFINITION.

Retirement funds are annuities or work-related plans for providing income when employment ends. (1-1-96)T

01. Retirement Funds as Resources. A retirement fund, owned by a client, is a resource if he has the option of withdrawing a lump sum, even though he is not yet eligible for periodic retirement payments. If the client is eligible for periodic retirement payments, the fund is not a countable resource. Periodic payments are income. The fund is subject to resources counting rules in the month following the month in which it first becomes available. Subsections 277.01.a. through 277.01.c. list retirement fund conditions. See Subsection 688.02 for counting annuities as asset transfers for Medicaid. (1-1-96)T

a. Termination of employment. A retirement fund is not a resource if a client must end employment in order to obtain any payment. (1-1-93)

b. Fund becomes available. A retirement fund is a resource the month following the month it becomes available for withdrawal. A delay in payment for reasons beyond the client's control does not mean the retirement fund is not a resource. The client is legally able to obtain the money. It is a nonliquid resource. (1-1-93)

c. Claim for periodic payment denied. If a client is denied a claim for periodic retirement payments, but can withdraw the funds in a lump sum, the fund's lump sum value must be counted as resources, for the month following the month the client receives the denial notice. (1-1-93)

02. Periodic Retirement Benefits. Periodic retirement benefits are payments to a client at regular intervals, resulting from a retirement fund. The benefits are counted as unearned income the month received and resources the next month. (1-1-93)

03. Value of Retirement Fund. The value of a retirement fund is the amount of money a client can currently withdraw from the fund. If there is a penalty for early withdrawal, the fund's value is the amount available to a client after penalty deduction. However, any taxes due are not deductible in determining the fund's value. (1-1-93)

04. Filing For Retirement Benefits. If a client is eligible for periodic retirement benefits, she must apply for those benefits to be eligible for AABD. If she has a choice between periodic benefits and a lump sum, he must choose the periodic benefits. (1-1-93)

05. Deeming Exclusion For Retirement Fund. If an ineligible spouse, parent, spouse of parent, or a sponsor owns a retirement fund, it is excluded from the deeming process. (1-1-93)

278. INHERITANCES AS RESOURCES.

An inheritance is cash, a right, or noncash items received as the result of someone's death. Cash or noncash items in an inheritance are income the month received and a resource the following month. A contested inheritance is not counted as a resource. (1-1-96)T

01. Ownership Interest In an Estate. The client has ownership interest in an estate not probated, if documents show the client is an heir to property of a deceased. The client has ownership interest in an estate not probated, if he uses a deceased's property or receives income from it. The client has ownership interest in an estate not probated, if documents show, or the client states, a relationship between himself and the deceased which, under State intestacy laws, awards the client a share in the distribution of the deceased's property. Until the inheritance can be used to meet the client's needs, it is not a resource or income. (1-1-96)T

02. Right to Sell Inheritance as a Resource. The right to an inheritance is a resource in the month the client sells the right. If the client gives up, transfers or sells the right to an inheritance, for less than fair market value, he may be subject to the Medicaid asset transfer penalty in Section 682. (1-1-96)T

279. LIFE INSURANCE AS A RESOURCE.

A life insurance policy is a resource if it has a cash surrender value. It is a resource in the amount of the cash surrender value. A life insurance policy is an excluded resource if its face value, plus the face value of all other life insurance policies the client owns on the same insured person, total one thousand five hundred dollars (\$1,500) or

less. If the combined face values of all life insurance policies a client owns on a given insured person exceeds one thousand five hundred dollars (\$1,500), the cash surrender value of the policies is a resource to the client. A client ineligible from excess life insurance can convert to a policy of lower value. The client is not eligible until the month after the month the policy is converted. Subsections 279.01 through 279.07 list life insurance terms and descriptions. (1-1-93)

01. **Face Value of Life Insurance Policy.** The face value is the amount of basic death benefit contracted for at the time the policy is purchased. A policy's face value does not include any dividend addition added after the policy is issued. Face value does not include additional sums payable in the event of accidental death or because of other special provisions. Face value does not include the amount of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other. (1-1-93)

02. **Cash Surrender Value of Life Insurance Policy.** A policy's cash surrender value is a form of equity value it gains over time. The owner of a policy can get the cash surrender value only by turning the policy in before it matures or the insured dies. A loan against a policy reduces its cash surrender value. (1-1-93)

03. **Dividends.** The insurer may pay a share of any surplus company earnings to the policy owner as dividends. (1-1-93)

04. **Dividend Additions.** Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and cash surrender value. The table of cash surrender values with a policy does not reflect the added cash surrender value of any dividend additions. (1-1-93)

05. **Dividend Accumulations.** Dividend accumulations are dividends the policy owner has received but left in the custody of the insurer to gain interest. Dividends are not a value of the policy. The owner can obtain them at any time without affecting the policy's face value or cash surrender value. (1-1-93)

06. **Supplementary Contract.** A supplementary contract is not a life insurance policy. It is an agreement when the policy matures or the insured dies, the proceeds are paid not in a lump sum, but in another manner elected by the client, usually as periodic payments. Supplementary contracts are treated as an IRA or other type of retirement fund. (1-1-93)

07. **Burial Insurance.** A burial insurance policy is a contract whose terms prevent the use of its proceeds for anything other than payment of the insured's burial expenses. If the owner has access to a cash surrender value, the policy is not burial insurance for AABD purposes. (1-1-93)

280. CHECKING/SAVINGS ACCOUNTS.

The person designated as owner in the account title is assumed to own all the funds in the account. If there is no evidence to the contrary, assume the person shown as owner in the account title has the legal right to withdraw funds from the account. An agent's right to withdraw funds is the same as the owner's right to withdraw them. (1-1-93)

281. CONSERVATORSHIP.

If court order under state law specifically requires funds be made available for the care and maintenance of a client, absent evidence to the contrary, they are the client's resource. This is true even if the client or his agent is required to petition the court to withdraw funds for the client's care. (1-1-93)

282. TIME DEPOSITS.

A time deposit is a contract between an individual and a financial institution. The individual agrees to leave funds on deposit for a specified period and the financial institution agrees to pay interest at a specified rate for that period. Certificates of deposit (CDs) and savings certificates are common forms of time deposits. Time deposits are resources. Withdrawal of a time deposit before the specified period expires incurs a penalty, usually imposed against the principal. This penalty does not prevent the time deposit from being a resource. Early withdrawal reduces the value of the resource by the amount of the penalty. On rare occasions, the terms of a time deposit will prohibit early withdrawal. (1-1-93)

01. **Early Withdrawal of Time Deposit Prohibited.** If the owner of a time deposit cannot under any circumstances withdraw it before it matures, it is not a resource. It becomes a resource on the date it matures, and may

affect countable resources for the following month. If the owner has no access to the interest before the deposit matures, the interest is not a resource and is income in the month the deposit matures. (1-1-93)

02. Time Deposit Value as a Resource. The resource value of a time deposit is the amount the owner would receive upon withdrawing it, excluding interest paid that month. This is the amount originally deposited, plus interest for all but the current month, less any penalty for early withdrawal. (1-1-93)

283. STOCKS AS RESOURCES.

Shares of stock represent ownership in a business corporation. Their value shifts with demand and may vary widely. This Section applies to all stocks, including preferred stocks, warrants and rights and options to purchase stocks. Absent evidence to the contrary, each owner owns an equal share of the value of the stock. Absent evidence to the contrary, the owner of shares of stock can sell them at will at current value. Broker fees do not reduce the value stocks have as resources. (1-1-93)

01. Publicly Traded Stocks Resource Value. The current market value of a stock is its closing price on the last business day of the preceding month. (1-1-93)

02. Resource Value of Stock Not Publicly Traded. The stock of some corporations is held within close groups and traded very infrequently. The sale of such stock is often handled privately and subject to restrictions. As a rule, it cannot be converted to cash within twenty (20) working days. The client must prove the value of such stock. (1-1-93)

284. MUTUAL FUND SHARES.

A mutual fund is a company whose primary business is buying and selling securities and other investments. Shares in a mutual fund represent ownership in the investments held by the fund. Mutual Fund Shares are resources. (1-1-93)

285. U.S. SAVINGS BONDS.

U.S. Savings Bonds are debts of the Federal Government. Unlike other government bonds, they are not transferable. They can only be sold back to the Federal Government. U.S. Savings Bonds cannot be redeemed for six (6) months after the issue date specified on the face of the bond. U.S. Savings Bonds are not resources during the six (6) month mandatory retention period. They are resources as of the first moment of the seventh month. A U.S. Savings Bond is not a resource to a client if a co-owner has and will not relinquish physical possession. (1-1-93)

286. MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS.

Municipal, corporate, and government bonds are negotiable and transferable. Their value as a resource is their current market value. The redemption value, available only at maturity, is not counted. These bonds are described in Subsections 286.01 through 286.04. (1-1-93)

01. Bond. A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferrable. (1-1-93)

02. Municipal Bond. A municipal bond is the obligation of a state or a locality (county, city, town, village or special purpose authority such as a school district). (1-1-93)

03. Corporate Bond. A corporate bond is the obligation of a private corporation. (1-1-93)

04. Government Bond. A government bond, as distinct from a U.S. Savings Bond, is a transferrable obligation issued or backed by the Federal Government. (1-1-93)

287. REAL ESTATE AND OTHER CONTRACTS AS RESOURCES PRIOR TO SETTLEMENT.

The resource value of a promissory note, loan, or property agreement, is its outstanding principal balance, unless the client furnishes reliable evidence it has a lower current market value. When a client sells real estate by a contract, he owns the real estate and the contract until the settlement of the sale is completed. The real estate is not a resource because the client cannot convert it to food or shelter. The real estate sale contract is a property agreement. Its value as a resource must be determined. The principal balance of a real estate contract is excluded from resources for a long-term care client if it meets the conditions in Subsection 287.04. This exclusion is not used if it would be more restrictive to the client's Medicaid eligibility than counting the contract as a resource. Payment on the principal of a

negotiable real estate contract is a resource. Payment on the interest of a negotiable real estate contract is unearned income. Payment on a nonnegotiable real estate contract is unearned income. Payment on an excluded real estate contract is unearned income. A real estate contract is negotiable where legal title to the instrument itself and the face value can be transferred from one person to another. (7-1-94)

01. Promissory Note. A promissory note is a written, unconditional agreement where one party promises to pay a specified sum of money at a specified time, or on demand, to another party. It may be given in return for goods, money, or services. (1-1-93)

02. Loan. A loan is a transaction where one party advances money to or for another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under State law. A written loan agreement is a form of promissory note. (1-1-93)

03. Property Agreement. A property agreement is a pledge or security of particular property for the payment of a debt within a specified period. Property agreements on real estate are referred to as mortgages but may be called land contracts, contracts for deed, and deeds of trust. Personal property agreements for pledges of crops, fixtures, or inventory are commonly known as chattel mortgages. (1-1-93)

04. Excluded Real Estate Contract for Long-Term Care Client. The principal balance of a real estate contract is excluded from resources for a long-term care client if it meets all conditions in Subsections 287.04.a. through 287.04.c. The exclusion ends the first month the contract fails to produce income. The principal balance is a resource the first moment of the next month. See Subsection 611.08 for treatment of payments on an excluded real estate contract. This exclusion is not used if it would be more restrictive to the client's Medicaid eligibility than counting the value of the contract. (7-1-94)

a. Income producing. The contract produces income when payments are made to the client by the purchaser. (7-1-94)

b. Adequate rate of return. The contract has a rate of return no less than two (2) percentage points below the bank market rate for loans on similar property in the community when the contract was signed. (7-1-94)

c. Remainder to estate. The remainder of the contract is part of the estate when the client dies. There are no conditions in the contract putting the contract out of reach of Medicaid estate recovery. (7-1-94)

288. VALID TRANSFER OF RESOURCE OWNERSHIP.

When a client's property is transferred, the Department must decide if the transfer of the resource was valid. The property, or share of property, whose ownership has been transferred, is no longer the former owner's resource. If transferred, the former owner's total resources have a different value or have taken on a different form. If a transfer is not valid, the property is still the client's resource and subject to the counting rules. (1-1-93)

01. Transfers of Resource Ownership. Transfers of resource ownership may occur through property sale or purchase, trade or exchange of one property for another, or giving property to another person. (1-1-93)

02. Value of Payment For Transfer of Resources. Payment for the transfer of resources is valued as shown in the following Subsections 288.02.a. through 288.02.d. (1-1-93)

a. Payment in cash. The value of the payment received is based on the agreement and expectations at the time of transfer or contract for sale. The value of the payment is the gross amount paid or to be paid. Expenses attributed to the sale do not reduce the value of the payment. (1-1-93)

b. Payment not in cash. The value of a payment not made in cash is the fair market value of the resource at the time of transfer or contract for sale. (1-1-93)

c. Payment by services. Services to the client for a resource are valued based on the current market value, monthly or annually depending on the agreement, and their frequency and duration under the agreement. (1-1-93)

d. Payment by assumption of a legal debt. Payment in the form of assumption of the client's debt for a resource is valued at the outstanding principal amount. Interest payments are not valued. The debt must be documented. (1-1-93)

289. TRANSFER OF A RESOURCE AT LESS THAN FAIR MARKET VALUE.

Transfer of a resource at less than fair market value is giving away a countable resource, or selling it for less than adequate payment. The transfer of a resource at less than fair market value, after June 30, 1988, does not affect AABD eligibility. (1-1-93)

290. CONDITIONAL BENEFITS RULE.

A client, or couple, who meets all other eligibility requirements, but fails to meet the resource limit due solely to excess nonliquid resources, can receive AABD benefits for a limited period. AABD benefits, based on a conditional exclusion of the excess nonliquid resources, are available if the client, couple, or deemor meets two (2) conditions. First, the countable liquid resources must not exceed three (3) times the client's AABD cash assistance need standard. Second, the client, couple, or deemor must agree, in writing, to sell excess nonliquid resources at their current market value, within a specified period. (1-1-93)

01. Undue Hardship For Joint Resident Owner of Excess Real Property. Excess real property is an excluded resource, for as long as the property is jointly owned and its sale would cause undue hardship due to loss of housing to the other owner(s). If undue hardship no longer applies because the joint owner moves or dies, the client may be eligible for conditional benefits. (1-1-93)

02. Conditional Eligibility and Retirement Funds. A client with excess nonliquid resources, such as retirement funds, may qualify for conditional benefits while awaiting payment. (1-1-93)

03. Unsuccessful Reasonable Efforts to Sell Excess Real Property. The client must continue to make reasonable efforts to sell excess real property. If the property does not sell, the reasonable efforts to sell it must continue. (1-1-93)

04. Conditional Benefits Payments Disposal/Exclusion Period. The disposal period and exclusion period for excess nonliquid resources begins on the date the client signs the Agreement to Sell Property, and after the Department determines the client meets all AABD eligibility rules, except resources. This includes disability or blindness requirements. The disposal and exclusion periods can begin earlier for a client who met all requirements to receive conditional benefits before his first opportunity to sign the Agreement to Sell Property. The client must sign the Agreement to Sell Property before his application is approved. (7-1-93)

05. Time Period for Disposal of Excess Resources. The time period for disposal of excess nonliquid personal property is three (3) months. The value of excess real property is not counted as a resource, as long as the client makes reasonable efforts to sell the property at its current market value, and his reasonable efforts to sell are not successful. (1-1-93)

06. Real Property Disposal and Exclusion Period Ending Date. The real property disposal and exclusion period ends when the first of the following events occur: The property is sold; reasonable efforts to sell end; the client's submits a written request for cancellation; or countable resources, without the exclusion, fall within the limit. (1-1-93)

07. Personal Property Disposal and Exclusion Period Extension for Good Cause. One (1) three (3) month extension, for sale of personal property, may be allowed when good cause exists. (1-1-93)

08. Conditional Benefit Payment Period. Conditional benefits are paid only for full calendar months. The first (1st) month of conditional benefits is the month after the month the client signs the agreement to sell. Conditional benefits end the month the excess resources are sold, the client stops making efforts to sell, or the client cancels the agreement to sell. (1-1-93)

09. Conditional Benefits and Terminations of AABD. A client who reapplies for AABD benefits, after termination of prior eligibility, may be subject to a new conditional benefits period if excess resources exist. (1-1-93)

10. Conditional Benefits and Reasonable Efforts to Sell Excess Nonliquid Property. The client must make reasonable efforts to sell excess nonliquid property. The client must take required steps to sell excess nonliquid property using media serving the geographic area where the property is located. (1-1-93)

11. Reasonable Efforts to Sell Real Property. Within thirty (30) days of signing a conditional benefits agreement, the client must show efforts to sell the property. The client must list the property with an agent or begin to advertise in at least one (1) of the local media. The client must place a "For Sale" sign on the property, if permitted, and begin to conduct open houses or show the property to interested parties on a continuing basis. The client must try any reasonable methods of sale such as posting notices on community bulletin boards or distributing fliers. Reasonable efforts to sell must be assessed. The client's circumstances must be considered. Sales methods must not be restricted to traditional methods, such as employing a real estate agent. The owner must maintain efforts to sell excess real property with breaks of no more than one (1) week. (1-1-93)

12. Monitoring Efforts to Sell Real Property. The Department must contact the client thirty-five (35) days after approval of his application, and every sixty (60) days, until the property is sold or AABD is stopped. The Department must document efforts to sell. The Department must document an offers to buy. If an offer has been made and refused, the Department must document the client's explanation for refusal. The Department must document if there was good cause. (1-1-93)

13. Conditional Benefits and Reasonable Offer to Buy Real Property. The client must not reject any reasonable offer to buy the excess real property. An offer to buy real property is reasonable if it is at least two-thirds (2/3) of the estimated current market value. If the client rejects an offer, he must prove to the Department it was not reasonable. (1-1-93)

14. Conditional Benefits Good Cause for Not Making Efforts to Sell Excess Property. Good cause exists for not making efforts to sell property, when circumstances beyond a client's control prevent his taking the required actions. Without good cause, the client is not making reasonable efforts to sell the property. The client's countable resources must include the value of the excess property, retroactive to the beginning of the conditional benefits period. The client owes the resulting overpayment. With good cause, failure to meet the selling criteria means the conditional benefits period continues. Good cause examples are listed in Subsections 290.14.a. through 290.14.e. (1-1-93)

a. No offer to buy. The client makes good faith efforts to sell excess nonliquid resources during the disposal period but receives no offer to buy them. (1-1-93)

b. Reliance on an offer that does not result in a sale. A legitimate offer to buy an excess nonliquid resource halts further efforts to sell it for a prolonged period. The prospective buyer subsequently cannot or will not complete the purchase. (1-1-93)

c. Escrow begins but closing does not take place within disposal period. The client accepts an offer to buy real property. Escrow begins, preventing acceptance of another offer. Closing the sale, where full or partial payment and transfer of title are exchanged, does not take place within the disposal period. (1-1-93)

d. Incapacitating illness or injury. The client becomes homebound or hospitalized for a prolonged period, due to illness or injury. The client cannot take the steps necessary to sell the resource or to arrange for someone to sell it on her behalf. (1-1-93)

e. Part-time owner dies. A part-owner of a resource dies. Administration or probate of the estate delays efforts to sell the resource. (1-1-93)

15. Conditional Benefits Not Repaid. AABD and Medicaid assistance paid while the client's excess real or personal property is excluded is not an overpayment, unless the Department determines the client's efforts to sell the property were not reasonable and he did not have a good cause for lack of reasonable efforts to sell. (1-1-93)

16. Separation of an AABD Couple. Separation of an AABD couple before disposal of the excess nonliquid resources does not affect the conditional benefits agreement. If both are owners of the resource, both will have signed the binding agreement. (1-1-93)

17. Death of Member of Eligible Couple. Conditional benefits paid at the couple rate through the month of death are treated at the couple rate. Conditional benefits paid at the couple rate, after the month of death, are an overpayment. Any excess overpayment is subject to normal recovery procedures. (1-1-93)

18. Conditional Benefits and Exchange of Excess Property. The exchange or trade of property does not satisfy the terms of the Agreement to Sell Property. If the newly acquired property is an excluded resource, the client no longer has excess nonliquid resources and the conditional benefits period ends. If the newly acquired property is an excess nonliquid resource, the client can satisfy the agreement by selling the new property within what remains of the disposal/exclusion period. The new property cannot qualify for a new conditional benefits agreement. (1-1-93)

291. -- 299. (RESERVED).

300. INCOME DEFINITION.

Income is anything that can be used to meet the needs for food, clothing, or shelter. Income is cash, wages, pensions, in-kind payments, inheritances, gifts, awards, rent, dividends, interest, or royalties the client receives during a month. (1-1-93)

301. PROSPECTIVE ELIGIBILITY.

Eligibility for an AABD grant and Medicaid is prospective. Anticipated income for the month is compared to the client's income limit that month. See Section 612 for patient liability income rules. (1-1-96)T

302. PROJECTING MONTHLY INCOME.

Income is projected for each month to determine grant amount. Past income may be used to project future income. Expected changes must be considered. Section 303 lists criteria for projecting income. Income received less often than monthly is not prorated or converted. Patient liability income is not prorated or converted. (1-1-96)T

303. CRITERIA FOR PROJECTING MONTHLY INCOME.

Monthly income is projected as described in this Section. (1-1-96)T

01. Income Already Received. Count income already received during the month. Convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. (1-1-96)T

a. If the actual amount of income from any pay period that month is known, use the actual pay period amounts to determine the total month's income. Convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. (1-1-96)T

b. If no pay changes are expected, use the known actual pay period amounts for the past thirty (30) days to project future income. Convert the actual income to a monthly amount if a full month's income has been received or is expected to be received. (1-1-96)T

02. Anticipated Income. Count income the client and the Department believe the client will get. Convert the income to a monthly amount. (1-1-96)T

a. If the exact income amount is uncertain or unknown, the uncertain or unknown portion must not be counted. The certain or known amount is counted. If the date of receipt of income cannot be anticipated for the month of the eligibility or grant determination, that portion must not be counted. (1-1-96)T

b. If the income has not changed and no changes are anticipated, past income can be used as an indicator of anticipated income. (1-1-96)T

c. If income changes, and income received in the past thirty (30) days does not reflect anticipated income, the Department can use income received over a longer period to anticipate income. (1-1-96)T

d. If income changes seasonally, the Department can use income from the last comparable season to anticipate income. (1-1-96)T

03. Full Month's Income Not Expected. Ongoing income is income from an ongoing source. Ongoing income has been received in the past and is expected to be received in the future. (1-1-96)T
- a. If a full month's income is not expected from an ongoing source, count the amount of income expected for the month: (1-1-96)T
 - i. If the actual amount of income is known, use the actual income. (1-1-96)T
 - ii. If the actual amount of income is unknown, project the expected income. (1-1-96)T
 - iii. Convert the income to a monthly amount. Use zero (0) income for any pay period in which income was not received that month. (1-1-96)T
 - b. If income is from a new source and a full month's income is not expected, count the actual amount of income expected for the month. Do not convert the new source of income to a monthly amount. (1-1-96)T
 - c. If income is from a terminated source and no additional income is expected in a future month from this source, count the actual income received during the month. Do not convert the terminated source of income. (1-1-96)T
 - d. If a full month's income is not expected from a new or terminated source of income, count the amount of income expected for the month. (1-1-96)T
 - i. If the actual amount of income is known, use the actual known income. (1-1-96)T
 - ii. If the actual amount of income is unknown, project the income. (1-1-96)T
 - iii. Do not convert the income to a monthly amount if a full month's income from a new or terminated source is not expected. (1-1-96)T
04. Income Paid on Salary. Income paid on salary, rather than an hourly wage, is counted at the expected monthly salary rate. (1-1-96)T
05. Income Paid at Hourly Rate. Compute anticipated income paid on an hourly basis by multiplying the hourly pay by the expected number of hours the client will work in the pay period. Convert the pay period amount to a monthly basis. (1-1-96)T
06. Fluctuating Monthly Income. When monthly income fluctuates each pay period and the rate of pay remains the same, average the income from the past thirty (30) days to determine the average pay period amount. Convert the average pay period amount to a monthly amount. When income changes and income from the past thirty (30) days is not a valid indicator of future income, the Department can use a longer period of income history to anticipate income. (1-1-96)T
07. Converting Income to a Monthly Amount. If a full month's income is expected, but is received on other than a monthly basis, convert the income to a monthly amount using one of the formulas in this Subsection. (1-1-96)T
- a. Multiply weekly amounts by four point three (4.3). (1-1-96)T
 - b. Multiplying bi-weekly amounts by two point one five (2.15). (1-1-96)T
 - c. Multiplying semi-monthly amounts by two (2). (1-1-96)T
 - d. Use the exact monthly income if it is expected for each month. (1-1-96)T
08. Income Received Less Often Than Monthly. Recurring income, such as quarterly payments or annual income, must be counted in the month received, even if the payment is for multiple months. The income is not

prorated or converted. If the actual amount to be received is known, use the actual. If the actual amount is unknown, use the best information available to anticipate income. Past income can be used as an indicator of anticipated income. Income received in the last comparable payment can be used to anticipate income. (1-1-96)T

304. (RESERVED).

305. APPLICATION FOR POTENTIAL BENEFITS.

The client must apply for benefits, including RSDI, VA, pensions, Workman's Compensation, or Unemployment Insurance, when there is potential eligibility. The client must apply for SSI benefits, if he is potentially eligible, to get an AABD grant. The client does not have to apply for SSI benefits to get AABD-related Medicaid. Clients entitled to a VA pension as of December 31, 1978 cannot be required to file for Veterans Administration Improved Pension Plan (VAIP), to get an AABD grant. The client must apply for a VAIP to get AABD-related Medicaid, unless he receives SSI. EITC, AFDC, BIA General Assistance and victim's compensation benefits are exempt from the filing requirement. Child support and alimony payments are not program benefits. A client is not required to file for them. The Department must tell the client the benefit to apply for, in writing. The client must prove, to the Department, he applied for potential benefits as requested. The client must be allowed at least thirty (30) days to supply proof he has applied. When a client fails to apply for potential benefits, the AABD application must be denied. An open AABD case must be closed as soon as possible following timely notice. (1-1-95)

306. INCOME BURDEN OF PROOF.

Clients must give the Department proof of income. Clients, or their AABD payees, must report any changes in income. (1-1-93)

307. INCOME AND AGENT FOR CLIENT.

An agent is a person or group acting for the client. An AABD client may be an agent for another person or have an agent acting for him. When an agent performs a transaction for the client, it is counted as if performed by the client. (1-1-93)

308. RELATIONSHIP OF INCOME TO RESOURCES.

Anything received in a month, from any source, is income to a client. Anything the client owned before the budget month is a resource. If the client keeps countable income after the month it is received, it is counted as a resource. (1-1-93)

309. TYPES OF INCOME.

Income is either earned or unearned. Different rules apply to each income type. Either income type may be cash or in-kind. (1-1-93)

01. Earned Income. Earned income is wages, net earnings from self-employment, and payments from a sheltered workshop or work activities center. Earned income is the amount paid the client, before any deductions. (1-1-93)

02. Unearned Income. Unearned income is all income other than earned income. Annuities, pensions, and other periodic payments are unearned income. Alimony and support payments are unearned income. Dividends, interest, and royalties are unearned income. Rents are unearned income. Prizes and awards are unearned income. (1-1-93)

310. FORMS OF INCOME.

Income is either cash or noncash. (1-1-93)

01. Cash Income. Cash income is currency, checks, money orders, or electronic funds transfers (EFT). Cash income includes Social Security checks, unemployment checks, and payroll checks. (1-1-93)

02. In-Kind Income. In-kind income is not cash. In-kind income is food, clothing, or shelter. Wages paid as in-kind earnings, such as food, clothing or shelter, are counted for AABD. Other in-kind income is not counted for AABD. (1-1-93)

311. WHEN INCOME IS COUNTED.

Income is counted the earliest of when received, when credited to a client's account, or when set aside for the client's use. Income from SSA, SSI or VA is counted for the month it is intended to cover. (1-1-93)

312. -- 321. (RESERVED).

322. EXCLUDED INCOME.

The following kinds of income are excluded in determining a client's AABD eligibility and grant amount: (1-1-93)

01. Adoption Assistance Under Title IV-B or Title XX. Adoption assistance payments, provided under Title IV-B or Title XX of the Social Security Act, are not income because they are social services. (1-1-93)

02. Agent Orange Settlement Fund Payments. Effective January 1, 1989, payments made from the Agent Orange settlement fund or awards from Agent Orange product liability judgement are not counted as income. (1-1-93)

03. Alaska Native Claims Settlement Act. Public Law 100-241 gives AABD income and resource exclusions to Alaska Natives and their descendants. Items listed in Subsections 322.03.a. through 322.03.e. are excluded from income and resources. (1-1-93)

a. Cash from a native corporation, including cash dividends on stock, is excluded up to two thousand dollars (\$2,000) per person per year. (1-1-93)

b. Stock, including stock issued by a native corporation as a dividend is excluded. (1-1-93)

c. A partnership interest in a native firm is excluded. (1-1-93)

d. Land or an interest in land, including land given by a native corporation as a stock dividend is excluded. (1-1-93)

e. Alaskan native interest in a settlement trust is excluded income. (1-1-93)

04. Assistance Based on Need (ABON). ABON is aid paid under a program using income as a factor of eligibility. The aid must not use federal funds in any phase of the state or local program. ABON is funded wholly by a state, or a political subdivision of a state, or an Indian tribe, or a combination of these sources. ABON is excluded from income. (1-1-93)

05. Austrian Social Services Payments. Austrian Social Services payments are based on wage credits under Paragraphs 500-506 of the Austrian Social Insurance Act. Austrian Social Services payments are not counted as income. (1-1-93)

06. Bureau of Indian Affairs (BIA) Foster Care. BIA foster care payments are social services. They are excluded from income for the foster child and foster family. (1-1-93)

07. Blind or Disabled Student Child Earned Income. To qualify for this exclusion, the child must be blind or disabled. The child must be under age twenty-two (22). The child must not be married or the head of a household. The child must be a student regularly attending a school, college, university or course of vocational or technical training, designed to prepare him for gainful employment. Up to four hundred dollars (\$400) per month of earned income, but not more than one thousand six hundred twenty dollars (\$1,620) in a calendar year, is excluded. (1-1-93)

08. "Buy-In" Reimbursement. The SSA reimbursement for self-paid Medicare Part B "Buy-In" premiums is excluded. (1-1-93)

09. Commodities, Food Stamps and Food Programs. Food, under the Federal Food Stamp Program, Donated Commodities Program, School Lunch Program, and Child Nutrition Program, is not counted as income. This includes free or reduced price food for women and children under the National School Lunch Act and the Child

Nutrition Act of 1966. (1-1-93)

10. Contributions For Adult Residential Care Facility Residents. Contributions from a third party, for a client residing in an adult residential care facility, are excluded from the client's income and resources. The contribution must be paid directly to the facility. The contribution must pay for items or services, other than medical care, provided to the client by the facility. The items or services must not be included in the client's AABD payment, or must be charges for care exceeding the Department's Adult Residential Care Facility Level I, II or III Allowance. The client must not be charged a higher rate than other residents of the facility. The person making the contribution must provide a signed statement to the Department. The statement must identify the item or service the payment covers, the reason the item or service is needed by the client, and the monthly amount of the payment. The contributor must state the payment is made directly to the facility for the client. If contributions are made for charges exceeding the Department's AABD room and board payment standard, the facility operator must state the charge is made to all residents of the adult residential care facility. (1-1-93)

11. Conversion or Sale of a Resource Not Income. Payment from the sale, exchange, or replacement of a resource is not income. The payment is a resource that changed form. (1-1-93)

12. Credit Life or Disability Insurance Payments. Credit life or credit disability insurance covers payments on loans and mortgages, in case of death or disability. Insurance payments are made directly to loan or mortgage companies, and are not available to the client. These payments are not counted as income. (1-1-93)

13. Department of Education Scholarships. Any grant, scholarship, or loan, to an undergraduate for educational purposes, made or insured under any program administered by the Commissioner of Education, is excluded from income and resources. (1-1-93)

14. Disaster Assistance. Payments received because of a major disaster, declared by the President, are excluded from income. This includes payments to repair or replace the person's own home or other property, and disaster unemployment aid. (1-1-93)

15. Domestic Volunteer Service Act Payments. Compensation, other than wages, provided to volunteers in the Foster Grandparents Program, RSVP, and similar National Senior Volunteer Corps programs under the under Sections 404(g) and 418 of the Domestic Volunteer Service Act. (1-1-93)

16. Earned Income Tax Credits. Earned Income Tax Credits advance payments and refunds are excluded income. (1-1-93)

17. Support and Maintenance Assistance and Home Energy Assistance. Support and Maintenance Assistance (SMA) is not counted as income. SMA is in-kind support and maintenance, or cash paid for food, clothing, or shelter needs. It includes Home Energy Assistance. SMA Home Energy Assistance is aid to meet the costs of heating or cooling a home. Home Energy Assistance is not counted as income. The aid must be provided to persons, based upon need certified by the Department. The aid must be provided in-kind by a nonprofit organization. The aid must be in cash or in-kind by suppliers of home heating gas or oil or a municipal utility providing home energy, or an entity whose revenues are derived on a rate-of-return basis by the state or federal government. (1-1-93)

18. Federal Housing Assistance. Payments for housing are excluded from income and resources if paid under the acts listed in Subsection 322.18.a. through 322.18.e. (1-1-93)

- a. United States Housing Act of 1937, Section 1437 et seq. of 42 U.S. Code. (1-1-93)
- b. The National Housing Act, Section 1701 et seq. of 12 U.S. Code. (1-1-93)
- c. Section 101 of the Housing and Urban Development Act of 1965, Section 1701s of 12 U.S. Code, and Section 1451 of 42 U.S. Code. (1-1-93)
- d. Title V of the Housing Act of 1949, Section 1471 et seq. of 42 U.S. Code. (1-1-93)
- e. Section 202(h) of the Housing Act of 1959. (1-1-93)

19. Foster Care Payments Under Title IV-B or Title XX. Foster care payments using funds provided under Title IV-B or Title XX of the Social Security Act are not income because they are social services. Payments for foster care of a non SSI-child placed by a public or private non-profit child placement or child care agency are excluded income. (1-1-93)

