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These rules (4200s) were repealed effective 1/1/2014 and have been replaced with Health Benefits Eligiblity & Enrollment (HBEE).

4200 Medicaid: Aged, Blind, and Disabled (02/01/2007, 06-46)

Individuals who are aged, blind, or disabled (rule 4211) are eligible for Medicaid if they meet the financial and nonfinancial requirements for participation in the Medicaid program. Financial requirements (rules 4220-4223) relate to the availability of resources (rules 4230-4264.2) and income (rules 4270-4284). Nonfinancial requirements include general requirements for Medicaid participation (rules 4100-4177), the criteria for one of the coverage groups identified in rules 4202-4204, citizenship (rules 4170, 4216), Vermont residency (rule 4217), and living arrangement (rule 4218). The coverage groups include the categorically needy groups described beginning with rule 4202, the medically needy group described at rule 4203, and the Medicare cost-sharing groups described beginning with rule 4204

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4201 **Date of this Memo** 06/29/2009 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

"Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24 hour care, has privacy, a lockable door, and is a homelike setting.

An institutionalized spouse is permitted to allocate income and resources to a community spouse when the community spouse resides in assisted living.

4201 Definitions (02/01/2007, 06-46)

This section defines terms used throughout rules 4200-4284.

A. Community Medicaid means Medicaid services other than long-term care.

B. Community spouse (CS) means the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. A person is considered a community spouse even when receiving waiver services if that person is the spouse of an individual who is receiving long-term care.

C. Coverage group refers to individuals who meet the specific financial and nonfinancial requirements of eligibility for Medicaid payment of particular medical services.

D. Financial responsibility group means the people whose income and resources are considered when determining eligibility for a Medicaid group.

E. Institutionalized individual means a person requesting Medicaid coverage for long-term care, whether the care is received at home in the community pursuant to a waiver or in a long-term care facility licensed by the Department of Disabilities, Aging and Independent Living.

F. Institutionalized spouse (IS) means an institutionalized individual whose spouse qualifies as a community spouse.

G. Long-term care means highest need and high need care, as determined by the licensing division of the Department of Disabilities, Aging and Independent Living received by people living in nursing facilities, rehabilitation centers, intermediate care facilities for the mentally retarded (ICF-MR), and other medical facilities for more than 30 consecutive days. It also includes waiver and hospice services.

H. Medicaid group means one of two kinds of groups in SSI-related Medicaid: or spouses where at least one spouse is aged, blind or disabled, or an aged, blind or disabled individual with no spouse. The countable income and resources of the financial responsibility group are compared against the income and resource standards applicable to the Medicaid groups size.

I. Medicaid services means medical services funded through Medicaid. They include Medicaid services (rules 7201-7508.7), long-term care (rules 7601-7608), and services defined in the Department for Disabilities, Aging and Independent Living (DAIL) Choices for Care regulations.

J. SSI-related Medicaid means health care coverage available to members of the Medicaid group who are aged, blind, or disabled and pass financial and nonfinancial eligibility criteria for Medicaid. SSI-related Medicaid is based on two financial assistance programs federally administered by the Social Security Administration: the supplemental security income program (SSI) and aid to the aged, blind and disabled program (AABD).

K. Waiver services means specialized medical services approved under an exception to standard Medicaid rules for a specific population.

It includes certain services administered by the DAIL:

1. home-based and enhanced residential care services for the aged and disabled (known as “Choices for Care”),

2. traumatic brain injury services (TBI waiver), and

3. home-and-community-based waiver services for the developmentally disabled (DS waiver).

It also includes services administered by the Vermont Department of Mental Health:

4. children's mental health waiver services.

DCF determines financial and nonfinancial eligibility, other than disability, for these services. DCF, through the disability determination services unit determines whether individuals are blind or disabled according to the criteria in rules 4213-4215, except as stated below.

- When DAIL administers the waiver services, it determines whether applicants need the level of care provided in a nursing facility, an intermediate care facility for the mentally retarded, or out-of-state rehabilitation facility qualified to serve persons with a traumatic brain injury. For the TBI and DS waivers, DAIL also determines whether applicants meet the disability criteria.
- When VDH administers the waiver services, it determines whether, if waiver services were not available, children under age 22 need the level of care provided in an inpatient psychiatric facility for children.

Categorically Needy Coverage Groups

4202 Categorically Needy Coverage Groups (08/01/2003, 02-11)

To be eligible for SSI-related Medicaid as categorically needy, individuals must meet the criteria in one or more of the following coverage groups, in addition to other nonfinancial and financial requirements. When an individual becomes ineligible for one coverage group, the department tests for other categorical and then medically needy eligibility. Medicaid remains open until an individual no longer passes any of the eligibility tests, per rule 4142.

4202.1 SSI/AABD Recipients (08/01/2003, 02-11)

Individuals granted SSI/AABD by the Social Security Administration are eligible for SSI-related Medicaid. In addition to SSI/AABD recipients, this group includes individuals determined presumptively disabled and those who do not receive an SSI/AABD payment because of recoupment.

4202.2 SSI-Eligible Coverage Groups (08/01/2003, 02-11)

The following individuals are eligible for SSI-related Medicaid as categorically needy.

A. Individuals who would be eligible for SSI/AABD except that they:

1. have not applied for SSI/AABD, or

2. do not meet SSI/AABD requirements not applicable to Medicaid, such as participation in vocational rehabilitation or a substance abuse treatment program.

Individuals in this categorically needy coverage group must have income and resources at or below SSI/AABD maximums and meet the nonfinancial criteria for SSI-related Medicaid.

B. Individuals who the Social Security Administration determines eligible under the Social Security Act §1619(b) because they meet all SSI/AABD eligibility requirements except for the amount of their earnings and who:

1. do not have sufficient earnings to provide the reasonable equivalent of publicly funded attendant care services that would be available if they did not have such earnings; and

2. are seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment.

4202.3 Long-Term Care Coverage Groups (09/01/2005, 05-19)

The following individuals are eligible for SSI-related Medicaid as categorically needy.

A. Medical institution - Individuals who live in a medical institution and have gross income under the institutional income standard.

B. Special income group – Individuals who qualify for waiver services and who:

1. would be eligible for Medicaid if they were living in a medical institution;

2. have gross income between the protected income level and the institutional income standard; and

3. can receive appropriate long-term medical care in the community, as determined by the Department of Disabilities, Aging and Independent Living.

C. Working people with disabilities – Individuals who qualify for home-based care under the waiver serving the aged and disabled and meet the financial eligibility requirements specified in rule 4202.4.

D. Hospice care - Individuals who:

1. would be eligible for Medicaid if they were living in a medical institution;

2. can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution; and

3. receive hospice care as described in rule 4412 and defined in section 1905(o) of the Social Security Act.

E. Disabled Child in Home Care (DCHC, Katie Beckett) - Individuals who:

1. require the level of care provided in a medical institution;

2. would be eligible for Medicaid if they were living in a medical institution;

3. can receive appropriate medical care in the community, the cost of which is no greater than the estimated cost of medical care in an appropriate institution;

4. are age 18 or younger;

5. have income, excluding their parents income, no greater than the institutional income standard; and

6. have resources, excluding their parents resources, no greater than the resource limit for a Medicaid group of one.

4202.4 Coverage Groups For New Applicants (08/01/2003, 02-11)

The following individuals are eligible for SSI-related Medicaid as categorically needy.

A. Breast or cervical cancer - Women found to have breast or cervical cancer, including precancerous conditions, screened through the National Breast and Cervical Cancer Early Detection Program and who:

1. are under age 65;

2. uninsured; and

3. otherwise not eligible for SSI-related or ANFC-related Medicaid.

Coverage under this category begins following the screening and diagnosis and continues as long as a treating health professional verifies the woman is in need of cancer treatment services.

B. Working people with disabilities - Individuals with disabilities who are working and otherwise eligible for SSI-related Medicaid and whose:

1. resources at the time of enrollment in the group do not exceed $5,000 for an individual and $6,000.00 for a couple (see rule 4248.8 for resource exclusion after enrollment);

2. income is below 250 percent of the federal poverty level (FPL) associated with the applicable family size;

3. income does not exceed either the Medicaid protected income level for one or the SSI/AABD payment level for two, whichever is higher, after disregarding the earnings, social security disability insurance benefits (SSDI), and any veterans disability benefits of the individual working with disabilities; and

4. earnings are documented by evidence of Federal Insurance Contributions Act tax payments, Self-employment Contributions Act tax payments, or a written business plan approved and supported by a third-party investor or funding source;

Earnings, SSDI, and veterans disability benefits are not disregarded for applicants with spenddown requirements who do not meet all of the above requirements and seek coverage under the medically needy coverage group (rule 4203).

4202.5 Coverage Groups For Former SSI Recipients (08/01/2003, 02-11)

The following individuals remain eligible for SSI-related Medicaid as categorically needy.

A. Children who lost their SSI or SSI/AABD eligibility because of the more restrictive definition of disability enacted in 1996 but who continue to meet all other SSI-related Medicaid criteria until their 18th birthday (Personal Responsibility and Work Opportunity Reconciliation Act §4913).

B. Surviving spouses or spouses who have obtained a legal dissolution and remain single (and was the spouse of the insured for at least 10 years) with a disability who meet one of the following groups of criteria under the Social Security Act (SSA §§1634(b)(1); 1634(d); 42 U. S. C. §§1383c(b)(1); 1383c(d)).

1. Individuals who:

   a. applied for SSI-related Medicaid no later than July 1, 1988;

   b. were receiving SSI/AABD in December, 1983 and lost SSI/AABD in January 1984 due to a statutory elimination of an additional benefit reduction factor for surviving spouses before attainment of age 60 who have been continuously entitled to surviving spouse insurance based on disability since January 1984; and

   c. would continue to be eligible for SSI/AABD if they had not received the increase in social security disability or retirement benefits.

2. Individuals who:

   a. lost SSI/AABD benefits due to a mandatory application for and receipt of social security disability, retirement or survivor benefits;

   b. are not yet eligible for Medicare Part A;

   c. are at least age 50, but have not yet attained age 65; and

   d. would continue to be eligible for SSI/AABD if they were not receiving social security disability or retirement benefits.

Categorically Needy Coverage Groups

C. Individuals with a disability under the Social Security Act (SSA §1634(c); 42 U. S. C. §1383c(c)) who:

1. are over age 18;

2. have blindness or a disability that began before age 22;

3. are entitled to social security benefits on their parents record due to retirement, death or disability benefits and lost SSI/AABD due to receipt of this benefit or an increase in this benefit; and

4. would remain eligible for SSI/AABD in the absence of the social security retirement, death or disability benefit or increases in that benefit.

D. Individuals determined eligible under the Pickle Amendment to Title XIX of the Social Security Act (SSA §1935(a)(5)(E); 42 U. S. C. §1396v(a)(5)(E)) who:

1. are receiving social security retirement or disability benefits;

2. became eligible for and received SSI or SSI/AABD for at least one month after April 1977; and

3. lost SSI/AABD benefits but would be eligible for them if all increases in their Medicaid groups social security benefits due to annual cost-of-living adjustments (COLAs) were deducted as income.

E. Individuals who were eligible for Medicaid in December 1973 and meet at least one of the following criteria:

1. an institutionalized individual who has been eligible for Medicaid each consecutive month after December 1973;

2. a blind or disabled individual who meets all current requirements for Medicaid eligibility except blindness or disability and has been eligible for Medicaid each consecutive month after December 1973; or

3. an essential spouse whose needs have been included in computing the SSI or SSI/AABD payment to an aged, blind, or disabled individual living with the essential spouse since December 1973 and both have continuously received AABD.

F. Individuals who:

1. were entitled to social security retirement or disability and eligible for AABD in August 1972 or would have been eligible if they had applied or were not in a medical institution or intermediate care facility; and

2. would be eligible for SSI or SSI/AABD now, except that the 20 percent cost-of-living increase in social security benefits effective September 1972 raised their income over the AABD limit.

Medically Needy Coverage Group

4203 Medically Needy Coverage Group (02/01/2007, 06-46)

Individuals who would be members of a categorically needy coverage group may qualify for Medicaid as medically needy even if their income or resources exceed coverage group limits. These individuals may become eligible if they incur enough non-covered medical expenses to reduce their income to the applicable standard. For community Medicaid, individuals must reduce their income to the protected income level (PIL). For long-term care, including waiver and hospice services, individuals also must spend down their income to the PIL. In addition, all individuals must have resources below the categorically needy program resource limit. The rules in 4431 – 4454 specify how individuals may use non-covered medical expenses to "spend down" their income or resources to the applicable limits.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation [ ] Medicaid SSI Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4204.1 Date of this Memo 12/01/2005 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

The resource test eligibility requirement for Qualified Medicare Beneficiaries (QMB) has been eliminated.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation [ ] Medicaid SSI Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4204.2 Date of this Memo 12/01/2005 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

The resource test eligibility requirement for Qualified Disabled and Working Individuals (QDWI) has been eliminated.

Medicare Cost-Sharing Coverage Groups

4204 Medicare Cost-Sharing Coverage Groups (02/01/2007, 06-46)

Limited Medicaid benefits are available to pay for out-of-pocket Medicare cost-sharing expenses for certain Medicare beneficiaries. Such beneficiaries are eligible for Medicaid payment of certain Medicare costs if they meet the additional criteria specified for one of the groups in rules 4204.1–4204.4.

Individuals eligible for one of the following Medicare cost-sharing coverage groups may also be eligible for the full range of Medicaid covered services if they also meet the requirements for one of the categorical (rule 4202) or medically needy coverage groups (rule 4203).

Applicants may not spend down income to meet the financial eligibility tests for these coverage groups. The department disregards annual cost-of-living (COLA) increases in social security benefits in determining eligibility for these groups until the month after the annual publication of the official poverty line revisions.

4204.1 Qualified Medicare Beneficiaries (QMB) (02/01/2007, 06-46)

Individuals are eligible for Medicaid payment of their Medicare Part A and Part B premiums, deductibles, and coinsurance if their Medicaid group has countable income at or below 100 percent of the federal poverty level.

Benefits under this provision become effective on the first day of the calendar month immediately following the month in which the individual is determined to be eligible.

4204.2 Qualified Disabled and Working Individuals (QDWI) (01/01/2006, 05-24)

Individuals who have lost their Medicare benefits based on disability because they returned to work, are eligible for Medicaid payment of their Medicare Part A premiums if they:

A. are disabled;

B. belong to a Medicaid group with countable income at or below 200 percent of the federal poverty level applicable to the Medicaid groups size;

C. are members of a Medicaid group with resources at or below twice the SSI-related Medicaid limit applicable to the groups size; and

D. are not otherwise eligible for Medicaid.

Benefits under this provision become effective on either the date of application or the date on which all eligibility criteria are met, whichever is later. The department may grant benefits for a retroactive period of up to three months prior to that effective date, provided that the individual meets all eligibility criteria.

4204.3 Specified Low-Income Medicare Beneficiaries (SLMB) (01/01/2006, 05-24)

Individuals are eligible for Medicaid payment of their Medicare Part B premiums if:

A. they receive Medicare Part A; and

B. their Medicaid group has countable income greater than 100 percent but no greater than 120 percent of the federal poverty level.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation [ ] Medicaid SSI Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4204.4 Date of this Memo 12/01/2005 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

The resource test eligibility requirement for Qualified Individuals (QI-I) has been eliminated.

