IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Welfare

16.03.05 – Eligibility for Aid to the Aged, Blind, and Disabled (AABD)

Who does this rule apply to?
For individuals who are 65 or older, blind, or disabled. Eligible individuals receive a certain amount of cash each month to help pay for everyday living expenses. The amount an individual receives is based their unique circumstances such as living arrangements, income, and resources.

What is the purpose of this rule?
These rules provide standards for issuing AABD cash benefits and related Medicaid benefits.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statute passed by the Idaho Legislature:

Public Assistance and Welfare -
- Section 56-202, Idaho Code – Public Assistance Law: Duties of the Director of the State Department of Health and Welfare

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Aid for the Aged, Blind, and Disabled Program
450 West State Street
Boise, ID 83702

P.O. Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5815 or 1-800-456-1233
Fax: (208) 334-5817
Email: SRProgramRules@dhw.idaho.gov
Webpage:
https://healthandwelfare.idaho.gov/services-programs/medicaid-health/apply-medicaid-elderly-or-disabled-adults

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000. LEGAL AUTHORITY.
Section 56-202, Idaho Code, authorizes the Department to adopt rules for the administration of public assistance programs. (7-1-24)

001. (RESERVED)

002. INCORPORATION BY REFERENCE.
The following are incorporated by reference (7-1-24)

01. "Medicare Modernization Act - Prescription Drug Program Guidance to States for the Low Income Subsidy (LIS)," dated May 25, 2005. The guidelines may be viewed at the main office of the Department. It is also available online at https://www.cms.gov/Medicare/Eligibility-and-Enrollment/LowIncSubMedicarePresCov/Downloads/StateLISGuidance021009.pdf. (7-1-24)

02. Social Security Administration Program Operations Manual System (POMS) SI 01320.00, Deeming Resources, effective date: 10/17/2022. This Deeming of Income section is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0501320000. (7-1-24)

03. Social Security Administration Program Operations Manual System (POMS) SI 01330.00, Deeming Resources, effective date: 02/24/2010. This Deeming of Resources section is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0501330000. (7-1-24)

04. Social Security Administration Program Operations Manual System (POMS) SI 02302.200 Charted Threshold Amounts for Calendar Year 2023, effective date: 01/24/2023. This Charted Threshold Amounts table is available at: https://secure.ssa.gov/apps10/poms.nsf/lnx/0502302200. (7-1-24)

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. AABD Cash. An EBT payment to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments. AABD Cash is a payment of a supplemental cash amount to an individual who meets the program requirements. This payment may be made through direct deposit or an electronic benefits card. (7-1-24)

02. Applicant. A person applying for public assistance from the Department, including individuals referred to the Department from a health insurance exchange or marketplace. (7-1-24)

03. Annuity. A right to receive periodic payments, either for life, a term of years, or other interval of time, whether or not the initial payment or investment has been annuitized. It includes contracts for single payments where the single payment represents an initial payment or investment together with increases or deductions for interest or fees rather than an actuarially based payment from an insurance pool. (7-1-24)

04. Asset. Includes all income and resources of the individual and the individual's spouse, including any income or resources that the individual or their spouse is entitled to, but does not receive because of action by: (7-1-24)

a. The individual or their spouse; (7-1-24)

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or their spouse; or (7-1-24)

c. A person, including any court or administrative body, acting at the direction or upon the request of the individual or their spouse. (7-1-24)

05. Asset Transfer for Sole Benefit. An asset transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. (7-1-24)

06. Child. Any individual from birth through the end of the month of their nineteenth birthday. (7-1-

24)

07. Citizen. A person having status as a "national of the United States" defined in 8 USC 1101(a)(22) that includes both citizens of the United States and non-citizen nationals of the United States. (7-1-24)

08. Department. The Department of Health and Welfare. (7-1-24)

09. Direct Deposit. The electronic deposit of a participant's AABD cash to the participant's personal account with a financial institution. (7-1-24)

10. Electronic Benefits Transfer (EBT). A method of issuing AABD cash to a participant, a participant's guardian, or a holder of a limited power of attorney for EBT payments for a participant. (7-1-24)

11. Essential Person. A person of the participant's choice whose presence in the household is essential to the participant's well-being. The essential person provides the services a participant needs to live at home. (7-1-24)

12. Fair Market Value. The price for which an asset can be reasonably expected to sell on the open market, in the geographic area involved. (7-1-24)

13. Long-Term Care. Services provided to an institutionalized individual as defined in 42 USC 1396p(c)(1)(C). (7-1-24)

14. Medicaid. Idaho's Medical Assistance Program administered by the Department. See Title XIX. (7-1-24)

15. Needy. A person is considered needy for AABD cash payments if the person meets the non-financial requirements of Title XVI of the Social Security Act and the criteria in Section 514 of these rules. Title XVI of the Social Security Act, known as "Grants to States for Aid to the Aged, Blind, or Disabled," is a program for financial assistance to needy individuals who are sixty-five (65) years of age or over, are blind, or are eighteen (18) years of age or over and permanently and totally disabled. (7-1-24)

16. Non-Citizen. Same as "alien" defined in Section 101(a)(3) of the Immigration and Nationality Act (INA) (8 USC 1101 (a)(3)), and includes any individual who is not a citizen or national of the United States. (7-1-24)

17. Participant. An individual who is eligible for, and enrolled in, a Health Care Assistance Program or Medicaid. (7-1-24)

18. Partnership Policy. A qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code of 1986, which meets the requirements of the long-term care insurance model regulation and Long-term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (NAIC), as incorporated in 42 USC 1396p(b)(5)(A). (7-1-24)

19. Premium. A regular, periodic charge or payment for health coverage. (7-1-24)

20. Reasonable Opportunity Period. A period allowed for an individual to provide requested proof of citizenship or identity. A reasonable opportunity period extends for ninety (90) days beginning on the 5th day after the notice requesting the proof has been mailed to the applicant. This period may be extended if the Department determines that the individual is making a good faith effort to obtain necessary documentation. (7-1-24)

21. Pension Funds. Retirement funds held in individual retirement accounts (IRAs), as described by the Internal Revenue Code, or in work-related pension plans, including plans for self-employed individuals sometimes referred to as Keogh plans. (7-1-24)

22. Sole Beneficiary. The only beneficiary of a trust, including a beneficiary during the grantor's life, a beneficiary with a future interest, and a beneficiary by the grantor's will. (7-1-24)

23. **Title XIX**. Of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states that provides medical care for eligible individuals. Please see https://www.ssa.gov/OP_Home/ssact/title19/1900.htm. (7-1-24)

24. **Title XXI**. Of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a federal and state partnership that provides health insurance to targeted, low-income children. Please see https://www.ssa.gov/OP_Home/ssact/title21/2100.htm. (7-1-24)

25. **Treasury Rate**. The five (5) year security note rate listed in the "Daily Treasury Yield Curve Rate" by the US Treasury on January 1 of each year, and is used for the entire calendar year. (7-1-24)

26. **Working Day**. A calendar day when regular office hours are observed by the state of Idaho. Weekends and state holidays are not considered working days. (7-1-24)

011. -- 019. (RESERVED)

020. ABBREVIATIONS.

01. **AABD**. Aid to the Aged, Blind, and Disabled. (7-1-24)

02. **COLA**. Cost of Living Adjustment. (7-1-24)

03. **CSA**. Community Spouse Allowance. (7-1-24)

04. **CSNS**. Community Spouse Need Standard. (7-1-24)

05. **CSRA**. Community Spouse Resource Allowance. (7-1-24)

06. **EBT**. Electronic Benefits Transfer. (7-1-24)

07. **EITC**. Earned Income Tax Credit. (7-1-24)

08. **FSI**. Federal Spousal Impoverishment. (7-1-24)

09. **HCBS**. Home and Community Based Services. (7-1-24)

10. **ICF/IID**. Intermediate Care Facility for Individuals with Intellectual Disabilities. (7-1-24)

11. **INA**. Immigration and Nationality Act. (7-1-24)

12. **PASS**. Plan for Achieving Self-Support. (7-1-24)

13. **RSDI**. Retirement, Survivors, and Disability Insurance. (7-1-24)

14. **SSA**. Social Security Administration. (7-1-24)

15. **SSI**. Supplemental Security Income. (7-1-24)

16. **SSN**. Social Security Number. (7-1-24)

17. **TAFI**. Temporary Assistance for Families in Idaho. (7-1-24)

18. **VA**. Veterans Administration. (7-1-24)

021. -- 048. (RESERVED)

049. SIGNATURES.

An individual applying for benefits, receiving benefits, or providing additional information as required by these rules, may do so with the depiction of the individual's name either handwritten, electronic, or recorded telephonically. Such signature serves as intention to execute or adopt the sound, symbol, or process for the purpose of signing the related record. (7-1-24)

050. APPLICATION FOR ASSISTANCE.

01. Application Submitted by Participant. The participant must submit an application form to the Department. An adult participant, a legal guardian, or a representative must sign the application form. (7-1-24)

02. Application Submitted Through SSA Low-Income Subsidy Data Transmission. For low-income subsidy applicants identified on the SSA data transmission, the protected Medicare Savings Program application date is the day they applied for the low-income subsidy. (7-1-24)

051. EFFECTIVE DATE.
The effective date for aid is the first day of the month of application. Medicaid eligibility begins as described in this rule. (7-1-24)

01. AABD Cash. AABD cash aid is effective on the application date. (7-1-24)

02. Normal Medicaid Eligibility. Medicaid coverage begins on the first day of the application month. (7-1-24)

03. Retroactive (Backdated) Medicaid Eligibility. Medicaid benefits must be backdated to the first day of the calendar month, for each of the three (3) months before the month of application, if the participant was Medicaid-eligible during that month. If the participant is not eligible for Medicaid when they apply, retroactive eligibility is evaluated. (7-1-24)

04. Ineligible Non-Citizen Medicaid. Ineligible legal or illegal non-citizen coverage is restricted to emergency services. Coverage begins when the emergency treatment is required. Coverage ends with the last day emergency treatment is required. (7-1-24)

052. -- 069. (RESERVED)

070. TIME LIMITS.
The application must be processed within forty-five (45) days for an applicant sixty-five (65) years of age or older. The application must be processed within ninety (90) days for a disabled applicant. The time limit can be extended by events beyond the Department’s control. (7-1-24)

071. DEATH OF APPLICANT.
An application may be filed for a deceased person. The application must be filed within the backdated eligibility period. Medicaid can be approved, through the date of death, if an AABD applicant dies before eligibility is determined. (7-1-24)

072. REQUIRED VERIFICATION.
Applicants must prove their eligibility for aid. The participant is allowed ten (10) calendar days to provide requested proof. The application is denied if the applicant does not provide proof in ten (10) calendar days of the written request and does not have good cause for not providing proof. The Department may also use electronic verification sources when they are available. (7-1-24)

073. -- 090. (RESERVED)

091. OUT-OF-STATE APPLICANTS.
A participant receiving AABD cash from another state must not receive AABD cash in Idaho until they are living in Idaho and the cash benefit has ended in the other state. A participant may receive Medicaid in Idaho before AABD cash or Medicaid stops in another state. AABD cash from another state is unearned income for Medicaid. Out-of-state medical coverage is a Medicaid third-party resource. Idaho residents temporarily out of the state, and not receiving

aid, may apply for aid in Idaho. (7-1-24)

092. CONCURRENT BENEFIT PROHIBITION.
If a person is potentially eligible for AABD cash, TAFI, or foster care, only one (1) program may be chosen. (7-1-24)

093. -- 099. (RESERVED)

100. RESIDENCY.
The participant must be living in Idaho and have no immediate intention of leaving. For Medicaid, other persons are Idaho residents if they meet any of the following criteria. (7-1-24)

01. Foster Child. A participant living in Idaho and receiving child foster care payments from another state. (7-1-24)

02. Incapable Participant. A participant who is incapable of indicating their state of residency after age twenty-one (21) is considered a resident of Idaho when: (7-1-24)

a. Their parent or guardian lives in Idaho; or (7-1-24)

b. They reside in an Idaho institution. (7-1-24)

03. Placed in Another State by Idaho. A participant placed by the state of Idaho in an institution in another state. (7-1-24)

04. Homeless. A participant not maintaining a permanent home or having a fixed address who intends to remain in Idaho. (7-1-24)

05. Migrant. A migrant working and living in Idaho. (7-1-24)

101. TEMPORARY ABSENCE.
A participant may be temporarily absent from their home and still receive AABD cash and Medicaid. A participant is temporarily absent if they intend to return home within one (1) month. Temporary absence may exceed one (1) month for a child attending school or vocational training or a participant in a medical institution, hospital, or nursing home. (7-1-24)

102. US CITIZENSHIP VERIFICATION REQUIREMENTS.
Any individual who participates in AABD cash, Health Care Assistance, or Medicaid benefits must provide proof of US citizenship unless they have otherwise met the requirements under 42 CFR 435.406, Citizenship and Non-Citizen Eligibility. (7-1-24)

103. SOCIAL SECURITY NUMBER (SSN) REQUIREMENT.

01. SSN Required. The applicant must provide their SSN, or proof they have applied for an SSN, to the Department before approval of eligibility. If the applicant has more than one (1) SSN, all numbers must be provided. (7-1-24)

a. The SSN must be verified by the SSA electronically. An applicant with an unverified SSN is not eligible for AABD cash, Health Care Assistance, or Medicaid benefits. (7-1-24)

b. The Department must notify the applicant in writing if eligibility is denied or lost for failure to meet the SSN requirement. (7-1-24)

02. Application for SSN. To be eligible, the applicant must apply for an SSN, or a duplicate SSN when they cannot provide their SSN to the Department. If the SSN has been applied for but not issued by the SSA, the Department cannot deny, delay, or stop benefits. The Department will help an applicant with required documentation when the applicant applies for an SSN. (7-1-24)

03. Failure to Apply for SSN. The applicant may be granted a good cause exception for failure to apply for an SSN if they have a well-established religious objection to applying for an SSN. A well-established religious objection means the applicant: (7-1-24)

a. Is a member of a recognized religious sect or division of the sect; and (7-1-24)

b. Adheres to the tenets or teachings of the sect or division of the sect and for that reason is conscientiously opposed to applying for or using a national identification number. (7-1-24)

04. SSN Requirement Waived. An applicant may have the SSN requirement waived when they are: (7-1-24)

a. Only eligible for emergency medical services under 42 CFR 440.255, Emergency and Poststabilization Services; or (7-1-24)

b. A newborn child deemed eligible under 42 CFR 435.117, Deemed Newborn Children. (7-1-24)

104. – 105. (RESERVED)

106. EMERGENCY MEDICAL CONDITION.
An individual who meets eligibility criteria for a category of assistance but does not meet US citizenship requirements or eligible non-citizen requirements may receive medical assistance under a Title XIX or Title XXI coverage group as follows: (7-1-24)

01. Emergency Medical Conditions. An individual not meeting the US citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery. Emergency medical conditions have acute symptoms of severity, including severe pain. (7-1-24)

02. Determination of Emergency Medical Conditions. The Department determines if a condition meets criteria of an emergency medical condition. (7-1-24)

03. Limitation on Medical Assistance. Medical assistance is limited to the period established for the emergency medical condition. (7-1-24)

04. Documentation Waived. For undocumented individuals with emergency medical conditions, the SSN requirement is waived because an SSN cannot be issued. Individuals must be otherwise eligible for Title XIX or XXI. (7-1-24)

107. INSTITUTIONAL STATUS.
An institution provides treatment, services, food, and shelter to four (4) or more people, not related to the owner. A participant living in an ineligible institution an entire calendar month is not eligible for AABD cash, unless they qualify for the institution payment exception. (7-1-24)

01. Eligible Institutions for AABD and Medicaid. Are listed below. (7-1-24)

a. Medical institution. A public or private medical institution, including a hospital, nursing care facility, or an ICF/IID is an eligible institution. A participant is not eligible for AABD cash if they are a resident of a medical institution the full month. (7-1-24)

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. A child care institution for mental diseases is an eligible institution if it has sixteen (16) beds or less. A participant is not eligible for AABD cash if they are a resident of a child care institution for the full month. (7-1-24)

c. Community residence. A community residence is a facility providing food, shelter, and services 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. The Community Restorium in Bonners Ferry, Idaho, is an eligible institution even though more than sixteen (16) residents are served. (7-1-24)

02. Ineligible Institutions for AABD and Medicaid. Are listed below. (7-1-24)

a. Public institutions, unless listed in Subsection 108.01 of these rules. (7-1-24)

b. Institution for mental diseases, a facility maintained primarily for the care and treatment of persons with mental diseases. (7-1-24)

c. Institution for tuberculosis, a facility maintained primarily for the care and treatment of persons with tuberculosis. (7-1-24)

d. Correctional institution, a facility for prisoners, persons detained pending disposition of charges, or held under court order as material witnesses or juveniles. (7-1-24)

03. Medicaid Exception for Inmates. An inmate can receive Medicaid while they are an inpatient in a medical facility. The inmate must meet all Medicaid eligibility requirements. (7-1-24)

108. AABD ELIGIBILITY IN INELIGIBLE INSTITUTIONS.

A participant may get AABD cash in an ineligible institution or a medical institution if they meet one (1) of the conditions listed below. (7-1-24)

01. First Month in Institution. An AABD participant can get AABD cash for the month they entered the institution. Eligibility for the entry month applies to these residents: (7-1-24)

a. Resident of a public institution. The person is a resident if they, or anyone, pays for their food, shelter, and other services in the institution. (7-1-24)

b. Patient in a medical institution. A person receiving room, board, and professional services in a medical institution, including an institution for tuberculosis or mental diseases. (7-1-24)

02. Temporary Institution Stay. An AABD participant can get up to three (3) months' AABD payment during a temporary stay in an institution. A participant entering a public medical or psychiatric institution, a hospital, a nursing facility, or an ICF/IID may continue to get AABD payments. The Department must receive the temporary stay data no later than the ninetieth full day of confinement, or the release date, whichever is first. The payments may continue up to three (3) months if these conditions are met: (7-1-24)

a. The Department is informed of the institutional stay. (7-1-24)

b. A physician certifies the participant's stay is not likely to exceed three (3) full months. (7-1-24)

c. A signed statement from the participant or a responsible party showing the participant's need to continue to maintain and pay for the place they intend to return to live. (7-1-24)

109. CONDITIONS FOR TEMPORARY AABD IN INSTITUTIONS.

Special conditions for AABD when a participant is in an institution are listed below: (7-1-24)

01. Living Arrangement. AABD cash is paid based on the participant's living arrangement the month before the first month in the institution. Changes in living arrangement costs are used to determine AABD cash eligibility and benefit amount. (7-1-24)

02. Participant Becomes Ineligible. If the participant becomes ineligible for AABD during their temporary institutional stay, their AABD payment must be ended after proper notice. (7-1-24)

03. AABD Status. A participant must get AABD for the month they enter the institution to receive continued AABD payments. (7-1-24)

04. Counting Three Full Months. A full month is a month the participant is in the institution every day of the month. If the participant enters after the first day of a month, the month of entry is not included in the three (3) full months. If the participant is discharged before the last day of the month, the month of discharge is not included in the three (3) full months. (7-1-24)

05. SSI Benefits. If SSA decides a participant's SSI benefit will continue while the participant is in the institution, AABD payments can also continue. (7-1-24)

110. -- 129. (RESERVED)

130. ESTATE NOT IN PROBATE.
An administrator for public aid for a deceased participant's AABD cash can be court-appointed. The administrator must spend AABD cash, accessible through EBT before the participant's death, for the estate. The AABD cash can only be spent to meet the needs of the participant, or their dependents, for the month it was paid. If a participant had no debts for themself, or their dependents, the administrator must return the AABD cash to the Department. AABD benefits paid by direct deposit or posted to the participant's EBT account, after the participant's death, are the property of the State of Idaho. (7-1-24)

131. ESTATE IN PROBATE.
AABD cash received by a participant before their death is disbursed as part of the participant's estate if it is probated. The probate administrator spends the AABD cash under their oath of administration. (7-1-24)

132. -- 154. (RESERVED)

155. AABD FOR THE AGED.
To qualify for AABD for the aged, a person must be age sixty-five (65) or older. (7-1-24)

156. AABD FOR THE BLIND OR 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. (7-1-24)

01. SSA Decision for Disabled. SSA's disability decision is binding on the Department unless: (7-1-24)

a. The participant states their disabling condition is different from, or in addition to, their condition considered by SSA, and the participant has not reapplied for SSI; or (7-1-24)

b. More than twelve (12) months have passed since the SSA made a final determination the participant was not disabled, and the participant states their condition has changed or become worse since that final determination, and the participant has not reapplied for SSI. (7-1-24)

