MEDICAID

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OVERVIEW

This chapter describes Medicaid resource requirements. Resource policies that apply to all coverage groups are described in the first part of the chapter:

♦ Attribution of resources between an institutionalized spouse and a community spouse.
♦ Estate recovery for clients who are over age 55 or and in a medical institution.
♦ Transfers of assets.
♦ Trusts.

These sections are followed by sections on resource requirements which are specific to either:

♦ Children in certain coverage groups, whether FMAP-related or SSI-related;
♦ People whose eligibility is based on their relationship to the Family Medical Assistance Program (FMAP-related coverage groups), including dependent children and their families; or
♦ People whose eligibility is based on their relationship to the Supplemental Security Income program (SSI-related coverage groups), including persons who are aged, blind, or disabled.

ATTRIBUTION OF RESOURCES

Legal reference: 441 IAC 75.5(3)

When one spouse enters a medical institution or applies for waiver services, resources are attributed to the community spouse to protect sufficient resources for that person to remain in the community.

8-A defines a “community spouse” as a person who is not in an institution but who is the spouse of a person who is in an institution or waiver. The community spouse could live:

♦ In the couple’s own home.
♦ In a custodial home, such as a residential care facility.
♦ In an apartment.
♦ With relatives.
♦ In another nonfacility or noninstitutional setting.
ATTRIBUTION OF RESOURCES

Iowa Department of Human Services

Title 8  Medicaid

Chapter D  Resources

Revised July 20, 1999

Complete the attribution using the resources the couple had as of the first day of the month that:

♦ The institutionalized spouse enters a medical institution (on or after September 30, 1989) expecting to stay 30 consecutive days or more, or

♦ The Iowa Foundation for Medical Care determines that the HCBS waiver applicant meets level of care.

Information needed to attribute resources is included on the Medicaid application forms. Use form 470-2577, Resources Upon Entering a Medical Institution, to attribute resources when:

♦ The month of entry to the institution and the month of application are different, or
♦ A married Medicaid recipient requests home- and community-based waiver services, or
♦ Either the institutionalized spouse or the community spouse requests attribution but does not apply for Medicaid.

When a Medicaid application is filed, complete the attribution within 30 days. If the attribution is requested without a Medicaid application, complete the attribution within 45 days. Do not approve Medicaid until the attribution is completed.

Complete only one attribution per community spouse per case. After an attribution has been completed, do not complete a new attribution if:

♦ The institutionalize spouse is discharged after the 30 days but later reenters a medical institution.

♦ The attribution was completed for waiver services and the waiver spouse later enters a medical facility.

♦ A person whose attribution was completed in another state applies for institutional care in Iowa. However, if that state has a lower minimum community spouse resource allowance, recalculate the attribution and assign Iowa’s minimum.

In specific circumstances, attribution guidelines may be different:

♦ If both spouses entered an institution but one goes home, complete an attribution for the month the spouse who remains institutionalized entered the institution.

♦ If the previously institutionalized spouse goes home and then the community spouse enters a medical institution expecting to stay for 30 days or more, complete a new attribution for the new institutionalized spouse.
♦ If either spouse dies in the month of application or died in the retroactive period, attribute resources for the month of entry to the institution. Use the attributed resources to determine eligibility for months the spouse was living.

♦ If the client marries after entering the institution but before Medicaid eligibility is determined, complete an attribution of resources for the community spouse. Complete the attribution for the month of entry.

♦ If the a single client or a client who was widowed after the attribution marries after entering the institution and after Medicaid eligibility for institutional care has been established, do not complete an attribution. If the institutionalized spouse later becomes ineligible for Medicaid and reapply for Medicaid benefits, complete an attribution for the month of entry.

Revise attribution results when:

♦ A final appeal establishes a greater amount of protected resources for the community spouse. See If the Client Appeals the Attribution Amount.

♦ The client is later able to verify resources that were owned at the date of entry to the institution. See Calculating the Amount to Attribute to the Community Spouse.

If a person who requests an attribution without filing a Medicaid application fails to cooperate in determining attribution, a new determination is not necessary when you receive an IRS report. (However, do complete the attribution and consider the IRS report when the person later applies for Medicaid if you receive verification and can establish what resources existed when the person entered the institution.)

Further details on the attribution procedure are organized as follows:

♦ Resources excluded from attributions
♦ Calculating the amount to attribute the community spouse
| ♦ Processing a Medicaid application after the attribution is completed
| ♦ Summary examples of attribution situations

**Resources Excluded From Attribution**

**Legal reference:** 441 IAC 75.5(3)“c”

Some resources are not considered for attribution, whether owned by one or both spouses. Resources that do not count in the attribution process also do not count when determining eligibility. Do not count for either the attribution process or eligibility:

♦ **One vehicle** regardless of value.
♦ **Burial and related expense funds** for each spouse which are separately identified and set aside for that purpose. Each spouse may have a fund or multiple funds but no more than $1,500. Subtract from this $1,500 limit the total face value of excluded whole life and term life insurance policies and any amounts in irrevocable trusts or arrangements available to meet burial and related expenses.

♦ **Burial spaces** held for either spouse or any other member of the immediate family.

♦ **Disaster Relief Act Assistance** and Emergency Act Assistance or other assistance provided because of a Presidential declaration of disaster. Exclude these resources and any interest earned on the funds for nine months, beginning with the date of receipt. (These funds may be excluded for a longer period, if good cause is shown.)

♦ **Household goods and personal effects**, regardless of value.

♦ **Housing assistance** paid by HUD or FMHA for housing occupied by the community spouse.

♦ **Life insurance policies** with a total face value of $1,500 or less for each spouse.

♦ **Property in a homestead**, including the home and related land.

♦ **Property used for self-support** of either spouse if it would be excluded by SSI.

♦ **Real property** up to $6,000 if it is earning six percent of equity.

♦ **Relocation assistance** provided by a state or local government which is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

♦ **Resources of a blind or disabled person** who has a Plan for Achieving Self-Support, as determined by the Division of Vocational Rehabilitation, DHS, or the Department for the Blind.

♦ **Resources necessary for self-employment**.

♦ **Shares of stock held by natives of Alaska** in a regional or village corporation. Exclude for the period of 20 years in which the stock is inalienable (as provided in Section 7 (h) and Section 8 (c) of the Alaska Native Claim Settlement Act).

♦ **Underpayment of SSI or Social Security** which is due either spouse for any month before the month it is received. Exclude for six months after receipt.

♦ **Victim’s compensation** from a fund established by a state for victims of crime. Do not count the assistance for nine months from receipt. The client must prove that the payment was for expenses incurred or losses suffered as a result of a crime.
See SPECIFIC SSI-RELATED RESOURCES for more descriptive information about these excluded resources. (Note that there are other types of resources described under that heading that are excluded for determining eligibility, but not for attribution.)

Resources affected by a prenuptial or antenuptial agreement are countable as resources unless excluded under the criteria listed above.

**Calculating the Amount to Attribute to the Community Spouse**

**Legal reference:** 441 IAC 75.5(3)“c,” “d,” and “f”; P.L. 100-365, P.L. 100-485

Use SSI-related resource policies when determining which resources to count in completing an attribution. To calculate how much to attribute to each spouse:

1. Determine what resources the couple owned as of the first moment of the first day of the month of entry into the medical institution (or the month the HCBS waiver applicant meets the institutional level of care).

   Count all resources not listed under SPECIFIC SSI-RELATED RESOURCES that are owned by either spouse. It does not matter which spouse owns the resource. Include the value of resources that are for sale.

   The client must provide verification of the value of the resources. Count only those resources that can be verified. If the client provides partial verification, use that documentation to determine the attribution.

   **Example:**

   Mr. and Mrs. G claimed resources of $60,000 on the application for attribution. However, they could provide verification for only $50,000. The attribution was based on the verified resources of $50,000.

   Count the uncompensated value of any divested resources owned by either spouse if the resource was owned on the first moment of the first day of the month. “Uncompensated value” is the fair market value of the asset minus the amount that was received for the asset.

   **Note:** If either spouse transferred resources at less than fair market value to attain eligibility, see TRANSFER OF ASSETS for procedures to handle such transfers when determining eligibility.
2. Add together all resources of both spouses.

3. Attribute one-half of the documented resources to each spouse. If necessary, adjust the division so that the community spouse will receive no less than $24,000 (if there is that much) but no more than $99,540.

<table>
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<th>Value of Combined Resources</th>
<th>$0 - $47,999</th>
<th>$48,000 - $199,080</th>
<th>$199,080 or more</th>
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<td>Amount attributed to:</td>
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<td>Community spouse</td>
<td>$24,000</td>
<td>One-half</td>
<td>$99,540</td>
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<tr>
<td>Institutionalized spouse</td>
<td>Remainder</td>
<td>One-half</td>
<td>Remainder</td>
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After the attribution is complete, send each spouse the results on form 470-2588, Notice of Attribution of Resources (NOA), with copies of the resource documents. The notice includes an explanation of the spouses’ appeal rights. (See If the Client Appeals the Attribution Amount.)

If a court or administrative appeal decision has ordered an amount greater than half the resources for the community spouse, or more than $99,540, attribute the amount ordered.

1. Mr. A enters a medical institution and his wife remains at home. Mr. and Mrs. A furnish verification of a total of $69,500 in resources. One-half of this is $34,750. Mrs. A is attributed $34,750 and Mr. A is attributed $34,750.

2. Mr. B enters skilled care expecting to stay indefinitely. His wife remains at home. Their total resources are $24,792. One-half of this is $12,396. Since this result is less than $24,000, the minimum amount of $24,000 is attributed to Mrs. B. $792 is attributed to Mr. B.

3. Mrs. D enters a hospital and is expected to stay over 30 days. Her husband remains at home. Their total resources are $200,000. One-half of this is $100,000. The community spouse cannot be attributed more than $99,540 without a court order or final appeal decision. Therefore, $100,460 is attributed to Mr. D and $99,540 is attributed to Mrs. D ($200,000 - $99,540 = $100,460).

4. Mr. M enters a nursing facility and Mrs. M remains at home. The total value of their resources is $40,000. However, the court has ordered that $30,000 be transferred to Mrs. M for support. In this case, $30,000 is attributed to Mrs. M, even though this amount exceeds the $24,000 minimum; $10,000 is attributed to Mr. M.
If the Client Appeals the Attribution Amount

Legal reference: 441 IAC 75.5(3)“f”

The current minimum monthly maintenance needs allowance (MMMNA) for a community spouse is $2,488.50. If the income available to the community spouse is less than the MMMNA, the applicant or the community spouse may file an appeal to set aside additional resources that would generate income equal to the difference between the income available to the community spouse and the MMMNA.

The appeal request must be filed within 30 days of the Notice of Attribution of Resources (NOA) or any Notice of Decision (NOD) regarding medical assistance. If the client does not file an appeal within 30 days of an NOA or NOD, the client loses the right to a hearing on the attribution for that application. If requested, help the client to complete form 470-0487 or 470-0487(S), Appeal and Request for Hearing.

If the appeal is filed after one or more applications has been denied, and the appeal sets aside additional resources that result in the institutionalized spouse now being eligible, the date of approval begins with the most recent application. Only one appeal to set aside additional resources will be conducted.

---

1. Mr. Q enters a facility in January 2002. Mrs. Q remains at home. The Qs file an application for medical assistance in March 2002. An attribution of resources is completed, and the application is denied in April 2002. Another application is filed for Mr. Q in February 2003.

   The worker totals all of the household resources and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in March 2003.

   A third application is filed for Mr. Q in March 2004. The worker again totals all of the household resources and subtracts the community spouse resource allowance assigned in the attribution process. Again the remaining resources continue to exceed the resource limit. The worker issues an NOD denying benefits in March 2004.

   Mr. Q files an appeal in April 2004 regarding the March 2004 NOD. A hearing is granted. Mrs. Q’s income is low enough that the cost of an annuity is used to set aside additional resources for Mrs. Q. The final appeal decision attributes additional resources to Mrs. Q.
The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. Q. The March 2004 application decision is reversed. The prior decisions on the March 2002 and March 2003 applications stand as issued.


   The worker totals all of the household resources, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in July 2004.

   Mrs. Z files an appeal in July 2004 regarding the NOD. A hearing is granted. Neither Mrs. nor Mr. Z provides annuity quotes. The administrative law judge closes the record and issues a final decision upholding the original attribution. Once this decision becomes final, no other hearings regarding the attribution will be granted, as the Zs were granted a hearing on the attribution of resources.

3. Mr. M enters a facility in January 2005. Mrs. M remains at home. The Ms file an application for medical assistance for Mr. M in August 2005. An attribution of resources is completed. Mrs. M is attributed $24,000. The Ms have $6,000 in resources. The application is approved.

   The review form is sent out in January 2006 and not returned. The case is canceled effective February 1, 2006. Another application is filed in February 2006. The Ms now have $42,000 in resources.

   The worker subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources exceed the resource limit. The worker issues an NOD denying the application in February 2006.

   Mr. M files an appeal in February 2006 regarding the NOD. A hearing is granted. The final appeal decision attributes additional resources to Mrs. M. The couple’s income is low enough that the average of the annuities, $99,424, is used to set aside additional resources for Mrs. M.

   The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. M. The February 2006 decision to deny the application based on excess resources is reversed.
Verify the couple’s available gross monthly income. Do not count income that is earned by resources used in the attribution process.

When determining gross monthly income, include any income the community spouse may be entitled to but is not receiving. When the community spouse works only part of the year and received income only during the time worked, annualize the income as directed in 8-E, Determining Income from Self-Employment.

For couples where one spouse became institutionalized on or after February 8, 2006, consider the income that can be made available to the community spouse in the client participation calculation according to 8-I.

For couples where one spouse became institutionalized before February 8, 2006, count only the community spouse’s income.

1. Mrs. B enters a facility in January 2006. Mr. B remains at home. The Bs file an application for medical assistance for Mrs. B in March 2006. An attribution of resources is completed. The worker totals all of the household resources as of January 1, 2006, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in April 2006.

   Mrs. B files an appeal regarding the NOD. A hearing is granted. Since Mrs. B entered the facility before February 8, 2006, only Mr. B’s income is used when the Bs provide a quote for the cost of an annuity to set aside additional resources for Mr. B.

2. Mrs. C enters a facility on February 9, 2006. Mr. C remains at home. The Cs file an application for medical assistance for Mrs. C in March 2006. An attribution of resources is completed. The worker totals all of the household resources as of February 1, 2006, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in April 2006.

   Mrs. C files an appeal regarding the NOD. A hearing is granted. Since Mrs. C entered the facility after February 8, 2006, Mr. C’s income, plus the income that will be made available from Mrs. C, is used when the Cs provide a quote for the cost of an annuity to set aside additional resources for Mr. C.
Note: Do not annualize the community spouse’s income when determining the diversion to the community spouse in the client participation calculation.

The appellant must obtain one estimate of the cost of a single-premium lifetime annuity that would generate income equal to the difference between:

♦ The couple’s available gross income and
♦ The MMMNA in effect when the appeal was filed.

Neither the applicant nor the community spouse has to purchase an annuity as a condition of Medicaid eligibility.

If the client is unable to obtain one estimate, assist the client by contacting financial institutions. If the institution requires the identity of the client, obtain a release of information from the client.

If the financial institution is unable to provide an estimate, determine the shortfall between the couple’s available gross income and the MMMNA. Multiply the shortfall by 12. Multiply this amount by the community spouse’s life expectancy in years column from the Table for an Annuity for Life from the Mortality Table issued by the Iowa Department of Revenue. (See next page.)

Formula: \[(\text{MMMNA} – \text{couple’s available gross monthly income}) \times 12 \times \text{community spouse’s life expectancy in years} = \text{single-premium lifetime annuity quote.} \]

Complete form 470-3144, Attribution of Resources Appeal Summary, according to instructions in 6-Appendix. Report the verified available income of the couple. Note and estimate the amount of any benefits for which the community spouse is eligible but is not receiving. Attach copies of the annuity bid to the form.

Send the form to the Appeals Section, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114.

If the annuity quote is greater than the original attribution amount, the administrative law judge will order that the annuity quote be used instead of the original amount. Send a new Notice of Attribution reflecting the revised amount. (The 90-day transfer policy applies as of the date of Medicaid approval. See Transfers to Establish Ongoing Eligibility.)
Iowa Department of Human Services
Title 8 Medicaid
Chapter D Resources

ATTRIBUTION OF RESOURCES
Calculating the Amount to Attribute to the Community Spouse
Revised May 19, 2006

If the annuity quote is equal to or less than the original attribution amount, the original attribution is left as is.

### TABLE FOR AN ANNUITY FOR LIFE

**Source:** Iowa Department of Revenue Mortality Table

1980 CSO-D MORTALITY TABLE BASED ON BLENDING 50% MALE-50% FEMALE
(PIVOTAL AGE 45) AGE NEAREST BIRTHDAY

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Increase in Maximum Allowance for Community Spouse

The maximum resource allowance for the community spouse increases each year. This fact is noted on form 470-2588, *Notice of Attribution of Resources*. No further notice or action is necessary unless the client applies for Medicaid or requests a revision of the attribution based on the increase in the maximum allowance.

When a household with the maximum community spouse attribution files an application or requests a revision of the attribution, assess the case to determine if the revised maximum must be attributed to the community spouse. (You do not need to increase attributed resources if the institutionalized spouse’s eligibility is already established.)

If the new maximum applies, complete a revision and send the client a written statement. Do not send a *Notice of Attribution*. Suggested wording is as follows:

```
The Department of Human Services completed an attribution of resources for your household in *(month, year)*. At that time, the community spouse was attributed the maximum resource allowance of *(amount)*. You have *(filed an application or requested a revision of the attribution)*.

We have revised the attribution, based on an increase in the maximum community spouse resource allowance to *(amount)*. As of *(date)*, the community spouse is attributed *(current maximum)*.

We subtract this amount from your household’s total resources at the time of the Medicaid application to determine the institutionalized spouse’s countable resources.

If you have questions, please contact me.
```
Processing a Medicaid Application After Attribution

Legal reference: 441 IAC 75.5(4)“a”(1), P.L. 100-360, P.L. 100-485

When determining eligibility for the institutionalized spouse, the amount of resources to count is the difference between the couple’s total resources at the time of application and the amount attributed to the community spouse.

Follow the requirements of 8-B to process a Medicaid application. However, do not approve Medicaid before completing an attribution of resources.

If the couple does not have an attribution, total the countable resources of both spouses at the first moment of the month of entry. Exempt only those resources listed under Resources Excluded From Attribution. Complete the attribution as directed under Calculating the Amount to Attribute to the Community Spouse.

Determine and verify countable resources of both spouses as of the first moment of the first day of the month for which application is being made (if this is a different month). Subtract the amount of resources attributed to the community spouse as of the date of entry to the facility from the total resources owned in the month of application. Count the remaining balance towards the Medicaid resource limit for the institutionalized spouse.

Mr. Z enters a nursing facility on May 22, 1994. Mrs. Z files a Medicaid application for him in September 1995. She lists resources of their homestead, one car, a $20,000 CD, a checking account of $55,000, and $5,000 in a savings account.

When Mr. Z entered the facility, the Zs owned the following resources: their homestead, one car, $60,000 in CDs, a checking account of $65,000, and $15,000 in a savings account. Of these resources, the following items are used in completing the attribution:

| $ 60,000  | CDs |
| 65,000    | Checking account |
| + 15,000  | Savings account  |
| $ 140,000 | Total resources  |

The worker divides $140,000 by two, which equals $70,000. This amount is attributed to each spouse.
When determining Mr. Z’s eligibility, the worker uses the Zs’ resources at the time of application:

<table>
<thead>
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<th>$ 20,000</th>
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<tbody>
<tr>
<td>55,000</td>
<td>Checking account</td>
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<tr>
<td>+ 5,000</td>
<td>Savings account</td>
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<tr>
<td>$ 80,000</td>
<td>Total resources</td>
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</table>

The worker then subtracts the community spouse resource allowance ($70,000 for Mrs. Z) from the total resources. This leaves $10,000 available for Mr. Z. He is not resource-eligible for Medicaid payment of nursing facility care.

The attributed amount protected for the community spouse is maintained from the month of entry through the initial determination of the institutionalized spouse’s Medicaid eligibility. Even if the total resources have increased or decreased by the time the spouse applied for Medicaid, the amount protected for the community spouse is the value of the resources attributed when the other spouse entered the institution.

However, if resources attributed to the community spouse are below the minimum allowance, and the couple later acquires resources that were not counted for attribution, these resources can be transferred to the community spouse to bring that spouse’s resources up to the minimum.

1. When Mr. H enters a medical institution, the resources attributed to Mrs. H are $24,000. When Mr. H applies for Medicaid, the resources of Mr. and Mrs. H are $25,000 as of the first moment of the first day of the month of application.

   The worker subtracts the $24,000 attributed to Mrs. H from the total. Mr. H has $1,000. He is resource-eligible under any Medicaid coverage group.

2. Mr. and Mrs. J are SSI-eligible. When Mrs. J enters a medical institution in November, Mr. and Mrs. J have $2,997 in resources. All of the resources are attributed to Mr. J to meet the minimum protection of $24,000. Mrs. J is resource-eligible for Medicaid payment of nursing facility care.

3. Mr. and Mrs. K are eligible for Medically Needy. Their resources are $9,800 when Mr. K enters skilled care in December. All of the resources are attributed to Mrs. K to meet the minimum protection of $24,000. Mr. K is resource-eligible for Medicaid payment of nursing facility care.
4. Mr. I enters a nursing facility in December. At that time, resources attributed to Mrs. I are $25,000. Mr. I applies for Medicaid six months later. He reports that his resources have increased. The total is $75,000 at the time of application. However, only $25,000 can be attributed to Mrs. I. The other $50,000 is countable to Mr. I.

If the institutionalized spouse’s resources exceed limits for nursing facility coverage groups, check eligibility under the QMB group or Medically Needy coverage group. Review resources eligibility at redetermination to ensure that coverage group continues to be correct.

Mr. D enters a nursing facility in November. Mrs. D remains at home. Their resources total $28,950 in November. Mrs. D is attributed $24,000 and $4,950 is attributed to Mr. D. He is resource-eligible for Medically Needy coverage.

Mrs. D asks that the resources be reevaluated in February, since their resources have decreased. As of the first moment of the first day of the month, the combined resources of both spouses are $24,784. Subtracting the $24,000 attributed to Mrs. D, Mr. D has $784 in resources. Mr. D is resource-eligible under any Medicaid coverage group.

**When Spouses Are Estranged**

**Legal reference:** 441 IAC 75.5(4)“a”(3)

Attribute resources for estranged couples. “Estrangement” means a breakdown to the point that the spouses would not be living together if one was not institutionalized or were not living together before one spouse entered the institution. Determine estrangement by talking with the applicant.

If the institutionalized spouse is estranged from the community spouse, do not deny eligibility because of excess resources or failure to provide verification if the applicant can show hardship. To prove hardship, the applicant must demonstrate that:

- The applicant cannot get information about the community spouse’s resources after exploring all legal means.
- The applicant is unable to access the estranged community spouse’s resources after exploring all legal means, even though the community spouse’s resources cause the applicant to be ineligible.
Do not deny Medicaid for the institutionalized spouse if resources owned by the institutionalized spouse are less than eligibility limits and if the institutionalized spouse either:

♦ Has assigned any rights to support from the community spouse to the state, or
♦ Lacks the ability to execute an assignment because of physical or mental impairment.

To decide if the applicant lacks the ability to assign support rights, determine if the applicant has a guardian or conservator. If the client did not voluntarily choose to have a guardian or conservator, the client lacks the ability to assign support rights. No further verification is required.

If the client chose to have a guardian or conservator but it is alleged that the client lacks the ability to assign support rights, verify the lack of assignment ability with a physician’s statement.

If you approve eligibility for a client who voluntarily or involuntarily has a guardian or conservator, send the following information to the Division of Financial, Health and Work Supports:

♦ The names and addresses of both spouses.
♦ The amount of the community spouse resource allowance.
♦ The amount of resources owned by the community spouse.

Staff in the Health Support Team will pursue support from the community spouse on a case-by-case basis. The state has the right to bring a support proceeding against a community spouse without an assignment.

The applicant is ineligible if the applicant owns resources that exceed limits, even if the applicant assigns support rights or lacks the ability to assign support rights.

**Transfers to Establish Ongoing Eligibility**

**Legal reference:** 441 IAC 75.5(4)“a”(2)

After the month the institutionalized spouse is determined eligible, do not consider the resources owned by the community spouse to be available to the institutionalized spouse.
Resources that are owned wholly or in part by the institutionalized spouse and that are not transferred to the community spouse are counted when determining ongoing eligibility. However, do not consider these resources if the institutionalized spouse has declared, in writing, the intent to transfer ownership of the resources to the community spouse. The transfer must take place within 90 days.

If the institutionalized spouse does not intend to transfer resources, establish eligibility for the month of application only. Deny ongoing eligibility at the end of that month.

1. Mr. W, the institutionalized spouse, had $1,900 in resources attributed to him and was eligible for Medicaid. He actually jointly owns a CD valued at $20,000. To remain eligible for Medicaid payment to the nursing facility, he must transfer $18,000 of the CD to reduce his ownership down to $2,000. He may transfer the total value if he wishes.

2. Mr. J is determined eligible for Medicaid in a medical institution. The amount of resources attributed to Mrs. J (the community spouse) and owned by Mrs. J is $7,000, which is under the $24,000 minimum.

A year later, Mr. J receives an inheritance of $5,000. The IM worker verifies that Mrs. J’s resources at the time Mr. J received the inheritance were $6,000.

Mr. J’s intends to transfer $4,000 to Mrs. J since her resources are under the $24,000 minimum. He has signed a statement to this effect. His remaining resources are $1,000 ($5,000 - $4,000 = $1,000). He is therefore below resource limits for Medicaid payment and continues to be eligible.

When the client intends to transfer the resource, monitor the progress of the transfer. Send the client a notice similar to the following:

Medicaid has been approved effective ______________, since your intent is to transfer resources to your spouse within 90 days of the date of this eligibility determination. Failure to transfer the resource within 90 days will result in cancellation of Medicaid benefits, unless unusual circumstances exist. Please notify this office when the resource is transferred and provide proof that the resource was transferred. 8-D, Transfers to Establish Ongoing Eligibility.
The client must provide verification of the transfer. Contact the client or authorized representative within 45 days of the notice to check the status of the transfer. Contact the client at the end of 90 days to see if the resources were transferred.

If the institutionalized spouse is not able to transfer excess resources because of circumstances beyond the client’s control, you can allow another 90 days. If, at the end of this extended 90-day period, the resources have not been transferred, cancel the case.

In some cases, the transfer of resources may cause Medicaid ineligibility for the community spouse. After the transfer has been made, examine the effect of the transfer on the community spouse’s Medicaid eligibility.

Mr. and Mrs. K were eligible for SSI-related 503 program at home. Mrs. K entered a nursing facility in January. All $2,900 of resources were attributed to Mr. K, who actually owned them. Mr. K is ineligible for the 503 program if the $2,900 resources are retained. However, he is eligible for the Medically Needy program.

Summary Examples

Mr. R enters a nursing facility on September 2, 1995. Mrs. R files an Attribution of Resources Upon Entry to a Medical Facility. The Rs list resources of a farm that includes their homestead, $4,000 in bonds, $20,000 in stock, 2 cars, and $3,000 in a checking account.

Completing the Attribution

The following items are used to complete the attribution:

| $ 4,000 | Bonds |
| 20,000 | Stocks |
| 1,500 | One car |
| + 3,000 | Checking account |
| $ 28,500 | Total resources |

The worker divides $28,500 by 2, which equals $14,250. Because this is less than $24,000, the amount attributed to Mrs. R (the community spouse) is $24,000. The remaining amount of $4,500 is attributed to Mr. R.
Appealing an Attribution

After the attribution is complete, Mrs. R files an appeal to set aside additional resources that would generate income equal to the difference between the couple’s available income and the MMMNA. The deficit in income is $1,622.

The cost of an annuity to generate $1,622 per month is $103,119. Because $103,119 is more than the $24,000 attributed to Mrs. R, the attribution will be modified to substitute $103,119 for the $24,000 previously attributed to Mrs. R. No resources are attributed to Mr. R.

Determining Eligibility After the Appeal

After the appeal, Mrs. R applies for Medicaid for Mr. R. The total resources now equal $80,000. The worker subtracts the community spouse allowance of $103,119. This leaves no resources available to Mr. R. He is resource-eligible for Medicaid payment for nursing facility care. Mr. R has 90 days to transfer resources to Mrs. R to maintain his eligibility.

Mrs. J enters a nursing facility and files form 470-2577, Resources Upon Entering a Medical Facility. The Js list resources of a $150,000 farm, a homestead, $10,000 in bonds, $100,000 in CDs, one car, $10,000 in a checking account, and $35,000 in a savings account.

Completing the Attribution

The following items are used to complete the attribution:

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<th>Resource</th>
<th>Value</th>
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<td>Bonds</td>
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<td>CDs</td>
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<td>Checking account</td>
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</tr>
<tr>
<td>Savings account</td>
<td>$35,000</td>
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</tbody>
</table>

$305,000 is attributed to Mr. J. $205,460 is attributed to Mrs. J.
Appealing an Attribution

After the attribution is complete, Mr. J files an appeal to set aside additional resources to generate income equal to the difference between the couple’s available income and the MMMNA. The couple’s available income is $1,844 per month ($2,488.50 - $1,844 = $644.50 unmet need).

The average of the three annuity estimates of the amount needed to generate $644.50 per month is $45,000. Because this amount is less than the $99,540 attributed to Mr. J, the attribution remains the same.

Determining Eligibility After the Appeal

After the appeal, Mr. J files an application for medical assistance for Mrs. J. The Js have the following resources at the time of application:

<table>
<thead>
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<th>Resource</th>
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<tbody>
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<td>Total resources</td>
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</table>

The worker subtracts the community spouse allowance of $99,540. This leaves $57,380 in resources available to Mrs. J. She is ineligible for Medicaid payment for nursing facility care, because she is over the resource limit.

Estate Recovery

Legal reference: 441 IAC 76.12(7)

Upon the death of certain Medicaid recipients, medical assistance paid on behalf of the recipient is subject to recovery from the estate of the recipient. All assets included in the estate of a Medicaid recipient are subject to probate for the purposes of Medicaid estate recovery.

Recipients affected by the estate recovery policy are:

♦ Those who are 55 years of age or older. (Recipients aged 55 or over are subject to estate recovery whether or not they are living in an institution.)