Medicare Cost-Sharing Coverage Groups

Benefits under this provision become effective on either the date of application or the date on which all eligibility criteria are met, whichever is later. The department may grant benefits for a retroactive period of up to three months prior to that effective date, provided that the individual meets all eligibility criteria.

4204.4 Qualified Individuals (QI-1) (01/01/2006, 05-24)

Individuals who receive Medicare Part A and do not receive other federally funded medical assistance, except for coverage for excluded drug classes under Part D when the individual is enrolled in Part D, are eligible for Medicaid payment of their Medicare Part B premium.

The QI-1 coverage group includes individuals in a Medicaid group with income that is at least 120 percent but less than 135 percent of the federal poverty level that are eligible for Medicaid payment of their Medicare Part B premium.

Benefits under this provision become effective on the first day of the calendar month immediately following the month in which the individual is determined to be eligible. The department may grant benefits for a retroactive period of up to three months from the date of application, provided that all eligibility criteria are met. The benefit period ends in December of each calendar year. People requesting this coverage must reapply each calendar year.

Nonfinancial Eligibility Tests

4210 Nonfinancial Eligibility Tests (08/01/2003, 02-11)

The following sections specify the nonfinancial eligibility tests that individuals not receiving SSI/AABD benefits must pass in order to receive SSI-related Medicaid.

Relationship to SSI

4211 Relationship to SSI (08/01/2003, 02-11)

Applicants for SSI-related Medicaid must establish their categorical relationship to SSI by qualifying as one or more of the following:

A. aged, by being 65 years of age or over;

B. blind, by being determined blind by the state's disability determination services (DDS) unit or in receipt of social security disability benefits based on blindness; or

C. disabled, by being determined disabled by the state's disability determination services unit or in receipt of social security disability benefits based on disability.

Definition of Age

4212 Definition of Age (08/01/2003, 02-11)

Individuals qualifying on the basis of age must be at least 65 years of age in or before the month in which eligibility begins.

Blind or disabled children are individuals who are single or not the head of a household and are:

A. under age 18

B. under the age of 22 and a student regularly attending school, college or university, or a course of vocational or technical training to prepare him or her for gainful employment.

4213 Definition of Disability (08/01/2003, 02-11)

Individuals age 18 or older are considered disabled if they are unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, individuals must have a severe impairment, which makes them unable to do their previous work or any other substantial gainful activity which exists in the national economy. To determine whether individuals are able to do any other work, the disability determination unit considers their residual functional capacity, age, education, and work experience.

Children under age 18 are considered disabled if they have a medically determinable physical or mental impairment, or combination of impairments, resulting in marked and severe functional limitations, that can be expected to result in death or that have lasted or can be expected to last for at least 12 consecutive months. Children engaging in substantial gainful activity may not be considered disabled.

4213.1 Substantial Gainful Activity (08/01/2003, 02-11)

Substantial gainful activity is work activity that is both substantial and gainful.

Substantial work activity involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if individuals do less, get paid less or have less responsibility than when they worked before.

Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

Individuals who are working with disabilities shall be exempt from the substantial gainful activity (SGA) step of the sequential evaluation of the disability determination if they otherwise meet the requirements set forth in rule 4202.4 for the categorically needy working disabled.

Definition of Blindness

4214 Definition of Blindness (08/01/2003, 02-11)

Blindness means having central visual acuity of 20/200 or less, even with glasses, or a limited visual field of 20 degrees or less in the better eye with the use of a correcting lens.

Determining Disability or Blindness

4215 Determining Disability or Blindness (08/01/2003, 02-11)

Disability and blindness determinations are made by the disability determination services unit in accordance with the applicable requirements of the social security administration (SSA) based on information supplied by the applicant and by reports obtained from the physicians and other health care professionals who have treated the applicant.

The department explains the disability determination process to applicants, helps them complete the required forms and forwards this information to the disability determination unit.

The disability determination unit may determine individuals are disabled in any of the circumstances described below.

A. Individuals who have not applied for SSI/AABD.

B. Individuals who have applied for SSI/AABD and were found ineligible for a reason other than disability.

C. Individuals who have applied for SSI/AABD and SSA has not made a disability determination within 90 days from the date of their application for Medicaid.

D. Individuals who have been found "not disabled" by SSA, have filed a timely appeal with SSA, and a final determination has not been made by SSA.

E. Individuals who claim that:

1. their condition has changed or deteriorated since the most recent SSA determination of "not disabled,"

2. a new period of disability meets the durational requirements of the Act,

3. the SSA determination was more than 12 months ago, and

4. they have not applied to SSA for a determination with respect to these allegations.

F. Individuals who claim that:

1. their condition has changed or deteriorated since the most recent SSA determination of "not disabled",

2. the SSA determination was fewer than 12 months ago,

3. a new period of disability meets the durational requirements of the Act, and

4. they have applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or they no longer meet the nondisability requirements for SSI but may meet the state’s nondisability requirements for Medicaid.

The department has primary responsibility, through its disability determination services unit, for assuring that adequate information is obtained upon which to base the determination. If additional information is needed to determine whether individuals are disabled or blind according to the Social Security Act, consulting examinations may be required. The reasonable charge for any medical examinations required to render a decision on disability or blindness shall be paid by the department.

Citizenship and Identity

4216 Citizenship and Identity (01/01/2007, 06-48)

The rules for citizenship and identity are in rule 4170.

4216.1 Emergency Medical Services (01/01/2007, 06-48)

The rule for emergency medical services is in rule 4177.

Residence

4217 Residence (10/07/2005, 05-25)

An individual must be a resident of Vermont to meet the residence requirement. The state of residence of an individual is determined according to the following:

A. For individuals receiving a state supplemental payment, the state of residence is the state paying the supplement.

   Exception: Individuals involved in work of a transient nature or who have moved to Vermont to seek employment, may claim Vermont as their state of residence and be granted Medicaid in Vermont if they meet all other eligibility criteria. These individuals may be granted Vermont Medicaid even though they continue to receive a state supplemental payment from another state.

B. For any blind or disabled individual under the age of 21 who is not residing in an institution, the state of residence is the state in which the individual is living.

C. For any institutionalized individual under the age of 21, or who is 21 or older and became incapable of indicating intent prior to the age of 21, state of residence is that of

   1. the parents or legal guardian, if one has been appointed, or
   2. the parent applying for Medicaid on behalf of the individual if the parents live in different states, or
   3. the individual or party who has filed the application on behalf of the applicant if the applicant has been abandoned by his or her parents and does not have a legal guardian.

D. For any non-institutionalized individual age 21 or older, residence is in the state in which the individual is living

   1. with intent to remain permanently or for an indefinite period of time, or
   2. while incapable of stating intent, or
   3. after entering with a job commitment or in pursuit of employment whether or not currently employed.

E. For any institutionalized individual age 21 or older and who became incapable of stating intent at or after age 21, residence is in the state in which the individual is physically present, unless another state arranged for the individual's placement in a Vermont institution. (rule 4217.2).

F. For any other institutionalized individual age 21 or older, residence is in the state where the individual is living with the intention to remain there permanently or for an indefinite period, unless another state has made a placement (see rule 4217.2). An institutionalized individual cannot be considered a Vermont resident if the individual owns a home (see rule 4241.1) in another state which the individual intends to return to even if the likelihood of return is apparently nil.

G. For a blind or disabled child of a parent in the Armed Forces whose SSI eligibility continues even though he/she moves overseas, Vermont Medicaid does not continue and, in addition, the child is no longer eligible for the State Supplement (AABD) to SSI.

4217.1 Temporary Absence (10/07/2005, 05-25)

Temporary absences from Vermont for any of the following purposes do not interrupt or end Vermont residence:

A. visiting,

B. obtaining necessary medical care,

C. obtaining education or training under a program of Vocational Rehabilitation, Work Incentive or higher education program, or

D. residence in a long-term care facility in another state, if arranged by an agent of the State of Vermont, unless the individual or his/her parents or guardian, as applicable, state intent to abandon Vermont residence and to reside outside Vermont upon discharge from long-term care.

4217.2 Placement in Vermont Institutions (10/07/2005, 05-25)

When an agent of another state arranges for an individual's placement in a Vermont institution, the individual remains a resident of the state which made the placement, irrespective of the individual's intent.

4217.3 Incapable of Stating Intent (08/01/2003, 02-11)

Individuals are incapable of stating intent regarding residence if:

A. their IQ is 49 or lower, or they have a mental age of 7 or lower, based on tests acceptable to the Developmental Disabilities Division of the Vermont Department of Developmental and Mental Health Services, or

B. they are judged legally incompetent, or

C. medical documentation, or other documentation acceptable for disability determination purposes, supports a finding that they are incapable of stating intent.

4217.4 Residence as Payment Requirement (08/01/2003, 02-11)

An individual must be a resident of Vermont at the time a medical service is rendered in order for Vermont Medicaid to pay for that service. The service does not, however, have to be rendered in Vermont.

4217.5 Specific Prohibitions (08/01/2003, 02-11)

Medicaid eligibility may not be denied to an applicant for any of the following reasons:

A. failure to reside in the state for a specified period; or

B. failure of an institutionalized person to establish residence in the state before entering the institution, if the individual satisfies the residency rules set forth in this section; or

C. temporary absence from the state if the individual intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for purposes of Medicaid; or

D. failure to have a permanent or fixed address. Homeless individuals may designate a mailing address with the exception that individuals who are also receiving 3SquaresVT may not designate the U. S. Post Office, c/o General Delivery.

4218 Living Arrangements (08/01/2003, 02-11)

Individuals or couples living in their own home, in the household of another or living in certain institutions listed in rules 4218.1 – 4218.2 meet the living arrangement requirement. An institution is an establishment that furnishes food, shelter and some treatment or services to four or more persons unrelated to the proprietor. The financial responsibility of relatives varies depending upon the type of living arrangement. Homeless individuals are considered to be living in their own home. See the Section Income and Resources: Introduction for definitions and treatment of relative responsibility.

4218.1 Public Institution (08/01/2003, 02-11)

A public institution is defined as any institution meeting all of the following conditions:

A. The institution is owned, maintained or operated in whole or in part by public funds; and

B. control is exercised, in whole or in part, by any public agency or an official or employee of that agency; and

C. the institution furnishes shelter and care and can be termed a public institution by reason of its origin, charter, ownership, maintenance or supervision.

Only the following individuals meet the living arrangement requirements if they are living in a public institution:

A. Patients under the age of 21 in the Vermont State Hospital (VSH). If a Medicaid recipient is a patient of VSH upon reaching his/her 21st birthday, eligibility may be continued to the date of discharge or his/her 22nd birthday, whichever comes first, upon a finding by the VSH Disability Determination Team that the individual is blind or disabled according to SSI/AABD standards.

B. Patients age 65 or older in the Vermont State Hospital.

C. Residents in an Intermediate Care Facility for the Mentally Retarded.

D. Patients of any age in a facility supported in whole or in part by public funds whose primary purpose is to provide medical care other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.

Residence in an institution is determined by the dates of admission and discharge. A person at home in the community on a visiting pass is still a resident of the institution.

4218.2 Private Facility (08/01/2003, 02-11)

A private facility is defined as any home privately owned and operated, or any home or institution supported by private or charitable funds, over which neither the State nor any of its subdivisions has supervision or control even though individuals may be boarded or cared for therein at public expense. Vermont private institutions include boarding homes, fraternal homes, religious homes, community care homes, residential care facilities, medical facilities (i.e. general hospitals) and nursing facilities licensed by the State of Vermont.

An individual living in a private facility meets the living arrangement requirement if:

A. the primary purpose of the facility is to provide medical care other than the treatment of mental diseases, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.; and

B. the facility meets the following criteria:

1. there is no agreement or contract obliging the institution to provide total support to the individual;

2. there has been no transfer of property to the institution by the individual or on his/her behalf, unless maintenance by the institution has been of sufficient duration to fully exhaust the individual's equity in the property transferred at a rate equal to the monthly charges to other residents in the institution; and

3. there is no restriction on the individual's freedom to leave the institution.

Individuals under the age of 21 or age 65 or older meet the living arrangement requirement if they live at the Brattleboro Retreat. In addition, individuals who are patients at the facility upon reaching their 21st birthday, have eligibility continued to the date of discharge (or end of ten day notice period, if later) or their 22nd birthday, whichever comes first, as long as continue to meet all other eligibility requirements.

4218.3 Correctional Facility (08/01/2003, 02-11)

Individuals living in a correctional facility, including a juvenile facility are not eligible for Medicaid. Residence in a correctional facility begins on the date of admission and ends when the individual moves out of the correctional facility. An individual transferred from a correctional facility to a medical facility is considered to be still living in the correctional facility.

Individuals who are Medicaid recipients immediately prior to confinement have their Medicaid enrollment terminated as soon as administratively possible, including the provision for advance notice of termination.

4220 Financial Eligibility (10/07/2005, 05-25)

Individuals requesting SSI-related Medicaid must meet the nonfinancial requirements of citizenship, residence, living arrangement, and relationship to SSI/AABD specified in rules 4210–4218.3. The department then determines whether the person requesting Medicaid meets the financial requirements specified in rules 4220-4284 and 4400–4474.4. This includes financial eligibility determinations for Medicaid waiver programs operated by the Vermont Department of Mental Health (DMH) and the Department of Disabilities, Aging and Independent Living (DAIL), except that DMH determines patient share costs for children eligible under its waiver program and DAIL determines patient share costs for individuals enrolled in the home-and-community-based waiver for the developmentally disabled.

To determine an individuals eligibility for SSI-related Medicaid, the department compares countable income and resources of the individuals financial responsibility group to maximums based on the size of the individuals Medicaid group. The first step in determining financial eligibility is to identify which individuals are members of the financial responsibility group and which are members of the Medicaid group. Aged, blind, or disabled persons requesting SSI-related Medicaid are always members of both groups.

The rules for forming the SSI-related Medicaid group and financial responsibility group are specified in rules 4221 and 4222.

4220.1 Definitions (02/01/2007, 06-46)

These definitions apply throughout the SSI-related Medicaid financial eligibility sections.

A. Dependent child means an individual who has always been single, lives with the parent, and is:

1. under age 18; or
2. a disabled student age 18 up to age 21.

B. A child is not considered living with the parent when:

1. the parent has relinquished control to a school or vocational facility;
2. the child is confined to a public institution or in the custody of a public agency;
3. the child is a member of the armed forces;
4. the child lives in a private nonmedical facility; or
5. the child has been admitted to long-term care.

A child away at school who returns to a parents home for vacations, holidays, or some weekends is considered living with the parent.

A child who qualifies for the Katie Beckett coverage group is not considered a dependent child for the purposes of determining financial eligibility for SSI-related Medicaid.

Individuals are no longer considered dependent children on the first day of the month following the calendar month in which they no longer meet the definition of dependent child.

C. Adult means an individual who is not a dependent child.

D. Ineligible child means

1. the applicant's natural child or adopted child, or

2. the natural or adopted child of the applicants spouse, or

3. the natural or adopted child of the applicants parent or of the applicant parent's spouse, who lives in the same household with the applicant, and is a dependent child.

E. Ineligible parent means

1. a natural or adoptive parent, or

2. the spouse of a natural or adoptive parent, who is not eligible for SSI-related Medicaid and who lives with a child applying for SSI-related Medicaid. The income of parents who do not meet the nonfinancial eligibility criteria only affects the eligibility of an applicant who is a dependent child.