20. Garnishments. Garnishments of unearned income are counted as unearned income. Garnishments of earned income are counted as earned income. From October 1989 through December 1993, garnishments of unearned income are excluded income. (7-1-94)

21. German Reparations. Reparations payments from the Federal Republic of Germany received on or after November 1, 1984 are excluded income. (1-1-93)

22. Medical or Social Services. (1-1-95)

a. Governmental payments authorized by Federal, State, or local law, for medical or social services, are not income. (1-1-95)

b. Any cash provided by a nongovernmental medical or social services organization (including medical and liability insurers) for medical or social services already received is not income. (1-1-95)

c. Medical services are diagnostic, preventive, therapeutic, or palliative treatment. Treatment of a medical condition must be performed, directed, or supervised by a State licensed health professional. Medical services include room and board provided during a medical confinement. Medical services include in-kind medical items such as prescription drugs, eye glasses, prosthetics, and their maintenance. In-kind medical items include devices intended to bring the physical abilities of a handicapped person to a par with an unaided person who is not handicapped. Electric wheelchairs, modified scooters, and seeing eye dogs and their dog food are in-kind medical items. A social service is any service, other than medical. A social service helps a handicapped or socially disadvantaged person to function in society on a level comparable to a person not handicapped or disadvantaged. Housebound and Aid and Attendance Allowances, including Unusual Medical Expense Allowances, received from the Veterans Administration are not counted as AABD income. (1-1-95)

23. Grants, Scholarships, and Fellowships. Grants, scholarships, or fellowships used for paying tuition, fees, required educational expenses are excluded from income. This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter. (1-1-93)

24. Home Produce for Personal Use. Home produce is excluded from income if it is consumed by the client or his household. Home produce includes livestock grown for personal consumption. (1-1-93)

25. In-Home Supportive Services. Payments made by Title XX or other governmental programs to pay an ineligible spouse or ineligible parent for in-home supportive services provided to a client is excluded income. In-home supportive services include attendant care, chore services and homemaker services. (1-1-93)

26. Income Excluded by Law. Any income excluded by federal statute, is excluded income. (1-1-93)

27. Indian-Related Exclusions. Indian-related payments made to members of Indian tribes and Indian groups are excluded from income and resources. Income exclusions are listed in Subsections 322.27.a. through 322.27.i. (1-1-93)

a. Distribution of Judgement Payments. Per capita distribution payments by the Blackfeet and Gros Ventre tribal governments to members, which resulted from judgment funds to the tribes are excluded by Public Law 92-254-Sec. 4. (1-1-93)

b. Distribution of Judgement Funds. Per capita distribution payments to members of Indian tribes who were due judgment funds, under the Secretary of the Interior, are excluded. Funds distributed or held in trust under public laws enacted before October 19, 1973 by Public Law 93-134-Sec.7. (1-1-93)

- c. Receipts from Lands Held in Trust for Indian Tribes. Payments from certain trust lands and distributed to members of select Indian tribes are excluded. Lands, mineral rights and receipts are excluded from income and resources, unless they were subject to the Mineral Leasing Act of 1920 and distributed before October 17, 1975 by Public Law 94-114-Sec. 6. (1-1-93)
- d. Distribution of Judgement Funds. Per capita payments made to, or held in Trust for members of the Grand River Band of Ottawa Indians are excluded by Public Law 94-540-Sec. 6. (1-1-93)
- e. Distribution of Judgement Funds. Judgment funds, including interest and investment income which accrued on Indian judgment funds while held in trust and initial purchases made with distributed judgment funds are excluded by Public Law 97-458. (1-1-93)
- f. Distribution of Judgement Funds. Per capita distributions of funds held in trust by the Secretary of the Interior to members of an Indian tribe are excluded by Public Law 98-64. Dividends paid on stock held in an Alaska Native Corporation are not excluded under this statute. (1-1-93)
- g. Distribution of Money and Land. Cash payments of two thousand dollars (\$2,000) or less made by an Alaska Native Corporation to Alaska natives and descendants of Alaska natives are excluded by Public Law 100-241. (1-1-93)
- h. Distribution of Money and Land. All money and lands transferred to the members of the Puyallup Tribes under the Puyallup Tribe of Indians Settlement Act of 1989 are excluded by Public Law 101-41-Sec. 10. (1-1-93)
- i. Up to two thousand dollars (\$2,000) per calendar year of payments to individual Indians resulting from their interests in trust or in restricted lands are excluded from income by 25 U.S.C. Section 1408. (7-1-94)
28. Infrequent or Irregular Income. Infrequent or irregular income, under ten dollars (\$10) per month earned income and twenty dollars (\$20) per month unearned income, is excluded. If the infrequent or irregular income exceeds these limits the total amount received is counted. Income is infrequent if the client gets it once in a calendar quarter from a single source. Income is irregular if the client could not reasonably expect to receive it. (1-1-93)
29. Japanese-American and Aleutian Restitution Payments. Restitution payments made by the U.S. Government to Japanese-Americans and Aleuts who were interned or moved during World War II are excluded from income and resources. Payments to survivors, because of death, are excluded from income and resources. (1-1-93)
30. Loans. Bona fide loans, where the client has a signed written repayment agreement, are not counted as income. A bona fide loan can be made by a business, by a person, or by an organization. The person or organization does not need to be in the business of making loans. The signed agreement must state how the loan will be repaid. The signed agreement can be secured by real or personal property. The loan can be repaid within a specified time or when expected income is received. The signed written agreement can be obtained after the loan is received. If a loan is not bona fide, the proceeds are unearned income in the month received. Items bought on credit are paid with a loan are not income. A client may make a loan to another person. Money repaid to a client on the principal of a loan is not income, it is a resource. Interest received by a client on money loaned by him is countable income. (1-1-93)
31. Manpower Development and Training Act Payments. Payments made under the Manpower Development and Training Act of 1962, as amended by the Manpower Act of 1965 are not counted as income for AABD. (1-1-93)
32. Nutrition Programs for Older Americans. Payments, other than a wage or salary, made under Chapter 35 of Title 42 of the U.S. Code, Programs for Older Americans, is excluded from income. (1-1-93)
33. Personal Services. A personal service performed for a client is not counted as income. Personal services include lawn mowing, house cleaning, grocery shopping, and baby sitting. (1-1-93)

34. Radiation Exposure Compensation Act Payments. Payments made to persons under the Radiation Exposure Compensation Act are not counted as income. (1-1-93)

35. Rebates, Refunds, and Replacement Checks. Rebates, refunds, and other returns of money already paid are not income. A replacement check is not income. Retroactive payment, made to correct an AABD underpayment, is not counted as income. (1-1-93)

36. Relocation Assistance. Relocation assistance is given to persons displaced by projects which seize real property. Payments under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, Subchapter II, Chapter 61, Title 42 of the U.S. Code are excluded from income. Relocation payments paid to civilians of World War II per Public Law 100-383 are not counted as income. (1-1-93)

37. Replacement of Income Already Received. Replacement of a client's lost, stolen, or destroyed income is not income. (1-1-93)

38. Return of Mistaken Payments Not Income. A payment is not income when the client is not due the money. The client must return the check uncashed or fully repay the mistaken payment. If the client keeps the mistaken payment, it is income. (1-1-93)

39. Tax Refunds. Refunds of Federal, State or local taxes paid on income, real property, or food bought by the client and his family, are not counted as income. (1-1-93)

40. Victims' Compensation Payments. Any payment made from a State-sponsored fund to aid victims of crime is excluded from income. (1-1-93)

41. Vocational Rehabilitation Services Payments. Payments other than wages made to an eligible handicapped individual employed in a Vocational Rehabilitation Services project under Title VI of the Rehabilitation Act of 1973. (1-1-93)

42. Volunteer Services Income. Payments to volunteers under Chapter 66 of Title 42 of the U.S. Code Domestic Volunteer Services (ACTION programs) are excluded from income and resources. Payments are not excluded, if the Director of the ACTION agency determines the value, adjusted for hours served, is equal to or greater than the Federal or State minimum wage. (1-1-93)

43. Weatherization Assistance. Weatherization assistance is not counted as income. (1-1-93)

44. Utility Payments. Payments for utility costs made to low-income housing tenants by a local housing authority. Payments are excluded when paid directly to the tenant or jointly to the tenant and the utility company. (7-1-93)

45. Expense of Obtaining Income. Unearned income does not include that part of a payment which is for an essential expense of getting the payment. An expense is essential if the client would not receive the income unless he paid the expense. Legal fees and medical expenses essential to getting income are deducted. Expenses of receiving income, such as withheld taxes, are not deducted. (7-1-93)

323. EARNED INCOME.

Earned income is wages, net earnings from self-employment, and sheltered workshop or work activities center payments. Earned income is counted in computing the AABD grant after disregards and exclusions are applied. (1-1-93)

01. Wages. Wages are payment to the client, before deductions, for working as an employee. Wages are salaries, commissions, bonuses, severance pay, and other employment-related pay. Wages are in-kind earnings such as food, clothing or shelter paid instead of cash. Wages include payments to an inmate of a public institution, if an employer-employee relationship exists. Wages are counted, at the earliest of: When received, when credited to client's account, or when set aside for client's use. (1-1-93)

02. Sick Pay Counted As Earned Income. Sick pay is provided by an employer, or a private third party,

for sickness or accident disability. Sick pay or disability pay, to an employee or the employee's dependents, is wages. Sick or disability payments, under a State Temporary Disability Insurance (TDI) program, are wages. Sick pay or disability pay is wages, only within the first six (6) months, after the last month the employee worked. The six (6) month period begins with the first (1st) day of non-work. It includes the remainder of the calendar month, plus the next six (6) full calendar months. (1-1-93)

03. Sick Pay Not Counted As Earned Income. Sick pay and accident disability payments, paid more than six (6) months after work stopped because of that sickness or accident, is unearned income. (1-1-93)

04. Advances On Wages. Advances on wages are income. Advances on wages are counted when received. (1-1-93)

05. Deferred Wages. Wages are deferred if they are received later than their normal payment date. Deferred wages include vacation pay, dismissal pay, severance pay, back pay, and bonuses. Deferred wages are counted when received. (1-1-93)

324. INCOME OF CONTRACTUAL EMPLOYEE.

Earned income received by a client employed on a contractual basis is to be prorated over the period of the contract to arrive at the monthly amount to be used in determining eligibility and grant amount. (1-1-93)

325. SELF-EMPLOYMENT INCOME.

Income from self-employment is earned income. Gross self-employment income is self-employment earnings plus capital gains. Gross self-employment income includes any profit or loss in a partnership. Net income from self-employment is the gross income from any trade or business, less allowable costs for that trade or business. Income disregards are subtracted from the net self-employment income. The remaining income from self-employment is counted toward the AABD grant. (1-1-93)

01. Self-Employment Costs Allowed. Allowable costs must be necessary to produce self employment income. Allowable costs for self-employment must be subtracted from the gross self-employment income. Allowable costs include, but are not limited to, the items listed in Subsections 325.01.a. through 325.01.f. (1-1-93)

a. Labor of other persons required for self-employment. The client must not be allowed a cost for wages paid to himself. (1-1-93)

b. Stock and raw materials required for self-employment. (1-1-93)

c. Seed and fertilizer required for self-employment. (1-1-93)

d. Interest paid to purchase income-producing property and equipment. (1-1-93)

e. Insurance premiums required for self-employment. (1-1-93)

f. Taxes paid on income-producing property for self-employment. (1-1-93)

02. Self-Employment Costs Not Allowed. Costs not allowed for self employment income are listed in Subsections 325.02.a. through 325.02.g. These costs must not be subtracted from the gross self-employment income. (1-1-93)

a. Payments on the principal of real estate mortgages on income-producing property. (1-1-93)

b. Money paid to purchase capital assets, equipment, machinery, and other durable goods. (1-1-93)

c. Payments on the principal of loans to purchase capital assets, equipment, machinery, and other durable goods. (1-1-93)

d. Federal, state and local income taxes. (1-1-93)

- e. Money set aside for retirement purposes. (1-1-93)
- f. Expenses of personal business, personal transportation and entertainment. (1-1-93)
- g. Amounts claimed as depreciation. (1-1-93)
- 03. Determining Net Self-Employment Income. Self-employment income and allowable costs must be determined using one (1) of the methods in Subsections 325.03.a. through 325.03.d. (1-1-93)
 - a. Determine self-employment income, less allowable costs, on a monthly basis. (1-1-93)
 - b. If the client has been self-employed for one (1) year or more, subtract the allowable costs from the annual self employment income. Divide the net annual self-employment income by twelve (12) to arrive at a monthly amount. (1-1-93)
 - c. If the client has been self-employed for less than one (1) year, average the self-employment income, less allowable costs, over the period the business has been in operation. The monthly average is the monthly amount of self-employment income. (1-1-93)
 - d. If a monthly average does not reflect the client's actual monthly income, because of an increase or decrease in business, the client's self-employment income must be considered on a monthly basis. (1-1-93)
- 04. Net Self-Employment Income Seven Point Sixty-Five Percent (7.65%) Deduction. Net self-employment income in excess of four hundred dollars (\$400) per year must be allowed a deduction of seven point sixty-five percent (7.65%). This deduction compensates for Social Security taxes paid. If self-employment Social Security tax is not paid, this deduction must not be allowed. (7-1-94)
- 05. Self-Employment Income Information Sources. Income from self-employment and costs of self-employment must be determined using available information. Information sources include, but are not limited to those listed in Subsections 325.05.a. through 325.05.e. (1-1-93)
 - a. Appropriate IRS forms and supporting documentation. (1-1-93)
 - b. Other documents accepted by the IRS as proof of income. (1-1-93)
 - c. Written statements from a Certified Public Accountant with knowledge of the client and his self-employment. (1-1-93)
 - d. Written statements from the attorney employed to handle affairs of the client's self employment. (1-1-93)
 - e. Written statements from a lending institution holding notes on the income-producing property. (1-1-93)

326. ROYALTIES AND HONORARIA.

Royalties are unearned income, unless they are received as part of a trade or business, or for publication of the client's work. Royalties received as part of a trade or business, or for publication of the client's work are earned income. Royalties are payments to the holder of a copyright or patent. Royalties may be paid to the owner of a mine, oil well, timber tract, or other resource, for the right to sell or extract the sale or extraction of a product. Proceeds from timber leases are royalties. Proceeds from timber sales are conversion of a resource. An honorarium is a voluntary payment, reward or donation, received for services rendered. Payment of an honorarium cannot be enforced by law. An honorarium for services rendered is earned income. An honorarium for travel expenses and lodging for a guest speaker is unearned income in the amount it exceeds the expenses. The portion that equals the expenses is excluded as an expense of obtaining the income. (7-1-96)

327. SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER PAYMENTS.

Payments for services performed in a sheltered workshop or work activities center are earned income. The client

receives the payment for taking part in a program designed to help him become self-supporting. (1-1-93)

328. JOB TRAINING PARTNERSHIP ACT (JTPA).

JTPA payments are earned income. Payments such as child care, transportation, medical care, meals, and other reasonable expenses, provided in cash or in-kind, are not income because they are social services. (1-1-93)

329. PROGRAMS FOR OLDER AMERICANS.

Wages or salary paid under U.S. Code, Title 42, Chapter 35, "Programs for Older Americans," is earned income. (1-1-93)

330. UNIFORMED SERVICES PAY AND ALLOWANCES.

Basic pay is earned income. All other pay and allowances are unearned income. The Army, Navy, Air Force, Marine Corps, and Coast Guard are uniformed services. Uniformed services include active duty, reserve, and national guard personnel. The Public Health Commissioned Officers Corps is a uniformed service. The National Oceanic and Atmospheric Administration (NOAA) Commissioned Officers Corps is a uniformed service. (1-1-93)

331. RENTAL INCOME.

Net rental income is unearned income. Rent is payment a client receives for the use of real or personal property, such as land, housing, or machinery. If the net rental income is from self-employment, from the business of renting properties, it is earned income. Net rental income is gross rent less the ordinary and required expenses paid in the same month. These expenses are listed in Section 331. Expenses do not include the principal of a mortgage payment. Expenses do not include capital improvements to the property. (7-1-96)

332. INCOME FROM JOINT BANK ACCOUNTS.

When an AABD client has a joint bank account with a person not getting AABD, who is not a deemor, interest to the account is unearned income in the month posted. When an AABD client has a joint bank account with a person not getting AABD, who is not a deemor, deposits made by the other person, are unearned income in the month deposited. When two or more AABD clients are joint account holders, deposits made by one person are not income to the other. Interest income is divided and counted equally among the joint holders. (1-1-93)

333. INTEREST RECEIVED ON MONEY LOANED.

Interest received by a client, from a loan he has made, is unearned income. (1-1-93)

334. OVERPAYMENT WITHHOLDING OF UNEARNED INCOME.

The part of an SSI benefit payment withheld to recover an overpayment is unearned income for AABD. The amount withheld is not income if the overpaid benefit amount was used to calculate the AABD payment. Unearned income, including RSDI, withheld by other benefit programs to recover an overpayment is unearned income. The amount withheld is not income if the overpaid benefit amount was used to calculate the AABD payment. (7-1-93)

335. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI).

RSDI monthly benefits are unearned income. Income from RSDI is counted for the month it is intended to cover. The client must apply for RSDI benefits, when there is potential eligibility. To compute retroactive AABD benefits for a client not considered a drug addict or alcoholic by SSA, retroactive RSDI payments must be counted as income in monthly increments, against the client's monthly budgeted needs, for the retroactive period. In a situation other than computing retroactive AABD payments, and for a client not a drug addict or alcoholic, retroactive RSDI payments are unearned income in the month received. For a drug addict or alcoholic getting his retroactive RSDI benefit in installments, the total benefit is income in the month the first installment is paid. Later installment payments of that retroactive RSDI benefit are not income. Special age seventy-two (72) payments are also unearned income. Premiums deducted for Supplementary Hospital Insurance or Supplementary Medical Insurance (Part A, and/or Part B premiums) under Medicare, from RSDI benefits, are income. RSDI suspended or stopped because of payment restrictions for drug addicts and alcoholics is available income. (7-1-96)

336. SSI PAYMENTS.

SSI monthly payments are unearned income. Income from SSI is counted for the month it is intended to cover. The income is the amount reported by SSA, regardless of penalties imposed by SSA to recover an SSI overpayment. SSI withheld to recover an SSI overpayment is unearned income for AABD. SSI Withheld. SSI withheld by SSA because SSA has determined a public institution or congregate care facility where the client lives is substandard, is available

income. SSI suspended or stopped because of payment restrictions for drug addicts and alcoholics is income. No Increase for Offset. If the client receives SSI, his AABD payment must not be increased to offset a reduction in SSI benefits imposed by SSA, because he used excluded burial funds for some other purpose. Retroactive AABD. To compute retroactive AABD benefits, retroactive SSI payments must be counted in monthly increments, against the client's monthly budgeted needs for the retroactive period. To compute regular AABD benefits, retroactive SSI payments are unearned income in the month received. (7-1-96)

337. BLACK LUNG BENEFITS.

Black Lung benefit payments are unearned income. Black Lung benefits are paid to miners and their survivors under the Federal Mine Safety and Health Act (FMSHA). (1-1-93)

338. RAILROAD RETIREMENT PAYMENTS.

Payments made by the Railroad Retirement Board are unearned income. Premiums deducted for Supplementary Medical Insurance (Part A and/or Part B premiums) from a Railroad Retirement benefit is unearned income. (1-1-93)

339. UNEMPLOYMENT INSURANCE BENEFITS.

Unemployment insurance benefits received under State and Federal unemployment laws are unearned income. Payments made by unions or employers as unemployment benefits are unearned income. (1-1-93)

340. UNIFORM GIFTS TO MINORS ACT (UGMA).

UGMA property, including earnings or additions, are not income to the minor. UGMA payments from the custodian to the minor are income to the minor. UGMA money used for support, benefit, or education of the minor is not counted as income. All UGMA property becomes available to the donee, and is income, in the month the minor becomes eighteen (18) years of age. (1-1-93)

341. WORKERS' COMPENSATION.

The workers' compensation payment, less the expenses required to get the payment, is unearned income. Workers' compensation designated for medical, legal, or related expenses paid or deducted from the claim is not income. Workers' compensation payments are awarded to an injured employee or his survivors under federal and state workers' compensation programs and the Longshoremen and Harbor Worker's Act. The payments may be made by a federal or state agency or an insurance company. (1-1-93)

342. MILITARY PENSIONS.

Military pensions are unearned income. (1-1-93)

343. VA PENSION PAYMENTS.

VA Pension payments are unearned income. The twenty dollar (\$20) general income exclusion does not apply to VA pensions except by a special act of Congress. A Protected VA pension is a pension VA first awarded before January 1, 1979. An Improved VA pension is a pension awarded January 1, 1979 or later. (7-1-93)

344. VA COMPENSATION PAYMENTS.

VA compensation payments to a veteran, spouse, child, or widow(er) are unearned income. The twenty dollar (\$20) general income exclusion applies. VA compensation payments to a surviving parent of a veteran are federally funded income based on need. The twenty dollar (\$20) general income exclusion does not apply. (1-1-93)

345. VA EDUCATIONAL BENEFITS.

VA educational payments funded by the government, but not part of vocational rehabilitation, are unearned income for AABD purposes. VA vocational rehabilitation payments are not income. VA educational benefits, which are withdrawals of the veteran's contributions, are a resource conversion and not income. (1-1-93)

346. VA AID AND ATTENDANCE AND HOUSEBOUND ALLOWANCES.

VA aid and attendance and housebound allowances are not income for AABD. (1-1-93)

347. VA PAYMENT ADJUSTMENT FOR UNUSUAL MEDICAL EXPENSES.

Increases in a needs-based VA pension or needs-based compensation payment, resulting from unusual medical expenses, are not income. (1-1-93)

348. AUGMENTED OR APPORTIONED VA PAYMENTS.

The portion of a VA pension, compensation or educational benefit added for a dependent is not counted as income to the veteran. Augmented VA payments include extra money for dependents. Apportioned VA payments provide a separate payment to the dependent. The portion of a VA improved pension for a dependent is income to the dependent only if the dependent is a member of an eligible AABD couple. If both the veteran and his spouse are receiving, or applying, for AABD as a couple, and neither spouse is in a nursing home, the Augmented VA payment to the veteran's spouse is counted as income to the AABD unit. The portion of an Augmented VA protected pension payment for a spouse is not income to the veteran or spouse. (7-1-93)

349. ALIMONY, SPOUSAL, AND ADULT SUPPORT.

Alimony, spousal, and other adult support payments are unearned income. (1-1-93)

350. CHILD SUPPORT PAYMENTS.

Child support payments are unearned income. One-third (1/3) of a child support payment is excluded for the child receiving support. Child support collected by a State and retained for AFDC payments is not income. (1-1-93)

01. Child Support Fifty Dollar (\$50) Pass-Through. Child support collected by a State and paid to an AFDC budget unit as a fifty dollar (\$50) bonus is not income to an AABD child, if the AFDC budget unit would receive the same bonus with the AABD child removed from the AFDC family unit. (1-1-93)

021. Excess Child Support Amounts. Child support collected by a state, but paid to an AFDC family because the support exceeds the amount which the state is entitled to keep as reimbursement for AFDC, is a payment of child support. A per capita portion of this payment is income in the form of child support to the AABD child. The per capita portion is determined by dividing the excess payment by the number of children on whose behalf the child support payment was originally made. (1-1-93)

03. Direct Child Support. Support collected by a state for an AABD child, and paid as a child support payment directly to the family, is child support income to the AABD child. (1-1-93)

351. DIVIDENDS AND INTEREST.

Dividends and interest are unearned income. Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts. This income is counted the earliest of: the month credited to a client's account; the month set aside for the client's use; or the month received by the client. Account service fees or penalties for early withdrawal do not reduce the interest or dividend income. (1-1-93)

352. BURIAL FUND AND BURIAL SPACE INTEREST INCOME.

Interest income from an excluded burial fund or burial space purchase agreement is excluded. The burial fund or burial space purchase agreement must be excluded at the time the interest is paid. Interest is unearned income, if the burial fund or space purchase agreement is not excluded when the interest is paid. Increases in value and interest must remain in the fund to be excluded from income. Interest or equity paid to the client is unearned income. (1-1-93)

353. COMMINGLED BURIAL FUNDS INTEREST INCOME.

Interest income from an excluded burial fund or space purchase agreement is excluded, if the fund or space is commingled with burial funds or spaces not excluded. Interest income on the non-excluded burial funds or spaces is unearned income. (1-1-93)

354. AWARDS.

An award is unearned income. An award is a payment resulting from a decision by a court or board of arbitration. (1-1-93)

355. GIFTS.

A gift is unearned income. A gift is subject to the rules on irregular and inconsequential income. A gift is something a client receives, which is not repayment for goods or services. The gift must not be goods or services to repay a debt. A gift must be a permanent transfer. (1-1-93)

356. GIFTS OF DOMESTIC TRAVEL TICKETS.

A ticket for domestic travel received as a gift by a client or spouse is excluded from income. The ticket must not be

converted to cash. Domestic travel is travel by a client or spouse among the fifty (50) states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. The value of gifts of non-domestic travel tickets is counted as unearned income. (1-1-93)

357. PRIZES.

A prize is unearned income. A prize is something won in a contest, lottery, or game of chance. (1-1-93)

358. WORK-RELATED UNEARNED INCOME.

Work-related payments are unearned income. Work-related payments are listed in Subsections 358.01 through 358.04. (1-1-93)

01. Earnings in Institution. Money paid to a resident of a public institution for work performed. (1-1-93)

02. Tips. Tips under twenty dollars (\$20) per month. Tips over this amount are earned income. (1-1-93)

03. Jury Fees. Payments made to jurors for performing jury services. Expense money for jurors is not income. (1-1-93)

04. Armed Forces Benefits. Food, clothing, and shelter given to members of the Uniformed Services and their families. Cash allowances for food, clothing, and shelter. All types of special and incentive pay. (1-1-93)

359. COMMUNITY SERVICE BLOCK GRANTS.

Community service block grants are unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. Community service block grants are provided by the Department of Health and Human Services. (1-1-93)

360. FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS.

FEMA funds are counted as unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. (1-1-93)

361. BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE (BIA GA).

BIA GA payments are unearned income. BIA GA payments are federally-funded income based on need. They are paid in cash or in-kind. The twenty dollar (\$20) general income exclusion does not apply. (1-1-93)

362. BIA ADULT CUSTODIAL CARE (ACC) AND CHILD WELFARE ASSISTANCE (CWA) PAYMENTS.

BIA ACC and CWA payments, other than foster care, made to clients out of an institution, are unearned income. BIA ACC and CWA payments are made for clients in or out of an institution. BIA foster care payments are made under the ACC and CWA programs. (1-1-93)

363. INDIVIDUAL INDIAN MONEY (IIM) ACCOUNTS.

Deposits to an unrestricted IIM account are income in the month deposited. Withdrawals from a restricted IIM account is unearned income the month of withdrawal. A restricted IIM account requires BIA approval for the client to make a withdrawal. An unrestricted account does not require BIA approval for the client to make a withdrawal. (1-1-93)

364. ACCELERATED LIFE INSURANCE INCOME.

Accelerated life insurance payments are unearned income in the month received. Accelerated life insurance payments are paid to the policyholder before death. The payments involve early payout of the proceeds of the life insurance policy. Because the client gets proceeds from the life insurance policy, and not the policy resource value, the accelerated payment is not a conversion of a resource. The client is not required to apply for accelerated life insurance payments, to participate in the AABD or Medicaid programs. (1-1-93)

365. REAL ESTATE CONTRACT INCOME.

Payments on the interest of a negotiable real estate contract are unearned income. Payments on the principal of a

negotiable real estate contract are a resource. Payments on a nonnegotiable real estate contract are unearned income. Payments on an excluded real estate contract of a long-term care client are unearned income. (7-1-94)

366. -- 373. (RESERVED).

374. INCOME DEEMING.

Income deeming counts the income of another person as available to an AABD client. Income is deemed because of relationship or legal association with the client. A husband and wife living together must share income and resources. A parent and child, related by blood, marriage, or adoption, and living together, must share income and resources. The deemed income must be used to determine the client's eligibility for and amount of AABD. (1-1-93)

01. Income Deeming Exclusions. Income excluded from deeming is listed in Table 374.01.

TABLE 374.01 - INCOME DEEMING EXCLUSIONS

Type of Income	Ineligible Spouse or Parent Ineligible Child Eligible Legal Non-citizen	Essential Person	Sponsor of Legal Non-citizen
Income excluded by Federal laws other than the Social Security Act	Excluded	Excluded	Excluded
Public Income Maintenance (PIM). Public income maintenance payments include TAFI, AABD, SSI, refugee case assistance, BIA-GA, VA payments based on need, local, county and state payments based on need, and payments under the 1974 Disaster Relief Act.	Excluded	Not Excluded	Not Excluded
Income used by a PIM program to determine amount of payment to someone other than an SSI recipient.	Excluded	Not Excluded	Not Excluded
Grants, scholarships, fellowships	Excluded	Not (unless excluded by Federal laws)	Not (unless excluded by Federal laws)
Foster care payments.	Excluded	Not Excluded	Not Excluded
Food Stamps and Dept. of Agriculture donated foods	Excluded	Not Excluded	Not Excluded
Home grown produce.	Excluded	Not Excluded	Not Excluded
Tax refunds on real property or food	Excluded	Not Excluded	Not Excluded
Income used in an approved plan for achieving self-support (PASS).	Excluded	Not Excluded	Not Excluded
Income used to pay court ordered or Title IV-D support payments.	Excluded	Not Excluded	Not Excluded
Payments based on age and residence (Alaska residents only).	Excluded (not applicable to children)	Not Excluded	Not Excluded
Disaster Assistance.	Excluded	Excluded	Excluded
Infrequent or irregular income.	Excluded	Not Excluded	Not Excluded
Blind Work Expenses (BWE).	Excluded	Not Excluded	Not Excluded
Payments to provide in-home support.	Excluded	Not Excluded	Not Excluded

Type of Income	Ineligible Spouse or Parent Ineligible Child Eligible Legal Non-citizen	Essential Person	Sponsor of Legal Non-citizen
Home energy assistance and support and maintenance assistance	Excluded	Excluded	Excluded
Child's earned income, up to four hundred dollars (\$400) per month and one thousand six hundred and twenty dollars (\$1,620) per year.	Excluded (not applicable to spouses or parents)	Does not Apply	Does not Apply
Impairment-related work expenses (IRWE)	Excluded	Not Excluded	Not Excluded

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02. When Deeming Starts and Stops. Deeming starts the first full calendar month the client is in a deeming situation. Deeming ends the first full calendar month the client is not in a deeming situation. (1-1-93)

03. Income Deeming Child Age Limit. Deeming to a child ends the month after the child's eighteenth (18th) birthday. Deeming to the child ends even if he lives with his ineligible parent, or the ineligible spouse of his ineligible parent. (1-1-93)

375. DEEMING INCOME FROM INELIGIBLE SPOUSE TO CLIENT.

Income must be deemed from an ineligible spouse to the client, if they reside in the same household. A household is defined by its living arrangement. Clients in a household can live in a home owned or being purchased, the private household of another, rented housing, a board and room home, or a semi-independent group residential facility. Clients living in an institution are not a household. The client's actual needs, as if he is a single person living alone, must be computed. The client's own income, less exclusions and disregards, must be subtracted from his needs. If there is no budget deficit, the client is not eligible for AABD. If there is a budget deficit, the procedures in Subsections 375.01 through 375.10 must be followed to deem income and determine the client's AABD eligibility and grant. (1-1-93)

01. Compute Child's Living Allowance. (1-1-93)

a. Budget each ineligible child in the household the living allowance. The living allowance is the difference between the basic allowance for a person living alone and the basic allowance for a couple. Round up cents to the next dollar. A child receiving public income-maintenance payments is not budgeted a living allowance. (1-1-95)

b. Subtract each child's unearned income from his living allowance. (1-1-95)

c. Subtract the child's earned income from any living allowance remaining. (1-1-93)

02. Compute Unearned Income of Spouse. Compute the gross unearned income of the ineligible spouse. (1-1-93)

03. Compute Earned Income of Spouse. Compute the gross earned income of the ineligible spouse. (1-1-93)

04. Adjust Spouse Income with Child's Living Allowance. Subtract the remaining living allowance, for each ineligible child in the household, from the ineligible spouse's gross unearned income, then from gross earned income. (1-1-93)

05. Add Adjusted Earned and Unearned Incomes. Add adjusted earned and unearned income. This is the deeming income of the ineligible spouse. (1-1-93)

06. Compute Client's Needs as a Single Person. Compute the client's budgeted AABD needs as if he

was a single person, living alone. (1-1-93)

07. Deeming Income Equal to or Less than One-Half (1/2) of Client's Needs. If the deeming income is equal to, or less than, one-half (1/2) of the client's budgeted needs, computed as if he was a single person living alone, no income must be deemed from the ineligible spouse to the client. Compute the client's grant as if he were a single person living alone. Do not deem any income. (1-1-93)

08. Deeming Income More than One-Half (1/2) of Client's Needs. If the deeming income is more than one-half (1/2) of the client's budgeted needs, computed as if he was a single person living alone, proceed with the deeming process. (1-1-93)

09. Compute Client's Income. (1-1-94)

a. Add the remaining earned and unearned ineligible spouse deeming income (after the ineligible child deduction) to the gross earned and unearned income of the client. This is the total earned and unearned income. (1-1-94)

b. Deduct the standard disregard of twenty dollars (\$20) from the total unearned income. (1-1-93)

c. If the total unearned income is less than twenty dollars (\$20), deduct the remainder from the total earned income. (1-1-93)

d. Deduct the earned income disregard of sixty-five dollars (\$65) from the earned income. (1-1-93)

e. Deduct one-half (1/2) of the remaining earned income. (1-1-93)

f. Combine the remaining unearned income and the remaining earned income to compute the total countable income of the client. (1-1-93)

g. Determine the couple's budgeted needs as if they were an eligible couple. (1-1-93)

h. If the client's countable income, including deemed income, is more than the couple's budgeted needs, the client is ineligible to receive AABD. (1-1-93)

i. If the client's countable income, including deemed income, is less than the couple's budgeted needs compute the client's AABD grant. (1-1-93)