♦ Those under age 55 who are residents of a nursing facility, intermediate care facility for the mentally retarded, or a mental health institute and who cannot reasonably be expected to be discharged and return home.
An “estate” includes all real property, personal property, or any other asset in which the member had any legal title to or interest in at the time of the death of the member, to the extent of such interest. This includes, but is not limited to, interest in jointly held property, interest in trusts and retained life estates.

Note: It is not allowable for assets of a deceased member to be used to pay for travel expenses of family members of the deceased at the time of the member’s death.

Issue a copy of Comm. 123, *Estate Recovery Program*, to all Medicaid applicants, including QMB, SLMB, E-SLMB, and QDWP applicants, at the time of application and at each review.

**Establishing Whether a Member Under Age 55 Can Return Home**

**Legal reference:** 441 IAC 76.12(7)

Presume that a member in a medical institution who is under age 55 is unable to return home. Inform members of this policy by issuing form 470-2980, *Estate Recovery Notice for New Approvals*, to all members who are under 55 years old and a resident of a medical institution at the time of Medicaid approval.

If a member under 55 years old is discharged before six months has elapsed, no further action is necessary. Estate recovery will not be pursued because the member was not permanently institutionalized.

A member in a medical institution who is under age 55 has the right to rebut this presumption. To do so, the member must make a written request to the Department after being in the institution for six months.

Six months after their admission into the medical institution, inform members who are under 55 years of this right by issuing them form 470-3209, *Estate Recovery Six-Month Follow-Up*. Also, issue form 470-3209 to the family or someone acting on the member’s behalf if the member under 55 years old dies in the medical institution after a stay of less than six months.

If a member dies before six consecutive months of institutionalization, the family or another interested party may submit a written request to the Department to rebut the presumption that the member could not have been reasonably expected to be discharged.
Send all rebuttal requests to the Iowa Medicaid Enterprise (IME) Medical Services Unit either via local mail or by sending them to PO Box 36478, Des Moines, Iowa 50315. The IME Medical Services Unit determines whether the client can reasonably be expected to return home and sends a copy of its decision to you and to the member.

If the IME Medical Services Unit determines that the member cannot reasonably expect to return home, the IME Medical Services Unit will provide information to the member and to you about whether the member was ever able to return home within the first six months of institutionalization and the date the expectation and ability to return home ceased. File a copy of the IME Medical Services Unit determination in the case record.

A member may appeal an adverse decision. The member first appeals through the IME Medical Services Unit for reconsideration. If the member disagrees with the reconsideration decision, the member or someone acting responsibly for the member can appeal an adverse reconsideration decision by IME Medical Services Unit though normal DHS appeal procedures.

Requests for the IME Medical Services Unit determination are timely when filed within 30 calendar days from the date form 470-3209, Estate Recovery Six-Month Follow-Up, is issued. The member may still make a request at a later date. However, if the decision then is that the member is reasonably able to return home, assistance received before the date the request was submitted to DHS is still subject to estate recovery.

**Amount Due**

**Legal reference:** 441 IAC 76.12(7)“d” and “f”

The debt due the Department from the member’s estate is equal to all medical assistance provided on the member’s behalf on or after:

- The date the person attained age 55, or
- The date a person under age 55 entered a medical institution with no reasonable expectation of returning home.

However, no debt is due for assistance provided before July 1, 1994 (the beginning of the estate recovery program). Interest accrues on a debt due, beginning six months after the death of a Medicaid member, surviving spouse, or surviving child, or upon the minor child reaching age 21.
If a member under the age of 55 is discharged from the facility and returns home before six consecutive months, no debt is assessed for Medicaid payments made on the member’s behalf for the time of the institutionalization.

The claim against the estate of the person who is eligible for Medicaid because the person’s resources are disregarded under the Long-Term Care Asset Preservation program is computed differently. The amount of the assets disregarded under this program is not subject to estate recovery. **Exception:** Medicaid paid before the member attained eligibility due to long-term care asset preservation is still recovered from the estate.

The Department does not use liens in the estate recovery program.

**Estate Recovery Agent**

Estate recovery is completed by the Iowa Medicaid Enterprise (IME) Revenue Collection Unit. The IME Revenue Collection Unit compares monthly Medicaid eligibility tapes against Vital Statistics tapes on reported deaths in Iowa to determine when estate recovery can be initiated for an individual.

Additionally, IM workers refer the names of all deceased Medicaid members to the IME Revenue Collection Unit using the *Estate Recovery Program Referral*, form 470-4122. Send the completed form to the address on the form.

The IME Revenue Collection Unit may request a copy of the member’s first and last application or review form to determine resources that could be subject to estate recovery. When sending a copy of the requested forms, record the member’s name, state identification number, social security number, and case number on each sheet sent to the IME Revenue Collection Unit.

**When Estate Recovery Is Waived**

**Legal reference:** 441 IAC 76.12(7)“b” and “c”

Collection of the debt from the estate of a Medicaid member is waived when collection of the debt would result in:

♦ Reduction in the amount received from the member’s estate by a surviving spouse, or by a surviving child who is under age 21, blind, or permanently and totally disabled at the time of the member’s death, or
Other undue hardship. Undue hardship exists when all of the following are true:

- The household that claims hardship has gross monthly income, as defined by FIP policy, of less than 200% of the poverty level for a household of the same size.
- The household that claims hardship has total resources, as defined by FIP policy, that do not exceed $10,000.
- Application of estate recovery would deprive a person of food, clothing, shelter, or medical care such that the person’s life or health would be endangered.

Waiver of collection from the estate based on undue hardship is determined on a case-by-case basis. When a person claims undue hardship, research the household’s income and resources. If the income or the resources are under FMAP limits, send a recommendation for undue hardship to the IME Revenue Collection Unit either via local mail or by sending it to PO Box 36445, Des Moines, Iowa 50315. Include the information you used to make the determination.

If collection of all or part of a debt is waived for a surviving spouse or child, or for hardship, the amount waived creates a debt due from:

- The estate of the member’s surviving spouse or blind or disabled child, upon the death of the spouse or child,
- A surviving child who was under 21 years of age at the time of the member’s death, or upon the child reaching age 21,
- The estate of a surviving child who was under age 21 at the time of the member’s death, if the child dies before reaching age 21, or
- The person who received the hardship waiver if the hardship no longer exists or from the estate of the person, whichever is first.

The debt owed by the surviving spouse, child, or person who received the hardship waiver will not exceed the amount in which recovery was waived.
TRANSFER OF ASSETS

Legal reference: 441 IAC 75.23(249A), P.L. 100-360

“Transfer of assets” occurs when a person transfers resources or countable income for less than fair market value in order to become eligible or maintain eligibility for Medicaid. Transfer of assets includes, but is not limited to:

♦ Giving away property to someone else.
♦ Establishing a trust for the benefit of someone else.
♦ Removing a name from an asset.
♦ Disclaiming an inheritance on or after July 1, 2000.
♦ Failure to “take” against a deceased spouse’s will on or after July 1, 2000.
♦ Reducing ownership interest in an asset.
♦ Transferring or disclaiming the right to income not yet received.
♦ Use of funds to purchase some annuities.
♦ Use of funds to purchase some promissory notes, loans, and mortgages.
♦ Use of funds to purchase some life estates.

See Determining the Value of a Resource when establishing the fair market value or equity value of a resource. Assume that a person who transfers assets does so to become eligible for Medicaid unless the client proves otherwise. See Rebuttal of Transfer of Assets.

Some transfers do not result in a penalty. These are listed under Transfers That Do Not Cause Penalty. The penalty for transferring assets depends upon:

♦ The date the transfer occurred,
♦ To whom the assets were transferred, and
♦ How much the assets were worth at the time of the transfer.

The transfer of assets penalty affects Medicaid coverage of certain long-term care services for persons under FMAP-related and SSI-related Medicaid coverage groups. See Penalties for Transferring Assets.

A claim may need to be established against a person who received the transferred assets, as explained under Claims Against a Person Who Receives Transferred Assets.
Transfer of Assets Flow Chart

Does the transfer meet any of the criteria for transfers that do not cause a penalty?

No → Was the transfer on or after February 8, 2006?

No → There is no penalty.

Yes → Was the transfer made, within 60 months of application for Medicaid, to or by a trust? or Was any other type of transfer made within 36 months of application for Medicaid?

No → There is no penalty.

Yes → Calculate period of ineligibility based on the statewide average at time of application. Drop any partial month of ineligibility. Begin the period of ineligibility on the first day of the month the transfer was made.

Was the transfer made within 60 months of application for Medicaid?

No → There is no penalty.

Yes → Calculate period of ineligibility based on the statewide average at time of application. Do not drop the partial month of ineligibility.

Is the date the (first) transfer was made later than the date the person would otherwise be Medicaid eligible for institutional care?

No → Begin the period of ineligibility on the day the person would otherwise be eligible for Medicaid and is receiving institutional care.

Yes → Begin the period of ineligibility on the first day of the month the transfer was made.
Transfers That Cause a Medicaid Penalty

Legal reference: 441 IAC 75.6(249A), 75.15(249A), 75.23(249A), P.L. 100-360

Transfers that currently may result in a Medicaid penalty being applied are:

♦ Transfers by a person or a spouse to someone other than a spouse that are made between August 10, 1993, and February 8, 2006, and within the 36 months before the Medicaid application is filed or after the application date.

♦ Transfers by an applicant or an applicant’s spouse involving funds in a trust that are made after August 10, 1993, and during the 60 months before the Medicaid application is filed and after institutionalization.

♦ Transfers by a person or a spouse to someone other than a spouse that are made on or after February 8, 2006, and within 60 months before the Medicaid application is filed or after the date of application.

Transfers of assets that do not meet these criteria do not result in a penalty being applied to current Medicaid eligibility. However, if the transfer was after July 1, 1993, and was within 60 months before the Medicaid application date, a claim against the person who received the transferred assets may still be applicable. See Claims Against a Person Who Receives Transferred Assets.

Purchases Considered a Transfer of Assets for Less Than Fair Market Value

Legal reference: 441 IAC 75.23(8), (9), (10), and (11)

A transfer of assets includes, but is not limited to, the following actions:

♦ The disclaimer of an inheritance done on or after the application date and:
  • Before February 8, 2006, and within the 36 months before the date of application, or
  • On or after February 8, 2006, and within 60 months before the date of application is filed.
Failure to take a share of an estate as a surviving spouse (also known as “taking against a will”) if the value received by taking against the will would exceed the inheritance received under the will when done on or after the application date and:

- Before February 8, 2006, and within the 36 months before the date of application, or
- On or after February 8, 2006, and within 60 months before the date an application is filed.

Purchase of an annuity before February 8, 2006, if the expected return on the annuity is not commensurate with a reasonable estimate of life expectancy, also referred to as “actuarially sound.” When an annuity purchased before February 8, 2006, is “actuarially sound,” then it is not considered a transfer of assets for less than fair market value. The annuitant has just converted the resources to income.

To determine whether the annuity is “actuarially sound,” use the life expectancy tables compiled from information published by the Office of the Actuary of the Social Security Administration (that follows).

The average number of years of expected life remaining for the annuitant must coincide with the life of the annuity. If the annuitant is not reasonably expected to live as long or longer than the guarantee period of the annuity, the annuitant will not receive fair market value for the annuity based on the projected return.

In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place. The penalty is assessed based on a transfer of assets for less than fair market value that is considered to have occurred at the time the annuity was purchased or the date the annuity became available as a countable resource, whichever is later.

1. Mr. W, at age 65, purchases a $10,000 annuity to be paid over the course of ten years. His life expectancy according to the table is 15.84 years. Thus, the annuity is actuarially sound.

2. Mr. A, at the age of 80, purchases a $10,000 annuity to be paid over the course of ten years. His life expectancy is only 7.23 years. Thus, a payout of the annuity for approximately three years is considered a transfer of assets for less than fair market value and the amount is subject to penalty.
## LIFE EXPECTANCY TABLE — MALES

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## LIFE EXPECTANCY TABLE — FEMALES

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♦ Purchase of an annuity on or after February 8, 2006, unless the annuity also meets one of the four conditions described below:

- The annuity is an annuity described in subsection (b) or (q) of section 408 of the United States Internal Revenue Code of 1986, or

- The annuity is purchased with proceeds from:
  - An account or trust described in subsection (a), (c), or (p) of section 408 of the United States Internal Revenue Code of 1986;
  - A simplified employee pension (within the meaning of section 408(k) of the United States Internal Revenue Code of 1986); or
  - A Roth IRA described in section 408A of the United States Internal Revenue Code of 1986; or

- The annuity:
  - Is irrevocable and nonassignable;
  - Is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration (see Annuities); and
  - Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made; or

- The annuity has the state of Iowa named as either:
  - The remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant, or
  - The remainder a beneficiary in the second position, after the community spouse, minor child or disabled child, and in the first position if the spouse or a representative of the child does dispose of the remainder for less than fair market value.
♦ Purchase of a promissory note, loan, or mortgage at less than fair market value. Any purchase of a promissory note, loan, or mortgage made on or after February 8, 2006, is considered to be a transfer of assets for less than fair market value unless the note, loan, or mortgage meets all of the following criteria:

- It has a repayment term that is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration (see Loans);
- It provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
- It prohibits the cancellation of the balance upon the death of the lender.

♦ Purchase of a life estate in property at less than fair market value. Purchase of a life estate in another individual’s home on or after February 8, 2006, shall be treated as assets transferred for less than fair market value unless the purchaser resides in the home for a period of at least one year after the date of the purchase.

**Transfers That Do Not Cause Penalty**

Legal reference: 441 IAC 75.23(5)

The following are situations in which a transfer is exempt and does not cause a penalty:

♦ A joint account is divided into separate accounts that reflect separate ownership, as long as the funds are divided equally in proportion of ownership. Funds not equally divided in proportion of ownership may be considered transferred and subject to penalty.

---

Mr. J and Ms. H have $8,000 in a joint account (A) and $3,000 in another joint account (B) that they cannot separate. Ms. H also has an account of $500 in her name alone.

Mr. J enters a nursing home and applies for Medicaid. Ms. H has spent $5,000 from account A and $1,000 from account B on Mr. J’s nursing home care. At that point, she removes Mr. J’s name from the accounts.

Since Ms. H spent more than half of the accounts on Mr. J’s care ($6,000 out of $11,000), she has rebutted the presumption of divesting. The account owned by Ms. H does not enter into the rebuttal of divesting.
A transfer is made to the institutionalized person’s child or adult child who is disabled as defined by Social Security Administration. The child is considered disabled if the child is:

- Receiving SSI, Social Security disability benefits, or Railroad Retirement benefits as a disabled child, or
- Declared disabled by a Department disability determination. See 8-C, Department Disability Determination Process.

Ms. E applies for Medicaid while living in an SNF. She has transferred $10,000 to her son, who she says is disabled, but who is not receiving any disability benefits. The Department refers the son to apply for SSI, because he has no income.

Ms. E’s application for other medical services is approved, but is pended for facility payments due to the need for the determination of the son’s disability. If the son does not apply for SSI, the Department determines disability. If the son is not determined to be disabled, transfer of asset penalties are applied.

A community spouse transfers an asset that would have been attributed to the community spouse.

Mr. and Mrs. D have $11,000 in assets in March. They gave away $5,000 in CDs to their daughter in April, before Mrs. D enters a medical institution to stay.

Since in the month before entry and attribution, the Ds owned assets of less than the protected amount for the community spouse, the transfer is not for the purpose of qualifying for Medicaid.

A transfer was made into a trust established solely for the benefit of:

- The person’s child or adult child who is blind or disabled, as defined by the Social Security Administration.
- A person under 65 years of age who is disabled, as defined by the Social Security Administration.
A transfer is made between spouses or to another person for the sole benefit and support of the community spouse.

1. Mr. Q transfers his half of a $25,000 CD to his daughter on November 14, 1995, for Mrs. Q’s benefit. Mr. Q then applies for Medicaid on November 20, 1995. On December 1, 1995, he enters an SNF. Mr. Q furnishes a statement that the money was transferred because Mrs. Q is handicapped, and the daughter will be handling Mrs. Q’s finances.

This transfer does not disqualify Mr. Q for payment of nursing facility services, because the transfer was for the benefit of his community spouse.

2. Mr. W transfers his Mercedes, valued at $25,000, to Mrs. W while living at home. Mr. W applies for Medicaid. This is not a disqualifying transfer, since the car was transferred to the spouse, and the spouse did not transfer it.

A transfer was made in response to a court order that the institutionalized spouse provide support for the community spouse, and the assets were transferred for:

- The support of the community spouse, or
- The support of a minor or dependent child, dependent parent, or dependent sibling of the institutionalized or community spouse, who lives with the community spouse.

When Mr. P enters a nursing facility, there is a court order stating that Mr. P should transfer $10,000 to First National Bank for the support of his son, Pat, who lives with Mrs. P. Since Pat lives with Mrs. P, and there is a court order requiring this transfer, it is not a disqualifying transfer. Mr. P is eligible for payment for nursing facility services.

The transfer results in denial of eligibility that causes an undue hardship to the client. Undue hardship exists only when all of the following conditions are met:

- Application of the transfer of asset penalty would deprive the client of food, clothing, shelter, medical care, or other necessities of life, such that the client’s health or life would be endangered.
- The person who transferred the resource or the person’s spouse has exhausted all means to recover the resource, including legal remedies and consultation with an attorney.
- The client’s remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay-resident, counting the value of all resources except for:
The home, if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.

- Household goods.
- A vehicle required by the client for transportation.
- Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for nursing facility services.

Mr. C transfers his home, with an equity value of $75,000, to his nephew and applies for Medicaid payments in a nursing home. The IM worker determines that Mr. C is ineligible for Medicaid for 30 months.

Mr. C replies that he does not have the money to pay for care. He goes to his lawyer, who writes to the nephew requesting that the nephew return the home. The nephew refuses to return the home, and the attorney advises that no further legal recourse is available.

Mr. C has met the requirement of exhausting legal means. Mr. C has the following assets: $500 cash and a burial fund of $1,500. The $500 is countable because it is available. Since the $1,500 is earmarked for burial and under $4,000, it is not available.

Because Mr. C’s available assets are less than the average statewide cost of nursing facility services, he also meets the second requirement and a hardship exception is granted.

Because the transfer of asset penalty will not be applied and Mr. C is otherwise eligible, Medicaid nursing facility payments are approved from the date of entry.

- The person who transferred the asset makes a satisfactory showing that the person intended to dispose of the asset either at fair market value or for other valuable consideration equal to the fair market value. The person must verify the attempts to sell the asset for fair market value through an independent source.

- The person who transferred the asset makes a satisfactory showing that the asset was transferred exclusively for another purpose other than to establish eligibility for Medicaid. See Rebuttal of Transfer of Assets.
The person’s home is transferred to one of the following:

- The spouse of the institutionalized person.
- A child of the institutionalized person who is under age 21, or who is blind or disabled. A blind or disabled person is a person who:
  - Receives SSI or Social Security benefits as a blind or disabled person.
  - Receives railroad benefits as a disabled person under the same definition as the Social Security Administration.
  - Has been declared disabled by DHS through Disability Determination Services.
- A sibling of the institutionalized person who has an equity interest in the home and who lived in the home at least one year immediately before the person became an institutionalized person or eligible for waiver services. Verify that the sibling has an equity interest and lived in the home for the required period of time.
- A son or daughter who was living in the parent’s home for at least two years immediately before the date the parent became institutionalized, and who provided care to the parent that allowed the parent to live at home rather than in a medical institution. The parent can be either a biological parent or stepparent. Verify with a third party the length of time that the parent was able to stay home due to the care of the son or daughter.

1. On September 17, while Mr. W is living at home on his farm, he transfers his farm to his son, age 51. Mr. W enters an NF on September 29. His son is not disabled, and did not provide care to Mr. W while Mr. W was at home.

   The worker determines Mr. W is subject to a penalty, because the son to whom the farm was transferred did not meet the criteria for exempting the transfer.

2. Ms. O has a 32-year-old daughter who has always lived with her, but does not provide care to Ms. O to enable her to stay at home rather than in a medical institution. She wants her daughter to have the home and transfers it after her entry to the SNF.

   The daughter does not receive SSI, Social Security, or Railroad Retirement, but alleges a disability. Disability Determination Services determines that the daughter is disabled. The transfer of the home is not a disqualifying transfer.
3. Mr. E, who lives in an SNF, transfers his share of his home to his brother. They inherited the home from their father and had lived there together for 20 years. This transfer does not disqualify Mr. E for payment of nursing facility services, since the brother had an equity interest and they had lived together more than one year before Mr. E’s entry to a nursing facility.

Rebuttal of Transfer of Assets

Legal reference: 20 CFR 416.1246, 75.23(5)“(c”(249A)

Assume all clients who transfer assets do so to become eligible for Medicaid unless the client proves otherwise. The burden of proof is on the client to prove assets were not transferred to meet eligibility requirements. The client must:

♦ Explain why the asset was transferred.
♦ Explain the client’s relationship to the person who received the transferred asset.
♦ Establish the fair market value and the equity value of the resource.
♦ Verify an attempt to dispose of the asset for a fair market value.
♦ Explain why less than the fair market value was accepted.
♦ Establish that an agreement, contract, or expectation was created at the time of transfer stating the client received or will receive compensation for the value of the transfer. Compensation is money, real or personal property, food, shelter, or services received by an owner in exchange for an asset.
♦ Explain how the client planned for self-support after the asset was transferred.

Include in the case record documents or letters made at the time of the transfer as evidence to verify that a transfer was not done to qualify for Medicaid.

Certain factors may indicate that a transfer was done for some reason other than to obtain Medicaid eligibility, such as:

♦ The transfer was made before the client was diagnosed with a previously undetected disabling condition or became suddenly traumatically disabled (for example, due to a car accident).
The transfer that would have prevented eligibility was made before the client unexpectedly lost other assets or income. For example, at the time the assets were transferred, the client had enough income or assets to meet the client’s own needs without the use of Medicaid but then unexpectedly lost that income or asset.

In July, Mr. J sells property valued at $8,000 for $5,000. He applies for Medicaid in October. Mr. J explains that he sold the property to pay medical bills of $3,900 incurred by his recently deceased wife. Although he was asking $8,000 for the property, he accepted less than fair market value because he needed the money quickly.

At the time of the sale, Mr. J was receiving $400 in Social Security, $200 from a private pension, $200 in dividends from a company in which he owned stock, and $500 monthly cash support from his son.

But in August, Mr. J’s son died and the cash support payments ceased. In September, the company from which he had been drawing dividends went bankrupt, rendering his stock worthless, and removing that source of income.

Mr. J presents as evidence copies of paid medical bills, a March agreement with a realtor to sell the property, copies of canceled checks showing monthly $500 payments to Mr. J, a copy of his son’s death certificate, and newspaper clippings regarding the bankruptcy of the dividend-paying company.

Mr. J has established that he sold the property exclusively for some other purpose than establishing Medicaid eligibility. The transfer does not affect Medicaid eligibility.

The rationale for this determination is that Mr. J attempted to sell the property at fair market value and at the time of the sale had income that would have made him ineligible to receive Medicaid. He could not reasonably have expected to become entitled to Medicaid as a result of the sale.

The transfer was of an asset that was excluded on the date of transfer and would continue to be excluded even if retained. Property that was excluded as a homestead property is considered an asset for this purpose. (See 42 U.S.C. sec. 1396p(e)(5)).

If an excluded home is transferred for less than fair market value, the fact that it was excluded on the date of transfer and would continue to be excluded even if retained is not sufficient to establish that the transfer was done for some reason other than to obtain Medicaid eligibility.

The transfer was a gift and a pattern has been established of giving gifts or contributing to a charity.
Mr. Z applies for Medicaid on November 6. He has given his son $500 for Christmas every year since the son was born. Mr. Z shows convincing evidence that he made such gifts to his son every year at Christmas. The presumption that the assets were transferred to qualify for Medicaid is rebutted.

♦ The transfer was in exchange for support, maintenance, or services provided to the client. Determine the full market value of the services received and the length of time the services will be provided.

Mrs. H transferred her savings account of $5,000 to her son in July 1996, pursuant to a written agreement they made in October 1995 for him to provide her care until she went in the nursing home.

The $5,000 was determined by the son charging $500 a month for 10 months of care. She rebutted the presumption that the transfer was made to attain eligibility.

If services will be provided for the life of the client, use the table of Average Number of Years of Life Remaining to determine if the resources were transferred for less than they are worth. This table comes from the Social Security Administration Office of the Actuary.

To determine the total value of support and maintenance for the client, multiply the current market value of the support and maintenance by the figure for average years of life remaining opposite the age of the client. If the client’s age is not on the chart, use the next lowest age on the chart. If the value of the service is equal to or more than the asset, there is no transfer of assets.
Average Number of Years of Life Remaining

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Penalties for Transferring Assets

Legal reference: 441 IAC 75.23(1)

Transfer of assets after August 10, 1993, for less than fair market value by either an institutionalized person or the institutionalized person’s spouse disqualifies the person for Medicaid payment for:

♦ Nursing facility services.

♦ Level of care in a medical institution equivalent to that of nursing facility services.

♦ Home- and community-based waiver services. (A person receiving home- and community-based waiver services is considered as an institutionalized person.)

♦ Home health-care services.
Home and community care for functionally disabled elderly people.

Personal care services.

Other long term care services.

The penalty period for transferring assets depends on when the assets were transferred and how much the assets were worth at the time the transfer occurred.

The value of the assets transferred is divided by the statewide average cost of nursing facility services at the time of application.

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To establish the penalty period for transfers made before February 8, 2006:

1. Determine the equity value of all assets transferred in the 36 months before the client applied for Medicaid, other than those transferred to or by a trust.

2. Determine the equity value of all assets transferred into or by a trust in the 60 months before the client applied for Medicaid.

3. Divide the total equity value of the transferred assets by the average monthly cost of nursing services at the time of application to determine the number of months of penalty. Drop any fraction remaining, so the result is in whole months.

4. Start the penalty on the first day of the month assets were transferred.
1. Mr. T transfers $100,000 to his next-door neighbor on April 11, 2005. He enters a nursing facility and applies for Medicaid on June 3, 2006. The worker determines that the transfer was made to qualify for Medicaid. The penalty period is figured by dividing $100,000 by $3,697.55, with a result of 27.05 months.

Since the date the transfer was made is before February 8, 2006, the partial month of ineligibility is rounded down to 27 months. Also, the penalty period begins on the first day of the month the transfer was made. Mr. T’s period of ineligibility begins April 1, 2005, and lasts through June 30, 2007. He can reapply for Medicaid nursing facility payment and be approved, if he is otherwise eligible, on July 1, 2007.

2. Mrs. A transfers $3,000 to her daughter on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on June 9, 2006. The worker determines that the transfer was made in order to qualify for Medicaid. The penalty period is figured by dividing $3,000 by $3,697.55, with a result of 0.811. Since the transfer was made before February 8, 2006, the result is rounded down and there is no period of ineligibility.

To establish the penalty period for transfers made on or after February 8, 2006:

1. Determine the equity value of all assets transferred in the 60 months before the client applied for Medicaid.

2. Divide the amount from step 1 above by the average monthly statewide cost of nursing facility services.

3. Multiply the full number of months from step 2 by the average monthly statewide cost of nursing facility services to determine the amount of the transfer that would be used to cover the full months.

4. Subtract (result of step 3) from the total assets transferred (amount in step 1) to determine the balance or partial month amount.

5. Divide the partial month amount (result from step 4) by the daily average statewide cost of nursing facility services to come up with the number of additional days for the partial month penalty.

6. Start the penalty on:
   - The first day of the month in which the person would otherwise be eligible for Medicaid payment of long-term care services, or
   - The first day of the month assets were transferred, whichever is later.
1. Mr. Z transfers $95,000 to his next-door neighbor on February 11, 2006. He enters a nursing facility on March 3, 2006, and applies for Medicaid payment of his nursing facility care on June 9, 2006. The worker determines that the transfer was made in order to qualify for Medicaid. The transfer took place after February 8, 2006, so the partial month of ineligibility is not rounded down.

The penalty period is figured as follows:

a. Divide the total transferred by the statewide monthly cost of nursing facility services ($95,000 ÷ $3,697.55 = 25.69).

b. Figure the amount used in the full 25 months of penalty (25 months × $3,697.55 = $92,438.75).

c. Subtract this from the total transferred to come up with the partial month balance ($95,000 – $92,438.75 = $2,561.25).

d. Take the partial month balance and divide by the statewide daily average cost of nursing facility services ($2,561.25 ÷ $121.63 = 21 days).

The penalty period is 25 months and 21 days.

If there were no penalty for transferring his assets for less than fair market value, Mr. Z could have been eligible for Medicaid payment of his facility care effective March 3, 2006. Since this date is later than the date he made the transfer, Mr. Z’s period of ineligibility begins March 3, 2006, and lasts through May 23, 2008. He can reapply for Medicaid nursing facility payment and be approved, if he is otherwise eligible, on May 24, 2008.

2. Mrs. G transfers $3,000 to her daughter on February 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on June 9, 2006. The worker determines that the transfer was made to qualify for Medicaid. The transfer was made after February 8, 2006, so the partial month of ineligibility is not rounded down.

The penalty period is figured and results in a penalty for 24 days ($3,000 ÷ 121.63 = 24.66). If there were no penalty for transferring her assets for less than fair market value, Mrs. G would have been eligible for Medicaid payment of her facility care effective March 3, 2006. Since this date is later than the date she made the transfer, Mrs. G’s period of ineligibility begins March 3, 2006, and lasts through March 26, 2006. She can be approved, if she is otherwise eligible, effective March 27, 2006.
Do not put a penalized person in a facility aid type. If the person has been receiving Medicaid under another coverage group, leave the aid type the same as it was before the person entered the facility. If the person is a Medicaid applicant who is eligible under a coverage group not contingent on living in a medical institution, use the nonfacility aid type for that coverage group.

Code the COPAY field on TD03 to reflect the penalty period. (See instructions in 14-B-Appendix.) Put a tickler in the system for the month before the end of the penalty period, and redetermine eligibility at that time.

**Multiple Transfers**

**Transfers Before February 8, 2006**

When an applicant or recipient makes more than one transfer of assets for less than fair market value before February 8, 2006, determine ineligibility as follows:

♦ If the penalty periods would not overlap, consider each transfer separately. Drop the partial month of ineligibility and begin each period of ineligibility on the first day of the month when the transfer was made.

♦ If the penalty periods would overlap, consider the total uncompensated value as one transfer. Drop the partial month of ineligibility and begin the period of ineligibility on the first day of the month when the first transfer was made.

**Transfers on or After February 8, 2006**

When there are multiple transfers made on or after February 8, 2006, total all of the transfers made on or after February 8, 2006, and within the 60 months before application. Consider the total uncompensated value as one transfer.