F. Ineligible spouse means the spouse living with the applicant who does not meet the nonfinancial eligibility criteria for SSI-related Medicaid.

Formation of Financial Responsibility Group

4221 Formation of Financial Responsibility Group (02/01/2007, 06-46)

The SSI-related financial responsibility group consists of the individuals whose income and resources are considered available to the Medicaid group in the eligibility determination. With some exceptions, spouses are considered financially responsible for each other, and parents are considered financially responsible for their dependent children. The following subsections set forth the rules for determining membership in the financial responsibility group and the portion of the groups income considered available to the Medicaid group.

4221.1 Financial Responsibility Groups for Single Adults (02/01/2007, 06-46)

The financial responsibility group for an adult requesting SSI-related Medicaid, including long-term care, is the same as the adults Medicaid group.

4221.2 Financial Responsibility Groups for Children (02/01/2007, 06-46)

The financial responsibility group for a dependent child requesting SSI-related Medicaid includes the child and any parents living with the child, until the child reaches the age of 18.

4221.3 Financial Responsibility Groups for Sponsored Noncitizens (02/01/2007, 06-46)

The financial responsibility group for a noncitizen admitted to the United States on or after August 22, 1996 based on a sponsorship under section 204 of the Immigration and Nationalization Act (INA) includes the income and resources of the sponsor and the sponsor's spouse, if living with the sponsor, when all four of the following conditions are met:

A. the sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to conform to the requirements of Section 213A(b) of INA;

B. the noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;

C. the noncitizen is not battered; and

D. the noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

The above financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the Social Security Administration (rule 4221.4 on Qualifying Quarters of Coverage).

4221.4 Qualifying Quarters of Coverage (08/01/2003, 02-11)

A. An alien shall be credited with the following qualifying quarters of coverage, as defined under title II of the Social Security Act:

1. those worked by the alien;

Formation of Financial Responsibility Group

2. those worked by a parent of such alien while the alien was under age 18 unless the parent received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited after December 31, 1996, and

3. those worked by a spouse of the alien while they were spouses, as long as the alien remains the spouse or the spouse is deceased and the spouse did not receive any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited after December 31, 1996.

B. For this purpose federal means-tested benefits do not include:

1. emergency medical assistance;

2. short-term, non-cash, in-kind emergency disaster relief;

3. assistance under the National School Lunch Act or the Child Nutrition Act of 1966;

4. public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;

5. payments for foster care and adoption assistance under parts B and E of Title IV of the Social Security Act, under certain conditions;

6. programs, services, or assistance specified by the Attorney General;

7. programs of student assistance under titles IV, V, IX, and X of the Higher Education Act of 1965, and titles III, VII and VIII of the Public Health Service Act;

8. means-tested programs under the Elementary and Secondary Education Act of 1965;

9. benefits under the Head Start Act; or

10. benefits under the WIA.

Formation of the Medicaid Group

4222 Formation of the Medicaid Group (10/07/2005, 05-25)

The SSI-related Medicaid group consists of individuals whose needs are included in the financial eligibility determination for SSI-related Medicaid. The following subsections set forth the rules for determining membership in the Medicaid group. The department compares countable income and resources of the financial responsibility group to maximums based on the size of the Medicaid group.

4222.1 Medicaid Groups for Single Adults (10/07/2005, 05-25)

The department treats a single adult requesting SSI-related Medicaid, including long-term care, as a Medicaid group of one.

4222.2 Groups for Adults with Spouses (10/07/2005, 05-25)

When two spouses are living together, the department considers both the individual requesting Medicaid and the individuals spouse members of the individuals SSI-related Medicaid group, a Medicaid group of two, unless one of the exceptions specified in rule 4222.3 applies. This is true whether or not the spouse is also requesting Medicaid.

A couple is also considered living together in any of the following circumstances:

A. until the first day of the month following the calendar month of death or separation, when one spouse dies or the couple separates;

B. when the number of days one spouse is expected to receive long-term care services, including waiver and hospice services, is fewer than 30 days; and

C. when the department assesses and allocates the resources of the couple as of the date of application for Medicaid coverage of long-term care services, including waiver and hospice services.

4222.3 Exceptions for Adults with Spouses (08/01/2003, 02-11)

Adult applicants with spouses are treated as a Medicaid group of one in the following circumstances.

A. When one spouse in a couple is receiving long-term care services, including waiver and hospice services, and applying for Medicaid, the individual is treated as a Medicaid group of one for the determination of initial and ongoing income eligibility and resource reviews of eligibility. The department considers the couple no longer living together as of the first day of the calendar month the institutionalized spouse began receiving long-term care services. This remains true even if the other spouse begins receiving long-term care services in a subsequent month.

B. When the department determines the Medicaid eligibility of a community spouse whose spouse already receives waiver or hospice services at home, the department considers each spouse a Medicaid group of one.

C. When both members of the couple are admitted to the same residential care home, the department considers each spouse a Medicaid group of one, if the home is designed for four or more residents.

D. When both members of the couple are admitted to the same long-term care facility in the same month and have lived there at least six months beginning with the first month following the month of their admission, the department uses two separate Medicaid groups of one for the determination of initial and ongoing income eligibility and resource reviews of eligibility. They may be treated as one Medicaid group of two, however, if that is to their advantage.

   This rule also applies if the couple lives in their home or a residential care home in the community, both were granted waiver services during the same month, and both have received waiver services for at least six months.

E. Applicants receiving custodial care in their home, as defined in the departments Aid to the Aged, Blind, or Disabled rules at 2766.

4222.4 Medicaid Groups for Children (08/01/2003, 02-11)

The department treats a blind or disabled child requesting SSI-related Medicaid as a Medicaid group of one.

When a parent and dependent child living together are both requesting SSI-related Medicaid, the department treats them as two Medicaid groups of one, if the parent is not living with a spouse. If the parent is living with a spouse, the department treats the parents as a Medicaid group of two and the child as a Medicaid group of one.

Deeming

4223 Deeming (08/01/2003, 02-11)

SSI-related Medicaid financial eligibility is based on the financial eligibility rules for the Social Security Administrations Supplemental Security Income program (SSI). Like SSI, the department uses the term deeming to identify countable resources and income from other people belonging to applicants. When the deeming rules apply, it does not matter whether the resources or income of the other person are actually available to applicants.

Resources and income from two categories of individuals may be counted for SSI-related Medicaid applicants. These people are members of the financial responsibility group. The department considers:

- spousal resources and income to decide whether it must deem some of it to the Medicaid group; and
- parental resources and income for dependent children to decide whether it must deem some of it to the Medicaid group.

Rule 4260 specifies the resources counted by the department when determining SSI-related Medicaid financial eligibility.

Rule 4281 specifies the income counted by the department when determining SSI-related Medicaid financial eligibility.

4223.1 Temporary Absences (08/01/2003, 02-11)

During a temporary absence, the department considers the absent person a member of the household.

A temporary absence occurs when applicants or their ineligible spouses, parents, or ineligible children leave the household but intend to and do return in the same month or the next month.

The department considers applicants who are eligible children temporarily absent from their parents' household if they are away at school but come home on some weekends or lengthy holidays and are subject to the control of their parents.

If the applicants ineligible spouse or parent is absent from the household due solely to a duty assignment as a member of the armed forces on active duty, the department considers that person to be living in the same household as the applicant, unless evidence indicates that the applicants spouse or parent should no longer be considered to be living in the same household. When such evidence exists, the department stops deeming their resources and income beginning with the month after the spouse or parent no longer lived in the same household.

Resources

4230 Resources (10/07/2005, 05-25)

This section gives an overview of resource requirements. Resources are available cash or other property owned by individuals and available for their support and maintenance. Resources are treated in different ways depending on the rules of the coverage group involved (rules 4202-4204) and the type and liquidity of the resource (rule 4231). All resources of the members of the financial responsibility group must be counted except those specifically excluded (rule 4240). Resources are counted only if group members have the right, authority, or power to liquidate a resource or their share of the resource.

Resources are counted based upon their availability and the ease with which an item can be converted into cash. Availability is often affected when more than one person has an ownership interest in the same resource.

The department considers equity value as well as availability when determining the amount of a resource that counts (rule 4250). Equity value means the price an item can be reasonably expected to sell for on the local open market minus any encumbrances.

Resource limits vary depending on the type of category and services and size of the Medicaid group. Resource eligibility for each coverage group is determined by comparing the resources of the financial responsibility group to the resource limit based on the size of the Medicaid group. Resource maximums are specified at P-2420 in the Medicaid procedures manual.

Types of Resources

4231 Types of Resources (08/01/2003, 02-11)

This section describes some of the kinds of resources whose availability the department considers in determining Medicaid eligibility. It cross-references rules is 4240 which define additional resources whose availability is considered by the department in determining Medicaid eligibility. Rule 4240 also specifies when these resources are excluded from the departments Medicaid eligibility determination.

Nonliquid Resources

4232 Nonliquid Resources (08/01/2003, 02-11)

A nonliquid resource means property that is not cash, including real and personal property that cannot be converted to cash within 20 working days. Real property, life estates, burial funds, and life insurance, described below, are some of the more common kinds of nonliquid resources.

Certain noncash resources, though they may occasionally be liquid, are nearly always nonliquid. These include, but are not limited to, household goods and personal effects, vehicles, livestock, and machinery.

4232.1 Real Property (08/01/2003, 02-11)

Real Property means land and generally whatever is erected, growing on, or affixed to land.

4233 Liquid Resources (08/01/2003, 02-11)

Liquid resources mean cash or other personal property that can be converted to cash within 20 days. Liquid resources ordinarily include, but are not limited to, accounts in financial institutions; retirement funds; stocks, bonds, mutual funds, and money market funds; annuities; mortgages and promissory notes; and home equity conversion plans.

4233.1 Accounts in Financial Institutions (08/01/2003, 02-11)

Accounts in depository financial institutions such as banks and credit unions include, but are not limited to, savings accounts, checking accounts, joint fiduciary accounts, and certificates of deposit. Depository institutions may also manage mutual fund and money market fund accounts for depositors.

Nondepository financial institutions such as brokerage firms, investment firms, and finance companies also offer certificates of deposits as well as accounts and services related to the purchase and sale of stocks, bonds, mutual funds, money market funds, and other investments.

4233.2 Stocks, Bonds, and Funds (02/01/2007, 06-46)

A. Definition

Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

1. United States Savings Bonds

   a. Series E and EE bonds are sold at one half of their face value and increase in redemption value as interest accrues.

   b. Series I bonds are sold at their full face value and increase in redemption value as interest accrues.

   c. Series H and HH bonds are sold at their full face value and do not increase in value. Instead, they pay interest to the owner each six months.

4233.3 Annuities (02/01/2007, 06-46)

A. Definition

For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank, charitable organization, or other registered or licensed entity. It may also be a private contract between two parties. There are two phases to an annuity: an accumulation phase and a payout phase. Annuities vary in how they accumulate and payout money. Annuities may accumulate money by payment of a single lump sum or by payments on a schedule, which accumulate interest over time. Once an annuity has matured, money is paid to the beneficiary according to the terms of the annuity contract.

1. Parties to an annuity

There are always two parties to an annuity: the writer of the annuity, usually an insurance carrier or charitable organization, and the purchaser who owns the annuity (sometimes referred to as the annuitant).

In addition to the formal parties to an annuity, annuities also name a beneficiary: the person who will be paid a regular stream of income from the annuity in equal payments. Anyone can be a beneficiary, including but not limited to, the owner of the annuity, a spouse, dependent, trust, estate, commercial entity, proprietorship, or charitable organization.

Beneficiaries may be revocable or irrevocable. A revocable beneficiary can be changed by the owner of the annuity at any time. An irrevocable beneficiary can be changed only by the written permission of that beneficiary.

In addition to the primary beneficiary, annuities can provide for a contingent beneficiary or residual beneficiary. A contingent or residual beneficiary will receive annuity payments upon the occurrence of a specified condition

2. Types of annuities

There are many types of annuities. For Medicaid purposes, the department considers whether annuities of any type are available as a liquid resource. Since annuities are trust-like instruments, the department uses terminology similar to trusts when it describes the availability of cash from annuities.

Annuities that name revocable beneficiaries are available because the owner can change the beneficiary, surrender, cash in, assign, or transfer the annuity. The department presumes revocability when an annuity contract is silent regarding revocability.

Annuities are unavailable when the owner of an annuity is not the individual requesting Medicaid or the individuals spouse or the individual or spouse has abandoned all rights of ownership.

3. Standard annuity contract provisions

Annuity contracts provide for payments over a certain period. For the purposes of Medicaid eligibility, the payout period of an annuity must be within the life expectancy of the person on whose life the annuity is based or else it will be counted as a resource or considered a transfer of assets at less than fair market value. The department determines life expectancy as specified in rule 4472.1.

4233.4 Mortgages and Promissory Notes (09/01/2005, 05-19)

A mortgage is the pledging of real estate or conveyance of an interest in land to a creditor as security for repayment of a debt. A promissory note is a written promise to pay a certain sum of money to a certain person, the bearer, upon demand or on a specified date.

Resources Managed by Third Party

4234 Resources Managed by Third Party (12/01/2003, 03-17)

Resources managed by third parties include, but are not limited to, trusts, guardianship accounts, and retirement funds. Resources of a member of the financial responsibility group managed by a third party (e.g., trustee, guardian, conservator, or power of attorney) are considered available to the member as long as the member can direct the third party to dispose of the resource or the third party has the legal authority to dispose of the resource on the members behalf without the members direction.

4234.1 Power of Attorney (12/01/2003, 03-17)

Power of attorney means a written document signed by a person giving another person authority to make decisions on behalf of the person signing it, according to the terms of the document. Vermont law requires a power of attorney to be executed according to certain formalities, such as being signed, witnessed, and acknowledged. Funds managed by agents under a power of attorney are not property of the agent and cannot be counted as resources of the agent.

4234.2 Guardian (12/01/2003, 03-17)

Guardian means a person or institution appointed by a court in any state to act as a legal representative for another individual, such as a minor or a person with disabilities. Guardianship accounts are presumed to be available for the support and maintenance of the protected individual. Individuals may rebut the presumption of the availability of guardianship funds by presenting evidence to the contrary, including, but not limited to, restrictive language in the court order establishing the account or in a subsequent court order regarding withdrawal of funds.

4234.3 Representative Payee (12/01/2003, 03-17)

Representative payee means an individual, agency, or institution selected by a court or the Social Security Administration to receive and manage benefits on behalf of another person. A representative payee has responsibilities to use these payments only for the use and benefit of the beneficiary, notify the payor of any event that will affect the amount of benefits the beneficiary receives or circumstances that would affect the performance of the payee responsibilities, and account periodically for the benefits received. Funds managed by a representative payee are not property of the representative payee and cannot be counted as resources of the representative payee.

Excluded Resources

4240 Excluded Resources (02/01/2007, 06-46)

This section specifies the resources whose value the department excludes in determining SSI-related Medicaid eligibility.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation [ ] Medicaid SSI Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4241.1 Date of this Memo 01/01/2011 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

For calendar year 2011, the substantial home equity limit is $506,000. Beginning in calendar year 2012, refer to the Medicaid Procedures Manual at P-2420C for any increases to this limit.