10. Determine Grant. (1-1-93)

a. Subtract the client's countable and deemed incomes from the budgeted needs of the couple, to compute the budget deficit. (1-1-93)

b. Compute the budget deficit using the client's budgeted needs, as if he was a single person living alone. (1-1-93)

c. The AABD grant is the smaller of the two budget deficits. (1-1-93)

376. DEEMING INCOME FROM INELIGIBLE PARENT TO AABD CHILD.

Income must be deemed from an ineligible parent, or from the ineligible spouse of an ineligible parent, to a child client under age eighteen (18), if they reside in the same household. A household is defined by its living arrangement. Clients in a household can live in a home owned or being purchased, the private household of another, rented housing, a board and room home, or a semi-independent group residential facility. Clients living in an institution are not a household. Subsections 376.01.a. through 376.02.e. must be followed to determine income deemed from the parents. The deemed income is counted in determining the child's AABD eligibility and grant. A stepparent's income is not deemed to the child for Medicaid eligibility. A stepparent's income is deemed to the child for AABD grant amount. (7-1-94)

01. Income Deemed from Ineligible Parent. (1-1-94)
- a. Compute child's living allowance. (1-1-93)
- i. Budget each ineligible child in the household a living allowance. The living allowance is the difference between the basic allowance for a person living alone and the basic allowance for a couple. Round up cents to the next dollar. A child receiving public income-maintenance payments is not budgeted a living allowance. (1-1-95)
- ii. Subtract each child's unearned income from his living allowance. (1-1-93)
- iii. Subtract the child's earned income from any living allowance remaining. (1-1-93)
- b. Compute the gross unearned income of the ineligible parent. (1-1-93)
- c. Compute the gross earned income of the ineligible parent. (1-1-93)
- d. Subtract the remaining living allowance, for each ineligible child in the household, from the ineligible parent's gross unearned income. If any living allowance remains, subtract it from the parent's earned income. (1-1-93)
- e. The parent may have remaining income. Go to Subsection 376.02. (1-1-93)
02. Parent with Remaining Income. (1-1-93)
- a. Subtract the standard twenty dollar (\$20) disregard from the parent's unearned income. If unearned income is less than twenty dollars (\$20) subtract the balance of the twenty dollars (\$20) from the parent's earned income. (1-1-93)
- b. Subtract the sixty-five dollar (\$65) earned income disregard from the parent's earned income. Subtract one-half (1/2) of the remaining balance of the parent's earned income. (1-1-93)
- c. Combine any remaining parental earned income with any remaining parental unearned income. (1-1-93)
- d. Budget a living allowance for the ineligible parent. For one (1) parent, the living allowance is the basic allowance for a person living alone. For two (2) parents, the living allowance is the basic allowance for a couple. A parent receiving public income maintenance payments is not budgeted a living allowance. Subtract the parent living allowance from the remaining balance of the parent's income. This is the deemed parental income. (1-1-95)
- e. If there is more than one (1) child client in the household, the deemed parental income must be divided equally between those children. Each child's share of parental income must only reduce the amount of his AABD grant to zero (0), when combined with the child's own countable income. Excess deemed parental income, remaining after a child client's grant is reduced to zero (0), must be divided equally between the other child clients in the household. The excess deemed income must be combined with their share of the parental income available for deeming. (1-1-93)
- f. Subtract the standard twenty dollar (\$20) disregard from each child client's unearned income, including deemed income. If a child's total unearned income is less than twenty dollars (\$20), deduct the balance of the standard disregard from the child's earned income. (1-1-93)
- g. Subtract the sixty-five dollar (\$65) earned income disregard and one-half (1/2) of the balance from each child's own earned income. (1-1-93)
- h. Combine each child's unearned income with his earned income. If the child's remaining countable income is more than his actual budgeted needs, the child is not eligible for AABD. If the child's remaining countable

income is less than his actual budgeted needs, the child has a budget deficit. If the child is otherwise eligible, his AABD grant is the budget deficit. (1-1-93)

377. DEEMING INCOME FROM ESSENTIAL PERSON TO CLIENT.

If a client and an essential person reside in the same household, the essential person's income must be deemed to the client. A household is defined by its living arrangement. Clients in a household can live in a home owned or being purchased, the private household of another, rented housing, a board and room home, or a semi-independent group residential facility. Clients living in an institution are not a household. The procedures in Subsections 377.01 through 377.05 are used to determine a client's eligibility and grant amount, when the client resides with an essential person. If essential person deeming would cause the client to be ineligible, do not use essential person deeming. Do not consider the essential person's needs, income, or resources in determining the client's eligibility and grant. If the essential person is the client's ineligible spouse, ineligible parent of a child client, or ineligible spouse of the parent of a child client, and essential person deeming would cause the client to be ineligible for AABD, use the regular deeming provisions in Sections 375 and 376. (1-1-96)T

01. Compute Income. Compute the total earned and unearned income of the essential person. Count the amount as the client's unearned income. Do not count excluded income. (1-1-96)T

02. Add Unearned Income. Add the unearned income of the essential person to the client's unearned income. (1-1-93)

03. Subtract Disregard. Subtract income disregards from the client's income. (1-1-93)

04. Count Income. Any remaining income must be counted to determine the client's eligibility for AABD and grant amount. (1-1-93)

05. Compute Needs. Compute the client's budgeted needs, as though the client and the essential person were an AABD couple. (1-1-93)

06. Subtract Income. Subtract the countable income from the client's budgeted needs. The client's AABD grant, if he is otherwise eligible, is the deficit. (1-1-93)

07. No Deficit. Essential person income is not deemed to the client if there is no budget deficit. If there is no deficit, determine the client's eligibility and grant as though he did not live with an essential person. If the essential person is the client's ineligible spouse, the ineligible parent of a child client, or ineligible spouse of the parent of a child client, use the regular deeming procedures in Sections 375 and 376. (1-1-96)T

378. DEEMING INCOME FROM INELIGIBLE SPOUSE TO CLIENT AND CHILD CLIENT.

If a client, his ineligible spouse and their child client reside in the same household, income is deemed from the client to the child client. A household is defined by its living arrangement. Clients in a household can live in a home owned or being purchased, the private household of another, rented housing, a board and room home, or a semi-independent group residential facility. Clients living in an institution are not a household. The procedures in Subsections 378.01 through 378.05 must be followed to find the deemed income of the ineligible spouse. The deemed income is counted to determine the AABD eligibility and grant of the child client. (1-1-93)

01. Compute Grant. Use the procedures in SubSection 382 to determine if the client is eligible for an AABD grant. If the client is eligible for an AABD grant, no income is deemed to the child client. (1-1-93)

02. Client Not Eligible. If the client has too much income, either his own income or his own income plus income deemed from the ineligible spouse, to be eligible for an AABD grant, all income over the amount needed to reduce the client's AABD grant to zero is deemed to the client child. (1-1-93)

03. Divide Deemed Income. If there is more than one (1) child client in the household, the deemed parental income must be divided equally between those children. Each child's share of parental income must only reduce the amount of his AABD grant to zero (0), when combined with the child's own countable income. Excess deemed parental income, remaining after a child client's grant is reduced to zero (0), must be divided equally between

the other child clients in the household. The excess deemed income must be combined with their share of the parental income available for deeming. (1-1-93)

379. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN PARTICIPANT - NO I-864 AFFIDAVIT OF SUPPORT.

A sponsored alien, admitted to the United States for permanent residence, is subject to deeming from the sponsor. If the alien has a sponsor and the sponsor has executed an affidavit of support or similar agreement, the income and resources of the sponsor, and the sponsor's spouse if living with him, must be deemed. The deemed income must be counted to determine the client's eligibility and grant amount, even if the client does not reside in the sponsor's household. The sponsor's income must not be deemed to the alien for Medicaid eligibility. The client must have been admitted for permanent residence within five (5) years of the date of his application for AABD. The alien client must not be exempt from deeming. Deeming from the sponsor to the alien stops the end of the month, five (5) years from the date the sponsored client lawfully entered the United States for permanent residence. (7-1-94)

01. Alien Client Exempt From Deeming. A lawfully admitted alien client is exempt from sponsor to-alien deeming if one (1) or more of the conditions in Subsections 379.012.a. through 379.01.j. applies. (1-1-93)

a. The alien client was admitted to the United States as a refugee, asylee, or parolee. (1-1-93)

b. The alien client first applied for AABD before October 1, 1980. (1-1-93)

c. The alien client is a permanent resident under color of law. (1-1-93)

d. The alien client's entry into the United States was sponsored by a church, other social service organization, or an employer who has extended a job offer to him. (1-1-93)

e. The alien client becomes blind or disabled after he is admitted to the United States (1-1-93)

f. The alien client was sponsored by and resides in the same household with his ineligible spouse or ineligible parent. The alien client is subject to deeming only from the ineligible spouse and ineligible parent. (1-1-93)

g. The alien's sponsor dies. (1-1-93)

h. The alien entered the United States before January 1, 1972 and has continuously resided here since then. (1-1-93)

i. The alien was legalized under the Immigration Reform and Control Act of 1986. (1-1-93)

j. The alien has resided in the United States for thirty-six (36) months beginning with the month he was admitted for permanent residence or granted permanent residence status. (1-1-93)

k. The alien was admitted under section 249 of the Immigration and Nationality Act. These aliens are called "registry" aliens. (1-1-95)

l. The alien is an applicant for permanent residence who is an Amerasian or a specified relative of an Amerasian. The Amerasian must be born in Vietnam between January 1, 1962 and January 1, 1976. A specified relative is a spouse, child, parent or stepparent of the Amerasian, or someone who has acted in the place of a parent of an Amerasian and/or his spouse or child. (1-1-95)

m. The alien is an applicant for adjustment under the Cuban/Haitian provisions of section 202 of the Immigration Reform and Control Act of 1986. (1-1-95)

02. Sponsor/Alien Relationships. Sponsor/alien relationships and deeming rules are listed in Subsections 379.02.a. through 379.02.f. (1-1-93)

a. If the alien client's sponsor is his ineligible spouse, and the alien client does not reside in the same household with his ineligible spouse, the sponsor to alien deeming provisions must apply. (1-1-93)

b. If the alien client is a child, and does not reside in the same household with his sponsor parent(s), the sponsor to alien deeming provisions must apply. (1-1-93)

c. If the client is a child whose ineligible parent(s) and sponsor both have income available for deeming to him, the income of the ineligible parent(s) must be deemed as in Subsection 376. (1-1-93)

d. If the child remains eligible after income is deemed from his ineligible parent(s), the sponsor's income must be deemed to him under the sponsor to alien deeming procedures. (1-1-93)

e. If each member of a client couple has his own sponsor, separate deeming computations must be used to find the income to be deemed. The couple's countable income must include the combined deemed incomes. (1-1-93)

f. If one (1) member of a couple with separate sponsors is not eligible, the income of the ineligible spouse must be deemed to the client as in Subsection 376. This is in addition to income deemed from the sponsor. (1-1-93)

03. Sponsor to Alien Client Deeming Procedures. The alien client's budget deficit must be computed. Budget the alien client's actual needs, as if he is a single person living alone. Subtract the alien client's own income, less exclusions and disregards. If the alien client has a client spouse who is also an alien, compute their needs as an ineligible couple. Subtract the couple's income, less applicable income exclusions, from the needs of the couple. If there is no budget deficit, the alien client is not eligible for AABD. If there is a budget deficit, the procedures in Subsections 379.03.a. through 379.03.e. must be followed. This determines the income of the alien client's sponsor and the sponsor's spouse, if living with him, deemed when computing the alien client's eligibility and grant amount. A sponsor's income is not deemed to the alien for Medicaid eligibility. (7-1-93)

a. **Subject to Deeming.** The alien client must be subject to the sponsor -to-alien deeming requirement. (1-1-93)

b. **Compute Income.** Compute the gross monthly earned and unearned income of the sponsor, and the sponsor's spouse, if living with him. Do not count income excluded from deeming. (1-1-93)

c. **Subtract Living Allowance.** Subtract a living allowance for the sponsor the sponsor's spouse, if living with him. The sponsor's living allowance is the basic allowance for a single person living alone. The living allowance for the sponsor's spouse is one-half the basic allowance for a single person living alone. Round up cents to the next dollar. (1-1-95)

d. **Subtract Dependent Living Allowance.** Subtract a living allowance for each dependent claimed by the sponsor on his most recent Federal tax return. Do not subtract an allowance for the alien client. Do not subtract an allowance for the sponsor's spouse in this step. The living allowance for each dependent is one-half the basic allowance for a single person living alone. Round up cents to the next dollar. Do not reduce the living allowance by the dependent's income. (1-1-95)

e. **Deem Income.** Income remaining is deemed to the client from the sponsor. It is counted as unearned income. The deemed income is added to the client's other unearned income to compute AABD eligibility and grant amount. (1-1-93)

380. -- 399. (RESERVED).

400. FINANCIAL NEED AND GRANT AMOUNT.

The AABD grant is the amount of financial need. Allowances for basic living expense and special needs must be computed. The client's total income must be computed. Income exclusions and disregards must be deducted. The client's allowances and net income are compared. If the client's allowances exceed his net income, there is financial need. (7-1-93)

401. -- 404. (RESERVED).

405. FINANCIAL NEED AND GRANT AMOUNT FOR DRUG ADDICTS AND ALCOHOLICS.

SSI or SSDI (Social Security Disability Insurance) continues to count as income for financial need and grant amount when suspended or stopped because of drug addiction or alcoholism. (7-1-96)

406. SPECIAL NEEDS ALLOWANCES.

Special needs allowances include a restaurant allowance and a guide dog food allowance, and a home care allowance. (1-1-93)

01. Eating in Restaurants. The special needs allowance for eating in restaurants is fifty dollars (\$50) monthly. The client must be budgeted the allowance if a physician states, in writing, the client is physically unable to prepare food in his home. A client physically able to prepare his food, but living in a place where cooking is not permitted, must be budgeted the special needs allowance for eating in restaurants. The allowance for living in a place where cooking is not permitted must not be issued more than three (3) months. (1-1-93)

02. Guide Dog Food. The special needs allowance for guide dog food is seventeen dollars (\$17) monthly. A blind client, using a guide dog trained by a recognized guide dog school, must be budgeted the allowance. (1-1-93)

03. Home Care. The special needs allowance for home care is fifty dollars (\$50) monthly. The allowance must be budgeted if the following conditions are met. The client must live with a relative in the relative's home. The client must not be charged for room and board. The relative can charge rent. If not budgeted a home care allowance, the client might be placed outside his or his relative's home. (1-1-93)

407. BASIC ALLOWANCE.

The basic allowance is budgeted for clients not living in a nursing facility. The client's living situation listed in Subsections 407.01 through 407.09 of these rules must be used to determine his basic allowance. (7-1-93)

01. Living Alone. A client must be budgeted four hundred ninety-five dollars (\$495) monthly as a basic allowance, if there is one (1) person in the AABD grant. (1-1-95)

02. Living with Essential Person. The essential person is chosen by the client. The presence of the essential person, in the household, must be essential to the client's well being. The essential person must give services to the client that would have to be provided anyway if the client lived alone. The client must decide if an essential person he lives with is to be included in his AABD grant. The needs, income, and resources of the essential person included in the AABD grant, must be counted in determining the AABD grant. The monthly total basic allowance for the client and the essential person is six hundred ninety-six dollars (\$696). (1-1-95)

03. Living with Another Client. The other client must not be the AABD client's spouse. The other client may receive AFDC if he is not the AABD client's spouse or dependent child. The grant for each client is determined separately. The AABD client must be budgeted a basic allowance of four hundred ninety-five dollars (\$495) monthly, if there is one (1) person in the AABD grant. (1-1-95)

04. Living with Client Spouse. If the AABD client lives with his AABD client spouse in the same household, the basic allowance is based on two (2) persons in the AABD grant. The two (2) AABD spouses in the AABD grant must be budgeted a basic allowance of six hundred ninety-six dollars (\$696) monthly. (1-1-95)

05. Living in Another Person's Household. A client living in another person's household must be budgeted a basic allowance of four hundred ninety-five dollars (\$495) monthly for one (1) person in the AABD grant. For two (2) persons in the AABD grant, the basic allowance is six hundred ninety-six dollars (\$696) monthly. (1-1-95)

06. Living with AFDC Child. A client living with his AFDC child must be budgeted four hundred ninety-five dollars (\$495) monthly as a basic allowance, if there is one (1) person in the AABD grant. If there are two (2) persons in the AABD grant the basic allowance for two (2) clients is six hundred ninety-six dollars (\$696)

monthly. (1-1-95)

07. Living in Hotel or Rooming House. A client, living in a hotel or rooming house, must be budgeted the basic allowance of four hundred ninety-five dollars (\$495) monthly. A client and his AABD spouse, living in a hotel or rooming house must be budgeted the basic allowance for two (2) clients, six hundred ninety-six dollars (\$696) monthly. (1-1-95)

08. Room and Board, Adult Care, or Foster Care. An AABD client living in a room and board home, a licensed adult residential care facility, or a licensed adult foster care home is budgeted a basic allowance of fifty-eight dollars (\$58) monthly. (1-1-93)

09. SIGRIF. An AABD client living in a semi-independent group residential facility must be budgeted a basic allowance of three hundred forty-nine dollars (\$349) monthly. A client living with his client spouse in a SIGRIF must be budgeted a basic allowance of three hundred and forty-nine dollars (\$349) monthly. (7-1-96)

408. ROOM AND BOARD ALLOWANCES.

Each client living in a room and board home must be budgeted a basic allowance of fifty-eight dollars (\$58) monthly. The client is budgeted a special needs allowance if he has a guide dog. Each AABD client living in a room and board home is budgeted the actual amount paid for room and board, but not more than four hundred seventy-two dollars (\$472) monthly. (1-1-95)

409. LICENSED ADULT RESIDENTIAL CARE FACILITY ALLOWANCES.

Each client living in a licensed adult residential care facility must be budgeted a basic allowance of fifty-eight dollars (\$58) monthly. The client is budgeted a special needs allowance if he has a guide dog. A client's allowance for the licensed adult residential care facility is the monthly allowance for his level of care. If the client gets a lower level of care than his assessed level, his allowance must be for the lower level of care. Care levels and monthly allowances are listed in Subsections 409.01 through 409.03. (1-1-95)

01. Level I. Six hundred fifty dollars (\$650). (1-1-95)

02. Level II. Seven hundred three dollars (\$703). (1-1-95)

03. Level III. Seven hundred fifty-three dollars (\$753). (1-1-95)

410. ADULT RESIDENTIAL CARE ASSESSMENT AND LEVEL OF CARE.

The Regional Adult Residential Care Committee (ARCC) must approve the client's need for care, the level of care, a plan of care, and the licensed adult residential care facility's ability to provide the care. The assessment of care is a condition of the licensed adult residential care facility allowance. The assessment must be documented in the case record. It must include the level of care and the effective date. (1-1-93)

01. Frequency of ARCC Assessment. A level of care assessment is required when a client is admitted to a licensed adult residential care facility. Level of care must be reviewed if the ARCC determines the level of care required by the client may have changed. A level of care assessment is required when a client living in an adult residential care facility moves to a different adult residential care facility. (1-1-93)

02. Admission Without Assessment-Emergency Placement. An AABD client may be admitted to a licensed adult residential care facility in an emergency, before an assessment is done. The client must be budgeted the Adult Residential Care Facility Allowance for the lowest level of care in the living situation, until an assessment is completed and the level of care assigned. The ARCC must determine if the placement, without an assessment, is an emergency placement. Emergency placements include discharge from a hospital or nursing facility with no living situation to return to, and the need to remove the client from an unsafe environment. If the level of care assigned by the ARCC is higher than the lowest level, an underpayment must be restored. The underpayment must begin the date the client was admitted to the facility. If the ARCC finds the client does not need care in the adult residential care facility, the client must be budgeted the room and board allowance. If the client needs care at a level higher than the facility is licensed to provide, the client must be budgeted the room and board allowance. (1-1-93)

03. Admission Without Assessment-Not An Emergency Placement. An AABD applicant may be

admitted to an adult residential care facility without an assessment of level of care. If the admission is not an emergency, the AABD application must be held pending the assessment, or for thirty (30) days from the date of application, whichever is earlier. If the Department did not place the client in the facility, the AABD payment must be based on room and board allowances. The room and board allowance continues until the assessment is completed, or for thirty (30) days, whichever is earlier. If the ARCC is responsible for delay in assessment, but the assessment and level of care are eventually completed, the client's AABD payment must be based on the budget allowances for his assessed level of care, starting with the earliest date the assessment would have been completed had the ARCC acted timely. (1-1-93)

04. **ARCC Change in Level of Care.** The ARCC may assess a different level of care than being paid. This is caused by a change in the client's needs, or a level of care provided by the residential care facility, lower than the assessed level of care. The client's eligibility and payment must be determined using the new level of care. (1-1-93)

05. **Increase in Level of Care.** A client in an adult residential care facility may have an increase in level of care. The Examiner must verify the client requires and receives a higher level of care with the ARCC. The proof must include the effective date of the change in level of care. The increase is effective the date the ARCC reassesses the client's level of care. The supplemental payment, if any, is the difference between the AABD grant at the lower level of care and the AABD grant at the higher level of care. (1-1-93)

06. **Decrease in Level of Care.** When a client, in an adult residential care facility, has a decrease in his level of care during a month, the AABD payment must be changed. The Examiner must verify with the ARCC the client requires a lower level of care. The grant must be decreased or closed, following timely notice. No overpayment exists for the month. (1-1-93)

411. -- 420. (RESERVED).

421. MOVE FROM LICENSED ADULT RESIDENTIAL CARE FACILITY TO LIVING SITUATION OTHER THAN A NURSING HOME OR HOSPITAL.

A client may move from a licensed adult residential care facility to a living situation, other than a nursing home or hospital. No change to his AABD grant must be made, based on the move, until the next month. (1-1-93)

422. MOVE TO A LICENSED ADULT RESIDENTIAL CARE FACILITY FROM NURSING HOME OR HOSPITAL.

A client may move to an adult residential care facility from a nursing home or hospital. AABD eligibility, payment amount and underpayment must be determined for the month of the move. An underpayment for a month a client moves to a licensed adult residential care facility, from a nursing home or hospital, is determined using Subsections 410.01 through 410.06. (1-1-93)

01. **STEP 1.** Determine the amount of the Adult Residential Care Facility Allowance. Divide the monthly allowance by thirty (30). Do not exceed the maximum Adult Residential Care Facility Allowance. (1-1-93)

02. **STEP 2.** Multiply the result by the number of days remaining in the month. Begin with the day after the day the client's nursing home or hospital care ceases. Use this amount to compute the AABD payment in the Adult Residential Care Facility. Income already used to meet patient liability in the nursing home must not be counted against the AABD grant in the Adult Residential Care Facility for the month of the move. (1-1-93)

03. **STEP 3.** Subtract from the available income the nursing home personal needs allowance. (1-1-93)

04. **STEP 4.** Multiply the client's daily rate for nursing home care by the number of days in the month the client got nursing home care. (1-1-93)

05. **STEP 5.** Subtract this amount from the remaining income. (1-1-93)

06. **STEP 6.** Use the remaining income to compute the AABD payment in the Adult Residential Care Facility for the month of the move. All income must be counted to determine AABD income limit for the month. (1-1-93)

423. MOVE TO A LICENSED ADULT RESIDENTIAL CARE FACILITY FROM LIVING SITUATION OTHER THAN NURSING HOME OR HOSPITAL.

A client may move to a licensed adult residential care facility, from a different living situation, other than a nursing home or hospital. The AABD underpayment for the month of the move is determined using Subsections 423.01 through 423.03. (1-1-93)

TABLE 423 - COMPUTING ADULT RESIDENTIAL CARE UNDERPAYMENT AFTER MOVING FROM OTHER LIVING SITUATION

- (30).
01. STEP 1. Divide the Adult Residential Care Facility Allowance for the client's level of care by thirty (1-1-93)
 02. STEP 2. Multiply the result by the number of days remaining in the month. Begin counting with the day the client entered the adult residential care facility. (1-1-93)
 03. STEP 3. Any remainder is the amount of the client's AABD underpayment for the month of the move. The remainder must be rounded to the next higher dollar, if it is not an even dollar. (1-1-93)

424. LICENSED ADULT FOSTER CARE HOME ALLOWANCES.

Each client living in a licensed adult foster care home must be budgeted a basic allowance of fifty-eight dollars (\$58) monthly. The client is budgeted a special needs allowance if he has a guide dog. A client's allowance for the licensed adult foster care home is the cost for the level of care. The allowance must not exceed the monthly allowance for his level of care. If the client gets a lower level of care than his assessed level, his allowance must be for the lower level of care. Care levels and monthly allowances are listed in Subsections 424.01 through 424.03. (1-1-95)

01. Level I. Six hundred fifty dollars (\$650). (1-1-95)
02. Level II. Seven hundred three dollars (\$703). (1-1-95)
03. Level III. Seven hundred fifty-three dollars (\$753). (1-1-95)

425. LICENSED ADULT FOSTER CARE HOME ASSESSMENT AND LEVEL OF CARE.

The Regional Adult Residential Care Committee (ARCC) must approve the client's need for care, the level of care, a plan of care, and the licensed adult foster care home's ability to provide the care. The assessment of care is condition of paying the licensed adult foster care home allowance. The assessment must be documented in the case record. It must include the effective date and the level of care. (1-1-93)

01. Frequency of ARCC Assessment. A level of care assessment is required when a client is admitted to an adult foster care home. Level of care must be reviewed if the ARCC determines the level of care required by the client may have changed. A level of care assessment is required when a client, living in an adult foster care home, moves to a different adult foster care home. (1-1-93)
02. Admission Without Assessment-Emergency Placement. An AABD client may be admitted to an adult foster care home in an emergency, before an assessment is done. The client must be budgeted the adult foster care home allowance for the lowest level of care in the living situation, until an assessment is completed and the level of care assigned. The ARCC must determine if the placement, without an assessment, is an emergency placement. Emergency placements include discharge from a hospital or nursing facility with no living situation to return to, and the need to remove the client from an unsafe environment. If the level of care assigned by the ARCC is higher than the lowest level, an underpayment must be restored. The underpayment must begin the date the client was admitted to the foster home. If the ARCC finds the client does not need adult foster care home care, the client must be budgeted the room and board allowance. If the client needs care at a level higher than the facility is licensed to provide, the client must be budgeted the room and board allowance. (1-1-93)

03 Admission Without Assessment - Not An Emergency Placement. An AABD applicant may be admitted to a licensed adult foster care home without an assessment of level of care. If the admission is not an emergency the AABD application must be held pending the assessment, or for thirty (30) days from the date of

application, whichever is earlier. If the Department did not place the client in the home, the AABD payment must be based on room and board allowances. The room and board allowance continues until the assessment is completed, or for thirty (30) days, whichever is earlier. If the ARCC is responsible for delay in assessment, but the assessment and level of care are eventually completed, the client's AABD payment must be based on the budget allowances for his assessed level of care, starting with the earliest date the assessment would have been completed had the ARCC acted timely. (1-1-93)

04. ARCC Change in Level of Care. The ARCC may assess a different level of care than being paid. This is caused by a change in the client's needs, or a lower level of care provided by the adult foster home than the assessed level of care. The client's eligibility and payment must be determined using the new level of care. A grant decrease or closure must be made as soon as possible, following timely notice. A grant increase must be effective the date of the new ARCC assessment. The underpayment is the difference between the AABD grant at the lower level of care and the AABD grant at the higher level of care. (1-1-93)

05. Increase in Level of Care. A client in an adult foster home may have an increase in his level of care. The Examiner must verify the client requires and receives a higher level of care with the ARCC. The proof must include the effective date of the change in level of care. The increase is effective the date the ARCC reassesses the client's level of care. The supplemental payment, if any, is the difference between the AABD grant at the lower level of care and the AABD grant at the higher level of care. (1-1-93)

06. Decrease in Level of Care. When a client in an adult foster home has a decrease in his level of care during a month, a change must be made to the AABD grant payment. The Examiner must verify, with the ARCC, the client requires a lower level of care. A grant decrease or closure must be made as soon as possible, following timely notice. (1-1-93)

426. MOVE FROM LICENSED ADULT FOSTER CARE HOME TO LIVING SITUATION OTHER THAN A NURSING HOME OR HOSPITAL.

A client may move from a licensed adult foster care home to a living situation, other than a nursing home or hospital. No change to his AABD grant must be made, based on the move, until the next month. (1-1-93)

427. MOVE TO A LICENSED ADULT FOSTER CARE HOME FROM NURSING HOME OR HOSPITAL.

A client may move to a licensed adult foster care home from a nursing home or hospital. AABD eligibility, payment amount and underpayment must be determined for the month of the move. An underpayment for a month a client moves to a licensed adult foster care home, from a nursing home or hospital, is determined using Subsections 427.01 through 427.06. (1-1-93)

01. STEP 1. Determine the amount of the Adult Foster Care Home Allowance. Divide the monthly allowance by thirty (30). Do not exceed the maximum Adult Foster Care Home Allowance. (1-1-93)

02. STEP 2. Multiply the result by the number of days remaining in the month. Begin with the day after the day the client's nursing home or hospital care ceases. Use this amount to compute the AABD payment in the Adult Foster Care Home. Income already used to meet patient liability in the nursing home must not be counted against the AABD grant in the Adult Foster Care Home for the month of the move. (1-1-93)

03. STEP 3. Subtract from the available income the nursing home personal needs allowance. (1-1-93)

04. STEP 4. Multiply the client's daily rate for nursing home care by the number of days in the month the client got nursing home care. (1-1-93)

05. STEP 5. Subtract this amount from the remaining income. (1-1-93)

06. STEP 6. Use the remaining income to compute the AABD payment in the Adult Foster Care Home for the month of the move. All income must be counted to determine AABD income limit for the month. (1-1-93)

428. MOVE TO A LICENSED ADULT FOSTER CARE HOME FROM LIVING SITUATION OTHER THAN NURSING HOME OR HOSPITAL.

A client may move to a licensed adult foster care home, from a different living situation, other than a nursing home or hospital. The AABD underpayment for the month of the move is determined using Subsections 428.01 through 428.03. (1-1-93)

01. STEP 1. Divide the Licensed Adult Foster Care Home Allowance for the client's level of care by thirty (30). (1-1-93)

02. STEP 2. Multiply the result by the number of days remaining in the month. Begin counting with the day the client entered the adult residential care facility. (1-1-93)

03. STEP 3. Any remainder is the amount of the client's AABD underpayment for the month of the move. The remainder must be rounded to the next higher dollar, if it is not an even dollar. (1-1-93)

429. SEMI-INDEPENDENT GROUP RESIDENTIAL FACILITY ALLOWANCE.

The Adult Residential Care Committee (ARCC) must certify need for care, before the semi-independent group residential facility allowances can be budgeted. Each client living in a semi-independent group residential facility must then be budgeted a basic allowance of three hundred forty-nine dollars (\$349) monthly. The client must be budgeted a special needs allowance if he has a guide dog. A client's monthly semi-independent group residential facility allowance is two hundred forty-four dollars (\$244) monthly. (1-1-95)

01. Verifying Need for Semi-Independent Group Residential Facility Care. A client living in a semi-independent group residential facility must show need for this type of care. A statement from the Adult Residential Care Committee (ARCC) in the case file must certify the client's need for semi-independent group residential care. After need for care is certified, no redetermination of need for care is required. (1-1-93)

02. Need For Care Not Approved by ARCC. When the ARCC shows the client does not require semi-independent group residential facility care, or no longer requires such care, his allowances must not exceed those of a client living independently. (1-1-93)

430. ADULT RESIDENTIAL CARE FACILITY OR ADULT FOSTER HOME NOT LICENSED.

A client may live in an adult residential care facility, or adult foster care home, that is not licensed. Unlicensed adult residential care facilities and unlicensed adult foster care homes must be reported to the Licensure and Certification Section of the Department's Facility Standards Program. Each client living in the unlicensed adult residential care facility or adult foster home must be budgeted a basic allowance of fifty-eight dollars (\$58) monthly. The client must be budgeted a special needs allowance if he has a guide dog. A client's unlicensed adult residential care facility or unlicensed adult foster care home allowance is the cost for his level of care. His allowance must not exceed three hundred and thirty dollars (\$330) monthly. (1-1-93)

431. -- 440. (RESERVED).

441. TABLE 441 - CHANGE IN LIVING SITUATIONS THAT CAN RESULT IN UNDERPAYMENT.

FROM	TO
Client's Own Home	Room and board home, unlicensed adult residential care facility, or unlicensed adult foster care home.
Rented Housing	Room and board home, unlicensed adult residential care facility, or unlicensed adult foster care home.
Semi-independent Group Residential Facility	Room and board home, unlicensed adult residential care facility, or unlicensed adult foster care home.
Room and Board Home	Client's own home, rented housing, or a semi-independent group residential facility.
Unlicensed Adult Residential Care Facility	Client's own home, rented housing, or a semi-independent group residential facility.
Unlicensed Adult Foster Care Home	Client's own home, rented housing, or a semi-independent group residential facility.