Begin the period of ineligibility in the month of the first transfer or in the month the person would otherwise have been eligible for Medicaid payment of facility care, whichever is later.

♦ When the date the person would otherwise have been eligible for Medicaid facility payment is later than the date the transfer was made, the period of ineligibility begins on the date the person would have been eligible.
When the date the person would otherwise have been eligible for Medicaid facility payment is earlier than the date the first transfer was made, the period of ineligibility begins on the date the first transfer was made.

1. Mrs. B transfers $3,000 to her daughter on November 25, 2005, and another $3,500 to her son on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on March 9, 2006.

The worker determines that the transfers were made in order to qualify for Medicaid. The transfers were made before February 8, 2006, so partial months of ineligibility are rounded down. No penalty is imposed because the amounts transferred were less than the statewide average cost of nursing facility services and the penalty of less than one month is not imposed.


The penalty period is figured by dividing $60,000 by $3,697.55, with a result of 16.23. The 16-month-period of ineligibility for the transfer made in 2005 would overlap the date of the next transfer made in 2006. The transfers were made before February 8, 2006. Total the two transfers and treat them as one transfer.

The penalty period is figured by dividing $120,000 by $3697.55, with a result of 32.45. The partial month of ineligibility is started on the first day of the month of the first transfer. The period of ineligibility begins on January 1, 2005, and runs through August 31, 2007. Mrs. M can reapply and, if otherwise eligible, be approved effective September 1, 2007.

3. Mrs. D gave her daughter $6,000 on February 1, 2006, and another $6,000 in March 2006. Mrs. D entered a nursing facility on March 3, 2006, and applied for Medicaid in June 2006. The worker determined the transfers were made in order to qualify for Medicaid. The first transfer was made before February 8, 2006, and the second one was made after February 8, 2006.

The penalty period for the first transfer is one month. The partial month of ineligibility is rounded down ($6,000 ÷ $3,697.55 = 1.62 or 1 month). This period of ineligibility is started on the first day of the month of the transfer (February 2006). Mrs. D’s period of ineligibility for the second transfer is determined to be 1 month and 19 days. It is started on March 3, 2006, and runs through April 20, 2006. If otherwise eligible, Mrs. D can be approved effective April 21, 2006.
4. Mrs. C transfers $3,000 to her daughter on February 25, 2006. She enters a nursing facility on March 3, 2006. On April 3, 2006, Mrs. C inherits $3,500 and transfers it to her son. On June 10, 2006, she applies for Medicaid payment of her nursing facility care. The worker determines that the transfers were made in order to qualify for Medicaid. The transfers were made after February 8, 2006. Total the two transfers and treat them as one transfer.

The penalty period is figured by dividing the total of $6,500 by $3,697.55, with a result of 1.76 months or 1 month and 23 days. If there were no penalty for transferring her assets, Mrs. C would have been eligible for Medicaid payment of her facility care effective March 3, 2006.

Since the date the first transfer was made is earlier than the date she would otherwise have been eligible, Mrs. C’s period of ineligibility begins on March 3, 2006 (the day she would have been eligible). The penalty period lasts through April 25, 2006. If Mrs. C is otherwise eligible, she can be approved effective April 26, 2006.

If the transfer period is determined and the community spouse later becomes eligible for Medicaid payment of facility care, divide the remaining period of ineligibility in half and apply one-half of the penalty period to each spouse. When the transfer was made before February 8, 2006, combine the two partial months of ineligibility to equal one month and apply that month to the spouse that initiated the transfer.

If one spouse dies before the penalty period is completed, apply the remaining period of ineligibility to the living spouse.

1. Mrs. L transfers $71,000 in January 2005. Mr. L enters a nursing facility in March 2006, and files an application for nursing facility care. A 19-month period of ineligibility is determined ($71,000 ÷ $3,697.55 = 19.2). Since the transfer was made before February 8, 2006, the period of ineligibility begins on the first day of the month the transfer was made. Mr. L is ineligible from January 1, 2005, through July 31, 2006.

Mrs. L enters the facility on April 3, 2006. Sixteen months of the period of ineligibility have passed. The worker divides the remaining three months of ineligibility between the couple (3 months ÷ 2 = 1.5). Because Mrs. L initiated the transfer, she is ineligible for two months and Mr. L is ineligible for one month. Mrs. L is ineligible for nursing facility care beginning April 1, 2006 through May 31, 2006. Mr. L’s period of ineligibility is shortened to end May 31, 2006.
2. Mrs. S transfers $71,000 on February 20, 2006. Mr. and Mrs. S both enter a nursing facility on March 1, 2006, and file an application for nursing facility care in June 2006. A 19-month period of ineligibility is determined ($71,000 ÷ $3,697.55 = 19.2) or 19 months + 6 days. The total period of ineligibility is divided between Mr. and Mrs. S (19 months + 6 days ÷ 2 = 9 months + 18 days each).

Since the transfer was made after February 8, 2006, the period of ineligibility begins on the first day that Mr. and Mrs. S would otherwise have been eligible for Medicaid payment of their facility care. The partial month of ineligibility is not rounded down. A period of ineligibility is imposed for both Mr. and Mrs. S beginning on March 1, 2006, through December 18, 2006.

Mrs. S passes away on April 3, 2006. One month and 2 days of her period of ineligibility have passed. The remaining 8 months and 16 days of ineligibility are imposed on Mr. S. Mr. S’s period of ineligibility is extended to September 2, 2007.

Return or Partial Return of the Transferred Asset

Legal reference: 20 CFR 416.1246(a)(2), 441 IAC 75.23(5)(c)

If the transferred asset is returned, there is a change in the period that the uncompensated value of the asset affects eligibility. If the asset is returned in its entirety, the transfer penalty is expunged as of the first moment of the first day of the month after the return.
If the asset is partly returned, the period of ineligibility is determined by the difference in the value of the property transferred and the value of the property returned. Determine the changed period of ineligibility and apply it beginning the first month the transfer occurred.

The increase or decrease in value of the property transferred that may have occurred due to inflation or deflation from the time of transfer to the time of return does not affect the length of the period of ineligibility.

Changing the disqualification period does not necessarily establish eligibility.

Claims Against a Person Who Receives Transferred Assets

Legal reference: 441 IAC 89.1(249F), 89.2(1), 89.3(249F), 89.4(249A)

The Department may file a claim against a person who received transferred assets. When the client transfers assets for less than fair market value a claim may be filed against the person who received the transferred assets, when the following occurs:

♦ A transfer was within 60 months of application or while on Medicaid: and
♦ There is intent on the part of the person who received the assets to gain Medicaid eligibility for the person who transferred the asset.

Note: The claim is for reimbursement for all Medicaid services paid on behalf of the client (transferor) but not greater than the uncompensated value of the assets transferred.

Establish a claim if the asset was transferred for less than fair market value was made:

♦ While the person who transferred the resource is receiving Medicaid or within 60 months before an application for Medicaid, and
♦ With the intent, on the part of the person who received the asset and the person making the transfer, of enabling the person making the transfer to obtain or maintain eligibility for Medicaid. A transfer is presumed to be for the purpose of obtaining Medicaid eligibility unless clear and convincing evidence is provided showing that Medicaid was not part of the reason for accepting the transferred assets.
This policy does not affect a client’s Medicaid eligibility, nor is it related to the Estate Recovery Program.

Estate recovery is separate and should be determined separately. However, if the client is now deceased, it is helpful to let DIA know that, so that DIA is aware that the estate recovery unit will be involved. It is also helpful to let the estate recovery contractor know that a DIA referral for transfer of assets has been made.

The claim is for reimbursement for all Medicaid services paid on behalf of the client transferor but not greater than the uncompensated value of the assets transferred.

Do not establish a claim if the transfer involved:

♦ Assets that would have been exempt from consideration if they were retained by the Medicaid applicant or recipient.
♦ Resources transferred for the sole benefit of a spouse.
♦ Resources transferred for the sole benefit of a disabled or blind child.
♦ A dwelling that serves as the home for one of the following:
  • A child under age 21.
  • A child who was residing in the dwelling for a period of at least two years and who provided care that kept the parent from earlier admission to the nursing facility.
  • A sibling who has equity interest in the home and was residing in the dwelling for a period of at least one year before the person entered the medical institution.
♦ Transfer to a trust established solely for the benefit of a person under 65 years old who is disabled, as defined by the Social Security Administration.

In addition, the following table shows the exemptions in place for specific periods. When the table indicates that a transfer made during the stated period was an exempt transfer, a DIA referral is not appropriate.
<table>
<thead>
<tr>
<th>Asset Transferred</th>
<th>Between 7/1/96 and 7/1/00</th>
<th>On or After July 1, 2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer of a homestead</td>
<td>DIA referral is not appropriate.</td>
<td>Yes, DIA referral is appropriate unless the transfer meets one of the other exemptions.</td>
</tr>
<tr>
<td>Resources transferred for the sole benefit of a child under age 21</td>
<td>DIA referral is not appropriate.</td>
<td>Yes, DIA referral is appropriate, unless the transfer meets one of the other exemptions.</td>
</tr>
<tr>
<td>Transfer of a dwelling that serves as the home to the spouse</td>
<td>Yes, DIA referral is appropriate, unless it meets the criteria as a transfer for the sole benefit of the spouse.</td>
<td>DIA referral is not appropriate.</td>
</tr>
<tr>
<td>Transfer of a dwelling that serves as the home to the disabled child</td>
<td>Yes, DIA referral is appropriate, unless it meets the criteria as a transfer for the sole benefit of the disabled child.</td>
<td>DIA referral is not appropriate.</td>
</tr>
<tr>
<td>Transfers to a trust solely for the benefit of the person’s child who is blind or disabled as defined by the Social Security Administration</td>
<td>DIA referral is not appropriate because this would meet the criteria of transfers for the sole benefit of a disabled child.</td>
<td>DIA referral is not appropriate.</td>
</tr>
<tr>
<td>Transfers of less than $2,000</td>
<td>DIA referral is not appropriate when less than $2,000 per calendar year was transferred.</td>
<td>DIA referral is not appropriate when less than $2,000 was transferred in the five years before application.</td>
</tr>
</tbody>
</table>
Establishing a Claim

Legal reference: 441 IAC 89.3(249F)

To establish a claim against a person who has received transferred assets for less than fair market value:

1. List all items transferred for less than fair market value after July 1, 1993, and within the 60 months before a Medicaid application was filed.

2. Review the exemptions listed in the previous section, based on the date of the transfer, to check if the transferred items are exempt.

3. Determine the uncompensated value of all countable assets transferred for less than the fair market value. Uncompensated value is the equity value of the asset minus the amount that was received for the asset. The uncompensated value cannot exceed the amount that would have been counted toward the income or resource limit if the asset had been retained.

4. Complete form 470-3159, DIA Referral for Transfer of Assets, for all countable assets transferred for less than fair market value.

5. Send form 470-3159 as instructed in the forms appendix. Send all other written requests for information, conferences, or hearings, to the Department of Inspections and Appeals (DIA) within five working days of receipt.

1. Mr. W applies for Medicaid in a nursing facility on June 26, 2000. Mr. W transferred $160,500 to his son on May 11, 1999. The worker determines that the transfer is not exempt and that the transfer was made with the intent to qualify for Medicaid.

   Mr. W is ineligible for NF care for 60 months from the date of the transfer ($160,500 divided by $2,673). His period of ineligibility is May 1, 1999, through April 30, 2004. Mr. W is approved for other Medicaid services under a non-facility aid type. Because the transfer is not exempt, the worker prepares form 470-3159, and sends it to DIA for further action.
2. Mrs. M files an application for nursing facility care on May 30, 1998. Mrs. M transferred the following for the purpose of qualifying for Medicaid:

- $8,000 to her daughter on October 2, 1997
- $25,000 a non-homestead farm property to her son on December 1, 1997
- $25,000 to her niece on January 5, 1998
- $15,000 to another daughter on April 10, 1998

The worker determines the period of ineligibility for Medicaid payment to the nursing facility. Mrs. M’s period of ineligibility is 30 months. The period of ineligibility is October 1, 1997, through April 30, 2000.

Because the transfer is not exempt, the worker prepares form 470-3159 for all transfers and sends the form to DIA.

3. Ms. Z transferred $10,000 to her daughter on April 11, 1994. Ms. Z establishes an irrevocable trust of $150,000 on April 30, 1994. Both transfers were for the purpose of qualifying for Medicaid.

Ms. Z applies for Medicaid nursing facility payment December 1996. The worker determines the period of ineligibility for Medicaid payment for certain services by dividing the transfers by the statewide average private pay rate.

The worker also establishes a referral and sends form 470-3159 to DIA.

4. Mrs. Q files an application for FMAP-related Medicaid. Five months previously, she transferred $10,000 to her mother with the purpose of qualifying for Medicaid. The four-month period of ineligibility for this transfer has expired. The worker establishes a referral and sends form 470-3159 to DIA.
TRUSTS

Legal reference: 441 IAC 75.23(8), 20 CFR 416.1201

Treatment of resources in a trust depends on:

♦ The client’s role in relation to the trust.
♦ Whether the trust was established with the client’s assets or with someone else’s assets.
♦ Whether the trust is revocable or irrevocable.
♦ When the trust was established.
♦ What use of the trust income and principal is allowed by the terms of the trust.
♦ The coverage group under which eligibility is being explored or established when a child is the grantor or beneficiary of the trust. (See RESOURCE ELIGIBILITY OF CHILDREN later in this chapter, and 8-F, COVERAGE GROUPS, for more information.)

A person is considered to have established a trust if the person’s assets were used to form all or part of the principal of the trust and if any of the following established the trust:

♦ The person.
♦ The person’s spouse.
♦ A person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of the person or the person’s spouse.

“Assets” means all income and resources of the person and the person’s spouse. This includes any income or resources that the person or the person’s spouse is entitled to but does not receive, because of action taken by:

♦ The person or the person’s spouse.
♦ Another person, court, or administrative body acting at the direction or upon the request of the person or the person’s spouse.
♦ Another person, court or administrative body with legal authority to act in place of or on behalf of the person or the person’s spouse.

Policy on trusts is organized as follows:

♦ Definitions of the basic terms used in describing trusts.
♦ Instructions for evaluating trusts, depending on the roles a client has in relation to the trust.
♦ Treatment of assets in a trust, including a chart comparing the major kinds of trusts.
♦ More information on specific kinds of trusts.
Trusts established with assets not owned by the beneficiary include testamentary trusts (established by a will) and inter vivos trusts (established by one living person to another).

Trusts established with assets owned by the beneficiary are treated differently depending on whether they are revocable or irrevocable and whether they were established after August 10, 1993. Irrevocable trusts established on or before August 10, 1993, are known as “Medicaid qualifying trusts.”

Certain kinds of irrevocable trusts established after August 10, 1993, provide that the assets go to reimburse the state for the client’s Medicaid expenses after the client’s death. Trusts that are subject to different treatment because of these provisions are:

♦ Medical assistance income (Miller) trusts.
♦ Special needs trusts for persons under 65.
♦ Special needs trusts with no age limit.

**Trust Definitions**

A trust is an arrangement whereby one or more persons (the trustees) hold property for the benefit of one or more others (the beneficiaries). A trust can be established by a written document, including a will. A trust can also be established by a verbal understanding between the grantor and the trustee when the property has been transferred to the trustee.

No court involvement is necessary to establish a trust. The grantor and the beneficiary can be the same person, and the grantor can be the trustee, but the trustee and the beneficiary cannot be identical. If the trustee and the beneficiary are identical, the trustee/beneficiary owns the property outright.

Trusts include two types of assets:

♦ **Trust principal** is the property placed in trust by the grantor which the trustee holds, subject to the rights of the beneficiary, plus any trust earnings paid into the trust and left to accumulate the month following the month of receipt.

♦ **Trust earnings or income** are amounts earned by trust principal, such as interest, dividends, royalties, or rents. These amounts are unearned income to the beneficiary if the beneficiary is legally able to use them for personal support and maintenance.
A *grantor* is a person who sets up a trust. A person may be a grantor if an agent or someone legally empowered to act on behalf of the person or the person’s spouse (such as a legal guardian, representative payee, person acting under a power of attorney, or conservator) establishes the trust with the person’s funds or property. The terms grantor, trustor, and settlor may be used interchangeably.

A *trustee* is a person or entity who holds legal title to property for the use or benefit of another person. In most instances, the trustee has no legal right to revoke the trust or use the property for the trustee’s own benefit. However, if the client is a trustee and has the legal ability to revoke the trust and use the money for the client’s own benefit, the trust is a resource to the client.

A *beneficiary* is a person who benefits from the principal or income. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it. A trust may have more than one beneficiary.

A *residual or residuary beneficiary* benefits from the income and principal after the primary beneficiary is no longer involved, for example, due to the death of the primary beneficiary. The residuary beneficiary receives no benefit from the trust until certain conditions are met.

A *Totten trust* is a tentative trust in which a grantor makes himself or herself trustee of his or her own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Therefore, consider the principal and income of a Totten trust available to the client. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

A *conservatorship* is similar to a trust. A conservatorship is always established by a court, which explicitly appoints a conservator to act on the ward’s behalf for the ward’s financial affairs. Treat a conservatorship established on or after February 9, 1994, as a trust. See [Revocable Trusts](#) and [Irrevocable Trusts](#) to determine availability and whether transfer of asset policies apply.
Evaluating a Trust

The following charts provide a guide to understanding trusts. Use the appropriate chart depending on whether the client is the grantor, the trustee, or the beneficiary. The client may occupy one, two, or all three roles.

1. Mr. J is the grantor of a trust. He is also the beneficiary of the trust. Use the grantor and the beneficiary trust charts to determine availability and accessibility of the trust principal and income when determining Medicaid eligibility.

2. Mr. D is the grantor and trustee of a trust that names his niece as the beneficiary. Use the grantor and trustee charts to determine the availability of the trust principal and income when determining Mr. D’s Medicaid eligibility.

3. Ms. M is the beneficiary of a trust. Use the beneficiary chart to determine the availability of the trust principal and income when determining Ms. M’s Medicaid eligibility.
TRUSTEE CHART

Use this chart if the client holds legal title to property for the use or benefit of another. (The client is the trustee.)

Does the trustee have power to revoke and use the trust principal and income for the trustee’s own benefit?

NO

Is the trustee also a beneficiary?

NO

The trust principal and income are not available. Look for trustee fees.

YES

Is the client both sole trustee and sole beneficiary (or are all trustees also all beneficiaries)?

NO

See the beneficiary chart and refer the trust to Central Office.

YES

The trust principal and income are available to the client (or to all trustees as a joint asset). Refer the trust to Central Office.
**BENEFICIARY CHART**

Use this chart if a trust exists for the benefit of the client. (The client is the beneficiary.) The client does not hold legal title to the trust property but does have an equitable ownership interest in it.

**Is the beneficiary also the grantor?**

- **NO**
  - Apply appropriate SSI-related or FMAP-related policy.

- **YES**
  - **Was the trust established after August 10, 1993?**
    - **NO**
      - For trusts established on or before August 10, 1993, apply Medicaid qualifying trust policies.
    - **YES**
      - For trusts established after August 10, 1993, evaluate the trust under the revocable or irrevocable policies unless it is:
        - A special needs trust for persons under 65 years old,
        - A medical assistance income trust, or
        - A special needs trust (no age limit).
      - Treat according to the policies found in this chapter.

**Treatment of Resources in a Trust**

When determining eligibility, first review the trust to see if it is accessible. If the principal and income are accessible, count the amounts toward the resource limits and use them when determining eligibility, client participation, and spenddown.

For eligibility purposes, there is no requirement that the beneficiary of a trust take legal action to attempt to gain access to the trust principal.
<table>
<thead>
<tr>
<th><strong>Testamentary and Inter Vivos Trusts</strong></th>
<th><strong>Medicaid Qualifying Trust (set up before 8/10/93)</strong></th>
<th><strong>Irrevocable Trust (set up after 8/10/93)</strong></th>
<th><strong>Revocable Trust (set up after 8/10/93)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Established by:</strong></td>
<td>Someone other than the client is the grantor of the trust.</td>
<td>The client or someone acting on the client’s behalf is the grantor of the trust.</td>
<td>The client or someone acting on the client’s behalf is the grantor of the trust.</td>
</tr>
<tr>
<td><strong>Established with:</strong></td>
<td>Funds not owned by the beneficiary before the trust was established.</td>
<td>Funds owned by the grantor or funds that the grantor is entitled to.</td>
<td>Funds owned by the grantor or funds that the grantor is entitled to.</td>
</tr>
<tr>
<td><strong>Availability of principal and income</strong></td>
<td>Discretionary: Principal and income are not necessarily available to the beneficiary. Principal and income available to the beneficiary for basic needs is countable as resources and income when determining eligibility, client participation, and spenddown. Principal and income available for nonbasic needs only are not countable as resources and income.</td>
<td>Discretionary: The maximum amount that may be made available by the trustee under the terms of the trust, assuming the trustee exercises full discretion in the distribution of the income and principal is countable in determining eligibility, client participation, and spenddown. See TRANSFER OF ASSETS for any principal or income not available to the grantor.</td>
<td>The principal and income are considered available and countable to the extent they could be made available, under any circumstances or for any purpose, according to the terms of the trust. See TRANSFER OF ASSETS for any principal or income not available to the grantor.</td>
</tr>
</tbody>
</table>
# Testamentary and Inter Vivos Trusts

- Count amounts available according to the terms of the trust.

# Medicaid Qualifying Trust

- Amounts that count toward FIP, SSI, or SSA cash payments are not used when determining Medicaid eligibility.

# Irrevocable Trust

- Any principal or income available counts toward resource limits. Amounts not available, see transfer of asset policy.

# Revocable Trust (set up after 8/10/93)

- Count principle and income as available.

## Programs Affected:

- FMAP-related and SSI-related Medicaid, State Supplementary Assistance

Refer trusts and conservatorships via *Clarification Request* to the Division of Financial, Health, and Work Supports when:

- You need help understanding the terms of the trust.
- An inaccessible trust is held by an active recipient.
- The trustee is not abiding by the terms of the trust.
- The trustee has the authority to use the principal of the trust for medical expenses but has not done so. This is a Third Party Liability referral.

In the clarification request, identify who the client is and whether the client has applied for FMAP-related or SSI-related Medicaid. Indicate when this is a referral of a Trust for Third Party Liability of medical expenses. Attach to the request:

- A copy of the legal document or trust agreement.
- A release of information from the client that allows the Department and the Attorney General’s office to discuss the trust with the trustees.
- A summary of the principal and payments made from the trust including:
  - The age of the beneficiary.
  - The trust’s fiscal year.
  - The principal of the trust at the beginning of the past fiscal year.
  - The income of the trust for the past year.
  - The itemized description of the expenses of and payments from the trust for the past year.
Trusts Established With Assets Not Owned by Beneficiary


If the client is the beneficiary but not the grantor of a trust, Medicaid eligibility is determined by the terms of the trust. These trusts may be testamentary trusts or inter vivos trusts.

Examine the terms of the trust to determine if it is countable. Under both SSI and FMAP-related policy, income and resources are available to a client who is the beneficiary as follows:

♦ Trust principal and income are countable resources and income to the beneficiary when the terms of the trust require the trustee to pay or to make available to the beneficiary trust principal and income for the beneficiary’s basic needs.

♦ Trust principal and income are countable income, but not a countable resource, to the beneficiary when the terms of the trust allow the trustee to make income or principal available to the beneficiary for basic needs, and the trustee makes either trust principal or income available to the beneficiary for basic needs.

♦ Trust principal and income are countable resources and income to the beneficiary when the terms of the trust allow the beneficiary to withdraw trust principal and income for basic needs.

Income and resources are not available to the beneficiary under both SSI-related and FMAP-related policy if:

♦ The terms of the trust prohibit the trustee from making either trust principal or income available for the beneficiary’s basic needs.

♦ The terms of the trust allow the trustee, at the trustee’s discretion, to make income or principal available to the beneficiary for basic needs, but the trustee does not make either income or resources available for basic needs.

In both cases, any payments from either trust principal or trust income that are made to the client or made for the client’s basic needs are countable income in the month of receipt and a resource thereafter. If payments are made to vendors for basic needs, see policies in 8-E, SSI-RELATED IN-KIND INCOME or In-Kind Unearned Income.
Medicaid Qualifying Trusts

Legal reference: 441 IAC 75.9(249A), P.L. 99-272, P.L. 99-509, section 9435(c)

A Medicaid qualifying trust is a trust or similar legal device which:

♦ Was established on or before August 10, 1993.
♦ Is not established by a last will and testament.
♦ Is established by a client, the client’s spouse, or someone acting for them.
♦ Is established from funds belonging to the client or the spouse.
♦ Allows or names the client to be the beneficiary of payments from the trust.
♦ Has one or more trustees determine the distribution of payments.
♦ Permits the trustees to exercise discretion with respect to the distribution of trust principal and income to the beneficiary.

When someone with power of attorney, a conservator, a guardian, a lawyer, or a court acts on behalf of the applicant or recipient to set up the trust, treat it as though the client set up the trust.

The amount of income and principal from a Medicaid qualifying trust that is considered available is the maximum amount that may be permitted under the terms of the trust, assuming the trustees exercise full discretion in the distribution of the income and principal.

Exception: Trusts or initial trust decrees established before April 7, 1986, solely for the benefit of a mentally retarded person who lives in an intermediate care facility for the mentally retarded are exempt.

Evaluate an irrevocable trust established on or before August 10, 1993, under this policy. The terms of the trust that specify the available income and principal determine the amount counted as available to the client, regardless of whether any payments are actually being made. Treat a trust established for medical payments as a third-party resource.

1. Miss T established a trust in July 1985 as the result of a settlement of a malpractice suit. Since she is mentally retarded and lives in an ICF/MR, and since the trust was established before April 7, 1986, this is not a Medicaid qualifying trust.

2. Mr. D established a trust for himself and his wife in 1972. Mrs. D applies for Medicaid and she is a co-beneficiary of the trust. This is a Medicaid qualifying trust.
A trust established by the last will and testament of a spouse is not a Medicaid qualifying trust. Trusts set up with funds not owned by the client or spouse are not Medicaid qualifying trusts. Burial trusts set up by a client or spouse, are not Medicaid qualifying trusts when the funds are available only upon death, and the client is not the beneficiary of the trust.

Trusts set up by charity or a fund-raising activity are not Medicaid qualifying trusts unless the money is given to the client, who then creates the trust. **Note:** If the charity or fund-raising present the proceeds to the person and the receiver sets up a trust on or before August 10, 1993, this is a Medicaid qualifying trust.

**Counting Income or Resources**

**Legal reference:** 441 IAC 75.9(2)

Consider trust income available as specified by the terms of the trust, even if the trustees do not actually pay the income according to the terms of the trust.

Count trust principal (including accumulated income) available to the client as a resource.

**Exception:** If the terms of the trust explicitly limit the amount of principal that is made available on an annual (or specified less frequent) basis, the principal is countable income beginning the month it becomes available. Prorate it for the period of accessibility and intended use.

Trust principal and income available for daily living expenses (food, clothing or shelter), including things not thought of as essential to daily living, are countable as resources and income.

Income and principal available only for non-basic-needs vendor payments are considered not available as income to the client when determining eligibility.

Trusts established for medical payments are a third-party resource. Do not count trust principal and income if the terms of the trust specify that they are available only for medical care. The principal and income for these trusts are not countable as income and resources in determining eligibility.
For trust established for educational benefits, deduct the expenses of education depending on what the related FMAP or SSI standards allow. If the trust is to be used for education but is totally available at any time, count the trust as a resource. When counting income for educational benefits, see also 8-E.

To establish eligibility for FIP, SSI, or State Supplementary Assistance, use the countable income from the trust according to the related policy. Then apply the income from the Medicaid qualifying trust and other income of a FIP or FMAP-related person, exclusive of FIP, SSI, or State Supplementary Assistance, to the FIP Schedule of Basic Needs for the family group.

Trust income and principal already counted toward FIP, SSI, or State Supplementary Assistance eligibility are not counted a second time for determining Medicaid eligibility. However, if the person is ineligible for FIP and is eligible for Medicaid, then the income is countable according to the FMAP- or SSI-related policy.

To establish eligibility for an SSI-related Medicaid person, add together the income from the Medicaid qualifying trust and other income, exclusive of FIP, SSI, or State Supplementary Assistance, and compare the total income to the limit for the number of people in the SSI-related Medicaid case.

Once the resources of the client are compared to FIP, SSI, or State Supplementary Assistance standards, count the principal of the trust as a resource for Medicaid to the fullest extent allowed by the trust, unless the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis.

Compare the total countable resources, including the amount from the trust, to the resource limit of the coverage group under which the person seeks assistance.

**Determining Eligibility**

**Legal reference:** 441 IAC 76.11(249A)

When the client who has a Medicaid qualifying trust is applying for a money payment (FIP, SSI or SSA benefits) determine financial assistance first. (This determination may involve income or resources from the trust.) The client may be eligible for FIP, SSI, or State Supplementary Assistance but be ineligible for Medicaid.
After the financial assistance is determined, add the income and resources from the Medicaid qualifying trust that were not used in the determination of the financial assistance amount to other income and resources for determining Medicaid eligibility.

If the income or resources exceed Medicaid limits, deny Medicaid even when the client receives FIP, SSI, or State Supplementary Assistance.

If the client is ineligible by counting income and resources of a Medicaid qualifying trust according to the policies of the coverage group, determine whether the client is eligible under any other coverage group.

If the required filing unit is eligible for FMAP-related Medicaid, and a sibling or child in the filing unit has a Medicaid qualifying trust that makes the family ineligible for Medicaid, the filing unit may exclude the sibling or child. However, an excluded person is ineligible for all Medicaid coverage groups.

| 1. Ms. P receives SSI. She has a Medicaid qualifying trust that provides for “care and keep.” Any of the principal of $12,000 can be used to meet her living expenses, but no money is currently provided for her. $12,000 is added to Ms. P’s other countable resources. Ms. P is not eligible for Medicaid since $12,000 is greater than any resource limit. |
| 2. Ms. W, a CMAP applicant, has a Medicaid qualifying trust set up as the result of a malpractice suit. The trust provides for payment only for medical care. There is $100,000 in the trust. Since the trust provides for medical care only, it is not a resource. It is a third party medical resource. Ms. W is evaluated for resources based on her other resources of $500. She is income- and resource-eligible for Medicaid, based on the CMAP coverage group. The worker prepares and sends a memo to TPL stating the basic trust provisions and the name and address of the trustee(s). |
| 3. Mr. N, a 503 applicant, has a Medicaid qualifying trust that provides payments of $100 a month from trust income. No principal can be used. The trustee has not made the income available. When determining eligibility for the 503 coverage group, the worker determines whether Mr. N would qualify for SSI by adding all income together, including the $100 a month, and by disregarding his COLAs. His social security income at time of cancellation was $230. He has no other income. $230 + $100 - $20 = $310. He is eligible under the 503 group. |
4. Mr. O is living in an NF. He applied for SSI-related Medicaid on May 6, 1993. His gross social security and VA income is $965.30 monthly. He has $1,700 in savings and checking accounts as of April 30, 1993, at midnight.