Real Property

4241 Real Property (02/01/2007, 06-46)

The department excludes the following real property as resources when determining Medicaid eligibility.

4241.1 Home and Contiguous Land (02/01/2007, 06-46)

The department excludes a persons home as a resource, regardless of its value. For long-term care applicants, however, the department considers the home a resource when the applicant has equity greater than $500,000 in it (rule 4252.6). The department also may consider it as a resource when determining whether the applicant has transferred it and should be subject to a penalty period (rule 4470).

Home means the property in which an individual resides and has an ownership interest and which serves as the individuals principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located, related outbuildings, and surrounding property not separated from the home by intervening property owned by others. Public rights of way, such as roads that run through the surrounding property and separate it from the home, will not affect the exemption of the property. The home includes contiguous land and any other buildings located on the land.

The home exclusion applies even if the owner is making an effort to sell the home.

The home exclusion also applies if the owner is absent from the home due to institutionalization, provided that the owner has not placed the home in a revocable trust and:

- intends to return to the home even if the likelihood of return is apparently nil;
- has a spouse or dependent residing in the home; or
- has a medical condition that prevented the owner from living there before institutionalization.

Dependent means: child, stepchild, or grandchild; parent, stepparent, or grandparent; aunt, uncle, niece, or nephew; brother or sister, stepbrother or stepsister, half brother or half sister; cousin; or in-law.

Unless one of the exceptions listed above applies, the home becomes a countable resource when the owner moves out of the home without the intent to return, because it is no longer the owners principal place of residence.

Temporary absences, such as for hospitalization or convalescence with a relative, do not affect the determination of an individual's principal place of residence.

4241.2 Sale of Excluded Home (08/01/2003, 02-11)

The department excludes proceeds from the sale of a home to the extent that the owner intends to use them and, in fact, uses or obligates them to purchase or construct another home within three months of the date the proceeds are received. Use of proceeds from the sale of a home to pay costs of another home will be excluded only if the other costs are paid within three months of the sale of the home. Such costs are limited to the down payment, settlement costs, loan processing fees and points, moving expenses, necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) identified and documented prior to occupancy, and mortgage payments for the new home.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4241.4 Date of this Memo 02/01/2010 Page 1 of 1
This Memo: [ ] is New [X] Replaces one dated 03/04/2005

UPDATE:

Any income received from a home equity conversion plan is excluded in the month of receipt. If the income is retained after the month of receipt, count it as a resource beginning the month after receipt.

The value of a promissory note or similar installment sales contract constitutes a "proceed." Other proceeds consist of the down payment and the portion of any installment amount constituting payment against the principal. These are also excluded if used within 3 months to make payment on the replacement home.

When all of the proceeds are not timely reinvested as specified above, the portion of the proceeds retained by the individual are combined with the value of the note or installment sales contract and counted as a resource beginning with the month following the month the note is executed. If the entire proceeds are fully reinvested in a replacement home at a later date, the value of the note and reinvested proceeds are excluded beginning with the month after the month in which they are reinvested, but any proceeds not reinvested as specified above remain a countable resource until fully reinvested.

4241.3 Real Property for Sale (08/01/2003, 02-11)

The department excludes real property from countable resources as long as owners verify that they are making reasonable efforts to sell it. Reasonable efforts to sell property means taking all necessary steps to sell it for fair market value in the geographic area covered by the media serving the area in which property is located, unless owners are prevented by circumstances beyond their control from taking these steps.

The steps considered necessary to sell the property depend on the method of sale. Owners may choose to list the real property with a real estate agent or undertake to sell it themselves. If owners choose to list it with a real estate agency, they must take the necessary step of listing it and cooperating with the real estate agents efforts to sell it. If owners choose to sell it without an agent, they must take all of the following necessary steps:

A. advertise it in at least one of the appropriate local media continuously;

B. place a “For Sale” sign on the property continuously, unless prohibited by zoning regulations;

C. conduct open houses or otherwise show the property to prospective buyers; and

D. attempt any other appropriate methods of sale.

If any prospective buyer makes a reasonable offer for the property, owners must accept it or demonstrate why it was not a reasonable offer. Any offer at least two-thirds of the most recent estimate of the propertys fair market value is considered a reasonable offer.

Fair market value means a certified appraisal or an amount equal to the price of the property on the open market in the locality at the time of the transfer or contract for sale, if earlier.

4241.4 Home Equity Conversion Plans (08/01/2003, 02-11)

A. Definition

Home equity conversion plans are financial instruments used to secure loans with real property as collateral. Home equity conversion plans include reverse mortgages, reverse annuity mortgages, sale-leaseback arrangements, time-sale agreements, and deferred payment loans.

B. Exclusion

The department excludes as a resource, in the month of receipt, funds from any home equity conversion arrangements on real estate.

4241.5 Jointly Owned Real Property (08/01/2003, 02-11)

A. General exclusion

The department will exclude jointly owned real property from countable resources as long as the joint owner refuses to sell, if the joint ownership was created:

1. before July 1, 2002; or
2. more than 36 months before the date of application.

The department considers that the addition of new joint owners creates a new joint interest and will be evaluated as a countable resource under rule 4252.3.

B. Exclusion due to undue hardship

Jointly owned real property will be excluded from resources if sale of the property by an individual would cause the other owner undue hardship due to loss of housing. Undue hardship would result when:

1. the property serves as the principal place of residence for one (or more) of the other owners;
2. sale of the property would result in loss of that residence, and
3. no other housing would be readily available for the displaced other owner.

4241.6 Life Estates (08/01/2003, 02-11)

A. Definition

Life estate means a legal arrangement entitling the owners to possess, rent, and otherwise profit from real or personal property during their lifetime. The owner of a life estate sometimes may have the right to sell the life estate but does not normally have future rights to the property. Ownership of a life estate may be conditioned upon other circumstances, such as a new spouse. The document granting the life estate includes the conditions for the life estate and the right of the owner to sell or bequeath it, if these property rights were retained.

B. Exclusion for life estate interests created on or after July 1, 2002

The department excludes life estates in real property when the owner does not retain the power to sell or mortgage the real property.

When owners retain the power to sell or mortgage the entire real property, including any remainder interest, the department excludes the value of the life estate in the real property only if the life estate is an interest in the individuals home (rule 4241.1). For this purpose, the value of the life estate includes the value of the remainder interest.

C. Exclusion for life estate interests created before July 1, 2002

When owners retain the power to sell the entire real property, including any remainder interest, the department excludes the value of the life estate in the real property only if the life estate is excludable on another basis, such as because it is real property producing significant income (rule 4241.7).

The department excludes life estates in real property when the owner does not retain the power to sell the real property.

Real Property

4241.7 Income-Producing Real Property (09/01/2005, 05-19)

Real property producing significant income is exempt from consideration as a resource. Real property is considered to produce "significant income" if it generates at least 6 percent of its fair market value in net annual income after allowable expenses related to producing the income are deducted.

Until July 1, 2003, determinations and redeterminations of eligibility for individuals who have received SSI-related or ANFC-related Medicaid at any time between July 1, 2001 and June 30, 2002, and have property producing significant income, shall have property producing significant income evaluated based on the rules in effect on June 30, 2002.

4241.8 Goods For Home Consumption (09/01/2005, 05-19)

Real property used to produce goods for only home consumption (e.g., a garden plot used to raise vegetables to be eaten at home or a wood lot used to provide fuel to heat the home) is exempt from consideration as a resource. When real property is used to produce goods for both home consumption and income production, the department excludes only the part used to produce goods for home consumption. The part of the property used for income production is evaluated for exclusion under rule 4241.7.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4242 **Date of this Memo** 07/01/2004 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

Interest or dividend income generated is excluded for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by a countable resource.

Interest or dividend income generated is counted for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by an excluded resource.

Exclude interest or dividend income from countable resources.

- savings accounts, checking accounts, mutual funds, CD's, stocks
- Revocable Trusts
- Life Insurance Policies

Count interest or dividend income when the resource generating it is considered an excluded resource.

Take special care to evaluate the following resources. They may be countable or excludable, depending on their terms. Please contact AOps if you need help to determine whether one of these types of resources should be counted or excluded.

- Promissory Notes
- Irrevocable Trusts
- Annuities

Insurance

4242 Insurance (02/01/2007, 06-46)

4242.1 Life Insurance (02/01/2007, 06-46)

A. Definition

Life insurance is a contract that provides for its purchaser to pay premiums to the insurer, who agrees to pay a specific sum to a designated beneficiary upon the death of the insured. Life insurance is usually sold by an insurance company but may also be sold by other financial institutions, such as brokerage firms.

The face value of a life insurance policy is the amount it pays the beneficiary upon the death of the insured. Term life insurance is life insurance that does not accumulate any cash value through time as premiums are paid. Whole life insurance (sometimes called ordinary life, limited payment, or endowment insurance) accumulates value as premiums are paid. It may also pay periodic dividends on this value when all premiums have been paid. These dividends may be paid to the owner, or they may be added to the cash surrender value of the policy.

The cash surrender value (CSV) of a whole life policy represents the amount the owner would receive upon terminating the policy before the insured dies. It is a form of equity that accumulates over time as life insurance premiums are paid. The policy owner may borrow against the CSV according to the terms of the policy. A loan against a policy reduces its CSV.

A life insurance policy can be either a group or individual policy. Group policies are usually issued through a company or organization insuring the participating employees or members and perhaps their families. The group policy may be paid partially by the employer. Group insurance policies generally have no CSV.

B. Exclusion

The value of a life insurance policy is excluded as a resource according to the following rules:

1. If the combined face value of the whole life insurance policies owned by any one member of the financial responsibility group does not exceed $1500, their cash value may be excluded. If the total face value exceeds $1500, their cash value, excluding any amounts up to $1500, and all dividend additions are considered a countable resource.

2. Regardless of its face value, term life insurance is not countable as a resource.

4242.2 Long Term Care Insurance Partnership (02/01/2007, 06-46)

A. Definition

The term “Qualified State Long-Term Care Insurance Partnership” means a State plan amendment that provides for the disregard of any assets or resources in an amount equal to the insurance benefits payments that are made under a long-term care insurance policy (including a certificate issued under a group insurance contract), but only if—

- the policy covers an insured who, at the time coverage under the policy first becomes effective, is a resident of such State or of a State that maintains a Qualified Long-Term Care Insurance Partnership;
- the policy is a qualified long-term care insurance contract within the meaning of section 7702B(b) of the Internal Revenue Code of 1986;

- the policy provides some level of inflation protection as set forth in regulations promulgated by the Vermont Department of Banking, Insurance, Securities and Health Care Administration;
- the policy satisfies any requirements of State or other applicable law that apply to a long-term care insurance policy as certified by the Vermont Department of Banking, Insurance, Securities and Health Care Administration; and
- the issuer of the policy reports—
  - to the Secretary of the federal agency of Health and Human Services (HHS), such information or data as the Secretary may require; and
  - to the State, the information or data reported to the Secretary of HHS (if any), the information or data required under the minimum reporting requirements developed under section 2(c)(1) of the State Long-Term Care Partnership Act of 2005, and such additional information or data as the State may require.

B. Exclusion

Subject to approval by the federal Center for Medicare and Medicaid Services, the department will exclude assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a qualified State long-term care insurance partnership policy. This section is further contingent on the passage of changes to 33 VSA § 1908a necessary to bring the Vermont statute on Long-Term Care Partnership Insurance into conformance with the requirements of section 6021 of the federal Deficit Reduction Act of 2005.

4243 Burial Funds (08/01/2003, 02-11)

A. Definition

A burial fund is any separately identifiable fund clearly designated as for burial expenses through the title to the fund or by a sworn statement provided to the department. Burial funds include contracts, trusts, or other agreements, accounts, or instruments with a cash value. Some burial funds include accumulated interest, and the value of some burial funds may change through time (e.g., when the fund consists of bonds). Burial expenses include burial spaces, items related to burial spaces, and services related to burial spaces.

The cash value of life insurance policies may also be treated as burial funds for the purposes of determining Medicaid eligibility if owned by an individual whose income and resources are considered in determining Medicaid eligibility and designated as specified above.

For the purposes of determining Medicaid eligibility, burial spaces, if not fully paid, are considered burial funds and include burial plots, gravesites, crypts, mausoleums, caskets, urns, and other repositories customarily and traditionally used for the deceased bodily remains. Items related to burial spaces include, but are not limited to, vaults, headstones, markers, plaques, and burial containers for caskets. Services related to burial include, but are not limited to, embalming, opening and closing of the gravesite, and care and maintenance of the gravesite, sometimes called an endowment or perpetual care.

B. Exclusion

For any individual whose income and resources are considered in determining SSI-related Medicaid eligibility, the department excludes up to $10,000 of burial funds, as long as the member shows that the funds are designated for burial expenses through the title to the fund or by a sworn statement provided to the department. They must be separately identifiable and not commingled with other funds.

A burial fund may be excluded as of the first day of the month in which the individual whose income and resources are considered in determining Medicaid eligibility established it. Interest and appreciation accrued on burial funds is excluded if the funds have been left to accumulate.

The value of certain burial spaces may also be excluded under the allowable limit of $10,000 for each individual whose income and resources are considered in determining Medicaid eligibility. Such spaces must be held for the burial of a member of the applicants immediate family. For this purpose, the immediate family includes the members spouse, children, brothers, sisters, and parents.

Irrevocable burial trusts established prior to July 1, 2002 and funded in excess of $10,000 shall be excluded up to the value of the trust as of June 30, 2002.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4244 **Date of this Memo** 07/01/2004 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

Interest or dividend income generated is excluded for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by a countable resource.

Interest or dividend income generated is counted for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by an excluded resource.

Exclude interest or dividend income from countable resources.

- savings accounts, checking accounts, mutual funds, CD's, stocks
- Revocable Trusts
- Life Insurance Policies

Count interest or dividend income when the resource generating it is considered an excluded resource.

Take special care to evaluate the following resources. They may be countable or excludable, depending on their terms. Please contact AOps if you need help to determine whether one of these types of resources should be counted or excluded.

- Promissory Notes
- Irrevocable Trusts
- Annuities

4244 Other Income-Producing Resources (02/01/2007, 06-46)

A. Annuities

The department does not count as a resource annuities that meet the criteria in (1) (a) through (e) below. Annuities in their accumulation phase may be liquidated or sold and are a countable resource under rule 4252.1. Annuities that do not meet the criteria below or are not countable under rule 4252.1 are evaluated for whether they are subject to a transfer penalty, under rule 4473.4.

1. Annuities are not a countable resource if they:

   a. have no beneficiary or payee other than an individual requesting Medicaid or his or her spouse; and

   b. provide for payments to applicants or their spouses in equal intervals and equal amounts; and

   c. do not exceed the life expectancy of the applicants or their spouses, as determined by the department using the annuity tables published by the Office of the Chief Actuary of the Social Security Administration (http://socialsecurity.gov/OACT/STATS/table4c6.html) and specified in the Medicaid procedures manual ; and

   d. return to the beneficiary at least the amount used to establish the contract and any additional payments plus any earnings, as specified in the contract; and

   e. do not pay anyone other than the applicant, the applicants spouse, even if the applicant or spouse dies before the payment period ends.

2. The department will also consider an annuity to meet the requirements of subsections (a) and (e) above, if the owner of the annuity elects to designate Vermont Medicaid as the primary beneficiary up to the amount of long-term care and community Medicaid payments it made on behalf of the applicant or spouse, and names a contingent beneficiary other than the applicant or spouse to receive any surplus after Vermont Medicaid is paid.