(7-1-96)

442. CLIENT MOVES FROM NURSING HOME OR HOSPITAL.

When a client moves from a nursing home or hospital, to a different living situation, but not an adult residential care facility or adult foster care home, his AABD payment for the month is determined as though he had lived in his new living situation the entire month. His AABD payment for the month is his AABD allowances less his countable income. (7-1-96)

443. MOVE FROM INSTITUTION TO PRIOR LIVING ARRANGEMENT.

A client eligible for AABD payments, because of conditional release from an institution for mental diseases must not receive an underpayment for the month he returns to his prior living arrangement, unless his costs increase for the month he returns. The client may receive an underpayment from a past month. (1-1-93)

444. EARNED INCOME DISREGARDS AND EXCLUSIONS.

Earned income disregards and exclusions are taken from AABD earned income in the order listed in Subsections 444.01 through 444.09. They are applied the month the income is paid. Any unused earned income disregard or exclusion is never applied to unearned income. Any unused portion of a monthly disregard or exclusion cannot be carried over for use in future months. (1-1-93)

- 01. EITC. Earned income tax credit payments, are excluded. (1-1-93)
- 02. Infrequent or Irregular Income. Up to ten dollars (\$10) of earned income in a month is excluded if it is infrequent or irregular. (1-1-93)
- 03. Blind or Disabled Student Child. Up to four hundred dollars (\$400) per month, but not more than one thousand six hundred twenty dollars (\$1,620) in a calendar year, of the earned income of a blind or disabled student child is excluded. (1-1-93)
- 04. Unused Unearned Income Disregard. Any portion of the twenty dollar (\$20) monthly income disregard not used for unearned income is taken from earned income. Apply only once a month per couple. (1-1-93)
- 05. Sixty-Five Dollar (\$65) Earned Income Disregard. Sixty-five dollars (\$65) of earned income in a month is disregarded. Apply only once a month per couple. (1-1-93)
- 06. Impairment-Related Work Expense (IRWE). Earned income of disabled persons used to pay impairment-related work expenses is excluded. (1-1-93)
- 07. One-Half (1/2) Remaining Earned Income Disregard. One-half (1/2) of remaining earned income in

a month is disregarded. (1-1-93)

08. Blindness Work Expense Disregard. Earned income of blind persons used to meet work expenses is excluded. (1-1-93)

09. PASS. Earned income used to fulfill an approved plan to achieve self-support is excluded. (1-1-93)

445. SIXTY-FIVE DOLLAR (\$65) EARNED INCOME DISREGARD.

Sixty-five dollars (\$65) of earned income in a month are not counted. Apply the sixty-five dollar (\$65) disregard only once a month to a couple in the same household. The disregard must be used in the month the income is received. (1-1-93)

446. IMPAIRMENT-RELATED WORK EXPENSE (IRWE) DISREGARD.

Impairment-related work expenses are items and services needed and used by a disabled, AABD client to perform work. The items must be needed because of the client's impairment. The items may be bought or rented. The cost for impairment-related work expenses must be subtracted from the client's earned income, to determine eligibility and grant amount. An item disregarded as a blindness work expense, or as part of a PASS, cannot be disregarded as an impairment-related work expense. The exclusion must meet the rules in Subsections 446.01 through 446.01.e. Disregarded impairment-related work expenses are listed in Subsections 446.02 through 446.02.h. (7-1-93)

01. IRWE Exclusion Rules. IRWE are excluded for AABD purposes when the following rules are met. (1-1-93)

a. Disabled. The client is disabled, but not blind. The client is under age sixty-five (65) or received SSI or disability payments under a former state plan as a disabled person for the month before reaching age sixty-five (65). Blindness Work Expenses (BWE) should be used for a client who is blind because BWE are more generous than IRWE. (7-1-93)

b. Impairment requires items or services. The severity of the impairment requires the person to purchase or rent items and services to work. (1-1-93)

c. Not paid by another source. The cost is paid in cash, including checks or other forms of money, by the disabled client. The cost must not be payable from another source, such as Medicare, Medicaid, or private insurance. (1-1-93)

d. Reasonable expense. The cost of the impairment-related item or service must be reasonable. The cost must not exceed the current charge for the item or service under Medicare. If not listed in the Medicare guidelines, the cost must not exceed the normal charge for the same or similar item or service in the client's community. (1-1-93)

e. Month of expense. Payment must be made during a month the client is working, or during the eleven (11) month period preceding the month he began working. If payment was made during the prior period, the amount must be prorated over the twelve (12) consecutive month period beginning with the month of the payment. The payment disregarded is the prorated portion for the month work began and the following work months. (1-1-93)

02. Disregarded Impairment-Related Work Expenses. (1-1-93)

a. Attendant care services. Payments for attendant care services related to enabling the client to work. Payments to family members related by blood, marriage, or adoption, are disregarded only if the family member suffers an economic loss. The loss must be due to ending or reducing work hours to give attendant care. The family member may or may not live with the client. (1-1-93)

b. Medical devices. Medical devices include, but are not limited to wheelchairs, hemodialysis equipment, canes, crutches, inhalators and pacemakers. (1-1-93)

c. Prosthetic devices. Prosthetic devices needed to perform work. (1-1-93)

d. Special equipment. Work-related special equipment including, but not limited to, one-half typewriters, visual aids, communication devices for the deaf, and tools designed to accommodate a person's impairment. (1-1-93)

e. Residential modifications. Residential modifications under the following conditions: For clients who work at home, only those modifications related to creating a working space to accommodate the person's impairment. For clients who work away from home, only those modifications made to the outside of the home to provide access to transportation including, but not limited to, a wheelchair ramp or special railings or pathways. (1-1-93)

f. Medical expenses. Payments for prescribed drugs, medical supplies, medical services or physical therapy necessary to control the client's impairment. (1-1-93)

g. Transportation costs. Costs of vehicle modification critical to the client's operation or use of the vehicle. The costs must be impairment-related and do not include the cost of the vehicle. Costs of hiring transportation needed to reach work, including amounts paid to a hired driver, taxicab, or other hired vehicle costs. An allowance for mileage at the IRS mileage rate if a client must drive his own unmodified vehicle to and from work because his impairment prevents use of public transportation. The need to drive cannot be caused by lack of public transportation. A physician or other source must verify the need to drive is caused by the client's impairment. (1-1-93)

h. Maintenance. Costs of installing, maintaining, and repairing items deductible as impairment-related work expenses. (1-1-93)

447. ONE-HALF REMAINING EARNED INCOME DISREGARD.

One-half (1/2) of earned income remaining, after the IRWE is subtracted, is not counted as income. (1-1-93)

448. BLINDNESS WORK EXPENSE DISREGARD.

Earned income of a blind person, used to pay costs of earning the income, is excluded. The blind person must be under age sixty-five (65). If the blind person is age sixty-five (65) or older, he must have received SSI for blindness or received AABD for the month before he became age sixty-five (65). (1-1-93)

01. Blind Work Expense Conditions. Blindness work expenses will be disregarded. No maximum will be applied to the monthly amount of disregarded expenses. The amount must be reasonable and must not exceed the client's monthly earnings. (1-1-93)

02. No Duplication for Blind Work Expenses. Expenses, subtracted under the impairment-related work expense disregard, cannot be subtracted again under this disregard. (1-1-93)

03. Disregards for Blind Work Expenses. Expenses which can be disregarded are listed in Subsections 448.03.a. through 448.03.f.iii. (1-1-93)

a. Transportation expenses. (1-1-93)

i. The actual cost of bus or cab fare. (1-1-93)

ii. The cost of operating a private automobile, computed at the per mile rate allowed by the IRS. (1-1-93)

b. Training or instruction. (1-1-93)

i. Cane travel instruction. (1-1-93)

ii. Braille instruction. (1-1-93)

iii. Instructions in grammar, if work-related. (1-1-93)

- iv. Stenotype instruction for blind typist. (1-1-93)
- v. Key punch training. (1-1-93)
- vi. Computer program training course. (1-1-93)
- c. Job-related expenses. (1-1-93)
 - i. Equipment needed to perform job. (1-1-93)
 - ii. Licenses. (1-1-93)
 - iii. Professional association dues. (1-1-93)
 - iv. Safety shoes. (1-1-93)
 - v. Tools needed to perform job. (1-1-93)
 - vi. Uniforms and the cost of their care. (1-1-93)
 - vii. Union dues. (1-1-93)
- d. Blind-related expenses. (1-1-93)
 - i. One (1) guide dog and his upkeep. (1-1-93)
 - ii. Optical aids. (1-1-93)
 - iii. Reader. (1-1-93)
 - iv. Translation of materials into Braille. (1-1-93)
 - e. Other disability expenses. (1-1-93)
 - i. Prosthesis needed to perform job, even if not related to blindness. (1-1-93)
 - ii. Wheelchair, if necessary due to other disability. (1-1-93)
 - f. Other expenses. (1-1-93)
 - i. Child care costs, if not otherwise provided. (1-1-93)
 - ii. Lunches. (1-1-93)
 - iii. State and federal income taxes. (1-1-93)

449. STANDARD DISREGARD.

The standard disregard is twenty dollars (\$20). The standard disregard is first subtracted from unearned income. If the unearned income is less than the standard disregard, the remainder of the standard disregard is subtracted from earned income. (1-1-93)

01. Standard Disregard and a Couple. A husband and wife, living together in the same household, can have only one (1) standard disregard subtracted from their combined income. (1-1-93)

02. Standard Disregard Exception. The standard disregard must not be applied to nonservice-connected VA payments. (1-1-93)

450. PLAN TO ACHIEVE SELF-SUPPORT (PASS).

A blind or disabled client, with an approved plan to achieve self-support (PASS), must have income and resources disregarded for AABD eligibility and grant amount. Conditions for this disregard are listed in Subsections 450.01 through 450.03. (1-1-93)

01. Under Sixty-Five (65). The client must be under sixty-five (65), or have received AABD for the blind or disabled during the month of his sixty-fifth (65th) birthday. (1-1-93)

02. Approved PASS. A client receiving SSI must have a PASS approved by the Social Security Administration. A client not receiving SSI must have a PASS approved by the Department. (1-1-93)

03. Income Necessary for Self-Support. The income and resources disregarded under the PASS must be necessary for the client's to achieve self-support. (1-1-93)

451. -- 460. (RESERVED).

461. PASS APPROVED BY DEPARTMENT.

A PASS approved by the Department must be in writing. The PASS must contain all the items in Subsections 461.01 through 461.06. (1-1-93)

01. Occupational Objective. The PASS must specify an occupational objective. (1-1-93)

02. Specific Goals. The PASS must specify goals for using the disregarded income and resources to achieve self-support. (1-1-93)

03. Time Limit. An approved PASS is limited to an initial period of eighteen (18) months. An extension period up to eighteen (18) more months can be added. The extra time must be needed to achieve the occupational goal. A second extension of up to twelve (12) months can be granted, when the original PASS included an occupational goal requiring extensive education or vocational training. The PASS must show a specific target date to achieve the goal. (1-1-93)

04. No Duplication of Disregards. An item disregarded as an impairment-related work expense or under the blindness exception cannot be disregarded under the PASS. (1-1-93)

05. Resource Limitation. The PASS disregard must not be applied to resources, unless the resources cause the client to be ineligible without the PASS disregard. (1-1-93)

06. Disregard of Resources. The PASS must show resources the client has, or will receive, under the plan. The PASS must show how the resources will be used to achieve the occupational goal. The PASS must list goal-related items or activities requiring savings or purchases and the amounts the client plans to save or spend. The PASS must list resources disregarded under the plan. The PASS must show how resources disregarded under the plan will be kept identifiable from the client's other resources. (1-1-93)

462. COUPLE INCOME COMPUTATION FOR MARRIED CLIENTS.

The method of computing AABD income for a couple depends on whether they live in a household or an institution. When the client and his client spouse live together in the same household, their income is combined to determine their AABD eligibility and grant amount. The twenty dollar (\$20) standard income disregard and the sixty-five dollar (\$65) earned income disregard are applied once a month, per couple. A couple living in an institution must have income budgeted for two (2) single people. (1-1-93)

01. Household for Couple. A household includes a home owned, or being bought, by the couple. The couple can rent housing. The couple can live in the private home of another person. The couple can live in a room and board home. (7-1-96)

02. Institutional Living Arrangement Not a Household for Couple. An institutional living arrangement is not a household. An institutional living arrangement includes a hospital, a nursing home, an adult residential care facility, an adult foster care home or a semi-independent group residential facility. None of these living arrangements

is a household. (7-1-96)

03. Couple Living Arrangement for Entire Month. A couple living together as of the first day of a month, is counted as living together throughout that month. Budgeting as a couple continues through the month the couple stops living together. (1-1-93)

463. AABD GRANT PAYMENTS.

AABD grant payments must be made at one hundred percent (100%) of a client's budget deficit. (1-1-93)

01. AABD Payment for Couple. An AABD couple living together in the same household will receive their monthly AABD payment in one (1) warrant. (1-1-93)

02. AABD Payment Procedures. If a client for AABD is found eligible, the Department must take all necessary actions to issue the AABD grant payment. If the budget deficit is not in an even dollar amount, the AABD grant payment must be paid at the next higher dollar. (1-1-93)

03. Months For Which AABD Payment is Made. If a client meets all eligibility factors for AABD on the date of application, the effective date of the AABD grant is the date of application. AABD grant payments must continue to be made to a client through the month eligibility ceases. A client for AABD for the aged will be eligible to receive a grant payment starting the month he reaches age sixty-five (65). (1-1-93)

04. Form and Negotiation of Payment. AABD grant payments are made in the form of a state warrant. AABD grant payments must be delivered to clients through the U.S. Postal Service. Even if a client requests otherwise, AABD grant payments are to be delivered only to persons awarded the grant. State warrants must be endorsed only by the person named on the warrant. If a client endorses his warrant by mark rather than by signature, the mark must be witnessed by two (2) persons who can write. Each witness is to sign the warrant and list his place of residence in full. (1-1-93)

464. -- 499. (RESERVED).

500. NOTICE OF LOWERING OR ENDING BENEFITS.

The client must be sent timely and adequate notice aid will be ended, if he is not eligible for aid. The client must be sent timely and adequate notice aid will be lowered, if the AABD grant will be less than paid the previous month. (1-1-93)

501. ADEQUATE NOTICE.

Adequate notice is a written statement telling the client what action the Department is taking. The notice must tell the reasons for the action and the rules supporting the action. The notice must give an explanation of the hearing/appeal process. All notices must be adequate. (1-1-93)

502. TIMELY NOTICE.

Timely notice means a notice must be mailed at least ten (10) days before the effective date of the action. If timely notice is not required, adequate notice must be sent on or before the date of action. Timely notice is not required when the conditions in Subsections 503.01 through 503.11 are met. (1-1-95)

503. TEN (10) DAY NOTICE NOT REQUIRED.

Ten (10) day notice is not required, when the conditions in Subsections 503.01 through 503.11 are met. The notice must be adequate. (1-1-95)

01. Death of Client. The Department has proof of the client's death. (1-1-93)

02. Statement of Client. The Department receives a clear written statement signed by a client that he no longer wishes aid, or gives information requiring ending or reduction of aid. The client must state, in writing, he understands ending or lowering of aid is the result of giving the information.

(1-1-93)

03. Client in Institution. The client has been admitted or committed to an institution, and further payments to that individual do not qualify for federal financial participation under the state plan. (1-1-93)

04. Nursing Care. The client has been placed in a nursing facility, or Intermediate Care for the Mentally Retarded. (1-1-93)

05. Client's Address Unknown. The client's whereabouts are unknown. Department mail directed to him has been returned by the Post Office, showing no known forwarding address. The client's check must be made available to him if his whereabouts become known during the payment period covered by the check. (1-1-93)

06. Aid in Another State. A client has been approved for aid in another state. The new state providing aid has verified the client's status. (1-1-93)

07. Change in Level of Care. The client's doctor prescribed a change in the level of long-term care. (1-1-93)

08. Eligible One (1) Month. The client is eligible for aid only during the calendar month of his application for aid. (1-1-93)

09. Alien with Emergency. The client is an alien whose MA eligibility ends the day his emergency medical condition stops. (1-1-93)

10. Retroactive Medicaid. The client is not now eligible for Medicaid but is eligible for a prior period. (1-1-93)

11. Special Allowance. A special allowance granted for a specific period is stopped. The client was told, in writing, at the start of the allowance, it would continue only for the specified period. (1-1-93)

504. RETROACTIVE AABD PAYMENTS.

Retroactive AABD payments will be made in the circumstances listed below. (1-1-93)

01. AABD Payments Due to Department Error. Retroactive AABD payments are made if a client is underpaid, due to Department error. (1-1-93)

02. AABD Payments Due to Hearing Decision. Retroactive AABD payments are made if a fair hearing decision is favorable to a client. Retroactive AABD payments are made if the dispute is resolved in the client's favor before the fair hearing. The Department must make AABD payments retroactively to the date of the incorrect action. The client must remain eligible for AABD during the period reviewed by the hearing. (1-1-93)

505. RETROACTIVE AABD PAYMENTS AND CLIENT DETERMINED SSI ELIGIBLE FOLLOWING APPEAL.

A client is not eligible for AABD based on blindness or disability, if the SSA finds a client does not meet its definition of blindness or disability for eligibility for RSDI and SSI benefits. If the client files an appeal with SSA contesting their decision and, as a result of his appeal, is found blind or disabled and eligible for SSI, the client can get AABD. The client must be otherwise AABD eligible. The client's eligibility for backdated AABD coverage must be determined. Backdated AABD payment criteria are listed in Subsections 505.01 through 505.04. (1-1-93)

01. Dates. Backdated AABD payments must begin no earlier than the month a client applied for AABD. Backdated AABD payments must begin no earlier than the month following the month a client's grant was ended due to SSI closure. (1-1-93)

02. Eligibility. If the client was eligible the application month, eligibility for backdated AABD must be determined each month, to the current month. The payments must not be made for any month in the retroactive period the client did not meet all AABD eligibility criteria. (1-1-93)

03. SSI Eligibility. Before issuance of AABD payments, the client must prove to the Department his appeal to SSA resulted in eligibility for SSI. (1-1-93)

04. Proof of SSI Finding. The Department must verify the SSI eligibility and document action taken to make backdated AABD payments. (1-1-93)

506. AABD UNDERPAYMENT.

An AABD payment, less than the client is eligible for, is an underpayment. Failure to issue an AABD payment, to an eligible client, is also an underpayment. (1-1-93)

507. CORRECTION OF AABD UNDERPAYMENT.

The Department must correct the underpayment within ten (10) working days after discovery. The Department must pay the whole underpayment, less any overpayment, starting with the first (1st) month of an underpayment. (1-1-93)

508. AABD OVERPAYMENT AND AABD UNDERPAYMENT.

When an underpayment is computed, any overpayment for the month must be deducted. When an overpayment is computed, any underpayment for the month must be deducted. (1-1-93)

509. AABD OVERPAYMENTS.

A larger AABD payment than the client is eligible for, is an overpayment. An overpayment may result from either a Department or a client error. Income received by the client, and not reported, is an overpayment, unless the income is not counted. If the Department is able to count the income for the budget month when it would normally be counted, an overpayment does not occur. Overpayments paid to open AABD cases must be collected. (1-1-93)

510. SSI-RELATED AABD OVERPAYMENTS.

A client may receive SSI, pending a timely disposal of excess resources. A client may receive SSI because of a presumptive disability condition. AABD or Medicaid may be approved based upon receipt of this SSI. If a client fails to honor his agreement to dispose of excess resources, his AABD and Medicaid is an overpayment. The overpayment must be recovered. If SSA ends SSI, because a client willfully misstated, withheld, or falsified information about his disability, the AABD and Medicaid is an overpayment. The overpayment must be recovered by the Department. (1-1-93)

511. AABD OVERPAYMENT NOT COLLECTED.

Overpayments caused by excess resources of fifty dollars (\$50) or less are not recovered. The client must not knowingly and willfully fail to make an accurate and timely report of the resources. (1-1-93)

512. NOTICE OF OVERPAYMENT.

The Department must notify the client when an overpayment exists. The notice must tell the client of mandatory recovery, the right to a hearing, the method for repayment and the need to arrange a repayment interview. (1-1-93)

513. REPAYMENT FOR OPEN CASES.

A client can repay an overpayment by direct payment to the Department. In an open case, the client must be advised of his option to repay the overpayment by grant reduction. A client must be allowed the choice of these two (2) methods of overpayment recovery. If the client chooses, a repayment in full or in part may be made from income or resources. Any balance of the overpayment can be repaid by grant reduction. Grant reduction to repay an overpayment is voluntary, not mandatory. (1-1-93)

514. REPAYMENT FOR REOPENED CASE.

When a case is reopened, and an overpayment balance exists, the client must be told the overpayment can be recovered by grant reduction. The client may choose to repay the amount in full. (1-1-93)

515. (RESERVED).

516. GRANT REDUCTION RECOVERY RATE.

The grant reduction recovery rate for all active cases is ten percent (10%) of the monthly AABD standard of need. The client may choose a grant reduction of greater than ten percent (10%). Recovery rate is up to the amount of the payment if it is less than ten percent (10%) of the standard of need. (1-1-93)

517. GRANT REDUCTION POSTPONED PENDING A HEARING DECISION.

A client has ten (10) days after the grant reduction notice date to request a hearing. After the hearing request is filed, the AABD payment must continue at the current level. If the hearing decision is against the client, AABD paid pending the decision is an overpayment and must be recovered. (1-1-93)

518. RECOVERY FOR CLOSED CASES.

An AABD overpayment is recovered, from a person no longer receiving AABD, from the income or resources of the person. A former client must repay an overpayment through direct payment to the Department. (1-1-93)

519. MEDICAID OVERPAYMENT.

A Medicaid overpayment occurs when a client receives Medicaid services during a month, but is ineligible for Medicaid. A Medicaid overpayment occurs when a client is eligible for Medicaid, but too little patient liability or HCBS client participation is calculated. (1-1-93)

520. RECOVERY OF MEDICAID OVERPAYMENTS.

All Medicaid overpayments are subject to recovery. Medicaid overpayments are recovered by direct payment except for patient liability and HCBS client participation overpayments. The client must be informed of the Medicaid overpayment. A Medicaid overpayment can be repaid in a lump sum or in installments. The client must be told, in writing, when his Medicaid overpayment is fully recovered. (1-1-94)

521. RECOVERY FROM ELIGIBLE CLIENT WITH UNDERSTATED PATIENT LIABILITY OR HCBS CLIENT PARTICIPATION.

Patient liability or HCBS client participation must be adjusted for the months the patient liability or HCBS client participation was understated. The overpayment must be collected by withholding funds from the nursing home or HCBS provider unless the client repays the Department directly. (1-1-93)

522. RECOVERY FROM INELIGIBLE CLIENT.

Medicaid benefits, paid for a month the client was not eligible for Medicaid, are an overpayment. The client must repay the benefits, unless the nursing home had eligibility information and failed to notify the Department. The examiner will calculate the overpayment and refer the case to collections. (1-1-93)

523. RECOVERY FROM NURSING HOME.

Medicaid benefits, paid for a month the client was not eligible for Medicaid, are an overpayment. The nursing home must repay the benefits, if it had eligibility information and failed to notify the Department. In this situation the Department will recover from the nursing home. The examiner will calculate the overpayment and refer the case to collections. (1-1-93)

524. (RESERVED).

525. NOTICE TO CLIENT OF GRANT REDUCTION.

No reduction in AABD can be made to recover any overpayment until the recipient has been supplied with a "Notice of Decision" form (HW 0915). The notice must advise the client of his right to a fair hearing. The Department must inform the client, in writing, when his debt due the State has been repaid. (1-1-93)

526. RECOVERY FROM A CLIENT'S ESTATE.

If a client with an overpayment dies, the Department must determine whether to file a claim, against the deceased client's estate, to recover the overpayment. If the overpayment is not the result of willful misstatement or withheld information, recovery must be started within twelve (12) months from the date of the overpayment. The Department must consider factors making recovery unwise. Factors include a surviving spouse or other dependent with a continuing need for the property in the estate. Factors include an estate too small, after expenses of the last illness and expenses of administration, to warrant recovery. The Department's recovery decision must be recorded in the case record. (1-1-93)

527. REPAYMENT AGREEMENT.

The written agreement, between the client and the Department, must state the client's debt, show the repayment schedule, and be legally enforceable. The repayment schedule must take into account the client's income and

resources, including the AABD grant and the amount of the debt. If the client has an open AABD case, the monthly repayment must not be less than ten percent (10%) of the AABD grant. (1-1-93)

528. SUSPECTED FRAUD REPORTING.

Any Department employee, with evidence AABD or Medicaid payments have been made due to fraud, must report the case to the Region's Fraud Investigator. Fraud is defined in Idaho Code, Section 56-227. The Department may refer a case for prosecution, whether or not the client is currently getting aid. (1-1-93)

529. REQUEST FOR PROOF.

Proof of continuing eligibility and benefit amount must be requested when the Department learns of a change affecting the client's benefits, from the client or another source. The Department must request proof necessary to establish the client's continued eligibility and benefit amount. Proof is third party information or documents required to complete a change or review eligibility. Proof must be provided in a timely manner. If the client is unable to provide proof, the Department must help him. (7-1-94)

01. Request for Needed Proof. The client must be told what items are required and for which programs. The request must state that failure to provide proof may result in a decrease or termination of benefits. The client must be told the deadline to provide the proof. If a deadline falls on a weekend or holiday, the client must be allowed until the close of the next working day. The client must be told he may contact the field office before the proof deadline to request an extension, if he is unable to obtain the proof. The request for proof and any extension of the deadline must be documented in the case record. (7-1-94)

02. Deadline to Provide Proof - Decrease. Proof is needed in time to allow the Department to act on the change causing a decrease in benefits within ten (10) calendar days from the change report date. (7-1-94)

03. Deadline to Provide Proof - Increase. The client must be allowed ten (10) calendar days from the change report date to provide proof of the change causing an increase in benefits. (7-1-94)

04. Deadline Extension. The client may need an extension if he is unable to provide the proof by the deadline. The client must request the extension before the deadline falls. The extension must be granted if the client shows good cause for the delay. Good cause includes hospitalization or illness of the client or a member of the client's family, lost or stolen mail confirmed by the Postal Service, and catastrophe caused by fire, flood, or a severe weather condition. The client must be told of the new deadline for providing proof. (7-1-94)

530. CHANGES AFFECTING ELIGIBILITY.

If a client reports a change potentially affecting eligibility, the Department must request proof of the change. If proof is provided within timelines, benefits are adjusted or terminated as appropriate. If proof is not provided within timelines, the case is closed following timely notice. If the client provides the proof after the closure action but before the first day of the calendar month in which he would be ineligible, benefits are continued and adjusted, or terminated as appropriate. Whenever benefits are continued or terminated, adequate notice must be provided. (1-1-96)T

531. TIMELINES FOR ACTING ON CHANGES.

The Department has ten (10) calendar days from the date a change is reported to secure proof and complete action on a change which causes a decrease or termination of benefits. The client must be allowed ten (10) calendar days timely notice, if the change causes a termination or decrease in benefits. If the change will cause an increase in benefits, the client has ten (10) calendar days to provide proof of the change from the date of report. If proof of the change is not provided by the tenth calendar day, the Department must decrease or terminate the benefits following timely notice. If the verification is provided, the Department completes the change. (1-1-96)T

532. EFFECTIVE DATE FOR INCREASES.

Increases are effective as shown in Subsections 532.01 through 532.06. (1-1-96)T

01. Change Reported Timely and Proof Provided Timely. Increase benefits effective the month the change is reported. (1-1-96)T

02. Change Not Reported Timely, but Proof Provided Timely. Increase benefits effective the month the change is reported. (1-1-96)T

03. Change Reported Timely, but Proof Not Provided Timely. Increase benefits effective the month the change is reported, if good cause exists. Terminate benefits for failure to provide proof of the change, following timely notice if good cause does not exist. For a reported change that would result in an increase in, or prevent a decrease in, the amount of an income deduction used to compute patient liability or client participation, decrease benefits for failure to provide proof of the change. If the client provides proof after the closure or decrease action, but before the first day of the calendar month in which the negative action was taken, benefits are continued and increased effective the month the proof is provided. (1-1-96)T

04. Change Not Reported Timely, and Proof Not Provided Timely. Terminate benefits for failure to provide proof of the change, following timely notice. For a change that would result in an increase in, or prevent a decrease in, the amount of an income deduction used to compute patient liability or client participation, decrease benefits for failure to provide proof of the change. If the client provides the proof after the closure or decrease action, but before the first day of the calendar month in which the action was taken, benefits are continued and increased effective the month the proof is provided. (1-1-96)T

05. Failure to Report Timely with Good Cause. Increase benefits effective the month the change would have been submitted, if reported timely. (1-1-96)T

06. Failure to Provide Proof Timely with Good Cause. Increase benefits effective the month the proof would have been provided, if proof had been provided timely. (1-1-96)T

07. Good Cause. Good cause exists if circumstances beyond the client's control prevented him from reporting timely or providing proof timely. Good cause includes hospitalization or documented serious illness of the client or a member of the client's family, lost or stolen mail confirmed by the Postal Service, and catastrophe caused by fire, flood or a weather condition. (1-1-96)T

533. EFFECTIVE DATE FOR TERMINATION OR DECREASE.

If a reported change results in a decrease or termination of benefits, the Department must issue a Notice of Decision within ten (10) calendar days of the date of the report. The decrease or closure will be effective as soon as possible following timely notice. Adequate notice may be provided, if an exception to timely notice exists. An overpayment exists, if the AABD grant is not decreased timely. (1-1-96)T

534. -- 539. (RESERVED).

540. REPORTING REQUIREMENTS.

The client must report and provide proof of changes in circumstances within timelines. Clients must report all changes in circumstances including those listed in Subsections 551.01 through 551.098. The Department must act timely to determine continued eligibility and adjust the grant amount. The client must report any change of circumstances verbally or in writing, within ten (10) calendar days from the date the change becomes known to the client. (1-1-96)T

541. DATE AND METHODS OF REPORT.

Date of report for verbal reports is the date the client contacts the Department and reports the change. The date of report for written reports is the date the written report is received by the field office. Changes may be reported by telephone, personal contact, or mail. Written changes may be reported on the Change Report Form (HW 0594). All written reports must be date stamped by the Department on the date received. (1-1-96)T

542. FAILURE TO REPORT.

If a client's failure to report a change results in an overpayment of benefits, the overpaid benefits must be recovered. See Section 509. (1-1-96)T

543. GOOD CAUSE WHEN CHANGE REPORT NOT RECEIVED.

If circumstances beyond the client's control prevented him from reporting the change on time, good cause exists. If good cause exists, the AABD benefit can be reinstated. Good cause includes hospitalization or documented serious illness of the client or a member of the client's family, lost or stolen mail confirmed by the Postal Service, and catastrophe caused by fire, flood, or a severe weather condition. (1-1-96)T

544. ELIGIBILITY REDETERMINATION.

The AABD redetermination process is the same as the initial determination of an applicant's AABD eligibility. All eligibility factors subject to change must be checked by the Department during the redetermination. The redetermination assures continued eligibility and correct payment. (1-1-93)

01. Redetermination Frequency. A redetermination of eligibility must be completed at least once every year. The first redetermination is due one (1) year after the case is approved. A redetermination of eligibility may be done when a change affecting eligibility occurs. (1-1-93)

02. Redetermination Procedure. Each AABD client must complete in full a redetermination form. The Department must compare the client's newly completed forms with the most recent application or redetermination forms. When a husband and wife are living together and both are recipients of AABD, one (1) redetermination form can be completed for both. Both the husband and wife must sign the form. (7-1-94)

03. Change of Eligibility or Payment Upon Redetermination. If the redetermination finds the AABD client is ineligible, the Examiner must record the reason in the client's case record. If the redetermination results in a decrease in the grant, the Department must send advance notice to the client, ten (10) days before the decrease is effective. If the redetermination results in an increase in the grant, the Department must send notice to the client and increase the grant as soon as possible. (1-1-93)

545. CLIENTS WHO MOVE.

If an AABD client reports a move to an area served by a different Field Office, he must be told the address and telephone number of the new Field Office. The client must be told to contact the new Field Office as soon as possible, to avoid delay or ending of benefits. The client must be told action will be taken to stop aid if the request for transfer of the case record is not received within thirty (30) days. (1-1-93)

01. Transfer of Case Record. The client must report his new address to the new Field Office as soon as possible. The new Field Office must then request the case record from the Field Office holding the case record. (1-1-93)

02. Holding AABD Payment. If the client's next AABD payment will be mailed to his old address, the Field Office must hold the payment. The receiving Field Office must release the payment to the new address. (1-1-93)

03. Termination of AABD Benefits. If the request for transfer of the case record is not received by the thirtieth (30th) day, action will be taken to stop aid. Any AABD checks due the client must be delivered if possible. (1-1-93)

546. RECEIVING FIELD OFFICE.

When the receiving Field Office gets a client's case record, the Examiner may conduct an interview or home visit with the client. (1-1-93)

547. SPECIAL HELP TO HANDICAPPED CLIENT.

The Department must provide interpreters or special help for clients with visual, mental, hearing, literacy, language impairments, or other communications difficulties. Help must be given to explain aid programs. Eligibility factors, benefits, rights, and responsibilities must be explained. Explanations must include the result of failing to provide proof or refusing to cooperate. (1-1-93)

548. -- 549. (RESERVED).