He also has a trust that he set up when he went into the NF in May 1990. The trust was set up four years ago, so divesting is not considered. According to the trust, money is available if he needs it, but he can have no more than one-third of the principal of the trust each year.

The trustee verified the principal as of the first of the year to be $99,000. Mr. O has used $1,000 of the trust this year.

His resource from the trust is: $99,000 divided by 3 = $33,000 that can be withdrawn minus $1,000 used = $32,000 remainder.

Therefore $32,000 plus his other resources of $1,700 is counted toward the resource limit. He is not eligible.

5. Mr. and Mrs. C and their children are eligible for FIP. Mrs. C has a Medicaid qualifying trust.

Trust income is not counted for FIP, as the trust is discretionary and nothing is paid to Mrs. C. The income that could be paid at the discretion of the trustee is $200 per month. The $200 that would be paid is countable for FMAP-related Medicaid programs.

6. Ms. J, an SSI recipient in an RCF, has a Medicaid qualifying trust for educational benefits that she set up with inheritance funds. Each year she receives $2,500 for tuition, books, and living expenses.

Since SSI policy provides that the income for living expenses counts for eligibility and is included as income for SSI, there is no more income to count for the Medicaid qualifying trust.

Also since the only amount available from the trust is for education, the trust is not count as a resource.
7. Mr. E applies for Medically Needy. His income is $200 Veteran’s Assistance and $350 Social Security. He also has a Medicaid qualifying trust with income of $240 monthly for “other expenses.”

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>$350.00</td>
</tr>
<tr>
<td>Veterans Assistance</td>
<td>$200.00</td>
</tr>
<tr>
<td>Trust income</td>
<td>$240.00</td>
</tr>
<tr>
<td>Monthly countable</td>
<td>$790.00</td>
</tr>
<tr>
<td>General disregard</td>
<td>$20.00</td>
</tr>
<tr>
<td><strong>Monthly net countable income for Medically Needy</strong></td>
<td>$770.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td><strong>$770.00</strong></td>
</tr>
<tr>
<td>Social Security</td>
<td>$350.00</td>
</tr>
<tr>
<td>Veterans Assistance</td>
<td>$200.00</td>
</tr>
<tr>
<td>Trust income</td>
<td>$240.00</td>
</tr>
</tbody>
</table>

Code people who are ineligible for Medicaid due to a Medicaid qualifying trust as denied (or canceled if the only program for which the person applied is Medicaid).

**Note:** This also applies to SSI recipients. If the person or group is denied Medicaid but receives State Supplementary Assistance grant, use the fund code of 7.

**Client Participation**

**Legal reference:** 441 IAC 75.5(9)

Consider all income, including countable income from the Medicaid qualifying trust, as available when determining client participation in a medical institution, unless the income is expressly exempt income, as listed in 8-E.

Mrs. P, an NF resident, has social security income of $245. She also has civil service income of $310. She has a Medicaid qualifying trust that could pay $120 a month for expenses if she needed the money.

<table>
<thead>
<tr>
<th>Income Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust income</td>
<td>$120.00</td>
</tr>
<tr>
<td>Social Security</td>
<td>$245.00</td>
</tr>
<tr>
<td>Civil Service income</td>
<td>$310.00</td>
</tr>
<tr>
<td><strong>To compare to the 300% income limit (Medicaid cap)</strong></td>
<td>$675.00</td>
</tr>
</tbody>
</table>

Her income used to determine client participation is $675.00.
**Trusts Established After August 10, 1993**

When the client or someone acting on the client’s behalf created a trust using the client’s assets after August 10, 1993, determine whether the client is a beneficiary of the trust. If the client is not a beneficiary, investigate the trust as a transfer of assets.

If the client is a beneficiary, treatment of the trust depends on whether the trust is revocable or irrevocable. Three special kinds of irrevocable trusts (Miller trusts and two special needs trusts) also receive different treatment.

**Revocable Trusts**

**Legal reference:** 441 IAC 75.24(2)“a”

When a client establishes a revocable trust established after August 10, 1993, the principal of the trust is an available resource. Payments from the trust to or for the benefit of the client (as beneficiary) are countable income to the client in the month of receipt when determining income eligibility for Medicaid.

Any payments from the trust other than those made to or for the benefit of the client (beneficiary) are assets transferred for less than fair market value.

**Irrevocable Trusts**

**Legal reference:** 441 IAC 75.24(2)“b”

If the client or the client’s spouse establishes an irrevocable trust after August 10, 1993, which names the client as a beneficiary, determine what payments are allowed from the trust.

If payment could be made to or for the benefit of the client (as beneficiary) for any purpose, count the portion of the principal from which payment to the client could be made as a resource. Also count any income earned on the principal from which payment to the client could be made.

Payments from the trust principal or income to or for the benefit of the client (beneficiary) are countable income in the month of receipt and a countable resource the following month.
Payments from trust principal or income for any other purpose are a transfer of assets for less than fair market value. Determine the period of ineligibility according to Penalties for Transferring Assets.

Any portion of the trust or any income on the principal from which no payment could be made to the client (beneficiary) under any circumstances is a transfer of assets for less than fair market value. The transfer occurred as of the date the trust was established, or the date on which payment to the beneficiary was foreclosed (no longer available), whichever is later.

Determine the value of the transfer by including the amount of any payments made from the trust after the date of foreclosure. Determine a period of ineligibility according to Penalties for Transferring Assets.

Payments made on behalf of the beneficiary are countable income in the month the payment is made despite the purpose of the payment. FIP and SSI rules do not apply to irrevocable trusts established with a client’s own assets after August 10, 1993.

**Special Needs Trust for Persons Under 65 Years Old**

Legal reference: 441 IAC 75.24(3)“a”

The special needs trust for persons under 65 years old:

♦ Is an irrevocable trust.

♦ Is established after August 10, 1993.

♦ Contains the assets of a person under age 65, who is disabled (as defined by the Social Security Administration).

♦ Is established for the benefit of the beneficiary by a parent, grandparent, legal guardian of the beneficiary, or a court.

♦ Provides that the state of Iowa will receive all amounts remaining in the trust upon the death of the beneficiary, up to an amount equal to the total Medicaid paid on behalf of the beneficiary.

A person who has not been determined disabled by the Social Security Administration or Railroad Retirement disability must be determined disabled for this policy to apply, according to the Social Security Administration definition.
The Department must determine disability in these instances. Send a referral to the Disability Determination Services Bureau for this situation. See 8-C, Department Disability Determination Process.

When a trust qualifies as a special needs trust, the principal is not a countable resource. Income paid into the trust is not countable. Count only the income paid from the trust or made available to the client as income. Payments from the trust follow the same rules as described in 8-E, Medical Assistance Income Trusts.

When a person with a special needs trust turns age 65, the exemption terminates. Refer the trust to the Division of Financial, Health and Work Supports if you need assistance in determining if there is countable resource or income from the trust.

When a recipient with a special needs trust dies, send a memo to inform the HMS, SUMO Group, 904 Walnut St, Suite 502, Des Moines, IA 50309-3507.

**Medical Assistance Income Trust (Miller Trust)**

**Legal reference:** 441 IAC 75.24(3)“b”

A medical assistance income trust, or Miller trust, is an irrevocable trust established for the benefit of an individual established after August 10, 1993. It is a trust where:

♦ Only the beneficiary’s income, both earned and unearned, is assigned to and deposited into the trust, and

♦ The State is the residuary beneficiary of the trust and will receive all amounts remaining upon the death of the beneficiary, up to the amount Medicaid paid out for the beneficiary.

If the trust meets these requirements, the principal is not a countable resource. Determine available income according to directions in 8-I, Clients with a Medical Assistance Income Trust, and 8-E, Medical Assistance Income Trusts.

When a recipient with a medical assistance trust dies, send a memo to inform the HMS, SUMO Group, 904 Walnut Street, Suite 502, Des Moines, IA 50309-3507.

**Special Needs Trust (No Age Limit)**

**Legal reference:** 441 IAC 75.24(3)“c”

A special needs trust with no age limit is a trust that meets the following conditions:

♦ The trust is irrevocable.

♦ The trust was established after August 10, 1993.
The trust contains the assets of a person who is disabled (as defined by Social Security Administration).

The trust is established and managed by a nonprofit association.

The association maintains a separate account for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts.

Accounts in the trust are established solely for the benefit of people who are disabled (as defined by Social Security Administration).

Accounts are established by the parent, grandparent, or legal guardian of the beneficiary or by a court.

Upon death of the beneficiary, all amounts remaining in the beneficiary’s account not retained by the trust are paid to the state of Iowa up to the amount of medical assistance paid on behalf of the beneficiary.

For this policy to apply to a person who has not been determined disabled by the Social Security Administration, the Department must determine disability. See 8-C, Department Disability Determination Process.

When a trust qualifies as a special needs trust, count the principal and income as available according to the terms of the trust.

RESOURCE ELIGIBILITY OF CHILDREN


Disregard the resources of all household members when determining eligibility for children in certain coverage groups. Continue to count resources when determining eligibility for children in all other coverage groups according to the policies in this chapter.

The age limit for determining if a person is a child or an adult is the age limit for the coverage group under which Medicaid is being received or under which eligibility is being explored or established. See 8-F, COVERAGE GROUPS, for more information.

The following chart lists all coverage groups under which children can establish eligibility and whether household resources are disregarded or counted in determining children’s eligibility.
<table>
<thead>
<tr>
<th>Coverage Group Name</th>
<th>Are Resources An Eligibility Factor For Children?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medical Assistance Program (FMAP)</td>
<td>No</td>
</tr>
<tr>
<td>Transitional Medicaid (TM)</td>
<td>NA. Resources are not an eligibility factor for children or adults</td>
</tr>
<tr>
<td>Extended Medicaid due to receipt of support</td>
<td>No</td>
</tr>
<tr>
<td>Child Medical Assistance Program (CMAP)</td>
<td>No</td>
</tr>
<tr>
<td>Mothers and Children (MAC)</td>
<td>No</td>
</tr>
<tr>
<td>Ineligible for FMAP due to residence in a medical institution</td>
<td>No</td>
</tr>
<tr>
<td>SSI recipients in their own homes and recipients of mandatory supplements</td>
<td>Yes</td>
</tr>
<tr>
<td>SSI recipients in medical institutions</td>
<td>Yes</td>
</tr>
<tr>
<td>People eligible for SSI benefits but not receiving them</td>
<td>No</td>
</tr>
<tr>
<td>Essential persons</td>
<td>NA. A child cannot be an essential person.</td>
</tr>
<tr>
<td>Ineligible for SSI or SSA due to requirements that do not apply to Medicaid</td>
<td>Yes</td>
</tr>
<tr>
<td>Ineligible for SSI or SSA due to Social Security COLAs (503 medical only)</td>
<td>Yes</td>
</tr>
<tr>
<td>Ineligible for SSI or SSA due to Social Security benefits paid from a parent’s account</td>
<td>Yes</td>
</tr>
<tr>
<td>Ineligible for SSI or SSA due to Social Security increase of October 1972</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### RESOURCE ELIGIBILITY OF CHILDREN

<table>
<thead>
<tr>
<th>Coverage Group Name</th>
<th>Are Resources an Eligibility Factor for Children?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ineligible for SSI due to substantial gainful Activity (1619b)</td>
<td>Yes</td>
</tr>
<tr>
<td>Ineligible for SSI or SSA due to actuarial change for widowed persons</td>
<td>Yes</td>
</tr>
<tr>
<td>Ineligible for SSI or SSA due to receipt of widow’s social security benefits</td>
<td>Yes</td>
</tr>
<tr>
<td>Ineligible for SSI due to residence in a medical institution</td>
<td>Yes</td>
</tr>
<tr>
<td>People in medical institutions under 300% income level</td>
<td>No</td>
</tr>
<tr>
<td>Qualified disabled and working persons (QDWP)</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Medicare beneficiaries (QMB)</td>
<td>Yes</td>
</tr>
<tr>
<td>Specified low-income Medicare beneficiaries (SLMB)</td>
<td>Yes</td>
</tr>
<tr>
<td>Expanded specified low-income Medicare beneficiaries (expanded SLMB)</td>
<td>Yes</td>
</tr>
<tr>
<td>Home health specified low-income Medicare beneficiaries (home health SLMB)</td>
<td>Yes</td>
</tr>
<tr>
<td>Medically Needy</td>
<td>No</td>
</tr>
<tr>
<td>Medicaid for employed people with disabilities</td>
<td>Yes</td>
</tr>
<tr>
<td>Iowa Family Planning Network</td>
<td>No. Resources are not an eligibility factor for children or adults.</td>
</tr>
</tbody>
</table>
Examples:

1. The C family applies for the HCBS MR waiver for Child C. Child C is the grantor and beneficiary of a trust with a countable value of $197,345. Income produced by the trust is countable, not excluded. If all other eligibility factors are met, Child C is eligible under the 300% group, since household resources are disregarded in determining children’s eligibility under this group.

2. Child B, age 15, lives in an ICF/MR and is eligible for Medicaid and facility care under the coverage group for people who are ineligible for SSI due to residence in a medical institution. Child B has countable monthly income of $100 and countable resources of $1,800.

   At the annual review, the worker determines that Child B’s countable resources now total $2,100. Since Child B is no longer eligible under this coverage group, the worker completes an automatic redetermination. Child B can be determined eligible under the 300% group, since resources are not an eligibility factor for children in the 300% group and because Child B’s income exceeds the SSI maximum for a person in a medical institution ($30).

3. Mrs. A and her two children, ages 6 and 8, apply for Medicaid. Countable income is under the FMAP limit for a three-member household. Mrs. A reports the following household resources:

   - Savings account of the 6-year-old $200
   - Savings account of the 8-year-old $300
   - Mrs. A’s checking account $50
   - 1990 Chevrolet Impala $3,500 equity value
   - 1992 travel trailer $5,000

   In determining FMAP eligibility for the children, household resources are disregarded. The children are eligible for Medicaid under FMAP. In determining FMAP eligibility for Mrs. A, the countable value of household resources is $9,050. Mrs. A is not eligible under FMAP. She is eligible under Medically Needy with zero spenddown.

4. Household composition:

   - Child D, age 10
   - Mr. D, father of Child D
   - Mrs. D, mother of Child D

   The Ds file an application for Medicaid. Mr. D was injured in an automobile accident and has no health insurance. He is at home and is unable to work. Child D is the grantor and beneficiary of a trust with a countable value of $97,755. The trust is purchasing health insurance for Child D.

   The Ds can choose to voluntarily exclude Child D so that the trust will not be a countable resource in determining eligibility for Mr and Mrs. D. The Ds’ countable resources then total $843. If all other eligibility factors are met, Mr. and Mrs. D are eligible for Medicaid under FMAP, since their countable resources are within FMAP limits.
GENERAL SSI-RELATED RESOURCE POLICIES

The following sections describe SSI-related policies on:

♦ Resource limits.
♦ What resources to count.
♦ Joint ownership of real property.
♦ Disputed ownership.
♦ Determining the value of a resource.
♦ Deeming resources from a spouse or parent.
♦ Eligibility while trying to sell a nonliquid resource.
♦ Long-term care asset protection.

SSI-Related Resource Limits

Legal reference: 20 CFR 416.1205, 441 IAC 50.2(1), 75.1(249A), 75.1(39)“a”(5), 76.5(2)

To be eligible for SSI-related Medicaid, the resource limit is:

♦ $2,000 for an individual.
♦ $3,000 for a married couple living together.

Exceptions:

♦ $4,000 is the limit for an individual who qualifies for one of the following coverage groups:
  • Qualified Medicare beneficiaries
  • Specified low-income beneficiaries
  • Qualified disabled and working persons
  • Expanded specified low-income Medicare beneficiaries

♦ $6,000 is the limit for an eligible married couple living together who qualify for one of the following coverage groups:
  • Qualified Medicare beneficiaries
  • Specified low-income beneficiaries
  • Qualified disabled and working persons
  • Expanded specified low-income Medicare beneficiaries
What Resources to Count

Legal reference: 20 CFR 416.1201

“Resources” are liquid and nonliquid assets owned by a person that the person is not legally restricted from using for support and maintenance, and that could be converted to cash to use for support and maintenance. Unless specifically exempt, all resources are considered countable.

Guardianship, conservatorship, and power of attorney are not legal restrictions on a resource. Continue to count an adult client’s resources if the client has (or is waiting for) a guardian, conservator, or person with power of attorney.

A client is not required to start a lawsuit to access or sell a resource. However, a resource is counted if the person (or the person’s conservator) has to petition the court to request access, because this action is not a lawsuit. (See Trust Definitions for more information on conservatorships.)

Include the resources of everyone who is considered part of the SSI-related household. See 8-C, NONFINANCIAL SSI-RELATED ELIGIBILITY, when establishing the SSI-related household. Determine countable resources and resource eligibility as of the first moment of the first day of each month, including the retroactive period. If resource values change during the month, eligibility will not be affected until the next month.

Nonliquid Resources

“Nonliquid resources” are assets that cannot be converted to cash in 20 days. Examples are:

♦ Homes and homesteads. See Property in a Homestead.
♦ Nonhomestead property.
♦ Personal property, such as household goods, personal effects, tractors, motor vehicles, machinery, and livestock.
**Liquid Resources**

“Liquid resources” are assets that can be converted to cash in 20 days. Following are examples of liquid resources.

♦ **Annuities.** Count the salable value of an annuity or the amount the company will pay back to the client if the annuity is cashed in. Ask the client to obtain a statement from the company regarding the lump sum and the cash-in amount.

If the annuity cannot be cashed in but is assignable or can be transferred, ask three knowledgeable sources what its value is. Average the three values.

Most annuities allow benefits to be assigned or ownership sold. A client who claims that an annuity cannot be sold or transferred must obtain verification.

♦ **Bonds.** The countable value of the bond is its redemptive value on the first moment of the first day of the month.

♦ **Cash,** unless it was counted as income for the month or specifically excluded as a resource, such as a retroactive SSI lump sum.

♦ **Checking and savings accounts.** Subtract verified outstanding checks and any funds included in the accounts that are specifically excluded as a resource.

If funds intended for the following month are direct deposited or deposited by the client before the intended month, do not count the funds as a resource in the month they were intended to cover. Remember to count the funds as income.

Mrs. J has $2,000 in checking as of midnight on May 31. She receives her social security check of $700 June 1. This check is not a factor in determining resources, because $2,000 was countable as of the first moment of the first day of the month.

For co-owned accounts, if two or more account holders are either Medicaid applicants or recipients or are people whose income and resources must be considered for Medicaid eligibility (such as spouses or parents of minor children), count an equal share of the account for each.

If only one of the account holders is a Medicaid applicant or recipient or a person whose income and resources must be considered for Medicaid eligibility, count the entire amount in a co-owned account unless the client can establish that the client (or deemer) cannot access the funds. See Disputed Ownership.
Ms. G has $3,000 in a joint checking account with her sister, Ms. H, and their mother, Mrs. I. Ms. G and Ms. H are both over the age of 21 and are both receiving SSI-related Medicaid. Mrs. I has not applied for and does not receive Medicaid. Countable amounts are $1,500 for Ms. G and $1,500 for Ms. H, unless either can establish that they do not have access to the account.

- **Individual Retirement Accounts (IRA).** Use the value of the IRA if cashed-in minus any penalties for early withdrawal.

- **Mutual funds.** Count the value for which the shares can be sold.

- **Oil leases.** The value must be established by a knowledgeable source, such as a brokerage firm or bank. The lease value can be excluded if it is under $6,000 and the land earns a net income of 6% of equity, or if the land is being sold. The leasehold is the right to use the property for a specified period. It does not convey ownership of the property.

- **Promissory notes** that can be sold or discounted.

- **Stocks.** Use the closing price of the stock on the first moment of the first day of the month.

Do not count resources that have no cash value, that cannot be liquidated, or that the client does not have the right to liquidate and use for support and maintenance. **Note:** Do not count property jointly owned by spouses involved in a divorce when the property is unavailable until a decision on distribution has been made. Do not consider the terms of a prenuptial agreement when determining Medicaid eligibility.

Do not count a resource until ownership is known to the client. A client who is not aware of owning a resource must prove that it was reasonable not to know about it. Forgetting a resource is not evidence. Count the value of the resource plus any interest as income in the month of discovery. Count it as a resource the next month.

Mr. N’s grandfather had transferred land to Mr. N in October but had not told him. Mr. N was told the following May. Mr. N provides verification with a letter from his uncle establishing that there was no prior knowledge. The $5,000 value of the land is income to Mr. N in May. The land is a resource in June unless it is sold.

If the client has the legal ability to convert a resource to cash, it is not necessary that the client have possession of the resource for it to be counted. **Exception:** A client must possess a savings bond for it to be counted. Savings bonds have no resource value for six months from the issue date.
Joint Ownership of Real Property

Legal reference: 20 CFR 416.1201, 416.1201(a), 416.1245(a)

If real property is owned by more than one person, assume all persons have equal shares, unless you are able to determine differently. If a client does not own an equal share in a resource, count only the portion owned by the client.

If the client jointly owns real property, evaluate the details of ownership and the particulars of the situation to determine how shared ownership affects the value of the property as a resource.

In Iowa, people who jointly own property and wish to dispose of their interest in the property may do so. The refusal of one owner does not preclude any other owners from selling their ownership interest. (After the sale of the property, the new owners can petition the court for a partition action.) So, joint ownership does not preclude the property from being a countable resource, but it may affect the countable value of the seller’s interest.

If a client jointly owns real property in another state, state law there may require the co-owner to move if the property is sold. If so, exclude it as a resource if the disposal of this property would cause undue hardship to the co-owner due to lack of housing. Obtain verification of the joint ownership and the applicable state law. The co-owner must use the property as the principal place of residence and have no other housing readily available.

“Tenancy in common” means that two or more persons have a fractional interest in the property. Any owner has the right to sell or dispose of that owner’s share of the property. If an owner dies, that person’s portion passes to the heirs.

Mr. J owns 40% of a 100-acre farm as tenant in common with his brother. The interest is referred to as “undivided.” Specific acres are not identified as belonging to Mr. J, but he could sell his 40% interest. If Mr. J dies, his ownership passes to his heirs.

“Joint tenancy” means that two or more persons own an interest in and possession of the entire property. An owner’s portion can be sold. If an owner dies, the ownership passes to the other owner.
Mr. J owns 40% of the 100-acre farm with Mr. T in joint tenancy. His interest is undivided but he could sell his 40% interest. If Mr. J dies, his ownership interest passes to Mr. T.

“Leasehold” means the lessee has the right to the use of the property for a specified period of time. A lessee may sell that right. Verify the countable value with a statement from a knowledgeable source.

**Disputed Ownership**

**Legal reference:** 20 CFR 416.1201, 416.1201(a), 416.1245(a)

Count jointly owned resources unless the client rebuts ownership. Allow the client to rebut ownership of all or part of jointly owned liquid and nonliquid resources. To do this, the client must establish:

♦ That the client’s money is not deposited in the resource, or the proportion of money deposited by the client in relation to the total money deposited.

♦ The reason for the joint ownership.

♦ Whether the client made any withdrawals from the resource for the client’s own use, or made withdrawals proportional to the client’s share of the money.

♦ Whether the resource was altered to reflect true ownership interest.

If the client successfully shows either no ownership or partial ownership and changes the resource to reflect this, the ownership is then established at the beginning of the financial arrangement. Count only the part that the client could not prove belonged to another person. See **Liquid Resources** for countable amounts of co-owned checking and savings accounts.

Mrs. N and Mr. F, who are brother and sister, jointly own a bank account. Mrs. N has her name on the account to handle Mr. F’s business, since he is not able to do so. Mr. F is not a Medicaid applicant or recipient.

Mrs. N applies for Medicaid on October 11. She lists the account, which has $6,000 as of October 1. She proves that all the deposits were Mr. F’s and she did not use any of the withdrawals. She changes the name on the account to show the true ownership. This account is not countable to Mrs. N.
Determining the Value of a Resource

Legal reference: 20 CFR 416.1201

The countable value of a resource is the equity value. The equity value is the current fair market value minus any legal debt on the item. To be considered a debt against the resource, the debt must be legally recognized as binding on the resource’s owner. The current fair market value is the amount an item can be sold for on the open market.

When determining the equity value of a resource:

♦ Deduct from the current market value only the principal amount of the debt and any prepayment penalties required. Do not consider any future interest owed.

♦ Determine the ownership of jointly held resources, such as joint checking or savings accounts and jointly held real estate, according to the intent of the parties who created the joint interests upon the creation of the joint interest.

If the document creating the joint interests, such as a deed to real estate or a bank account signature card, specifies the shares of the parties, divide the fair market value of the entire resource between the joint owners according to the shares specified.

If the shares of the joint owners are not specified, assume equal shares for all joint owners, unless evidence of intent shows unequal shares. Examples of evidence of intent showing unequal shares include:

• The source of the funds used to purchase or create the joint resource.
• The use made of the joint resource.
• The inclusion of one of the joint owners as a caretaker for the convenience of the other, etc.

♦ If excluded funds are combined with countable resources, assume the countable resources are spent first.

♦ Consider the sale or transfer of a resource as a change in the form of the resource. Do not consider the transfer or sale of a resource as income.
♦ A court restriction may make all or part of the resource unavailable to the client. Consult your supervisor if you have questions about the legal restrictions. Legal restrictions on resources can be included in:

- Liens.
- Qualified domestic orders.
- Divorce decrees.
- Probate matters.
- Bankruptcy proceedings.

**Deeming Resources**

**Legal reference:** 20 CFR 416.1160, 416.1163, 416.1202

Deeming is the process of assigning a specified amount of resources of an ineligible spouse, parent, or sponsor when determining Medicaid eligibility. An “ineligible spouse” is a spouse who is not receiving SSI-related Medicaid. See 8-L, *ALIENS*, when deeming resources from a sponsor to an alien.

Do not apply deeming policies if the applicant’s or couple’s resources alone are over the resource limits after including all appropriate disregards and exclusions.

Deem resources as of the first moment of the first day of the month of eligibility.

**Deeming From a Spouse**

**Legal reference:** 20 CFR 416.1202

To determine eligibility, include resources of an ineligible spouse when:

♦ An eligible person was living in the same household with the ineligible spouse at any time during the month, or

♦ An SSI-eligible person was living with an SSI-eligible spouse during the last six months unless:
  - The spouses have divorced,
  - One of them has died, or
  - One of them moved to a medical facility.
When an applicant is living in the same household with an ineligible spouse, include the resources of the ineligible spouse in determining the application’s eligibility. Do not, however, deem pension funds controlled by an employer or union, or IRA or Keogh accounts.

If spouses who are both eligible for Medicaid separate, including when one spouse enters a medical facility, discontinue deeming the month after the month of the separation. Separation means that the spouses are not expected to be living together for a full calendar month.

Before entering a nursing facility, Mrs. L was living at home with her spouse. She will be in the facility for less than 30 days. Their countable resources are as follows:

- $1,800 Savings account in Mr. L’s name only
- $500 Vacant lot owned by Mr. L
- $2,300 Total resources of Mr. and Mrs. L
- $3,000 Limit for a couple
- $0 Excess resources

Since resources deemed to Mrs. L do not exceed the resource limit for a couple, eligibility exists.

**Deeming From a Parent to a Child**

**Legal reference:** 20 CFR 416.1202

A “child” is a person who is:

- Not married,
- Not the head of the household, and
- Either under age 18 or under age 22, if a student regularly attending a school, college, university, or course of vocational or technical training to prepare for gainful employment.

Before deeming resources from a parent to a child, see 8-D, RESOURCE ELIGIBILITY OF CHILDREN. If the child’s eligibility is determined under a coverage group where resources are exempt, there is no need to deem resources from the parents.

When an eligible child is living in the household with an ineligible parent or stepparent, include the parent’s and stepparent’s resources when determining the child’s eligibility unless the stepparent is the only person living with the child. If the child lives with the stepparent and not the biological parent, there is no deeming.
Do not deem a parent’s resources to other ineligible children. Do not count or deem resources of ineligible children to the eligible child.

The child’s resources are any resources the child owns plus any resources deemed from the parents. Determine the child’s resources independently of the parents’ resources. Consider household goods and personal effects owned by the child separately from those owned by the parents. Do not exclude more than one home and one vehicle for the family.

To deem the parents’ resources to a child:

1. Allow the parents all the exclusions for which they would be eligible if they were eligible for Medicaid. Do not deem an ineligible parent’s pension funds if they are controlled by the employer or by the union or are in an IRA or Keogh account.

2. Deduct $2,000 for an individual (if one parent) or $3,000 for a couple (if two parents) before deeming to the child.

3. Deem the remaining countable resources to the child.

A child is not eligible if the child’s own resources plus the value of the resources deemed from the parents exceeds the $2,000 resource limit unless the child is eligible under QMB, SLMB, or Medically Needy. See 8-F.

Sam, age 17, was living with his parents and two brothers before entering an RCF. Sam has a $50 savings account in his own name. The parent’s resources are as follows:

- $30,000 Value of home in which they live
- $3,200 Parent’s joint savings account

The home is excluded. $200 resources are available for deeming. ($3,200 minus $3,000 SSI exclusion for a couple.)

- $200 Deemed from parents
- $50 Sam’s own resources
- $250 Total resources

Since resources deemed to Sam plus Sam’s own resources do not exceed the resource limit for an individual, Sam meets the resource standard.

Do not deem parents’ income or resources to a child the month following the month of entry into a medical institution or RCF.
Eligibility While Trying to Sell a Nonliquid Resource

Legal reference: 20 CFR 416.1240-416.1245, 441 IAC 50.5(249A), 76.2(3)

Clients who have countable nonliquid resources that exceed the applicable resource limit may not receive Medicaid under a “Medicaid only” coverage group while they are attempting to sell the resource.

However, such clients may be able to receive State Supplementary Assistance (SSA) or Supplemental Security Income (SSI) benefits until the resource is sold. These benefits are called “conditional benefits.” Clients who are conditionally eligible for SSI are not eligible for Medicaid but clients who are conditionally eligible for SSA may receive Medicaid in the same manner as any other SSA recipient.