02. Medicaid Pending SSA Appeal. When SSA decides a participant is no longer disabled, they meet the AABD disability requirement and can continue receiving Medicaid if they appeal SSA's decision. Medicaid ends if the SSA decision is upheld. (7-1-24)

03. Grandfathered Participant for Aid to the Permanently and Totally Disabled or Aid to the Blind. A participant is disabled if they were eligible as disabled in December 1973, and continues to meet the disability requirement in effect in December 1, 1973. They must also meet the other current eligibility requirements. (7-1-24)

157. -- 165. (RESERVED)

166. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.
A participant is ineligible to receive AABD for any month during which they are fleeing to avoid prosecution for a felony, fleeing to avoid custody or confinement after a felony conviction, or violating a federal or state condition of probation or parole. (7-1-24)

167. FRAUDULENT MISREPRESENTATION OF RESIDENCY.
A participant is ineligible for AABD for ten (10) years if they were convicted in a federal or state court of having fraudulently misrepresented residence to get AABD, SSI, TAFI, Food Stamps, or Medicaid from two (2) or more states at the same time. (7-1-24)

168. -- 199. (RESERVED)

200. RESOURCES DEFINED.
Resources are cash, personal property, real property, and notes receivable. A participant, or spouse, must have the right, authority, or power to convert the resource to cash. The participant must have the legal right to use the resource for support and maintenance. Liquid resources are resources in cash or resources convertible to cash within twenty (20) workdays. Nonliquid resources are any resources, not in the form of cash, which cannot be converted to cash within twenty (20) workdays. (7-1-24)

201. RESOURCE LIMIT.
The value of countable resources must be two thousand dollars ($2,000) or less, for a single person to be AABD eligible. A married person must have countable resources of three thousand dollars ($3,000) or less to be eligible for AABD cash. Resources are counted the first moment of each calendar month and apply to the entire month. (7-1-24)

202. CHANGE IN VALUE OF RESOURCES.
A change in the value of resources is counted the first moment of the next month. (7-1-24)

203. RESOURCES AND CHANGE IN MARITAL STATUS.
A change in marital status changes the resource limit. The resource limit change is effective the month after individual participants are married, divorced, separated, or one (1) spouse dies. (7-1-24)

204. FACTORS MAKING PROPERTY A RESOURCE.
Property of any kind is a resource if the participant has an ownership interest in the property and the legal right to spend or convert the property to cash. (7-1-24)

205. COUNTING RESOURCES AND INCOME.
An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. (7-1-24)

206. – 207. (RESERVED)

208. SHARED OWNERSHIP RULE.
Except for checking and savings accounts and time deposits, each owner of shared property owns only their fractional interest in the property. The total value of the property is divided among the owners, in direct proportion to each owner's share. (7-1-24)

209. 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. (7-1-24)

210. RESOURCES EXCLUDED BY FEDERAL LAW.
A resource excluded by federal law is not counted in determining the resource amount available to the participant. (7-1-24)

211. -- 214. (RESERVED)

215. DEEMING RESOURCES.
Resource deeming is determined by the SSA Program Operations Manual System (POMS) SI 01330.00, Deeming Resources, incorporated by reference under Section 002 of these rules. The participant's circumstances are assessed the first moment of the month. Deeming starts the first full calendar month the participant is in a deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. (7-1-24)

216. HOUSEHOLD FOR RESOURCE COMPUTATIONS.
A participant living in an institution is not a household for resource computations. (7-1-24)

217. UNKNOWN RESOURCES.
An asset is not a resource if the participant is unaware of their ownership. The asset is a resource the month after discovery. (7-1-24)

218. -- 221. (RESERVED)

222. VEHICLES AS A RESOURCE.
If more than one (1) vehicle is owned, the exclusion applies in the best way for the participant. (7-1-24)

01. One Vehicle Excluded. One (1) vehicle is excluded, regardless of value. (7-1-24)

02. Other Vehicles Not Excluded. The equity value of a vehicle not excluded under Subsection 222.01 of this rule is a resource. (7-1-24)

223. BURIAL FUNDS EXCLUDED FROM RESOURCE LIMIT.
Burial funds up to one thousand five hundred dollars ($1,500) per person, set aside for the burial expenses of the participant or spouse, are excluded from resources. To be excluded, burial funds must be kept separate from assets not burial-related. A burial contract that can be revoked or sold, without significant hardship, is a resource. Any portion of the contract for the purchase of burial spaces is excluded from resources. A burial contract that cannot be revoked, and cannot be sold without significant hardship, is not a resource. The burial fund portion of the contract counts against the one thousand five hundred dollar ($1,500) burial funds exclusion. The burial space portion of the contract does not count against the burial funds exclusion. Interest earned on excluded burial funds is also excluded. (7-1-24)

01. Life Insurance Policy as Burial Funds. The participant can designate a countable life insurance policy as a burial fund. The face value of excluded life insurance policies on the participant counts against the burial funds exclusion. (7-1-24)

02. Face Value of Burial Insurance Policies Not Counted. The face value of burial insurance policies does not count toward the one thousand five hundred dollar ($1,500) life insurance limit, when computing the total face value of life insurance policies owned by a participant. Interest on excluded burial funds does not count toward the one thousand five hundred dollar ($1,500) burial funds exclusion. (7-1-24)

03. Effective Date of Burial Funds Exclusion. The exclusion is effective the month after the month the funds were set aside. Burial funds can be designated retroactively, back to the first day of the month the participant intended the funds to be set aside. The participant must confirm the designation in writing. (7-1-24)

04. Penalty for Misusing Burial Funds. If the participant does not get SSI, burial funds used for another purpose lose the exclusion. An overpayment must be recovered. If the participant gets SSI, and is penalized by SSA because they used excluded burial funds for another purpose, their AABD payment must not be increased to compensate the SSA penalty. (7-1-24)

224. BURIAL SPACE OR PLOT EXCLUSION.
A burial space is a burial plot, grave site, crypt, mausoleum, casket, urn, niche, or other repository normally used for the deceased's remains. A burial space, or burial space purchase agreement, held for the burial of the participant, spouse, or other member of their immediate family, is an excluded resource. (7-1-24)

01. Burial Space Contract. Must list all burial spaces and include a value for each space or the total value of all the spaces. The contract must not require further payment after the contract is signed. (7-1-24)

02. Space Held by Ineligibles Excluded. A space held by an ineligible spouse or parent, for the burial of a participant, spouse, and any member of the participant's immediate family, is excluded. A space held by a legal non-citizen sponsor, or essential person, for their own burial is excluded only if the sponsor is a member of the

participant's immediate family. (7-1-24)

225. -- 234. (RESERVED)

235. EXCLUDED HOUSEHOLD GOODS AND PERSONAL EFFECTS.
Household goods and personal effects are excluded from resources, regardless of their dollar value. (7-1-24)

236. (RESERVED)

237. REAL PROPERTY DEFINITION.
Real property is land, including buildings or immovable objects attached permanently to the land. Real property is a resource unless excluded. (7-1-24)

238. HOME AS RESOURCE.
An individual's home is property they own, and serves as their principal place of residence. Their principal place of residence is the place they consider their principal home. If the individual is absent from their home, it is still their principal place of residence if they intend to return. (7-1-24)

01. AABD Cash, and Medicaid With the Exception of Long-Term Care. For AABD Cash and Medicaid except for long-term care, the value of an individual's home is an excluded resource. (7-1-24)

02. Long-Term Care Services. For long-term care services, when the value of a participant's equity in the home is seven hundred fifty thousand dollars ($750,000) or less, the home is excluded as a resource. When the equity value exceeds seven hundred fifty thousand dollars ($750,000), the individual is ineligible for long-term care services. The equity value, regardless of the amount, is an excluded resource when one (1) of the following applies: (7-1-24)

a. The spouse of the individual lives in the home; or (7-1-24)

b. The individual's child, who is under age twenty-one (21), or is blind, or meets the disability requirements for AABD cash, lives in the home. (7-1-24)

239. SALE OF EXCLUDED HOME AND REPLACEMENT.
If the participant plans to buy another excluded home, proceeds from the sale of a participant's excluded home are excluded resources. Proceeds from the sale of an excluded home must be used to replace the home within three (3) calendar months. Proceeds retained beyond three (3) calendar months are a countable resource. (7-1-24)

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 payments, up to an additional nine (9) months. The extension can be made if, for the first nine (9) months, circumstances beyond the participant's control prevent repair or replacement of the lost, damaged, or stolen property and keep the participant from contracting for repair or replacement. This exclusion can be extended for twelve (12) more months for a catastrophe the President declares a major disaster. Interest earned by funds excluded under this provision is excluded from resources. (7-1-24)

241. UNDUE HARDSHIP EXCLUSION FROM SALE OF JOINTLY OWNED REAL PROPERTY.
A participant'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 coowner uses the property as their principal place of residence, would have to move if the property were sold, and has no other readily available housing. (7-1-24)

242. AMERICAN INDIAN PROPERTY EXCLUDED.
For the purposes of determining eligibility for an individual who is an American Indian, the following property is excluded: (7-1-24)

01. Property. Real property and improvements located on a reservation, including any federally

recognized Indian Tribe's reservation, pueblo, or colony, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs. (7-1-24)

02. Natural Resources. Ownership interest in rents, leases, royalties, or usage rights related to natural resources resulting from the exercise of federally protected rights. (7-1-24)

03. Other Ownership Interests or Usage Rights. Ownership interests in or usage rights to property not covered by Subsections 242.01 or 242.02 of this rule that have a unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or traditional lifestyle under applicable tribal law or custom. (7-1-24)

243. RESOURCES ASSOCIATED WITH PROPERTY.
Resources associated with real property are mineral rights, timber rights, easements, leaseholds, water rights, remainder interests, and sale of natural resources. These resources are counted as real property. (7-1-24)

244. RESOURCES ESSENTIAL FOR SELF-SUPPORT EXCLUDED.
Resources are excluded as essential to self-support, if they fall into one (1) of the categories described below. (7-1-24)

01. Essential Property in Current Use. Property in current use in the type of activity that qualifies it as essential to self-support is excluded, regardless of value or rate of return. Trade or business property, government permits, and personal property used by an employee for work are excluded regardless of value or rate of return. If the property is not in current use, for reasons beyond the participant's control, there must be a reasonable expectation the required use will resume. If the participant does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use. (7-1-24)

02. Nonbusiness Property Producing Goods or Services. Up to six thousand dollars ($6,000) of the equity value of nonbusiness property, used to produce goods or services essential to daily activities, is excluded regardless of rate of return. Equity value over six thousand dollars ($6,000) is not excluded. This exclusion is not used for income-producing property. (7-1-24)

03. Nonbusiness Income-Producing Property. Up to six thousand dollars ($6,000) equity in nonbusiness income-producing property is excluded if the property produces a net annual return equal to at least six percent (6%) of the excluded equity. If a participant 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 the earnings decline is for reasons beyond the participant's control, up to twenty-four (24) months can be allowed for the property to resume producing a six percent (6%) return. 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 after the month the twenty-four (24) month period ends. (7-1-24)

245. RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT (PASS) EXCLUDED.
PASS allows blind and disabled participants 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 participant would be ineligible due to excess resources. To disregard resources, the PASS must show how resources the participant 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 separately from the participant's other resources, list items or activities requiring savings or purchases and the amounts the participant anticipates saving or spending, and show a specific target date to achieve the objective. (7-1-24)

246. LIFE ESTATE INTEREST IN ANOTHER'S HOME.
The purchase of a life estate interest in another individual's home is a resource unless the purchaser resides in the home for a period of at least twelve (12) consecutive months after the date of purchase. (7-1-24)

247. -- 255. (RESERVED)

256. RETROACTIVE SSI AND RSDI BENEFITS.

Retroactive SSI and RSDI benefits are issued after the calendar month for which they are paid. Retroactive SSI and RSDI benefits are excluded from resources for nine (9) calendar months after the month they are received. Interest earned by excluded funds is counted as income. (7-1-24)

257. DISASTER ASSISTANCE.
Assistance received because of a major disaster declared by the President is excluded from resources. Interest earned on excluded funds is excluded from income and resources. (7-1-24)

258. CASH TO PURCHASE MEDICAL OR SOCIAL SERVICES.
Cash paid by a recognized medical or social services program, for the participant to purchase medical or social services, is not a resource for one (1) calendar month after receipt. The cash must not be repayment for a bill already paid. (7-1-24)

259. (RESERVED)

260. ALASKA NATIVE CLAIMS SETTLEMENT ACT.
Payments to Alaska Natives and their descendants from the Alaska Native Claims Settlement Act, under PL 100-241, are excluded from resources. (7-1-24)

261. STOCK IN ALASKA REGIONAL OR VILLAGE CORPORATIONS.
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. (7-1-24)

262. VICTIMS' COMPENSATION PAYMENTS.
Payments, from a fund set up by a State to aid victims of crime, are excluded from resources for nine (9) months. Interest earned on unspent victims' compensation payments is counted for income and resources. (7-1-24)

263. -- 264. (RESERVED)

265. TAX ADVANCES AND REFUNDS RELATED TO EARNED INCOME TAX CREDITS.
A federal tax refund or payment made by an employer, related to Earned Income Tax Credits (EITC), is excluded from resources for the month after the month the refund or payment is received. Interest earned on unspent tax refunds related to EITC is counted for income and resources. (7-1-24)

266. IDENTIFYING EXCLUDED FUNDS COMMINGLED WITH FUNDS NOT EXCLUDED.
Excluded funds must be separately identifiable to remain excluded. (7-1-24)

267. DEDICATED ACCOUNT FOR SSI PARTICIPANT.
A dedicated account for past-due SSI benefits, set up in a financial institution for an SSI participant under age eighteen (18) is an excluded resource. The account must be set up by the child's SSI representative payee, and excluded by SSA. (7-1-24)

268. SUPPORT AND MAINTENANCE ASSISTANCE.
Support and Maintenance Assistance (SMA) is in-kind support and maintenance, or cash paid for food or shelter needs. It includes Home Maintenance Assistance aid to cover costs of heating or cooling a home. SMA is an excluded resource. (7-1-24)

269. -- 271. (RESERVED)

272. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al., are excluded from resources for Medicaid by PL 105-33. These payments are not excluded for AABD cash. (7-1-24)

273. -- 275. (RESERVED)

276. EXCLUDED REAL ESTATE CONTRACT.
The principal balance of a real estate contract is excluded from resources of a participant in long-term care when the

Department determines it is in the Department's best interest to exclude the contract. The determination by the Department of its best interest is final. (7-1-24)

277. FEES PAID TO A CONTINUING CARE RETIREMENT COMMUNITY (CCRC) OR LIFE CARE COMMUNITY.
An entrance fee to a CCRC or a life care community is a resource if the participant or applicant for long-term care has discretion to spend the fee or if the fee may be used to pay for care in a contingency. A CCRC or life care community is a type of long-term care facility that offers varying levels of care and in which a resident contracts with the facility to obtain care that is intended to endure for the remainder of the resident's life in exchange for valuable consideration. (7-1-24)

278. TRUSTS.
A trust is a resource to a participant with the legal right to revoke the trust, and use the principal for their own support and maintenance. See Sections 838 through 873 in these rules for treatment of trusts for Medicaid. (7-1-24)

279. RETIREMENT FUNDS.
Retirement funds are work-related plans for providing income or pensions when employment ends. A retirement fund, owned by a participant, is a resource if they have the option of withdrawing a lump sum, even though they are not yet eligible for periodic retirement payments. If the participant is eligible for periodic retirement payments, the fund is not a countable resource. The value of a retirement fund is the amount of money a participant can currently withdraw from the fund. (7-1-24)

280. INHERITANCE.
An inheritance is cash, a right, including probate allowances, trust payments and annuities, 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 next month. Participants are required to make claims and take all reasonable action necessary to obtain any inheritance to which they may be entitled. Failure to make such claims or take reasonable steps to obtain an inheritance is an asset transfer. A contested inheritance is not counted as a resource until the contest is settled and money is distributed. (7-1-24)

281. LIFE INSURANCE.
A life insurance policy is an excluded resource if its face value, plus the face value of all other life insurance policies the participant owns on the same insured person, totals one thousand five hundred dollars ($1,500) or less. If the face values exceed one thousand five hundred dollars ($1,500) the policies are a resource in the amount of the cash surrender value. (7-1-24)

282. CONSERVATORSHIP.
Funds required to be made available for the care and maintenance of a participant, under a court order, are the participant's resource. This is true even if the participant or their agent is required to petition the court to withdraw funds for the participant's care. (7-1-24)

283. CONDITIONAL BENEFITS.
A participant ineligible due solely to excess nonliquid resources, can receive AABD cash and related Medicaid. The participant must meet two (2) conditions. First, their countable liquid resources must not exceed three (3) times the participant's AABD cash budgeted needs. Second, the participant agrees, in writing, to sell excess nonliquid resources at their fair market value, within three (3) months. The value of excess real property is not counted as a resource, if the participant makes reasonable efforts to sell the property at its fair market value, and their reasonable efforts to sell are not successful. This exclusion is also used to compute deemed resources. (7-1-24)

01. Conditional Benefits Payments Disposal/Exclusion Period. The disposal and exclusion period for excess nonliquid resources begins on the date the participant signs the Agreement to Sell Property. The disposal and exclusion periods can begin earlier for a participant who met all requirements to receive conditional benefits before their first opportunity to sign the Agreement to Sell Property. The participant must sign the Agreement to Sell Property before their application is approved. (7-1-24)

02. Period for Disposal of Excess Resources. The disposal period for excess nonliquid personal property is three (3) months. One (1) three (3) month extension, for sale of personal property, is allowed when good

cause exists. (7-1-24)

03. Good Cause for Not Making Efforts to Sell Excess Property. The participant has good cause for not making efforts to sell property, when circumstances beyond their control prevent their taking the required actions. Without good cause, the participant's countable resources include the value of the excess property, retroactive to the beginning of the conditional benefits period. (7-1-24)

284. RESOURCE TRANSFER FOR LESS THAN FAIR MARKET VALUE.
AABD cash participants are subject to a period of ineligibility if they transfer resources for less than fair market value. The participant is not subject to a period of ineligibility if their total countable resources in the transfer month were under two thousand dollars ($2,000), even if they have kept the transferred resources. Excluded resources, except for the excluded home and associated property, are not subject to the resource transfer period of ineligibility. The exceptions to the period of ineligibility for transfer of resources are listed in Section 292 of these rules. (7-1-24)

01. Transfer of Resources. Includes reducing or eliminating the participant's ownership or control of the resource. Transfer of resources includes giving away cash resources without receiving fair market value. (7-1-24)

02. Transfer of Participant's Resources by a Spouse of Either Spouse's Resources. Subjects the participant to the resource transfer period of ineligibility. (7-1-24)

03. Transfer of Participant's Resources by a Co-Owner. Subjects the participant to a period of ineligibility based on their share of the co-owed resources. (7-1-24)

04. Transfer of Participant's Resources by a Legal Representative Such as a Legal Guardian or Parent of Minor Child. Subjects the participant to a period of ineligibility. (7-1-24)

285. AABD PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.
The resource transfer period of ineligibility is a period of AABD ineligibility for up to sixty (60) months. The period of ineligibility begins the first day of the month after the transfer month. The participant must be notified in writing at least ten (10) days before a resource transfer period of ineligibility is imposed. (7-1-24)

286. RESOURCE TRANSFER LOOK-BACK PERIOD.
The resource transfer penalty applies to any transfer for less than fair market value made during a period preceding a request for cash assistance. Any resource transferred, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for cash, or the date of the transfer, whichever is later in time. (7-1-24)

287. CALCULATING THE PERIOD OF INELIGIBILITY FOR RESOURCE TRANSFERS.
The period of ineligibility is the number of months computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the participant's living arrangement. For an applicant, the Department will use the full AABD allowance for the application month. For a participant, the Department will use the full AABD allowances for the transfer month. For an AABD couple, the period of ineligibility is computed by dividing the difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement. The number of months of ineligibility is computed to two (2) decimal places and rounded down to the nearest whole number. If the amount transferred is less than the participant's AABD allowances for one (1) month, the participant is not subject to a period of ineligibility. (7-1-24)