550. CLIENT RIGHTS.

The client has rights protected by federal and state laws and Department rules. The Department must tell clients their rights during the application process and eligibility reviews. (1-1-93)

01. Right to Apply. Any person has the right to apply for any type of public aid. Applications must be in writing on forms provided by the Department. (1-1-93)

02. Right to Hearing. The client can request a fair hearing to contest a Department decision. (1-1-93)

03. Civil Rights. The Department must respect client's rights under the U.S. and Idaho Constitutions and federal and state laws. The Department must respect the client's rights under the Social Security Act, Title VI of the Civil Rights Act of 1964, and the Rehabilitation Act of 1973. (1-1-93)

551. CLIENT RESPONSIBILITIES.

The client must provide correct and complete information, so the Department can make accurate eligibility and benefit decisions. The client must provide proof requested by the Department to determine eligibility. The client must report any change of circumstances, verbally or in writing. The client must report within ten (10) calendar days, from the date he becomes aware of the change. The client must report changes listed in Subsections 551.01 through 551.08. (1-1-96)T

01. Change in Name or Address. The client must report any change in name or address. (1-1-93)

02. Change in Employment Status. The client must report any change in employment status. This includes any increase or decrease of earned income, change in source or earned income and change in hourly rate or salary. (1-1-96)T

03. Change in Income. The client must report any changes in income. This includes earned or unearned income. (1-1-93)

04. Change in Resources. The client must report any change in available resources. This includes getting money or goods of worth from any source. (1-1-93)

05. Change in Household Composition. The client must report any changes in the number of persons in, or the composition of, the household. (1-1-93)

06. Change in Special Needs. The client must report any changes in special needs. (1-1-93)

07. Change in Marital Status. The client must report any change in marital status. (10-1-93)

08. Change in AABD Grant Payment. The client must report any increase in grant payment of ten dollars (\$10) or more, if prior written notice from the Department was not received. (1-1-93)

552. ACKNOWLEDGING RIGHTS.

The client must formally acknowledge rights and reporting requirements for AABD. When the client signs the "Declaration of Circumstances Form" he formally acknowledges rights and reporting requirements for AABD. (1-1-93)

553. COOPERATION WITH QUALITY CONTROL.

The client must help Quality Control, if his case is selected for review. The client must provide information needed by Quality Control. (1-1-93)

01. Failure to Cooperate with Quality Control. Benefits must be stopped, following notice, when a client is unwilling to take part in a Quality Control review. Benefits must be stopped, following notice, when a client is unwilling to provide information requested by Quality Control. (1-1-93)

02. Eligibility After Failure to Cooperate With Quality Control. A client may reapply for benefits, if aid is stopped for failure to cooperate with Quality Control. The application must be approved, if all eligibility requirements are met. The client must fully cooperate with Quality Control and the Department's Field Office. (1-1-93)

554. DEPARTMENT INFORMING RESPONSIBILITIES.

The Department must tell the client what is expected from him, in the eligibility process. The Department must tell the client the information in Subsections 554.01 through 554.08. (1-1-93)

01. Eligibility Factor. The Department must inform the client about meeting eligibility requirements. (1-1-93)
02. Eligibility Verification. The Department must inform the client all eligibility factors must be verified. (1-1-93)
03. Consequences of Failure to Cooperate. The Department must inform the client about consequences for failure to provide or permit proof of eligibility factors. (1-1-93)
04. Methods for Verification. The Department must inform the client about methods available to the client to verify eligibility factors, when the client does not have verification. (1-1-93)
05. Department Methods for Verification. The Department must inform the client about methods the Department will use to verify eligibility factors, when the client is unable to provide proof. (1-1-93)
06. Aid Available. The Department must inform the client about financial, medical, and social services aid available. (1-1-93)
07. Social Security Number Use. The Department must inform the client his Social Security Number will be used to get wage, income, and employment information. Information is obtained from the Department of Employment (DOE), the Social Security Administration (SSA), and the Internal Revenue Service (IRS). (1-1-93)
08. Clients Rights and Responsibilities. The Department must inform the client about the client's rights and responsibilities. (1-1-93)

555. DEPARTMENT ACTION RESPONSIBILITIES.

The Department must act to correct a grant payment, when it gets information causing a change in grant amount. The Department will respond in writing to the client, within twenty-four (24) hours, if he warns his AABD payment is different from the amount advised. The Department must confirm the amount as correct or tell the client of a grant change. (1-1-93)

556. REPORTING CHILD ABUSE OR NEGLECT.

Persons having reasonable cause to believe any child, under age eighteen (18), has been neglected or abused must report this to the Department, or law enforcement agency. Any vendor of goods or services, to or for the Department, must report any suspected child abuse or neglect. (1-1-93)

557. -- 599. (RESERVED).

600. MEDICAID ELIGIBILITY.

A client must meet the eligibility requirements for at least one (1) Medicaid coverage group to be eligible for Medicaid benefits. The client must meet the Medicaid eligibility requirements listed in these rules. Medicaid eligibility is prospective. Income and circumstances in the current month are used to determine eligibility for the current month. Resources are counted as of the first moment of a month. (See Subsection 205). (7-1-94)

601. MEDICAID APPLICATION.

Any person may apply for Medicaid benefits. All applications for Medicaid must be in writing on forms prescribed by the Department. The Department must process applications without delay. (1-1-93)

01. Medicaid Application for Deceased. An application for Medicaid may be made on behalf of a deceased person. (1-1-93)
02. Newborn Applicant. A child, born to an eligible Medicaid client, has applied for Medicaid. The child is eligible as of the date of his birth. An application for Medicaid is required after the child's first (1st) birthday. The mother must either stay eligible for Medicaid, or would be eligible if pregnant. The child must live with her. (1-1-93)

03. Separate Application Required. A separate Medicaid application is required when a client is not eligible for AABD. A separate Medicaid application is required when a client does not wish to apply for AABD. A separate Medicaid application is required for an SSI recipient, not receiving AABD, if he wishes to receive Medicaid. (1-1-93)

602. TIME LIMITS.

Each application for Medicaid for the blind or aged will be processed within forty-five (45) days. Each application for Medicaid for the disabled will be processed within ninety (90) days. The time limit can be extended by events beyond the Department's control. The time limit is counted from the application date to the date the Medicaid identification card, or notice of denial, is mailed to the client. The time limit must not be used as a waiting period for acting on an application. The time limit must not be used as the basis for denial of an application. Table 602 lists time limits. (1-1-93)

Table 602 - APPLICATION TIME LIMITS

PROGRAM	TIME LIMIT
MEDICAID FOR AGED APPLICANT	45 DAYS
MEDICAID FOR DISABLED APPLICANT	90 DAYS

603. MEDICAID EFFECTIVE DATE.

An applicant must meet all eligibility requirements on the date of application. The Medicaid effective date is the first (1st) day of the application month if the client is eligible. The Medicaid effective date can be backdated. Medicaid effective dates are listed in Subsections 603.01 through 603.05. (1-1-93)

01. Normal Eligibility. Medicaid coverage begins on the first (1st) day of the application calendar month and up to three (3) months before the application month. (1-1-93)

02. Backdated Eligibility Applicant Eligible in Application Month. If an applicant is determined eligible for Medicaid, the effective date of eligibility must be no earlier than the first day of the third calendar month before the application was filed, provided the applicant was eligible for Medicaid during the prior period. (1-1-93)

03. Backdated Eligibility Applicant Not Eligible in Application Month. An applicant not eligible for Medicaid at the time of his application, must have his eligibility for backdated coverage determined. The effective date of eligibility must be no earlier than the first day of the third calendar month before the application was filed. Medicaid coverage must be provided for each month the client was eligible during the three (3) month period. (1-1-93)

04. Partial Backdated Eligibility. If an applicant for Medicaid was eligible at one (1) or more separate times during the backdated period, the Department (at the applicant's request) must determine the Medicaid eligible months. Coverage must be provided for each eligible month services payable by Medicaid were received. (1-1-93)

05. Ineligible Alien. Ineligible Alien coverage is restricted to emergency services. (1-1-93)

604. IDAHO MEDICAID RESIDENCY.

The client must live in Idaho and intend to continue living in Idaho. A client living in Idaho does not lose residency for Medicaid when he is temporarily visiting in another state and intends to return to Idaho. An Idaho resident who intends to move to another state does not lose Idaho residency until he actually moves from Idaho. A person is a special Idaho resident for Medicaid if he meets one of the criteria in Sections 604.01 through 604.06. (1-1-93)

01. Foster Child. A client living in Idaho and receiving child foster care payments from another state is an Idaho resident for Medicaid. (1-1-93)

02. Incapable Client. A client in an Idaho institution, who became incapable of indicating his intended residency before age twenty-one (21), is a resident of the state where his parent or guardian lives. A client in an Idaho institution, who became incapable of indicating his state of residency after age twenty-one (21), is an Idaho resident

for Medicaid. A client is incapable if: (1-1-93)

- a. Intelligence Quotient (IQ) is forty-nine (49) or less. (1-1-93)
- b. Mental age is seven (7) or less. (1-1-93)
- c. Judged legally incompetent. (1-1-93)
- d. Cannot state intent, based on medical records. (1-1-93)

03. Placed in Another State by Idaho. A client placed by the state of Idaho in an institution in another state is an Idaho resident for Medicaid. The client's intent or ability to show intent to reside in the other state is not a factor. (1-1-93)

04. Homeless. A client not maintaining a permanent home or having a fixed address is an Idaho resident for Medicaid, if he is in Idaho and intends to remain. (1-1-93)

05. Migrant. A migrant working in Idaho is an Idaho resident for Medicaid, while living in Idaho. (1-1-93)

06. Disputed Resident. Idaho and another state may enter into an agreement to establish a client's residency. The agreement can use residency criteria different from these rules. The agreement must not cause loss of residency in both states. If Idaho and another state cannot agree on the client's residency, the client is a resident of the state where he is physically located. (1-1-93)

605. CITIZENSHIP AND LEGAL NON-CITIZEN REQUIREMENT.

The client must be a citizen or national of the United States, or an eligible alien. The client or legal guardian, if the client is under age eighteen (18), must sign a declaration, under penalty of perjury, attesting to citizenship or alien status. (1-1-93)

01. Eligible Aliens. Eligible aliens are legal aliens admitted to the United States for permanent residence. Eligible aliens are also persons lawfully living in the United States, under color of the law. (See Subsections 605.01.a. through 605.01.s.) (1-1-93)

a. Aliens granted lawful temporary resident status under sections 245A and 210 of the INA, if the individual is aged, blind or disabled using AABD criteria, under eighteen (18) years of age or a Cuban/Haitian Entrant. (1-1-93)

b. Aliens granted lawful temporary resident status under section 210. of the INA. (1-1-93)

c. Aliens residing in the United States with knowledge and permission of the INS whose departure the INS does not enforce. (1-1-93)

d. Aliens admitted under section 203(a)(7) of the INA. Ask for a copy of INS Form I-94 endorsed "Refugee-Conditional Entry". (1-1-93)

e. Aliens, including Cuban/Haitian entrants, paroled in the United States under section 212(d)(5). Ask for a copy of INS Form I-94 stamped Cuban/Haitian entrant (Status Pending) reviewable January 15, 1981. (1-1-93)

f. Aliens residing in the United States under an indefinite stay of deportation. Ask for an INS letter with this information or INS Form I-94 with this notation. (1-1-93)

g. Aliens residing in the United States under an indefinite voluntary departure. Ask for an INS letter or INS Form I-94 showing voluntary departure has been granted. (1-1-93)

h. Aliens and their families on whose behalf a relative petition has been approved, who are entitled to voluntary departure, and whose departure the INS does not enforce. Ask for a copy of INS Form I-94 or Form I-210

or a letter showing status. (1-1-93)

i. Aliens who have filed applications for change of status under section 245 of the INA, the INS has accepted as "properly filed" and whose departure INS does not enforce. Ask for a copy of INS Form I-94 or I-181 or a passport appropriately stamped. (1-1-93)

j. Aliens granted stays of deportation by court order, statute or regulation, or by individual decision of the INS under section 106 of the INA or relevant INS instructions whose departure INS does not enforce. Ask for a copy of INS Form I-94 or a letter for INS or a copy of a court order establishing the alien's status. (1-1-93)

k. Aliens granted asylum under section 208 of the INA. Ask for a copy of INS Form I-94 properly endorsed. (1-1-93)

l. Aliens admitted as refugees under section 207 or section 203(a)(7) of the INA. Ask for a copy of INS Form I-94 properly endorsed. (1-1-93)

m. Aliens granted voluntary departure under section 242(b) of the INA whose departure the INS does not enforce. Ask for INS Form I-94 or Form I-120 bearing a departure date. (1-1-93)

n. Aliens granted deferred action status under INS Operations Instruction 1003.01(a)(ii) before June 15, 1984 or 242.1(a)(22) issued June 15, 1984 and later. Ask for a copy of INS Form I-210 or a letter showing departure has been deferred. (1-1-93)

o. Aliens residing in the United States under orders of supervision under section 242 of the INA. Ask for a copy of Form I-220 B. (1-1-93)

p. Aliens who have entered and continuously resided in the United States since before January 1, 1972 or any date established by section 249 of the INA. (1-1-93)

q. Aliens granted suspension of deportation under Section 244 of the INA and whose departure the INS does enforce. Ask for an order from an immigration judge showing deportation has been withheld. (1-1-93)

r. Aliens whose deportation has been withheld under section 243(h) of the INA. Ask for an order from an immigration judge showing deportation has been withheld. (1-1-93)

s. Any other aliens living in the United States with the knowledge and permission of the INS and whose departure the INS does not enforce. This group includes permanent non-immigrants as established by Public Law 99-239, and persons granted Extended Voluntary Departure due to conditions in the alien's home country based on a decision of the Secretary of State. (1-1-93)

02. Ineligible Legal Aliens. Ineligible legal aliens are admitted to the U.S. for permanent residence. They are not eligible for AABD. Ineligible legal aliens are listed in Subsections 605.02.a. and 605.02.b. (1-1-93)

a. Non-disabled alien admitted under INA Section 245. Legal aliens admitted for temporary or permanent residence under section 245A of the INA, who are age eighteen (18) through sixty-four (64), not pregnant, and not blind or disabled under SSA criteria for blindness and disability. (1-1-93)

b. Special Agricultural Workers (SAW). Legal aliens admitted as Special Agricultural Workers under the section 210 of the INA, who are age eighteen (18) through sixty-four (64), not pregnant, and not blind or disabled under SSA criteria for blindness and disability. (1-1-93)

03. Other Aliens. Aliens other than those listed in Subsections 605.02.a. and 605.02.b. are eligible only for treatment of an emergency medical condition, including emergency labor and delivery, if they would otherwise qualify for Medicaid. These aliens are not required to furnish a SSN or make a written declaration of their alien status. (1-1-93)

04. Other Aliens. Aliens other than those listed in Subsections 605.02.a. and 605.02.b. are eligible only

for treatment of an emergency medical condition, including emergency labor and delivery, if they would otherwise qualify for AABD. These aliens are not required to furnish a SSN or make a written declaration of their alien status. (1-1-95)

606. ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT.

The assignment of medical support rights to Idaho goes into effect by operation of Section 56-209b(3), Idaho Code, when the client signs the AFA. He also assigns the rights of any other client, for whom he can legally make the assignment, such as his minor child. The assignment covers medical care support under a court or administrative order, or against any third party, except Medicare, who is or may become liable to pay all or part of the client's medical costs. (1-1-95)

01. Cooperation in Securing Medical Support. To qualify for Medicaid, the client must cooperate in securing medical care support and payments, on behalf of himself, and any other person for whom he can legally assign rights to medical support. (1-1-95)

02. Elements of Cooperation in Securing Medical Support. Cooperation in securing medical support and care includes the elements listed in Subsections 606.02.a. through 606.02.e. (1-1-95)

a. The client must appear at Department offices to provide verbal or written information or evidence known to, possessed by, or obtainable by the client. The client must provide information to secure medical care support and payments, and identify third party payers, including an absent parent of a minor child. The client must cooperate in establishing paternity of a minor child born out of wedlock. (1-1-95)

b. The client must appear as a witness in court or in any other proceeding, if the proceeding is relevant to securing medical care support and payments. (1-1-95)

c. The client must provide any requested information, or attest under penalty of perjury to the lack of such information, if the information is relevant to securing medical care support and payments, and identifying third party payers. (1-1-95)

d. After support has been assigned, the client must pay to the Department any medical care support and payments received, covered by the assignment. (1-1-93)

e. The client must take any other reasonable steps to assist in establishing paternity, securing medical care support and payments and identifying third party payers. (1-1-95)

03. Failure to Cooperate in Securing Medical Support and Payments. A client is not eligible for Medicaid if he refuses to identify a liable third party payer or to pay to the Department payments he receives from a liable third party, such as an insurance company or absent parent, for medical care which the Department has paid in his behalf. A client is not eligible if he refuses to cooperate for another person whose medical support rights he can legally assign. (1-1-95)

04. Penalty for Failure to Cooperate. Medicaid must be denied or ended, after the notice requirements have been met, for any client who refuses to cooperate as required. (1-1-93)

05. Exception to Medical Support Cooperation Requirement. Medicaid must be provided to any client who cannot legally assign his own rights and would be eligible for Medicaid except for the refusal of a person legally able to assign the client's rights in his behalf, but who has refused to cooperate in securing medical care support and payments. (1-1-95)

06. Waiver of Cooperation for Good Cause - Minor Child. The client may claim good cause for failure to cooperate in securing medical support for a minor child. The client must be offered the opportunity to claim good cause before and after application. The HW043, "Notice to Applicants and Recipients," is written notice of the client's right to claim good cause. This form must be signed and reviewed with the client, whether or not the client wishes to claim good cause. Good cause can be claimed at any time before or after Medicaid approval. At application and redetermination, the client must be advised to cooperate in securing medical support unless he can show good cause for a waiver of cooperation. (1-1-95)

a. Good cause for failure to cooperate includes the client's fear of the absent parent inflicting physical or emotional harm to the child(ren) or the client. This must be supported by medical evidence, police reports, or as a last resort, an affidavit from a knowledgeable source. Good cause includes pending adoption. If legal adoption proceedings are not pending, the discussion between the client considering an adoption placement for the child and the Social Service Agency must not exceed three (3) months. Good cause may be claimed for a child conceived due to documented incest or forcible rape. (1-1-95)

b. A client claiming good cause for not cooperating must submit a notarized letter to the Examiner identifying the good cause exempted child. The letter must state the reasons for claiming good cause. The client must be allowed twenty (20) days to supply evidence to the Examiner supporting the claim. The evidence must be reviewed by the Examiner and the Supervisor and a good cause decision made within forty-five (45) days of the claim. If the client requests additional time to provide proof, an additional ten (10) days may be allowed. Medicaid must not be denied, delayed or stopped pending a decision of good cause. If the Medicaid application is approved, the Assignment of Rights to Support on the AFA must be sent to the Bureau of Child Support Services (BCSS) with the notation "Medicaid Good Cause Claim Pending." BCSS must review good cause claims and make recommendations. If Eligibility staff finds good cause exists, BCSS must be notified immediately. If BCSS contests the determination, a conference must be held between Eligibility staff and BCSS staff. Eligibility makes the final good cause decision. (1-1-95)

c. Pending a decision on the good cause claim, the Examiner must notify the Third Party Recovery (TPR) unit that a good cause claim is pending by sending a copy of the Assignment of Rights to Support on the AFA with the notation "Good Cause Claim Pending". When the Medicaid application is approved before the good cause decision, this notification must be made as soon as possible and before any Medicaid claims for services for the client and child are processed. (1-1-95)

d. If good cause exists, the cooperation requirement is waived. No further support action is taken by BCSS. No recovery from the absent parent is pursued by the TPR unit. If good cause does not exist, the client must be notified of the requirement to cooperate and the case must be referred to BCSS and TPR. The client must be allowed to withdraw the application or have the case closed. (1-1-95)

e. At each redetermination, the circumstances of approved good cause claims must be reviewed. If good cause no longer exists, the cooperation requirements are applied. (1-1-95)

07. Waiver of Cooperation for Good Cause - Adult. The client may claim good cause for failure to cooperate in securing medical care support and payments for himself or another client who is not a minor child, and for whom he can legally assign medical support rights. (1-1-95)

a. Good cause exists if the Department finds that cooperation is against the best interests of the client or the other person because it is anticipated that cooperation will result in physical or emotional harm to the client or the other person. Good cause can be claimed at any time before or after Medicaid approval. This must be supported by medical evidence, police reports, or as a last resort, an affidavit from a knowledgeable source. (1-1-95)

b. A client claiming good cause for not cooperating in securing medical support must submit a notarized letter to the Examiner identifying the good cause exempted person. The letter must state the reasons for claiming good cause. The client must be allowed twenty (20) days to supply evidence to the Examiner supporting the claim. The evidence must be reviewed by the Examiner and the Supervisor and a good cause decision made within forty-five (45) days of the claim. If the client requests additional time to provide proof, an additional ten (10) days may be allowed. Medicaid must not be denied, delayed or stopped pending a decision of good cause. If the Medicaid application is approved, the Assignment of Rights to Support on the AFA must be sent to the Third Party Recovery unit with the name of the person for whom good cause is claimed and the notation "Medicaid Good Cause Claim Pending." When the Medicaid application is approved before the good cause decision, this notification must be made as soon as possible and before any Medicaid claims for services for the client or the other person are processed. If Eligibility staff finds good cause exists, the TPR unit must be notified immediately. (1-1-95)

c. If good cause exists, the cooperation requirement is waived. No further recovery action is taken by the TPR unit. If good cause does not exist, the client must be notified of the requirement to cooperate and the case

must be referred to BCSS and TPR. The client must be allowed to withdraw the application or have the case closed. (1-1-95)

d. At each redetermination, the circumstances of approved good cause claims must be reviewed. If good cause no longer exists, the cooperation requirements are applied. (1-1-95)

607. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

The Medicaid client must furnish his SSN(s) as a condition of Medicaid eligibility. The Department must help the client if he has difficulty getting an SSN. If the client has applied for an SSN, assistance must not be denied, delayed, or terminated pending issuance of the SSN. If the client fails to furnish his SSN, or if he applies for an SSN and fails to furnish his SSN when issued, Medicaid must be stopped after proper notice. If the Medicaid client is also an AABD client, the SSN requirement for AABD applies. An ineligible alien with an emergency medical condition is not subject to the SSN requirement. (1-1-93)

608. GROUP HEALTH PLAN ENROLLMENT REQUIREMENT.

To be eligible for Medicaid, a client must apply for and enroll in a cost-effective group health plan if one is available. A group health plan is any plan contributed to by an employer to provide health care to the employees, former employees, or their families. Medicaid must not be denied, delayed, or stopped pending the start of a client's group health insurance coverage. A child entitled to enroll in a group health plan must not be denied Medicaid solely because the caretaker relative fails to apply for the child's enrollment. The client's eligibility for cost-effective group insurance coverage must be determined by the Department. (1-1-93)

01. Cost Effective Group Health Plan. The group health plan is cost effective if the cost to Medicaid, for a set of services, will be more than paying group health plan premiums and cost sharing, for the services. The expense of premiums and cost sharing obligations will be met by the Idaho Medicaid Program. (1-1-93)

02. Eligibility for Group Health Plan. An applicant's eligibility for cost effective group insurance coverage must be assessed during the application process, or as soon as possible following Medicaid approval. Medicaid clients must have group insurance coverage determined at redetermination, or when the client gains or loses employment. (1-1-93)

609. MEDICAID QUALIFYING TRUST PAYMENTS.

This policy applies to trusts established before August 11, 1993 and to trusts funded before August 11, 1993. The maximum payment permitted to be made to a client from a Medicaid Qualifying Trust, must be counted to determine Medicaid eligibility. The maximum payment is counted whether or not the trustee actually distributes payments to the client. (1-1-94)

01. Medicaid Qualifying Trust. A Medicaid Qualifying Trust is a trust or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of payments from the trust is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual. The trust may be revocable or irrevocable. A trust set up for another purpose than qualifying for Medicaid can be a Medicaid qualifying trust. The beneficiary is the person who benefits from the trust, by receiving payments from the trust or goods or services paid for from the trust. The trustee is the person or institution holding the money for the beneficiary. When the individual who establishes the trust and the beneficiary are the same person, and the trustee has the power to decide how the benefits from the trust will be paid out, the trust is a Medicaid Qualifying Trust. (7-1-93)

02. Trust Established by Parent or Guardian. A trust established by an individual's guardian or legal representative, acting on the individual's behalf, falls under the definition of a Medicaid qualifying trust. If an individual is not legally competent, a trust established by his legal guardian (including a parent) using the individual's assets can be treated as having been established by the individual, since the individual could not establish the trust for himself. (7-1-93)

03. Medicaid Qualifying Trust Payments and Medicaid Eligibility. Maximum payments available from a Medicaid Qualifying Trust, but not paid to the client, are counted as income for that month for Medicaid eligibility. The maximum payments available are income each month, until paid to the client. On payment, amounts paid from the trust income (interest) are income and amounts paid from the trust principal are a resource. AABD eligibility and

grant amount count only the payments from a Medicaid Qualifying Trust actually made to a client by the trustee. (7-1-93)

04. Exception to Medicaid Qualifying Trust. These provisions do not apply to any trust or initial trust decree made before April 7, 1986, solely for the benefit of a mentally retarded individual. The client must reside in an intermediate care facility for the mentally retarded. (1-1-93)

610. MEDICAID ELIGIBILITY FOR AABD CLIENT.

A person eligible for AABD is eligible for Medicaid, except for the conditions listed below. An AABD client does not need a separate application for Medicaid. (1-1-93)

01. AABD Client in Institution. An AABD client in an ineligible institution, including a public correctional institution, is not eligible for Medicaid. (1-1-93)

02. Medicaid Qualifying Trust. A client entitled to payments from a Medicaid Qualifying Trust, exceeding his Medicaid income or resource limit, is not eligible for Medicaid. (1-1-93)

611. LONG-TERM CARE RESIDENT AND MEDICAID.

A resident of a long-term care facility must meet the AABD eligibility criteria to be eligible for Medicaid. (1-1-93)

01. Client Certified for Long-Term Care. To be eligible for Medicaid long-term care payments, the client must be certified to require long-term care. Long-term care certification is determined using Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Subsection 160.09. (1-1-93)

02. Resources of Long-Term Care Resident. The resource limit of a long-term care resident is two thousand dollars (\$2,000). Computation of the resources of a married person in long-term care is subject to spousal impoverishment rules. Under the Federal Spousal Impoverishment (FSI) method, the long-term care spouse has a two thousand dollar (\$2,000) resource limit. Under the Community Property (CP) method one spouse applying for Medicaid has a two thousand dollar (\$2,000) resource limit. If both spouses apply, CP has a three thousand dollar (\$3,000) resource limit for the couple. Under CP, the month, after the month, one or both spouses leave their mutual home to enter nursing care, the resource limit is two thousand dollars (\$2,000) for each spouse. Under the SSI method, if both spouses apply, there is a three thousand dollar (\$3,000) resource limit for the couple. Under the SSI method, the month, after the month, one or both spouses leave their mutual home to enter nursing care, the resource limit is two thousand dollars (\$2,000) for each spouse. Under the SSI method, spouses can use the three thousand dollar (\$3,000) couple resource limit once they have been in the nursing home in the same room for six (6) months. The principal balance of a real estate contract excluded under Section 287 is not a resource to the long-term care resident. This exclusion is not used if it would be more restrictive to the client's Medicaid eligibility than counting the contract as a resource. (7-1-94)

03. Medicaid Income Limit of Client In Long-Term Care Facility Thirty (30) Days or More. Monthly income of a long-term care facility resident must not exceed three (3) times the federal SSI benefit payable monthly to a single person. The client must be in long-term care thirty (30) consecutive days or more, or must be likely to remain in long-term care at least thirty (30) consecutive days. The Department's Regional Medicaid Unit (RMU) will make the decision if a client is likely to remain in the long-term care facility thirty (30) consecutive days or more. If the client does not remain in a long-term care facility thirty (30) consecutive days, the RMU decision remains valid. The thirty (30) consecutive days must not begin on a day the client is hospitalized. The client's eligibility can begin as early, as the first day of the thirty (30) consecutive days, if otherwise eligible. A client eligible for the long-term care limit, hospitalized, then readmitted to long-term care, with no other living situation, continues to qualify for the long-term care income limit. (1-1-95)

04. Medicaid Income Limit For Client in Long-Term Care Facility Less Than Thirty (30) Days. A client in a long-term care facility less than thirty (30) consecutive days, not likely to remain at least thirty (30) consecutive days, must not exceed the AABD income limit. The AABD income limit is based on the client's last living situation, before entry into long-term care. A married client can choose the SSI or CP budget method to compute the income limit, if his spouse is also in a long-term care facility or is an HCBS client. The Medicaid income limits for a client, in a long-term care facility less than thirty (30) days, are listed in Subsections 611.04.a. through 611.04.c. (1-1-93)

a. AABD need standard. For a single person, and for a married person choosing the SSI method, the actual AABD need standard, as if he were still at home, is his income limit. (1-1-93)

b. CP method and AABD need standard. Married clients, living together on the first day of the month, may choose the Community Property (CP) method of budgeting income and resources. If one member of the couple is in the nursing home, and applying for Medicaid, the AABD need standard for a single person, in his previous living situation, is the income limit. If the couple is in the nursing home, and both spouses are applying for Medicaid, the AABD need standard for the couple, in their previous living situation, is the income limit. (1-1-93)

c. Most recent AABD need standard. The actual AABD need standard for his most recent living situation, other than a long-term care facility or a hospital, is his income limit if the client's most recent admission to long-term care was from a hospital. (1-1-93)

05. Income Not Counted. The income listed in Subsections 611.05.a. through 611.05.d. must not be counted to calculate Medicaid eligibility for a long-term care facility resident. The income is counted in determining client participation in the cost of long-term care, except for a VA "Aid and Attendance" allowance and any increment which represents a VA Unusual Medical Expense allowance. (1-1-95)

a. Excluded AABD income. Income excluded or disregarded, in determining eligibility for an AABD money payment, is not counted. (1-1-93)

b. RSDI increase. The amount of the September 1972 RSDI increase is not counted. (1-1-93)

c. VA aid and attendance. Any VA Aid and Attendance allowance, including any increment which is the result of a VA Unusual Medical Expense allowance, is not counted. These allowances are not counted for patient liability. (1-1-95)

d. RSDI COLA increase. RSDI benefit increases, from cost-of-living adjustments after April 1977, are not counted if they made the client lose SSI or AABD eligibility. The COLA increases after SSI or AABD stopped are not counted. (1-1-93)

e. Income paid into exempt pension trust. Income paid into a pension trust exempt from counting for Medicaid eligibility under Subsections 691.03 and 705.03 is not counted, if used for patient liability. Income transferred to the trust as income used to calculate patient liability, and not used for patient liability, is subject to the asset transfer penalty in Subsection 690. (7-1-94)

06. Medicare Part B Premium. The Medicare Part B deduction from Social Security benefits must be counted as income for Medicaid eligibility. The repayment a long-term care client gets from SSA, for his payment of the Medicare Part B premium, must not be counted for eligibility. The Part B repayment must not be counted for client participation in the cost of long-term care. (1-1-93)

07. Income from Exempt Pension Trust. Income paid into a pension trust, exempt from counting for Medicaid eligibility under Subsections 691.03 and 705.03, counts as income for patient liability. The monthly amount counted as income to calculate patient liability is equal to the amount of funds in the exempt trust, up to the cost of care reimbursable by Medicaid. This income is added together with the client's other income. (7-1-94)

08. Income from Excluded Sales Contract. Payments on a sales contract with equity value excluded from resources of a long-term care resident under Section 287 is unearned income for eligibility and patient liability. This exclusion is not used if it would be more restrictive to the client's Medicaid eligibility than counting the contract as a resource. (7-1-94)

612. PATIENT LIABILITY - INCOME AVAILABLE TO MEET COST OF LONG-TERM CARE.

The Department must count some of the Medicaid client's income toward the cost of long-term care. The client's income counted toward his cost of care is his patient liability. The client's income is counted toward his cost of care in the month the income is received. The income must not be converted or prorated. The Department must reduce Medicaid payment to the nursing facility by the patient liability income. Patient liability starts the first (1st) full

calendar month the client resides in a long-term care facility. A client entering the facility on the first (1st) day of the month, and residing in the facility the full month, is charged patient liability for the month. The income computation is different for a single client, for a married client whose spouse is also in long-term care, and for a married client whose spouse is in the community. The terms in Subsections 612.01 through 612.04 apply to computing income to meet the cost of long-term care. (1-1-96)T

01. Long-Term Care Spouse. The long-term care spouse gets long-term care. A long-term care spouse must be in a medical institution or nursing facility, or be an HCBS client, for thirty (30) consecutive days, or appear likely to remain in the facility or need HCBS thirty (30) days. The husband or wife of the long-term care spouse is not in a medical institution or nursing facility and is not an HCBS client. (1-1-93)

02. Community Spouse. The community spouse is the husband or wife of the long-term care client. The community spouse lives in the community, is not in long-term care, and is not an HCBS client. (1-1-93)

03. Community Spouse Allowance (CSA). The maximum amount a long-term care spouse may have deducted from income, if paid for the support of the community spouse. (1-1-93)

04. Community Spouse Need Standard (CSNS). The income the community spouse needs for his support. (7-1-94)

613. PATIENT LIABILITY - INCOME AVAILABLE TO MEET COST OF LONG-TERM CARE FOR PERSON WITH NO COMMUNITY SPOUSE.

Income to meet the cost of long-term care, also called patient liability, for a person with no community spouse, is computed as described below. (1-1-93)

01. Income of Single Person or Person With Long-Term Care Spouse. For a single person, or person whose spouse is also in long-term care and chooses the SSI method of calculating the amount of income and resources, the patient liability is his total income less the deductions in Subsections 613.01.a. through 613.01.f. of these rules. (1-1-93)

a. Income excluded in determining eligibility for an AABD money payment must be deducted. (1-1-93)

b. A VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse must be deducted. (1-1-95)

c. Deductions for client in facility. The deductions specified in Subsection 613.03 of these rules must be subtracted. (1-1-93)

d. The SSI payment for a person with special SSI eligibility status, entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long-term care facility must be deducted. (1-1-93)

e. The AABD payment, and income used to compute the AABD payment, for a client paid continued AABD payments up to three (3) months in long-term care, must be deducted. (1-1-93)

f. The protected VA pension for a veteran with no spouse or dependents or for a surviving spouse with no dependents must be deducted. The month after the veteran or a surviving spouse enters a nursing facility, VA will reduce his pension (including Aid and Attendance) to a protected amount. This protected pension must not be counted for patient liability. (7-1-93)

02. Community Property Income of Long-Term Care Client With Long-Term Care Spouse. Income used to calculate patient liability for a person, whose spouse is also in long-term care, who chooses the community property method of calculating income and resources, is one-half (1/2) his share of the couple's community income, plus his own separate income. The deductions specified in Subsections 613.01.a. through 613.01.f. of these rules must be taken from his income. (1-1-93)

03. Income of Client in Facility. A person residing in the long-term care facility at least one (1) full

calendar month, beginning with his most recent admission, must have the deductions in Subsections 613.03.a. through 613.03.i. of these rules taken from his income. AABD exclusions are first applied to the income. Total monthly income includes income paid into a pension (Miller) trust that month. The income deductions must be taken in the order listed. Remaining income is his patient liability. A client not residing in the long-term care facility for at least one (1) full calendar month, beginning with his most recent admission, has no patient liability computed.

(7-1-96)

a. Deduct thirty dollars (\$30). This is kept by the client for his personal needs. For a veteran or surviving spouse with a protected VA pension, the protected pension substitutes for the thirty dollar (\$30) personal needs deduction.