If the person has been approved for conditional SSI or federally administered State Supplementary Assistance benefits, there will be a “C” code in the 60 PAYMENT CODE field on the SDX.

There is usually no retroactive Medicaid eligibility for a recipient who has been approved for conditional SSI or State Supplementary Assistance benefits. However, the recipient’s countable resources, including the excess resources, may have been under the Medically Needy limits. Also, some resources may not have been countable in the retroactive period, e.g., a house in which the recipient was living.

Ms. A, a minor child, is approved for SSI effective August 1, 1996. Her parents receive 10 acres of land on August 6 as an anniversary gift. The land has a value of $6,000. In October, her parents sign an agreement to sell the land and repay SSI.

The IM worker evaluates resources of Ms. A and her family for the Medicaid retroactive period of May, June, and July, to determine if resources were under the limit. Since they did not own the land before August, retroactive eligibility is not affected by the 10 acres. The conditional benefits period begins in November (the month the agreement was signed). For the months of September and October, the land value of $6,000 is a countable asset.
Long Term Care Asset Preservation

Legal reference: 441 IAC 75.5(5), Iowa Code 249G

A person aged 65 or older may be eligible for Medicaid if the person is:

♦ Eligible for Medicaid under SSI-related aged programs, except for excess resources, and

♦ The beneficiary of a certified long-term care insurance policy or enrolled in a prepaid health care delivery plan that provides long-term care services.

Such a person is eligible for Medicaid if the excess resources causing ineligibility do not exceed an “asset adjustment.” Assets are adjusted by disregarding the amount paid out under the person’s long-term care insurance policy for Medicaid-covered long-term care services.

The policy or plan must meet the minimum standards established for long-term care insurance policies and certificates as established by the Division of Insurance. All long-term care insurance policies sold after January 26, 1994, must include a statement on the cover sheet of the policy telling whether the policy qualifies under the Iowa long-term care insurance program for Medicaid asset preservation.

On a quarterly basis, the insurer provides the beneficiary with a copy of the amount of payment made that qualifies as Medicaid covered long-term care services. The quarterly report includes the amount paid in the last quarter and total amount paid on behalf of the insured.

Subtract the total amount paid on the person’s behalf by the policy or delivery plan from the person’s total resources. Compare the remaining resources to the resource limit to determine Medicaid resource eligibility. If the person’s remaining resources exceed the resource limit, issue a Notice of Decision denying or canceling Medicaid.
**Resources Exempted for Medicaid for Employed People With Disabilities**

**Legal reference:** 441 IAC 75.1(39)“(a”(5)

Additional resources are exempt for persons who qualify for Medicaid eligibility under Medicaid for employed people with disabilities. They are:

- **Assistive technology accounts**: Assistive technology accounts include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value that are set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology services or assistive technology devices.

These accounts must be held separate from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology, assistive technology services, or assistive technology devices for the working person with a disability.

“Assistive technology” is defined as the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by people with disabilities in areas such as education, rehabilitation, technology devices, and assistive technology services.

An “assistive technology device” is any item, piece of equipment, product system, or component part (whether acquired commercially, modified, or customized), that is used to increase, maintain, or improve functional capabilities or to address or eliminate architectural, communication, or other barriers confronted by people with disabilities.

“Assistive technology service” means any service that directly assists a person with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

Require the client to provide written verification from a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist that the technology being saved for is medically necessary and that the technology, device, or service can reasonably be expected to enhance the client’s employment. Also require verification of an estimated cost for the technology.
♦ **Medical savings accounts.** These are accounts exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220). A person who has such an account will have documentation from the bank or other financial institution that set it up.

♦ **Retirement accounts.** This includes any retirement or pension fund or account listed in Iowa Code section 627.6(8)“f” as exemption from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account. The following are exempt under this provision:

- Pension or retirement plans authorized under federal law, as follows:
  - Simplified employee pension plans.
  - Self-employed pension plans.
  - Keogh plans (also know as “H.R. 10 plans”).
  - Individual retirement accounts.
  - Roth individual retirement accounts.
  - Savings incentive matched plans for employees.
  - Salary reduction simplified employee pension plans (also known as “SARSEPs”).
  - Similar plans for retirement investments authorized under federal law after May 17, 1999.

- Retirement plans established pursuant to a “qualified domestic relations order” as defined by federal law (26 U.S.C. § 414).

If unclear from documentation provided, verify with plan administrator or send clarification request to central office.
SPECIFIC SSI-RELATED RESOURCES

This section lists specific types of resources that are countable or excluded, in total or in part, when determining initial or ongoing eligibility for SSI-related coverage groups. Some countable resources require calculations to determine the countable value to the applicant or recipient. Some resources are excluded only up to a certain limit, after which the remainder is countable.

And finally, some resources are exempt in the month of receipt and in some cases, the month following the month of receipt. Examples include:

- Death benefits
- Earned income credit
- Income tax refunds
- Retroactive cash payments
- Social services expenses
- Third party medical payments

See individual items for more information. (See EXEMPT RESOURCES FOR FMAP for comparable information for FMAP-related coverage groups.)

**AIDS/HIV Settlement Payments**

Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

Payments from the original settlement or the Ricky Ray Hemophilia Relief Act of 1998, are exempt as a resource.

**Annuities**

An annuity is a contract in which a person receives fixed payments for a specified time period. The person who receives the payments is referred to as the annuitant. The term of the annuity contract can be for either:

- The lifetime of the buyer;
- The lifetime of the buyer, with a minimum return of principal to a residuary beneficiary if a specified portion of the principal is not returned before the buyer’s death; or
♦ A certain number of years, with a guaranteed payment amount if the annuitant dies before the specified period has expired.

Review a copy of each annuity to determine the terms of the contract. Annuity contracts may be assigned, transferred, or cashed in for a lump sum. Or the contract may state that once payments are being made to the annuitant, the contract cannot be assigned, transferred, or cashed in for a lump sum.

♦ If the annuity can be assigned, transferred, or cashed in for a lump sum, the loan value or the amount the company will pay back to the annuitant is a countable resource.

♦ If the annuity may be assigned or transferred, but not cashed in, the annuitant must verify the amount that the annuity can be assigned or transferred for. The annuitant should obtain three estimates from knowledgeable sources. Use the average of these estimates to determine the countable value of the annuity.

♦ If the annuity is counted as a resource and the annuitant is eligible for Medicaid, obtain verification of the portion of the payment that is interest and the portion of the payment that is principal.

Count the interest portion of the annuity payments as income to the annuitant when determining eligibility, spenddown, and client participation. Do not count the principal portion of the payment; this is already counted as a source.

♦ If the annuity cannot be assigned, transferred, or cashed in and the annuitant verifies that the annuity has no cash value, the annuity is not a countable resource. Count the total annuity payment as income to the annuitant when determining eligibility, spenddown, and client participation.

Annuities must also be reviewed to determine if the purchase of the annuity constitutes a transfer of assets for less than fair market value. See Transfers That Cause a Medicaid Penalty.
If you need help interpreting the terms of an annuity or the income and resource policies that apply to it, send the annuity with a clarification request through your service area office to central office.

**Burial Contracts**

20 CFR 416.1201, 20 CFR 416.1236(1) and (15)

Exclude a prepaid burial contract as a resource if it meets one of the following conditions:

- The contract is irrevocable and the client can’t access the funds.
- Mutual consent of the client and the contract seller is required to revoke or access the contract, and the seller’s consent can’t be obtained.
- Liquidation of the contract would create a significant hardship to the client. Usually, the only hardship considered significant is requiring the client to move out of Iowa to access the funds.

Unless the contract clearly indicates that the burial contract is irrevocable, obtain a written statement from the contract seller that the funds committed to the contract are unavailable to the person. Investigate contracts drawn up in other states to determine whether the law in the other state permits irrevocable burial contracts and whether the contract is irrevocable under that law.

If a CD or another form of funds is tied to the irrevocable contract, only the amount specified in the irrevocable contract is excluded.

If the burial contract is set up by purchasing a life insurance policy, check if the funeral home either owns the policy or is the irrevocable beneficiary. If the funeral home owns the policy, both the whole cash value and the dividends are unavailable. However, if the funeral home is the beneficiary, only the cash value is unavailable. Count dividends that are available to the client.

Since there is no limit on the amount of money in the burial contract, some clients may use prepaid burial contracts to protect assets. If the amount of the burial contract exceeds $8,514, which is the average cost of a funeral in Iowa, ask for an itemized list of funeral costs.
If the amount is less than or equal to the cost of the funeral, exclude the contract from resource consideration. If the amount in the burial contract exceeds the itemized listing, consider the excess deposits or payments as a transfer of assets for less than fair market value. See TRANSFER OF ASSETS.

The amount of money considered transferred is the amount designated for the contract minus the specified cost of the burial. Determine whether transferring has occurred rather than determining how much of the irrevocable burial contract is a countable resource.

If a relative changes the selection of services in the burial contract at the time of the funeral, this is not a transfer of resources.

**Burial Funds**

 Exclude funds up to $1,500 for the client and up to $1,500 for the spouse that are held in a separate account designated for burial purposes. Examples of funds set aside for burial are:

- Revocable burial contracts.
- Trusts.
- Cash value of any life insurance policies.
- Any account or resource designated by the client for burial, cremation, or other funeral arrangements. An account or resource designated for burial could be bank accounts, CDs, real property, etc.

Burial funds must be in separately identifiable accounts. If funds are combined with other funds that are not for burial purposes, the client must separate the funds.

The client must sign a statement designating the funds for burial purposes. File a copy of the statement in the case record and give a copy to the client. Exclude the fund as of the first of the month in which the fund is separated and designated as a burial fund.
Reduce the amount the client set aside for burial by any excluded whole life, term life, and irrevocable burial contracts. For policies on burial space, see Burial Space. To determine the amount of burial funds that can be applied under this exclusion:

1. Obtain copies of irrevocable burial arrangements and life insurance policies to determine what burial funds the client owns.

2. If the irrevocable contract is over $1,500, no other burial funds can be excluded. (The irrevocable burial contract is an excluded resource, but it does have an effect on whether any other funds can be set aside for burial.)

3. If the burial contract is less than $1,500, determine the face value of any excluded whole life and term life insurance policies designated for burial funds. (Life insurance with a face value of $1,500 or less is excluded. Life insurance with a face value of more than $1,500 is not excluded.)

4. Add together the face value of excluded life insurance and the burial contract. Subtract this amount from the $1,500 set-aside amount. If there is no remainder, no additional funds can be set aside for burial.

If the total amount set aside in the burial contract and excluded life insurance is under $1,500, the client can designate additional funds for burial to make up the difference. The total cannot exceed $1,500.

1. Mr. N has $2,500 in a burial fund that is revocable. He has no other burial funds. The maximum excluded from resource consideration is $1,500. $1,000 is a countable resource.
2. Mrs. B has life insurance with a face value of $3,000. The cash value is $1,800. This policy is not exempt and she has no other funds set aside for burial. Because Mrs. B has no funds set aside for burial, the worker excludes $1,500 of the $1,800 cash value for burial. $300 is a countable resource.

3. Mrs. H has a $2,000 burial fund that is revocable. She has life insurance with a face value of $800. $700 of the burial fund that can be excluded and the interest earned on this $700 are exempt as income and a resource. The remaining $1,300 is countable as a resource. The $1,300 counts towards the resource limit and the interest on this amount is counted, subject to infrequent and irregular income.

4. Mrs. P has $1,000 in a savings account that she has designated for burial. She also has a $1,000 face value life insurance policy.

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<th>Maximum exclusion</th>
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<tr>
<td>Life insurance</td>
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<td>Remaining exclusion</td>
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<tr>
<td>Countable resource</td>
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5. Mr. Q has a $1,600 life insurance policy and a $1,000 irrevocable burial contract. The cash value of the life insurance policy is $1,975. Mr. Q designated the cash surrender value of his life insurance as funds set aside for burial.

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<tr>
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<th>Maximum potential exemption</th>
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<tr>
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<tr>
<td>Countable resource</td>
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Mr. Q’s worker informs him that he could irrevocably assign the life insurance ownership to the irrevocable burial contract, at which point it would no longer count as a resource.
If the client spends any of the burial fund, count the amount spent as income during the period it was spent.

A client in a nursing home has $1,400 in a burial fund, but spends $1,000 in June. This $1,000 is used for June eligibility, and client participation is adjusted for June.

**Burial Fund’s Increase in Value**

20 CFR 416.1124, 416.1231

Do not count increases in the value of the burial funds that are excluded. Count the interest and increase in value on the **countable** portion of the burial funds. These increases may be due to interest income or the appreciation in value of the burial arrangement.

To do this, determine the countable percent and apply the percentage toward the value of the burial funds at the time they are gathered.

When an SSI-related client had excluded funds set aside for burial at the time of cancellation:

♦ Exclude increased funds at the time of cancellation if the client becomes eligible for a SSI-related Medicaid within 12 months of cancellation. If, however, the person loses SSI because the person is no longer disabled, allow the increased funds to be excluded only if the person becomes eligible for an SSI-related program within three months.

♦ Allow only the same percentage increase in funds that was allowed before cancellation if the burial fund account is only partially excluded because the client has other burial funds. This is subject to the same 12-month period.

Contact the SSI representative at the district Social Security office to determine the amount of funds excluded at the time of cancellation when an SSI person becomes ineligible and then goes to another SSI-related coverage group.
Burial Space

20 CFR 416.1231(a)

Do not count a burial space that is owned by the client and intended for the client, spouse or any other member of the client’s immediate family. A “burial space” is:

- A conventional grave site, including opening and closing the grave.
- A crypt, vault, or mausoleum.
- The casket, urn, burial containers, and items traditionally used for the remains of a deceased person.
- Headstones, markers, or plaques.

A space can be all items that traditionally go with the burial space. For example, a space can include both a lot and a casket, but not an urn in addition to the lot and casket.

The immediate family includes a client’s:

- Children, stepchildren, adopted children
- Brothers, sisters
- Parents, stepparents, adoptive parents

The client’s immediate family does not include members of an ineligible spouse’s family. If a space is not intended for the use of an immediate family member, count it as a resource.

Exclude only one space for each person. Document in the case record for whom each space is intended.

Child Tax Credit

20 CFR 416.1235

Exclude the child tax credit as a resource for nine months following the month of receipt.
Entrance fees paid by persons residing in continuing care retirement communities or life care communities that collect an entrance fee on admission are considered a resource available to the person if:

- The person has the ability to use the entrance fee, or the contract between the person and the community provides that the entrance fee can be used to pay for care;
- The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the community contract; and
- The entrance fee does not confer an ownership interest in the community.

Exclude the funds in a dedicated account as a resource for people receiving SSI. When past-due benefit payments are paid for an eligible person under age 18, the Social Security Administration requires the representative payee to establish a dedicated account. The dedicated account may be used only for:

- Medical treatment, education, and job skills training.
- Personal needs assistance, special equipment, housing modification, and therapy or rehabilitation if related to the child’s impairment.
- Other items and services related to the child’s impairment approved by the Social Security Administration.

Stop excluding the funds in a dedicated account when the person loses SSI eligibility, even if the person later reapplies and is approved.
<table>
<thead>
<tr>
<th><strong>Disaster Assistance</strong></th>
<th>Exclude disaster assistance from a state, federal or local programs as a resource.</th>
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<tbody>
<tr>
<td>20 CFR 416.1201, 416.1210, 416.1228, 416.1236; P.L. 101-508</td>
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<thead>
<tr>
<th><strong>Earned Income Credit</strong></th>
<th>Exclude the earned income credit as a resource for nine months following the month of receipt.</th>
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<tr>
<td>Public Law 101-508</td>
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<table>
<thead>
<tr>
<th><strong>Educational Assistance</strong></th>
<th>All student financial assistance received under Higher Education Act (HEA) or under Bureau of Indian Affairs (BIA) student assistance programs is excluded as a resource, regardless of use and regardless of how long the assistance is held.</th>
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</thead>
<tbody>
<tr>
<td>20 CFR 416.1236(7), 416.1236(15)</td>
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</table>

Examples of HEA (Title IV) programs are:

- PELL grants
- State Student Incentives
- Academic Achievement Incentive Scholarships
- Byrd Scholars
- Federal Supplemental Educational Opportunities Grants (FSEOG)
- Federal education loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)
- Upward Bound
- Gear Up (Gaining Early Awareness and Readiness for Undergraduate Programs)
- LEAP (Leveraging Educational Assistance Partnership)
- SLEAP (Special Leveraging Educational Assistance Partnership)
- Work-study programs
Other grants, scholarships, fellowships, or gifts used or intended to be used to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, are excluded from resources for nine months beginning the month after the month the assistance was received. This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter.

“Necessary educational expenses” include the following:

♦ Laboratory fees
♦ Student activity fees
♦ Transportation
♦ Stationery supplies
♦ Books
♦ Technology fees
♦ Impairment-related expenses necessary to attend school or perform schoolwork (special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment, etc.)

Grants, scholarships, fellowships, and gifts that are retained after the nine-month exclusion period are countable resources beginning the month after the exclusion period ends.

Excluded educational assistance becomes countable as income in the earliest of:

♦ The month any portion of the excluded assistance is used for something other than tuition, fees, or other necessary educational expenses, or
♦ The month the person no longer intends to use the funds to pay educational expenses.
Exclude any cash or in-kind assistance provided under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program, including:

- Winterization of old or substandard dwellings. (Neither the cost of the materials, nor the cost of labor is counted.)
- Insulation.
- Emergency loans and grants to install energy conservation devices.
- Alternative fuel supplies and special fuel vouchers or stamps.
- Alternative transportation activities designed to save fuel and guarantee continued access to training, education, and employment.
- Legal or technical training relating to the energy crisis.
- Fuel to operate food preparation appliances, or meals provided because utilities have been shut off.

Exclude the value of:

- Allotment paid under the Food Stamp Act
- Food provided under WIC
- School lunches or breakfasts
- Congregate meals
- Federally donated food

Verification is not required.

A gift given to a child under 21 is not considered an available resource under the Uniform Gift Act. When the child turns 21, the gift becomes a countable resource. Verify the amount of the gift before excluding it. See 8-E for how to treat all other types of gifts.

Exclude household goods and personal effects if the equity value is less than $2,000. Count any amount over $2,000 toward the resource limit.
“Household goods” are items used to maintain the home as well as to accommodate, comfort and entertain the occupants.

“Personal effects” are belongings of family members, including clothing, books, and grooming aids. Do not count one set of a client’s wedding and engagement rings.

Exclude items required by any household member because of the person’s medical or physical condition, regardless of value. For example, exclude prosthetic devices, dialysis machines, wheel chairs, and hospital beds.

If the client reports household goods or personal effects equal to or more than $500, investigate the total value of the household and personal effects against the $2,000 exclusion. Accept the client’s estimated value of household goods and personal effects.

Exclude household goods and personal effects that were excluded in the attribution of resources. In spousal impoverishment cases, the household goods and personal effects retained by the community spouse are excluded as resources to the institutionalized spouse when determining Medicaid eligibility.

Do not count rent subsidies, cash toward utilities, and indirect assistance (guaranteed loans, mortgages, and mortgage insurance) provided to homebuyers by the Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture/World Development. Do not count any rent reduction to a person in low-income housing when the assistance is under the U.S. Housing Act of 1937, as amended.

Verify the authority for the client’s federal or federally assisted housing. If the client cannot get verification, contact the local public housing authority. If HUD and a private owner have entered into a contract directly, contact the owner or manager of the project to verify the nature and authority for the housing assistance payments. Record the findings in the client’s case record.
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<th>Resource Type</th>
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<td><strong>Income Tax Refunds</strong></td>
<td>Exclude federal income tax refunds as a resource for the month of receipt and the month following the month of receipt.</td>
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<td>20 CFR 416.1103(d)</td>
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<tr>
<td><strong>Individual Development Accounts</strong></td>
<td>An individual’s contributions that are deposited in a Demonstration Project IDA are excluded from resources. Any matching funds that are deposited in a Demonstration Project IDA and interest earned are excluded from resources.</td>
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<tr>
<td>20 CFR 416.1201, 416.1210, 416.1236;</td>
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<td>P.L. 105-285, Section 415</td>
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<tr>
<td>P.L. 106-554</td>
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<tr>
<td><strong>Indian Assistance</strong></td>
<td>Exclude judgment funds distributed to members of Indian tribes and payments that were received from certain lands and subsurface mineral rights, then distributed to tribal members. Exclude up to $2,000 in interest payments per year from Indian trusts or restricted lands. Exclude any land that the client or spouse cannot dispose without the consent of the tribe, a federal government agency, or other persons.</td>
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<td>20 CFR 416.1201, 416.1210, 416.1228,</td>
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<td>92-254, P.L. 94-114, P.L. 103-66</td>
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<tr>
<td><strong>Insurance (Death Benefits)</strong></td>
<td>Exclude in the month of receipt and the following month proceeds from life insurance or death benefits not spent on the insured’s last illness or burial. If the money is reimbursement for expenses of the last illness or burial, exclude it only for the month of receipt.</td>
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<td>20 CFR 416.1201, 416.1210, 416.1236;</td>
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<tr>
<td>P.L. 101-508</td>
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<tr>
<td><strong>Insurance (Life)</strong></td>
<td>Exclude the cash surrender value of life insurance policies with a combined face value totaling $1,500 or less per owner. If the total face value of life insurance owned by the client is more than $1,500, count the cash surrender value toward the resource limit. Exclude all life insurance that has no cash surrender value, such as term insurance. For purposes of this comparison, the countable face value of a life insurance policy is the total face value minus any face value purchased with dividends from the policy. If the face value of the policy increases in other ways, use the adjusted face value. Do not include additional sums payable if the client dies in an accident.</td>
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<td>20 CFR 416.1230</td>
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The cash surrender value is the amount that the insurance company will pay if the policy is canceled before death (this value usually increases with the age of the policy). The cash surrender value may include dividends and may decrease with loans.

Funds paid as accelerated payments from the policy do not change the value of the resource. These payments, called accelerated death benefits, are counted as income.

1. Mr. X owns two life insurance policies, one with a face value of $750 and the other with a face value of $500. Since the total face value of life insurance is $1,250, the policies are exempt from resource consideration.

2. Mr. Y owns three life insurance policies with face values of $1,000, $750, and $500, totaling $2,250. Mrs. Y owns one life insurance policy with a face value of $1,000. Mrs. Y’s policy is ignored in the computation because its face value is less than $1,500 per owner. Since Mr. Y’s policies total $2,250, the cash surrender value of each policy must be determined.

3. Mr. and Mrs. Q and their child have life insurance with a face value of $4,000. Mr. Q owns the policy. The cash value is counted towards the resource limit.

Count accumulated dividends that are not used to purchase additional insurance as a resource in the same manner as money in a bank account. Count the accumulated dividends even if the countable face value of the policy is less than $1,500 and the cash value of the life insurance is excluded.

Mr. B has a $1,000 whole life policy that he purchased in 1942. His dividends purchased an extra $3,000 in face value in 1976. Now, the total face value of the policy is $4,000, the cash value is $2,800, and dividends are $800.

Because the policy’s face value, (not including the face value due to insurance purchased with dividends) is less than $1,500, the cash value is excluded. However, the $800 in dividends that were not used to buy additional insurance are countable resources.
Dividend accumulations may be considered as cash set aside for burial if all burial fund criteria are met. Do not automatically assume that the dividends are set aside for burial because the cash value of the life insurance is designated for burial.

If the life insurance policy is assigned to the funeral home in an irrevocable burial contract, do not count the cash value or the dividends as a resource. If the funeral home is the beneficiary along with an irrevocable burial contract, do not count the cash value of the policy, but count any accessible dividends as a resource to the client.

At the time of application, send form 470-0444, *Insurance Report*, to verify the:

- Total face value of the whole life insurance policy not including dividend additions.
- Amount of accumulated dividends not used to purchase additional insurance.
- Interest earned on accumulated dividends.

At annual reviews, send 470-0444 unless the total face value of all policies is $1,500 or less and the last report indicated that the face values will not change. See 6-Appendix for instructions on form 470-0444.

**Life Estates or Remainderman Interest**

Property can be divided into two parts, the life estate and the remainder interest. This applies whether the property is real estate or personal property, or is liquid or nonliquid.

The owner of the entire, undivided property can divide the property into the two parts, and can either:

- Keep the life estate and transfer the remainder interest, or
- Transfer the life estate and keep the remainder interest, or
- Transfer both the remainder interest and the life estate to two different people.
People who receive or retain a life estate ("life tenants") have the right to use the property during their lifetime, including the right to any income generated by the property during their life. Count income generated according to policy. See 8-E, INCOME: Lump Sum Income, and Recurring Lump Sum.

This right has a value and can be sold to someone else. If the original owner of the life estate transfers or sells the life estate to someone else, the recipient of the life estate gets the right to use the property during the life of the original holder. The "life" that determines the life estate does not change with the transfer.

The owner of a remainder interest, the remainderman, has the right to receive the property when the life estate ends. Before the life estate ends, the owner of the remainder interest has no right to use the property or to receive any income from it.

The right to receive the property when the life estate ends also has value and can be sold. As with a transfer of the life estate, the transfer of the remainder interest does not change the life that controls the life estate. When the life estate ends, the remainderman then owns the entire property. It is no longer divided into a life estate and remainder interest.

Mrs. A, a nursing facility resident, has a life estate. She reports that the property held in the life estate was sold. Request documentation to determine if both the life estate and the remainder interest were sold, or if just the life estate or the remainder interest was sold.

If just the remainder interest was sold, Mrs. A continues to hold a life estate in the property. If both the life estate and the remainder interest were sold, Mrs. A is entitled to that portion of the sale proceeds that represent the value of the life estate. If only the life estate was sold, Mrs. A is entitled to all of the proceeds.
Life estates and remainder interests generally count as resources for eligibility purposes. However, if the underlying property would be exempt, the life estate or remainder interest is also exempt. For example, exclude real property in a life estate as a homestead if the owner of the life estate lives in the dwelling, or if the other exclusion policies for a homestead apply. See Property in a Homestead.

The value of a life estate or remainder interest depends on the value of the underlying property and the life expectancy of the person whose life controls it (the original holder of the life estate).

If the life controlling the life estate is likely to be short, the value of the life estate is smaller and the value of the remainder interest greater. Conversely, if the life controlling the life estate is likely to be long, the value of the life estate is greater and the value of the remainder interest smaller.

To determine the value of a life estate or remainder interest, first determine the fair market value of the entire underlying property (as if it was not divided into a life estate and remainder interest) from a disinterested, knowledgeable source. This determination is made as for any other undivided property.

For real estate, the fair market value of the underlying property is the amount it could be sold for on the open market. A disinterested, knowledgeable source can be a real estate broker, Farmer’s Home Administration, bank, mortgage company, or other lending institution.

For liquid resources such as a certificate of deposit or bank account, the fair market value is the amount that would be received if the resource were cashed in.
To determine the value of the life estate when the client is the life estate holder:

1. Determine the fair market value of the entire underlying property (as if it was not divided into a life estate and a remainder interest).

2. Find the line on the life estate column corresponding with the age of the person whose life controls the life estate (the original holder of the life estate) as of the date for which a value is being determined.

3. Multiply the fair market value by the figure in the life estate column.

To determine the value of the remainder interest when the client is the remainderman of a life estate:

1. Determine the fair market value the entire underlying property (as if it was not divided into a life estate and a remainder interest).

2. Find the line on the remainder column corresponding with age of the person whose life controls the life estate (the original holder of the life estate) as of the date for which a value is being determined.

3. Multiply the fair market value by the figure in the remainder column.

If the client maintains that the life estate or remainder interest cannot be sold for the amount determined using the table, the client must present other evidence to support this.

The client must obtain a statement from a disinterested, knowledgeable third party stating the value of the life estate or remainder interest. This could be a financial institution or a business that buys life estates, remainder interest, or contracts.
If the client provides such statements, determine the value of the life estate or remainder interest based on all the available evidence, including the value given by the table.

A disinterested, knowledgeable source may establish that a life estate or remainder interest has no value if it could not be sold at any price. Obtain verification of the value of the life estate or remainder interest valued at zero with each annual review.

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<th>Life Estate</th>
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### Unisex Life Estate or Remainder Table

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Source: 49 Federal Register/Vol. 49 No. 93/5-11-84
Table -- Unisex Life Estate or Remainder Table.
Loans and Promissory Notes

Any amount that is borrowed through a loan is a resource if it is retained into the month following the month the loan is received.

When an applicant or recipient makes a loan to another person, determine the resource value of the loan or promissory note. The loan or promissory note can be sold or transferred from one person to another. The resource value is the amount a disinterested third party would pay to receive the balance of the payments on the loan or promissory note.

Loans and promissory notes must also be reviewed to determine if use of the funds to purchase or make the loan constitutes a transfer of assets for less than fair market value. See Transfers That Cause a Medicaid Penalty.

Mortgages and Contracts

Count mortgages and contracts as resources. The countable value of a mortgage or contract is:

- The remaining balance on the contract; or
- The gross price for which it can be sold or discounted on the open market minus any legal debts, claims, or liens against the property.

Offer the client the opportunity to:

- Show that a contract is not legally transferable; or
- Establish the fair market value of the contract.

The fair market value of a mortgage or contract is the amount that the buyer would pay the seller for the mortgage or contract. To establish the fair market value of the contract, tell the client to obtain three written estimates of the mortgage or contract value.

Inform the client that obtaining outside estimates of the market value could increase or decrease the countable value of the resource. The institutions from which the estimates are obtained do not need to be in the area where the property is located.
The fair market value must be determined as the contract or mortgage stands, without any modification or conditions. However, the following conditions to a valuation are acceptable and do not prevent it from being a bona fide estimate of fair market value:

- Establishment of ownership.
- Production of abstract.
- Payment of filing fees. Deduct filing fees from the value of the contract.

Average the estimates provided by the client. If you receive only one unbiased estimate, use that value.

Make sure the financial institution is stating the actual worth of the contract and not an opinion on whether it wishes to buy the contract. Do not use the valuation of a contract to determine eligibility if it contains conditions such as:

- Credit approval of the buyer (unless there has been a recent credit approval of the buyer known to the client).
- Changes in the terms of the contract.
- Appraisal of the property at or above a particular value (unless there has been a recent appraisal at or above the stated value).

If a contract is jointly owned, the client’s interest may be sold without the consent of the other owner. In Iowa, real property mortgages and contracts are usually legally transferable, even if the terms of the contract or mortgage prevent it. Although such terms are not legally enforceable, a nontransferable clause or an uncooperative co-owner may affect the fair market value.

If the contract is a countable resource, the portion of a mortgage or contract payment that represents interest, minus any interest used to purchase the property, is counted as unearned income. The principal portion of the payment is treated as a resource.