3. For applications filed before October 7, 2005, the department does not count annuities regardless if revocable or in the accumulation phase if either:

   a. purchased more than 36 months before the date of application; or

   b. purchased less than 36 months before the date of application and meet criteria (1)(a) through (e) above.

B. Promissory Notes and Other Income Producing Resources

The department does not count as a resource promissory notes and similar resources that produce income if:

1. they meet the requirements in subsection (A)(1)(a) through (e) above, or

2. the individual owned a nonnegotiable or nonassignable promissory note executed before September 1, 2005 and the individual or spouse can expect to receive the full fair market value of the resource within the expected lifetime of the individual or spouse, as determined by the department using the annuity tables published by the Office of the Chief Actuary of the Social Security Administration (http://socialsecurity.gov/OACT/STATS/table4c6.html) and specified in the Medicaid procedures manual.

Other Income-Producing Resources

All other promissory notes and similar resources that produce income are evaluated for whether they are a countable resource as specified in rule 4252.5 or subject to a transfer penalty as specified in rule 4473.6. Notes and similar income-producing resources that do not meet the criteria at rule 4244 and are determined to have fair market value shall be considered either as an available resource, or subject to a transfer penalty, in the discretion of the department.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4245 **Date of this Memo** 07/01/2004 **Page** 1 of 1

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INTERPRETIVE MEMO

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Reference 4245 **Date of this Memo** 07/01/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

The purpose of this interpretive memorandum is to clarify Medicaid regulations with respect to the application of the resource exclusion rules and application of the transfer of assets penalty provisions on pooled trusts established by individuals age 65 and older.

4245 Resources Managed by Third Party: A pooled trust is considered an excluded resource if it provides that upon the death of the beneficiary, the trust will notify Vermont Medicaid of the individual's death and request the amount owed to Vermont Medicaid. The trust shall pay the amount owed, subject to a reasonable administrative fee on the part of the trust.

Background: At the request of the Centers for Medicare and Medicaid Services, we have reviewed our regulations and policies on pooled trusts to assure they meet Federal statutory requirements. A pooled trust is a trust that can be established for a disabled individual under the authority of §1917(d)(4)(C) of the Social Security Act (the Act). A trust that meets the requirements of this section of the statute is exempt from being treated under the normal Medicaid trust rules in §1917(d) of the Act. A pooled trust is run by a non-profit organization. The trust (or more accurately, a sub-account within the trust) is established for each individual beneficiary. All the beneficiary sub-accounts are pooled for investment and management purposes. Upon the death of the disabled individual, the balance remaining in the account is paid back to the State Medicaid agency in an amount equal to the medical assistance paid on behalf of the beneficiary.

The statute also allows the trust to retain some portion of the balance remaining after the death of the beneficiary. The amount a pooled trust can retain is subject to reasonable restrictions on the part of the State. Although Vermont rules currently imply a full payback of Medicaid expenses is required by a pooled trust, this memorandum clarifies that while the pooled trust must contain a Medicaid payback provision, payback may be limited only insofar as it is subject to reasonable administrative fees on the part of the trust.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

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Reference 4245.2 **Date of this Memo** 07/01/2008 **Page** 1 of 1

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Resources Managed by Third Party

4245 Resources Managed by Third Party (08/01/2003, 02-11)

4245.1 Definition of Trust (08/01/2003, 02-11)

A trust is a legal document setting forth the terms of any arrangement in which a person (the grantor) transfers liquid or nonliquid property (the trust principal) to another person or entity (the trustee) with the intention that it be held, managed, or administered by the trustee for the benefit of one or more individuals (the grantees). In some cases, the grantor is named as a grantee. The grantor may also be called the settlor or the trustor. The grantee may also be called the beneficiary.

Trust income refers to monies earned by the trust property. It may take various forms, such as interest, dividends, or rent payments. Trust income may also be called trust earnings. The trust principal plus the trust income make up the trust property.

A person shall be considered the grantor of a trust if both of these two conditions are met:

A. the assets of the person were used to form all or part of the principal of the trust; and

B. one of the following established the trust:

   1. the person;

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

   3. another person, court, or administrative body, acting at the direction of or upon the request of the person.

The trustee may be an individual or an entity, such as a bank or insurance company. In most cases, trustees do not have the legal right to use the trust property for their own benefit. Some, but not all, trusts grant discretion to the trustee to use judgment as to when or how to handle trust principal or trust income. A trust may provide reasonable compensation to the trustee for managing the trust as well as reimbursement for reasonable costs associated with managing the trust property.

A trust may name a person or entity, called the residual beneficiary, as the recipient of the trust property upon the death of the grantee.

4245.2 Excluded Trusts (10/07/2005, 05-25)

In general, the department excludes trusts as a resource to individuals who cannot revoke the trust or receive trust property, whether or not the trustee exercises his or her full discretion. Trust property is also excluded as a resource when the grantor is a member of the financial responsibility group and established a testamentary trust, also known as establishing a trust by will.

The following trust property is excluded as a resource when either the grantor or the grantee is a member of the financial responsibility group:

A. trust property in a trust established prior to April 7, 1986, for the sole benefit of a mentally retarded person residing in an ICF-MR;

B. trust property in a trust for which the grantee is a disabled child under Sullivan v. Zebley, 493 U. S. 521 (1990);

C. trust property or any portion of the trust property that cannot be made available to the member of the financial responsibility group, either through full exercise of the trustees discretion under the terms of the trust or through revocation of the trust by a member of the financial responsibility group;

D. trust property in a trust (known as third-party or supplemental needs trusts) established by persons other than the individual or spouse are excluded unless the terms of the trust permit the individual to revoke the trust or to have access to it without trustee intervention;

E. irrevocable trusts, including homes placed in irrevocable trusts by institutionalized individuals who intend to return to them, from which no payment under any circumstances could be made to the individual; or

F. special needs trusts or pooled trusts that meet the following requirements:

1. The special needs trust names a beneficiary under the age of 65 and meets all the criteria below in rule 4245.2.

2. The pooled trust was established and managed by a nonprofit association, a separate account is maintained for each beneficiary of the trust, and it meets all the criteria below in rule 4245.2.

3. The special needs or pooled trust:

a. contains the assets of a disabled individual;

b. was established by a parent, grandparent, or legal guardian of the individual or by a court;

c. was established for the sole benefit of the beneficiary, which means that no individual or entity except the disabled beneficiary can benefit from the trust in any way, until after the death of the beneficiary and then not before the department receives sums owed under the payback provision; and

d. includes a payback provision which requires that, upon the death of the beneficiary, any amounts remaining in the trust will first be paid to the department in an amount equal to the total Medicaid payments made on behalf of the individual.

In the case of a trust with more than one grantor, these exclusions apply only to that portion of the trust attributable to the income or resources of a member of the financial responsibility group. In the case of a trust with more than one grantee, the exclusions apply only to that portion of the trust available for the benefit of a member of the financial responsibility group.

4245.3 Trusts Excluded Due to Hardship (08/01/2003, 02-11)

The department may exclude trust property that has not been distributed if counting it as a resource would cause undue hardship to a grantor or grantee who is a member of the financial responsibility group.

Undue hardship includes situations in which a member of the financial responsibility group or someone in the members immediate family would be forced to go without life-sustaining services because the trust property could not be made available to pay for the services. For this purpose, the immediate family includes the members spouse, children, brothers, sisters, and parents.

Resources Managed by Third Party

The following situations also would cause undue hardship:

A. funds can be made available for medical care only if trust property is sold, and this property is the sole source of income for the member or someone in the members immediate family; and

B. funds can be made available for medical care only if income-producing trust property is sold and, as a result of this sale, the member or someone in the members immediate family would qualify for Supplemental Security Income, Reach Up, Aid for the Aged, Blind or Disabled, General Assistance, 3SquaresVT, or another public assistance program requiring a comparable showing of financial need.

Undue hardship does not exist when application of the trust regulations does not cause individuals risk of serious deprivation.

Individuals claiming undue hardship must submit a written request and any supporting documentation. Claims of undue hardship are forwarded to the commissioners designee for evaluation. Required documentation from the individual can include but is not limited to the following:

- a statement from the attorney, if one was involved;
- verification of medical insurance coverage and statements from medical providers relative to usage not covered by the insurance; or
- a statement from the trustee.

When application of trust provisions are waived because they would cause the individual undue hardship, only amounts actually distributed from the trust and held for more than a month are counted as a resource. Request for consideration of undue hardship does not limit an individuals right to appeal denial of eligibility for any reason, including the determination of undue hardship.

Early Withdrawal and Surrender Penalties

4246 Early Withdrawal and Surrender Penalties (08/01/2003, 02-11)

The department excludes early withdrawal penalties and surrender fees assessed by the financial institution to the extent that they reduce the value of the liquidated proceeds. Examples of these resources are retirement funds, annuities, bonds, and certificates of deposit.

Income tax withholding and tax penalties for early withdrawal are not excluded.

4247 Jointly Held Accounts (08/01/2003, 02-11)

The department will exclude a jointly held account only if the owner rebuts the presumption of availability by:

A. submitting a statement, along with corroborating statements from other account holders, regarding who owns the funds in the joint account, why there is a joint account, who has made deposits to and withdrawals from the account, and how withdrawals have been spent;

B. submitting account records showing deposits, withdrawals, and interest, if any, in the months for which ownership of funds is at issue; and

C. taking one of the following two actions:

1. correcting the account title to show that the member of the financial responsibility group is no longer a co-owner, if the member owns none of the funds; or

2. if the member owns only a portion of the funds, separating the funds owned by other account holders from the members funds and correcting the account title on the member's funds to show they are solely owned by the member.

4247.1 Fiduciary for a Joint Fiduciary Account (08/01/2003, 02-11)

A. Definition

A joint fiduciary account is a deposit in a financial institution in the name of an owner naming one or more fiduciaries. The owner makes a clear statement about how the money can be used, and the fiduciary is required to follow those instructions and keep track of how the money is spent.

B. Exclusion

When an individual owns such an account, it is counted as a resource. When an individual is designated a fiduciary, the joint fiduciary account is an excluded resource for the fiduciary.

4248 Other Excluded Resources (09/01/2005, 05-19)

The department also excludes the following resources.

4248.1 Personal Property (09/01/2005, 05-19)

The department excludes home furnishings, apparel, personal effects, and household goods. This includes tools, equipment, uniforms and other nonliquid property required by an individuals employer or essential to self-support.

4248.2 Vehicles (09/01/2005, 05-19)

The department excludes all automobiles. It also excludes other vehicles, such as trucks, boats, and snowmobiles, only if they are used to provide necessary transportation (i.e., an automobile is unavailable or cannot be used to transport the aged, blind or disabled individual).

4248.3 Independent Living Contracts (09/01/2005, 05-19)

A. Definitions

Contracts for medical care, assistive technology devices, and home modifications means any written agreement, contract, or accord (including modifications) for reasonable and necessary medical care, assistive technology devices, or home modifications not covered by Medicare, private insurance, or Medicaid and determined by the Department of Disabilities, Aging, and Independent Living (DAIL) to be needed to keep an individual at home and out of a skilled nursing facility.

Medical care means care not covered by the Choices for Care waiver, including but not limited to, general supervision when required by the cognitive impairment of the individual and/or unstable medical condition that requires monitoring of the individual.

Assistive technology devices means any item, piece of equipment or product system whether acquired commercially off the shelf, modified, or customized, to increase, maintain, or improve the individuals functional capabilities.

Home modifications means physical adaptations to the individuals home that ensure the health and welfare of the individual, or that improve the individuals ability to perform activities of daily living or instrumental activities of daily living.

B. Exclusion

Resources set aside for a contract or contracts for medical care, assistive technology devices, or home modifications (contract) shall be considered to be an available resource unless all of the following criteria are met:

1. The contract is in writing and signed before any services are provided;
2. The funds, not to exceed a total of $30,000, are held in a separate bank account from other resources in the sole name of the Medicaid applicant;
3. Any amounts due are paid after the services are rendered;
4. The payments for:

a. medical care or assistive technology services do not exceed $500 per month; and

b. home modifications shall not exceed a one-time expenditure of $7,500;

5. The payments to nonlicensed individuals or providers do not exceed the fair market value of such services being provided by similarly situated and trained nonlicensed individuals, not to exceed the amount paid under the DAIL Choices for Care waiver, currently $10 per hour.

6. Periodic accountings, as requested by the Department for Children and Families, must be provided specifying the amount of each expenditure, who was paid, the service given, and the number of hours and dates of service covered;

7. The applicant/recipient has the power to modify, revoke or terminate the contract for care;

8. The contract ceases upon the death of the applicant/recipient. It also ceases upon admission to a nursing facility for more than 45 days if not eligible for the home upkeep deduction (rule 4462.2) or 6 months if eligible for the deduction. In addition, revocation or termination of the contract ceases the agreement.

9. Upon cessation of the contract as specified in the previous paragraph, any remaining balance of funds set aside for the contract for care shall be treated either:

a. as an asset of the Medicaid beneficiary's estate, if the Medicaid beneficiary is deceased; or

b. as an available resource that may not be converted to an excluded resource and must be applied at the Medicaid pay rate toward nursing facility services if the Medicaid beneficiary is admitted to a nursing facility for more than 6 months. In cases where the Medicaid beneficiary dies before the resource is fully expended, the remainder shall become an asset of the Medicaid beneficiary's estate; or

c. as an excluded resource, if the individual revokes or terminates the contract and continues to receive services under the Choices for Care waiver.

4248.4 Cash (02/01/2007, 06-46)

The department excludes income as a resource in the month of receipt, such as automatic deposit of a social security check into a checking account. The department excludes cash necessary to operate a business, using a month's average expenditures as determined by tax returns, or business receipts and expenses for the past 12 months. No more than three times the average monthly cash expenditures can be excluded.

4248.5 Retirement Funds (02/01/2007, 06-46)

A. Definition

Retirement funds include any resources set aside by a member of the financial responsibility group to be used for self-support upon the withdrawal from active life, service, or business. Retirement funds include but are not limited to IRAs, Keogh plans, 401K plans, pensions, mutual funds, stocks, bonds, securities, money market accounts, whole life insurance, and annuities.

Other Excluded Resources

B. Exclusion

The department excludes retirement funds owned by a member of the financial responsibility group requesting Medicaid when:

1. The individual must terminate employment in order to obtain any payment; or

2. The individual does not have the option of withdrawing a lump sum from the fund; or

3. The individual is not eligible for periodic payments; or

4. The individual has reached retirement age and the individual is drawing on retirement funds at a rate consistent with the individuals life expectancy, as specified in rule 4472.1

If the individual is eligible for lump sum or periodic benefits, the individual must choose the periodic benefits. If the individual receives a denial on a claim for periodic retirement benefits but can withdraw the funds in a lump sum, the department counts the lump sum value in the resources determination for the month following that in which the individual receives the denial notice.

When a member of the financial responsibility group who is seeking long-term care Medicaid services holds pension funds held in an individual retirement account (IRA) or in work-related pension plans (including Keogh plans) as defined by the Internal Revenue Code, no change in title of ownership to these funds is required in order for them to be treated as an excluded resource for the benefit of the community spouse.

4248.6 Tax Refunds (02/01/2007, 06-46)

The department excludes tax refunds on real property, income, and food.