(7-1-93)

b. An employed client or client engaged in sheltered workshop or work activity center activities, is also budgeted the lower of the personal needs deduction of eighty dollars (\$80) or his earned income. The client's total personal needs allowance must not exceed one hundred and ten dollars (\$110). For a veteran or surviving spouse with sheltered workshop or earned income, and a protected VA pension, the total must not exceed eighty dollars (\$80). This is a deduction only. No actual payment can be made to provide for personal needs.

(7-1-93)

c. Two hundred and twelve dollars (\$212) for home maintenance cost must be deducted if the client had an independent living situation, before his admission for long-term care. His physician must certify in writing the client is likely to return home within six (6) months, following the month of admission to a long-term care facility. For a person who was in a room and board home prior to admission to long-term care, the Room and Board Allowance is deducted. This is a deduction only. No actual payment can be made to maintain the client's home.

(1-1-93)

d. A maintenance need deduction must be allowed for a family member, living in the long-term care client's home. A family member is claimed, or could be claimed, as a dependent on the Federal Income Tax return of the long-term care client. The family member must be a minor or dependent child, dependent parent, or dependent sibling of the long-term care. The maintenance need deduction is the AFDC need standard for the number of dependents. The AFDC need standard is in Idaho Department of Health and Welfare Rules, Title 03, Chapter 01, Section 414, Rules Governing Aid to Families with Dependent Children. The maintenance need deduction is reduced by the family member's countable income. His countable income is his gross income, minus AABD exclusions, minus the first twenty dollars (\$20) of unearned income and the first sixty-five dollars (\$65) of earned income. Round the remainder to the next highest dollar if an uneven amount. The remainder is deducted from the client's income as the dependent's maintenance need.

(7-1-96)

e. Deduct expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, not subject to payment by a third party. Deduction of Medicare Part B premiums is limited to the first two (2) months of Medicaid eligibility. Medicare Part B premiums must not be deducted, if the client got SSI or AABD payment the month prior to the month for which patient liability is being calculated.

(1-1-93)

f. **Mandatory Income Taxes.** Deduct taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the client receives the income.

(7-1-96)

g. **Guardian Fees.** Deduct court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars (\$25). Where the guardian and trustee are the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars (\$25) monthly.

(7-1-96)

h. **Trust Fees.** Deduct up to twenty-five (\$25) monthly paid to the trustee for administering the client's trust.

(7-1-96)

i. **Impairment-Related Work Expenses.** Deduct impairment-related work expenses for an employed client who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services, purchased or rented to perform work. The items must be needed because of the client's impairment. The actual monthly expense of the impairment-related items is deducted. Expenses must not be averaged.

(7-1-96)

614. INCOME OWNERSHIP OF CLIENT WITH COMMUNITY SPOUSE.

01. Income Ownership of Client with Community Spouse. The income ownership of a Medicaid client in long-term care, with a community spouse, must be determined before patient liability can be computed. The income ownership of the client must be counted as shown in Subsections 614.01.a. through 614.01.d. (1-1-93)

a. Income paid solely in the name of a spouse, and not paid from a trust, must be counted as the separate income of the spouse. (1-1-93)

b. If income payment is made in the names of both the long-term care client and the community spouse, half will be counted to the community spouse and half to the long-term care client. (1-1-93)

c. If income payment is made in the names of the long-term care client and/or the community spouse and another person, the income will be counted as available to each spouse, in proportion to the spouse's ownership. If payment is made to both spouses, and no proportion of ownership is specified, one-half (1/2) of the income will be counted to each spouse. (1-1-93)

d. In the case of VA Aid and Attendance Allowance paid in the veteran's name, with an increment for the veteran's spouse, the increment is counted to belong to the long-term care spouse. (7-1-93)

02. Income Ownership From Property or Trust. Income from a trust must be counted to each spouse as specified by the trust. If the trust does not specify how the income is to be divided, Subsections 613.01.a. through 613.01.f. must be used. One-half (1/2) of income, from property with no instrument establishing ownership, must be counted available to the long-term care client and one-half (1/2) to the community spouse. (1-1-93)

03. Client Disagrees With Income Ownership Findings. The long-term care client, or representative, can rebut the Department's ownership decision if he disagrees. If the client does not rebut within thirty (30) days, or does not provide all of the required evidence, the original income ownership decision of the Department will be used to determine Medicaid eligibility and patient liability. If the client submits all required evidence on time, the Department must again determine the income ownership interest. The Department's findings must be documented in the case record. The income from the ownership interest determined by the Department from the client's rebuttal must be used to determine patient liability. Income ownership specified by a trust is not subject to rebuttal. The rebuttal procedure is listed in Subsections 614.03.a. through 614.03.g. (1-1-93)

a. A rebuttal of the Department's decision of income ownership must be done within thirty (30) days of notification of the decision. (1-1-93)

b. Rebuttal statement. The client must provide a written, signed statement listing his income ownership. The client must state the reason for his receipt of the income, or for his name appearing as an owner of the income. (1-1-93)

c. If the long-term care client or his representative says the client cannot give a statement of income ownership in writing, a written statement of his income signed by his legal guardian or a person with his power of attorney is acceptable. (1-1-93)

d. The client must prove his rebuttal by signed statements from the other income owners. A change in the instrument of ownership redirecting the income to the actual owners, and copies of the original and revised documents must be provided to the Department. (1-1-93)

e. The documents submitted by the client, or representative, must be reviewed by the Regional Deputy Attorney General when the rebuttal concerns income from property with no instrument establishing ownership, or where the couple says ownership shown on the instrument is not correct. The Attorney General must identify ownership or advise what evidence is needed to establish ownership. (1-1-93)

f. If the Department finds the client's rebuttal to be correct, the income ownership decision must be changed. (1-1-93)

g. If the client decides to abandon a rebuttal of an income ownership decision, he must provide the Department a written statement of this decision. (1-1-93)

615. LONG-TERM CARE CLIENT WITH COMMUNITY SPOUSE - PARTICIPATION IN COST OF CARE (PATIENT LIABILITY).

After income ownership of the long-term care client and the community spouse has been decided by the Department, participation in the cost of care is determined using Subsections 614.01 through 614.05 of these rules. Patient liability starts the first full calendar month the client resides in a long-term care facility. Income excluded in determining AABD eligibility is also excluded for patient liability. (1-1-95)

01. Step 1. Compute total income for long-term care client. Total monthly income includes income paid into a pension (Miller) trust that month. VA Aid and Attendance Allowance and VA UME are not counted as income for eligibility or patient liability. (1-1-95)

02. Step 2. Subtract the SSI payment for a person with special SSI eligibility status. The person is entitled to receive SSI at his at-home rate for up to two (2) months, while temporarily in a long - term care facility. (1-1-93)

03. Step 3. Subtract the AABD payment, and income used to compute the AABD payment, for a client paid continued AABD payments up to three (3) months in long-term care. (1-1-93)

04. Step 4. Subtract the income deduction computed in Subsections 616.01 through 616.05.c. of these rules. (7-1-96)

05. Step 5. Remaining income is the patient liability and must be applied toward the cost of care for long-term care client. (1-1-93)

616. COMPUTING INCOME DEDUCTION FOR LONG-TERM CARE CLIENT WITH COMMUNITY SPOUSE.

The income deduction is computed by adding the allowances in Subsections 616.01 through 616.09 of these rules. These allowances are used starting the first full calendar month the client resides in a long-term care facility. (7-1-96)

01. Personal Needs Allowance. Thirty dollars (\$30) is allowed for the long term care client's personal needs. (1-1-93)

02. Employed and Sheltered Workshop Activity Needs. An employed client or a client engaged in sheltered workshop or work activity center activities, is also allowed the lower of eighty dollars (\$80) or his earned income, for his personal needs. The total personal needs allowance must not exceed one hundred ten dollars (\$110) for long-term care client. (1-1-93)

03. Community Spouse Allowance. CSA is determined by performing the calculations in the following Subsections 616.05.a. through 616.05.c. of these rules. (1-1-93)

a. Compute the Shelter Adjustment. Add the Standard Utility Allowance to the community spouse's shelter costs. The Standard Utility Allowance is the current Food Stamp Program Standard Utility Allowance. Shelter costs include rent, mortgage principal and interest, homeowner's taxes, insurance, and condominium or cooperative maintenance charges. The Standard Utility Allowance must be reduced by the value of any utilities included in maintenance charges for a condominium or cooperative. Subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is used to compute the Shelter Adjustment. The Shelter Standard is thirty percent (30%) of one hundred and fifty percent (150%) of one-twelfth of the income official poverty line defined and revised annually by the Federal Office of Management and Budget for a family of two (2) persons. The Shelter Standard changes annually in July. The Shelter Adjustment is the positive balance remaining. (7-1-96)

b. Compute the Community Spouse Need Standard (CSNS). Add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred and fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined and revised annually by the Federal Office of Management and Budget for a family unit of two (2) members. The minimum CSNS is revised annually in July. The total CSNS may not exceed the

maximum CSNS. The maximum CSNS is calculated by applying to fifteen hundred dollars (\$1,500) the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January. (7-1-96)

c. Compute the Community Spouse Allowance. Subtract the community spouse's gross income from the CSNS. Round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. If a court orders the long-term care client to contribute a larger amount for the support of the community spouse, the support amount ordered by the court must be used as the CSA. The CSA ordered by a court is not subject to the CSA limit. (1-1-93)

04. Family Member Allowance. A family member is claimed, or could be claimed, as a dependent on the Federal income tax return of either spouse. The family member must be a minor or dependent child, dependent parent or dependent sibling of either spouse. The family member must live in the community spouse's home. Any remainder is the FMA for that family member. The FMA is allowed, whether or not it is actually paid by the client. To figure the FMA, follow the steps outlined in Subsections 661.04.a. through 616.04.d. of these rules. (1-1-93)

a. Compute the family member's gross income. (1-1-93)

b. Subtract the family member's gross income from the minimum CSNS. (1-1-95)

c. Divide the difference by three (3). (1-1-93)

d. Round cents to the next higher dollar. (1-1-93)

05 Health Insurance Costs Allowance. Add costs for Medicare and other health insurance premiums. Subtract coinsurance charges and deductibles not subject to payment by a third party. Medicare Part B premiums are limited to the first two (2) months of Medicaid eligibility. Medicare Part B premiums must not be added if the client got SSI or AABD payment the month prior to the month patient liability is being calculated. (1-1-93)

06. Mandatory Income Taxes. Deduct taxes mandatorily withheld from unearned income for income tax purposes. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the client receives the income. (7-1-96)

07. Guardian Fees. Deduct court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars (\$25). Where the guardian and trustee are the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars (\$25) monthly. (7-1-96)

08. Trust Fees. Deduct up to twenty-five dollars (\$25) monthly paid to the trustee for administering the client's trust. (7-1-96)

09. Impairment Related Work Expenses. Deduct impairment-related work expenses for an employed client who is blind or disabled under AABD criteria. Impairment-related work expenses are purchased or rented items and services, purchased or rented to perform work. The items must be needed because of the client's impairment. The actual monthly expense of the impairment-related items is deducted. Expenses must not be averaged. (7-1-96)

10. CSA Allowed As Actually Paid. The CSA must be allowed only as actually paid by the long-term care spouse to the community spouse. If the long-term care spouse pays less than the CSA, the actual amount paid must be the CSA. If the long-term care spouse pays more than the CSA, only the CSA is allowed. (1-1-93)

11. Fair Hearing On CSA Decision. Either spouse may ask for a fair hearing, to show the community spouse must have income above the CSA. The hearing officer must consider if the community spouse's income and resources are being used to the spouse's best advantage. The hearing officer must consider if the CSA causes significant financial hardship for the community spouse, due to unusual conditions. If the fair hearing decision finds the community spouse needs income above the level provided by the CSA, the CSA must include the additional income. (7-1-94)

617. MEDICAID ELIGIBILITY OF MARRIED PERSONS.

To determine Medicaid eligibility of an aged, blind, or disabled married person or couple, the proper income and resource counting method must be used. Three methods exist: The SSI method, the Community Property (CP) method, and the Federal Spousal Impoverishment (FSI) method. The FSI method takes precedence, even where the client is an SSI recipient. If the client is not subject to the FSI method, the CP or SSI methods can be used. (7-1-93)

01. Choice of SSI or CP Method. Each client, not subject to the FSI method, who is an aged, blind, or disabled married person must be furnished a clear and simple written explanation of SSI and CP income and resource counting methods. The couple chooses the most useful method, based on their circumstances. The couple has a choice of methods for backdated Medicaid. Different methods can be used for different months of the backdated period. The couple cannot choose a different method, than the one used to determine previous eligibility for a spouse, if the previous eligibility period overlaps the backdated period. (1-1-93)

02. Changing the Income and Resource Counting Methods. A couple, not subject to FSI, has the right to change the method of counting income and resources when they decide another method is more useful. The decision to choose the CP or SSI method, or to change methods, must be in writing on a form provided by the Department. Both spouses must sign the form unless one (1) or both is unable to sign. If one (1) spouse is unable to sign the form, his spouse, his court-appointed guardian or a person holding his power of attorney can sign for him. If both spouses are unable to sign, each spouse's court-appointed guardian or the holder of a power of attorney can sign for him. A change in methods cannot be effective earlier than the month following the month the couple notifies the Department, in writing, of their desire to change from one (1) method to another. A client choosing to change from the SSI method to the CP method, and who voluntarily causes his SSI payment to be stopped in order to change to the CP method, must not be penalized for stopping his SSI. (1-1-93)

03. Default to SSI Method. If a couple, not subject to FSI, cannot agree on the method of counting income and resources, the SSI method must be used for both, until they agree to a change. (1-1-93)

04. Ceremonial and Common Law Marriage. A person married by ceremony or under common law is married for purposes of Medicaid. The ceremonial marriage must be proved by a marriage certificate, or by SSA treating the couple as married to award benefits. The common law marriage must not be presumed because a man and woman live together and claim to the community they are married. The common law marriage must be established by a court having jurisdiction, or attested to in writing by the spouses, on a form provided by the Department. If a couple claims to be married under the common law provisions of another state, the couple must establish the existence of a valid common law marriage under that other state's law to the satisfaction of the Department. Common law marriage is proved if SSA treats the couple as married to award benefits. (1-1-93)

05. Explanation of Common Law Marriage to Client. A couple claiming to be married under common law must be provided a verbal and written description of the elements of common law marriage. The verbal and written explanation of common law marriage must inform the couple in order for a common law marriage to exist, both parties must be legally free to marry. Both parties must be of legal age to marry, must not be first cousins or closer in relationship, and any previous marital relationship, including a common law marriage must have been terminated by divorce, death or annulment. Both parties consent to enter into the marriage under common law by living together, holding themselves out to the community as husband and wife, and by mutually taking on the rights, duties and responsibilities of marriage. (1-1-93)

618. FEDERAL SPOUSAL IMPOVERISHMENT (FSI) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.

The FSI method must be used to calculate income and resources of an aged, blind, or disabled married client, who entered long-term care on or after September 30, 1989. The FSI method must be used where the client is an SSI recipient. The client must have a spouse living in the community. A married aged, blind, or disabled client in long-term care, without a spouse in the community, is subject to the SSI or CP method. Terms used in the FSI method are listed in Subsections 618.01.a. through 618.01.e. of these rules. (7-1-93)

01. Terms Used In FSI Method. (1-1-93)

a. The long-term care spouse is in long-term care. A long-term care spouse must be in a medical institution or nursing facility, or be an HCBS client, for thirty (30) consecutive days, or appear likely to remain in the

facility or need HCBS thirty (30) days. The husband or wife of the long-term care spouse must not be in a medical institution or nursing facility, or an HCBS client. (1-1-93)

b. The community spouse is the husband or wife of the long-term care client. The community spouse lives in the community, is not in long-term care or an HCBS client. (1-1-93)

c. A continuous period of long-term care is a period of residence either in a medical institution providing nursing facility services, or at home receiving HCBS. A continuous period of long-term care is a combination of institution and personal care services likely to last at least thirty (30) consecutive days. A client is likely to remain in an institution and/or receive HCBS for thirty (30) consecutive days if the Regional Medicaid Unit decides the client is likely to remain in long-term care for at least thirty (30) consecutive days. The client may not actually remain in long-term care. Continuity is broken by absence from the institution, or a lapse in HCBS eligibility, of thirty (30) consecutive days. The thirty (30) consecutive days of long-term care must not begin on a day the client is hospitalized. Hospitalization during the thirty (30) consecutive days, but subsequent to the first day, does not interrupt the thirty (30) consecutive days. (1-1-93)

d. The start of a continuous period of long-term care is the first (1st) month of long-term care or receipt of HCBS. (1-1-93)

e. Nursing facility services are services at the nursing facility level or the intermediate care for the mentally retarded level provided in a medical institution such as a long-term care facility. (1-1-93)

02. **Assessment Date and Counting FSI Resources.** The assessment date is the start date of the first continuous period of long-term care, on or after September 30, 1989. The assessment date must be used to determine the couple's total FSI resources. The resource assessment is done at the request of either spouse, after one spouse is in long-term care or begins HCBS. The couple may request an assessment before applying for Medicaid. The Department must assess and document the total value of the resources either spouse, or both spouses, had ownership interest in, as of the date of the first continuous period of long-term care on or after September 30, 1989. This is the only assessment. No later assessment is done. State laws relating to community property or the division of marital property are not applied in determining the FSI total combined resources of the couple. The long-term care spouse and community spouse must provide proof of the composition and value of all resources held by the couple as of the assessment date. The Department must identify the types of proof required and assist in obtaining the proof when requested. The assessment must not be completed until all proof is obtained. Resources excluded in determining AABD eligibility are excluded in determining the couple's total combined FSI resources except: There is no limit on the total value of household goods and personal effects and one (1) automobile is excluded regardless of its value. Any additional automobiles are countable resources in the amount of their equity value. Excess resources offered for sale, are not excluded from the couple's total combined resources for the FSI resource assessment. Jointly owned real property is not excluded, if the community spouse is the joint owner. The SSI method or CP method is used when long-term care began before September 30, 1989. (7-1-96)

03. **Compute the One-Half (1/2) Spousal Share.** The Department must compute the spousal share of the couple's resources. The spousal share is one-half (1/2) of the couple's total combined resources on the assessment date. The spousal share does not change, even if the client leaves long-term care and then enters long-term care again. The Department must complete a resource assessment form listing all resources held by the community spouse, long-term care spouse, or both, as of the assessment date. The total resource value and spousal share, must be entered on the resources assessment form. The separate resources of the community spouse must be entered and totalled on the resources assessment form. The couple must sign the resources assessment form attesting, under penalty of perjury, the list is accurate and complete to the best of their knowledge. The signature requirement may be waived for the long-term care spouse if he or his representative says he is unable to sign the resources assessment. A copy of the assessment form must be provided to each spouse when eligibility is determined or when either spouse requests a assessment prior to application. The resource assessment form must tell the couple either spouse has the right to a hearing if he disagrees with the Department's decision of available resources or ownership of resources, or the amount of the CSRA. A person who is not an applicant for Medicaid at the time of the resources assessment may be billed for the cost of an appraisal of his property deemed necessary and ordered by the Department in the assessment process. The purchase of a property appraisal and the decision to bill the person for the cost of a property appraisal purchased in his behalf must be approved, in writing, by the welfare eligibility supervisor. Where a resource

assessment has been requested but no application filed, trial resource eligibility for the long-term care spouse must be computed. (1-1-93)

04. The Community Spouse Resource Allowance (CSRA). The CSRA protects resources for the community spouse. The CSRA is determined by subtracting the greater of the minimum resource allowance, or the spousal share from the assessment, from the couple's total combined resources. The deduction must not be more than the maximum resource allowance. The maximum resource allowance is calculated by applying to sixty thousand dollars (\$60,000), the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. The minimum resource allowance is calculated by applying to twelve thousand dollars (\$12,000), the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the current calendar year. If the result is not an even one hundred dollar amount, round up to the next one hundred dollars. The minimum and maximum resource allowances are revised annually in January. The couple's resources exceeding the CSRA are resources of the long-term care spouse for determining Medicaid eligibility, regardless of which spouse owns the resources. (1-1-95)

05. Revisions of the CSRA. If a fair hearing shows the community spouse's own income, plus income produced by income-producing resources included in the CSRA, is less than the minimum Community Spouse Allowance (CSA), the CSRA may be increased by enough resources, transferred from the long-term care spouse, to raise the community spouse's income to the minimum CSA. The resources to be included in the transfer are presumed to produce income of five percent (5%) yearly, whether or not the resources produce income, or produce five percent (5%). If the transferred resources produce more than five percent (5%) yearly income, the actual income produced is used to determine the amount of resources that can be transferred to the community spouse to increase the CSRA. The long-term care spouse must transfer the resources to the community spouse, or no revision to the CSRA is allowed. If the hearing officer, determines the community spouse is making reasonable use of his current income and resources, to generate adequate income, the hearing officer may waive the five percent (5%) yearly income requirement. In determining reasonable use, the hearing officer may compare the income earned from a resource against current interest earned on conservative investments. If either spouse claims the Department's CSRA is not correct, and the claim is confirmed by a fair hearing decision, the CSRA must be revised. If the original CSRA was based on incorrect information and an incorrect protected resources amount resulted, the CSRA must be recalculated using correct information. Actual income produced by the resources transferred to the community spouse is used to compute the community spouse allowance for patient liability. (7-1-96)

06. The Resource Transfer Allowance (RTA). The resource transfer allowance (RTA) is computed by subtracting the community spouse's resources at the time of application from the CSRA. The RTA is the resources transferred, without penalty, from the long-term care spouse to the community spouse, to bring the community spouse's resources up to the CSRA. The community spouse must own less than the CSRA to get an RTA. The RTA is subtracted from the long-term care spouse resources and added to the community spouse resources to bring the community spouse resources up to the CSRA. If the institutional spouse transfers more than the RTA, the amount of the couple's resources over the CSRA continues to count as the institutional spouse's resources. During the continuous period a long-term care spouse is in an institution, and after the month in which a long-term care spouse is determined Medicaid eligible under FSI, resources of the community spouse, within the CSRA, are not considered available to the long-term care spouse for his resource eligibility. (7-1-96)

07. The Resource Protected Period for RTA Transfer to Community Spouse. The long-term care spouse has a protected period of sixty (60) days, from the date his application is approved to legally transfer RTA resources. The long-term care spouse must state, in writing, his intent to transfer the resources to the community spouse, within the protected period, before he can be Medicaid eligible. If the long-term care spouse, or his representative, say the long-term care spouse is unable to give his intent in writing, a written statement of his intent signed by his legal guardian or a person with his power of attorney is acceptable. Resources not transferred to the community spouse by the end of the sixty (60) day protected period are counted available to the long-term care spouse, toward the two thousand dollar (\$2,000) resource limit, effective the date of entry into the facility. (1-1-93)

08. Extension for RTA Transfer. The protected period can be extended beyond sixty (60) days if necessary because of the client's circumstances. An extension may be granted when more time is needed to obtain guardianship over the long-term care spouse. The reason for allowing an extension must be documented in the case record. Transfer of resources is normally made through a marriage settlement agreement. When transfer must be

made through a court, rather than a marriage settlement agreement, either spouse is allowed the length of time necessary to accomplish the transfer through the court. The protected period of eligibility is available immediately following an eligibility decision, and when a long-term care spouse gets additional resources at a later date. Additional resources a long-term care spouse gets during a protected eligibility period are not counted when the new resources, combined with other resources the long-term care spouse intends to retain, do not exceed the two thousand dollar (\$2,000) limit or the community spouse has resources below the CSRA and the long-term care spouse intends to transfer the new resources to the community spouse within a protected period. The intent to transfer must be put in writing before the protected period can be established. (1-1-93)

09. FSI Resources and Backdated Medicaid. Medicaid eligibility can start three (3) months before the date of application. FSI resource eligibility is met for any of the three (3) months, if the couple's countable resources, minus the protected resources amount calculated at or for the first continuous period of long-term care beginning on or after September 30, 1989, is less than two thousand dollars (\$2,000). While the application is pending, the long-term care spouse must state his intent, in writing, to transfer the RTA to the community spouse. Where the long-term care spouse or representative says the long-term care spouse is unable to give his intent in writing, a written statement of his intent signed by his legal guardian or a person with his power of attorney is acceptable. (1-1-93)

10. FSI Income Eligibility of Non-HCBS Long-Term Care Spouse. During any month a long-term care spouse is in the institution, no income of the community spouse is counted for Medicaid eligibility of the long-term care spouse. Income of the long-term care spouse must not exceed the financial need standard for his nursing facility care or HCBS living arrangement. The CP method must be used to determine income for Medicaid eligibility for a non-HCBS client subject to the FSI method, but not eligible for Medicaid using the FSI method because of income. Under the CP method, each spouse owns one-half (1/2) of the couple's community income plus his own separate income. A client eligible under the CP method, must use the FSI method to compute patient liability. (1-1-93)

11. FSI Income Eligibility of HCBS Long-Term Care Spouse. An HCBS client subject to FSI, but not eligible for Medicaid using FSI, because of income or resources, is entitled to use the CP method to determine his income and resources for Medicaid eligibility. A client eligible under the CP method, must use the FSI method to determine client participation. (See Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Subsection 146.10, "Rules Governing Medical Assistance.") (1-1-93)

12. FSI and Resource Eligibility for Community Spouse. When the community spouse is a Medicaid client, the spouse's resources are counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. For the month the couple stopped living together in their mutual home, resources of the community spouse available for his Medicaid eligibility are the resources owned by the couple. If the resources owned by the couple are less than the AABD couple resource limit, the community spouse is resource eligible for the month the couple stopped living together in their mutual home. (1-1-93)

13. FSI and Income Eligibility for Community Spouse. When the community spouse is a Medicaid client, the spouse's income is counted using Medicaid rules. The FSI rules apply only to the long-term care spouse. The community spouse may choose between the SSI and CP methods for determining income for Medicaid eligibility. (1-1-93)

14. Change In Circumstances for FSI. The FSI method of calculating income and resources stops the first (1st) full calendar month following a change in circumstances resulting in a couple no longer having a community spouse and a long-term care spouse. (1-1-93)

15. FSI Notice and Fair Hearing. FSI clients are subject to the regular notice and hearing requirements in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 05, Chapter 03, "Rules Governing Contested Cases and Declaratory Rulings." Special notice and fair hearing rules also apply for FSI client. When eligibility for Medicaid of the long-term care spouse is determined, or when requested by either spouse or a representative acting on behalf of either spouse, the Department must provide the CSA and family member allowance, the CSRA and how it was computed, and the RTA. The client has the right to a fair hearing about counting of income or resources, and the CSA or the RTA. Any hearing requested about the CSRA or the RTA must be held within thirty (30) days of the date of the request for hearing. (1-1-93)

619. SSI METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.

A married couple may choose the SSI budget method, if not subject to the FSI method. The SSI method is the same method used to count income and resources for AABD. The client and spouse must have their income and resources counted as mutually available in the SSI budget method. Income and resources of a married couple are mutually available for Medicaid eligibility in long-term care, when one (1) or both spouses apply during the month they separated, because one (1) or both left their mutual home to enter a long-term care facility. The SSI method must be used for months either spouse of a couple, not subject to the FSI method, gets an SSI or AABD payment, or an SSI and/or AABD application is filed and approved. Couples entitled to choose between the SSI method and the CP method must use the same method for both spouses. The method must be used for Medicaid eligibility, and liability for the cost of long-term care, whether one (1) or both spouses apply for Medicaid. (1-1-93)

01. SSI Method and Separation of Couple. Couple status ends the month, following the month the couple stopped living together in their mutual home. For couple status, a long-term care facility is not a home. The actual AABD need standard, as if the client were still at home, is his income limit. If the couple is determined eligible, patient liability, and the AABD grant for the spouse residing at home, must be computed by counting income as if each client is a single person. If the couple is not eligible, either spouse, but not both, may apply for Medicaid the month following, the month of separation and have his eligibility determined as a single person. (1-1-93)

02. SSI Method for Couple In Long-Term Care Facility. When both members of a couple have continuously lived in the same room in a long-term care facility for six (6) months, couple status ends the next month. Couple status must continue if treating the husband and wife as two (2) individuals prevents either from being eligible for Medicaid. If treating the couple as two (2) individuals prevents either from being eligible for Medicaid, they will continue to be treated as a couple until couple status is no longer useful to them. (1-1-93)

620. COMMUNITY PROPERTY (CP) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.

The CP method is based on the community property provisions of Chapter 9, Title 32, Idaho Code. The CP method of counting the income and resources of an aged, blind, or disabled married person for Medicaid eligibility, is intended to protect the community and separate property rights of the married person, whether or not the spouses live together. A married and aged, blind, or disabled person in long-term care, without a spouse remaining in the community, is subject to the CP method. The CP method is used for determining income eligibility of a married person subject to the FSI method, but not income eligible using the FSI method. The CP method must not be used to determine resource eligibility of a long-term care spouse subject to the FSI method. The CP method must not be used to compute patient liability for an aged, blind or disabled married person, even where the CP method is used to determine his eligibility for Medicaid. For couples entitled to choose between the SSI method and the CP method, the same method of counting income and resources must be applied to both spouses, whether one (1) or both is applying for Medicaid. (1-1-94)

01. CP Method. Under the CP method, each spouse has an equal one-half (1/2) share of the couple's community income and resources. Each spouse also has his or her own separate income and resources. Whether the spouses live together or, if not living together, the length of time they have lived apart, does not change the way income and resources are counted. A spouse's property includes income, personal property and real property. The income and resources of a married couple acquired during the marriage are presumed to be community property of the couple. The couple must be permitted to provide evidence to rebut the presumption that property acquired during the marriage is community property. (1-1-93)

02. CP Effect on Other Medicaid Requirements. Use of the CP method to calculate the amount of income and resources of a married person does not raise or eliminate the income and resource limits for the aged, blind, and disabled. Use of the CP method does not affect other Medicaid eligibility provisions. (1-1-93)

03. Separate Property Agreement and CP. Under the CP method, a client's separate property is not included in the amount of his spouse's income and resources. Separate property, as defined in Section 32-903, Idaho Code, is all property of either the husband or the wife, owned by him or her before marriage and property acquired afterward by gift, bequest, devise or descent. Property a spouse gets with the proceeds of his or her separate property, is still separate property. Income produced by separate property is presumed to be community property, to the extent the income is produced during the marriage. The client is entitled to offer evidence to rebut this presumption. (1-1-93)

04. Marriage Settlement Agreement and CP. Property can be changed from separate property to community property and vice versa by a valid marriage settlement agreement. A valid marriage settlement agreement must meet the conditions of Subsections 620.04.a. through 620.04.e. An agreement not meeting these conditions is not valid in determining eligibility for Medicaid under the CP method. (1-1-93)

a. A marriage settlement agreement can be made before the marriage or during the marriage. The marriage settlement agreement must be entered into by husband and wife, and must be in writing. (1-1-93)

b. A marriage settlement agreement involving real property must be entered into by husband and wife, must be in writing and recorded in the county where the real property is located. (1-1-93)

c. A marriage settlement agreement involving income or personal property must be entered into by husband and wife, must be in writing and notarized. The date the agreement is notarized is the date the property is changed from separate to community and vice versa. (1-1-93)

d. A marriage settlement agreement can involve a transfer of property, as when property is separated and then changed back to community property. (1-1-93)

e. Medicaid eligibility is not affected where the couple has entered into a devolution agreement under Section 15-6-201(c), Idaho Code. A devolution agreement provides for property, at the death of one spouse, to pass to the surviving spouse. Department questions about the validity of an agreement, represented as a devolution agreement, must be referred to the Region's Deputy Attorney General. (1-1-93)

05. Transfer of Rights to Future Income Not Valid. An agreement between spouses, transferring or assigning rights to future income from one (1) spouse to the other, is not used to determine eligibility for Medicaid. (1-1-93)

06. Need Standard. The need standard for a married client choosing the CP method depends on his living situation. The need standard depends on whether his spouse is living with him, and whether his spouse is applying for Medicaid. The need standard for a client, whose spouse is not a Medicaid applicant, or who is not living with his spouse, or not living with his spouse on the first (1st) day of the month, is budgeted allowances for a single person. The need standard for a couple applying for Medicaid who live together, or were living together on the first day of the month, is the need standard for a couple. The budgeted allowances for the couple's needs, are the need standard. (1-1-93)

07. Resource Limit. The resource limit for a married client, choosing the CP method, depends on his living situation. The resource limit depends on whether he is living with his spouse, and if his spouse is a Medicaid applicant. The resource limit for a client, whose spouse is not a Medicaid applicant, or a client who was not living with his spouse on the first (1st) day of the month, is two thousand dollars (\$2,000). The resource limit for a couple applying for Medicaid, living together, or living together on the first (1st) day of the month, is three thousand dollar (\$3,000). (1-1-93)

08. Income Disregards. The AABD income disregards are applied to the income of a married client, choosing the CP method. A client not living with his spouse, whose spouse is not applying for Medicaid, or who was not living with his spouse on the first (1st) day of the month, gets the standard disregard of twenty dollars (\$20). If the client has earned income he gets the first sixty-five dollars (\$65), plus one-half (1/2) of the remaining earned income, disregarded. A couple, living together, or living together on the first (1st) day of the month, and applying for Medicaid, gets couple income disregards. The couple gets the standard AABD disregard of twenty dollars (\$20) on their combined unearned income. The couple gets the earned income disregard of sixty-five dollars (\$65) on their combined earned income. One-half (1/2) of the balance of earned income is subtracted from the couple's remaining earned income. (1-1-93)

621. 1972 RSDI RECIPIENT.

A Medicaid client, meeting all other current Medicaid eligibility requirements, remains eligible for Medicaid, if he meets any of the conditions in Subsections 621.01 through 621.03. (1-1-93)

01. Money Payment in August 1972. The client was eligible for, or was receiving, in August 1972, a state money payment of OAA, AB, APTD or AFDC.

(1-1-93)

02. Eligible If Not in Institution. The client would have been eligible for OAA, AB, APTD or (AFDC) if he were not in a medical institution or intermediate care facility in August 1972.

(1-1-93)

03. Getting RSDI in August 1972. The client was receiving RSDI benefits in August 1972. He became ineligible for a state money payment due to the RSDI benefit increase effective in September 1972, and payable in October 1972.

(1-1-93)

622. (RESERVED).