288. LENGTH OF PERIOD OF INELIGIBILITY.
The period of ineligibility begins with the month after the month the transfer took place. The period of ineligibility continues whether or not the participant receives AABD. Ineligibility continues until all the resources are returned to the participant or spouse, adequate consideration for all the resources is received, sixty (60) months passes, or the penalty period ends. (7-1-24)

289. SPOUSE APPLIES AFTER PERIOD OF INELIGIBILITY IS COMPUTED.
If the spouse applies after the period of ineligibility is computed, the Department will compute the spouse's period of ineligibility by multiplying the number of months in the period of ineligibility already expired by the full AABD

allowances for the couple's living arrangement. The Department will subtract the total from the original difference between the fair market value of the resource and the amount the participant received for the resource. The Department will divide the remaining difference between the fair market value of the resource and the amount the participant received for the resource by the full AABD allowances for the couple's living arrangement for the first month of ineligibility. (7-1-24)

290. MULTIPLE RESOURCE TRANSFERS.
If the participant makes more than one (1) resource transfer, the difference between the fair market value of all the transferred resources and the amount the participant received for all the transferred resources is used to determine the length of the period of ineligibility. The period of ineligibility begins with the month after the month of the first transfer. (7-1-24)

291. TRANSFERS TO TRUSTS.
A trust established from the participant's resources is a resource transfer for less than fair market value, unless it meets an exception in Section 292 of these rules. If the trust includes resources of another person, the resource transfer period of ineligibility applies to the participant's share of the trust. (7-1-24)

01. Payment from Trust Not for Participant. If a payment is made to another individual from a trust counted as a resource, and the payment is not for the benefit of the participant, the payment is a resource transfer for less than fair market value. (7-1-24)

02. Payment from Trust Restricted. If the participant acts so no payment from a trust counted as a resource can be made for any reason, the trust is a resource transfer for less than fair market value. By taking the action, the participant causes the trust to be no longer counted as a resource and the participant is subject to the period of ineligibility. The date of the action restricting payment is the date of the transfer. (7-1-24)

292. PERIOD OF INELIGIBILITY EXCEPTIONS.
A participant or spouse is not subject to the resource transfer period of ineligibility if one (1) of the following conditions is satisfied. (7-1-24)

01. Home to Spouse. Title to the home is transferred solely to the spouse. (7-1-24)

02. Home to Minor Child or Disabled Adult Child. Title to the home is transferred to the child of the participant or spouse. The child must be under age twenty-one (21), blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-24)

03. Home to Sibling. Title to the home is transferred to a sibling of the participant or spouse who must have had an equity interest or life estate in the transferred home and was residing in that home for at least one (1) year immediately before the month the home was transferred. (7-1-24)

04. Home to Adult Child. Title to the home was transferred to a child of the participant or spouse, other than a child under the age of twenty-one (21). The child must have resided in that home for at least two (2) years immediately before the month the participant entered a medical facility or long-term care. The child must have provided care to the participant, which permitted them to live at home rather than enter a medical facility or long-term care. (7-1-24)

05. Benefit of Spouse. Resources, other than the home, were transferred to the participant's spouse or to another person for the sole benefit of the spouse. (7-1-24)

06. Transfer from Spouse. The resources were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. (7-1-24)

07. Transfer to Child. The resources were transferred to the participant's child or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. (7-1-24)

08. Transfer to Trust for Person Under Sixty-Five. The resources were transferred to a trust for the

sole benefit of a person under age sixty-five (65) who is blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-24)

09. Transfer to a Trust That Is a Countable Resource. The resources were transferred to a trust and the trust is a countable resource for AABD in the amount of the transfer. (7-1-24)

10. Intent to Receive Fair Market Value. The participant or spouse proves they intended to dispose of the resources at fair market value or for other adequate consideration, but can prove good cause for not doing so. (7-1-24)

11. Resources Returned. All resources transferred for less than fair market value have been returned to the participant. (7-1-24)

12. No AABD Purpose. The participant or spouse proves the resources were transferred exclusively for a purpose other than qualifying for AABD. Purposes other than qualifying for AABD include: (7-1-24)

a. After the resource transfer the participant has a traumatic onset of disability. (7-1-24)

b. After the resource transfer a previously unknown disabling condition is diagnosed. (7-1-24)

c. After the resource transfer the participant has an unexpected loss of income or resources resulting in eligibility for AABD. (7-1-24)

d. The resource was excludable in the transfer month. (7-1-24)

e. The transfer of resources was court-ordered, provided the participant did not petition the court to order the transfer. (7-1-24)

f. The participant took a vow of poverty and gave the resources to a religious order. (7-1-24)

13. Undue Hardship. The participant proves failure to receive AABD would deprive them of food or shelter and their total available funds, including income and liquid resources, are less than their AABD allowances for the month they claim undue hardship. Undue hardship must be proven for each month of the period of ineligibility. When determining total available funds for a child, the Department will count any income and resources deemed from their parents. (7-1-24)

14. Exception to Fair Market Value. The amount received is reasonable, even if less than fair market value if a forced sale was done under reasonable circumstances, and little or no market demand exists for the type of resource transferred, or the resource was transferred to settle a legal debt approximately equal to the fair market value of the transferred resource. (7-1-24)

15. No Benefit to Participant. The participant received no benefit from the resource because they or their spouse held title to the property only as a trustee for another person, or the transfer was done to clear title to property and the participant or spouse had no interest in the property that would benefit them. (7-1-24)

16. Fraud Victim. The resource was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the resources or property or its equivalent in damages. The participant must assign recovery rights to the State of Idaho. (7-1-24)

293. EFFECT ON MEDICAID ELIGIBILITY.

Ineligibility for AABD cash because of property transfer does not make the participant ineligible for Medicaid. (7-1-24)

294. -- 299. (RESERVED)

300. INCOME DEFINITION.

Income is anything that can be used to meet needs for food, or shelter. Income is cash, wages, pensions, in-kind

payments, inheritances, gifts, awards, rent, dividends, interest, or royalties the participant receives during a month. (7-1-24)

01. Cash Income. Is currency, checks, money orders, or electronic funds transfers. Cash income includes Social Security checks, unemployment checks, and payroll checks. (7-1-24)

02. In-Kind Income. Is not cash. In-kind income is food or shelter. Wages paid as in-kind earnings, such as food or shelter, are counted as unearned income. Other in-kind income is not counted. (7-1-24)

03. Inheritances. 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 next month. A contested inheritance is not counted as income until the contest is settled and money is distributed. (7-1-24)

301. APPLICATION FOR POTENTIAL BENEFITS.

The participant must apply for benefits, including RSDI, VA, pensions, Workman's Compensation, or Unemployment Insurance, when there is potential eligibility. The participant must apply when they reach the earliest age to qualify for the benefit. (7-1-24)

01. SSI. To get AABD cash, the participant must apply for SSI benefits, if they are potentially eligible. To get AABD-Medicaid, the participant does not have to apply for SSI benefits. (7-1-24)

02. VAIP. Participants entitled to a VA pension as of December 31, 1978, are not required to file for Veterans Administration Improved Pension Plan (VAIP), to get AABD cash or AABD-related Medicaid. (7-1-24)

03. Other Benefits. EITC, TAFI, BIA General Assistance, and victim's compensation benefits are exempt from the filing requirement. (7-1-24)

302. RELATIONSHIP OF INCOME TO RESOURCES.

Income is counted as income in the current month. If the participant keeps countable income after the month received, it is counted as a resource. (7-1-24)

303. WHEN INCOME IS COUNTED.

Income is counted the earliest of when received, when credited to a participant's account, or when set aside for the participant's use. Income from SSA, SSI, or VA is counted for the month it is intended to cover. (7-1-24)

304. PROSPECTIVE ELIGIBILITY.

Eligibility for AABD cash and Medicaid is prospective. Expected income for the month is compared to the participant's income limit that month. (7-1-24)

305. PROJECTING MONTHLY INCOME.

Income is projected for each month to determine AABD cash amount. Past income may be used to project future income. Expected changes must be considered. Income received less often than monthly and patient liability income are not prorated or converted. (7-1-24)

306. CRITERIA FOR PROJECTING MONTHLY INCOME.

Monthly income is projected as described below. (7-1-24)

01. Converting Income to a Monthly Amount. If a full month's income is expected, but is received on other than a monthly basis, the Department will convert the income to a monthly amount using one (1) of the formulas in the table below.

TABLE 306.01 MONTHLY CONVERSION OF INCOME

	Conversion	Procedure
a.	Weekly to Monthly	Multiply weekly amounts by 4.3.

TABLE 306.01 MONTHLY CONVERSION OF INCOME		
	Conversion	Procedure
b.	Biweekly to Monthly	Multiplying bi-weekly amounts by 2.15.
c.	Semimonthly to Monthly	Multiplying semi-monthly amounts by 2.
d.	Exact Amount	Use the exact monthly income if it is expected for each month.

(7-1-24)

02. Income Already Received. The Department will count income already received during the month and will convert the actual income to a monthly amount if a full month's income has been received or is expected to be received as described below. (7-1-24)

a. If the actual amount of income from any pay period a month is known, the Department will use the actual pay period amounts to determine the total month's income and will convert the actual income to a monthly amount if a full month's income has been received or is expected. (7-1-24)

b. If no pay changes are expected, the Department will use the known actual pay period amounts for the past thirty (30) days to project future income and will convert the actual income to a monthly amount if a full month's income has been received or is expected. (7-1-24)

03. Expected Income. The Department will count income that the participant and the Department believe the participant will get. The Department will convert expected income to a monthly amount as described below. (7-1-24)

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. (7-1-24)

b. If the income has not changed and no changes are expected, past income can be used to project future income. (7-1-24)

c. If income changes, and income received in the past thirty (30) days does not reflect expected income, income received over a longer period is used to project future income. (7-1-24)

d. If income changes seasonally, income from the last comparable season is used to project future income. (7-1-24)

04. Ongoing Income. Comes from an ongoing source. It was received in the past and is expected to be received in the future. The Department will convert ongoing income to a monthly amount as described below. (7-1-24)

a. If a full month's income is not expected from an ongoing source, the Department will count the amount of income expected for the month. If actual income is known, the Department will use actual income. If actual income is unknown, the Department will project expected income and will convert income to a monthly amount. The Department will use zero (0) income for any pay period in which income was not received that month. (7-1-24)

b. If a full month's income from a new source is not expected, the Department will count the actual income expected for the month. The Department will not convert the income to a monthly amount. (7-1-24)

c. If income stops and no additional income is expected from the terminated source, the Department will count the actual income received during the month. The Department will not convert the terminated source of income. (7-1-24)

d. If a full month's income is not expected from a new or terminated source, the Department will

count the income expected for the month. If the actual income is known, the Department will use the known income. If the actual income is unknown, the Department will project the income and will not convert the income to a monthly amount if a full month's income from a new or terminated source is not expected. (7-1-24)

05. Income Paid on Salary. Income paid on salary, rather than an hourly wage, is counted at the expected monthly salary rate. (7-1-24)

06. Income Paid at Hourly Rate. The Department will compute expected income paid on an hourly basis by multiplying the hourly pay by the expected number of hours the participant will work in the pay period. The Department will convert the pay period amount to a monthly basis. (7-1-24)

07. Monthly Income Varies. When monthly income varies each pay period and the rate of pay remains the same, the Department will average the income from the past thirty (30) days to determine the average pay period amount and will 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, a longer period of income history is used to project income. (7-1-24)

08. Income Received Less Often Than Monthly. Recurring income, such as quarterly payments or annual income, is counted in the month received, even if the payment is for multiple months. The income is not prorated or converted. If the amount is known, the Department will use the actual. If the amount is unknown, the Department will use the best information available to project income. (7-1-24)

307. COUNTING RESOURCES AND INCOME.
An asset cannot be counted as income and resources in the same month. Assets received in cash or in-kind during a month are income. Income held past the month received is a resource. (7-1-24)

308. -- 309. (RESERVED)

310. 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 excluded income. Adoption assistance payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. (7-1-24)

311. -- 312. (RESERVED)

313. ASSISTANCE BASED ON NEED (ABON).
ABON is aid paid under a program using income as a factor of eligibility. ABON is funded wholly by a State, or a political subdivision of a State, or an Indian tribe, or a combination of these sources. Federal funds are not used. ABON is excluded income. (7-1-24)

314. (RESERVED)

315. BUREAU OF INDIAN AFFAIRS (BIA) FOSTER CARE.
BIA foster care payments are social services. They are excluded income for the foster child and foster family. (7-1-24)

316. BLIND OR DISABLED STUDENT EARNED INCOME.
To qualify for this exclusion, the student must be blind or disabled and be under age twenty-two (22). The student must be regularly attending high school, college, university, or a course of vocational or technical training designed to prepare them for gainful employment. The maximum monthly and annual exclusions cannot exceed the limits set by SSI for the current year. (7-1-24)

317. "BUY-IN" REIMBURSEMENT.
The SSA reimbursement for self-paid Medicare Part B "Buy-In" premiums is excluded. (7-1-24)

318. – 319. (RESERVED)

320. CONVERSION OR SALE OF A RESOURCE NOT INCOME.
Payment from the sale, exchange, or replacement of a resource is excluded. The payment is a resource that changed form. (7-1-24)

321. 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 participant. These payments are excluded. (7-1-24)

322. 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. (7-1-24)

323. (RESERVED)

324. GRANTS, SCHOLARSHIPS, AND FELLOWSHIPS.
Any grant, scholarship, or fellowship, not administered by the Commissioner of Education, and used for paying tuition, fees, or required educational expenses is excluded. This exclusion does not apply to any portion set aside or used for food or shelter. (7-1-24)

325. DISASTER ASSISTANCE.
Payments received because of a major disaster, declared by the President, are excluded. This includes payments to repair or replace the person's own home or other property and disaster unemployment aid. (7-1-24)

326. 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 Sections 404(g) and 418 of the Domestic Volunteer Service Act is excluded. (7-1-24)

327. EARNED INCOME TAX CREDITS.
Earned Income Tax Credits advance payments and refunds are excluded. (7-1-24)

328. FEDERAL HOUSING ASSISTANCE.
Federal housing assistance is excluded. (7-1-24)

329. FOSTER CARE PAYMENTS.
Foster care payments using funds provided under Title IV-B or Title XX of the Social Security Act are excluded. 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. Foster care payments using funds provided under Title IV-E are income. The twenty dollar ($20) standard disregard is not subtracted. (7-1-24)

330. EXPENSE OF OBTAINING INCOME.
Essential expenses of obtaining unearned income are subtracted from the income. An expense is essential if the participant would not receive the income unless they paid the expense. Expenses of receiving income, such as withheld taxes, are not subtracted. (7-1-24)

331. GARNISHMENTS.
Garnishments of unearned income are counted as unearned income. Garnishments of earned income are counted as earned income. (7-1-24)

332. (RESERVED)

333. GOVERNMENT MEDICAL OR SOCIAL SERVICES.
Governmental payments authorized by federal, state, or local law, for medical or social services, are excluded. Any cash provided by a nongovernmental medical or social services organization (including medical and liability insurers) for medical or social services already received is excluded. (7-1-24)

01. Medical Services. Are diagnostic, preventive, therapeutic, or palliative treatment. Treatment must be performed, directed, or supervised by a state-licensed health professional. Medical services include room and board provided during a medical confinement and in-kind medical items. (7-1-24)

02. Social Service. Any service, other than medical. Housebound and Aid and Attendance Allowances, including Unusual Medical Expense Allowances, received from the Veterans Administration are excluded. (7-1-24)

334. HOME ENERGY ASSISTANCE (HEA) AND SUPPORT AND MAINTENANCE ASSISTANCE (SMA).
HEA and SMA are excluded. (7-1-24)

335. (RESERVED)

336. 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 participant are excluded. In-home supportive services include attendant care, chore services, and homemaker services. (7-1-24)

337. INCOME EXCLUDED BY LAW.
Any income excluded by federal statute is excluded. (7-1-24)

338. INFREQUENT OR IRREGULAR INCOME.
The first thirty dollars ($30) of earned income and the first sixty dollars ($60) of unearned income per calendar quarter are excluded when they are infrequent or irregular payments. Income is infrequent if the participant receives it once in a calendar quarter from a single source. Income is irregular if the participant could not reasonably expect to receive it. (7-1-24)

339. (RESERVED)

340. LOANS.
Loans are excluded if the participant has signed a written repayment agreement. The signed agreement must state how the loan will be repaid. The signed written agreement can be obtained after the loan is received. Items bought on credit are paid with a loan and are not income. Money repaid to a participant on the principal of a loan is not income, it is a resource. Interest received by a participant on money loaned by them is countable income. (7-1-24)

341. (RESERVED)

342. NATIVE AMERICAN PAYMENTS.
Payments authorized by law made to people of Native American ancestry are excluded. (7-1-24)

343. (RESERVED)

344. NUTRITION PROGRAMS FOR OLDER AMERICANS.
Payments, other than a wage or salary, made under Chapter 35, Title 42, USC, Programs for Older Americans, are excluded. (7-1-24)

345. PERSONAL SERVICES.
A personal service performed for a participant is excluded. Personal services include lawn mowing, house cleaning, grocery shopping, and babysitting. (7-1-24)

346. (RESERVED)

347. REBATES, REFUNDS, AABD UNDERPAYMENTS, AND REPLACEMENT CHECKS.
Rebates, refunds, AABD underpayments, and returns of money already paid are excluded. A replacement check is excluded. (7-1-24)

348. RELOCATION ASSISTANCE.

Relocation payments under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, Subchapter II, Chapter 61, Title 42, USC, are excluded. Relocation payments paid to civilians of World War II per PL 100-383, are excluded. (7-1-24)

349. REPLACEMENT OF INCOME ALREADY RECEIVED.
Replacement of a participant's lost, stolen, or destroyed income is excluded. (7-1-24)

350. RETURN OF MISTAKEN PAYMENTS.
A returned mistaken payment is excluded. If the participant keeps the mistaken payment, it is income. (7-1-24)

351. TAX REFUNDS.
Refunds of federal, State, or local taxes paid on income, real property, or food bought by the participant and their family, are excluded. (7-1-24)

352. UTILITY PAYMENTS.
Payments for utility costs made to low-income housing tenants by a local housing authority are excluded when paid directly to the tenant or jointly to the tenant and the utility company. (7-1-24)

353. (RESERVED)

354. VICTIMS' COMPENSATION PAYMENTS.
Any payment made from a State-sponsored fund to aid victims of crime is excluded. (7-1-24)

355. 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, are excluded. (7-1-24)

356. VOLUNTEER SERVICES INCOME.
Payments to volunteers under Chapter 66, Title 42, USC Domestic Volunteer Services (ACTION programs) are excluded. 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. (7-1-24)

357. WALKER V. BAYER PAYMENTS.
Class action settlement payments in Susan Walker v. Bayer Corporation, et al., are excluded for Medicaid but not for AABD cash. (7-1-24)

358. WEATHERIZATION ASSISTANCE.
Weatherization assistance is excluded. (7-1-24)

359. TEMPORARY CENSUS INCOME.
For Medicaid only, all wages paid by the Census Bureau for temporary employment related to US Census activities are excluded. (7-1-24)

360. -- 399. (RESERVED)

400. EARNED INCOME.
Earned income remaining after disregards and exclusions are subtracted, is counted in computing AABD cash. Wages are counted the month they become available to the participant. (7-1-24)

401. COMPUTING SELF-EMPLOYMENT INCOME.
Countable self-employment income is the difference between the gross receipts and the allowable costs of producing the income, if the amount is expected to continue. Self-employment income is computed using one (1) of the methods listed in Subsections 401.01 through 401.03 of this rule. Subsection 401.04 of this rule can be used as an income deduction, if applicable. (7-1-24)

01. Self-Employed at Least One Year. For individuals who are self-employed for at least one (1) year, income and expenses are averaged over the past twelve (12) months. (7-1-24)

02. Self-Employed Less Than One Year. For individuals who are self-employed for less than one (1) year, income and expenses are averaged over the months the business has been in operation. (7-1-24)

03. Monthly Increase or Decrease. If a monthly average does not reflect actual monthly income because of an increase or decrease in business, the self-employment income is counted monthly. This method is not used for businesses with seasonal or unusual income peaks at certain times of the year. (7-1-24)