4248.7 Student Benefits (08/01/2003, 02-11)

The department excludes any portion of any grant, scholarship, or fellowship used to pay fees, tuition, or other expenses necessary to securing an education. Portions used to defray costs of food, clothing, or shelter must be counted.

4248.8 Savings from Excluded Income (08/01/2003, 02-11)

The department excludes savings from excluded income and resources. This includes but is not limited to the following:

A. liquid resources, including interest earned by the resources accumulated from earnings by a person working with disabilities (see rule 4202.4 on or after January 1, 2000, and kept in a separate bank account from other liquid resources, unless no bank within a reasonable distance from residence or place of work permits the person working with disabilities to establish a separate account without charging fees; and

B. nonliquid resources purchased by a person working with disabilities on or after January 1, 2000, with savings from earnings or with a combination of savings from earnings and other excluded income or resources.

Other Excluded Resources

4248.9 Federal Exclusions (08/01/2003, 02-11)

The following are excluded by federal law from both income and resources:

A. The value of meals and food commodities distributed under the National School Lunch Act and the Child Nutrition Act.

B. The value of 3SquaresVT or 3SquaresVT cash-out checks.

C. The value of food or vouchers received through the WIC Program.

D. The value of food or meals received under the Older Americans Act.

E. Compensation or remuneration received for volunteer work in ACTION programs including foster grandparents, RSVP, SCORE, ACV, ACE, VISTA, Senior Companion Program and UYA.

F. The value of assistance received under the U. S. Housing Act, U. S. Housing Authorization Act and the Housing and Urban Development Act.

G. The value of relocation assistance to displaced persons under the Uniform Relocation and Real Property Acquisition Policies Act.

H. Per Capital distributions to certain Indian Tribes and receipts from lands held in trust for certain Indian Tribes.

I. Payments received under the Alaskan Native Claims Settlement Act.

J. Grants or loans received for educational purposes under any U. S. Department of Education program.

K. Any assistance received under the Emergency Energy Conservation or Energy Crisis Program.

L. Any assistance received under the Low-Income Home Energy Assistance Act, either in cash or through vendor payments.

M. Compensation paid to Americans of Japanese or Aleut ancestry as restitution for their incarceration during World War II.

N. Agent Orange Settlement payments.

O. German reparations to concentration camp survivors, slave laborers, partisans, and other victims of the Holocaust. Settlement payments to victims of Nazi persecution or their legal heirs resulting from the confiscation of assets during World War II.

P. War reparations paid under the Austrian government's pension system.

Q. Radiation Exposure Compensation Trust Fund payments.

R. Assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a Federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States. Comparable assistance received from a State or local government, or from a disaster assistance organization is excluded. Interest earned on the assistance is also excluded.

S. Netherlands' Act on Benefits for Victims of Persecution 1940-1945 payments.

T. Any account, including interest or other earnings on the account, established and maintained in accordance with section 1631(a)(2)(F) of the Social Security Act. These accounts are

Other Excluded Resources

established with retroactive SSI payments made to a child under age 18 and used in ways specified in the Act. The exclusion continues after the child has reached age 18.

U. Earnings deposited in a special savings account under the Tangible Assets project managed by the Central Vermont Community Action Council and authorized by The Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

V. Payments as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. made to hemophiliacs who contracted the HIV virus from contaminated blood products.

Exclusions for Limited Periods

4249 Exclusions for Limited Periods (08/01/2003, 02-11)

The department excludes the following resources for specific periods, beginning with the date on which a member of the financial responsibility group received the resource.

4249.1 Retroactive Social Security and SSI/AABD (08/01/2003, 02-11)

The department excludes retroactive payments of federal SSI, the AABD supplement to SSI, or social security benefits for nine months beginning with the month after the month of receipt. These payments are also excluded as resources during the month of receipt.

4249.2 Funds for Replacing Excluded Resources (08/01/2003, 02-11)

The department excludes cash and interest earned on that cash received from any source, including casualty insurance, for the purpose of repairing or replacing an excluded resource that is lost, stolen, or damaged, if used to replace or repair that resource. The exclusion is allowed for nine months from the month of receipt. An extension of an additional nine months can be granted for good cause.

4249.3 Earned Income Tax Credit (08/01/2003, 02-11)

The department excludes state and federal earned income tax credit refunds and advance payments from consideration as resources.

4249.4 Medical or Social Services Payments (08/01/2003, 02-11)

The department excludes cash received for medical or social services for the calendar month following the month of receipt. The month following the month of receipt, the department counts it as a resource if it has been retained.

4249.5 Victim's Compensation Payments (08/01/2003, 02-11)

The department excludes state-administered victims' compensation payments for nine months after the month of receipt.

4249.6 Relocation Payments (08/01/2003, 02-11)

The department excludes state and local government relocation payments for nine months after the month of receipt.

4249.7 Expenses from Last Illness and Burial (08/01/2003, 02-11)

The department excludes payments, gifts, and inheritances occasioned by the death of another person provided that they are spent on costs resulting from the last illness and burial of the deceased by the end of the calendar month following the month of receipt.

Exclusions for Limited Periods

4249.8 Stocks, Bonds, and Funds (10/07/2005, 05-25)

A. Definition

Legal instruments authenticating an investment, such as stocks, bonds, mutual funds, and money market funds pay interest at specified intervals, sometimes pay dividends, and are convertible into cash either on demand or at maturity.

B. Exclusion

Savings bonds are excluded during their minimum retention period if individuals have requested a hardship waiver based on financial need due to medical expenses and received a denial from the United States Department of the Treasury, Bureau of Public Debt, Accrual Services Division in Parkersburg, P. O. Box 1328, Parkersburg, West Virginia26106-1328.

Upon verification of a denial of a hardship waiver, as described above, the department considers United States savings bonds owned by one or more individuals an available resource following the expiration of the minimum retention period. Once the minimum retention period expires, the denial of a hardship waiver is not a basis for exclusion of new bond purchases or other excluded assets purchased with the proceeds.

Savings bonds purchased before June 15, 2004 that have their minimum retention period expire after that date, continue to be an excluded resource if they are not redeemed, exchanged, surrendered, reissued, used to purchase or fund other excluded assets, or otherwise become available.

4249.9 Home-Based Long-Term Care Disregard (10/07/2005, 05-25)

Single individuals who qualify for SSI-related Medicaid are permitted to retain the standard $2,000 resource allowance. An additional resource disregard of $3,000 is allowed for aged and disabled individuals without a spouse who reside in and have an ownership interest in their principal place of residence and choose home-based long-term care services (rules 4201,4241.1), provided all other eligibility criteria are met.

The resource disregard remains available until the recipient is admitted to a nursing facility or receives enhanced residential care services. Thereafter, those who meet the requirements of the home upkeep deduction (rule 4462.2) are eligible to continue the resource disregard for up to 6 months.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4250 **Date of this Memo** 07/01/2004 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

Interest or dividend income generated is excluded for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by a countable resource.

Interest or dividend income generated is counted for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by an excluded resource.

Exclude interest or dividend income from countable resources.

- savings accounts, checking accounts, mutual funds, CD's, stocks
- Revocable Trusts
- Life Insurance Policies

Count interest or dividend income when the resource generating it is considered an excluded resource.

Take special care to evaluate the following resources. They may be countable or excludable, depending on their terms. Please contact AOps if you need help to determine whether one of these types of resources should be counted or excluded.

- Promissory Notes
- Irrevocable Trusts
- Annuities

4250 Value of Resources (08/01/2003, 02-11)

Unless an exception in one of the subsections below applies, the department values ownership interests of financial responsibility group members according to these general rules.

A. Resources not excluded under rule 4240 are valued at their equity value.

B. The portion of jointly owned resources not excluded under rule 4240 and countable toward the Medicaid resource limit is determined according to the rules in 4252.

C. The value of any resource owned in its entirety by members of the financial responsibility group and not excluded under rule 4240 is counted toward the Medicaid resource limit.

Equity value is the fair market value minus the total amount owed on it in mortgages, liens, or other encumbrances. The department will use the original estimate of the equity value of a resource unless the owner submits evidence from a disinterested, knowledgeable source that, in the departments judgment, establishes a reasonable lower value.

4251 Jointly Owned Resources (08/01/2003, 02-11)

This section defines each type of joint ownership and the amount of the resource counted.

When two or more parties share rights to sell, transfer, or dispose of part or all of personal or real property, the department counts the ownership share held by members of the financial responsibility group as prescribed by state law. Shared ownership or control occurs in different forms, including tenancy in common, joint tenancy, and tenancy by the entirety. The department determines the type of shared ownership involved and uses it to compute the countable value of the resource. If an individual submits evidence supporting another type of shared ownership, the department makes a decision about which type applies. When the department decides not to use the type suggested by the individual, it provides the individual with a written notice stating the basis for its decision.

Under Vermont law, a co-owner may demand partition, the dividing of lands held by more than one person. For this reason, the department counts the individuals proportionate share of the lands as an available resource, unless excluded as a home (rule 4241.1) or property up for sale (rule 4241.3).

4251.1 Tenancy in Common (10/07/2005, 05-25)

Tenancy in common applies to all jointly owned resources when title to the resource does not specify joint tenancy or tenants by the entirety.

Tenancy in common means that each party has a portion of interest that may not be equal. In tenancy in common, two or more persons each have an interest, which may not be equal, in the whole property for the duration of the tenancy. Co-owners may sell, transfer, or otherwise dispose of their respective shares of the property without permission of other owners but cannot take these actions with respect to the entire property. When a tenant in common dies, a surviving tenant has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, the deceased's interest passes to his or her estate or heirs.

When one or more members of the financial responsibility group (rule 4221) own a resource as tenants in common with one or more persons who are not members of the financial responsibility group, the department counts the resource depending on its classification as either a nonliquid resource (rule 4232) or a liquid resource (rule 4233).

A. Nonliquid Resources

The department divides the total value of the property among the total number of owners in direct proportion to the ownership interest held by each.

B. Liquid Resources

Unless otherwise excluded (rule 4247), the department counts the entire equity value of funds held in an account in a financial institution. The department considers that the entire equity value is available to the members of the financial responsibility group who own the account.

4251.2 Joint Tenancy (02/01/2007, 06-46)

Joint tenancy means each of two or more persons has an equal undivided interest in the whole resource.

The department follows state law in requiring the presence of four unities in order to recognize that joint tenants hold a resource. The four unities are: interest, possession, title, and time. A joint tenancy requires an undivided share and interest (interest) by all owners to possess the whole resource (possession). The words "joint tenants" must appear on the account or deed (title). Lastly, the joint tenants must have acquired their interest in the property at the same time (time).

When a member of the financial responsibility group owns a resource as a joint tenant, the department counts the entire equity value of the resource as available to the member. When the instrument creates an unequal interest of the joint tenants, the department counts only the portion available to the member of the financial responsibility group.

Upon the death of one of only two joint tenants, the survivor becomes sole owner. Upon the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest.

4251.3 Tenancy by the Entirety (02/01/2007, 06-46)

Tenancy by the entirety means that each person owns all of the resource. It applies only to real property of spouses and must be so designated in the document establishing ownership. It means the property can be disposed of only with the consent of both parties. Upon the death of one tenant by the entirety, the survivor takes the whole. Upon legal dissolution, the former spouses become tenants in common (rule 4251.1), and one can sell his or her share without the consent of the other.

When a member of the financial responsibility group owns a resource as a tenant by the entirety, the department counts the entire equity value of the resource as available to the member.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4252 Date of this Memo 02/14/2008 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Health Savings Accounts (HSAs) are accounts used to set aside funds to meet medical expenses. A Health Savings Account (HSA) is counted toward the Medicaid resource limit unless the client can demonstrate the funds are not available.

4252 Value of Certain Resources (10/07/2005, 05-25)

The following sections describe exceptions to the general rules in 4250. They describe how the department values certain resources of financial responsibility group members.

4252.1 Annuities (10/07/2005, 05-25)

Unless otherwise excluded under rule 4244 or treated as a transfer under rule 4473.4, the department counts the fair market value of annuities, as defined in rule 4233.4 as well as those that may be cashed or sold.

The fair market value is equal to the amount of money used to establish the annuity and any additional payments used to fund the annuity, plus any earnings and minus any early withdrawals and surrender fees, unless the individual can furnish evidence from a reliable source showing that the annuity is worth a lesser amount to the beneficiary. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other the department considers, in its discretion, to be reliable.

4252.2 Life Estates (10/07/2005, 05-25)

Unless the life estate is excluded, the department establishes the value of life estates by multiplying the fair market value of the property at the time of the transfer by the number in the life expectancy table that corresponds with the individuals age at the time of the transfer creating the life estate. The life estate table is found in the Medicaid Procedures Manual. Individuals may submit evidence supporting another method of establishing the fair market value of such a life estate. The department shall make a decision about which method to use. If the department decides not to use the alternate method advocated by an individual, the department shall provide that individual with a written notice stating the basis for its decision.

4252.3 Jointly Owned Real Property (10/07/2005, 05-25)

Regardless of any co-owners refusal to sell, the department presumes that individuals who own real property jointly with others own the entire equity value of the real property if the joint ownership was created after July 1, 2002 and less than 36 months prior to the date of application. Individuals may rebut this presumption by showing through reliable sources that others have purchased shares of the property at fair market value. Reliable sources include cancelled checks or property transfer tax returns. When individuals establish that one or more co-owners purchased shares of the property, the department counts the proportional interest owned by the individual requesting long-term care.

4252.4 U.S. Savings Bonds (09/01/2005, 05-19)

Savings bonds are counted as a resource beginning on the date of purchase unless:

A. individuals have requested and been denied a hardship waiver pursuant to the provisions of rule 4249.8; or

B. individuals owned savings bonds that were in their minimum retention period on June 15, 2004 and the bonds have not been redeemed, exchanged, surrendered, reissued or otherwise become available.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4252.6 Date of this Memo 02/01/2010 Page 1 of 1
This Memo: [ ] is New [X] Replaces one dated 03/04/2005

UPDATE:

Any income received from a home equity conversion plan is excluded in the month of receipt. If the income is retained after the month of receipt, count it as a resource beginning the month after receipt.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation [ ] Medicaid SSI Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4252.6 Date of this Memo 01/01/2011 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

For calendar year 2011, the substantial home equity limit is $506,000. Beginning in calendar year 2012, refer to the Medicaid Procedures Manual at P-2420C for any increases to this limit.

To establish the value of the bonds, the department uses the Savings Bond Calculator or the Comprehensive Savings Bond Value Table on the U. S. Bureau of Public Debt's Internet web site at: www.publicdebt.treas.gov/sav/savcalc.htm. Alternatively, the department obtains the value by telephone from a local bank. The following general rules apply to valuation.

A. Series E and EE bonds are valued at their purchase price.

B. Series I bonds are valued at their face value.

C. Series HH bonds are valued at face value.

4252.5 Income-Producing Notes and Contracts (09/01/2005, 05-19)

Promissory notes are counted as a resource unless:

A. they meet the criteria for exclusion pursuant to the provisions of rule 4244; or

B. the individual owned a nonnegotiable promissory note executed before September 1 , 2005.

Unless one of the above criteria for exclusion is met, or is subject to a transfer penalty under rule 4473.6, the department counts the fair market value of promissory notes and similar income-producing resources (contracts). Regardless of negotiability, fair market value equals the amount of money used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received. If the individual furnishes evidence of a good faith effort to sell by obtaining three independent appraisals by reliable sources which reflect that the value of the note is less than the fair market value, the department will consider the note available only in the amount of this discounted value. Reliable sources include banks, other financial institutions, insurance companies, and brokers, as well as any other the department considers, in its discretion, to be reliable.