If the contract is not a resource and the principal is not treated as a resource, count the total payment on the contract as income.
Mr. H bought a property on contract that he is selling on contract. The value of the second contract is established at $1,500. He has a checking account that had $100 the first moment of the first day of the month, and no other resources. Mr. H is within resource limits.

Mr. H receives $150 per month payment from the contract. Of the $150 payment that he receives, $40 a month is interest.

He pays $12 a month interest in his payment for the property. The countable interest income for eligibility and client participation is $28 per month. ($40-$12=$28) The remaining $110, if retained is counted as a resource.

Mortgages and contracts must be reviewed to determine if the purchase constitutes a transfer of assets for less than fair market value. See Purchases Considered a Transfer of Assets for Less Than Fair Market Value.
Exclude the following federal payments:

- Income from any of the programs established under ACTION, Public Law 93-103, unless the director of the ACTION agency determines that the hourly rate is equal to or over the minimum wage. (So far, the director has never made this determination. Central Office will contact staff if that ever happens.) Programs under ACTION include:
  - University Year of Action (UYA).
  - Volunteers in Service to America (VISTA).
  - Foster Grandparents.
  - Retired Senior Volunteer Program (RSVP).
  - Senior Companion Program.
  - Special and Demonstration Volunteer Program.

- **Agent Orange Settlement Fund** payments or payments from any other fund established because of the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y).

- Dividend payments on shares of the **Alaska Native Fund**, and other revenue originated from the fund. The Alaska Native Fund was created by the Alaska Native Claims Settlement Act (Public Law 92-203), enacted on December 19, 1971.

- **Austrian Social Insurance** payments based partly or completely on wage credits granted under paragraphs 500-506 of the Austrian General Social Insurance Act. Use the award letter to determine how to count the payments.

- **Energy Employees’ Occupational Illness Compensation Program** payments made to former employees or their families. Beneficiaries will receive one or two lump sum payments, which are excluded as income and as a resource. Award letters sent to the recipient from the Department of Labor should verify the amount and source of the payments.

- **German Reparations** payments made to survivors of the Holocaust under the Federal Republic of Germany’s Law for Compensation of National Socialist Persecution, whether they are paid periodically or in a lump sum.
♦ **Japanese-American (or their survivors) and Aleut restitution** payments made by the U.S. Government to people who were interned or relocated during World War II.

♦ **Japanese-Canadian restitution** payments from the Canadian Government to Japanese-Canadians who were interned or relocated during World War II. Use documents from the client to identify or verify the nature of the payments.

If the client has no documents, ask if the client was imprisoned, relocated, deported, or deprived of other rights in Canada during the period of December 1941 to March 1949 because of Japanese ancestry. If yes, exclude the payment. If no, count the payment as a resource.

♦ **Radiation Exposure Compensation Act** payments that compensate persons for injuries or death resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person’s death, payments are made to the surviving spouse, children, or grandchildren. Any interest on these funds is counted as income.

♦ **Relocation Assistance** payments provided to owners, tenants, or occupants who were displaced when property was acquired by a federal, state, or local government-assisted project.

### Plan for Achieving Self-Support (PASS)

Excluding resources of a blind or disabled recipient under the age of 65 if they are needed to fulfill a plan for achieving self-support (PASS). People 65 or over get this exclusion only if they were receiving SSI payments because of blindness or disability in the month before they turned 65. Check the SDX when an SSI recipient states that a plan for achieving self-support exists.

### Property Necessary for Employment

Excluding any tools, equipment, and uniforms necessary for a client’s employment. The client must give you a signed statement listing the items required. If necessary, contact the employer for verification.
Property in a Homestead

Exclude a homestead as a resource regardless of value. A homestead is any shelter used as the principal place of residence by the client, spouse, or dependent (including a child under age 18 or the disabled adult child of the client or spouse). It includes surrounding contiguous land and any buildings on this land. It may be fixed or mobile and located on land or water.

Mr. K owns and operates the 80-acre farm on which he lives. The house, farm buildings, and farmland are exempt from consideration as a resource.

Mrs. Z owns 20 acres that is considered a homestead. Mrs. Z builds a second house and rents out the first house. Both houses are exempt as a resource because they sit on one contiguous homestead property.

Exclude the proceeds from the sale of the homestead (including homesteads sold on contract) for up to three months if the client intends to purchase another home. Ask the client to sign a statement such as the following:

“On ___(date)___ I received $___________ net proceeds from the sale of my home. I plan to use that money to replace that home with another home within three months, by ___(date)___.”

The client must report the date the new home is purchased and the purchase price. Count any excess proceeds from the sale of the old homestead that are not used to purchase the new homestead.

The homestead is sold for $45,000 on December 2. A new home is purchased on February 16 for $35,000. The $10,000 difference is a countable resource on March 1.

If the proceeds are not used within three months to buy another homestead, count the proceeds as a resource at the end of the three-month period.
Also exclude a homestead as a resource if it is not occupied by the client because of a temporary absence, such as a trip, visit, stay in a residential care facility or medical institution.

To be excluded, the client must intend to return to the home. If the client does not intend to return, the property becomes a nonhomestead property, and is countable.

Obtain a signed statement from the client or the client’s representative that the client intends to return home. Place the statement in the case record. If the statement contradicts previous statements by the client or representative regarding intent to return home, obtain additional verification from a knowledgeable source.

Also exclude a homestead if it is occupied by the client’s spouse or dependent relative while the client is absent. The dependency can be emotional, financial, or medical. If the dependent receives FIP assistance, the person can still be considered financially dependent on the client. Accept the client’s statement that the relative is dependent unless you have reason to question it.

“Dependent relative” includes:

♦ Child, grandchild, stepchild.
♦ Mother, stepmother, father, stepfather.
♦ Sister, stepsister, brother, stepbrother.
♦ Aunt, uncle, niece, nephew.
♦ Grandmother, grandfather.
♦ In-laws.

Effective January 1, 2006, a person is not eligible for payment of their nursing facility services or other long-term care services, if their equity interest in their home exceeds $500,000. This limit does not apply if the spouse, or child who is under age 21, or the person’s child who is blind or disabled, as defined by Social Security, resides in the home. The limit does not apply to people approved based on an application or request for payment of long-term care services filed before January 1, 2006.
**Property Earning Six Percent of Equity**

20 CFR 416.1201

Exclude real property as a resource if its equity value does not exceed $6,000 and the rate of return (net equity) earned on the property is at least six percent. *Equity* is the current market value of the property minus any legal debt on the property. *Market value* is the amount an item can be sold for on the open market.

If the client’s equity in the property exceeds $6,000 and the property is earning at least six percent of equity, count only the amount of equity over $6,000 as a resource.

If the property is not producing six percent of equity due to illness of the client, exclude it as a resource for up to 24 months, as long as the client plans to resume the business after the illness ends.

**Property Used for Self-Support**

20 CFR 416.1210

Exclude equity in non-income-producing real property that is valued under $6,000 and produces goods and services necessary to the client’s daily living. Liquid resources used for self-support are **not** excluded.

**Resource Replacement**


Exclude cash received for the replacement or repair of an excluded resource. Do not count the cash or the interest earned on the cash for nine months from the date it is received.

If the replacement or repair takes longer because of circumstances beyond the control of the client, exclude the cash for an additional nine-month period. Count it as a resource the first moment of the next month after the second nine-month period expires.

**Retirement Funds**


Exclude retirement funds if the client has to quit a job to withdraw the funds.

If the retirement funds are not excluded, count the verified net proceeds after penalties and taxes.

**Retroactive Cash Payments**

P.L. 101-508

Exclude any retroactive cash payments paid to ineligible spouses or parents for providing in-home supportive services to the client. Exclude the payments in the month of receipt and the following month.
Retroactive SSI and Social Security Lump-Sum Payments
20 CFR 416.1233

Exclude SSI and Social Security retroactive lump-sum income for nine months after receipt, as long as the funds are not combined with other funds and can be identified as the lump-sum funds.

Verify that the funds are separate and represent a retroactive lump sum. Before the ninth month, the recipient must again verify resources. If resources exceed the limit, cancel the recipient, giving timely notice.

An unmarried client receives a social security lump sum of $4,500 on October 12. The worker inputs a tickler for June 1. On June 19, the worker verifies the resources are $2,600.

On July 30, the client is canceled and is ineligible for SSI-related coverage groups that have a $2,000 resource limit. The worker completes a redetermination. Effective August 1, the client is eligible under Medically Needy.

Self-Employment
Property and Resources
P.L. 101-239

Exclude self-employment resources of the client, spouse, parent, or alien sponsor. Examples of self-employment resources are:

- Real property, buildings.
- Inventory, equipment, machinery.
- Farm equipment, livestock.
- Motor vehicles.
- Tools.

If the homestead is used as the place of self-employment, exclude it as a home and not as a self-employment resource.

If you question whether a resource is used for self-employment or is the client’s personal property, ask the client to sign a statement stating whether the resource is necessary for the self-employment. Allow the exclusion if client states the resource is necessary.

Exclude liquid resources valued up to three times the client’s average monthly expenses for self-employment. If the client can prove more than three times this amount is needed during certain months, i.e., for seasonal business, exclude the amount needed.
Continue to allow the exclusion if:

♦ The business is operating at a loss.

♦ An illness or disability prevents the continuation of the self-employment business. This exclusion cannot exceed two years.

♦ The business is seasonal and the client is not currently working but is expected to return within one year after the last day of use.

1. Before Mrs. B entered a nursing facility, she and her husband farmed together. Mr. B continues to farm. The resources necessary for self-employment, such as the animals, truck, and farm machinery, are not countable for attribution or eligibility determination. They are exempt as resources owned by the spouse necessary for self-employment.

2. Mr. and Mrs. W are farmers. They apply for Medically Needy and list livestock, a tractor, a combine, a car, two trucks, and a bank account as necessary for self-employment. All of the resources are determined to be necessary for self-employment, and are not counted.

Excluding payments for social service expenses for the month of receipt and the month after the month of receipt. If the funds are a reimbursement for bills previously paid by the client, count them as a resource in the month after receipt.

Do not count funds received to pay for a medical service. These funds are exempt as a resource the month of receipt and the month after the month of receipt. If the funds are repayment for bills already paid by the client, count the funds as a resource the month after receipt.

Social Services
20 CFR 416.1201, 416.1210, 416.1228, 416.1232, 416.1236; P.L. 101-508

Third-Party Medical Payments
20 CFR 416.1201, 416.1210, 416.1228; P.L. 101-508
Vehicles

20 CFR 416.1218

A vehicle is any device used to provide transportation, such as cars, trucks, boats, animals, animal-drawn devices, mopeds, etc. Vehicles can be unregistered or in need of repair, as long as the vehicle is used for transportation. Treat vehicles as follows:

1. Exclude one vehicle as a resource if it is:
   - Necessary for employment of the client or any household member.
   - Modified for operation or transportation of a handicapped person in the household.
   - Needed because of climate, terrain, or distance to perform essential daily activities.
   - Necessary for treatment of a specific or regular medical problem of the client or any household member.
   (This means it is used at least four times a year to obtain prescription drugs, counseling, or treatment, including osteopathic, chiropractic, and Christian Science practitioners. Shopping trips to buy nonprescription items, trips for routine physical exams, and visits to the dentist for routine checkups do not qualify.)

2. If no vehicle is excluded under step 1, exclude the current market value (CMV) of one vehicle per household up to a limit of $4,500. Count any amount above $4,500.

3. Count the equity value of any other vehicles.

4. Count the equity value of any vehicles used solely for purposes other than transportation, such as racing cars or antiques toward the resource limit. These vehicles are personal property, not household goods.

Do not count any vehicle that the client sold, even if the buyer has not recorded the title transfer with the appropriate authority.
To determine the value of vehicles, use a “blue book,” such as the National Automobile Dealers Association (NADA) *Used Car Guide Book*.

Find the amount listed in the column for “average trade-in value.” To find the specific value of the vehicle, use the value corresponding to the options that the vehicle has. If the vehicle is not listed in the “blue book,” contact a motor vehicle dealer or knowledgeable source in the community.

**Victim’s Compensation Funds**

Explain for nine months funds paid through the Crime Victim Reparation program. The Iowa Department of Justice administers this program, which compensates victims of crime for expenses incurred or losses suffered as a result of a crime. The funds should be separate and identifiable.

Expenses paid by the Crime Victim Reparation Program include:

- Medical bills.
- Lost wages.
- Loss of support.
- Clothing held in evidence.
- Counseling.
- Burial.
FMAP-RELATED RESOURCE POLICIES

Legal reference: 441 IAC 75.13(1), 75.9(249A), 75.15(249A), 75.56(249A)

Use FMAP-related policies regarding excluded resources, countable resources, and whose resources to consider when determining the resource eligibility of FMAP-related clients.

Use FMAP-related policy to determine the value of the client’s property and consider the property for Medicaid eligibility. Exclude nonhomestead property that produces income which is consistent with its fair market value and nonhomestead property that is up for sale at a price that is consistent with its fair market value. “Fair market value is the gross price for which the property could be sold on the open market.”

1. Ms. A and her children apply for FMAP. Ms. A owns nonhomestead real property valued at $40,000. The worker explains to Ms. A that this property will be considered an accessible resource for her eligibility unless she either lists it for sale at a price that is consistent with the fair market value or it produces income which is consistent with the fair market value.

   Ms. A chooses to list the property for sale at a fair market value and is approved for FMAP, as she meets all other eligibility factors.

2. Mr. L and his children receive FMAP. Mr. L inherits nonhomestead real property valued at $25,000 and timely reports this to his worker. The property has been a rental property and currently has a tenant paying rent. The worker verifies that this property is producing income consistent with the fair market value. This property is exempt and Mr. L continues to receive FMAP.

3. Same as Example 2, except that this property is being rented to a relative and the income it is producing is not consistent with the fair market value. Mr. L chooses not to increase the rent. Mr. L’s FMAP assistance is canceled effective the first of the next month allowing a 10-day notice. However, Mr. L’s children remain eligible since resources are not considered in determining FMAP-related eligibility for children. The children are now eligible under CMAP.

Use general Medicaid policy on trusts. Even though a trust may not be considered for the FIP determination, persons eligible for FIP who have a trust may not be eligible for Medicaid.
Ms. C and her son apply for FIP and Medicaid. Ms. C reports she is the beneficiary of a trust with a current principle of $55,000. The trust principle is not countable as a resource for FIP and the trust is not paying out any income to Ms. C. However, the trust is a Medicaid qualifying trust and therefore, countable for Medicaid.

The application is approved for FIP, but, since Ms. C’s countable resources exceed the resource limits of all Medicaid coverage groups, the application is denied for Medicaid for Ms. C. Ms. C’s son would be eligible for CMAP. It does not matter that Ms. C is a FIP participant.

A transfer of assets between persons who are not spouses results in ineligibility for Medicaid payment for all long-term-care services. A claim may be established against the transferee. See TRANSFER OF ASSETS for more information about eligibility.

Since transfers between spouses do not result in a penalty, a transfer of assets made by the stepparent to the spouse in order to qualify the group for FMAP does not disqualify the persons in the assistance unit from payment of nursing facility services.

A transfer of assets does not cause a period of ineligibility for specific Medicaid services for children when the children are eligible in a coverage group in which household resources are disregarded in determining children’s eligibility.

Eligibility for Medicaid payment of nursing facility services for persons in the household is not affected by a transfer of assets made by self-supporting parents. The self-supporting parents’ income is considered in determining Medicaid eligibility but their needs are not included in the eligibility determination. Remember, the resources of self-supporting parents are not included in the eligibility determination.

Parents who are not eligible for Medicaid, such as sanctioned parents, are included in the household size. Ineligible parent’s assets are considered when determining FMAP eligibility for adults. Therefore, if assets of ineligible parents are transferred to persons other than their spouse, the transfer affects the eligibility for certain Medicaid services, for adults in the assistance unit.

Mrs. A transferred five acres of land to her brother in September. She applied for Medicaid for herself and her three children in October. The application was approved on October 26 but denied Medicaid payment for certain services for Mrs. A.

On December 14, Mrs. A enters an NF, after being injured in a car accident. She is expected to return home within one year. Mrs. A is ineligible for Medicaid payment of NF care.
FMAP-Related Resource Limits

**Legal reference:** 441 IAC 75.9(249A), 75.56(249A)

For FMAP and FMAP-related Medicaid coverage groups, use FMAP resource limits:

- For an applicant filing unit, the resource limit is $2,000.
- For a recipient filing unit, the resource limit is $5,000.
- For transitional Medicaid, resources are not considered.
- $10,000 in liquid resources is the resource limit for the Mothers and Children coverage group. See 8-F, *Mothers and Children (MAC) Program*.
- $10,000 in liquid resources is the resource limit for FMAP-related Medically Needy. See 8-J, *MEDICALLY NEEDY*.

When using the FMAP resource limits, apply the $2,000 resource limit for each month of the retroactive period and for the month of application (even if retroactive Medicaid eligibility is established).

Apply the $2,000 limit when a person enters a household receiving Medicaid but is not in the same filing unit. Once the applicant becomes a recipient, the resource limit increases to $5,000.

Allow the $5,000 resource limit when:

- A recipient leaves one coverage group to enter another coverage group.
- A person enters an existing Medicaid-eligible unit.

1. Mrs. K and her two children receive FMAP. The father of the children returns home. Because he is a mandatory household member and because he is entering an existing Medicaid-eligible group, he is subject to the $5,000 resource limit.

2. Mr. P and his child apply for FMAP on January 2. Mr. P requests retroactive Medicaid for the three months before the month of application (October, November, and December). His resources are as follows:

<table>
<thead>
<tr>
<th>Month</th>
<th>Resources</th>
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<tbody>
<tr>
<td>October</td>
<td>$1,700</td>
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<td>November</td>
<td>$1,800</td>
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<tr>
<td>December</td>
<td>$1,900</td>
</tr>
<tr>
<td>January</td>
<td>$2,100</td>
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</tbody>
</table>
If all other eligibility requirements are met, Mr. P is resource eligible in the retroactive period because his resources do not exceed $2,000. A decision on his application is made in January and is denied for ongoing Medicaid, because he is over the $2,000 resource limit for January.

The resource limits apply to the entire eligible group. The data processing system determines whether to apply applicant or recipient limits according to the system entries you make. If system entries indicate an applicant household, the system looks at each person’s status in the month before the month of application. If the system finds an active FMAP or CMAP status for any member of the household for the month before the month of application, it applies the $5,000 recipient resource limit.

The system is not able to determine whether the Medicaid assistance received in the month before the month of application is subject to recoupment. Households are not considered recipients for a month of recoupment and thus are not entitled to the $5,000 recipient limit.

Therefore, when you approve a reapplication for a household that has countable resources in excess of $2,000 and received Medicaid in the month before the month of application, determine if that month’s medical is subject to recoupment. If so, make system entries (RSCM - “A” for applicant) to override the system-determined $5,000 recipient limit. This results in the system applying the $2,000 applicant limit, as required in such a situation.

1. Mr. D and his children are canceled from FMAP effective August 1. He reapplies on November 2. He has $3,000 in countable resources. On November 22, the worker, in error, enters a “P” for participant on the resource screen that causes the system to apply the $5,000 resource limit for recipients rather than the $2,000 limit for applicants.

Since it is past timely notice to cancel for December, the worker cancels FMAP effective January 1. An automatic redetermination is completed for the children under CMAP and for Mr. D under Medically Needy.

2. Same as Example 1, except on December 1, Mr. D verifies that his resources are $1,800. Mr. D is eligible for FMAP in December and ongoing. However, for November his children are eligible for CMAP and he is eligible for Medically Needy.
3. Family A is approved for FMAP effective October 12. The following March, the worker discovers that the family had these amounts in a savings account that the family had failed to report: October, $2,500; November, $2,500; December, $1,800; January, $2,400; February, $2,300; March, $2,400.

The adults were totally ineligible for FMAP in October and November, because their countable resources exceeded the $2,000 applicant limit. Complete an automatic redetermination to CMAP and Medically Needy. However, in December, the family was eligible, because their countable resources were below the $2,000 applicant limit.

Once eligibility is established, the $5,000 resource limit for recipients applies. Therefore, Family A continues to be eligible in January, February, and March.

An applicant becomes a recipient when the application is approved on the system, regardless of whether the date of decision is in the month of application or the following month. Therefore, apply the applicant limit through the month of decision. Apply the recipient limit beginning with the month after the month of decision.

1. Ms. A applies for Medicaid on October 15. The worker approves the application on November 12. The $2,000 applicant limit under FMAP applies to October and November. The $5,000 recipient limit applies beginning with the month of December.

2. Mr. B and his children apply for Medicaid on October 12. The worker makes the decision on November 8. In October, the applicant’s countable resources were $1,800. On the date of decision, Mr. B’s resources are $2,100. Mr. B is eligible for FMAP for October but is ineligible for FMAP for November unless he can establish resources were below the limit any time in November before the date of decision. Eligibility under Medically Needy needs to be examined for Mr. B. Mr. B’s children are eligible for CMAP.

Countable Resources

Whose Resources to Count

Legal reference: 441 IAC 75.56(249A), (2)

Count the resources of all persons in the eligible group. Include the resources of a parent who is living in the home with the eligible children but who is not a member of the eligible group (e.g., excluded parent).
Do not consider the resources of:

♦ An ineligible stepparent living in the home.
♦ A Supplemental Security Income (SSI) recipient.
♦ A self-supporting parent when determining eligibility for the minor parent’s child.
♦ An ineligible child living in the home. This means a child who is not included because the child receives subsidized adoption assistance.

Note: For more information on determining a child’s eligibility, see RESOURCE ELIGIBILITY OF CHILDREN.

What Resources to Count

Legal reference: 441 IAC 75.56(249A)

Unless specifically exempt, all resources are considered countable.

When an applicant or recipient leaves employment and receives a lump-sum payment from the employment retirement fund, count the employee’s portion, plus accumulated interest, as a resource. See 8-E, Nonexempt Lump Sums, regarding the employer’s share of the retirement fund.

The following table lists examples of countable and exempt resources:

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<tr>
<th>Resources</th>
<th>FMAP</th>
<th>MAC/Medically Needy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash on hand</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Money in checking or saving accounts</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Stocks (Use the closing price as of the date of decision or time of review.)</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Bonds (Use the redemptive value as of the date of decision or time of review.)</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Certificates of deposit</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Resources</td>
<td>FMAP</td>
<td>MAC/Medically Needy</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>A Medicaid qualifying trust whether trustee makes it available or not. If principal can be made available under discretion of trustee.</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Mutual funds</td>
<td>Countable</td>
<td>Countable</td>
</tr>
<tr>
<td>Retirement accounts (IRAs, Keoghs, 401Ks, IPERS)</td>
<td>Countable</td>
<td>Exempt</td>
</tr>
<tr>
<td>Promissory notes, mortgages and contracts</td>
<td>Countable</td>
<td>Exempt</td>
</tr>
<tr>
<td>Bank accounts used <strong>solely</strong> for a self-employment business</td>
<td>Countable</td>
<td>Exempt</td>
</tr>
<tr>
<td>Net market value of available nonhomestead real property (see Determining Net Market Value of a Countable Resource)</td>
<td>Countable</td>
<td>Exempt</td>
</tr>
<tr>
<td>Cash value of life insurance. This is the amount the insurance company pays upon borrowing against or canceling the policy before death. Use form 470-0444, Insurance Report, to obtain the client’s authorization to verify the amount of cash value and that the client has ownership or access to this cash value.</td>
<td>Countable</td>
<td>Exempt</td>
</tr>
<tr>
<td>Employee’s portion plus accumulated interest of a lump sum payment from the retirement fund when a client leaves employment.</td>
<td>Countable</td>
<td>Exempt</td>
</tr>
<tr>
<td>Motor vehicles (see Vehicles)</td>
<td>Countable</td>
<td>Exempt</td>
</tr>
</tbody>
</table>

Exempt one motor vehicle per household.
Count a resource only when:

♦ The applicant or recipient owns the property in part or in full and has control over it (meaning it can be occupied, rented, sold, etc. at the client’s discretion).

♦ The applicant or recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available.

Determine the availability of a resource regardless of the equity (net market) value.

An applicant or recipient need not gain title and control of an unavailable resource. Consider a resource unavailable when the client owns it in part or in full but has no control over it.

**Joint Ownership**

**Legal reference:** 441 IAC 75.56(249A), (6)

When a resource is owned by more than one person, assume everyone has equal shares unless you have verification to determine that the shares are different.

If an applicant or recipient owns a resource with another person but indicates that ownership is not equal, get a release signed so you can ask the co-owner to provide a written statement specifying the intent, degree, and terms of the joint ownership.

The intent of the co-owner is important. If the co-owner does not intend to provide the client access, the resource is unavailable. Examples include:

♦ An elderly parent of a FMAP recipient who has a joint account with the recipient in the event the parent becomes disabled.

♦ An adult child (a FMAP recipient) who is added to the title of a parent’s home for ease of transfer in the event the parent should die.

In cases such as these, ask the other owner to write a statement indicating whether or not the Medicaid recipient has access to the account. If the statement indicates no access to the resource, consider it unavailable. Periodically check the availability of the resource.
If the client has joint ownership or tenancy-in-common ownership:

1. Determine the equity (net market) value of the total resource. If the total value plus other resources owned by the client are less than resource limits, take no further action.

2. Determine the client’s share of the total equity (net market) value of the jointly owned resource. If the client’s share plus other resources owned by the client are less than the resource limit, take no further action.

3. If the client’s share of the equity value would affect eligibility, contact the co-owner to determine if the co-owner would be willing to sell the resource. If so, count the client’s share of the total equity value.

4. If the co-owner refuses to cooperate in the sale of the property, determine the equity (net market) value of only the client’s share. The client must provide a written estimate of the value from a knowledgeable source.

The source must consider local market conditions as well as the condition and location of the resource. The source must also consider that the client has only a partial interest and that the co-owner refuses to sell.

If the estimate provided by the client appears reasonable, accept it. If the estimate is questionable, ask the client to sign a release of information so that you can independently verify the estimate.

5. Approve assistance, if otherwise eligible, when the equity value of the client’s share in combination with other resources does not exceed resource limits. Deny or cancel assistance if that equity value, in combination with other resources, exceeds resource limits.

If the client disagrees with your decision, ask the client to supply additional information regarding the availability or value of the property.

If you are not able to determine availability, refer the case to central office staff on form Adm-4209-0, Clarification Request.
Determining Net Market Value of a Countable Resource

Legal reference: 441 IAC 75.56(5)

Determine the net market (equity) value of countable resources only. The net market value is the gross price for which an item or property can be sold on the open market, less any legal debts, claims, or liens against it.

Consider each resource separately. The value of one resource does not affect another.

To determine the net market value:

1. Establish the gross sale price, called the “fair market value.” Consider local market conditions and the condition and location of the property in determining the fair market value. For example:
   ♦ A piece of real property may be worth less in one part of the state than a similar property is worth in another part of the state, due to a distressed local economy.
   ♦ A piece of property may be worth less than it was previously because of depressed market conditions.
   ♦ An item of real property may have a lower fair market value because of the location of that property (on a flood plain, remote location, etc.).

   Contact a source knowledgeable about similar property, such as a car dealer, stockbroker, realtor, or banker.

   If the client disagrees with the fair market value you determine, give the client an opportunity to provide written evidence of a different valuation.

2. Verify and subtract legal debts, claims, or liens, and document them in the case record. To be considered a lien or encumbrance against a resource, a loan or lien must give the creditor a legal right to satisfy the debt from the resource in question. In most cases, loans from family or friends do not meet this requirement.

   When there is a legal debt against a combination of exempt and nonexempt property, look at the terms of the loan to see if any of the debt is deductible.
♦ When the terms of the loan require the proceeds from the sale of any part of the property to be applied to the balance of the loan, deduct the total legal debt from the fair market value of the nonexempt property.

♦ When the terms of the loan place a lien against the exempt property only, there is no legal debt to apply in determining the net market value of the nonexempt property.

1. Mr. A owns a home on 80 acres of land outside a city plat. There is a lien of $20,000 on the total property. Proceeds from the sale of any part of the property must be used to reduce the balance of the loan. Deduct the entire $20,000 from the gross value of the nonexempt property.

2. Ms. B owns a home on one acre of land inside a city. There is a lien of $40,000 on the house and one-half acre. Do not deduct the $40,000 from the gross value of the nonexempt property.

The balance after subtracting debts from fair market value is the net market (equity) value. Count as “zero” a resource that has a negative net value (that is, the debt against the property is more than the fair market value). Do not assign a negative number to any resource.

Subtract the client’s expenses in selling the property only after it is sold.

**Contracts**

**Legal reference:** 441 IAC 75.56(249A), (4)

The resource value of a mortgage or contract is the gross price for which it can be sold or discounted on the open market, minus any legal debts, claims, or liens against it.

In Iowa, mortgages and contracts are always legally transferable, even if the terms of the contract or mortgage prohibit it. Although such terms are not legally enforceable in Iowa, they may affect the current market value of the contract or mortgage.

If the mortgages or contracts have terms that, as a practical matter, prevent sale, do not count them as resources.
Ms. B owns a contract with her two sisters, Ms. C and Ms. D. The terms of the contract prohibit any transfer or sale of the contract without approval of all of the siblings. Neither Ms. C nor Ms. D is willing to sell her shares or to buy Ms. B’s share.

In reviewing the contract, a knowledgeable source determines that the terms of the contract prevent the sale. Even though these terms are not legally enforceable, they affect the market value of the contract or mortgage. Therefore, the contract is considered to have a value of zero.

Consider any principal payments received on a mortgage or contract as a resource upon receipt. Consider the monthly interest portion of the payment as a resource effective the first of the month after the month of receipt. If the interest is prorated, exempt it for the number of months in which the interest is prorated.

**Determining Contract Value**

Ask the client for a written estimate of the mortgage or contract value. The estimate must be based on local market conditions and the condition and location of the property. If the estimate provided by the client appears reasonable, accept that value.

If you have more than one valuation, average the values.

Ms. A owns a contract. She obtained three written valuations: $925, $850, and $800. The worker averages the three evaluations ($925 + $850 + $800 = $2,575 divided by 3 = $858). The average value of $858 is considered the fair market value of the contract.

If you doubt the value of the estimate, or if the client cannot get one, ask the client to sign a release of information so that you can independently verify or obtain the estimate.

Obtain one or more estimates of value from sources knowledgeable in the business of buying and selling contracts. These sources do not need to be in the area where the property is located, but the source must consider local market conditions and the condition and location of the property when determining the value. Valuations must be based on the most complete information possible.