04. Net Self-Employment Income Seven and Sixty-Five Hundredths Percent Deduction. If net self-employment income is over four hundred dollars ($400) per year, seven and sixty-five hundredths percent (7.65%) is deducted. This deduction compensates for Social Security taxes paid. If self-employment Social Security tax is not paid, this deduction is not allowed. (7-1-24)

402. SELF-EMPLOYMENT ALLOWABLE EXPENSES.
Allowable operating expenses subtracted from self-employment income are the allowable Internal Revenue Service self-employment expenses, except for those listed under Section 403 of these rules. (7-1-24)

403. SELF-EMPLOYMENT EXPENSES NOT ALLOWED.
Self-employment expenses not allowed are as follows: (7-1-24)

01. Payments on the Principal of Real Estate. Payments on the principal of real estate mortgages on income-producing property. (7-1-24)

02. Purchase of Capital Assets or Durable Goods. Purchases of capital assets, equipment, machinery, and other durable goods. Payments on the principal of loans for these items. (7-1-24)

03. Federal, State, and Local Income Taxes. (7-1-24)

04. Savings. Monies set aside for future use such as retirement or work-related expenses. (7-1-24)

05. Labor Paid to Any Family Member. (7-1-24)

06. Loss of Farm Income Subtracted From Other Income. (7-1-24)

07. Personal Transportation. (7-1-24)

08. Net Losses from Previous Periods. (7-1-24)

404. ROYALTIES.
Royalties received as part of a trade or business, or for publication of the participant's work, are earned income. Other royalties are unearned income. (7-1-24)

405. HONORARIA.
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. (7-1-24)

406. SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER PAYMENTS.
Payments for services performed in a sheltered workshop or work activities center are earned income. (7-1-24)

407. JOB TRAINING PARTNERSHIP ACT (JTPA).
JTPA payments are earned income. JTPA payments for child care, transportation, medical care, meals, and other reasonable expenses, provided in cash or in-kind, are not income. (7-1-24)

408. PROGRAMS FOR OLDER AMERICANS.
Wages or salary paid under Chapter 35, Title 42, USC, Programs for Older Americans, is earned income. (7-1-24)

409. UNIFORMED SERVICES PAY AND ALLOWANCES.
Basic pay is earned income. All other pay and allowances are unearned income. (7-1-24)

410. RENTAL INCOME.
Net rental income is unearned income, unless from the business of renting real property. Net unearned rental income is gross rent less the expenses on the rental property as listed below. Net rental income from the business of renting properties is self-employment earned income. (7-1-24)

01. Interest. Interest and escrow portions of a mortgage payment. (7-1-24)

02. Real Estate Insurance. (7-1-24)

03. Repairs. Minor repairs to an existing rental structure. (7-1-24)

04. Property Taxes. (7-1-24)

05. Yard Care. Lawn care, including tree and shrub care and snow removal. (7-1-24)

06. Advertising Costs for Tenants. (7-1-24)

411. OVERPAYMENT WITHHOLDING OF UNEARNED INCOME.
Money withheld by any benefit program to recover an overpayment is counted as income. Money withheld is not income if the overpaid benefit amount was used to compute AABD cash. (7-1-24)

412. RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI).
RSDI monthly benefits are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. (7-1-24)

413. SSI PAYMENTS.
SSI monthly payments are unearned income. The income is the amount reported by SSA, regardless of penalties to recover an SSI overpayment. An advance SSI payment to an applicant appearing SSI-eligible with a financial emergency, is not income the month received. When SSA reduces ongoing SSI to recover the advance, the SSI payment before the reduction continues to be counted as income. (7-1-24)

414. BLACK LUNG BENEFITS.
Black Lung payments are unearned income. (7-1-24)

415. RAILROAD RETIREMENT PAYMENTS.
Railroad Retirement Board payments are unearned income. (7-1-24)

416. UNEMPLOYMENT INSURANCE BENEFITS.
Unemployment insurance benefits received under state and federal unemployment laws are unearned income. (7-1-24)

417. UNIFORM GIFTS TO MINORS ACT (UGMA).
UGMA payments from the custodian to the minor are income to the minor. UGMA property, including earnings or additions, are not income to the minor until the month the minor becomes eighteen (18) years old. (7-1-24)

418. WORKERS' COMPENSATION.
Workers' compensation, less expenses required to get the payment, is unearned income. (7-1-24)

419. MILITARY PENSIONS.
Military pensions are unearned income. (7-1-24)

420. VA PENSION PAYMENTS.
VA pension payments are unearned income. The twenty dollar ($20) standard disregard is not subtracted, except by a special act of Congress. (7-1-24)

421. VA COMPENSATION PAYMENTS.
VA compensation payments to a veteran, spouse, child, or widow(er) are unearned income. (7-1-24)

422. VA EDUCATIONAL BENEFITS.
VA educational payments funded by the government are excluded. (7-1-24)

423. ALIMONY, SPOUSAL, AND ADULT SUPPORT.
Alimony, spousal, and other adult support payments are unearned income. (7-1-24)

424. 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 TAFI payments is not income. (7-1-24)

425. DIVIDENDS AND INTEREST.
Dividends and interest are unearned income. (7-1-24)

426. AWARDS, GIFTS, PRIZES.
Awards, gifts, and prizes are unearned income. (7-1-24)

427. WORK-RELATED UNEARNED INCOME.
Work-related payments that are not salary or wages are unearned income. (7-1-24)

428 – 430. (RESERVED)

431. FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS.
FEMA funds are unearned income, unless excluded by the type of aid, such as medical services or Support and Maintenance Assistance. (7-1-24)

432. BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE (BIA GA).
BIA GA payments are unearned income and are federally funded income based on need. They are paid in cash or in-kind. The twenty dollar ($20) standard disregard is not subtracted. (7-1-24)

433. BIA ADULT CUSTODIAL CARE (ACC) AND CHILD WELFARE ASSISTANCE (CWA) PAYMENTS.
BIA ACC and CWA payments, other than foster care made to participants out of an institution, are unearned income. (7-1-24)

434. INDIVIDUAL INDIAN MONEY (IIM) ACCOUNTS.
Deposits to an unrestricted IIM account are income in the month deposited. (7-1-24)

435. ACCELERATED LIFE INSURANCE INCOME.
Accelerated life insurance payments are unearned income in the month received. (7-1-24)

436. REAL ESTATE CONTRACT INCOME.
Payments received on the interest of a negotiable real estate contract are unearned income for Medicaid eligibility. Payments received on the principal of a negotiable real estate contract are a resource for Medicaid eligibility. Payments received on a nonnegotiable real estate contract are unearned income. Principal and interest payments received on an excluded real estate contract of a long-term care participant are unearned income for patient liability. (7-1-24)

437. LIMITED AWARD TO CHILD WITH LIFE-THREATENING CONDITION.
Any gift from a tax-exempt nonprofit organization to a child under age eighteen (18), who has a life-threatening condition, is excluded from income under the conditions below. (7-1-24)

01. In-Kind Gift. Is excluded if the gift is not converted to cash. (7-1-24)

02. Cash Gifts. Are excluded up to two thousand dollars ($2,000) for the calendar year the cash gifts are made. (7-1-24)

438. -- 450. (RESERVED)

451. DEEMING INCOME.
Income deeming counts the income of another person as available to an AABD participant, for eligibility and the amount of AABD cash. Income is deemed to the participant from their ineligible spouse, and to the child participant from their ineligible parent. Income deeming starts the first full calendar month the participant is in a deeming situation. Deeming ends the first full calendar month the participant is not in a deeming situation. Deeming to a child ends the month after the child's eighteenth birthday. (7-1-24)

01. Ineligible Parent. A natural or adoptive parent or stepparent, who does not receive AABD and lives in the same household as a child. (7-1-24)

02. Ineligible Spouse. A participant's spouse living with the participant and not receiving AABD is an ineligible spouse. The ineligible spouse of the parent of a child participant, living with the child participant and their parent, is an ineligible spouse. (7-1-24)

03. Ineligible Child. A child under age twenty-one (21) who does not receive AABD, and lives with the AABD participant. (7-1-24)

04. Income Deeming Exclusions. Income excluded from deeming is listed in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. (7-1-24)

452. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT.
Income is deemed from an ineligible spouse to the participant, if they live together. Income is deemed as described in Subsections 452.01 through 452.08 POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. (7-1-24)

453. DEEMING INCOME FROM INELIGIBLE PARENT TO AABD CHILD.
Income is deemed from an ineligible parent, or their ineligible spouse, to a child participant under age eighteen (18) living in the same household. A stepparent's income is deemed to the child for AABD cash, but not Medicaid. The income is deemed as described in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. (7-1-24)

454. DEEMING INCOME FROM ESSENTIAL PERSON TO PARTICIPANT.
If a participant and an essential person live in the same household, the essential person's income is deemed to the participant. If essential person deeming makes the participant ineligible, the Department will not use essential person deeming. The income is deemed as described in Subsections 454.01 through 454.06 POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. (7-1-24)

455. DEEMING INCOME FROM INELIGIBLE SPOUSE TO PARTICIPANT AND CHILD PARTICIPANT.
If a participant, their ineligible spouse, and their child participant live in the same household, income is deemed from the participant to the child participant. The income is deemed as described in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. (7-1-24)

456. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN PARTICIPANT -- NO I-864 AFFIDAVIT OF SUPPORT.
The Department will deem income as described in this rule, if the legal non-citizen's sponsor signed an affidavit of support other than the I-864. The deemed income is counted, even if the participant does not live in the sponsor's household. The sponsor's income is not deemed to the participant for Medicaid. (7-1-24)

01. Three-Year Limit. The deeming period, regardless of admission date, is three (3) years after the date the legal non-citizen is lawfully admitted. Deeming stops the end of the month, three (3) years from the date the

sponsored participant lawfully entered the US for permanent residence. (7-1-24)

02. Sponsored Legal Non-Citizen Exempt from Deeming. A lawfully admitted legal non-citizen participant is exempt from sponsor deeming if one (1) or more of the following conditions applies. (7-1-24)

a. The legal non-citizen was admitted to the US as a refugee, asylee, or parolee. (7-1-24)

b. The legal non-citizen first applied for AABD before October 1, 1980. (7-1-24)

c. The legal non-citizen is a lawful permanent resident. (7-1-24)

d. The legal non-citizen's entry into the US was sponsored by a church, other social service organization, or an employer who has offered them a job. (7-1-24)

e. The legal non-citizen becomes blind or disabled after they are admitted to the US. (7-1-24)

f. The legal non-citizen was sponsored by and resides in the same household with their ineligible spouse or ineligible parent. The Department will use ineligible spouse and ineligible parent deeming, not sponsor deeming. (7-1-24)

g. The legal non-citizen's sponsor dies. (7-1-24)

h. The legal non-citizen was legalized under the Immigration Reform and Control Act of 1986. (7-1-24)

i. The legal non-citizen has lived in the US for thirty-six (36) months beginning with the month they were admitted for permanent residence or granted permanent residence status. (7-1-24)

j. The legal non-citizen was admitted under Section 249 of the INA as a registry legal non-citizen. (7-1-24)

k. The legal non-citizen 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 their spouse or child. (7-1-24)

l. The legal non-citizen is an applicant for adjustment under the Cuban/Haitian provisions of Section 202 of the Immigration Reform and Control Act of 1986. (7-1-24)

03. Sponsor/Legal Non-Citizen Relationships. Sponsor/legal non-citizen relationships and deeming rules are listed in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules. (7-1-24)

04. Sponsor to Legal Non-Citizen Deeming Procedures. The Department will budget the legal non-citizen's actual needs, as if they are a single person living alone. The Department will subtract the legal non-citizen's own income, less exclusions and disregards. The Department will subtract the couple's income, less exclusions, from their needs. If there is no budget deficit, the participant is not eligible. If there is a budget deficit, the Department will follow the procedures in POMS Chapter SI 01320.000, incorporated by reference under Subsection 002.02 of these rules, to compute sponsor deemed income. (7-1-24)

457. DEEMING INCOME FROM SPONSOR TO LEGAL NON-CITIZEN -- SPONSOR SIGNED INS FORM I-864 AFFIDAVIT OF SUPPORT.

If the legal non-citizen's sponsor has signed an INS form I-864 Affidavit of Support, all income of the sponsor and the sponsor's spouse is deemed to the legal non-citizen for AABD cash and Medicaid eligibility. Deeming continues until the legal non-citizen becomes a naturalized citizen or has forty (40) quarters of work. Exceptions are listed below: (7-1-24)

01. Battery Exception. The legal non-citizen or the legal non-citizen child's parent was battered or subjected to extreme cruelty in the US. There is a substantial connection between the battery and the participant's need for assistance. The person subjected to the battery or cruelty no longer lives with the person responsible for the battery or cruelty. (7-1-24)

02. Indigence. Alien sponsor deeming is suspended for twelve (12) months, if the legal non-citizen is not able to get food and shelter without AABD cash. (7-1-24)

458. -- 499. (RESERVED)

500. FINANCIAL NEED.
The participant has financial need if their allowances, as described in Sections 501 through 513 of these rules, are more than their income. (7-1-24)

501. BASIC ALLOWANCE.
Each participant receives a basic allowance unless they live in a nursing facility. The basic allowance for each living arrangement is listed in this rule. The Semi-Independent Group Residential Facility, Room and Board, Residential and Assisted Living Facility, and Certified Family Home basic allowances do not change with the annual cost-of-living increase in the federal SSI benefit amount. (7-1-24)

01. Single Participant. A participant is budgeted five hundred forty-five dollars ($545) monthly as a basic allowance when living in a situation listed below. Beginning January 1, 2001, the basic allowance increase for a single participant is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a single person. (7-1-24)

a. Living alone. (7-1-24)

b. Living with their ineligible spouse. (7-1-24)

c. Living with another participant who is not their spouse. (7-1-24)

d. Living in another's household. This includes a living arrangement where the participant purchases lodging (room) and meals (board) from their parent, child, or sibling. (7-1-24)

e. Living with their TAFI child. (7-1-24)

02. Couple or Participant Living with Essential Person. A participant living with their participant spouse or their essential person is budgeted seven hundred sixty-eight dollars ($768) monthly as a basic allowance. Beginning January 1, 2001, the basic allowance increase for a couple is the dollar amount of the annual cost-of-living increase in the federal SSI benefit rate for a couple. The increase may be rounded up. (7-1-24)

03. SIGRIF. A participant living in a semi-independent group residential facility (SIGRIF) is budgeted three hundred forty-nine dollars ($349) monthly as a basic allowance. (7-1-24)

502. SPECIAL NEEDS ALLOWANCES.
Special needs allowances are a restaurant meals allowance and a service animal food allowance. (7-1-24)

01. Restaurant Meals Allowance. Is fifty dollars ($50) monthly. A physician must state the participant is physically unable to prepare food in their home. A participant able to prepare their food, but living in a place where cooking is not permitted, may be budgeted the restaurant meals allowance for up to three (3) months. (7-1-24)

02. Service Animal Food Allowance. Is seventeen dollars ($17) monthly. The allowance is budgeted for a blind or disabled participant using a trained service animal. (7-1-24)

503. -- 511. (RESERVED)

512. ROOM AND BOARD HOME ALLOWANCE.
Room and board is a living arrangement where the participant purchases lodging (room) and meals (board) from a person they live with who is not their parent, child, or sibling. (7-1-24)

01. Budgeted Room and Board Allowance. Beginning January 1, 2006, a participant living in a room and board home is budgeted six hundred ninety-three dollars ($693). Beginning July 1, 2013, the Room and Board allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The room and board allowance increase will be rounded to the next dollar. (7-1-24)

02. Basic Allowance for Participant in Room and Board Home. A participant living in a room and board home is budgeted seventy-seven dollars ($77) monthly as a basic allowance. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. (7-1-24)

513. RESIDENTIAL ASSISTED LIVING FACILITY (RALF) AND CERTIFIED FAMILY HOME (CFH) ALLOWANCES.
A participant living in a RALF under IDAPA 16.03.22, "Residential Assisted Living Facilities," or a CFH, under IDAPA 16.03.19, "Certified Family Homes," is budgeted a basic allowance of ninety-six dollars ($96) monthly. Beginning July 1, 2013, this basic allowance will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. The basic allowance increase will be rounded to the nearest dollar. (7-1-24)

01. Budgeted Monthly Allowance Based on Level of Care. A participant is budgeted a monthly allowance for care based on the level of care received as described in Section 515 of these rules. If the participant does not require State Plan Personal Care Services (PCS), their eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. (7-1-24)

02. Care Levels and Monthly Allowances. Beginning January 1, 2006, care levels and monthly allowances are those listed in Table 513.02 below. Beginning July 1, 2013, the RALF and CFH allowances for participants living in a RALF or CFH on State Plan PCS will be adjusted annually by the percentage of the annual cost-of-living increase in the federal SSI benefit rate for a single person. This adjustment will be effective on January 1st of each year. This increase will be rounded to the next dollar.

TABLE 513.02 - STATE PLAN PCS CARE LEVELS AND ALLOWANCES AS OF 1-1-06

	Level of Care	Monthly Allowance
a.	Level I	Eight hundred and thirty-five dollars ($835)
b.	Level II	Nine hundred and two dollars ($902)
c.	Level III	Nine hundred and sixty-nine dollars ($969)

(7-1-24)

03. CFH Operated by Relative. A participant living in a CFH operated by their parent, child, or sibling is not entitled to the CFH State Plan PCS allowances. They may receive the allowance for a person living with a relative as described in Section 501 of these rules. A relative for this purpose is the participant's parent, child, sibling, aunt, uncle, cousin, niece, nephew, grandparent, or grandchild by birth, marriage, or adoption. (7-1-24)

514. AABD CASH PAYMENTS.
Only a participant who receives an SSI payment for the month is eligible for an AABD cash payment in the same month. The AABD cash payment amount is based on the participant's living arrangement described in Subsections 514.01 through 514.04 of this rule. An AABD cash payment is the difference between a participant's financial need

and their countable income. If the difference is not an even dollar amount, AABD cash is paid at the next higher dollar. (7-1-24)

01. Single Participant Maximum Payment. For a single participant described in Subsection 501.01 of these rules, the maximum monthly AABD cash payment amount is fifty-three dollars ($53). (7-1-24)

02. Couple or Participant Living with Essential Person Maximum Amount. For participants described in Subsection 501.02 of these rules, the maximum monthly AABD cash payment amounts are: (7-1-24)

a. A couple receives twenty dollars ($20); or (7-1-24)

b. A participant living with essential person receives eighteen dollars ($18). (7-1-24)

03. Semi-Independent Group Maximum Payment. For a participant described in Subsection 501.03 of these rules, the maximum monthly AABD cash payment amount is one hundred sixty-nine dollars ($169). (7-1-24)

04. Room and Board Maximum Payment. For a participant described in Section 512 of these rules, the maximum monthly AABD cash payment is one hundred ninety-eight dollars ($198). (7-1-24)

05. RALF and CFH. A participant residing in a RALF or CFH is not eligible for an AABD cash payment. (7-1-24)

515. RALF CARE AND CFH ASSESSMENT AND LEVEL OF CARE.

The participant's need for care, level of care, plan of care, and the RALF's or CFH's ability to provide care is assessed by the Bureau of Long-Term Care (BLTC) when a participant is admitted. The BLTC must approve the placement before Medicaid can be approved. (7-1-24)

516. CHANGE IN LEVEL OF CARE.

A change in the participant's level of care affects eligibility as listed below. (7-1-24)

01. Increase in Level of Care. Is effective the month the BLTC reassesses the level of care. (7-1-24)

02. Decrease in Level of Care. When the BLTC verifies the participant has a decrease in their level of care, and their income exceeds their new level of care, their Medicaid must be stopped after timely notice. When the BLTC determines the participant no longer meets any level of care, their eligibility and allowances are based on the Room and Board rate in Section 512 of these rules. (7-1-24)

517. -- 523. (RESERVED)

524. MOVE FROM NURSING HOME OR HOSPITAL.

If a participant moves from a nursing home or hospital to a different living situation, other than a RALF or CFH, their AABD cash for the month is determined as if they lived in their new situation the entire month. Their AABD cash is their AABD allowances less their countable income. (7-1-24)

525. -- 530. (RESERVED)

531. COUPLE BUDGETING.

Income of an AABD participant and their participant spouse living in the same household is combined. The twenty dollar ($20) standard income disregard and the sixty-five dollar ($65) earned income disregard are subtracted once a month, per couple. Each member of a couple living in an institution must have income budgeted as a single person. 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. For couple budgeting, a household is a home, a rental, another's household, or room and board. (7-1-24)