For individuals requesting long-term care, contracts valued at a discount either shall be treated as an available resource at the discounted amount or subject to a transfer penalty to the extent of the amount discounted from the fair market value, in the discretion of the department. Where the contract is determined to have no value on the open market, a transfer penalty for the full value used to establish the contract and any additional payments used to fund it, plus any earnings and minus any payments already received shall be applied.

4252.6 Substantial Home Equity (10/07/2005, 05-25)

A. Definition

Home equity means the value of a home based on the town assessment minus the total amount owed on it in mortgages, liens, or other encumbrances. For example, when a Medicaid applicant has a joint tenancy with someone other than their spouse, the equity should be considered reduced by the amount of the other individuals equity interest in the property when the joint tenant resides in the home.

B. Substantial home equity precludes payment for long-term care services

Individuals with equity interest in their home (rule 4241.1) in excess of $500,000 are ineligible for long-term care services due to excess resources unless one of the following individuals lawfully reside in the individuals home.

1. Individual's spouse;

2. Individual's child who is under age 21; or

3. Individual's child who is blind or permanently and totally disabled, regardless of age.

Individuals with excess equity in their home who are found ineligible for long-term care services may receive other Medicaid services besides those for long-term care, if they meet the eligibility criteria for a coverage group that covers services other than long-term care.

Beginning with the year 2011, the $500,000 amount shall be increased from calendar year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

C. Hardship Waivers

Individuals who are ineligible for long-term care services due to excess equity in their homes may request an undue hardship waiver based on the criteria specified at rule 4474.4.

Individuals are permitted to use a reverse mortgage or home equity loan to reduce the individuals equity interest in the home. In such circumstances, the department values the funds as follows:

The department does not consider the existence of a line of credit to diminish the equity value except in amounts from the line of credit actually paid to the borrower.

During the month of receipt, lump sum payments are an excluded resource (rule 4241.4) and proceeds paid in a stream of income are excludable income (rule 4280.2). Lump sum payments from loans that are retained for more than a month, continue to be an excluded resource. Lump sum payments and streams of income are subject to transfer penalties if given away in the month of receipt or thereafter.

4260 Countable Resources (02/01/2007, 06-46)

The department determines countable resources by combining the resources of the members of the financial responsibility group (rule 4222), and comparing them to the Medicaid groups resource standard. The department determines countable resources for different types of SSI-related Medicaid groups: adults without spouses, adults with spouses, children, and individuals requesting long-term care. If the resources of the Medicaid group fall below or are equal to the applicable resource standard, the resource test is passed. If an excess resource amount remains after all exclusions have been applied (rule 4240), the individual has not passed the resource test. Individuals may become eligible for Medicaid by spending down or giving away excess resources as provided in rule 4431 subject to transfer of resource rules (4470) for those seeking long-term care coverage.

Individuals Other than Children

4261 Individuals Other than Children (02/01/2007, 06-46)

The department follows the general rule in 4260 to determine whether total resources, after exclusions, of individuals other than children fall below the resource maximum for one.

Individuals with Spouses and Not in Long-Term Care

4262 Individuals with Spouses and Not in Long-Term Care (02/01/2007, 06-46)

The department follows the general rule in 4260 to determine whether the total resources, after exclusions, of individuals living with their spouses and requesting SSI-related Medicaid, other than long-term care, fall below the resource maximum for two.

Blind or Disabled Children

4263 Blind or Disabled Children (02/01/2007, 06-46)

Unless otherwise specified in the coverage group rules at 4202.2–4203, the department determines the countable resources of blind or disabled children by:

A. combining the resources of the parents living with the child with the child's resources, until the child reaches the age of 18,

B. subtracting the resource maximum for one, if one parent or two, if two parents, from the parent's countable resources; and

C. deeming and adding the remainder to the blind or disabled child's own countable resources.

If the blind or disabled child's total countable resources fall below the resource maximum for one, the resource test is passed.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4264 **Date of this Memo** 06/29/2009 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

"Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24 hour care, has privacy, a lockable door, and is a homelike setting.

An institutionalized spouse is permitted to allocate income and resources to a community spouse when the community spouse resides in assisted living.

Individuals with Spouses and in Long-Term Care

4264 Individuals with Spouses and in Long-Term Care (08/01/2003, 02-11)

For individuals requesting long-term care who have spouses, the department performs the resource evaluation process of assessment and allocation set forth in rules 4264.1 and 4264.2 at the beginning of the first continuous period of long-term care. Individuals discharged from long-term care and readmitted later do not undergo these steps again; only the resources of and any new transfers by the readmitted spouse are counted.

An institutional spouse who receives additional resources after allocating less than the community spouse resource allocation (CSRA) maximum and being found eligible for Medicaid, may continue to transfer resources to their community spouse up to a combined total transfer of no more than the CSRA maximum until the annual review of eligibility. After the first regularly scheduled annual redetermination of eligibility, the rules regarding transfers apply (rule 4470).

4264.1 Individuals with a Community Spouse (08/01/2003, 02-11)

At the time of admission to long-term care and application for Medicaid long-term care services, including waiver programs, the department completes an assessment of resources. An individual or their spouse may also request an assessment prior to admission to long-term care. The department provides a copy of the assessment to each spouse and retains a copy. The assessment must include at least:

A. the total value of countable resources in which either spouse has an ownership interest;

B. the basis for determining total value;

C. the spousal share or one-half the total;

D. conclusion as to whether the institutionalized spouse would be eligible for Medicaid based on resources;

E. the highest amount of resources the institutionalized and community spouse may retain and still permit the institutionalized spouse to be eligible;

F. information regarding the transfer of assets policy; and

G. the right of the institutionalized spouse or the community spouse to a fair hearing at the time of application for Medicaid.

4264.2 Allocation to a Community Spouse (08/01/2003, 02-11)

The department completes an allocation of resources at the time of application for Medicaid long-term care services, including waiver programs, as follows:

A. The department determines the total countable resources of the couple at the time of application for Medicaid, regardless of which spouse has an ownership interest in the resource;

B. The department deducts the greatest of the following:

1. community spouse resource allocation maximum,

2. amount set by a fair hearing, or

3. amount transferred from the institutional spouse (IS) to the community spouse (CS) under a court order.

C. The department compares the remaining resources allocated to the IS, to the resource maximum for one, to determine whether or not the IS passes the resource test for Medicaid. If the IS does not pass the resource test, see the spenddown provisions at rules 4431–4450. The department considers the resources of the CS available to the IS until the month after the month in which the individual becomes eligible for long-term care coverage. If the CS fails to make the resources accessible to the IS, after the department has determined that they are available, the department may still grant long-term care coverage if:

1. the IS assigns any rights to support from the CS to the department; or

2. denial would work an undue hardship, as specified in rule 4474.4.

D. The department provides the CS with the amount determined to be the share of the CS (or to someone else for the sole benefit of the community spouse). The transfer from the IS to the CS must be completed by the next review of eligibility. The department verifies the transfer at the next regularly scheduled redetermination of eligibility.

4270 Income Requirements (08/01/2003, 02-11)

Income means any form of cash payment from any source received by individuals or their financially responsible relatives. Income is considered available and counted in the month it is received or credited to the individual with the exception of a lump sum receipt of earnings such as sale of crops or livestock. These receipts are only counted if received during the six-month accounting period and are averaged over the six-month period.

The department counts all earned and unearned income of individuals who are aged, blind or disabled and their financially responsible relatives, except income that is specifically excluded (rule 4280) or deducted (rule 4282). The department verifies all countable income.

Countable income depends on the coverage group for which individuals are eligible. It is determined according to the rules at (4281) and compared to the highest applicable income standard. If total countable income for the Medicaid group exceeds the income standard for every coverage group in rules 4202-4204.4, individuals are denied eligibility and given a spenddown (see rules 4430, 4440).

Types of Income

4271 Types of Income (08/01/2003, 02-11)

This section describes the kinds of income the department considers when determining SSI-related Medicaid eligibility.

Earned Income

4272 Earned Income (08/01/2003, 02-11)

Earned income includes all gross salary, wages, commissions, bonuses, severance pay received as a result of employment. It includes income from self-employment.

Earned income includes payments from Economic Opportunity Act of 1964 programs as recipients or employees, such as:

- Youth Employment Demonstration Act Programs
- Job Corps Program (Title I, Part A)
- Work Training Programs (Title I, Part B)
- Work Study Programs (Title I, Part C)
- Community Action Programs (Title II)
- Voluntary Assistance Program for Needy Children (Title II)

Earned income also includes income from:

- employment under Title I of the Elementary and Secondary Education Act (e.g., as a teacher's aide, lunch room worker, etc.)
- wages from participation in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U. S. C. §794d)
- earnings from the Senior Community Service Employment (SCSE) program.

4272.1 Self-Employment Income (08/01/2003, 02-11)

The department counts net earnings from self-employment. Net earnings means gross income from any trade or business less the allowable deductions specified in rule 4283.1.

The department uses tax forms to determine countable income from self-employment. Applicants who state that income on their tax forms is no longer reflective of their situation may submit alternate documentation.

When the applicants business has been the same for several years, the department uses income reported on tax forms from the last year.

When the applicants business was new in the previous or current year and the applicant has business records, the department uses income reported on tax forms and other available business records and divides the income by the number of months the individual has had the business.

When the applicants business has no records, is seasonal or has unusual income peaks, the department includes income reported on the applicants signed statement estimating annual income.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4273 **Date of this Memo** 07/01/2004 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

Interest or dividend income generated is excluded for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by a countable resource.

Interest or dividend income generated is counted for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by an excluded resource.

Exclude interest or dividend income from countable resources.

- savings accounts, checking accounts, mutual funds, CD's, stocks
- Revocable Trusts
- Life Insurance Policies

Count interest or dividend income when the resource generating it is considered an excluded resource.

Take special care to evaluate the following resources. They may be countable or excludable, depending on their terms. Please contact AOps if you need help to determine whether one of these types of resources should be counted or excluded.

- Promissory Notes
- Irrevocable Trusts
- Annuities

4273 Unearned Income (08/01/2003, 02-11)

Unearned income means any payments other than earned income from any source received by individuals or their financially responsible relatives. It is the gross payment, less allowable deductions at rule 4284. The department counts periodic benefits received by individuals as unearned income.

Unearned income includes income from capital investments in which the individual is not actively engaged in managerial effort. This includes rent received for the use of real or personal property, and interest earned on liquid resources. Ordinary and necessary expenses of rental property such as interest on debts, State and local taxes, the expenses of managing or maintaining the property, etc. are deducted in determining the countable unearned income from this source. The deduction is permitted as of the date the expense is paid. Depreciation or depletion of property is not a deductible expense.

Unearned income also includes, but is not limited to, the items listed below.

A. Social Security retirement, disability, supplemental security income, or survivor benefits for surviving spouses, children of the decedent, and dependent parents

B. Railroad Retirement

C. unemployment compensation

D. private pension plans

E. annuities

F. income from capital investments in which the individual is not actively engaged in managerial effort, such as rent for the use of real or personal property, and interest earned on liquid resources or life insurance dividends

G. regular and predictable voluntary cash contributions received from friends or relatives

H. cash prizes or awards

I. withheld overpayments of unearned income, unless the overpayment was counted as income in determining Medicaid eligibility in the month received

J. royalty payments to holders of patents or copyrights for which no past or present work was or is involved

K. retroactive Retirement, Survivors and Disability Insurance (RSDI) benefits for individuals with drug addiction or alcoholism and is treated as if it had all been received in a lump sum payment, even if paid in installments

L. Veterans Administration pension, compensation and educational payments that are not part of a VA program of vocational rehabilitation and do not include any funds which the veteran contributed

M. Interest payments received in the month of receipt

N. proceeds of a loan in the month received when the individual is the borrower

O. interest payments received by the individual on promissory notes, property agreements, and loan agreements that cannot be sold, when the individual is the lender

P. alimony and support payments received

Q. royalties which are payments to the holder of a patent or copyright, owner of a mine, etc., for which no past or present work was or is involved

Unearned Income

R. cash received by the beneficiary of a life insurance policy minus any expenses incurred, up to a maximum of $1,500, in paying for the cost of the insured individual's last illness and burial

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation [ ] Medicaid SSI Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4280.1 Date of this Memo 01/01/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Wages paid by the Census Bureau for temporary employment are excluded.

INTERPRETIVE MEMO

[X] Medicaid SSI Rule Interpretation **[ ] Medicaid SSI Procedure Interpretation**

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4280.2 **Date of this Memo** 07/01/2004 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

Interest or dividend income generated is excluded for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by a countable resource.

Interest or dividend income generated is counted for SSI-related Medicaid and any other programs that follow SSI-related rules when it is generated by an excluded resource.

Exclude interest or dividend income from countable resources.

- savings accounts, checking accounts, mutual funds, CD's, stocks
- Revocable Trusts
- Life Insurance Policies

Count interest or dividend income when the resource generating it is considered an excluded resource.

Take special care to evaluate the following resources. They may be countable or excludable, depending on their terms. Please contact AOps if you need help to determine whether one of these types of resources should be counted or excluded.

- Promissory Notes
- Irrevocable Trusts
- Annuities

4280 Income Exclusions (08/01/2003, 02-11)

4280.1 Earned Income Exclusions (08/01/2003, 02-11)

The following are excluded from earned income.

A. Support service payments made directly to the providers of services in the Limited Work Experience Program under the Workforce Investment Act of 1998 (29 U. S. C. §794d) or needs-based payments of $10 per day made to participants in the program are excluded income.

B. The earned income of a child under the age of 22 who is a student regularly attending school. This applies to wages received from regular employment, self-employment, or payments from the Neighborhood Youth Corps, Work Study and similar programs.

C. Infrequent or irregular earned income received, not to exceed $30 per calendar quarter.

D. Any in-kind assistance received from others.

E. Earned Income Tax Credit payments (both refunds and advance payments).

F. The earned income of a working disabled person when performing the second step of the categorically needy eligibility test redetermining net income, set forth in rule 4202.4.

G. The earned income of a child under the age of 18.

4280.2 Unearned Income Exclusions (10/01/2005, 05-25)

Unearned income exclusions are limited to the following items.

A. Expenses incurred as a condition of receiving the unearned income. For example, guardianship fees may be deducted if having a guardian is a requirement for receiving the income or attorney fees, and court costs may be deducted if they were incurred in order to establish a right to the income.

B. Certain Veterans Administration payments:

1. portion of pension or compensation payment for aid and attendance and housebound allowances, even when the provider is a spouse or a parent;

2. augmented portion of pensions, compensation or other benefits for a dependent of a veteran or veterans spouse;

3. $20 from educational benefits to the veteran funded by the government;

4. educational benefits paid as either part of a plan of vocational rehabilitation or by withdrawals from the veteran’s own educational fund;

5. clothing allowance; and

6. payment adjustments for unusual medical expenses

C. Ordinary and necessary expenses of rental property and other capital investments except depreciation or depletion of property. This includes but is not limited to interest on debts, state and local taxes. The expenses of managing or maintaining the property, as of the date the expense is paid, are deductible.