623. SSI RECIPIENT.

An SSI recipient is eligible for Medicaid if he meets one (1) of the conditions in Subsections 623.01 through 623.03 of these rules. An SSI recipient with a Medicaid Qualifying Trust, created and funded before August 11, 1993, is subject to the Medicaid Qualifying Trust policy in Section 609, for Medicaid eligibility. An SSI recipient is not entitled to Medicaid if he fails to assign his rights to medical support, or fails to cooperate in establishing paternity or securing medical support, as required by Section 606. An SSI recipient is not entitled to Medicaid if he is in an ineligible institution. An SSI recipient is not entitled to Medicaid if he has a trust that makes him ineligible for Medicaid. An "essential person" must not be treated as an SSI recipient, and is not eligible for Medicaid. (7-1-96)

01. Receives SSI. The client gets SSI payments, even if eligibility is based on presumptive disability or presumptive blindness. If the Department determines a person getting SSI is not eligible for SSI, SSA must be notified. Medicaid must not be stopped before SSI benefits are stopped by SSA.

(1-1-93)

02. Conditionally Eligible. The client is determined by SSA to be "conditionally eligible" for SSI, based upon his agreement to dispose of excess resources within a specified time.

(1-1-93)

03. Eligible Spouse. The client is determined by SSA to be an "eligible spouse". Even though he is eligible in his own right, his SSI payments are combined with his spouse's SSI payments.

(1-1-93)

04. SSI and Drug Addict or Alcoholic. The client is eligible for SSI, but SSI is suspended for two (2) or more months or stopped after thirty-six (36) months because of drug addiction or alcoholism. The client is not an SSI recipient for Medicaid if SSI stops after twelve (12) months of noncompliance with appropriate substance abuse treatment.

(7-1-96)

624. POTENTIAL SSI RECIPIENT.

A potential SSI recipient would be eligible to get SSI if he applied, or if he did not reside in a medical facility. The potential SSI recipient with a Medicaid Qualifying Trust, created and funded before August 11, 1993, is subject to the Medicaid Qualifying Trust policy in Section 609, for Medicaid eligibility. A potential SSI recipient is not entitled to Medicaid if he fails to assign his rights to medical support, or fails to cooperate in establishing paternity or securing medical support, as required by Section 606. A potential SSI recipient is not entitled to Medicaid if he is in an ineligible institution. A potential SSI recipient is not entitled to Medicaid if he has a trust that makes him ineligible for Medicaid.

(7-1-94)

625. (RESERVED).

626. PSYCHIATRIC FACILITY RESIDENT.

A resident of a long-term care psychiatric medical facility, is eligible for Medicaid if he is age sixty-five (65) or older. He must meet all the requirements of a long-term care resident. He must receive skilled or intermediate nursing care, in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Subsection 160.09, "Rules Governing Medical Assistance".

(1-1-93)

627. GRANDFATHERED SSI RECIPIENT.

A grandfathered SSI recipient is eligible for Medicaid. On December 31, 1973 a grandfathered SSI recipient received

or was eligible to receive APTD, APTD-MA, AB or AB-MA. A grandfathered SSI recipient received or was eligible to receive APTD-MA in long-term care on December 31, 1973, or had an application for this assistance on file December 31, 1973. (1-1-93)

01. Disability and Blindness Criteria. The grandfathered SSI recipient must have been eligible under the disability criteria for APTD or the blindness criteria for AB in effect on December 31, 1973. This criteria is on file with the Bureau of Welfare Programs. (1-1-93)

02. Eligibility Requirements. A grandfathered SSI recipient is eligible for Medicaid if he meets all current Medicaid rules, except the criteria for blindness or disability. For each consecutive month after December 1973, the grandfathered SSI recipient must continue to meet the criteria for disability or blindness. A long-term care person must also have remained in long-term care, and continue to need long-term care. (1-1-93)

628. RSDI RECIPIENT ENTITLED TO COLA DISREGARD.

A client is eligible for Medicaid if he is an aged, blind, or disabled person who became and remains ineligible for AABD payments or SSI payments after April, 1977. The client must still be entitled to AABD or SSI, except for a cost-of-living adjustment (COLA) in RSDI benefits. All RSDI COLAs the client, and his financially responsible spouse or parent, got since he was last eligible for, and received, RSDI and AABD or SSI at the same time, must be disregarded in determining his eligibility for Medicaid. The income and resources of a financially responsible spouse or parent are counted in determining the client's eligibility for Medicaid. (1-1-93)

629. PERSON ENTITLED TO SECTION 1619b SSI ELIGIBILITY STATUS.

A client is eligible for Medicaid as a blind or disabled SSI recipient, if SSA is evaluating him for, or has granted him, SSI eligibility status under Section 1619b of the Social Security Act. He is considered an SSI recipient as long as his 1619b status continues. (1-1-93)

630. APPEAL OF SSA DECISION BY MEDICAID APPLICANT.

An applicant denied for Medicaid because he does not meet SSI eligibility requirements, or Social Security disability requirements can appeal the SSA denial with SSA. He can get Medicaid if he is found eligible for SSI or Social Security disability as a result of his appeal. The effective date for Medicaid is the first day of the month of the Medicaid application denied because of the SSA denial. The client's eligibility for backdated Medicaid coverage must be determined. (1-1-96)T

631. APPEAL OF SSA DECISION AND CONTINUED MEDICAID.

If a client getting Medicaid based upon disability, is found by SSA not to be disabled under the SSI standard, the client can continue to get Medicaid if he appeals the SSA decision. The appeal must be filed within sixty (60) days of the SSA decision, before Medicaid benefits end. If the final administrative decision rules against the client's appeal, Medicaid benefits must end. Medicaid benefits paid during the appeal are not an overpayment. (1-1-93)

632. CERTAIN DISABLED CHILDREN.

A disabled child eligible for Medicaid in a medical institution, but not outside a medical institution, is eligible for Medicaid outside the institution if he meets all the conditions in Subsections 632.01 through 632.07.c. The parent's income and resources are not available to the child for Medicaid eligibility. For computing AABD payment, the income and resources of a parent living with the child are available to the child. Financial eligibility of Certain Disabled Children cases must be redetermined at least once each year. Level of care and cost-effectiveness must be redetermined at least once each year by RMU. Disability must be reviewed by the review date set in the latest disability review unless the disability is permanent. (7-1-93)

01. Age. The child must be under nineteen (19) years old. (1-1-93)

02. AABD Criteria. The child must meet the AABD age, blindness, or disability criteria. (1-1-93)

03. AABD Resource Limit. The child must meet the AABD single person resource limit of two thousand dollars (\$2,000). (1-1-93)

04. Income Limit. The child's monthly income must not exceed three (3) times the Federal SSI benefit payable monthly to a single person (1-1-96)T

05. Eligible for Long-Term Care. The child must meet the medical conditions for long-term care as specified in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Subsection 160.09, "Rules Governing Medical Assistance". (1-1-93)

06. Care Appropriate Outside Medical Institution. It must be appropriate to provide care for the child outside a medical institution. A physician's plan of care must identify services necessary to maintain the child outside a medical institution. (1-1-96)T

07. Cost of Care. (1-1-93)

a. The estimated cost of caring for the child at home must not exceed the cost of the child's care in a hospital, nursing facility, or ICF-MR. The estimated cost of home care is the Medicaid reimbursement rate for services required for the child's care at home, using the physician's orders. The Regional Medicaid unit will make the home care cost estimate. (1-1-93)

b. The estimated cost of care in a hospital, nursing facility, or ICF-MR is the actual monthly Medicaid cost if the child is living in the facility. (1-1-93)

c. The estimated cost of care in a hospital, nursing facility, or ICF-MR for a child not living in a facility is the rate for the level of care he requires, charged by the facility where the child would be placed if he were not living with his parent(s). (1-1-93)

633. EXTENDED (POSTPARTUM) MEDICAID FOR PREGNANT WOMEN.

A woman receiving Medicaid while pregnant continues to be eligible through the last day of the month in which the sixty (60) day post partum period ends. The sixty (60) day post partum period starts the last day of pregnancy. The last day of pregnancy is the day the child is born, the pregnant woman miscarries the fetus, or undergoes an induced abortion. The woman must meet Medicaid eligibility requirements during the sixty (60) day coverage period. Only pregnancy and postpartum services available under Idaho's Medicaid State Plan and those included in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, "Rules Governing Medical Assistance" are covered. Timely notice of termination must be mailed ten (10) days before the end of the coverage period, and can be mailed as early as the last day of pregnancy. An ineligible alien with a pregnancy-related emergency medical condition is not eligible. Applications for Extended Medicaid made during the month the child is born, but after the child's birthdate, must not be approved for Extended Medicaid. (1-1-93)

634. PERSON ENTITLED TO HOME AND COMMUNITY BASED SERVICES (HCBS).

An aged, blind or disabled person not eligible for SSI or AABD in his own home, because of income deeming or income limits, is eligible for Medicaid if he meets the conditions of this section. The waiver granted the Department, by the U.S. Department of Health and Human Services, to provide Medicaid to persons meeting HCBS criteria is in effect. (1-1-93)

01. Conditions for HCBS Medicaid. The client must meet the requirements in this Section for one of the two HCBS waiver coverage groups. The two HCBS waiver coverage groups are HCBS-NF and HCBS-DD. (7-1-95)

a. Age. The client must be at least twenty-one (21) years old. (1-1-93)

b. AABD Criteria. The client, if under age sixty-five (65), must meet the AABD blindness or disability criteria. (1-1-94)

c. AABD Resource Limit. The client must meet the AABD single person resource limit of two thousand dollars (\$2,000). The AABD resource exclusions are used to compute countable resources. (7-1-93)

d. HCBS Income Limit. Income for HCBS-NF must not exceed nine hundred and nine dollars (\$909). Income for HCBS-DD must not exceed three (3) times the Federal SSI benefit payable monthly to a single person. The AABD income exclusions and disregards are used to compute countable income. (1-1-96)T

e. The HCBS-NF client must meet the medical conditions for nursing facility care in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Subsection 160.09, "Rules Governing Medical Assistance". The HCBS-DD client must meet the medical conditions for ICF/MR care in accordance with Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Subsection 143, "Rules Governing Medical Assistance." (1-1-96)T

f. The HCBS-NF client must be capable of being maintained in his own home with Personal Care Services (PCS) furnished under the Department's HCBS waiver ("PCS under the waiver"). To qualify as receiving PCS under the waiver, the client must require and receive more than sixteen (16) hours of PCS during at least one (1) week of each month. (See Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 146, "Rules Governing Medical Assistance.") There must be a physician's plan of care identifying services necessary to maintain the client at home. The HCBS-DD client must be capable of being maintained in the community. The community is the client's home or a living arrangement approved by the ACCESS Unit. The ACCESS Unit is defined in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 003, "Rules Governing Medical Assistance." The community is not a hospital, nursing facility, ICF/MR, licensed Adult Residential Care Facility or Adult Foster Care home. (7-1-95)

g. The estimated cost of caring for the HCBS-NF client at home must not exceed the statewide average cost of care for the client's level of care. The estimated cost of home care is the Medicaid reimbursement rate for services required for the HCBS-NF client's care at home using the physician's orders. The Regional Medicaid Unit (RMU) will make the home care cost estimate for the HCBS-NF client. The estimated cost of caring for the HCBS-DD client in the community does not affect the client's eligibility. (7-1-95)

h. The estimated cost of care in a nursing facility for an HCBS-NF client not living in a facility is the statewide average rate for the level of care he requires, charge by the type of facility where the client would be placed if he were not living at home. (7-1-95)

02. HCBS-NF Medicaid Effective Date. Medicaid under HCBS is effective the first thirty (30) consecutive day period, the client required and received Personal Care Services (PCS) under the HCBS waiver. PCS under the waiver is described in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 146, "Rules Governing Medical Assistance." Medicaid is effective the first (1st) day of the month, in the month the thirty (30) consecutive days start. The client must be otherwise eligible. The RMU decides if the client is likely to meet the thirty (30) consecutive days' rule. He meets the rule, even though he may not actually receive personal care services throughout the thirty (30) day period. The thirty (30) consecutive days can be a combination of home care, and nursing facility care, so long as the client is not hospitalized at the beginning of the thirty (30) consecutive days. If the client is not likely to meet the thirty (30) consecutive days' requirement, Medicaid must be denied. (7-1-95)

03. HCBS-DD Medicaid Effective Date. Medicaid is effective the first thirty (30) consecutive day period the client required and received or is likely to receive HCBS-DD waiver services. The HCBS-DD waiver services are described in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 143, "Rules Governing Medical Assistance." Medicaid is effective the first day of the month, in the month the thirty (30) consecutive days start. The client must be otherwise eligible. The ACCESS Unit makes the determination the client meets the thirty (30) consecutive days' rule. The client meets the rules even though he may not actually receive waiver services throughout the thirty (30) day period. If the client is not likely to meet the thirty (30) consecutive days' rule, Medicaid must be denied. (7-1-95)

04. Client Living With Spouse. A married HCBS-NF or HCBS-DD client living with his spouse can choose the method of computing his income and resources for Medicaid eligibility. If the client lives at home with his spouse, and his spouse is not an HCBS client, he can choose between the SSI method, CP method, and the FSI method. If his spouse is also an HCBS client or is living in a nursing home, the couple can choose between the SSI method and the CP method, but each must use the same method. (7-1-95)

05. Requiring and Receiving Services. As a condition of HCBS Medicaid eligibility, the HCBS-NF client must continue to require and receive waiver PCS, under the physician's plan of care. The HCBS-DD client must continue to require and receive HCBS-DD waiver services, under the physician's plan of care. Medicaid under HCBS-NF or HCBS-DD must be stopped when there is any lapse in need for or receipt of waiver services, more than

thirty (30) days.

(7-1-95)

a. The Bureau of Medicaid Policy-Acute/Facility Care must monitor delivery of waiver services for HCBS-NF clients to assure this requirement continues to be met. The Bureau of Medicaid Policy-Acute/Facility Care must notify the Examiner within five (5) working days if it determines a lapse in delivery of HCBS-NF waiver services will exceed thirty (30) days.

(7-1-95)

b. The Bureau of Medicaid Policy-Coordinated Care and the Division of Family and Community Services must monitor delivery of waiver services for HCBS-DD clients to assure this requirement continues to be met. The Bureau of Medicaid Policy and Reimbursement or the Division of Family and Community Services must notify the Examiner within five (5) working days if either unit determines a lapse in delivery of HCBS-DD waiver services will exceed thirty (30) days.

(7-1-95)

06. **Limit on HCBS Clients Served.** The annual limit on the number of unduplicated count Medicaid recipients eligible to receive HCBS-NF waiver services will be the limit established each calendar year by Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 146., "Rules Governing Medical Assistance". The annual limit on the number of unduplicated count Medicaid recipients eligible to receive HCBS-DD waiver services will be the limit established each calendar year by the Bureau of Medicaid Policy under Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 143, "Rules Governing Medical Assistance." A person who applies for HCBS Medicaid, after the annual limit on HCBS-NF or HCBS-DD waiver clients is reached, must be denied Medicaid.

(7-1-95)

635. NEWBORN CHILD OF MEDICAID MOTHER.

A child is eligible for Medicaid without an application if the child is born to a woman who is receiving Medicaid on the date of the child's birth.

(1-1-93)

01. **Time Limit.** The child is considered to remain eligible for Medicaid for a period of up to one (1) year without having an application filed for him. The child must live with his mother. His mother must remain eligible for Medicaid, or would remain eligible for Medicaid if pregnant.

(1-1-93)

02. **Application.** An application for Medicaid must be filed on behalf of the child no later than his first (1st) birthday. He must continue to qualify for Medicaid if his Medicaid eligibility is to be extended beyond the month of his first (1st) birthday.

(1-1-93)

636. INELIGIBLE NON-CITIZEN WITH EMERGENCY MEDICAL CONDITION.

An ineligible alien is eligible for Medicaid only for medical services necessary to treat an emergency medical condition. He must otherwise be eligible for Medicaid. This coverage group includes lawful temporary or permanent resident and Special Agricultural Worker aliens who are barred from Medicaid for five years, non-immigrant aliens such as students and visitors, and illegal aliens.

(1-1-93)

01. **Emergency Medical Condition.** Without immediate medical attention, an emergency medical condition could reasonably be expected to result in serious jeopardy to the patient's health, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(1-1-93)

02. **Medical Determination.** The Bureau of Medicaid Policy and Reimbursement must determine if a condition is an emergency condition. The Bureau of Medicaid Policy and Reimbursement must determine if the care and services Medicaid is requested to pay are necessary to treat the emergency medical condition.

(1-1-93)

03. **Effective Date of Eligibility.** Medicaid eligibility under this provision can begin no earlier than the date the ineligible alien client experienced the emergency medical condition. Medicaid eligibility must end the date the emergency medical condition stops. The Medicaid beginning and ending dates are determined by the Bureau of Medicaid Policy and Reimbursement.

(1-1-93)

637. (RESERVED).

638. DISABLED ADULT CHILD.

A client is eligible for Medicaid if he is age eighteen (18) or older, received SSI or AABD based on blindness or a

disability which began before he reached age twenty-two (22), and becomes ineligible for and remains ineligible for AABD payments or SSI because he began receiving or had an increase in his adult disabled child RSDI benefit on or after July 1, 1987. (1-1-93)

01. RSDI Benefits Disregarded for Disabled Adult Child. If he became ineligible for SSI or AABD because he began receiving an adult disabled child Social Security benefit on or after July 1, 1987, the amount of his adult disabled child Social Security benefit at the time he lost SSI or AABD and any subsequent increase in his adult disabled child benefit is disregarded in determining his Medicaid eligibility. (1-1-93)

02. RSDI Increase Disregarded for Disabled Adult Child. If he became ineligible for SSI or AABD because his adult disabled child benefit increased on or after July 1, 1987, the amount of the increase in his adult disabled child Social Security benefit at the time he lost SSI and/or AABD and any subsequent increase in his adult disabled child Social Security benefit is disregarded for Medicaid eligibility. (1-1-93)

639. PERSON RECEIVING EARLY WIDOW'S OR WIDOWER'S SOCIAL SECURITY.

A client is eligible for Medicaid if he is an eligible widow or widower entitled to early widow's or widower's Social Security benefits who would be eligible for SSI and/or AABD but for the early widow's or widower's Social Security benefit. The client is deemed to be an SSI recipient for purposes of Medicaid eligibility. An eligible widow or widower was at least sixty (60) but not yet sixty-five (65) when he or she became entitled to early widow's or widower's Social Security benefits. The person must have received SSI and/or AABD before age sixty (60). (1-1-93)

640. EARLY WIDOWS AND WIDOWERS BEGINNING JANUARY 1, 1991.

Some widows and widowers have SSI recipient status, and are Medicaid eligible. Medicaid eligibility under this coverage group is available beginning January 1, 1991. To qualify under this coverage group, the client must meet the conditions in Subsections 640.01 through 640.06 of these rules. (7-1-96)

01. Age. The client age fifty (50) to sixty-four and one-half (64 1/2) began receiving early widow's or widower's Social Security benefits. (7-1-96)

02. Lost SSI or AABD. The client lost SSI or AABD because he began receiving early widows or widowers Social Security benefits. (7-1-96)

03. Received SSI or AABD. The client received SSI or AABD in the month, before the month, he became ineligible because he began receiving early widows or widowers Social Security benefits. (7-1-96)

04. Widows or Widowers Benefits. The client would still be eligible for SSI or AABD if his Social Security early widows or widowers benefits were not counted as income. (7-1-96)

05. No Part A Insurance. The client is not entitled to Medicare Part A hospital insurance. (1-1-93)

06. Applied On or After 1/1/91. The client filed an application for Medicaid on, or after, January 1, 1991, or had a Medicaid application pending as of that date. (1-1-93)

641. CERTAIN DISABLED WIDOWS AND WIDOWERS THROUGH JUNE 30, 1988.

To be Medicaid eligible under this category the client must have applied no later than June 30, 1988. A disabled widow or widower is Medicaid eligible, as an SSI recipient, any month the person gets Social Security disability payments. The client must be continuously entitled to Social Security benefits for disabled widows and widowers starting January, 1984 or earlier. The benefits are paid to persons under age sixty (60). The client must be ineligible for SSI because of an increase in SSA disability benefits starting January, 1984. (1-1-93)

642. QUALIFIED MEDICARE BENEFICIARY (QMB).

The Department pays Medicare premiums, coinsurance and deductibles for a QMB. A person meeting the eligibility requirements in Subsections 642.01 through 642.02.b. of these rules is QMB eligible. Benefits for a QMB not receiving Medicaid are limited to Department payment of Medicare premiums, coinsurance and deductibles. (1-1-93)

01. QMB Nonfinancial Eligibility Requirements. (1-1-93)

a. The QMB must be entitled to hospital insurance under Part A of Medicare at the time of his application. A person not required to pay a premium for hospital insurance under Part A of Medicare meets this requirement if enrolled in Medicare at the time of QMB application. A person who must pay a premium to receive Part A, and entitled to hospital insurance under Part A of Medicare, meets the requirement whether or not he has paid a Part A premium. The Department pays the Part A premium for the Medicare beneficiary required to pay his own Part A premium. The effective date a person is entitled to Part A of Medicare is shown on his Medicare card issued by SSA. If the person is not able to furnish proof of his entitlement by showing his Medicare card, the Department must assist him to obtain this proof from the local SSA office. (1-1-93)

b. The QMB must meet the Medicaid eligibility requirements of residence, citizenship, medical support cooperation, and SSN. An applicant meets citizenship and SSN requirements if enrolled in Part A of Medicare. The person's SSN is considered verified for Medicaid purposes. (7-1-96)

02. QMB Financial Eligibility Requirements. (1-1-93)

a. Income. Monthly income must not exceed one hundred percent (100%) of the official poverty line defined by the Federal Office of Management and Budget. Income is computed with AABD cash assistance methods. AABD payments are not counted as income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual federal poverty guideline revision is published. (1-1-93)

b. QMB Dependent Disregard. A QMB with a dependent family member has an income disregard for the dependent. A dependent family member lives with the QMB, is a minor child, adult child meeting SSA disability criteria, parent or sibling of the QMB or spouse, and is claimed or could be claimed on the Federal tax return of the QMB or spouse. The income disregard depends on family size. The spouse is included in family size, whether or not the spouse is also QMB. The disregard is based on the income official poverty line defined and revised annually by the Federal Office of Management and Budget. The disregard is the difference between the poverty line for one (1) person or two (2) persons, if the client has a spouse, and the poverty line for a family of the size that includes the client, spouse, if any, and dependent. Income of the dependent child, parent, or sibling is not counted. (7-1-96)

c. Income limits. The single person income limit is the poverty line for a family of one (1) person. The couple income limit is the poverty line for a family of two (2) persons. (1-1-93)

d. Income budget choice. The QMB has the CP or the SSI method choice for income budgeting. The income limit for a married client choosing the CP method is the couple income limit if both spouses are applying for Medicaid and live together or were living together on the first (1st) day of the month. The income limit for a married couple choosing the CP method is the single person limit if only one spouse is applying or if the couple is not living together or was not living together on the first day of the month. If either or both of the spouses is an HCBS client, the couple is not regarded as living together. The resource budget choice must be the same as the income budget choice. (7-1-96)

e. Resources. Countable resources are determined using the resource computation methods of the AABD cash assistance program. (1-1-93)

f. Resource limit. Resources for a single QMB must not exceed the limit of four thousand dollars (\$4,000). A couple's total resources must not exceed the limit of six thousand dollars (\$6,000). (1-1-93)

g. Resource budget choice. The QMB has the CP or SSI choice for resource computation. The resource limit for a married client choosing the CP method is the couple resource limit if both spouses are applying for Medicaid and live together or were living together on the first day of the month. The resource limit is the single person limit if only one (1) spouse is applying for Medicaid if the couple is not living together, or was not living together the first day of the month. If either or both of the spouses is an HCBS client, the couple is not regarded as living together. The resource budget choice must be the same as the income budget choice. (1-1-93)

03. Application Forms. A person not receiving Medicaid must file a written application for QMB on forms provided by the Department. (1-1-93)

04. Effective Dates. The effective date of QMB must be no earlier than the first (1st) day of the month

following the month of approval. The Department will buy into Medicare for an eligible QMB effective the month following the month of approval. A QMB is not entitled to backdated coverage of his Medicare premiums, coinsurance, and deductibles. (1-1-93)

643. SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB).

The Department pays Medicare Part B premiums for an SLMB. A person meeting the eligibility requirements in Subsections 643.01 through 643.04 of these rules is SLMB eligible. Benefits for an SLMB not receiving Medicaid are limited to Department payment of Medicare Part B premiums. (1-1-93)

01. SLMB Nonfinancial Eligibility Requirements. (1-1-93)

a. Medicare Part A. The SLMB must be entitled to hospital insurance under Part A of Medicare at the time of his application. The Department will not pay the Part A premium for a client not entitled to Part A. The effective date a person is entitled to Part A of Medicare is shown on his Medicare card issued by SSA. If the person is not able to furnish proof of his entitlement by showing his Medicare card, the Department must assist him to obtain this proof from SSA. (1-1-93)

b. Residence, citizenship, medical support cooperation, SSN. The SLMB must meet the Medicaid eligibility requirements of residence, citizenship, medical support cooperation and SSN. An applicant meets citizenship and SSN requirements if enrolled in Part a of Medicare. The person's SSN is considered verified for Medicaid purposes. (7-1-96)

02. SLMB Financial Eligibility Requirements. (1-1-93)

a. Income. Monthly income must exceed one hundred ten percent (110%), but must exceed one hundred percent (100%), of the official poverty line defined by the Federal Office of Management and Budget for 1993 and 1994. The monthly income must not exceed one hundred twenty percent (120%) of the official poverty line in 1995 and years after 1995. Income is computed with AABD cash assistance methods. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual federal poverty guideline revision is published. (1-1-93)

b. Income limits. The single person income is one hundred ten percent (110%) of the poverty line for a family of one (1) person. The couple income limit is one hundred ten percent (110%) of the poverty line for a family of two (2) persons. (1-1-93)

03. Income Budget Choice. The SLMB has the CP or the SSI method choice for income budgeting. The income limit for a married client choosing the CP method is the couple income limit if both spouses are applying for Medicaid and live together or were living together on the first (1st) day of the month. The income limit is the single person limit if only one (1) spouse is applying or if the couple is not living together or was not living together on the first (1st) day of the month. If either or both of the spouses is an HCBS client, the couple is not regarded as living together. The resource budget choice must be the same as the income budget choice. (1-1-93)

04. Resources. Countable resources are determined using the resource computation methods of the AABD cash assistance program. (1-1-93)

05. Resource Limit. Resources for a single SLMB must not exceed the limit of four thousand dollars (\$4,000). A couple's total resources must not exceed the limit of six thousand dollars (\$6,000). (1-1-93)

06. Resource Budget Choice. The SLMB has the CP or SSI choice for resource computation. The resource limit for a married client choosing the CP method is the couple resource limit if both spouses are applying for Medicaid and live together or were living together on the first day of the month. The resource limit is the single person limit if only one spouse is applying for Medicaid if the couple is not living together, or was not living together the first day of the month. If either or both of the spouses is an HCBS client, the couple is not regarded as living together. The resource budget choice must be the same as the income budget choice. (1-1-93)

07. Application Forms. A person not receiving Medicaid must file a written application for SLMB on forms provided by the Department. (1-1-93)

08. Effective Dates. SLMB coverage begins on the first (1st) day of the application month. SLMB may be backdated up to three (3) calendar months before the month of application. SLMB can be provided for each backdated month the client meets all SLMB eligibility requirements. (1-1-93)

644. QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI).

A QDWI is a disabled worker under age sixty-five (65). A QDWI is not eligible for Medicaid, but determined by SSA as qualified for Medicare under the provisions of Section 1818A of the Social Security Act. The Department pays only the Medicare Part A hospital insurance premium for the QDWI. The QDWI is not eligible for other Medicaid services. A person meeting the eligibility requirements in Subsections 644.01 through 644.02.b. is QDWI eligible. (1-1-93)

01. QDWI Nonfinancial Eligibility Requirements. (1-1-93)

a. A QDWI must meet the Medicaid eligibility requirements of citizenship, residence, and assignment of rights to medical support. The QDWI must furnish a SSN. (1-1-93)

b. A QDWI must be determined by SSA to meet the conditions of Section 1818A of the Social Security Act. (1-1-93)

02. QDWI Financial Eligibility Requirements. (1-1-93)

a. Monthly income must not exceed two hundred percent (200%) of the one (1) person official poverty line. The poverty line is defined by the federal Office of Management and Budget and published in the Federal Register annually. Monthly income is computed by the Department using AABD cash assistance methods. (1-1-93)

b. Resources must not exceed the limit of four thousand dollars (\$4,000). Monthly resources are computed using the AABD cash assistance methods. The QDWI does not have the CP or SSI choice. (1-1-93)

645. SPONSORED LEGAL NON-CITIZEN.

Income and resources of an alien's sponsor are not deemed to the alien for Medicaid eligibility. An alien ineligible for AABD grant payments because of deemed income or resources of a sponsor, is eligible for Medicaid. The alien must meet all Medicaid eligibility requirements. (7-1-93)

646. CHILD SUBJECT TO DEEMING.

Income and resources of a child's stepparent are not deemed to the child in determining his Medicaid eligibility. A child ineligible for AABD grant payments solely because of deemed income or resources of a stepparent, is eligible for Medicaid. The child must meet all Medicaid eligibility requirements. (7-1-94)

647. (RESERVED).

648. -- 680. (RESERVED).