532. -- 539. (RESERVED)

540. STANDARD DISREGARD.
The standard disregard is twenty dollars ($20), and 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. The participant retains the standard disregard for their personal use. (7-1-24)

01. Standard Disregard and a Couple. The Department will subtract the standard disregard only once a month from the combined income of a couple in the same household. (7-1-24)

02. Standard Disregard Exception. The standard disregard must not be subtracted from nonservice-connected VA payments, Title IV-E foster care payments, or BIA General Assistance. (7-1-24)

541. SUBTRACTION OF EARNED INCOME DISREGARDS.
Earned income disregards are subtracted from AABD earned income in the order listed in Sections 542 through 547. They are subtracted the month the income is paid. (7-1-24)

542. SIXTY-FIVE DOLLAR EARNED INCOME DISREGARD.
Sixty-five dollars ($65) of earned income in a month are not counted. The Department will subtract the sixty-five dollar ($65) disregard only once a month from the combined income of a couple in the same household. The sixty-five dollar ($65) disregard is a work incentive. The participant retains the sixty-five dollar ($65) disregard for their personal use. (7-1-24)

543. IMPAIRMENT-RELATED WORK EXPENSE (IRWE) DISREGARD.
IRWEs are items and services needed and used by a disabled AABD participant to work. The items must be needed because of the participant's impairment, and may be bought or rented. The cost for IRWEs is subtracted from the participant's earned income, for eligibility and AABD cash amount. An item disregarded as a blindness work expense, or as part of a PASS, cannot be disregarded as an IRWE. (7-1-24)

544. ONE-HALF REMAINING EARNED INCOME DISREGARD.
One-half (1/2) of remaining earned income, after the IRWE is subtracted, is not counted. The one-half (1/2) of remaining earned income is a work incentive. The participant retains the one-half (1/2) of remaining earned income for their personal use. (7-1-24)

545. BLINDNESS WORK EXPENSE DISREGARD.
The cost of earning income is subtracted from the earned income of a blind person. The blind person must be under age sixty-five (65). If the blind person is age sixty-five (65) or older, they must receive SSI for blindness, or have received AABD the month before they became sixty-five (65). (7-1-24)

01. Blind Work Expense Limit. Blindness work expenses are subtracted from earned income. The amount subtracted must not exceed the participant's monthly earnings. (7-1-24)

02. No Duplication for Blind Work Expenses. Expenses, subtracted under the IRWE disregard, cannot be subtracted again under this disregard. (7-1-24)

546. PLAN TO ACHIEVE SELF-SUPPORT (PASS).
A blind or disabled participant, with an approved PASS, must have income and resources disregarded. Conditions for this disregard are listed below. (7-1-24)

01. Under Age Sixty-Five. The participant must be under sixty-five (65), or receive AABD for the blind or disabled during the month of their sixty-fifth birthday. (7-1-24)

02. Approved PASS. A participant receiving SSI must have a PASS approved by SSA. A participant not receiving SSI must have a PASS approved by the Department. (7-1-24)

03. Income Necessary for Self-Support. The income and resources disregarded under the PASS must be necessary for the participant to achieve self-support. (7-1-24)

547. PASS APPROVED BY DEPARTMENT.

A PASS approved by the Department must be in writing, and contain all the following items: (7-1-24)

01. Occupational Objective. The PASS must have a specific occupational objective. (7-1-24)

02. Specific Goals. The PASS must have specific goals for using the disregarded income and resources to achieve self-support. (7-1-24)

03. Time Limit. The PASS must show a specific target date to achieve the goal. An approved PASS is limited to an initial period of eighteen (18) months. Extensions may be granted if needed. (7-1-24)

a. The first extension period lasts up to eighteen (18) months. (7-1-24)

b. A second eighteen (18) month extension period can be granted. (7-1-24)

c. A final extension, up to twelve (12) months can be granted. The PASS can be extended a total of forty-eight (48) months, when the original PASS goal required extensive education or vocational training. (7-1-24)

04. No Duplication of Disregards. An item disregarded as an IRWE or under the blindness exception cannot be disregarded under the PASS. (7-1-24)

05. Resource Limitation. The PASS disregard must not be used for resources, unless the resources cause the participant to be ineligible without the PASS disregard. (7-1-24)

06. Disregard of Resources. The PASS must list the participant's resources. The PASS must list any resources the participant will receive under the plan, and show how the resources will be used toward the occupational goal. The PASS must list goal-related items or activities requiring savings or purchases and the amounts the participant plans to save or spend, and list resources disregarded under the plan. The PASS must show resources disregarded under the plan can be identified separate from the participant's other resources. (7-1-24)

548. -- 599. (RESERVED)

600. DEPARTMENT NOTICE RESPONSIBILITY.
The participant must be notified of changes in eligibility or AABD cash amount. The notice must give the effective date, the reason for the action, the rule that supports the action, and appeal rights. See 42 CFR 435.917. (7-1-24)

601. ADVANCE NOTICE RESPONSIBILITY.
When a reported change results in closure or decrease, the participant must be notified at least ten (10) calendar days before the effective date of the action. (7-1-24)

602. ADVANCE NOTICE NOT REQUIRED.
Advance notice is not required when a condition listed below exists. The participant must be notified by the date of the action. (7-1-24)

01. The Department has Proof of the Participant's Death. (7-1-24)

02. Participant Requests Closure in Writing. (7-1-24)

03. Participant in Institution. The participant is admitted or committed to an institution. Further payments to the participant do not qualify for federal financial participation under the State Plan. (7-1-24)

04. Nursing Care. The participant is placed in a nursing facility or an ICF/IID. (7-1-24)

05. Participant Address Unknown. The participant's whereabouts are unknown. Department mail is returned with no forwarding address. (7-1-24)

06. Participant is Approved for Aid in Another State. (7-1-24)

07. Eligible One Month. The participant is eligible for aid only during the calendar month of their application for aid. (7-1-24)

08. Non-Citizen With Emergency. The participant is an illegal or legal non-citizen whose Medicaid eligibility ends the day their emergency medical condition stops. (7-1-24)

09. Retroactive Medicaid. The participant's Medicaid eligibility is for a prior period. (7-1-24)

10. Special Allowance. A special allowance granted for a specific period is stopped. (7-1-24)

11. Patient Liability or Participant Participation Changes. (7-1-24)

12. Participant's Level of Care Changes. (7-1-24)

603. (RESERVED)

604. PARTICIPANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
If the SSA finds a participant is blind or disabled, based on an appeal of an SSA decision, the participant meets the disability requirements for AABD cash and related Medicaid on the effective date determined by SSA. AABD cash payments are effective no earlier than the month SSA issues the favorable decision for SSI payments. (7-1-24)

605. REPORTING REQUIREMENTS.
The participant must report changes in circumstances verbally or in writing, by the tenth of the month following the month in which the change occurred. The participant must show good cause for not reporting changes. If failure to report a change results in an overpayment, the overpayment must be recovered. (7-1-24)

606. REQUIRED PROOF.
The participant must prove continuing eligibility for aid when a change could affect eligibility, and is allowed ten (10) calendar days to provide requested proof. The case is closed if the participant does not provide proof within ten (10) days and does not have good cause for not providing proof. (7-1-24)

607. CHANGES AFFECTING ELIGIBILITY OR AABD CASH AMOUNT.
If a participant reports a change that results in an increase, AABD cash is increased effective the month of report. If a participant reports a change that results in a decrease, AABD cash is decreased or ended effective the first month after proper notice. (7-1-24)

608. AABD CASH UNDERPAYMENT.
If the Department is at fault for issuing a payment less than the participant should have received, the Department will issue a supplemental payment for the difference. (7-1-24)

609. AABD CASH OVERPAYMENT.
If the participant is paid more AABD cash than they are eligible for, the Department must collect the overpayment. The Department must notify the participant of the right to a hearing, the method for repayment, and the need for a repayment interview. (7-1-24)

610. OFFSET OF OVERPAYMENT AND UNDERPAYMENT.
When an underpayment is computed, any overpayment for that month is subtracted from the underpayment. When an overpayment is computed, any underpayment for the month is subtracted. (7-1-24)

611. -- 616. (RESERVED)

617. HEARING REQUEST.
A participant may request a hearing to contest a Department decision. The participant must make the request within ninety (90) days of the date the Department mailed the notice of decision. Hearings will be conducted according to IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings." (7-1-24)

618. CONTINUED BENEFITS PENDING A HEARING DECISION.

The participant may continue to receive benefits upon request, pending the hearing decision. The Department must receive the participant's request for continued benefits before the effective date of the Department's action stated in the notice of decision. An applicant cannot receive continued benefits when appealing a denial for failure to provide citizenship and identity verification after the expiration of a reasonable opportunity period. (7-1-24)

01. Amount of Assistance. The Department will continue the participant's assistance at the current month's level while the hearing decision is pending, unless another change affecting assistance occurs. (7-1-24)

02. Continued Eligibility. The participant must continue to meet all eligibility requirements not related to the hearing issue. (7-1-24)

03. Overpayment. When the hearing decision is in the Department's favor, the participant must repay assistance received while the hearing decision was pending. (7-1-24)

619. (RESERVED)

620. MEDICAID OVERPAYMENT.
If the participant receives Medicaid services during a month they are not eligible, the Department must collect the overpayment. If too little patient liability or participant participation is computed, the Department must collect the overpayment. The participant must be notified of the overpayment. (7-1-24)

621. CHANGES IN PATIENT LIABILITY.

01. Increase in Patient Liability. If the patient liability is increased for the current or a past month, the Department will collect the patient liability directly from the participant. (7-1-24)

02. Decrease in Patient Liability. If the patient liability is decreased for a current or past month, the funds will be paid to the provider and the provider must reimburse the participant for the portion of the costs the participant paid more than their patient liability. (7-1-24)

622. (RESERVED)

623. ELIGIBILITY REDETERMINATION.
An eligibility redetermination is completed at least once every year and when a change affecting eligibility occurs. (7-1-24)

624. -- 649. (RESERVED)

650. COOPERATION WITH THE QUALITY CONTROL PROCESS.
When the Department or federal government selects a case for review in the quality control process, the participant must cooperate in the review of the case. Benefits must be stopped, following advance notice, when a participant is unwilling to take part in the quality control process. If the participant reapplies for benefits, they must fully cooperate with the quality control process before the application can be approved. (7-1-24)

651. -- 699. (RESERVED)

700. MEDICAID ELIGIBILITY.
A participant must meet the eligibility requirements for at least one (1) Medicaid coverage group to be eligible for Medicaid benefits. Income and circumstances in the current month are used for eligibility for the current month. Resources are counted as of the first moment of the month. (7-1-24)

701. MEDICAID APPLICATION.
An adult participant, a legal guardian, or a representative of the participant must sign the application. The participant must submit the application to the Department. A Medicaid application may be made for a deceased person. (7-1-24)

702. MEDICAL SUPPORT COOPERATION.
Medical support rights are assigned to the Department by signature on the application. The participant must cooperate

with the Department to secure medical support and payments to be eligible for Medicaid. The participant must cooperate on behalf of themself and any participant for whom they can legally assign rights. A participant who cannot legally assign their own rights must not be denied Medicaid if the legally responsible person does not cooperate. (7-1-24)

703. CHILD SUPPORT COOPERATION.
The participant must cooperate to identify and locate the noncustodial parent, establish paternity, and establish, modify, and enforce a child medical support order to be eligible for Medicaid. This includes support payments received directly from the noncustodial parent. The cooperation requirement is waived for poverty level pregnant women exempt from cooperating in establishing paternity and obtaining medical support from, or derived from, the father of a child born out of wedlock. A participant who cannot legally assign their own rights must not be denied Medicaid if the legally responsible person does not cooperate. (7-1-24)

704. COOPERATION DEFINED.
Cooperation includes providing all information to identify and locate the noncustodial parent. Cooperation for Medicaid includes identifying other liable third-party payers. (7-1-24)

01. Name of Noncustodial Parent. The participant must provide the first and last name of the noncustodial parent. (7-1-24)

02. Information About Noncustodial Parent. The participant must also provide at least two (2) pieces of information, about the noncustodial parent, listed below: (7-1-24)

a. Birth Date. (7-1-24)

b. SSN. (7-1-24)

c. Current address. (7-1-24)

d. Current phone number. (7-1-24)

e. Current employer. (7-1-24)

f. Make, model, and license number of any motor vehicle owned by the noncustodial parent. (7-1-24)

g. Names, phone numbers, and addresses of the parents of the noncustodial parent. (7-1-24)

705. GOOD CAUSE FOR NOT COOPERATING IN SECURING MEDICAL AND CHILD SUPPORT.
The participant may claim good cause for failure to cooperate in securing medical and child support for themself or a minor child. Good cause is limited to the following: (7-1-24)

01. Rape or Incest. There is proof the child was conceived because of incest or rape. (7-1-24)

02. Physical or Emotional Harm. There is proof the child's non-custodial parent may inflict physical or emotional harm to the participant, the child, the custodial parent, or the caretaker relative. There is proof another person may inflict physical or emotional harm to an AABD-related participant if the participant cooperates in securing medical and child support. (7-1-24)

03. Minimum Information Cannot Be Provided. Substantial and credible proof is provided indicating the participant cannot provide the minimum information regarding the non-custodial parent. (7-1-24)

706. CLOSURE AFTER REVIEW OF GOOD CAUSE REQUEST.
If the participant claims good cause for not cooperating, but the Department determines there is not good cause, the participant must be given the opportunity to withdraw the application or have their Medicaid closed. (7-1-24)

707. APPLICATION REQUIREMENTS FOR POTENTIAL MEDICAL COVERAGE.

01. Group Health Plan Enrollment Requirement. Each participant must apply for and enroll in a cost-effective employer group health plan as a condition of eligibility for Medicaid. Medicaid coverage must not be denied, delayed, or stopped pending the start of a participant's group health insurance coverage. A child entitled to enroll in a group health plan must not be denied Medicaid coverage solely because their caretaker fails to apply for the child's enrollment. (7-1-24)

02. Medicare Enrollment Requirement. Each participant who may be eligible for Medicare must apply for all parts of Medicare parts A, B, and D for which they are likely to be eligible, as a condition of eligibility for Medicaid. (7-1-24)

708. MEDICAID QUALIFYING TRUST PAYMENTS.
For Medicaid Qualifying Trusts established before August 11, 1993, the maximum payment permitted to be made to a participant from the trust must be counted for Medicaid eligibility. The maximum is counted whether or not the trustee actually distributes payments. (7-1-24)

709. MEDICAID ELIGIBILITY FOR AABD PARTICIPANT.
A participant eligible for AABD cash is eligible for Medicaid, unless they are in an ineligible institution, receive excess payment from a Medicaid Qualifying Trust, or have an irrevocable trust that is not exempt. (7-1-24)

710. -- 719. (RESERVED)

720. 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. A long-term care facility is a nursing facility or an ICF/IID. The need for long-term care is determined using IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-24)

01. Resources of Resident. The resident's resource limit is two thousand dollars ($2,000). Resources of a married person in long-term care are computed using Federal Spousal Impoverishment rules. Under the SSI method, spouses can use the three thousand dollar ($3,000) couple resource limit if more advantageous. The couple must have lived in the nursing home, in the same room, for six (6) months. (7-1-24)

02. Medicaid Income Limit of Long-Term Care Resident Thirty Days or More. The monthly income limit for a long-term care facility resident is three (3) times the federal SSI benefit for a single person. To qualify for this income limit, the participant must be, or be likely to remain, in long-term care at least thirty (30) consecutive days. (7-1-24)

03. Medicaid Income Limit of Long-Term Care Resident Less Than Thirty Days. The monthly income limit, for the resident of a long-term care facility for less than thirty (30) consecutive days, is the AABD income limit for the participant's living situation before long-term care. Living situations before long-term care do not include hospital stays. (7-1-24)

04. Income Not Counted. The income listed in Subsections 720.04.a. through 720.04.e. of this rule is not counted to compute Medicaid eligibility for a long-term care facility resident. This income is counted in determining participation in the cost of long-term care. (7-1-24)

a. Income excluded or disregarded in determining eligibility for AABD cash is not counted. (7-1-24)

b. The September 1972 RSDI increase is not counted. (7-1-24)

c. Any VA Aid and Attendance allowance, including any increment that is the result of a VA Unusual Medical Expense allowance, is not counted. These allowances are not counted for patient liability, unless the veteran lives in a state-operated veterans' home. (7-1-24)

d. RSDI benefit increases from cost-of-living adjustments (COLA) after April 1977 are not counted if they made the participant lose SSI or AABD cash. The COLA increases after SSI or AABD cash stopped are not counted. (7-1-24)

e. Income paid into an income trust exempt from counting for Medicaid eligibility under Subsection 872.02 of these rules is used for patient liability. Income paid to the trust and not used for patient liability is subject to the asset transfer penalty. (7-1-24)

05. Medicaid Participant Residing in a Skilled Nursing Facility. When a Medicaid participant who is a resident of a skilled nursing facility and meets that level of care as evidenced by the PAARR defined in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits," the resident is determined to be disabled for the duration of their residency in the skilled nursing facility. (7-1-24)

721. QUALIFIED LONG-TERM CARE PARTNERSHIP POLICY.
Participants who have received, or are entitled to receive, benefits under a Qualified Long-Term Care Partnership policy issued in Idaho after November 1, 2006, will have certain resources disregarded as described below. (7-1-24)

01. Value of the Participant's Resources. The total dollar amount of the insurance benefits paid out for a policy holder of a Qualified Long-Term Care Partnership policy is disregarded in calculating the value of the participant's resources for long-term care Medicaid eligibility. The amount that is disregarded is determined on the effective date of an initial application approval for long-term care Medicaid benefits. (7-1-24)

02. Resource Disregard Excluded from Estate Recovery. The amount of the resources disregarded from a Qualified Long-Term Care Partnership policy under Subsection 721.01 of this rule, is deducted from the assets of the estate for Medicaid estate recovery. (7-1-24)

722. PATIENT LIABILITY.
Patient liability is the participant's income counted toward the cost of long-term care. Patient liability begins the month after the first full calendar month the patient is receiving benefits in a long-term care facility. (7-1-24)

723. PATIENT LIABILITY FOR PERSON WITH NO COMMUNITY SPOUSE.
For a participant with no community spouse, patient liability is computed as described below. (7-1-24)

01. Income of Participants in Long-Term Care. For a single participant, or participant 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 their total income less the deductions in Subsection 723.03 of this rule. (7-1-24)

02. Community Property Income of Long-Term Care Participant with Long-Term Care Spouse. Patient liability income for a participant, whose spouse is also in long-term care, choosing the community property method, is one-half (1/2) their share of the couple's community income, plus their own separate income. The deductions under Subsection 723.03 of this rule are subtracted from their income. (7-1-24)