D. Infrequent or irregular payments of interest and dividends, up to $20.00 per month.

E. Royalties that represent self-employment earnings from a royalty-related trade or business.

Medical care and services or social services provided in cash or in-kind, including vocational rehabilitation and payment of medical insurance premiums by a third party

F. Any public agency's refund of taxes on food or real property.

G. Infrequent or irregular income payments that do not exceed $20.00 in a month.

H. Bills paid directly to vendors by a third party.

I. Replacement of lost, stolen or destroyed income.

J. Weatherization assistance.

K. Receipts from the sale, exchange or replacement of a resource.

L. Any assistance based on need which is funded wholly by the state, such as General Assistance.

M. Public assistance benefits of individuals who are living with an applicant, as well as any income that was used to determine the amount of those benefits

N. Any portion of a grant, scholarship or fellowship used to pay tuition, fees or other necessary educational expenses.

O. Home produce used for personal consumption.

P. Assistance and interest earned on assistance for a catastrophe from the Disaster Relief and Emergency Assistance Act or other comparable assistance provided by the federal, state or local government.

Q. Irregular and unpredictable voluntary cash contributions or gifts received from friends or relatives.

R. Payments for providing foster care for children or adults placed in the individuals home by a public or private non-profit placement agency.

S. One-third of child support payments received for a child in the household of the applicant or recipient. Note: the remaining two-thirds of the support payments are considered the unearned income of a child received from an absent parent.

T. Income paid for chore, attendant or homemaker services under a government program, such as Title XX personal services payments or the $90.00 Department of Veterans Affairs (VA) Aid and Attendance payments to veterans in nursing homes.

U. Any "in-kind" assistance received from others.

V. Assistance provided in cash or in kind (including food, clothing, or shelter) under a government program that provides medical care or services (including vocational rehabilitation).

W. That portion of a benefit intended to cover the financial need of other individuals, such as AABD-EP grants.

X. Retroactive payments of federal SSI, the AABD supplement to SSI or Old Age and Survivor and Disability Insurance (OASDI) benefits if the payments were included in determining financial eligibility for Medicaid in the month it was actually owed to the individual.

Income Exclusions

Y. Home energy assistance provided by a private nonprofit organization or a regulated supplier of home energy.

Z. State-administered victims' compensation payments.

AA. State or local government relocation payments.

AB. Payments occasioned by the death of another person to the extent that they are used to pay for the deceased persons last illness and burial, including gifts and inheritances.

AC. Payments occasioned by the death of another person to the extent that they are used to pay for the deceased persons last illness and burial, including gifts and inheritances.

AD. Earned Income Tax Credit payments (both refunds and advance payments).

AE. Cash received as the beneficiary of a life insurance policy minus any expenses incurred, up to a maximum of $1,500 set aside to pay for the cost of the insured individual's last illness and burial.

AF. Social security disability insurance benefits (SSDI) and veterans disability benefits provided to working disabled persons when determining categorically needy eligibility, specified in rule 4202.4.

AG. Income from reverse mortgages is not counted as income to that individual.

AH. Dividends paid on life insurance policies, excluding interest.

AI. Payments made to a supplemental needs trust.

AJ. Exclusions based on federal law as set forth in rule 4248.9.

4281 Determination of Countable Income (08/01/2003, 02-11)

The department counts the earned and unearned income of the members of the financial responsibility group. Income is considered available and counted in the month it is received or credited to the individual.

This section describes the general approach the department follows when it determines countable income for SSI-related Medicaid. These general rules apply to all applicants.

A. Determine income of the financial responsibility group

The department combines the income of all members of the financial responsibility group, and applies the appropriate exclusions (rule 4280) and standard deductions (rule 4282).

B. Compare countable income to the applicable income standard

Applicants pass the income test when their Medicaid groups income does not exceed the appropriate PIL, or the applicable income maximum, whichever is higher.

Applicants with income greater than the applicable income standard may establish financial eligibility by incurring eligible medical expenses that at least equal the difference between their countable income and the applicable PIL.

The subsections which follow specify how the department allocates and deems income based on the type of coverage sought and the size of the financial responsibility group.

4281.1 Financial Responsibility Group of One (08/01/2003, 02-11)

The department determines countable income for individuals seeking SSI-related community Medicaid with a financial responsibility group of one according to the following rules. Common financial responsibility groups of one include single adults, residential care home residents, and children seeking Katie Beckett coverage.

The following steps must be followed in determining the countable income of individuals who are aged, blind or disabled.

A. Determine and combine the total countable unearned income of the individual.

B. Subtract a $20 disregard unless all the unearned income is from a source that gives assistance based on financial need.

C. Deduct an allocation for each child in the household for whom the individual is financially responsible. The amount of each allocation is equal to the maximum allocation amount minus any countable income of the child. If the unearned income is not at least equal to the applicable allocation amount, any remaining allocation may be deducted from earned income.

D. Deduct from unearned income amounts used to comply with the terms of court-ordered support or Title IV-D support payments. If unearned income is insufficient, any remaining amounts may be deducted from earned income.

E. Determine and combine the individuals countable earned income.

F. Deduct any remaining amount of the $20 disregard, allocations for children and child support payments from the earned income.

G. Deduct $65 from the remaining earned income.

H. Deduct allowable work expenses for the disabled (rule 4283.3).

I. Deduct one-half of the remaining earned income.

J. Deduct any allowable work expenses for the blind (rule 4283.2).

K. Combine the remaining earned income with any remaining unearned income.

L. Deduct amount of Plan to Achieve Self-support (PASS), if applicable.

M. The result is the individual's countable income for the month. Compare it to the countable income to the PIL or the SSI/AABD payment standard for one, whichever is higher.

4281.2 Financial Responsibility Group of Two (08/01/2003, 02-11)

The department determines countable income for SSI-related Medicaid applicants with a financial responsibility group of two according to the rules at 4281.1, as well as the following additional rules.

A. Deem income at step 4281.1:

The department deems earned and unearned income to the applicant at step 4281.1 from their ineligible spouse or ineligible parent, except no income is deemed to adult applicants from their ineligible children.

B. Allocate income at step 4281.1(C):

The department allocates income from the financial responsibility group to each member of the financial responsibility group who is not applying for SSI-related Medicaid at step 4281.1 (C) in the amounts listed below:

1. For a child, the department allocates the difference between the SSI federal payment rate for one and the SSI federal payment rate for a couple. The department reduces the allocation for ineligible children if they have income, unless the ineligible children are students with earned income. No allocation is made to dependant children receiving public assistance.

2. For a parent in a one-parent financial responsibility group, the department allocates the SSI federal payment for one.

3. For parents in two-parent financial responsibility groups, the department allocates the SSI federal payment for two.

C. Count income at step 4281.1(M) for adult applicants applying for SSI-related Medicaid who have a spouse:

The department determines countable income for adults whose spouse is not applying for Medicaid, according to the rules at 4281.1, except at step 4281.1(M) the department compares the countable income of the Medicaid group to the PIL or the SSI/AABD payment standard for two, whichever is higher.

4281.3 Parent and Child Living Together (08/01/2003, 02-11)

When a parent and child in the same household both request SSI-related Medicaid, the department determines countable income as a financial responsibility group of two according to the following rules. These groups include a parent who is aged, blind or disabled and a child who is blind or disabled.

A. First determine the net income available to the adult applicant following the steps in rule 4281.1 if single, or rule 4281.2 if the adult applicant has a spouse, except do not allocate any income to the applicant child. Compare the adult applicants income to the protected income level (PIL) for one or, if married, the SSI/AABD payment standard for two.

   If the adult applicant's countable income is below the highest applicable income standard, the adult has passed the income test for eligibility. If the adult applicant's income exceeds the highest applicable income standard, deem the amount of income in excess of the highest applicable income standard to the child applicant as unearned income.

B. Second, determine the childs countable income by deeming any income from rule 4281.3 (a) above and then following the steps in 4281.4 D - N. If the child's income is less than the PIL, both the parent and the child pass the income test for Medicaid eligibility.

C. When both a parent and child have a spenddown requirement, the parent and child will pass the income test once the child's spenddown requirement has been met because the parent's excess income was deemed to the child.

   If the parent's spenddown requirement is less than the child's and the parent meets it, the parent will become eligible. The child, however, will remain ineligible until the remainder of the child's spenddown is met. The department deducts the parent's incurred eligible medical expenses from the spenddown requirements of both the parent and child because the parent's income was included in both income computations.

4281.4 Children Seeking Community Medicaid (02/01/2007, 06-46)

The department determines countable income for SSI-related Medicaid child applicants other than Katie Beckett (see rule 4281.1), children whose parent also requests Medicaid (see rule 4281.3), or long-term care (see rule 4281.5) as a financial responsibility group of one according to the following rules. Since parents are responsible for their children, their income must be considered available to their disabled or blind children requesting SSI-related Medicaid coverage, until the child reaches the age of 18.

A. Determine the total countable income, both earned and unearned, of the parents living with the child requesting coverage.

B. Deduct an allocation specified in rule 4281.2 (B) (2) or (B) (3) for the needs of the parents living in the household from the total countable income of the parents.

C. Deem the remaining amount to the blind or disabled child. If there is more than one blind or disabled child in the household, divide the remainder by the number of blind or disabled children and deem an equal portion to each. Do not deem more income to a child applicant than the amount which, when combined with the child's own income, would bring his or her countable income to the PIL. If the share of parental income that would be deemed to a child makes that child ineligible because that child has other countable income, deem parental income to other blind and disabled children under age 18 in the household and no portion to the child applicant.

D. Add the child's own unearned income. This is the total unearned income.

E. Deduct the $20 disregard. This is the total countable unearned income.

F. Determine the earned income of the child.

G. Deduct the balance of the $20 disregard.

H. Deduct the $65 earned income exclusion from any earned income.

I. Deduct any allowable work expenses of a disabled child (rule 4283.3).

J. Deduct one-half of the remaining earned income.

K. Deduct any allowable work expenses of a blind child. (rule 4283.2)

L. Combine the remaining earned and unearned income.

M. Deduct the amount of a Plan to Achieve Self-Support (PASS), if applicable.

N. The result is the applicant/recipient child's countable income. Compare it to the protected income level (PIL) for one. Children with income below the PIL, pass the income test.

4281.5 Individuals Seeking Long-Term Care (09/01/2005, 05-19)

The department determines countable income for SSI-related Medicaid long-term care applicants, including waiver and hospice services, according to the following rules.

The department compares the countable income of individuals requesting long-term care to the applicable income standard for their coverage group beginning with the date of admission to long-term care.

The institutional income standard (IIS) for individuals equals 300 percent of the maximum SSI federal payment to an individual living independently in the community. The IIS for couples equals twice the IIS for individuals.

When the department has an indication that individuals will need long-term care for fewer than 30 days, it uses the protected income level (PIL) for the month of admission, and applies the rules for SSI-related Medicaid, other than long-term care.

4281.6 Long-Term Care in Nursing Facilities (09/01/2005, 05-19)

The department determines countable income for applicants for long-term care in nursing facilities according to the rules at 4281.1, except the department:

A. allocates income to the community spouse, dependent children and for home upkeep, according to the rules in 4462;

B. allocates a personal needs allowance to the applicant; and

C. compares the countable income of the Medicaid group to the institutional income standard (IIS) beginning with the date of admission to long term care.

For individuals whose gross income exceeds the IIS, the department determines whether they may spenddown their excess income to the protected income level (PIL) to establish their financial eligibility as medically needy, according to the rules at 4433. The department determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

4281.7 Waiver or Hospice Services (09/01/2005, 05-19)

The department determines countable income for applicants for long-term care in nursing facilities according to the rules at 4281.1, except the department:

A. allocates income to the community spouse, dependent children and for home upkeep, according to the rules in 4462, and

B. allocates a community maintenance allowance to the applicant.

C. approves income eligibility if applicants:

1. have gross income that does not exceed the IIS; or

2. seek coverage for home-based waiver services for the aged and disabled, administered by the Department of Aging and Independent Living, and pass the net income test for individuals working with disabilities (4202.4 (B)).

For individuals whose gross income exceeds the IIS, the department determines whether they may spenddown their excess income to the PIL to establish their income eligibility as medically needy using the rules in 4433. The department determines whether the individual has incurred eligible medical expenses that equal the difference between their countable income and the PIL.

Income Deductions

4282 Income Deductions (08/01/2003, 02-11)

The department allows deductions from earned income (rule 4283), self employment (rule 4283.1), and unearned income (rule 4284).

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Reference 4283.2 Date of this Memo 09/26/2012 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

Mileage reimbursement rates are the rates established by the U.S. General Services Administration. The rates fluctuate periodically. It is important to refer to the federal website in order to determine the current rate. The website is: www.gsa.gov/mileage

4283 Earned Income Deductions (08/01/2003, 02-11)

A deduction of $65.00 and one-half of the remainder applies to all determinations of earned income.

4283.1 Business Expenses (08/01/2003, 02-11)

Deductions of business expenses from self-employment income are limited to the ones specified below.

A. Operating costs necessary to produce cash receipts, such as office or shop rental; taxes on farm or business property; hired help; interest on business loans; cost of materials, livestock and equipment required for the production of income; and any business depreciation.

B. The cost of any meals provided to children for whom individuals provide day care in their own homes, at the currently allowed rate per meal.

C. The actual operating expenses necessary to produce cash receipts for commercial boarding houses: an establishment licensed as a commercial enterprise that offers meals and lodging for compensation, or, in areas without licensing requirements, a commercial establishment that offers meals and lodging with the intention of making a profit.

D. Room and board, alone or as part of custodial care, provided that the amount shall not exceed the payment the household receives for room and board.

E. Foster care payments made by the Family Services Division (FSD) to licensed foster homes, including room and board of children in the custody of and placed by FSD when the Medicaid group includes a foster parent.

F. Ordinary and necessary expenses for active management of capital investments, like rental property. These may include fire insurance, water and sewer charges, property taxes, minor repairs which do not increase the value of the property, lawn care, snow removal, advertising for tenants and the interest portion of a mortgage payment

4283.2 Work Expenses of Blind Individuals (08/01/2003, 02-11)

In addition to other allowable deductions specified throughout rule 4282 and its subsections, work expenses from income of blind individuals includes the following items:

A. cost of purchasing and caring for a dog guide;

B. work-related fees such as licenses, professional association dues or union fees;

C. transportation to and from work including vehicle modifications;

D. training to use an impairment-related item such as braille or a work-related item such as a computer;

E. federal, state and local income taxes;

F. Social security taxes and mandatory pension contributions;

G. meals consumed during work hours;

H. attendant care services;

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I. structural modifications to the home; and

J. medical devices such as wheelchairs.

4283.3 Work Expenses of Disabled Individuals (08/01/2003, 02-11)

In addition to other allowable deductions specified throughout rule 4282 and its subsections, work expenses from income of disabled individuals includes the following items.

A. transportation to and from work, including vehicle modifications;

B. impairment-related training;

C. attendant care;

D. structural modifications to the home; and

E. medical devices such as wheelchairs.

Unearned Income Deductions

4284 Unearned Income Deductions (08/01/2003, 02-11)

A. The department deducts $20.00 from unearned income unless the source of income gives all assistance based on financial need.

B. The department deducts from unearned income amounts used to comply with the terms of court-ordered support or Title IV-D support payments.