681. MEDICAID PENALTY FOR PROPERTY TRANSFER FOR LESS THAN FAIR MARKET VALUE.

These rules apply to property transfers before August 11, 1994. A long-term care client or community spouse must not transfer his interest in real or personal property, for less than fair market value. The penalty does not involve resources excluded for AABD, except for the person's home and property associated with the home as described in the AABD rules. The home and property associated with the home are not excluded from resources for the property transfer penalty. The property transfer penalty applies only to an aged, blind, or disabled Medicaid client in long-term care and to the client's community spouse. A person in long-term care must be a patient in a nursing facility or a patient in a medical institution, requiring and receiving the level of care provided in a nursing facility. An HCBS client is counted as a long-term care person. The spouse of a long-term care person, remaining in the community, is called the community spouse. The Medicaid property transfer penalty applies to transfers by a long-term care client after June 30, 1988, and to transfers by the community spouse after December 18, 1989. The Medicaid property transfer provisions do not apply to transfers between spouses before October 1, 1989. A life estate may not be adequate payment. (1-1-94)

01. Property Transfer Time Periods. For a person entitled to Medicaid on the start date of long-term care, a transfer during the thirty (30) month period before the start of long-term care is subject to the penalty. For a person not entitled to Medicaid on the start date of long-term care, a transfer during the thirty (30) months before the date of application for Medicaid is subject to the penalty. A person "entitled to Medicaid" is receiving or applying for Medicaid at the time of long-term care and, except for the Medicaid property transfer penalty, would be eligible for the month of application or any of the three (3) calendar months before it. (1-1-93)

02. Medicaid Penalty for Property Transfer. The penalty for violation of the property transfer rules is restricted Medicaid coverage. Restricted coverage means the person is not entitled to Medicaid participation in the cost of nursing facility services, a level of care in a medical institution equivalent to nursing facility services, or PCS under the HCBS waiver. PCS under the HCBS waiver is described in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, Section 146, "Rules Governing Medical Assistance." (7-1-93)

03. Period of Restricted Coverage for Property Transfer. The period of restricted coverage is the smaller of, thirty (30) months from the date of transfer, or the number of months computed by dividing the unpaid property value by the statewide average cost of nursing facility services to a private patient of nursing facility services or HCBS. The cost is computed for the time of the client's most recent request for Medicaid. If the amount transferred is less than the cost of one (1) month's care, there is no penalty. The period of restricted coverage begins the month the property was transferred. The month the transfer took place is counted as one of the penalty months. Restricted coverage continues until the client or community spouse secures the return of the property transferred, or the client or community spouse receives adequate consideration for the property transferred, or the period of restricted coverage has ended. A period of restricted coverage begins the first (1st) day of the month the transfer occurred. A period of restricted coverage ends the last day of the last full month of the penalty period. If calculation of the penalty period results in a partial month, the partial month is dropped from the penalty period. (1-1-93)

04. Exceptions for Property Transfer Penalty. A client or community spouse is not subject to restricted coverage due to transfer of property for less than fair market value if one (1) of the conditions in Subsections 681.04.a. through 681.04.i. is met. (1-1-93)

a. The property transferred was a home and title to the home was transferred to the spouse. (1-1-93)

b. The property transferred was a home and title to the home was transferred to the child of the client or community spouse. The child must be under age twenty-one (21) or blind or totally disabled using the definitions of disability and blindness used in determining eligibility for Social Security and SSI benefits as contained in 20 CFR Part 416. (1-1-93)

c. The property transferred was a home and title to the home was transferred to a brother or sister of the client or community spouse. The brother or sister must have an equity interest in the transferred home, and reside in that home for at least one (1) year immediately before the month the client starts long-term care. (1-1-93)

d. The property transferred was a home and title to the home was transferred to a son or daughter of the client or community spouse, other than a child under the age of twenty-one (21). The son or daughter must reside in the home of the client or community spouse for a period of at least two (2) years immediately before the month the client started long-term care. The son or daughter must have provided care to the client which permitted him to reside at home rather than enter long-term care. (1-1-93)

e. Effective with transfers occurring October 1, 1989, or later, the property was transferred to or from the community spouse or to another person for the sole benefit of the community spouse. This exception to the penalty is void if the community spouse transfers the resources to another person other than the long-term care spouse without receiving adequate consideration. (1-1-93)

f. The property was transferred to the child of the client or community spouse. The child must be under age twenty-one (21) and blind or totally disabled using the definitions of disability and blindness used in determining eligibility for Social Security and SSI benefits as contained in 20 CFR Part 416. (1-1-94)

g. The client or community spouse establishes to the Department's satisfaction he intended to dispose

of the property at fair market value or for other adequate consideration. (1-1-93)

h. The client or community spouse establishes to the Department's satisfaction the property was transferred exclusively for a purpose other than to qualify for Medicaid. (1-1-93)

i. The Department determines denial of eligibility would work an undue hardship. The inability of the client to have the property transferred back to his ownership must be proved before this exemption can be allowed. (1-1-93)

05. Property Transfer Penalty Waived. A transfer without adequate consideration does not result in a penalty if one (1) of the conditions in Subsections 681.05.a. through 681.05.c. is met. (1-1-93)

a. If a forced sale was done under reasonable circumstances, the amount received may be considered adequate, even if less than fair market value. (1-1-93)

b. If there is little or no market demand for the type of transferred property, the amount received may be considered adequate even if less than fair market value. (1-1-93)

c. A transfer of property, to settle a legal debt approximately equal to the fair market value of the transferred property, is adequate consideration. The existence of a legally enforceable debt must be proven. Proof includes a legally recorded document, completed when the debt began, showing the existence of the debt. Cancelled checks, receipts, promissory notes, mortgages, or written agreements executed by the client and the creditor when the debt began prove the debt. The written statement of facts made under oath, or testimony under oath, of at least two (2) persons not parties to the transaction proves the debt. The parties must not benefit from the transaction either directly or indirectly. They must have first-hand knowledge of the arrangements between the client and creditor at the time the debt began. The statements must agree with the sworn statements of the client and creditor. (1-1-93)

06. Ownership Change Which is Not a Property Transfer. Interest in property, obtained under one (1) of the conditions in Subsections 681.06.a. through 681.06.d. is not a transfer. The Medicaid penalty does not apply. (1-1-93)

a. The client or community spouse is the victim of fraud misrepresentation or coercion, and the transfer was made on that basis. The client or community spouse must take any and all possible steps to recover the property, or its equivalent in damages. (1-1-93)

b. The property was transferred to a spouse in a divorce or legal separation settlement approved by or ordered by a court. (1-1-93)

c. The client or community spouse held title to the property only as a trustee for another person, with no beneficial interest to himself. (1-1-93)

d. The transfer was done to free title to property, in which the client or community spouse had no beneficial interest. (1-1-93)

07. Proof of Property Transfer. At application and at each redetermination of eligibility, the Department must obtain information about the couple's ownership interest in any real or personal property. The couple's transfer of an interest in any real or personal property and any claims or debts affecting the couple's interest in real or personal property must be verified. The Department must verify and document the mortgage and lien records, written agreements, sales contracts, promissory notes, bank records, business records, and cancelled checks. (1-1-93)

08. Case Record Information for Property Transfer. The Department must record in the case record all facts concerning the couple's ownership and transfer of any interest in real or personal property. The tax value, sale value at the time of transfer, the amount of any debts against the property and the terms of any agreement entered into at the time of the transfer, along with the source of the information, must be documented. (1-1-93)

682. ASSET TRANSFER FOR LESS THAN FAIR MARKET VALUE.

A client or spouse must not transfer either spouse's interest in assets, for less than fair market value, starting August

11, 1993. Assets are income and resources. The asset transfer penalty applies to Medicaid services received October 1, 1993 and later. Resources, including the home and property associated with the home, are subject to the asset transfer penalty. Excluded resources, other than the home and associated property, are not subject to the asset transfer penalty. The asset transfer penalty applies only to an aged, blind, or disabled Medicaid client while the client is in long-term care, and to the client's spouse. Transfer of either spouse's assets subjects the long-term care spouse to the asset transfer penalty. A person in long-term care must be a patient in a nursing facility or a patient in a medical institution, requiring and receiving the level of care provided in a nursing facility. An HCBS client is counted as a long-term care person. (7-1-96)

683. MEDICAID PENALTY FOR ASSET TRANSFERS.

Restricted Medicaid coverage is the asset transfer penalty for a person receiving nursing facility services. (1-1-96)T

01. **Restricted Coverage.** Restricted coverage means the person is not entitled to Medicaid participation in the cost of nursing facility services, or a level of care in a medical institution equivalent to nursing facility services. The penalty for a person receiving PCS or community services under the HCBS waiver is no Medicaid eligibility. Loss of PCS or community services under the HCBS waiver means loss of Medicaid eligibility. PCS and community services under the HCBS waiver are described in IDAPA 16, Title 03, Chapter 09, "Rules Governing Medical Assistance," Sections 143 and 146. (1-1-96)T

02. **Notice and Exemption.** The client must be notified in writing at least ten (10) days before an asset transfer penalty is imposed. The notice must include the right to a hearing on the penalty, the right to make a written request for the hardship exemption in Subsection 690.12 and a description of the hardship exemption. The notice must tell the client he has ten (10) days from the date of the notice to return his written request for a hardship exemption to the Department. The Department must make a decision on the hardship exemption within thirty (30) days of receiving the written request. Notice of the Department's decision on the hardship exemption must include the right to a hearing. (1-1-96)T

684. ASSET TRANSFER LOOKBACK.

The asset transfer penalty applies to transfers in a thirty-six (36) month look-back period. For transfers to or from a trust, the look-back period is sixty (60) months. For a person entitled to Medicaid on the start date of long-term care or HCBS, the look-back period is the thirty-six (36) or sixty (60) months before the start of long-term care. For a person not entitled to Medicaid on the start date of long-term care, the look-back period is the thirty-six (36) or sixty (60) months before the date of application for Medicaid. A person "entitled to Medicaid" is receiving or applying for Medicaid at the time of long-term care or HCBS and, except for the Medicaid asset transfer penalty, would be eligible for the month of application or any of the three (3) calendar months before it. (1-1-94)

685. PERIOD OF RESTRICTED COVERAGE FOR ASSET TRANSFERS.

The period of restricted coverage is the number of months computed by dividing the unpaid asset value by the statewide average cost of nursing facility services to a private patient of nursing facility services or HCBS. The cost is computed for the time of the client's most recent request for Medicaid. The period of restricted coverage is apportioned between the client and spouse, if the spouse becomes eligible for long-term care Medicaid. (1-1-94)

686. CALCULATING THE PENALTY PERIOD.

If the amount transferred is less than the cost of one (1) month's care, there is no penalty. The penalty period begins running the month the transfer took place, regardless of whether the client is a long-term care client that month. The month the transfer took place is counted as one of the penalty months. Restricted coverage continues until the client or spouse secures the return of all of the assets, or the client or spouse receives adequate consideration for all of the assets, or the period of restricted coverage has ended. A period of restricted coverage begins the first day of the month the transfer occurred. A period of restricted coverage ends the last day of the last full month of the penalty period. A partial month at the end of a single penalty period is dropped from the penalty period. A partial month at the end of consecutive penalty periods is dropped. Each partial month before the end of consecutive penalty periods is a penalty month. The penalty continues during months the client is not a long-term care client. (7-1-96)

687. MULTIPLE PENALTY PERIODS APPLIED CONSECUTIVELY.

A penalty period is calculated for each transfer. The penalty period for a transfer must expire before the next penalty period is applied. Penalty periods must not overlap. (1-1-94)

688. LIFE ESTATES AND ANNUITIES AS ASSET TRANSFERS.

Receiving a life estate in return for assets or purchasing an annuity may be transfer of assets for less than fair market value. (7-1-96)

01. Life Estate. A life estate is an asset transfer subject to the penalty, unless the value of the life estate at least equals the value of the transferred real property. Calculate the value of the life estate using Table 688.01. To calculate the value of the life estate, multiply the fair market value of the real property at the time of transfer by the remainder factor for the client's age at the time of transfer.

TABLE 688.01 - LIFE ESTATE REMAINDER TABLE			
AGE	LIFE ESTATE REMAINDER	AGE	LIFE ESTATE REMAINDER
0	.02812	55	.19954
1	.01012	56	.20994
2	.00983	57	.22069
3	.00922	58	.23178
4	.01019	59	.24325
5	.01062	60	.25509
6	.01116	61	.26733
7	.01178	62	.27998
8	.01252	63	.29304
9	.01337	64	.30648
10	.01435	65	.32030
11	.01547	66	.33449
12	.01671	67	.34902
13	.01802	68	.36390
14	.01934	69	.37914
15	.02063	70	.39478
16	.02185	71	.41086
17	.02300	72	.42739
18	.02410	73	.44429
19	.02520	74	.46138
20	.02635	75	.47851
21	.02755	76	.49559
22	.02880	77	.51258
23	.03014	78	.52951
24	.03159	79	.54643
25	.03322	80	.56341
26	.03505	81	.58030

TABLE 688.01 - LIFE ESTATE REMAINDER TABLE			
AGE	LIFE ESTATE REMAINDER	AGE	LIFE ESTATE REMAINDER
27	.03710	82	.59705
28	.03938	83	.61358
29	.04187	84	.63002
30	.04457	85	.64641
31	.04746	86	.66236
32	.05058	87	.67738
33	.05392	88	.69141
34	.05750	89	.70474
35	.06132	90	.71779
36	.06540	91	.73045
37	.06974	92	.74229
38	.07433	93	.75308
39	.07917	94	.76272
40	.08429	95	.77113
41	.08970	96	.77819
42	.09543	97	.78450
43	.10145	98	.79000
44	.10779	99	.79514
45	.11442	100	.19975
46	.12137	101	.19532
47	.12863	102	.19054
48	.13626	103	.18437
49	.14422	104	.17856
50	.15257	105	.16962
51	.16126	106	.15488
52	.17031	107	.13409
53	.17972	108	.10068
54	.18946	109	.04545

(7-1-96)

02. Annuity. An annuity is a contract in which an individual pays a sum of money in return for periodic payments for a fixed term of years. An annuity is a form of trust, but is evaluated using the asset transfer policy. The asset transfer penalty and sixty (60) month lookback apply if the annuity is irrevocable and does not provide fair market value. A revocable annuity is a resource in the amount for which it can be surrendered. A revocable annuity is

a resource in the amount for which it can be surrendered. Early surrender of a revocable annuity is not an asset transfer for less than fair market value. (1-1-96)T

a. To provide fair market value, an irrevocable annuity must meet the life expectancy and interest tests. First, the client's life expectancy must equal or exceed the term of the annuity. Using Table 688.02, divide the face value of the annuity by the client's life expectancy at the time of purchase. The annuity meets the life expectancy test if the result equals the term of the annuity, or more. Second, determine if the annuity produces interest of five percent (5%) yearly, or more. The client can rebut the five percent (5%) interest test. The client must show single premium annuities were not offered by insurers rated exceptional or superior by an insurance rating firm such as A.M. Best Co. now or when the annuity was purchased. A variable rate annuity meets the interest rate test if the average yearly rate for the most recent five (5) year period is five percent (5%) or more. If the annuity meets the life expectancy and interest tests, the client received fair market value. (1-1-96)T

b. If the irrevocable annuity does not provide fair market value, the asset transfer penalty applies. The value for calculating the asset transfer penalty is the difference between the actual rate produced by the annuity and five percent (5%) per year. (1-1-96)T

TABLE 688.02 - LIFE EXPECTANCY TABLE.

The Life Expectancy Table is as follows:

LIFE EXPECTANCY TABLE - FEMALE					
AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	78.79	40	40.61	80	9.11
1	78.42	41	39.66	81	8.58
2	77.48	42	38.72	82	8.06
3	76.51	43	37.78	83	7.56
4	75.54	44	36.85	84	7.08
5	74.56	45	35.92	85	6.63
6	73.57	46	35.00	86	6.20
7	72.59	47	34.08	87	5.79
8	71.60	48	33.17	88	5.41
9	70.61	49	32.27	89	5.05
10	69.82	50	31.37	90	4.71
11	68.63	51	30.48	91	4.40
12	67.64	52	29.60	92	4.11
13	66.65	53	28.72	93	3.84
14	65.67	54	27.86	94	3.59
15	64.68	55	27.00	95	3.36
16	63.71	56	26.15	96	3.16
17	62.74	57	25.31	97	2.97
18	61.77	58	24.48	98	2.80

LIFE EXPECTANCY TABLE - FEMALE					
AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
19	60.80	59	23.67	99	2.64
20	59.83	60	22.86	100	2.48
21	58.86	61	22.06	101	2.34
22	57.59	62	21.27	102	2.20
23	56.92	63	20.49	103	2.06
24	55.95	64	19.72	104	1.93
25	54.98	65	18.96	105	1.81
26	54.02	66	18.21	106	1.69
27	53.05	67	17.48	107	1.58
28	52.08	68	16.76	108	1.48
29	51.12	69	16.04	109	1.38
30	50.15	70	15.35	110	1.28
31	49.19	71	14.66	111	1.19
32	48.23	72	13.99	112	1.10
33	47.27	73	13.33	113	1.02
34	46.31	74	12.68	114	0.96
35	45.35	75	12.05	115	0.89
36	44.40	76	11.43	116	0.83
37	43.45	77	10.83	117	0.77
38	42.50	78	10.24	118	0.71
39	41.55	79	9.67	119	0.66

LIFE EXPECTANCY TABLE - MALES					
AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
0	71.80	40	35.05	80	6.98
1	71.53	41	34.15	81	6.59
2	70.58	42	33.26	82	6.21
3	69.62	43	32.37	83	5.85
4	68.65	44	31.49	84	5.51
5	67.67	45	30.61	85	5.19

LIFE EXPECTANCY TABLE - MALES					
AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
6	66.69	46	29.74	86	4.89
7	65.71	47	28.88	87	4.61
8	64.73	48	28.02	88	4.34
9	63.74	49	27.17	89	4.09
10	62.75	50	26.32	90	3.86
11	61.76	51	25.48	91	3.64
12	60.78	52	24.65	92	3.43
13	59.79	53	23.82	93	3.24
14	58.62	54	23.01	94	3.06
15	57.85	55	22.41	95	2.90
16	56.91	56	21.43	96	2.74
17	55.97	57	20.66	97	2.60
18	55.05	58	19.90	98	2.47
19	54.13	59	19.15	99	2.34
20	53.21	60	18.42	100	2.22
21	52.29	61	17.70	101	2.11
22	51.38	62	16.99	102	1.99
23	50.46	63	16.30	103	1.89
24	49.55	64	15.62	104	1.78
25	48.63	65	14.96	105	1.68
26	47.72	66	14.32	106	1.59
27	46.80	67	13.70	107	1.50
28	45.88	68	13.09	108	1.41
29	44.97	69	12.50	109	1.33
30	44.06	70	11.92	110	1.25
31	43.15	71	11.35	111	1.17
32	42.24	72	10.80	112	1.10
33	41.33	73	10.27	113	1.02
34	40.23	74	9.27	114	0.96
35	39.52	75	9.24	115	0.89
36	38.62	76	8.76	116	0.83
37	37.63	77	8.29	117	0.77

LIFE EXPECTANCY TABLE - MALES					
AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY	AGE	LIFE EXPECTANCY
38	36.83	78	7.83	118	0.71
39	35.94	79	7.40	119	0.66

(7-1-96)

689. (RESERVED).

690. TRUSTS AS ASSET TRANSFERS.

A trust established wholly or partly from the client's assets is an asset transfer. A trust established by a will is not an asset transfer. A trust established by a will is treated using Subsection 276. Assets transferred to a trust August 11, 1993 or later, may be an asset transfer, regardless of when the trust was established. A trust may be established by the individual, his spouse, a court, or an administrative body with legal authority to act for the individual or his spouse. The trust may be established by a person, court or administrative body acting at the direction of the individual or his spouse. Where the assets in the trust include assets of another person, the asset transfer penalty applies to the client's portion of the trust. (7-1-94)

691. TREATMENT OF ASSETS TRANSFERRED TO A TRUST.

Assets transferred to a trust are treated as shown in Subsections 691.01 through 691.03 of these rules. (7-1-94)

01. Revocable Trust. The body (corpus) of a revocable trust is a resource. Payments from the trust to or for the client are income. Any other payments from the trust are considered an asset transfer, triggering an asset transfer penalty period. (1-1-94)

02. Irrevocable Trust. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the client, is a resource. Payments made to or for the client are income. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. Any part of the trust from which payment cannot be made to, or for the benefit of, the client under any circumstances, is an asset transfer. The effective date of the transfer is the date the trust was established, or the date payments to the client were foreclosed. The value of the trust, for calculating the transfer penalty, includes any payments made from that portion of the trust after the date the trust was established or payments were foreclosed. (1-1-94)

03. Trust with Pension Money. Treat a trust established for the benefit of a person where all the money in the trust comes from the person's pensions, Social Security and his other income, as described in Subsection 691.01 or 691.02 of these rules, unless exempt from treatment as an asset transfer under Subsection 706.02 of these rules. The institutionalized person must be the sole beneficiary of the trust. The trust must be irrevocable. However, the trust document may include a revocability clause that will allow the trust to be revocable only for the circumstance where the client leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income. An income trust exempted from the asset transfer penalty under this Subsection, before July 1, 1994, and not meeting the requirements of this Subsection, as revised July 1, 1994, must be amended to keep the exemption. The client must obtain the necessary amendments within ninety (90) days of the date he was mailed a Department notice that his income trust no longer meets the exemption criteria. The trust must not provide for payments for a purpose other than for income used to calculate patient liability or client participation, unless the payments meet the hardship exemption in Subsection 693.12 of these rules. This hardship exemption is only for a trust for an HCBS client. Money paid into a pension trust is income for Medicaid eligibility the month received, unless the client lives in long-term care and is eligible for Medicaid except for excess income, or lives at home and is eligible for HCBS Medicaid except for excess income. The trust must be exempt from a trust penalty by Subsection 706.02 of these rules. Money paid into a pension trust is income for patient liability as provided in Subsection 611.07 of these rules. Income transferred to the trust as income used to calculate patient liability or client participation, and not used for that purpose, is subject to the asset transfer penalty in Section 690 of these rules, unless the income meets the hardship exemption in Subsection 693.12 of these rules. This hardship exemption is only for a trust for an HCBS client. (7-1-96)

04. Burial Trust. A revocable burial trust is a resource. Funds in the trust not earmarked for burial are an asset transfer, unless payable to the State of Idaho, up to the amount of Medicaid paid in the person's behalf by the State of Idaho. An irrevocable burial trust with face value of five thousand dollars (\$5000) or less is not an asset transfer and is exempt from trust treatment. An irrevocable burial trust with face value over five thousand dollars (\$5000) is subject to trust treatment in Subsection 705.02. Purchase of an irrevocable burial trust with face value over five thousand dollars (\$5000) is an asset transfer subject to the asset transfer penalty, unless the funds in the trust not earmarked for the client's burial expenses are payable to the State of Idaho, up to the amount of Medicaid paid in the person's behalf by the State of Idaho. (1-1-96)T

692. TRANSFER OF JOINTLY-OWNED ASSET.

Transfer of an asset owned jointly by the client and another person is considered a transfer by the client. The client's share of the asset is used to calculate the penalty. Where the client and his spouse are joint owners of the transferred asset, the couple's combined ownership is used to calculate the penalty. The period of restricted coverage is apportioned between the client and spouse, if the spouse becomes eligible for long-term care Medicaid. Transfer includes reducing or eliminating the client's ownership or control of the asset. The presumption is that the client is the owner of jointly owned assets. The client must be given an opportunity to prove he was not the owner. (7-1-94)

693. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.

A client or spouse is not subject to the asset transfer penalty due to transfer of assets August 11, 1993 or later for less than fair market value or transfer to a trust, if one (1) of the conditions in Subsections 693.01 through 693.125 of these rules is met. (7-1-96)

01. Home to Spouse. The asset transferred was a home and title to the home was transferred to the spouse. (1-1-94)

02. Home to Minor Child or Disabled Adult Child. The asset transferred was a home and title to the home was transferred to the child of the client or spouse. The child must be under age twenty-one (21) or blind or totally disabled using the definitions of disability and blindness used in determining eligibility for Social Security and SSI benefits, as contained in 20 CFR Part 416. (1-1-94)

03. Home to Brother or Sister. The asset transferred was a home and title to the home was transferred to a brother or sister of the client or spouse. The brother or sister must have an equity interest in the transferred home, and reside in that home for at least one (1) year immediately before the month the client starts long-term care. (1-1-94)

04. Home to Adult Child. The asset transferred was a home and title to the home was transferred to a son or daughter of the client or spouse, other than a child under the age of twenty-one (21). The son or daughter must reside in the home of the client or spouse for a period of at least two (2) years immediately before the month the client started long-term care. The son or daughter must have provided care to the client which permitted him to live at home rather than enter long-term care. (1-1-94)

05. Benefit of Spouse. The assets were transferred to the client's spouse or to another person for the sole benefit of the spouse. (1-1-94)

06. Transfer from Spouse. The assets were transferred from the client's spouse to another person for the sole benefit of the client's spouse. (1-1-94)

07. Transfer to Child. The assets were transferred to the client's child, or to a trust established solely for the benefit of the client's child. The child must be blind or totally disabled using the definitions of blindness and disability used in determining eligibility for Social Security and SSI benefits, as contained in 20 CFR Part 416. The child may be any age. (1-1-94)

08. Transfer to Trust for Person Under Sixty-Five (65). The assets were transferred to a trust for the sole benefit of a person under age sixty-five. "Sole benefit" means any remainder in the trust after the person's death must go to his estate, not to another person. The person must be blind or totally disabled using the definitions of blindness and disability used in determining eligibility for Social Security and SSI benefits, as contained in 20 CFR

- Part 416. (1-1-94)
09. Intent to Get Fair Market Value. The client or spouse establishes to the Department's satisfaction he intended to dispose of the assets at fair market value or for other adequate consideration. (1-1-94)
10. Assets Returned. All assets transferred for less than fair market value have been returned to the client. (1-1-94)
11. No Medicaid Purpose. The client or spouse establishes to the Department's satisfaction the assets were transferred exclusively for a purpose other than to qualify for Medicaid. (1-1-94)
12. Undue Hardship. The Department determines denial of eligibility would work an undue hardship. Undue hardship exists if: (1-1-94)
- a. The client proves he is not able to pay for his nursing facility services or his HCBS services any other way and he assigns his rights to recover the asset to the state of Idaho; or (7-1-96)
- b. The client proves he did not knowingly transfer the asset and he assigns his rights to recover the asset to the state of Idaho; or (7-1-96)
- c. The HCBS client proves he would be deprived of food, clothing or shelter if all income transferred into a pension trust is protected from being used for costs other than client participation, and assigns his rights to recover the asset to the state of Idaho. Where undue hardship is established, the amount of income paid to meet the client's needs for food, clothing or shelter, is exempt from the asset transfer penalty, does not invalidate the trust, and is not income for eligibility. (7-1-96)
13. Exception to Fair Market Value. The Department determines the amount received is adequate, even if not fair market value. This exception is for three (3) situations: (7-1-96)
- a. A forced sale was done under reasonable circumstances. (7-1-96)
- b. Little or no market demand exists for the type of asset transferred. (7-1-96)
- c. A transfer of assets, to settle a legal debt approximately equal to the fair market value of the transferred asset, is adequate consideration. The existence of a legally enforceable debt must be proven. Proof includes a legally recorded document, completed when the debt began, showing the existence of the debt. Cancelled checks, receipts, promissory notes, mortgages, or written agreements executed by the client and the creditor when the debt began prove the debt. The written statement of facts made under oath, or testimony under oath, of at least two (2) persons not parties to the transaction proves the debt. The parties must not benefit from the transaction either directly or indirectly. They must have first-hand knowledge of the arrangements between the client and the creditor at the time the debt began. The statements must agree with the sworn statements of the client and creditor. A life estate is not necessarily adequate consideration. (7-1-96)
14. No Benefit to Client. The Department determines the client received no benefit from the asset. This exception is allowed for two (2) situations: (7-1-96)
- a. The client or spouse held title to the property only as a trustee for another person, with no beneficial interest to himself. (7-1-96)
- b. The transfer was done to clear title to property, in which the client or spouse had no beneficial interest. (7-1-96)
15. Fraud Victim. The client or spouse is the victim of fraud, misrepresentation, or coercion, and the transfer was made on that basis. The client or spouse must take any and all possible steps to recover the assets or property, or its equivalent in damages. The client must assign recovery rights to the state of Idaho. (7-1-96)

694. -- 697. (RESERVED).

698. PROOF OF ASSET TRANSFER.

At application and at each redetermination of eligibility, the Department must obtain information about the client's ownership interest in assets. The client's transfer of an interest in any assets and any claims or debts affecting the client's interest in assets must be verified. The Department must verify and document sources and amounts of income, the mortgage and lien records, written agreements, sales contracts, promissory notes, bank records, business records, and cancelled checks. (1-1-94)

699. CASE RECORD INFORMATION.

The Department must record in the case record all facts concerning the client's ownership and transfer of any interest in assets. The income source and amounts must be documented. For real and personal property, the tax value, sale value at the time of transfer, the amount of any debts against the property and the terms of any agreement entered into at the time of the transfer, along with the source of the information, must be documented. (1-1-94)

700. -- 704. (RESERVED).

705. TREATMENT OF TRUSTS.

These rules apply to all Medicaid clients. These rules apply to trusts established with the client's assets, starting August 11, 1993. These rules also apply to trusts created before August 11, 1993, but funded August 11, 1993 or later. These rules do not apply to a trust established by the testator through a will. A trust established from an estate or through the probate process is not a trust established by the testator through a will. A trust established by a will is treated using Section 276 of these rules. An annuity is a trust, but is evaluated as an asset transfer under Section 688 of these rules. A client has established a trust if his assets were used to form part or all of the body of the trust. The trust may be established by the client, the client's spouse, by a person (including a court or administrative body), with authority to act in place of, or on behalf of, the client or the client's spouse. The trust may be established by a person (including any court or administrative body) acting at the direction of or at the request of the client or spouse. These rules apply no matter why the trust was established, what discretion the trustees have, what restrictions are placed on making distributions from the trust, or what restrictions are placed on how the distributions are used. These rules apply whether the trust is revocable or irrevocable. (7-1-96)

01. Revocable Trust. The body (corpus) of a revocable trust is a resource. Payments from the trust to or for the client are income. Any other payments from the trust are considered an asset transfer, triggering an asset transfer penalty period. (1-1-94)

02. Irrevocable Trust. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the client, is a resource. Payments made to or for the client are income. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. Any part of the trust from which payment cannot be made to, or for the benefit of, the client under any circumstances, is an asset transfer. The effective date of the transfer is the date the trust was established, or the date payments to the client were foreclosed. The value of the trust, for calculating the transfer penalty, includes any payments made from that portion of the trust after the date the trust was established or payments were foreclosed. (1-1-94)

03. Trust with Pension Money. Treat a trust established for the benefit of a person where all the money in the trust comes from the person's pensions, Social Security and his other income, as described in Section 691.01 or 691.02 of these rules, unless exempt from treatment as an asset transfer under Subsection 706.02 of these rules. The trust must be irrevocable. However, the trust document may include a revocability clause that will allow the trust to be revocable only for the circumstance where the client leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income. An income trust exempted from the asset transfer penalty under Section 691 of these rules, before July 1, 1994, and not meeting the requirements of Section 691 of these rules, as revised July 1, 1994, must be amended to keep the exemption. The client must obtain the necessary amendments within ninety (90) days of the date he was mailed a Department notice that his income trust no longer meets the exemption criteria. If the trust provides for payments for a purpose other than for income used to calculate patient liability or client participation, the trust is not exempt, unless the payments meet the hardship exemption in Subsection 693.12. Money paid into the pension trust is income for Medicaid eligibility the month received, unless the client lives in long-term care and is eligible for Medicaid except for excess income, or lives at home and is eligible for HCBS Medicaid except for excess income. The trust must be exempt from a trust penalty by

Subsection 706.02 of these rules. Money paid into a pension trust is income for patient liability as provided in Subsection 611.07 of these rules. Income transferred to the trust as income used to calculate patient liability or client participation, and not used for that purpose, is subject to the asset transfer penalty in Section 690 of these rules, unless the income used for another purpose meets the hardship exemption in Subsection 693.12 of these rules. (1-1-96)T

04. Burial Trust. Treat an irrevocable burial trust with face value over five thousand dollars (\$5000) as described in Subsection 691.02 of these rules, unless exempt from treatment as an asset transfer under Subsection 693.16 of these rules. An irrevocable burial trust with face value over five thousand (\$5,000) dollars is subject to trust treatment in Subsection 705.02, unless it meets the exemption criteria in Subsection 706.04. An irrevocable burial trust with face value of five thousand dollars (\$5000) or less is not an asset transfer and is exempt from trust treatment. (1-1-96)T

706. EXEMPT TRUST.

A trust, beginning August 11, 1993, is exempt from trust treatment under Section 705 of these rules and does not result in an asset transfer penalty if one (1) of the conditions in Subsections 706.01 through 706.03 of these rules is met. A trust exempt under this Section is not exempt from treatment under Section 707. (1-1-96)T

01. Trust for Disabled Person. The trust contains the assets of a person under age sixty-five (65). The trust must be irrevocable. The person must be blind or totally disabled using the definitions of blindness and disability used in determining eligibility for Social Security and SSI benefits, as contained in 20 CFR Part 416. The trust is established for the person's benefit by his parent, grandparent, legal guardian or a court. The amount remaining in the trust after the person's death must be payable to the state of Idaho, up to the amount of Medicaid paid in the person's behalf by the state of Idaho. (7-1-96)

02. Trust with Pension Money. The trust is established for the benefit of a person. The person must live in long-term care and be eligible for Medicaid except for excess income or, if not living in long-term care, must be eligible for HCBS Medicaid except for excess income. All the money in the trust comes from the person's pensions, Social Security and his other income. The trust can include income earned by the trust. The trust must be irrevocable. However, the trust document may include a revocability clause that will allow the trust to be revocable only for the circumstance where the client leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income. An income trust exempted from the asset transfer penalty under Section 691 of these rules, before July 1, 1994, and not meeting the requirements of Section 691 of these rules, as revised July 1, 1994, must be amended to keep the exemption. The client must obtain the necessary amendments within ninety (90) days of the date he was mailed a Department notice that his income trust no longer meets the exemption criteria. A trust is not exempt if it provides for payments for a purpose other than for income used to calculate patient liability or client participation, unless the payment meets the conditions for a hardship waiver under Subsection 693.12 of these rules. The amount remaining in the trust after the person's death must be paid to the state of Idaho, up to the amount of Medicaid paid in the person's behalf by the state of Idaho. The trust may be dissolved without penalty when the client is no longer a long-term care or HCBS Medicaid client for a reason other than death. (1-1-96)

03. Trust Managed by Nonprofit Association for Disabled Person. The trust must be irrevocable. The trust contains the assets of a disabled person. The person must be blind or totally disabled using the definitions of blindness and disability used in determining eligibility, his parent or his grandparent. A separate account is maintained for the person. The trust may pool accounts for investment and management purposes. Accounts in the trust are established solely for the benefit of disabled persons by the person's parent, grandparent, or legal guardian, by the person or by a court. To the extent the amount remaining in the trust is not distributed by the trust, the amount remaining in the trust after the person's death must be paid to the state of Idaho, up to the amount of Medicaid paid in the person's behalf by the state of Idaho. (7-1-96)

04. Burial Trust Over Five Thousand Dollars (\$5000). The trust must be irrevocable. Funds in the trust not earmarked for the client's burial expenses must be payable to the state of Idaho, up to the amount of Medicaid paid in the person's behalf by the state of Idaho. (1-1-96)T

707. PAYMENTS FROM AN EXEMPT TRUST FOR DISABLED PERSON OR POOLED TRUST.

Cash payments from the exempt trust made directly to a client with an exempt trust for a disabled person, or a pooled

trust, are income in the month received. Payments from the exempt trust made on behalf of the client for the client's food, clothing or shelter, are income in the month paid. See Subsections 611.05.e., 611.07, 691.03, 705.03 and 706.02 for treatment of payments from an exempt pension trust. (7-1-94)

708. -- 714. (RESERVED).

715. MEDICAID REDETERMINATION.

Medicaid eligibility must be redetermined each year as shown in Subsections 715.01 through 715.05. (1-1-93)

01. Financial Assistance Clients. The redetermination for financial assistance is the Medicaid redetermination for clients receiving both programs. (1-1-93)

02. SSI Recipients. Clients entitled to Medicaid because they get SSI, and who do not receive financial assistance, must have a redetermination once a year. The redetermination procedure is the same as the initial Medicaid determination. A face-to-face interview is not required. (1-1-93)

03. Other Medicaid Recipients. Medicaid clients, not getting financial assistance and not eligible for financial assistance if they applied, must have Medicaid redetermined by the rules of the financial assistance program most closely related to their Medicaid eligibility group. (1-1-93)

04. Certain Disabled Children. Disabled children not eligible for SSI because of deeming, and getting Medicaid, must have eligibility for Medicaid redetermined at least once a year. The redetermination procedure is the same as the initial Medicaid determination. If the initial disability review finds the disability is likely to be permanent, the Department may skip the yearly redetermination of disability. Other eligibility factors must be redetermined at least once per year. (1-1-93)

05. QMB and SLMB Clients. Clients receiving QMB or SLMB Medicaid must be redetermined once each year. The redetermination procedure is the same as the initial QMB or SLMB Medicaid determination. (1-1-93)

716. -- 729. (RESERVED).

730. SCOPE OF MEDICAL ASSISTANCE CARE AND SERVICES.

The scope of Medical Assistance care and services is listed in Idaho Department of Health and Welfare Rules, IDAPA 16, Title 03, Chapter 09, "Rules Governing Medical Assistance." (1-1-93)

731. -- 995. (RESERVED).

996. ADMINISTRATIVE PROVISIONS.

All contested case appeals and requests for a fair hearing shall be governed by the provisions of Idaho Department of Health and Welfare Rules, Title 05, Chapter 03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." (1-1-96)T

997. INCLUSIVE GENDER.

Gender, masculine, feminine, or neuter, and number, singular or plural, will include all others as the context requires. (1-1-93)

998. CONFIDENTIALITY.

Information received by the Department, from clients, is subject to the provisions of Idaho Department of Health and Welfare Rules, Title 05, Chapter 01, "Rules Governing Protection and Disclosure of Department Records." (1-1-93)

999. SEVERABILITY.

Idaho Department of Health and Welfare Rules, Title 03, Chapter 05, are severable. If any rule, or part thereof, or the application of such rule to any person or circumstance, is declared invalid, that invalidity does not affect the validity of any remaining portion of this chapter. (1-1-93)