03. Income of Participant in Facility. A participant residing in the long-term care facility at least one (1) full calendar month, beginning with their most recent admission, must have the deductions in below subtracted from their income, after the AABD exclusions are subtracted from the income. Total monthly income includes income paid into an income (Miller) trust that month. The income deductions must be subtracted in the order listed. Remaining income is patient liability. (7-1-24)

a. AABD Income Exclusions. Income excluded in determining eligibility for AABD cash is subtracted. (7-1-24)

b. Aid and Attendance and UME Allowances. VA Aid and Attendance allowance and Unusual Medical Expense (UME) allowance for a veteran or surviving spouse is subtracted, unless the veteran lives in a state operated veterans' home. (7-1-24)

c. SSI Payment Two (2) Months. The SSI payment for a participant entitled to receive SSI at their at-home rate for up to two (2) months is subtracted, while temporarily in a long-term care facility. (7-1-24)

d. AABD Payment. The AABD payment, and income used to compute the AABD payment, for a participant paid continued AABD payments up to three (3) months in long-term care is subtracted. (7-1-24)

e. First Ninety ($90) Dollars of VA Pension. The first ninety ($90) dollars of a VA pension for a veteran in a private long-term care facility or a State Veterans Nursing Home is subtracted. (7-1-24)

f. Personal Needs. Forty dollars ($40) is subtracted for the participant's personal needs. For a veteran or surviving spouse in a private long-term care facility or a State Veterans Nursing Home the first ninety ($90) dollars of VA pension substitutes for the forty dollar ($40) personal needs deduction. (7-1-24)

g. Employed and Sheltered Workshop Activity Personal Needs. For an employed participant or participant engaged in sheltered workshop or work activity center activities, the lower of the personal needs deduction of two hundred dollars ($200) or their gross earned income is subtracted. The participant's total personal needs allowance must not exceed two hundred and thirty dollars ($230). For a veteran or surviving spouse with sheltered workshop or earned income, and a protected VA pension, the total must not exceed two hundred dollars ($200). This is a deduction only. No actual payment can be made to provide for personal needs. (7-1-24)

h. Home Maintenance. Two hundred and twelve dollars ($212) is subtracted for home maintenance cost if the participant had an independent living situation, before their admission for long-term care. Their physician must certify in writing the participant is likely to return home within six (6) months, after the month of admission to a long-term care facility. This is a deduction only. No actual payment can be made to maintain the participant's home. (7-1-24)

i. Maintenance Need. A maintenance need deduction for a family member living in the long-term care participant's home is subtracted. A family member is claimed, or could be claimed, as a dependent on the Federal Income Tax return of the long-term care participant. The family member must be a minor or dependent child, dependent parent, or dependent sibling of the long-term care participant. The maintenance need deduction is the AFDC payment standard for the dependents, computed according to the AFDC State Plan in effect before July 16, 1996. (7-1-24)

j. Medicare and Health Insurance Premiums. Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges are subtracted, and 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 subtracted, if the participant got SSI or AABD cash the month prior to the month for which patient liability is being computed. (7-1-24)

k. Mandatory Income Taxes. Taxes mandatorily withheld from unearned income for income tax purposes are subtracted. To qualify for deduction of mandatory taxes, the tax must be withheld from income before the participant receives the income. (7-1-24)

l. Guardian Fees. Court-ordered guardianship fees of the lesser of ten percent (10%) of the monthly benefit handled by the guardian, or twenty-five dollars ($25) are subtracted. Where the guardian and trustee is the same person, the total deduction for guardian and trust fees must not exceed twenty-five dollars ($25) monthly. (7-1-24)

m. Trust Fees. Up to twenty-five dollars ($25) monthly paid to the trustee for administering the participant's trust is subtracted. (7-1-24)

n. Impairment-Related Work Expenses (IRWE). IRWEs for an employed participant who is blind or disabled under AABD criteria are subtracted. IRWEs are purchased or rented items and services that are purchased or rented to perform work. The items must be needed because of the participant's impairment. The actual monthly expense of the impairment-related items is subtracted. Expenses must not be averaged. (7-1-24)

o. Income Garnished for Child Support. Income garnished for child support to the extent the expense is not already accounted for in computing the maintenance need standard is subtracted. (7-1-24)

p. Incurred Medical Expenses. Amounts for certain limited medical or remedial care expenses that have current balances owed and are deemed medically necessary as defined in IDAPA 16.03.09, "Medicaid Basic Plan Benefits," are subtracted. Current medical expenses that are not covered by the Idaho Medicaid Plan, or by a third party, may be deducted from the base participation amount. (7-1-24)

q. Pre-existing Medical Expenses. Amounts for medical and remedial care expenses incurred within the three (3) months prior to the month of application are subtracted. The deductions for medical and remedial care expenses are limited to those medically necessary expenses incurred by the participant for the participant's care. These deductions are limited to the amount of liability owed by the participant, and if applicable, after any third-party insurance has been applied. The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero. (7-1-24)

724. INCOME OWNERSHIP OF PARTICIPANT WITH COMMUNITY SPOUSE.
Income ownership of a long-term care participant with a community spouse is determined before patient liability is computed. The participant's income ownership is counted as shown below. (7-1-24)

01. Income Paid in the Name of Spouse. Income paid solely in the name of a spouse, and not paid from a trust, is the separate income of the spouse. (7-1-24)

02. Payment in Name of Both Spouses. Income paid in the names of both the long-term care participant and the community spouse is divided evenly between each spouse. (7-1-24)

03. Payment in Name of Spouse or Spouses and Another Person. Income paid in the names of the participant and/or the community spouse and another person is 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 of the income is counted to each spouse. (7-1-24)

04. Payment of Aid and Attendance. 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 the veteran. (7-1-24)

725. PATIENT LIABILITY FOR PARTICIPANT WITH COMMUNITY SPOUSE.
For a participant with a community spouse, patient liability is computed as described in Subsection 723.03 of these rules with the addition of the following steps for Community Spouse Allowance (CSA): (7-1-24)

01. Shelter Adjustment. The Department will add the current Food Stamp Program Standard Utility Allowance to the community spouse's shelter costs. 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. The Department will subtract the Shelter Standard from the shelter and utilities. The Shelter Standard is thirty percent (30%) of one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the federal Office of Management and Budget (OMB) for a family of two (2) persons. The Shelter Adjustment is the positive balance remaining. (7-1-24)

02. Community Spouse Need Standard (CSNS). The Department will add the Shelter Adjustment to the minimum CSNS. The minimum CSNS equals one hundred fifty percent (150%) of one-twelfth (1/12) of the income official poverty line defined by the OMB 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 computed by multiplying one thousand five hundred dollars ($1,500) by the percentage increase in the consumer price index for all urban consumers (all items, US city average) between September 1988 and the September before the current calendar year. The maximum CSNS is revised annually in January. (7-1-24)

03. Community Spouse Allowance (CSA). The Department will subtract the community spouse's gross income from the CSNS. The community spouse's income includes income produced by their resources. The Department will round any remaining cents to the next higher dollar. Any positive balance remaining is the CSA. The CSA is subtracted as actually paid to the community spouse, up to the computed maximum. A larger spouse support amount must be used as the CSA, if court-ordered. The CSA ordered by a court is not subject to the CSA limit. (7-1-24)

726. PERSONAL NEEDS SUPPLEMENT (PNS).
A nursing home participant may receive a PNS to bring their gross income up to forty dollars ($40). Gross income is income after exclusions and before disregards, and includes money withheld to recover an AABD overpayment. The

PNS is the difference between the participant's gross income and forty dollars ($40). If not in an even dollar amount, the PNS is rounded up to the next dollar. The participant's income including the PNS must not exceed forty dollars ($40). (7-1-24)

727. FAIR HEARING ON CSA DECISION.
Either spouse may ask for a fair hearing to show the community spouse needs a higher CSA. The hearing officer must consider if, due to unusual conditions, using the computed CSA causes significant financial hardship for the community spouse. If the fair hearing decision finds the community spouse needs more income than the CSA, the CSA must include the additional income. (7-1-24)

728. -- 730. (RESERVED)

731. MEDICAID ELIGIBILITY OF MARRIED PERSONS.
There are three (3) methods for Medicaid eligibility of an aged, blind, or disabled married person: (1) the SSI method, (2) the Community Property (CP) method, and (3) the Federal Spousal Impoverishment (FSI) method. The FSI method takes precedence. If the participant is not subject to the FSI method, the CP or SSI methods can be used. (7-1-24)

732. CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD.
Table 732 is used to determine the resource counting method for a married person. If an HCBS participant with a spouse at home is not eligible using the FSI method, resources are computed using the SSI/CP method.

TABLE 732 - CHOOSING FSI, SSI, OR CP RESOURCE COUNTING METHOD

	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	SSI/CP	FSI	SSI/CP	SSI/CP	FSI
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	SSI/CP	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

(7-1-24)

733. CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD.

Table 733 is used to determine the income counting method for a married person. If a participant subject to the FSI method is not eligible using FSI, income is computed using the SSI/CP method.

TABLE 733 - CHOOSING FSI, SSI, OR CP INCOME COUNTING METHOD

	SPOUSE ONE (1) IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE (1) IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE (1) AT HOME NO HCBS	SPOUSE ONE (1) AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE (1) AT HOME WITH HCBS ON OR AFTER 9/30/89
SPOUSE TWO (2) IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME NO HCBS	FSI	FSI	SSI/CP	FSI	FSI
SPOUSE TWO (2) AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO (2) AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

(7-1-24)

734. CHOOSING FSI, SSI, OR CP PATIENT LIABILITY OR PARTICIPATION METHOD.

Table 734 is used to determine the patient liability or participant participation method for a married participant in long-term care or receiving HCBS.

TABLE 734 - PATIENT LIABILITY OR PARTICIPATION METHOD

	SPOUSE ONE IN NURSING HOME BEFORE 9/30/89	SPOUSE ONE IN NURSING HOME ON OR AFTER 9/30/89	SPOUSE ONE AT HOME NO HCBS	SPOUSE ONE AT HOME WITH HCBS BEFORE 9/30/89	SPOUSE ONE AT HOME WITH HCBS ON OR AFTER 9/30/89

TABLE 734 - PATIENT LIABILITY OR PARTICIPATION METHOD					
SPOUSE TWO IN NURSING HOME BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO IN NURSING HOME ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO AT HOME NO HCBS	FSI	FSI	N/A	FSI	FSI
SPOUSE TWO AT HOME WITH HCBS BEFORE 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP
SPOUSE TWO AT HOME WITH HCBS ON OR AFTER 9/30/89	SSI/CP	SSI/CP	FSI	SSI/CP	SSI/CP

(7-1-24)

735. FEDERAL SPOUSAL IMPOVERISHMENT (FSI) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
The FSI method must be used to compute income and resources of a married participant who requires long-term care as defined in Section 010 of these rules, and who has a community spouse. The participant must have entered long-term care on or after September 30, 1989. Terms used in the FSI method are listed below. (7-1-24)

01. Long-Term Care Spouse. Must be in a medical institution or nursing facility, or be an HCBS participant, for thirty (30) consecutive days, or appear likely to meet the thirty (30) days requirement. (7-1-24)

02. Community Spouse. The spouse of the long-term care participant. A community spouse is not in long-term care and is not an HCBS participant. (7-1-24)

03. Continuous Period of Long-Term Care. A period of residence either in a medical institution with nursing facility services, or at home with HCBS. A continuous period of long-term care is also a combination of institution and personal care services likely to last at least thirty (30) consecutive days. Absence from the institution, or a lapse in HCBS eligibility of thirty (30) consecutive days breaks continuity. The thirty (30) consecutive days of long-term care must not begin on a day the participant is hospitalized. If the participant is hospitalized after the first day of the thirty (30) consecutive days, the hospital stay does not interrupt the thirty (30) consecutive days. (7-1-24)

04. Start of Continuous Period of Long-Term Care. The first month of long-term care or HCBS. (7-1-24)

05. Nursing Facility Services. Services at the nursing facility level or the ICF/IID level provided in a medical institution. (7-1-24)

736. ASSESSMENT DATE AND COUNTING FSI RESOURCES.

The assessment date is the start date of the first continuous period of long-term care. The Department does a one-time assessment to determine the value of the couple's community and separate resources as of the date of the first continuous period of long-term care. The resource assessment is done at the request of either spouse, after one (1) spouse is in long-term care or meets the level of care for HCBS, whether or not the couple has applied for Medicaid. 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. (7-1-24)

737. TREATMENT OF RESOURCES FOR ASSESSMENT.
The resource rules used in determining eligibility for AABD cash and Medicaid are also used in determining the couple's total combined resources for the FSI resource assessment with the following exceptions: (7-1-24)

01. Resources for Sale. Excess resources offered for sale, are not excluded from the couple's total combined resources for the FSI resource assessment. (7-1-24)

02. Jointly Owned Real Property. Jointly owned real property that is not the principal residence of the participant is not excluded if the community spouse is the joint owner. (7-1-24)

03. Long-term Care Partnership Policy. Resources excluded because of a participant's qualified long-term care policy are not excluded for the FSI resource assessment. (7-1-24)

04. Excluded Home. As defined in 42 USC 1396r-5(c)(5), an excluded home placed in trust retains its exclusion for purposes of the resource assessment. (7-1-24)

738. ONE-HALF SPOUSAL SHARE.
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 participant leaves long-term care and then enters long-term care again. The Department must inform the couple of the resources counted in the assessment and the value assigned. The couple must sign the assessment form under penalty of perjury. The signature requirement may be waived for the long-term care spouse if they or their representative says they are 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 an assessment prior to application. (7-1-24)

739. -- 741. (RESERVED)

742. COMMUNITY SPOUSE RESOURCE ALLOWANCE.
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 couple's total combined resources as of the first day of the application month. The deduction must not be more than the maximum resource allowance at the time eligibility is determined. (7-1-24)

743. RESOURCE ALLOWANCE LIMITS.
The maximum resource allowance is computed by multiplying sixty thousand dollars ($60,000) by the percentage increase in the consumer price index for all urban consumers (all items, US city average) between September 1988 and the September before the current calendar year. The minimum resource allowance is computed by multiplying twelve thousand dollars ($12,000) by the percentage increase in the consumer price index for all urban consumers (all items, US city average) between September 1988 and the September before the current calendar year. If the result is not an even one hundred dollar ($100) amount, the Department will round up to the next one hundred dollars ($100). The couple's resources exceeding the CSRA are counted for the long-term care spouse. (7-1-24)

744. INCOME COUNTED FIRST FOR CSRA REVISION.
Income is determined prior to determining resources. If the couple's income is more than the minimum CSNS, the CSRA cannot be increased. If the community spouse has less income than the minimum CSNS, the CSRA may be increased as provided in Section 745 of these rules. Couple income is the community spouse's gross income plus the long-term care spouse's income. The long-term care spouse's income is their gross income less the AABD cash income exclusions and their patient liability income deductions, but not the CSA deduction. (7-1-24)

745. UPWARD REVISION OF CSRA.

If the community spouse's income, including income from their CSA and income-producing resources in their CSRA, is less than the minimum CSNS, the CSRA may be increased. The CSRA is increased by enough resources transferred from the long-term care spouse to raise the community spouse's income to the minimum CSNS Resources included in the transfer are presumed to produce income at the treasury rate, whether or not the resources produce income. If the community spouse shows they are making reasonable use of their income and resources to generate income, the Department may waive the treasury rate requirement. Actual income produced by the resources transferred to the community spouse is used to compute the CSA. A higher CSA can be requested under Section 727 of these rules. If the transferred resources produce more than the treasury rate, the actual income produced is used to determine the additional resources that can be transferred to the community spouse in the CSRA. The long-term care spouse must transfer the resources to the community spouse, or the CSRA is not revised. (7-1-24)

746. RESOURCE TRANSFER ALLOWANCE (RTA).
The RTA is computed by subtracting the community spouse's resources at the time of application from the CSRA. The community spouse must own less than the CSRA to get an RTA. The long-term care spouse may transfer the RTA to the community spouse without an asset transfer penalty. If the institutional spouse transfers more than the RTA, the amount of the couple's resources over the CSRA counts as the institutional spouse's resources. After the month, a long-term care spouse is determined Medicaid-eligible under FSI, resources of the community spouse are not considered available to them while they remain in long-term care. (7-1-24)

747. PROTECTED PERIOD FOR RTA TRANSFER.
The long-term care spouse has sixty (60) days, from the date their application is approved, to transfer their ownership of the RTA resources to the community spouse. The long-term care spouse must state, in writing, their intent to transfer the RTA resources to the community spouse within the protected period before they can be Medicaid-eligible. Resources not transferred within the sixty (60) day protected period are available to the long-term care spouse, effective the day they entered the facility. (7-1-24)

748. EXTENSION FOR RTA TRANSFER.
The protected period can be extended beyond sixty (60) days, if necessary, because of the participant's circumstances. (7-1-24)

749. RESOURCE ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, 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, resources of the community spouse available for their Medicaid eligibility are the resources owned by the couple. (7-1-24)

750. INCOME ELIGIBILITY FOR COMMUNITY SPOUSE.
When the community spouse is a Medicaid participant, 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. (7-1-24)

751. CHANGE IN CIRCUMSTANCES.
The FSI method of calculating income and resources stops the first full calendar month after a change in circumstances resulting in a couple no longer having a community spouse and a long-term care spouse. (7-1-24)

752. NOTICE AND HEARING.
The Department must tell the participant about the CSA, the family member allowance, the CSRA and how it was computed, and 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. (7-1-24)

753. -- 760. (RESERVED)

761. CHOICE OF SSI OR CP METHODS.
A married participant, not using FSI, must be furnished a written explanation of SSI and CP income and resource counting methods. The couple chooses the most useful method, based on their circumstances. The same method must be used for both spouses. (7-1-24)

762. SSI METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.

The SSI method is the same method used to count income and resources for AABD cash. Income and resources of the participant and spouse are counted as mutually available. This method must be used for months either spouse gets SSI or AABD cash, or an SSI and/or AABD application is filed and approved. This method must be used for Medicaid eligibility, and liability for the cost of long-term care, whether or not one (1) or both spouses apply for Medicaid. For long-term care, the couple's income and resources are mutually available 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. (7-1-24)

763. COMMUNITY PROPERTY (CP) METHOD OF COUNTING INCOME AND RESOURCES OF A COUPLE.
A married participant in long-term care, whose spouse is not in the community, can use the CP method. A married participant using the FSI method, but not income-eligible using FSI, may choose the CP method for income eligibility. The CP method must not be used for the FSI participant's resource eligibility or patient liability. (7-1-24)

764. CP METHOD.
The CP method gives each spouse an equal one-half (1/2) share of the couple's community income and resources. Each spouse also has their 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 can give evidence to rebut the presumption that property acquired during the marriage is community property. (7-1-24)

765. 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 valid for eligibility for Medicaid. (7-1-24)

766. CP METHOD NEED STANDARD.
The participant is budgeted as a single person if their spouse is not a Medicaid applicant, is not living with them, or was not living with them on the first day of the month. The participant and spouse are budgeted as a couple if they both apply and live together, or if they were living together on the first day of the month. (7-1-24)

767. CP METHOD RESOURCE LIMIT.
The participant's resource limit is two thousand dollars ($2,000) if their spouse is not a Medicaid applicant, is not living with them, or was not living with them on the first day of the month. The participant and spouse have a resource limit of three thousand dollars ($3,000) if they both apply and live together, or if they were living together on the first day of the month. (7-1-24)

768. CP METHOD INCOME DISREGARDS.
The participant gets the twenty dollar ($20) standard disregard if their spouse is not a Medicaid applicant, is not living with them, or was not living with them on the first day of the month. If the participant has earned income, they get the sixty-five dollar plus one-half ($65 + 1/2) of the remainder earned income disregard. The participant and spouse get the standard disregard on their combined unearned income if they both apply, and live together, or if they were living together on the first day of the month. If either spouse has earned income, they get the earned income disregard from their combined earned income. (7-1-24)

769. -- 776. (RESERVED)

777. ELIGIBLE SSI RECIPIENT.
An SSI recipient, or an individual who would be SSI eligible if they applied, is eligible for Medicaid if they meet any of the conditions below. (7-1-24)

01. Receives SSI. Gets SSI payments, even if eligibility is based on presumptive disability or presumptive blindness. (7-1-24)

02. Conditionally Eligible for SSI. Based on an agreement to dispose of excess resources. (7-1-24)

03. Eligible Spouse. Has their SSI payments combined with their spouse's SSI payments. (7-1-24)

778. INELIGIBLE SSI RECIPIENT.
An SSI recipient is not eligible for Medicaid if they meet any of the conditions below. (7-1-24)

01. Medicaid Qualifying Trust. Has excess income from a Medicaid Qualifying Trust, created and funded before August 11, 1993. (7-1-24)

02. Noncooperation. Fails to cooperate in establishing paternity or securing support. (7-1-24)

03. Is in an Ineligible Institution. (7-1-24)

04. Trust. Has a trust that makes them ineligible for Medicaid. (7-1-24)

779. PSYCHIATRIC FACILITY RESIDENT.
A resident of a long-term care psychiatric medical facility is eligible for Medicaid if they are age sixty-five (65) or older. They must meet all the requirements of a long-term care resident. (7-1-24)

780. (RESERVED)

781. RSDI RECIPIENT ENTITLED TO COLA DISREGARD.
A participant receiving RSDI is eligible for Medicaid if they became and remain ineligible for SSI payments as of April 2011, or for AABD cash or SSI payments from May 1977 through March 2011. The participant must still be entitled to AABD cash or SSI, except for a COLA in RSDI benefits. All RSDI COLAs received by the participant, and any person whose income and resources are counted in determining the participant's eligibility, are disregarded for Medicaid. (7-1-24)