If the client disagrees with your estimate, allow the client to provide additional information.
Vehicles

Legal reference: 441 IAC 75.56(249A), (2) and (1)“e”

A vehicle is any motorized means of transportation that moves persons or articles from place to place. This includes automobiles, trucks, motorcycles, tractors, snowmobiles, recreational vehicles, campers, and motorized boats.

Vehicle Exemption

Legal reference: 441 IAC 75.56(1)

Exempt one motor vehicle without regard to its value. This exemption applies to each FMAP-related eligible group. Count the value of any additional vehicles owned by the eligible group, as described in Equity Exclusion.

See Determining Net Market Value of a Countable Resource for instructions on how to calculate net market value of a vehicle. Use a current “blue book,” such as National Automobile Dealer’s Association (NADA) Used Car Guide Book (Blue Book) to determine value of a vehicle. Find the amount listed in the left-hand column, entitled “Average Trade-In Value.” Do not increase the value because of low mileage or optional equipment. This is the value to use unless the client can establish a lower value.

If the vehicle is not listed in the Blue Book, contact a motor vehicle dealer in the community. Ask the dealer what the cash value would be of the same make, model, size, material, or condition as the client’s vehicle.

Special equipment that modifies a vehicle for a disabled person does not increase the value of the vehicle.

Equity Exclusion

Legal reference: 441 IAC 75.56(249A), (2) and (1)“e”

Exclude the equity value up to $4,435 per vehicle of each adult (including a needy non-parental relative) and working teenage child whose resources must be counted in determining eligibility. (The equity value limit changes effective July to reflect the latest increase in the consumer price index for used vehicles.)
The exclusion applies regardless of who owns the vehicle, as long as the owner is a person whose resources must be counted.

Do not allow an exclusion for additional vehicles over and above the number of exclusions to which the eligible group is entitled. When a person whose resources must be counted has multiple vehicles, apply the exclusion to the vehicle with the highest equity value. Allow the exclusion for a working teenager regardless of the teen’s age, whether the teen has a driver’s license or whether the car is needed for the teen to drive to work.

The exclusion for the teen continues when the teen is temporarily absent from the job for illness, vacation, between jobs or due to the nature of employment (for example, if the teenager works only during summer vacation). The exclusion does not apply to a teenager who is looking for work but has not been employed in the past.

Ms. A receives FMAP benefits for herself and three children. One teenage daughter is employed. The family owns four vehicles; the equity values are $10,000, $8,000, $5,000, and $500. The family has no other resources.

<table>
<thead>
<tr>
<th>Equity value</th>
<th>Vehicle 1</th>
<th>Vehicle 2</th>
<th>Vehicle 3</th>
<th>Vehicle 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exemption/exclusion</td>
<td>$10,000</td>
<td>$8,000</td>
<td>$5,000</td>
<td>$500</td>
</tr>
<tr>
<td>Excess resources</td>
<td>- 10,000</td>
<td>- 4,435</td>
<td>- 4,435</td>
<td>- 0</td>
</tr>
<tr>
<td>Excess resources</td>
<td>$ 0</td>
<td>$3,565</td>
<td>$565</td>
<td>$500</td>
</tr>
</tbody>
</table>

♦ The motor vehicle with the highest equity value is exempt.
♦ The vehicle exclusion for Ms. A and the employed teen is deducted from the two vehicles with the next highest equity values.
♦ Count the equity value of the lowest valued vehicle since there is no exclusion.

Ms. A’s countable resources of $4,630 are within the $5,000 limit for recipients.

If Ms. A were an applicant for FMAP, her resources would exceed the $2,000 limit. The children may be eligible under CMAP and Ms. A may be eligible under MN or IowaCare.

When the household has a vehicle that is used for the self-employment enterprise and also for personal use, apply the one motor vehicle exemption policy, the $10,000 exemption for capital assets, and the vehicle exclusion. See Self-Employment Assets.
Ms. A, an FMAP applicant, has the following assets: one camper with $12,000 equity value, one car with $5,000 equity value, $1,000 in savings, $200 cash value in an insurance policy, and $5,000 equity in tools needed for her self-employment.

<table>
<thead>
<tr>
<th>Countable Resources</th>
<th>Exempt Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 565 Equity in car</td>
<td>$12,000 Equity in camper (exempt one motor vehicle)</td>
</tr>
<tr>
<td>1,000 Savings</td>
<td></td>
</tr>
<tr>
<td>200 Cash value of insurance</td>
<td>$ 4,435 Equity in car</td>
</tr>
<tr>
<td>$ 1,765 Countable resources</td>
<td>$ 5,000 Equity in tools</td>
</tr>
</tbody>
</table>

Ms. A is resource eligible for assistance.

**EXEMPT RESOURCES FOR FMAP**

**Legal reference:** 441 IAC 75.56(249A)(1)(1)“e,” (2)(6)(8)(9)c”(2) and 75.57(6)

Some resources are always exempt under FMAP. However, for other resources, the exemption lasts only for the month of receipt and the month following the month of receipt. Any resources remaining are then counted towards the maximum resource limit.

The following resources are exempt in the month of receipt and perhaps in the following month of receipt. See individual sections for more information.

- Corrective payments.
- Earned income credit (EIC) payments.
- Property settlements.
- Insurance settlements and damage judgments.

A listing of exempt resources follows. These resources are **totally exempt** for FMAP.

Count any resources not in the exempt lists as well as the value of any resources exceeding the excluded amounts toward the resource limit.
### AIDS/HIV Settlement Payments

**441 IAC 75.56(249A)**

Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

### AmeriCorps

**Public Law 103-82, 441 IAC 75.57(6)“i”**

Exempt as a resource the living allowance (stipend) payments made to participants in the AmeriCorps*VISTA program as long as the Director of ACTION determines that the value of all such payments is less than either the federal or state minimum wage when divided by the number of hours the volunteer is serving.

To date, no AmeriCorps*VISTA payments have been determined by the Director to equal or exceed the minimum wage.

Exempt the educational award as a resource, because the award is issued directly to the educational institution or the holder of the loan and is not considered available to the recipient.

Also exempt as a resource the health insurance, reasonable accommodations, supplies, and services made available for AmeriCorps participants who have disabilities.

### Burial Plot

**441 IAC 75.56(1)“i”**

Exempt one burial plot for each member of the eligible group. A burial plot is a gravesite, crypt, mausoleum, urn, or other repository customarily used for the deceased’s remains.

When the client owns more than one plot for each member of the eligible group, count the net market value of the excess plots toward the resource limit. Also count the net market value of a burial plot for an ineligible person whose resources must be considered (e.g., an excluded parent).
### Burial Trusts or Funeral Contracts

441 IAC 75.56(1)“h”

Exempt equity not to exceed $1,500 in one burial trust or funeral contract for each member of the eligible group. Count any amount over $1,500 towards the resource limit, unless the contract or trust is irrevocable. (“Irrevocable” means that the contract or trust cannot be terminated or amended unless both parties to the contract or trust agree.)

Count burial trusts and funeral contracts held by an ineligible person whose resources must be considered (e.g., an excluded parent).

### Child Support $50 Exemption

441 IAC 75.57(6)“u”

Exempt the first $50 of a current monthly support obligation or a voluntary support payment from either a parent of a child in the eligible group or from a person who is under court order to pay support for a member of the eligible group. (A parent of a child is considered legally responsible, whether or not that parent is ordered to pay support.)

The maximum exempt amount is the lowest of the following:

- $50.
- The amount paid.
- The monthly obligation.

### Corrective Payments

441 IAC 75.56(1)“f”

Exempt retroactive FIP payments in the month received and in the following month.

### Current Month’s Income

441 IAC 75.56(1)“f”

Do not add current month’s income to the total countable resource amount for that month. This includes situations when you prorate lump-sum or self-employment income and project it as future months’ income. Exclude the prorated income from consideration as a resource during the period of months over which you prorate it and count it as income.

When you verify that a liquid resource amount includes current month’s income, subtract the income from the resource amount you count for the month. Count any income remaining after the month of receipt as a resource.
### EXEMPT RESOURCES FOR FMAP

**Disaster and Emergency Assistance Payments**

<table>
<thead>
<tr>
<th>Title 8 Medicaid</th>
<th>Iowa Department of Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter D Resources</td>
<td>EXEMPT RESOURCES FOR FMAP</td>
</tr>
<tr>
<td>Disaster Emergency Assistance Payments</td>
<td>Disaster Emergency Assistance Payments</td>
</tr>
<tr>
<td>441 IAC 75.57(6)“y”</td>
<td>August 17, 1999</td>
</tr>
</tbody>
</table>

Exempt disaster and emergency assistance payments as provided under the Disaster Relief Act of 1974, as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

This policy covers:

- Payments provided by the Federal Emergency Management Agency (FEMA), including payments from the Individual and Family Grant Program.

- Disaster unemployment benefits provided under the 1988 amendments to the Disaster Relief Act of 1974. Under this Act, unemployment benefits are provided to persons who are out of work due to a major disaster, including self-employed persons and others who are not covered under regular unemployment insurance benefits.

- Disaster and emergency assistance provided under the 1988 Amendments to the Disaster Relief and Emergency Assistance Act of 1974 and comparable assistance provided by states, local governments, and disaster assistance organizations.

Exempt vendor payments made under Iowa’s Emergency Assistance program.

Before exempting the payments verify the source.

### Domestic Volunteer Services Act

<table>
<thead>
<tr>
<th>Title 8 Medicaid</th>
<th>Iowa Department of Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter D Resources</td>
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<tr>
<td>Domestic Volunteer Services Act</td>
<td>Disaster Emergency Assistance Payments</td>
</tr>
<tr>
<td>441 IAC 75.57(6)“j”</td>
<td>August 17, 1999</td>
</tr>
</tbody>
</table>

Exempt payments from programs under Titles II and III of the Domestic Volunteer Services Act made to volunteers for support services or reimbursement of out-of-pocket expenses.

Programs under this act include:

- University Year for Action (UYA)
- Service Corps of Retired Executives (SCORE)
- Active Corps of Retired Executives (ACE)
- Foster Grandparents
**Earned Income Credit (EIC) Payments**

441 IAC 75.56(1)“l”

Exempt Earned Income Credit (EIC) payments in the month received as well as in the following month. Exempt payments in these two months whether they are received with a regular paycheck or in a lump sum as part of a federal income tax refund. Funds remaining are countable resources after the end of the second month.

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**Education Assistance**

441 IAC 75.57(6)“r”

Exempt all earned and unearned financial assistance for education or training.

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**Energy Assistance Payments**

441 IAC 75.57(6)“f”

Exempt energy assistance payments made to eligible households through the Division of Community Action Agencies of the Department of Human Rights under the Low-Income Home Energy Assistance Act of 1981 (LIHEAP). LIHEAP covers costs such as:

- Insulation.
- Home energy assistance.
- Emergency lodging because utilities have been shut off.
- Winterizing old or substandard dwellings. (Neither the cost of the materials nor the cost of labor is counted as a resource.)

Exempt other support and maintenance energy assistance when the assistance is based on need and is furnished by a:

- Supplier of home heating gas or oil, whether in cash or in kind.
- Municipal utility providing home energy, whether in cash or in kind.
- Private nonprofit organization, but only if the assistance is in-kind.
- Rate-of-return entity providing home energy, whether in cash or in kind. “Rate-of-return” means that revenues are primarily received from charges to the public for goods or services, and the charges are based on rates regulated by a state or federal agency.
“Support and maintenance” assistance is any assistance designed to meet day-to-day living expenses. This includes assistance to pay for heating or cooling a home.

“Based on need” means that assistance is issued to or on behalf of a person according to income limits at or below 150 percent of the federal poverty level.

There may be other assistance for home energy costs provided to FMAP households. When other assistance meets the criteria above, that assistance is also exempt.

**Family Support Subsidy Program**

441 IAC 75.57(6)“p”

Exempt Iowa Family Support Subsidy payments made to families with children who have special educational needs due to physical or mental disabilities. The purpose of the program is to reduce the need for out-of-home placements or to facilitate the return of the child from an out-of-home placement.

**Food Programs**

| 441 IAC 75.57(6)“b” through “e” |

Exempt the value of:

♦ Allotment paid under the Food Stamp Act.
♦ Commodities donated by the U.S. Department of Agriculture.
♦ Supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended, (Public Laws 92-433 and 93-150).
♦ Congregate meals or other benefits received under Title III-C, *Nutrition Program for the Elderly*, of the Older Americans Act of 1965.

**Grants**

441 IAC 75.57(6)“q”

Exempt grants obtained and used under conditions that preclude their use for current living costs.
Home Produce for Personal Consumption

441 IAC 75.57(6)“a”

Exempt the value of home-produced garden products, orchards, animals, etc., that are eaten by the household. When home produce is raised for sale or exchange, consider it a business operation and treat it as self-employment income.

Homestead

441 IAC 75.56(1)“a” & (3)

Exclude the client’s homestead without regard to its value. A homestead is any house, mobile home, or similar shelter used as the client’s home. It may contain one or more adjacent lots or tracts of land, including buildings and equipment.

A homestead may contain any type or number of buildings within the land limits described including:

♦ A duplex. (Exempt the entire duplex.)

♦ An apartment. (If the client lives in the building and does not sell any of the apartments, exempt the entire apartment house. Apartments include both standard buildings and single-family houses converted to apartments.)

♦ A family home containing a room or apartment. (If the client lives in one of the units, exempt the home.)

♦ A condominium or row house occupied by the client. (Exempt only the unit occupied by the client.)

There is a limit on the amount of land that may be exempted as part of the homestead:

♦ When outside a city plat, exclude no more than a total of 40 acres of land.

♦ Within the city plat, exclude no more than one-half acre of land.

To determine if the homestead within a city plat is within size limits, multiply the length of the property by the width to calculate the square footage. Compare this figure to 21,780 -- the number of square feet in one-half acre. If necessary, obtain courthouse or tax records to find the legal descriptions of the property.

Property that exceeds the allowable limit is counted as a resource.
Exempt a homestead when a client temporarily leaves if the client:

♦ Is absent for a defined purpose, and
♦ Lived in the home immediately before the absence, and
♦ Intends to return when the purpose of the absence has been accomplished.

Regularly document the client’s intentions to return home. If the client does not intend to return home, the homestead becomes a countable resource.

Do not apply the homestead exemption to nonhomestead property which the household acquires intending to make the property its homestead in the future.

**Homestead for People Requesting Long-Term Care Payments**

441 IAC 75.26

Effective January 1, 2006, a person is not eligible for payment of nursing facility services or other long-term care services if the person’s equity interest in the person’s home exceeds $500,000. For more information, see Property in a Homestead for People Requesting Long-Term Care.

**Household Goods and Personal Effects**

441 IAC 75.56(1)“b”

Exempt household goods and personal effects without regard to their value. Household goods are items used in and about the house in connection with home occupancy. They are items used to maintain the home as well as to accommodate, comfort, and entertain the occupants.

“Personal effects” are the belongings of family members, including clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

Animals, pets, and collections are not excluded and must be counted.

**Inaccessible Resources**

441 IAC 75.56(6)“a,” “c,” “d”

Exempt resources that are not available to the client. Examples of instances in which a resource is not available include:

♦ Property jointly owned by spouses involved in a divorce proceeding. The property is not available until a decision on property distribution has been made.
♦ Real or personal property in which the terms of the joint tenancy or tenancy in common make the property unavailable. See Joint Ownership.

♦ Nonhomestead property jointly owned by a FMAP parent and a separated or divorced spouse or a deceased spouse’s estate, when the parent is not able to have control of it. This may occur because the other owner has possession of the property or because it is in litigation.

♦ Nonhomestead property for so long as the property is publicly advertised for sale at an asking price consistent with its fair market value. To verify that the property is up for sale at fair market value, use collateral contacts and documentation, such as newspaper ads or real estate broker listings.

**Income in Kind**

441 IAC 75.57(6)”o”

Exempt as a resource unearned income-in-kind such as money paid on a client’s behalf to a third party (vendor payments). Also exempt earned income in-kind, such as meals, reduced rent received in exchange for performing work or a service.

**Indian Tribe Judgment Funds**

441 IAC 75.57(6)”h”

Exempt as a resource Indian tribe judgment funds that have been or will be distributed to each member or held in trust for members of any Indian tribe.

When all or part of the payment is converted to another type of resource, also exempt that resource. If this resource decreases in value, the exemption applies to the remaining value of the resource. If the resource appreciates in value, only the original amount is exempted.

**Individual Development Accounts**

441 IAC 75.56(1)”m” & 75.57(6)”ab”

Individual Development Accounts (IDAs) are optional, interest-bearing accounts much like IRAs. IDAs encourage families to save and plan for the future, without the savings affecting eligibility for assistance. The accounts allow withdrawal without penalty for items such as educational expenses, business start-up, home ownership, and emergencies.
Exempt the balance in an IDA and any interest applied to the account.

**Insurance Settlemnts and Damage Judgements**

441 IAC 75.56(7)

Consider insurance settlements and damage judgments received for damage or destruction of an **exempt or nonexempt** resource as liquidating a resource and not as income.

When the client intends to repair or replace the resource, and signs a legal, binding commitment no later than the month after the payment is received, exempt the payments for the duration of the commitment (up to eight months following the commitment date).

For example, if a homestead is damaged by fire, the client must commit any settlement funds in excess of resource limits in a binding contract to rebuild or repair the home to avoid being over the resource limit.

Document the settlement and the legal commitment in the case record.

If the client does not intend to repair or replace the home, or the payments are for a **nonexempt** resource, count the amount of the settlement as a resource in the month following the month payment was received.

**Life Estates**

441 IAC 75.56(1)“k”

Exclude a life estate of the life estate holder. A life estate is defined as the ownership of the right to live on, use, or receive income from a property in which the person does not have full rights of disposition. The life estate holder may use the property but may not alter or transfer it.

Exclude any interest in a property held by an applicant or recipient when another person holds the life estate until the holder dies or surrenders the life estate to the client.
Life Insurance With No Cash Surrender Value
441 IAC 75.56(1)“c”

Exclude any types of life insurance that have no cash value, such as term insurance or group insurance. The owner of the life insurance policy is the person paying the premium who has the right to change the policy.

The cash surrender value of insurance is generally available to the premium payor, unless it is assigned or in some other manner actually transferred on the records of the insurance company to the insured or other named person. Do not automatically assume that the client does not own the policy simply because another person is paying the premium.

Loans
441 IAC 75.57(6)“v”

Exempt bona fide loans. A bona fide loan is one that includes an agreement between the lender and the borrower that the money is a loan. This agreement may be oral or in writing, as long as it indicates an intent to repay the money.

Lump Sum (Nonrecurring)
441 IAC 75.56(1) “f” & “l”

Exempt the amount of a nonrecurring lump sum that is reserved for current or future month’s income. See 8-E for more information about how to treat lump sums.

Medical Expense Settlement
441 IAC 75.56(1)“j”

Exempt settlements for payment of medical expenses.

Other Excluded Federal Payments
441 IAC 75.57(6)“w”

Exclude the following federal payments:

- Payments received through the Agent Orange Settlement Fund or any other fund established because of the settlement in the “In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.).”

- Payments made by the U.S. government under Public Law 92-203, the Alaskan Native Claims Settlement Act. Exempt the tax-exempt portions.
PAYMENTS MADE BY THE U.S. GOVERNMENT TO INDIVIDUAL JAPANESE-AMERICANS (OR THEIR SURVIVORS) WHO WERE INTERNED OR RELOCATED DURING WORLD WAR II.

PAYMENTS MADE TO ELIGIBLE CIVILIAN ALEUTS UNDER SECTION 206 OF PUBLIC LAW 100-383. THIS PAYMENT IS AVAILABLE ONLY TO THOSE ALEUTS WHO WERE LIVING ON AUGUST 10, 1988, THE DATE PUBLIC LAW 100-383 WAS ENACTED.

PAYMENTS MADE UNDER THE RADIATION EXPOSURE COMPENSATION ACT, PUBLIC LAW 101-426 WHICH COMPENSATES PERSONS FOR INJURIES OR DEATHS RESULTING FROM EXPOSURE TO RADIATION FROM NUCLEAR TESTING AND URANIUM MINING. AFTER THE AFFECTED PERSON’S DEATH, PAYMENTS ARE MADE TO THE SURVIVING SPOUSE, CHILDREN, OR GRANDCHILDREN.

PAYMENTS RECEIVED UNDER THE ENERGY EMPLOYEES’ OCCUPATIONAL ILLNESS COMPENSATION PROGRAM. PAYMENTS ARE MADE TO FORMER EMPLOYEES OR THEIR FAMILIES. RECIPIENTS MAY RECEIVE ONE OR TWO LUMP SUM PAYMENTS. AWARD LETTERS ARE SENT TO THE RECIPIENT FROM THE DEPARTMENT OF LABOR.

PAYMENTS FROM THE EXPERIMENTAL HOUSING ALLOWANCE PROGRAM UNDER ANNUAL CONTRIBUTION CONTRACTS ENTERED INTO BEFORE JANUARY 1, 1975, UNDER SECTION 23 OF THE U.S. HOUSING ACT OF 1936, AS AMENDED.


PROPERTY PRODUCING INCOME CONSISTENT WITH FAIR MARKET VALUE

EXEMPT THE VALUE OF NONHOMESTEAD PROPERTY PRODUCING INCOME CONSISTENT WITH THE PROPERTY’S FAIR MARKET VALUE. AN EXAMPLE WOULD BE WHEN INCOME FROM RENTAL PROPERTY IS CONSISTENT WITH RENTAL INCOME FOR SIMILAR RENTAL PROPERTIES IN THE AREA. ALLOW THE EXEMPTION EVEN WHEN THE PROPERTY PRODUCES THE INCOME ON A SEASONAL BASIS.
If the property does not produce income consistent with its fair market value, count the net market (equity) value of the property toward the resource limit.

**Note:** If the household uses the real property for self-employment purposes, consider the exemptions as described under Tools of the Trade.

See Determining Net Market Value of a Countable Resource for information determining net as well as fair market (gross) value. Also see Inaccessible Resources to determine availability of the nonhomestead property.

**Property Settlements**  
441 IAC 75.56(4)“a”  
Exempt property settlements that are part of a legal action in the dissolution of marriage or palimony suits, regardless if received as a lump sum or in periodic payments. Exempt settlements for the month of receipt and the following month.

**Property Sold Under Installment Contract**  
441 IAC 75.56(4)“b”  
Exempt property sold under an installment contract or held as security in exchange for a price consistent with its fair market value. Also exempt the value of the installment contract.

If the price is not consistent with the fair market value, count the net market (equity) value of the installment contract (rather than the equity value of the property) toward the resource limit. See Determining Net Market Value of a Countable Resource for information on determining contract value.

**Prorated Income**  
441 IAC 75.56(1)“f”  
Exempt prorated income during the period of months over which you prorate it. See Current Month’s Income.
Self-Employment Assets
441 IAC 75.56(9)

See 8-E for information on how to determine if an enterprise is considered self-employment.

See Current Month’s Income for more information.

Exempt inventory and supplies that are needed for self-employment.

“Inventory” is defined as all unsold items, whether raised or purchased, that are held for sale or use. Examples are:

♦ Merchandise
♦ Grain held in storage by a farmer
♦ Livestock raised for sale
♦ Antiques held by a dealer
♦ Cosmetics held by a beautician

Mr. A is a self-employed toy maker. His unsold toys (his inventory), as well as his lumber, glue, varnish, and other supplies are exempt as inventory.

“Supplies” are items that are necessary for the operation of the business like lumber, paint, seed, and fertilizer.

Capital assets are not considered to be inventory or supplies. These are assets that, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. (See below.)

Capital gains result from sale of a resource and are a resource upon receipt.

Continue to exempt self-employment inventory or supplies if the self-employment is temporarily interrupted due to circumstances beyond the control of the household (such as illness). There must be a defined purpose for the interruption and an intent to return to the self-employment. Apply prudent-person guidelines to determine if this is a situation where you can expect the person to return.
Exempt up to a total of $10,000 in equity (net market) value for tools of the trade or capital assets for self-employed households. First deduct what the client owes on the tools. Then count any equity value over $10,000.

The $10,000 limit applies to the entire household, regardless of how many members are self-employed.

Tools of the trade and capital assets are those items that, if sold, could be used to claim gains or losses for federal income tax purposes. A capital asset usually has a life span of more than one year. It can include real as well as personal property.

Examples include:

♦ Farm equipment of a farmer
♦ Farm land
♦ Hair dryers of a beautician
♦ Tools of a mechanic
♦ Electric saw and sander of a toy maker
♦ Computer and other equipment of a word processor
♦ Stoves and ovens of a baker
♦ Photocopy machines in a copy center

Livestock used for breeding, show, or dairy purposes are capital assets if depreciated for federal income tax purposes. If not, the livestock is considered inventory and is entirely exempt.

When the household has a vehicle that is used for the self-employment enterprise and also for personal use, apply the motor vehicle exemption policy, the $10,000 exemption for capital assets, and the vehicle exclusion. See Vehicles.
The tools of the trade exemption also applies when:

♦ The household is in the process of setting up a business, and provides verification, or

♦ A recipient’s self-employment is temporarily interrupted because of circumstances beyond the control of the household (for example, because of illness or training directly related to self-employment).

The $10,000 exemption no longer applies when the self-employment ends or when the client files Chapter 7 bankruptcy. The household loses this exemption beginning the month after the self-employment ends.

**Transfers to Minors**

When a child has assets in an account set up under the Uniform Transfers to Minors Act (Iowa Code Chapter 565B), an adult is named as custodian of the account. The adult has discretion in withdrawing money from the account to give to the child (or spend for the child).

When the custodian of the account lives with the FMAP household, consider the money in the account as a countable resource, regardless whether the custodian receives Medicaid with the other household members. If the custodian is a parent in the eligible group, count the money as available even if the parent is temporarily absent.

When the custodian is someone who does **not** live with the FMAP household (other than a parent who is temporarily absent), count as an available resource only the amount the custodian is willing to make available to the household.

Obtain a signed statement from the custodian to determine the amount the custodian is willing to make available to the FMAP household. Consider the remainder in the account as an unavailable resource.

The Act specifies that the custodianship terminates and the property is distributed when the minor turns 21.
VISTA Payments
441 IAC 75.57(6)“i”
Exempt as a resource Title I VISTA volunteer payments, as long as the value of all payments is less than either the federal or state minimum wage when dividing the payments by the hours of service.

To date, no VISTA payments have been determined by the Director of ACTION to equal or exceed the minimum wage.

Women, Infants and Children (WIC)
Nutrition Program
441 IAC 75.57(6)“d”
Exempt the value of food assistance received through the Women, Infants, and Children Nutrition Program administered by the Department of Public Health through local health agencies.
GENERAL LETTER NO. 8-D-41

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources. Title page, revised; Contents pages 1 and 2, revised, page 3, new; pages 1 through 65, revised; and pages 66 through 97, new.

Summary

This general letter transmits the revised chapter 8-D, Resources. Policy information from the existing VIII-D, SSI-Related Coverage Groups, has been rewritten and reorganized to incorporate the Department’s updated manual format and style. See the attached comparison chart that lists the sections and subsections of the current VIII-D and where these sections and subsections are located in the revised chapters.

There are no policy changes within this chapter.

Effective Date

August 1, 1996

Material Superseded

Remove all existing pages from Employees’ Manual, Title VIII, Chapter D, and destroy them.

Also obsolete the following interpretative memos:

♦ MS-VIII-92-10, “Substitution of Protected Resources for the Community Spouse”
♦ MS-V-95-1, “Jointly Owned Property”
♦ MS-V-88-6, “Intent to Gift”
♦ MS-VIII-92-6, “Antenuptial Agreement”
♦ MS-V-92-2, “Increased Cash Value of Life Insurance”
♦ MS-V-91-9, “Valuation of a Contract”
♦ MS-VIII-90-6, “Partial Return of a Resource”
♦ MS-V-90-4, “Financially Dependent”
♦ MS-V-89-12, “Face Value or Death Benefit Countable Toward Resource Limits”
♦ MS-V-89-7, “Funds Set Aside for Burial”
♦ MS-V-87-9, “Cost of Producing Interest Income”
Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
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GENERAL LETTER NO. 8-D-42

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, pages 35, 37, 38, and 83, revised; and page 38a, new.

Summary

The Iowa Legislature adopted changes to Iowa Code Chapter 249F during the 1996 session. One change clarifies the definition of a homestead to be consistent with federal regulations. Additional, changes eliminate 14 of the 22 exemptions that are either duplicates of the first 9 exemptions or that are not consistent with current federal regulations. These changes are effective with all transfers that occur on or after July 1, 1996.

The procedure to follow regarding the household goods and personal effects policy on page 83 is clarified.

Effective Date

July 1, 1996

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

<table>
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Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-43

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (pages 1, 2, and 3), revised; pages 5, 6, 7, 15, 16, 56, 70 through 74, and 75, revised; and pages 74a and 74b, new.

Summary

This chapter is revised to reflect the increase in the maximum community spouse resource allowance to $79,020, and the increase in the community spouse minimum monthly maintenance needs allowance to $1,975.50 per month.

Page 56 is revised to correct the cross reference to another chapter.

Pages 70 and 71 are revised to include information regarding annuities.

Page 72 is revised to delete a reference to a form that is not currently in use.

Page 74 is revised to include a comment and example. They explain that a person commonly is not eligible for retroactive Medicaid when granted conditional SSI or State Supplementary Assistance benefits while trying to sell a nonliquid resource.

Page 75 is revised to update the average cost of a funeral. The Iowa Funeral Directors’ Association has verified that the average cost of a funeral in Iowa is now $6,755.

Effective Date

January 1, 1997

Material Superseded

Remove from Employees’ Manual, Title 8, Chapter D, Contents (pages 1, 2, and 3), pages 5-7, 15, 16, 56, and 70-75, all dated June 18, 1996, and destroy them.

Additional Information

Please contact your regional benefit payment administrator if you need additional information.
June 3, 1997

GENERAL LETTER NO. 8-D-44

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, page 31, revised.

Summary

Paged 31 is revised to update the statewide average cost to private-pay residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

Effective Date

July 1, 1997

Material Superseded

Remove from Employees’ Manual, Title 8, Chapter D, page 31, dated June 18, 1996, and destroy it.

Additional Information

Please contact your regional benefit payment administrator if you need additional information.
GENERAL LETTER NO. 8-D-45

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (page 2), revised; and pages 3, 5 through 7, 15, 16, 24, 40, 46, 54 through 57, and 74b, revised.

Summary

Pages 3, 5, and 24 are being clarified per field requests.

Pages 5 through 7, 15, and 16 are revised to reflect the increase in the maximum community spouse resource allowance to $80,760, and the increase in the community spouse minimum monthly maintenance needs allowance to $2,019.00 per month.