782. MEDICAID BENEFITS UNDER SECTION 1619(B) OF THE SOCIAL SECURITY ACT.
A participant may be eligible for Medicaid under Section 1619(b) of the Social Security Act either under federal or state criteria, depending on their circumstances. (7-1-24)

01. Federally Qualified Under SSA Section 1619(b). An SSI recipient with a disability, previously eligible for SSI cash, who, because of earnings from employment, no longer meets the financial eligibility requirements for SSI cash, is eligible for Medicaid. SSA determines the qualification for eligibility under Section 1619(b). (7-1-24)

02. State-Only Qualified Under SSA Section 1619(b). An AABD cash participant with a disability, who, because of earnings from employment, no longer meets the financial eligibility requirements for AABD cash, may be eligible for Medicaid. The Department determines eligibility for State-only Section 1619(b) Medicaid. State-only Section 1619(b) Medicaid is authorized under Section 1905(q) of the Social Security Act. (7-1-24)

a. A participant must meet all the following requirements to be eligible for State-only 1619(b) Medicaid. The participant: (7-1-24)

i. Received AABD cash in the month prior to the first month of their eligibility under this rule. (7-1-24)

ii. Is under age sixty-five (65). (7-1-24)

iii. Continues to have a disability. (7-1-24)

iv. Must depend on Medicaid coverage to continue working. An individual depends on Medicaid coverage if they: (7-1-24)

(1) Used Medicaid coverage within the past twelve (12) months; (7-1-24)

(2) Expect to use Medicaid coverage in the next twelve (12) months; or (7-1-24)

(3) Would be unable to pay unexpected medical bills in the next twelve (12) months without Medicaid

coverage. (7-1-24)

v. Is not able to afford medical insurance equivalent to Medicaid, including attendant care. The participant meets this requirement if their earnings are under the limit referred to in Subsection 782.02.a.vii. of this rule. (7-1-24)

vi. Continues to meet all the non-disability eligibility requirements in these rules. (7-1-24)

vii. Has annual gross earned income less than the current calendar year's charted threshold for Idaho as developed by SSA for federal qualification for Section 1619(b) Medicaid. The charted threshold for Idaho is SI 02302.200 Charted Threshold Amounts, incorporated by reference in Subsection 002.04. (7-1-24)

b. State-only Section 1619(b) Medicaid ends when the participant meets one (1) of the following criteria. The participant: (7-1-24)

i. Is no longer eligible for AABD cash for a reason other than excess earned income; (7-1-24)

ii. Has gross earned income equal to or more than the current calendar year's annual earnings threshold for Idaho developed by the SSA for federal Section 1619(b) Medicaid; (7-1-24)

iii. Is age sixty-five (65) or older; or (7-1-24)

iv. Regains eligibility for AABD cash. (7-1-24)

783. APPEAL OF SSA DECISION - APPLICANT DETERMINED SSI ELIGIBLE AFTER APPEAL.
An applicant denied Medicaid, because they do not meet SSI eligibility or RSDI disability requirements, can appeal the SSA denial with SSA. They can get Medicaid, if found eligible for SSI or Social Security disability because of their appeal. The effective date for Medicaid is the first day of the month that the Medicaid application was denied, by SSA. The participant's eligibility for backdated Medicaid coverage must be determined. (7-1-24)

784. APPEAL OF SSA DECISION AND CONTINUED MEDICAID.
A Medicaid participant, denied RSDI or SSI because they are not disabled, can continue to get Medicaid if they appeal the SSA decision. The appeal must be filed within sixty (60) days of the SSA decision. If the final administrative decision rules against the participant's appeal, Medicaid benefits must end. Medicaid benefits paid during the appeal are not an overpayment. (7-1-24)

785. CERTAIN DISABLED CHILDREN.
A disabled child, not eligible for Medicaid outside a medical institution, is eligible for Medicaid if they meet the conditions below. (7-1-24)

01. Age. Is under nineteen (19) years old. (7-1-24)

02. AABD Criteria. Meets the AABD blindness or disability criteria. (7-1-24)

03. AABD Resource Limit. Meets the AABD single person resource limit. (7-1-24)

04. Income Limit. Has monthly income not exceeding three (3) times the federal SSI benefit payable monthly to a single person. (7-1-24)

05. Eligible for Long-Term Care. Meets the medical conditions for long-term care in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-24)

06. Appropriate Care. Is appropriately cared for outside a medical institution, under a physician's plan of care. (7-1-24)

07. Cost of Care. Can be cared for cost effectively outside a medical institution. The estimated cost of caring for the child must not exceed the cost of the child's care in a hospital, nursing facility, or ICF/IID. (7-1-24)

08. Share of Cost. The financially responsible adult of a certain disabled child, who has family income above one hundred fifty percent (150%) of the federal poverty guidelines, is required to share in the cost of the child's Medicaid benefits under IDAPA 16.03.18, "Medicaid Cost-Sharing." (7-1-24)

786. (RESERVED)

787. HOME AND COMMUNITY BASED SERVICES (HCBS).
An aged, blind, or disabled participant, who is not income eligible for SSI or AABD cash, in their own home or community setting, is eligible for Medicaid if they meet the conditions below and meets all requirements in one (1) of the waiver Sections 788 through 789 of these rules. (7-1-24)

01. Resource Limit. Meets the AABD single person resource limit. (7-1-24)

02. Income Limit. Income of the participant must not exceed three (3) times the federal SSI monthly benefit for a single person. A married participant living at home with their spouse who is not an HCBS participant, may choose between the SSI, CP, and FSI methods. If their spouse is also an HCBS participant or lives in a nursing home, the couple may choose between the SSI and CP methods. (7-1-24)

03. Maintained in the Community. The applicant must be able to be maintained safely and effectively in their own home or in the community with the waiver services. (7-1-24)

04. Cost of Care. The cost of the participant's care must be cost effective as provided in IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-24)

05. Waiver Services Needed. The participant must need and receive, or be likely to need and receive, waiver services for thirty (30) consecutive days. The participant is ineligible when there is a break in need for, or receipt of, waiver services for thirty (30) consecutive days. (7-1-24)

06. Effective Date. Waiver services are effective the first day the participant is likely to need and receive waiver services. Medicaid begins the first day of the month in which the first day of approved waiver services are received. (7-1-24)

07. Annual Limit. The Department limits the number of participants approved for waiver services each year. A participant who applies for waiver services after the annual limit is reached, must be denied waiver services. (7-1-24)

788. AGED AND DISABLED (A&D) WAIVER.
To be eligible for the Aged and Disabled (A&D) Waiver the participant must: (7-1-24)

01. Age Eighteen Through Sixty-Four. Be eighteen (18) through sixty-four (64) years old and meet the disability criteria, as provided in Section 156 of these rules, and need nursing facility level of care under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits"; or (7-1-24)

02. Age Sixty-Five or Older. Be age sixty-five (65) or older and need nursing facility level of care under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." (7-1-24)

789. DEVELOPMENTALLY DISABLED (DD) WAIVER.
To be eligible, the participant must be at least eighteen (18) years of age and need the level of care provided by an ICF/IID under IDAPA 16.03.10 "Medicaid Enhanced Plan Benefits." (7-1-24)

790. -- 798. (RESERVED)

799. MEDICAID FOR WORKERS WITH DISABILITIES.
An individual is eligible to participate in the Medicaid for Workers with Disabilities coverage group if the individual meets the requirements below. (7-1-24)

01. Non-Financial Requirements. An individual must: (7-1-24)

a. Be at least sixteen (16) but less than sixty-five (65) years of age; (7-1-24)

b. Meet the Medicaid residency requirement under Section 100 of these rules; (7-1-24)

c. Meet the citizenship requirements under 42 CFR 435.406, Citizenship and Non-citizen Eligibility; (7-1-24)

d. Meet the SSN requirements under Section 10 3of these rules; and (7-1-24)

e. Meet the child support cooperation requirements under Sections 703 through 706 of these rules. (7-1-24)

02. Disability. An individual must meet the medical definition for having a disability or blindness used by the SSA for Social Security Disability Insurance (SSDI) and SSI benefits. (7-1-24)

03. Employment. An individual must be employed which may include self-employment. Proof of employment must be provided to the Department. Hourly wage or hours worked will not be used to determine employment. (7-1-24)

04. Countable Resources. Cannot exceed ten thousand dollars ($10,000) for an individual or fifteen thousand dollars ($15,000) for a couple. When calculating resources, the following items will be excluded: (7-1-24)

a. Any resources excluded under Section 210 and Sections 222 through 299 of these rules; (7-1-24)

b. A second vehicle as described in Section 222 of these rules; (7-1-24)

c. Life insurance policies; (7-1-24)

d. Retirement accounts; and (7-1-24)

e. Exempt trusts as described in Section 872 of these rules. (7-1-24)

05. Countable Income. Is calculated using exclusions and disregards as described in Sections 300 through 547 of these rules. The countable income for: (7-1-24)

a. An individual cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of one (1). (7-1-24)

b. A couple cannot exceed five hundred percent (500%) of the current federal poverty guideline for a household of two (2). (7-1-24)

06. Earned Income Test. Gross income is the total of earned and unearned income before exclusions or disregards. Each individual's gross earned income must be at least fifteen percent (15%) of their total gross income to qualify. (7-1-24)

07. Cost-Sharing. A participant in the Medicaid for Workers with Disabilities coverage group may be required to cost-share; the costs are determined under the provisions in IDAPA 16.03.18, "Medicaid Cost-Sharing." (7-1-24)

800. – 801. (RESERVED)

802. WOMAN DIAGNOSED WITH BREAST OR CERVICAL CANCER.
A woman not otherwise eligible for Medicaid and meeting the conditions in Subsections 802.01 through 802.06 of this rule is eligible for Medicaid for the duration of her cancer treatment. Medicaid income and resource limits do not apply to this coverage group. (7-1-24)

01. Diagnosis. The participant is diagnosed with breast or cervical cancer through the CDC's National Breast and Cervical Cancer Early Detection Program. (7-1-24)

02. Age. The participant is under age sixty-five (65). (7-1-24)

03. Creditable Health Insurance. The participant is uninsured or, if insured, the plan does not cover her type of cancer. (7-1-24)

04. Non-Financial Eligibility. The participant meets the Medicaid non-financial eligibility requirements in Sections 100 through 108 and Sections 166 and 167 of these rules. (7-1-24)

05. Medical Support Cooperation. The participant meets the medical support cooperation requirement in Sections 702 through 706 of these rules. (7-1-24)

06. Group Health Plan Enrollment. The participant meets the requirement to enroll in available cost-effective employer group health insurance. (7-1-24)

07. Presumptive Eligibility. The Department can presume the participant is eligible for Medicaid, before a formal Medicaid eligibility determination is made. A clinic authorized to screen for breast or cervical cancer by the National Breast and Cervical Cancer Early Detection Program makes the presumptive eligibility determination. The clinic tells the participant how to complete the formal Medicaid determination process. The Medicaid notice and hearing rights do not apply to presumptive eligibility. No overpayment occurs if the formal Medicaid determination finds the participant is not eligible. (7-1-24)

08. End of Treatment. The Department determines the end of treatment date under IDAPA 16.03.10, "Medicaid Enhanced Plan Benefits." (7-1-24)

803. -- 805. (RESERVED)

806. DISABLED ADULT CHILD.
A participant age eighteen (18) or older is eligible for Medicaid if they received SSI or AABD cash based on blindness or a disability which began before they reached age twenty-two (22), and becomes ineligible for and remains ineligible for AABD cash or SSI because their disabled child RSDI benefit started or increased July 1, 1987, or later. (7-1-24)

01. RSDI Benefits Disregarded for Disabled Adult Child. If the participant became ineligible because they began receiving a disabled child benefit on or after July 1, 1987, the benefit amount and any later increases are disregarded. (7-1-24)

02. RSDI Increase Disregarded for Disabled Adult Child. If the participant became ineligible because their disabled child benefit increased on or after July 1, 1987, the increase and any later increases are disregarded. (7-1-24)

807. (RESERVED)

808. EARLY WIDOWS AND WIDOWERS BEGINNING JANUARY 1, 1991.
A participant who meets the conditions below is considered an SSI recipient for Medicaid. (7-1-24)

01. Age. The participant, age fifty (50) to age sixty four and one-half (64-1/2), began receiving early widows or widowers Social Security benefits. (7-1-24)

02. Lost SSI or AABD. The participant lost SSI or AABD cash because they began receiving early widows or widowers Social Security benefits. (7-1-24)

03. Received SSI or AABD. The participant received SSI or AABD cash in the month, before the month, they became ineligible because they began receiving early widows or widowers Social Security benefits.

(7-1-24)

04. Widows or Widowers Benefits. The participant would still be eligible for SSI or AABD cash if their Social Security early widows or widowers benefits were not counted as income. (7-1-24)

05. No "Part A" Insurance. The participant is not entitled to Medicare Part A hospital insurance. (7-1-24)

06. Applied On or After January 1, 1991. The participant's Medicaid application was filed, or pending, on or after January 1, 1991. (7-1-24)

809. (RESERVED)

810. QUALIFIED MEDICARE BENEFICIARY (QMB).
A person meeting all requirements below is eligible for QMB, which pays Medicare premiums, coinsurance, and deductibles. (7-1-24)

01. Medicare Part A. The participant must be entitled to hospital insurance under Part A of Medicare at the time of their application. (7-1-24)

02. Nonfinancial Requirements. The participant must meet the Medicaid residence, citizenship, support cooperation, and SSN requirements. (7-1-24)

03. Income. Monthly income must not exceed one hundred percent (100%) of the Federal Poverty Guidelines (FPG). 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. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. AABD cash is not counted as income. The income exclusions and disregards used for AABD are used for QMB. (7-1-24)

04. Dependent Income. Income of the dependent child, parent, or sibling is not counted. (7-1-24)

05. QMB Dependent Family Member Disregard. A dependent family member is a minor child, adult child meeting SSA disability criteria, parent or sibling of the participant or spouse living with the participant. The family member is or could be claimed on the federal tax return of the participant or spouse. A participant with a dependent family member has an income disregard based on family size. The spouse is included in family size, whether or not the spouse is also participant. The disregard is based on the official poverty line income as defined by the OMB. The disregard is the difference between the poverty line for one (1) person, or two (2) persons if the participant has a spouse, and the poverty line for the family size including the participant, spouse, and dependent. (7-1-24)

06. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for QMB. (7-1-24)

07. Effective Dates. The effective date of QMB coverage is no earlier than the first day of the month after the approval month. A QMB participant is not entitled to backdated Medicaid. (7-1-24)

811. SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB).
A person meeting all requirements below is eligible for SLMB. Medicaid pays the Medicare Part B premiums for a SLMB. The income and resource exclusions and disregards used for AABD are used for SLMB. (7-1-24)

01. Other Medicaid. The SLMB may be eligible for other Medicaid. (7-1-24)

02. Medicare Part A. The SLMB must be entitled to hospital insurance under Part A of Medicare at the time of their application. (7-1-24)

03. Nonfinancial Requirements. The SLMB must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. (7-1-24)

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred twenty percent (120%) of the FPG. (7-1-24)

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. (7-1-24)

06. Effective Dates. SLMB coverage begins on the first day of the application month, which may be backdated up to three (3) calendar months before the application month. (7-1-24)

812. QUALIFIED INDIVIDUAL (QI).

A person meeting all requirements below is eligible for QI. Medicaid pays the Medicare Part B premiums for a QI. The income and resource exclusions and disregards used for AABD are used for QI. (7-1-24)

01. Other Medicaid. The QI cannot be eligible for any other type of Medicaid. (7-1-24)

02. Medicare Part A. The QI must be entitled to hospital insurance under Part A of Medicare at the time of their application. (7-1-24)

03. Nonfinancial Requirements. The QI must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation, and SSN. (7-1-24)

04. Income. The annual Social Security cost of living increase is disregarded from income, until the month after the month the annual FPG revision is published. The single person limit is based on a family of one (1). The couple limit is based on a family of two (2). The monthly income limit is up to one hundred thirty-five percent (135%) of the FPG. (7-1-24)

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(p)(1)(C). The resource exclusions used for AABD are used for SLMB. (7-1-24)

06. Coverage Limits. There is an annual limit on participants served based on availability of federal funds. New applications are denied when the annual limit is reached. (7-1-24)

07. Effective Dates. QI coverage begins on the first day of the application month, which may be backdated up to three (3) calendar months before the application month. (7-1-24)

813. QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI).

A person meeting all requirements below is eligible for QDWI. The person must not be eligible for any other type of Medicaid. A QDWI is eligible only for Medicaid payment of their Medicare Part A premium. (7-1-24)

01. Age and Disability. The participant must be a disabled worker under age sixty-five (65). (7-1-24)

02. Nonfinancial Requirements. The participant must meet the Medicaid eligibility requirements of residence, citizenship, support cooperation and SSN. (7-1-24)

03. Section 1818A Medicare. SSA determined the participant meets the conditions of Section 1818A of the Social Security Act. (7-1-24)

04. Income. Monthly income must not exceed two hundred percent (200%) of the one (1) person official poverty line defined by the OMB. (7-1-24)

05. Resource Limit. The resource limit is equal to the amount defined under 42 USC 1396d(s). The resource exclusions used for AABD are used for QDWI. (7-1-24)

814. SPONSORED LEGAL NON-CITIZEN.

All income and resources of a legal non-citizen's sponsor are deemed for Medicaid eligibility if the sponsor has signed an I-864 affidavit of support. (7-1-24)

815. CHILD SUBJECT TO DEEMING.
Income and resources of a child's stepparent are not deemed to the child in determining their Medicaid eligibility. (7-1-24)

816. FUGITIVE FELON OR PROBATION OR PAROLE VIOLATOR.
A person denied SSI or AABD cash because of the prohibition against payment to fugitive felons and probation and parole violators is not disqualified from Medicaid. (7-1-24)

817. -- 830. (RESERVED)

831. ASSET TRANSFER RESULTING IN PENALTY.
Starting August 11, 1993, the participant is subject to a penalty if they transfer their income or resources for less than fair market value. The asset transfer penalty applies to Medicaid services received October 1, 1993 and later. Excluded resources, other than the home and associated property, are not subject to the asset transfer penalty. Asset transfers subject to penalty under these rules may be voided and set aside by court action as provided in Section 56-218, Idaho Code. The asset transfer penalty applies to a Medicaid participant in long-term care or HCBS. A participant in long-term care is 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. (7-1-24)

01. Rebuttable Presumption. Unless a transfer meets the requirements of Section 841 of these rules, it is presumed that the transfer was made for the purpose of qualifying for Medicaid. The asset transfer penalty is applied unless the participant shows that the asset transfer would not have affected their eligibility for Medicaid, or the transfer was made for another purpose than qualifying for Medicaid. (7-1-24)

02. Contract for Services Provided by a Relative. A contract for personal services to be furnished to the participant by a relative is presumed to be made for the purpose of qualifying for Medicaid. The asset transfer penalty applies unless the participant shows that: (7-1-24)

a. A written contract for personal services was signed before services were delivered. The contract must require that payment be made after services are rendered. The contract must be dated, and the signatures notarized. Either party must be able to terminate the contract; and (7-1-24)

b. The contract must be signed by the participant or a legally authorized representative through a power of attorney, legal guardianship, or conservatorship. A representative who signs the contract must not be the provider of the personal care services under the contract; and (7-1-24)

c. Compensation for services rendered must be comparable to rates paid in the open market. (7-1-24)

03. Transfer of Income or Resources. Transfer of income or resources includes reducing or eliminating the participant's ownership or control of the asset. (7-1-24)

04. Transfer of Income or Resources by a Spouse. A transfer by the participant's spouse of either spouse's income or resources, before eligibility is established, subjects the participant to the asset transfer penalty. After the participant's eligibility is established, a transfer by the spouse of the spouse's own income or resources does not subject the participant to the asset transfer penalty. (7-1-24)

05. Transfer of Certain Notes and Loans. Funds used to purchase a promissory note, loan, or mortgage are considered a transferred asset which subjects the participant to a period of ineligibility. The amount of the asset transfer of such note, loan, or mortgage is the outstanding balance due on the date of the Medicaid application, unless the note, loan, or mortgage meets the following: (7-1-24)

a. Has a repayment term that is actuarially sound; (7-1-24)

b. Provides for payments to be made in equal amounts during the term of the loan with no deferral and

no balloon payments; and (7-1-24)

c. Prohibits the cancellation of the balance upon the death of the lender. (7-1-24)

832. MEDICAID PENALTY FOR ASSET TRANSFERS.
The asset transfer penalty is restricted Medicaid coverage. (7-1-24)

01. Restricted Coverage. Means Medicaid will not participate in the cost of nursing facility services or in a level of care in a medical institution equal to nursing facility services. The penalty for a person receiving PCS or community services under the HCBS waiver is ineligibility. (7-1-24)

02. Notice and Exemption. The participant must be notified in writing, at least ten (10) days before an asset transfer penalty is imposed. (7-1-24)

833. ASSET TRANSFER LOOK-BACK PERIOD.
The asset transfer penalty applies to any transfer for less than fair market value made during a period preceding or following a request for long-term care services. Any asset transferred, regardless of type, is subject to a look-back period of sixty (60) months. The look-back period is counted from the date of the application for long-term care or HCBS services or the date of the transfer, whichever is later in time. (7-1-24)

834. PERIOD OF RESTRICTED COVERAGE FOR ASSET TRANSFERS.
The period of restricted coverage is the number of months computed by dividing the net uncompensated value of the transferred asset by the statewide average cost of nursing facility services to private patients. The cost is computed for the time of the participant's most recent request for Medicaid. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. (7-1-24)

835. APPLYING THE PENALTY PERIOD OF RESTRICTED COVERAGE.
Restricted coverage continues until the participant or spouse recovers all the assets, receives fair market value at the time of the transfer for all assets, or the period of restricted coverage ends. The penalty continues whether or not the participant is in long-term care. For assets transferred, the penalty period begins running the first day of the month after the month the transfer took place or was discovered to have taken place, or the date the individual would have been eligible for long-term care services or HCBS, if not for the transfer, whichever date is later in time. The value of all asset transfers made during the look-back period is accumulated for the purpose of calculating the penalty. If an additional transfer is discovered after the penalty has been served, a new penalty period begins the month following timely notice of closure of benefits. When a penalty period ends after the first day of the month, eligibility for long-term care services begins the day after the penalty period ends. (7-1-24)

836. MULTIPLE PENALTY PERIODS APPLIED CONSECUTIVELY.
A penalty period is computed for each transfer. One (1) penalty period must expire before the next begins. (7-1-24)

837. LIFE ESTATE AS ASSET TRANSFER.

01. Transfer of a Remainder Interest. When a life estate in real property is retained by an individual, and a remainder interest in the property is transferred during the look-back period for less than the fair market value of the remainder interest transferred, the value of the uncompensated remainder is subject to the asset transfer penalty as described in Sections 831 through 835 of these rules. To compute the value of the life estate remainder, multiply the fair market value of the real property at the time of transfer by the remainder factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.01 - REMAINDER TABLE

Age	Remainder	Age	Remainder	Age	Remainder	Age	Remainder
0	.02812	**28**	.03938	**56**	.20994	**84**	.63002
1	.01012	**29**	.04187	**57**	.22069	**85**	.64641

TABLE 837.01 - REMAINDER TABLE

Age	Remainder	Age	Remainder	Age	Remainder	Age	Remainder
2	.00983	**30**	.04457	**58**	.23178	**86**	.66236
3	.00992	**31**	.04746	**59**	.24325	**87**	.67738
4	.01019	**32**	.05058	**60**	.25509	**88**	.69141
5	.01062	**33**	.05392	**61**	.26733	**89**	.70474
6	.01116	**34**	.05750	**62**	.27998	**90**	.71779
7	.01178	**35**	.06132	**63**	.29304	**91**	.73045
8	.01252	**36**	.06540	**64**	.30648	**92**	.74229
9	.01337	**37**	.06974	**65**	.32030	**93**	.75308
10	.01435	**38**	.07433	**66**	.33449	**94**	.76272
11	.01547	**39**	.07917	**67**	.34902	**95**	.77113
12	.01671	**40**	.08429	**68**	.36390	**96**	.77819
13	.01802	**41**	.08970	**69**	.37914	**97**	.78450
14	.01934	**42**	.09543	**70**	.39478	**98**	.79000
15	.02063	**43**	.10145	**71**	.41086	**99**	.79514
16	.02185	**44**	.10779	**72**	.42739	**100**	.80025
17	.02300	**45**	.11442	**73**	.44429	**101**	.80468
18	.02410	**46**	.12137	**74**	.46138	**102**	.80946
19	.02520	**47**	.12863	**75**	.47851	**103**	.81563
20	.02635	**48**	.13626	**76**	.49559	**104**	.82144
21	.02755	**49**	.14422	**77**	.51258	**105**	.83038
22	.02880	**50**	.15257	**78**	.52951	**106**	.84512
23	.03014	**51**	.16126	**79**	.54643	**107**	.86591
24	.03159	**52**	.17031	**80**	.56341	**108**	.89932
25	.03322	**53**	.17972	**81**	.58033	**109**	.95455
26	.03505	**54**	.18946	**82**	.59705		
27	.03710	**55**	.19954	**83**	.61358		

(7-1-24)

02. Transfer of a Life Estate. When a life estate in real property is transferred by an individual during the look-back period for less than fair market value, the value of the life estate is subject to the asset transfer penalty as described in Sections 831 and 835 of these rules. To compute the value of the life estate, multiply the fair market value of the real property at the time of transfer by the life estate factor for the participant's age at the time of transfer listed in the following table:

TABLE 837.02 - LIFE ESTATE TABLE

Age	Life Estate	Age	Life Estate	Age	Life Estate	Age	Life Estate
0	.97188	**28**	.96062	**56**	.79006	**84**	.36998
1	.98988	**29**	.95813	**57**	.77391	**85**	.35359
2	.99017	**30**	.95543	**58**	.76822	**86**	.33764
3	.99008	**31**	.95254	**59**	.75675	**87**	.32262
4	.98981	**32**	.94942	**60**	.74491	**88**	.30859
5	.98938	**33**	.94608	**61**	.73267	**89**	.29526
6	.98884	**34**	.94250	**62**	.72002	**90**	.28221
7	.98822	**35**	.93868	**63**	.70696	**91**	.26955
8	.98748	**36**	.93460	**64**	.69352	**92**	.25771
9	.98663	**37**	.93026	**65**	67970	**93**	.24692
10	.98565	**38**	.92567	**66**	.66551	**94**	.23728
11	.98453	**39**	.92083	**67**	.65098	**95**	.22887
12	.98359	**40**	.91571	**68**	.63610	**96**	.22181
13	.98198	**41**	.91030	**69**	.62086	**97**	.21550
14	.98066	**42**	.90457	**70**	.60522	**98**	.21000
15	.97937	**43**	.89855	**71**	.58914	**99**	.20486
16	.97815	**44**	.89221	**72**	.57261	**100**	.19975
17	.97700	**45**	.88558	**73**	.55571	**101**	.19532
18	.97590	**46**	.87863	**74**	.53862	**102**	.19054
19	.97480	**47**	.87137	**75**	.52149	**103**	.18437
20	.97365	**48**	.86374	**76**	.50441	**104**	.17856
21	.97425	**49**	.85578	**77**	.48742	**105**	.16962
22	.97120	**50**	.83743	**78**	.47049	**106**	.15488
23	.96986	**51**	.83674	**79**	.45357	**107**	.13409
24	.96841	**52**	.82969	**80**	.43659	**108**	.10068
25	.96678	**53**	.82028	**81**	.41967	**109**	.04545
26	.96495	**54**	.81054	**82**	.40295		
27	.96290	**55**	.80046	**83**	.38642		

(7-1-24)

838. ANNUITY AS ASSET TRANSFER.
Except as provided in this rule, when assets are used to purchase an annuity during the look-back period, it is an asset transfer presumed to be made for the purpose of qualifying for Medicaid. To rebut this presumption, the participant must provide proof that clearly establishes the annuity was not purchased to make the participant eligible for Medicaid or avoid recovery from the estate following death. Proof is met if the participant shows the annuity meets

the requirements Subsections 838.02 through 838.05 of this rule. (7-1-24)

01. Revocable Annuity. Is an annuity that can be assigned. The surrender amount of a revocable annuity is a countable resource. (7-1-24)

02. Irrevocable Annuity. The purchase price of an irrevocable, non-assignable annuity is treated as an asset transfer, unless the requirements of Subsections 838.03 through 838.05 of this rule are met. (7-1-24)

03. Irrevocable Annuity Life Expectancy Test. The participant's life expectancy, as shown in the Social Security Actuarial - Period Life Table (2020), must equal or exceed the term of the annuity. Using the Table, compare the face value of the annuity to the participant's life expectancy at the purchase time. The annuity meets the life expectancy test if the participant's life expectancy equals or exceeds the term of the annuity. If the exact age is not in the Table, use the next lower age. See https://www.ssa.gov/oact/STATS/table4c6.html. (7-1-24)

04. State Named as Beneficiary. The purchase of an annuity is treated as an asset transfer unless the State of Idaho, Medicaid Estate Recovery is named as: (7-1-24)

a. The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this title; or (7-1-24)

b. The remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if the community spouse or a representative of the minor or disabled child disposes of any remainder for less than fair market value. (7-1-24)

05. Equal Payment Test. The annuity must provide for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made. (7-1-24)

06. Permitted Annuity. The purchase of an annuity is not treated as an asset transfer if the annuity meets any of the descriptions in Sections 408(b), or 408(q), Internal Revenue Code; or is purchased with proceeds from an account or trust described in Sections 408(a), 408(c), or 408(p), Internal Revenue Code, or is a simplified employee pension as described in Section 408(k), Internal Revenue Code, or is a Roth IRA described in Section 408A, Internal Revenue Code. (7-1-24)

839. TRUSTS AS ASSET TRANSFERS.

A trust established wholly or partly from the participant's assets is an asset transfer. Assets transferred to a trust on or after August 11, 1993 are subject to the asset transfer penalty, regardless of when the trust was established. If the trust includes assets of another person, the asset transfer penalty applies to the participant's share of the trust. (7-1-24)

840. TRANSFER OF JOINTLY OWNED ASSET.

Transfer of an asset owned jointly by the participant and another person is considered a transfer by the participant. The participant's share of the asset is used to compute the penalty. If the participant and their spouse are joint owners of the transferred asset, the couple's combined ownership is used to compute the penalty. If the spouse becomes eligible for long-term care Medicaid, the rest of the period of restricted coverage is divided between the participant and spouse. (7-1-24)

841. PENALTY EXCEPTIONS FOR ASSET TRANSFERS.

A participant is not subject to the asset transfer penalty for taking any action described in Subsections 841.01 through 841.15 of this rule. (7-1-24)

01. Home to Spouse. The asset transferred was a home. Title to the home was transferred to the spouse. (7-1-24)

02. Home to Minor Child or Disabled Adult Child. The asset transferred was a home. Title to the home was transferred to the child of the participant or spouse. The child must be under age twenty-one (21) or blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-24)

03. Home to Brother or Sister. The asset transferred was a home. Title to the home was transferred to

a sibling of the participant or spouse. The sibling 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 participant starts long-term care. (7-1-24)

04. Home to Adult Child. The asset transferred was a home. Title to the home was transferred to a child of the participant or spouse, other than a child under the age of twenty-one (21). The child must reside in that home for at least two (2) years immediately before the month the participant started long-term care. The adult child must prove they provided nursing facility level medical care to the participant which permitted them to live at home rather than enter long-term care. The child must not have received payment from Medicaid for home and community-based services provided to the participant. (7-1-24)

05. Benefit of Spouse. The assets were transferred to the participant's spouse or to another person for the sole benefit of the spouse. (7-1-24)

06. Transfer From Spouse. The assets were transferred from the participant's spouse to another person for the sole benefit of the participant's spouse. (7-1-24)

07. Transfer to Child. The assets were transferred to the participant's child, or to a trust established solely for the benefit of the participant's child. The child must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. The child may be any age. (7-1-24)

08. Intent to Get Fair Market Value. The participant or spouse proves they intended to dispose of the assets at fair market value or for other adequate consideration. (7-1-24)

09. Assets Returned. All assets transferred for less than fair market value have been returned to the participant. (7-1-24)

10. Medicaid Qualification Not the Intent. The participant or spouse proves the assets were transferred exclusively for a purpose other than to qualify for Medicaid or to avoid recovery. (7-1-24)

11. Undue Hardship. The participant, their representative, or the facility in which they reside may request the hardship waiver. The hardship waiver must be requested in writing within ten (10) days of the date of the asset transfer penalty notice. Undue hardship exists if any of the conditions below apply. (7-1-24)

a. The participant proves they are not able to pay for their nursing facility services or their waiver services by any means. (7-1-24)

b. The participant proves that they have made reasonable efforts, consistent with their physical and financial ability, to recover the transferred asset. The participant must fully cooperate with the State of Idaho in efforts to recover the transferred asset and, upon request, must assign their rights to recover the asset to the State of Idaho. (7-1-24)

c. The participant proves they did not knowingly transfer the asset. (7-1-24)

d. The participant proves they would be deprived of food, clothing, shelter, or other necessities of life if the asset transfer penalty is imposed and they assign their rights to recover the asset to the State of Idaho. (7-1-24)

12. Exception to Fair Market Value. The amount received is adequate, even if not fair market value. This exception must meet one (1) of the conditions below. (7-1-24)

a. A forced sale was done under reasonable circumstances. (7-1-24)

b. Little or no market demand exists for the type of asset transferred and the lack of market demand was not created by a voluntary act of the participant to qualify for assistance or to avoid recovery. (7-1-24)

c. The asset was transferred to settle a legal debt approximately equal to the fair market value of the transferred asset. (7-1-24)

13. No Benefit to Participant. The participant received no benefit from the asset. This exception must meet one (1) of the conditions below. (7-1-24)

a. The participant or spouse held title to the property only as a trustee for another person and had no beneficial interest in the property. (7-1-24)

b. The transfer was done to clear title to property. The participant or spouse had no beneficial interest in the property. The defect in the title was not created to transfer assets to qualify for assistance or avoid recovery. (7-1-24)

14. Fraud Victim. The asset was transferred because the participant or spouse was the victim of fraud, misrepresentation, or coercion. The participant or spouse must take all possible steps to recover the assets or property, or its equivalent in damages and assign recovery rights to the State of Idaho. (7-1-24)

15. Transfer to Trust of Disabled Person. The assets were transferred to a trust established solely for the benefit of an individual under sixty-five (65) years of age who is disabled. (7-1-24)

842. -- 870. (RESERVED)

871. TREATMENT OF TRUSTS.
This trust treatment rule applies to all Medicaid participants. This rules applies to trusts established with the participant's assets on August 11, 1993, or later, and to amounts placed in trusts on or after August 11, 1993. This rule does not apply to an irrevocable trust if the participant meets the undue hardship exemption in Subsection 841.11 of these rules. Assets transferred to a trust are subject to the asset transfer penalty. This rule does not apply to a trust created with assets other than those of the individual, including a trust established by a will. (7-1-24)

01. Revocable Trust. Is treated as listed below. A revocable burial trust is not a trust for the purposes of Subsection 871.01 of this rule. (7-1-24)

a. The body (corpus) of a revocable trust is a resource. (7-1-24)

b. Payments from the trust to or for the participant are income. (7-1-24)

c. Any other payments from the trust are an asset transfer, triggering an asset transfer penalty period. (7-1-24)

d. Under 42 USC 1396p(e)(5), the home and adjoining property loses its exclusion for eligibility purposes when transferred to a revocable trust, unless the participant or spouse is the sole beneficiary of the trust. The home is excluded again if removed from the trust. The exclusion restarts the month following the month the home was removed from the trust. (7-1-24)

02. Irrevocable Trust. Is treated as listed below. (7-1-24)

a. The part of the body of an irrevocable trust, from which corpus or income payments could be made to or for the participant, is a resource. (7-1-24)

b. Payments made to or for the participant are income. (7-1-24)

c. Payments from the trust for any other reason are asset transfers, triggering the asset transfer penalty. (7-1-24)

d. Any part of the trust from which payment cannot be made to, or for the benefit of the participant under any circumstances, is an asset transfer. (7-1-24)

e. The effective date of the transfer is the date the trust was established, or the date payments to the participant were foreclosed. (7-1-24)

f. 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. (7-1-24)

g. An irrevocable burial trust is not subject to treatment under Subsection 871.02 of this rule, unless funds in the trust can be paid for a purpose other than the participant's funeral and related expenses. The trust can provide that funds not needed for the participant's funeral expenses are available to reimburse Medicaid, or to go to the participant's estate. (7-1-24)

872. EXEMPT TRUSTS.
A trust, created or funded on or after August 11, 1993, is exempt from trust treatment and not subject to the asset transfer penalty if it meets a condition below. (7-1-24)

01. Trust for Disabled Person. To be exempt, a trust for a disabled person must meet all the conditions below. (7-1-24)

a. The trust contains the assets of a person under age sixty-five (65). (7-1-24)

b. The person is blind or totally disabled under the Social Security and SSI rules in 20 CFR Part 416. (7-1-24)

c. The trust is established for the person's benefit by their parent, grandparent, legal guardian, or a court. (7-1-24)

d. The trust is irrevocable. (7-1-24)

e. The trust is exempt until the person reaches age sixty-five (65). After the person reaches age sixty-five (65), additions or augmentations are not exempt from trust treatment. (7-1-24)

f. Upon the person's death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person's behalf. (7-1-24)

02. Income Trust. To be exempt, an income trust must meet all the conditions below. (7-1-24)

a. The trust is established for the sole benefit of a person who would be eligible for Medicaid in long-term care, or eligible for HCBS except for excess income. (7-1-24)

b. Any income, placed directly into an income trust in the same calendar month in which received by the recipient, is not considered income to the individual for determining long-term care Medicaid eligibility. Money paid into the trust is income for patient liability or participant participation. (7-1-24)

c. The trust is irrevocable. The trust document may include a clause allowing the trust to be revoked if the participant leaves the nursing facility or HCBS for a reason other than death, and is no longer eligible for Medicaid because of excess income, if Medicaid is reimbursed up to the amount Medicaid has paid on the person's behalf. (7-1-24)

d. Income transferred to the trust must be used to pay patient liability or participant participation. If income is not used to pay allowable expenses, it is subject to the asset transfer penalty, unless one (1) of the following exceptions applies. (7-1-24)

i. Benefit of the spouse in Subsection 841.05 of these rules; (7-1-24)

ii. Transfer from the spouse in Subsection 841.06 of these rules; or (7-1-24)

iii. Undue hardship in Subsection 841.11 of these rules. (7-1-24)

e. Upon the person's death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person's behalf. (7-1-24)

03. Trust Managed by Non-Profit Association for Disabled Person. To be exempt, a trust managed by non-profit association for a disabled person must meet all the conditions below. (7-1-24)

a. The trust is established and managed by a nonprofit association. The nonprofit association must not be the participant, their parent, or grandparent. (7-1-24)

b. The trust contains the assets of a disabled person. The person must be blind or totally disabled under Social Security and SSI rules in 20 CFR Part 416. (7-1-24)

c. Accounts in the trust are established only for the benefit of disabled persons. An account can be established by the disabled person, their parent, grandparent, legal guardian, or a court. A separate account must be maintained for each beneficiary of the trust. For purposes of investment and management, the trust may pool the funds in the accounts. (7-1-24)

d. The trust is irrevocable. (7-1-24)

e. Upon the person's death, the amount not distributed by the trust must first be paid to the State of Idaho, up to the amount Medicaid has paid on the person's behalf. (7-1-24)

873. PAYMENTS FROM AN EXEMPT TRUST FOR DISABLED PERSON OR POOLED TRUST.
Cash payments from an exempt trust for a disabled person or a pooled trust must be treated as described below. (7-1-24)

01. Cash Payments from Exempt Trust. For a disabled person are income in the month received. (7-1-24)

02. Cash Payments from Pooled Trust. Are made directly to the participant are income in the month received. (7-1-24)

03. Payments for the Participant's Food or Shelter. Are income in the month paid. The payments for food or shelter are valued at one-third (1/3) of the AABD budgeted needs for the participant's living arrangement. (7-1-24)

04. Payments Not Made to Participant. Payments from the exempt trust not made to, or on behalf of, the participant are an asset transfer. (7-1-24)

874. -- 914. (RESERVED)

915. MEDICAID REDETERMINATION.
Medicaid eligibility is redetermined each year. The redetermination for AABD cash is the Medicaid redetermination for participants receiving both programs. (7-1-24)

916. -- 999. (RESERVED)