Pages 40 and 54 through 57 change the name of the supplemental needs trusts to special needs trusts for consistency with Iowa statutory language.

Page 46 is being changed to request only one year of trust principal, income, and historical data information for completing a clarification request.

Page 74b is being changed to add AIDS/HIV settlement payments to the list of exempt resources when determining resource eligibility.

Effective Date

The community spouse resource allowance and maintenance needs allowance increases are effective January 1, 1998. Other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Contact your regional benefit payment administrator if you need additional information.
March 10, 1998

GENERAL LETTER NO. 8-D-46

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, *Resources*, page 75, revised.

Summary

Page 75 is revised to update the average cost of a funeral. The Iowa Funeral Directors’ Association has verified that the average cost of a funeral in Iowa is now $6,890.

Effective Date


Material Superseded

Remove from Employees’ Manual, Title 8, Chapter D, page 75, dated December 31, 1996, and destroy it.

Additional Information

Please contact your regional benefit payment administrator if you need additional information.
GENERAL LETTER NO. 8-D-47

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (page 1), revised; pages 7, 8, 31, and 74b, revised; and page 8a, new

Summary

Page 7 is revised to allow for a worker to determine the lifetime annuity cost for a community spouse in the attribution appeal process. Workers can use the procedure when no insurance company or bank will provide estimates of the cost of a single-premium lifetime annuity.

Page 31 is revised to update the statewide average cost to private-pay nursing facility residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

Page 74b is being changed to add that exempt AIDS/HIV settlement payments must be kept in a separate, identifiable account.

Effective Date

May 1, 1998, for the worker-determined annuity amount.
June 1, 1998, for AIDS/HIV settlement payments.
July 1, 1998, for statewide average cost of nursing care.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Please contact your regional benefit payment administrator if you need additional information.
September 29, 1998

GENERAL LETTER NO. 8-D-48

ISSUED BY: Bureau of Medical Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, pages 4, 60, and 74, revised.

Summary

A sentence has been added to Resources Excluded From Attribution to clarify that resources affected by a prenuptial or antenuptial agreement continue to be countable unless excluded under policy.

Page 60 is revised to update the affect of transfers of assets for FMAP recipients.

The section on determining the net market value of a motor vehicle is revised to clarify that any “blue book” source may be used for that purpose, including internet sources for automobile valuations. The current manual restricts workers to use only the NADA blue book.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

<table>
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Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-49

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (page 1), revised; pages 4 through 7, 15, 16, 22, and 23, revised; and pages 6a and 6b, new.

Summary

Pages 5 through 7, 15, and 16 are revised to reflect the increase in the maximum community spouse resource allowance to $81,960, and the increase in the community spouse minimum monthly maintenance needs allowance to $2,049.00 per month.

Also, Page 7 is revised to clarify when an appeal of an attribution of resources may be filed. An appeal request must be filed within 30 days of the Notice of Attribution or any Notice of Decision regarding medical assistance. If the client does not file an appeal within 30 days of a Notice of Attribution or a Notice of Decision, the client loses the right to a hearing on the attribution.

Page 22 eliminates the lookback chart, as these dates are no longer significant.

Effective Date

January 1, 1999, for spousal impoverishment increase.
February 1, 1999, for attribution appeal changes.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your regional benefit administrator.
GENERAL LETTER NO. 8-D-50

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (page 2), revised; pages 1, 31, 39, 57, 58, 59, 60, 61, 67, 68, and 75, revised; and pages 58a through 58d and 68a, new.

Summary

The Seventy-eighth Session of the Iowa General Assembly directed the Department to disregard resources in determining initial and ongoing Medicaid eligibility of children in those coverage groups for which the Department has the authority to do so.

A new section entitled RESOURCE ELIGIBILITY OF CHILDREN has been added to this chapter. This new section includes a chart listing all FMAP-related and SSI-related coverage groups indicating which coverage groups are affected by this change and which remain unchanged.

This change does not affect the types of resources to be considered, whose resources to consider, or how the countable value of a resource is determined. It does provide that resources of all household members will be disregarded when determining eligibility of children in the affected coverage groups.

Page 31 is revised to update the statewide average cost to private-pay nursing facility residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair marked value has occurred.

Policies on page 67 regarding the countable equity value of a jointly owned resource are revised. When evaluating an applicant’s or recipient’s interest in a resource, consider the intent of all of the parties involved when the jointly held resource was created.

Page 75 is revised to update the average cost of a funeral. The Iowa Funeral Directors’ Association has verified that the average cost of a funeral in Iowa is now $7,028.

Effective Date

July 1, 1999
Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-51

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (pages 2 and 3), revised; pages 1 through 6, 7, 24, 25, 33, and 60 through 97, revised; and pages 32a and 98 through 103, new.

Summary

Pages 1 and 2 are revised to include the limitation of the entry date for attribution cases and a definition for a community spouse.

Page 3 is revised to clarify that resources excluded in the attribution process are also excluded in the eligibility process.

Page 7 is revised to include directions to base the single-premium lifetime annuity estimate on the minimum monthly maintenance needs allowance in effect when the appeal is filed.

Page 24 is revised to add a condition to the policy regarding exemption from the penalty for transfer of assets because of undue hardship for the client. The hardship exception now applies only if the penalty would deprive the person of food, clothing, shelter, medical care, or other necessities of life, such that the person’s health or life would be endangered. This adds a current requirement in the Health Care Financing Administration’s State Medicaid Manual into rules.

Page 32a is added to include a reference to undue hardship in the directions for a manually issued Notice of Decision regarding transfer of assets penalty periods.

The heading SSI-RELATED RESOURCE POLICIES changes to GENERAL SSI-RELATED RESOURCE POLICIES on pages 60 through 72.

Page 72 is revised to change the Iowa Code reference from 249C to 249G.

The heading EXCLUDED SSI-RELATED RESOURCES changes to SPECIFIC SSI-RELATED RESOURCES on pages 73 through 103 and in cross-references. Policies on annuities, mortgages and contracts, and vehicles are moved into this section.

Page 73 is revised to create an overview section that includes countable and excluded resources.
Page 78 is revised to correct example 5.

Pages 80 and 81 are revised to include clarification of the exclusion of dedicated accounts as resources.

Page 84 is revised to clarify household goods and personal affects excluded in the attribution process are also excluded in the eligibility process for spousal impoverishment cases.

Pages 87 through 91 are revised to clarify policies concerning life estates and remainder interests. Policies and procedures regarding evaluating life estates and remainder interests remain the same.

**Effective Date**

August 1, 1999

**Material Superseded**

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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**Additional Information**

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-52

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (pages 2 and 3), revised; Contents (pages 4 and 5), new; pages 17 and 59 through 62, revised; and pages 104 through 134, new.

Summary

Chapter D is revised to include all resource policies for FMAP-related Medicaid, due to delinking Family Medical Assistance Program (FMAP) and FMAP-related Medicaid from the Family Investment Program (FIP). The FMAP section is moved to the end of the chapter. It includes the following policy changes:

♦ Exempt as a resource all earned and unearned financial assistance for education or training.

♦ Exempt earnings in kind as resources. (See General Letter 8-E-45 for more information.)

♦ Eliminate the requirement that FMAP applicants and recipients try to gain title and control of an unavailable resource. A resource is considered unavailable when the client owns it in part or in full but the client has no control over it.

♦ Exempt the value of nonhomestead property that is publicly advertised for sale at an asking price consistent with its fair market value.

♦ Exempt property sold under an installment contract or held in security in exchange for a price consistent with its fair market value. If the price is not consistent with its fair market value, count the net market (equity) value of the installment contract toward the resource limit.

♦ Exempt the value of nonhomestead property that produces income consistent with its fair market value. For example, rental property is exempt when income from it is consistent with rental income for similar rental properties in the area. Allow the exemption even when the property produces income on a seasonal basis. If the property does not produce income consistent with its fair market value, count the net market (equity) value of the property.

The section on SSI-related resource limits is revised to include expanded specified low-income Medicare beneficiaries and home-health specified low-income Medicare beneficiaries. The estate recovery section is revised to include the requirement to notify E-SLMB, HH-SLMB, and QDWP Medicaid applicants by giving them Comm. 123, Estate Recovery Program.
Implementation Instructions

Applicants

Apply the new policies when processing applications on or after September 1, even if the application date and the FMAP effective date are before September 1.

Count toward the resource limit the net market (equity) value of property that does not meet exemption criteria.

Recipients

Effective with the September 1999 benefit month:

♦ Do not cancel FMAP assistance for September 1 or later when a recipient fails to take action for gaining title and control of an unavailable resource.

♦ Apply the new property exemptions. If the property does not meet exemption criteria, consider the net market (equity) value toward the resource limit.

Effective Date

The following changes in policy are effective September 1, 1999:

♦ Exempt earnings in kind as a resource.
♦ Eliminate the requirement to try and gain title and control of an unavailable resource.
♦ Exempt property sold under an installment contract.
♦ Exempt the value of nonhomestead property that produces income consistent with its fair market value.
♦ Exempt nonhomestead property that is publicly advertised for sale.

All other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-53

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, pages 6, 6a, 15, and 16, revised.

Summary

Pages 6, 6a, 15, and 16 are revised to reflect the increase in the maximum community spouse resource allowance to $84,120, and the increase in the community spouse minimum monthly maintenance needs allowance to $2,103 per month.

Effective Date

January 1, 2000

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your regional benefit administrator.
February 15, 2000

GENERAL LETTER NO. 8-D-54

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, Resources, Contents (page 2), revised; pages 6, 31, 32a, 59, 61, and 62, revised; and pages 72a and 72b, new.

Summary

Revisions have been made to:

♦ Incorporate resource limits for new Medicaid coverage group, Medicaid for employed people with disabilities.

♦ Include additional resource exemptions for this coverage group.

♦ Correct a figure in the section on attribution of resources.

♦ Clarify the section on determining the penalty period for a transfer of assets.

Effective Date

March 1, 2000

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your regional benefit administrator.
GENERAL LETTER NO. 8-D-55

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, pages 1, 20, 21, 22, 31, 38a, 44, 46, 47, 48, 50 through 53, 56, 63, 64, 66, 99, 104, 106, 116, 117, 118, and 127, revised.

Summary

Pages 20 and 22 are revised to add two additional types of transfer of assets. House File 2321, enacted by Seventy-eighth General Assembly, 2000 Session, establishes that disclaiming of an inheritance and failure to take against a deceased spouse’s will are considered a transfer of assets when they occur on or after July 1, 2000. (Disclaimer of an inheritance or failure to take against a will do not cause a Medicaid penalty if they occur before July 1, 2000.)

Page 20 is also revised to instruct IM workers to gather information on claims of undue hardship under estate recovery and make a recommendation to the Bureau of Contract Management and Reimbursement.

Page 31 is revised to update the statewide average cost to private-pay nursing facility residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair marked value has occurred.

This general letter also transmits the yearly increase in the exemption of motor vehicle equity for FMAP-related applicants and recipients, based on the latest increase in the consumer price index for used vehicles. The new exemption amount is $3,959. Pages 116 through 118 are updated to reflect the new amount.

The phrase “FIP or FIP-related” has been updated to “FMAP-related” throughout the chapter. Legal references have been updated on pages 20, 48, 104, and 106.

An example has been clarified on page 52.

Page 56 is revised to instruct IM workers to notify the Bureau of Contract Management and Reimbursement when a recipient with a medical assistance income trust dies and to include a cross-reference to policy in 8-E on these trusts.

Pages 63 through 66 are revised to clarify the countable amount of jointly held checking and savings accounts.
Page 99 is revised to clarify the countable amount of retirement funds. Existing language is clarified on page 127.

**Effective Date**

July 1, 2000

Apply the new $3,959 exemption in the motor vehicle equity value beginning with the July 2000 benefit month. Apply the current $3,916 exemption when determining countable resources for any month before July 2000.

Do not cancel existing FMAP-related cases effective July 1, 2000, solely because countable resources exceed limits due to the current $3,916 motor vehicle equity exemption. Continue assistance if, by applying the new $3,959 exemption, the household is within the $5,000 resource limit for recipients. Reinstate FMAP-related cases that are canceled effective July 1, 2000, due to the current $3,916 exemption limit in accordance with the policies in 8-G, **Reinstatement**.

**Material Superseded**

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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<td>104, 106, 116-118, 127</td>
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**Additional Information**

Refer questions about this general letter to your regional benefit administrator.
GENERAL LETTER NO. 8-D-56

ISSUED BY: Bureau of Eligibility, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Contents (page 1), revised; and pages 6, 6a, 15, 16, 27, 32a, 33 through 37, 64, 87, 88, 106, 109, and 110, revised.

Summary

Pages 6, 6a, 15, and 16 are revised to reflect the increase in the maximum community spouse resource allowance to $87,000, and the increase in the community spouse minimum monthly maintenance needs allowance to $2,175 per month.

Page 37 is revised to incorporate changes relating to establishing a claim for transferred assets. This policy is for applications received on or after January 1, 2001. The following changes involve transfers that occur during the 60-month period (five years) before an application is filed:

♦ The amount for cash transfers over the five-year look-back period is limited from $2,000 per calendar year to $2,000 for the entire five-year period before the month of application.

Before January 1, 2001, the limit for transfers of assets was $2,000 for each calendar year in the five-year period before the month of application. This enabled a person to transfer as much as $10,000 in resources without having a referral done to DIA. Under the new policy, the amount of transfer is limited to $2,000 over the entire five-year period before the month of application.

♦ The exemption for the transfer of a homestead to anyone other than the people exempt under federal regulations is eliminated.

Before January 1, 2001, a DIA referral was not done for transfer of a homestead. For transfers after January 1, 2001, the only homestead transfers that will be exempt are transfers made to the following:

- Spouse.
- Disabled child or child under the age of 21.
- Child of the transferor who was residing in the dwelling for a period of at least two years and who provided care that kept the parent from earlier admission to the nursing facility.
- A sibling of the transferor who had lived with the transferor for at least one year before the transferor entered the institution and who has equity interest in the dwelling.
Page 32a is revised to correct the amount of funds for burial from $3,000 to $4,000.

Page 64 is revised to clarify that prenuptial agreements do not effect Medicaid.

Page 88 is revised to clarify how income generated by a life estate is counted.

Page 106 is revised to:
♦ Add a bullet that for transitional Medicaid, resources are not considered.
♦ Change the words “absent parent” to “father of the children.”
♦ Remove the reference to suspensions.

Pages 109 and 110 are revised to remove the reference to CMAP on what resources to count.

Pages 6a, 87, and 110 are revised to update form numbers.

Pages 27 and 33 are revised to correct legal references.

**Effective Date**

January 1, 2001

**Material Superseded**

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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**Additional Information**

Please contact your regional benefit administrator if you need additional information.
GENERAL LETTER NO. 8-D-57

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, pages 116, 117, and 118, revised.

Summary

This general letter conveys the yearly increase in the exemption of motor vehicle equity for FMAP-related Medicaid applicants and recipients, based on the latest increase in the consumer price index for used vehicles. The new exemption amount is $4,042.

Effective Date

July 1, 2001

Material Superseded

Remove the from Employees’ Manual, Title 8, Chapter D, pages 116, 117, and 118, all dated June 13, 2000, and destroy them.

Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-58

ISSUED BY: Bureau of Eligibility/HIPP, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, page 31, revised.

Summary

Page 31 is revised to update the statewide average cost to private-pay nursing facility residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

Effective Date

July 1, 2001

Material Superseded

Remove the following page from Employees’ Manual, Title 8, Chapter D, and destroy it:

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Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-59

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, pages 87 and 105, revised.

Summary

Page 87 is revised to clarify when not to count the cash value of an insurance policy.

Page 105 is revised to reflect a change in the way we sanction adults who do not cooperate with the Department, ineligible adult aliens, and adults who do not have a social security number.

The change will allow sanctioned adults, undocumented adult aliens, and adults who are ineligible due to no social security number to remain a part of the household size.

Ineligible children will not be included in the household size, nor will their income or resources be used in determining eligibility of the eligible group.

Effective Date

September 1, 2001

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
December 11, 2001

GENERAL LETTER NO. 8-D-60

ISSUED BY: Bureau of Eligibility Services, Division of Medical Services

SUBJECT: Employees’ Manual, Title 8, Chapter D, pages 6, 6a, 6b, 15, 16, and 75, revised.

Summary

This chapter is revised to:
♦ Increase the maximum community spouse resource allowance to $89,280.
♦ Increase the community spouse minimum monthly maintenance needs allowance to $2,232 per month.
♦ Increase the average cost of a funeral in Iowa to $7,373 on page 75.

Effective Date

January 1, 2002

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your regional benefit payment administrator.
GENERAL LETTER NO. 8-D-61

ISSUED BY: Unit of Health Support, Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, pages 7, 17, 20, 31, 32, 38, 38a, 44, 45, 56, 57, 64, 73, 74, 85, 86, 116, 117 and 118, revised.

Summary

This chapter is revised to:

♦ Clarify that when the community spouse is seasonally employed, the community spouse’s income can be annualized to determine the monthly deficit between the community spouse’s income and the minimum monthly maintenance needs allowance.

♦ Update the statewide average cost to private-pay nursing facility residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

♦ Replace the term “supplemental needs trust” with “special needs trust” and to refer workers to 8-E for information on income paid out of a special needs trust.

♦ Clarify how to count trust income and principal.

♦ Clarify that property is unavailable until a decision on property distribution has been made pending a divorce proceeding.

♦ Clarify that payments made under the Ricky Ray Hemophilia Relief Act of 1998 and funds in an individual development account are not counted as a resource in determining SSI-related Medicaid eligibility.

♦ Update the exemption of motor vehicle equity for FMAP-related Medicaid applicants and recipients, based on the latest increase in the consumer price index for used vehicles. The new exemption amount is $4,115.

♦ Incorporate an expansion in collection of a debt due for estate recovery. When collection of a debt is waived due to hardship, this creates a debt from the estate of the person who received the hardship waiver.

♦ Clarify that an estate includes retained life estates.
Update the address for referring hardship cases for estate recovery. Referrals will no longer be sent to central office. Referrals will be sent directly to HMS, Sumo Group, Estate Recovery Program, 904 Walnut St, Des Moines, IA 50309-3507.

**Effective Date**

Changes relating to estate recovery were effective on April 5, 2002, the effective date of 2002 Iowa Acts, House File 2539.

All other changes are effective July 1, 2002

**Material Superseded**

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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<td>July 20, 1999</td>
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<td>116, 117, 118</td>
<td>June 5, 2001</td>
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</table>

**Additional Information**

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-62

ISSUED BY: Unit of Health Support, Division of Financial, Health, and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Contents (page 4) revised; page 123, revised.

Summary

The word “scholarship” has been removed from the policy regarding grants obtained and used under conditions that preclude their use for current living costs. This is not a policy change. It is a clarification of policy.

Scholarships are almost always for educational purposes, and all earned and unearned financial assistance for education or training is exempt as income and as a resource. Therefore, no additional reference to a specific type of educational financial assistance is needed in this chapter.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

<table>
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<tr>
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Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-63

ISSUED BY: Unit of Health Support, Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, pages 6, 6a, 15, 16, 20, and 46, revised.

Summary

This chapter is revised to:
♦ Increase the maximum community spouse resource allowance to $90,660.
♦ Increase the community spouse minimum monthly maintenance needs allowance to $2,266.50 per month.
♦ Correct the language on referral of trusts to central office.
♦ Change address for estate recovery office.

Effective Date

January 1, 2003

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-64

ISSUED BY: Bureau of Financial Support, Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, page 7, revised.

Summary

Policy on appeal of an attribution of resources is changed to require only one estimate of the cost of a single-premium lifetime annuity that would generate income equal to the difference between the community spouse’s gross income and the minimum monthly maintenance needs allowance, instead of three estimates.

Effective Date

April 1, 2003

Material Superseded

Remove from Employees’ Manual, Title 8, Chapter D, page 7, dated July 2, 2002, and destroy it.

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-65

ISSUED BY: Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, pages 12, 16, 17, 20, 28, 31, 56, 57, 69, 70, 74, and 116, revised; and pages 74a through 74e, new.

Summary

Page 12 is revised to correct Division of Medical Services to Division of Financial, Health and Work Supports.

Page 16 is revised to clarify that medical assistance paid is recovered from the estate of the recipient only and does not include the estate of a spouse or child. Recovery from those individuals takes place only when the recovery is delayed or waived as discussed later in this chapter.

Page 17 is revised to remove reference to HH-SLMB.

Page 20 is revised for two changes to the policy on collection of a debt due for estate recovery.

♦ Currently, when collection of a debt due is waived due to a child under 21, collection is made when the individual turns 21. With this change, collection will also be made from the estate of the child if the child dies before reaching age 21.

♦ Currently, when collection of a debt due is waived due to hardship, collection is made from the estate of the person who received the hardship waiver. With this change, collection will also be made if the hardship no longer exists.

Page 28 is revised to clarify that property excluded as homestead property is not excluded as homestead property for the purposes of transfer of assets.

Page 31 is revised to update the statewide average cost to private-pay nursing facility residents. Use the statewide average cost to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

Page 56 is revised to clarify that the exemption of special needs trusts terminates when the individual turns age 65.

Page 69 is revised to clarify that resources do not need to be deemed from parents when the child’s eligibility is under a coverage group where resources are excluded for the child’s eligibility.
Page 74 is revised and pages 74a through 74e are added to clarify that annuities should be reviewed to determine whether the purchase of the annuity constitutes a transfer of assets for less than fair market value.

Page 116 is revised to clarify that the average trade-in value of vehicles is not increased because of low mileage or optional equipment. This change is effective upon receipt.

**Effective Date**

July 1, 2003

**Material Superseded**

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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<td>74, 116</td>
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**Additional Information**

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-66

ISSUED BY: Bureau of Financial Support Programs, Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Table of Contents (page 1), revised; pages 6, 6a, 15, 16, and 31 through 37, revised.

Summary

This chapter is revised to:

♦ Increase the maximum community spouse resource allowance to $92,760.

♦ Increase the community spouse minimum monthly maintenance needs allowance to $2,319 per month.

♦ Clarify transfer of assets policies.

Effective Date

January 1, 2004

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-67

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES pages 20, and 74b through 74e, revised.

Summary

This chapter is revised to:

♦ Change the address for the estate recovery contractor, HMS, Sumo, to reflect the current address.

♦ Update the life expectancy table used to determine whether an annuity is actuarially sound.

Effective Date

Upon receipt.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-68

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES pages 31, 35, 36, 37, 61, and 71, revised.

Summary

These changes:

♦ Update the statewide average cost to private-pay nursing facility residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

♦ Clarify the transfers made for less than fair market value that are exempt from referral to DIA.

♦ Remove references to home-health specified low-income Medicare beneficiaries.

♦ Clarify that people who are conditionally eligible for SSI or State Supplementary Assistance are not eligible for Medicaid unless they are receiving State Supplementary Assistance benefits.

Effective Date

The statewide average cost is effective July 1, 2004. All other changes are effective upon receipt.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-69

ISSUED BY: Bureau of Financial Support Programs,
Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Contents (page 2),
revised; pages 6, 6a, 15, 16, 31, 32, 57, 58, 80, 81, 82, 100, 106, 108, 109, 110,
113, 128, 131, and 133, revised; and page 80a, new.

Summary

This chapter is revised to:

♦ Increase the maximum community spouse resource allowance to $95,100.

♦ Increase the community spouse minimum monthly maintenance needs allowance to
$2,377.50 per month.

♦ Correct and clarify examples.

♦ Change the treatment of educational assistance and gifts.

♦ Revise how unspent funds from earned income tax and child tax credits are treated.

♦ Extend the exclusion of time retroactive SSI and Social Security payments from six to nine
months.

♦ Update legal references.

♦ Add cross-references.

♦ Add that when employment is terminated, the employee’s portion of any lump-sum payment
from the employee’s retirement account, plus accumulated interest, is counted as a resource.

♦ Add that a Transfer to Minors Act custodianship terminates when the minor turns age 21.

Effective Date

COLA changes are effective January 1, 2005.

All other changes are effective upon receipt.
Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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<td>December 5, 2000</td>
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<td>113, 128, 131, 133</td>
<td>August 17, 1999</td>
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</table>

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
March 25, 2005

GENERAL LETTER NO. 8-D-70

ISSUED BY: Bureau of Financial Supports, Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Table of Contents (page 1), revised; pages 6, 7, 8, 8a, 19, 20, 23, 32, 74a, 75, and 94, revised, and 20a, new.

Summary

This chapter is revised to make corrections that were omitted in previous revisions and to increase the average cost of a funeral in Iowa from $7,373 to $8,514.

A new procedure for estate recovery has been included. When a Medicaid recipient dies who is subject to estate recovery collection, the Department is requiring workers to complete a referral form and send electronically to HMS/SUMO. Use the Estate Recovery Program Referral, form 470-4122, which is available in the public state-approved forms folder on Outlook.

Effective Date

January 1, 2005.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter M, and destroy them:

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<td>July 20, 1999</td>
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Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-71

ISSUED BY: Bureau of Financial Supports, Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, pages 31, 109, 113, 116, 117, and 118, revised.

Summary

This chapter is revised to:

♦ Update the statewide average cost to private-pay nursing facility residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

♦ Update the motor vehicle equity exemption for Medicaid applicants and recipients. The motor vehicle equity exemption is updated each year based on the latest increase in the consumer price index for used vehicles. The new exemption amount is $4,164.

♦ Correct language and a legal reference.

Effective Date

The statewide average cost is effective July 1, 2005.

Apply the new $4,164 exemption in the motor vehicle equity value prospectively beginning with July 2005.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.
GENERAL LETTER NO. 8-D-72

ISSUED BY: Bureau of Medical Supports, Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Contents (page 3), pages 6, 6a, 15, 16, 92, 95, and 129, revised.

Summary

This chapter is revised to:

♦ Update the maximum community spouse resource allowance and examples of spousal situations.

♦ Add SSI and FMAP treatment of benefits from the Energy Employees’ Occupational Illness Compensation Program.

♦ Add a new section, “Loans,” under “SPECIFIC SSI-RELATED RESOURCES.”

Effective Date

The maximum community spouse resource allowance and the minimum monthly maintenance needs allowance for a community spouse are effective January 1, 2006.

The treatment of benefits from the Energy Employees’ Occupational Illness Compensation Program is effective upon receipt.

Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your area income maintenance administrator.
GENERAL LETTER NO. 8-D-73

ISSUED BY: Bureau of Medical Supports,  
Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, page 59, revised.

Summary

This chapter is revised to clarify that resources are not considered when determining eligibility for the Iowa Family Planning Network.

Effective Date

February 1, 2006.

Material Superseded

Remove from the Employees’ Manual, Title 8, Chapter D, page 59, dated February 15, 2000, and destroy it.

Additional Information

Refer questions about this general letter to your area income maintenance administrator.
GENERAL LETTER NO. 8-D-74

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Contents (pages 1 through 4), revised, pages 6a, 6b, 7, 8, 8a, 15, 16, 20a, 21, 22, 30 through 34, 74, 75, 80, 80a, 83, 92, 93, 94, 96, 97, 98, 123, 124, and 125, revised; and pages 8b, 20b through 20f, 34a, 34b, 34c, and 94a, new.

Summary

This chapter is revised to:

♦ Change how income is counted when comparing the income available to a community spouse to the minimum monthly maintenance needs allowance during the appeal of attribution of resources.

♦ Revise transfer of asset policies required by the Deficit Reduction Act of 2005.

♦ Revise how equity in a home is considered in determining eligibility for Medicaid and payment of facility or HCBS waiver services.

♦ Correct age for counting uniform gifts to minors.

♦ Correct the average annual bids to one annuity bid.

Effective Date

The home equity change is effective January 1, 2006, for applications processed on or after June 1, 2006.

The transfer of assets changes are effective June 1, 2006, for any transfer made on or after February 8, 2006. The changes to community spouse income are effective June 1, 2006, for any spouse that becomes institutionalized on or after February 8, 2006.

Implementation

No desk reviews are necessary.

When processing applications, reapplications, reviews, or redeterminations on or after June 1, 2006, apply the new look-back, penalty period, and transfer of asset policies to any transfer made on or after February 8, 2006.
When processing an application or reapplication on or after June 1, 2006, apply the home equity limitation to any person requesting payment of nursing facility care, a level of care equivalent to nursing facility level of care, or HCBS waiver services.

**Material Superseded**

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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**Additional Information**

Refer questions about this general letter to your area income maintenance administrator.
GENERAL LETTER NO. 8-D-75

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Contents (page 3), revised; and pages 20c, 31, 32, 33, 34a, 34b, 34c, 110, 116, 117, 118, and 132, revised.

Summary

This chapter is revised to:

♦ Update the statewide average cost to private-pay residents. The statewide average cost figure is used to calculate the period of ineligibility when a transfer of assets for less than fair market value has occurred.

♦ Correct examples on transfer of assets.

♦ Exempt one motor vehicle without regard to its value when determining Medicaid eligibility under Family Medical Assistance Program (FMAP) for adults.

♦ Update the motor vehicle equity exclusion for Medicaid applicants and recipients. The motor vehicle equity exclusion is updated each year based on the latest increase in the consumer price index for used vehicles. The new exclusion amount is $4,435.

Effective Date

The statewide average cost to private-pay residents is effective July 1, 2006. The motor vehicle equity exclusion and one motor vehicle exemption are effective July 1, 2006.

All other changes are effective upon receipt.
Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

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Additional Information

Refer questions about this general letter to your area income maintenance administrator.
GENERAL LETTER NO. 8-D-76

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees’ Manual, Title 8, Chapter D, RESOURCES, Contents (page 1), revised; pages 17 through 20, and 117, revised.

Summary

This chapter is revised to:

♦ Update the names of agencies that contract with the Department to reflect the incorporation of these contractors into the Iowa Medical Enterprise (IME) agency.

Health Management Services/SUMO, the Estate Recovery contractor, is now included as part of the IME Revenue Collection Unit.

Iowa Foundation for Medical Care (IFMC), the agency that determines a member’s ability to return home from an institution, is now included as part of the IME Medical Services Unit.

♦ Change the term “recipient” or “client” to “member” on the affected pages to reflect updated terminology of the Department.

♦ Add language to the section, “ESTATE RECOVERY.” For purposes of estate recovery, it is not allowable for funds of the deceased to be used for travel expenses of family members of the deceased at the time of the member’s death.

♦ Correct an example.

Effective Date

Upon receipt.
Material Superseded

Remove the following pages from Employees’ Manual, Title 8, Chapter D, and destroy them:

<table>
<thead>
<tr>
<th>Page</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contents (page 1)</td>
<td>May 19, 2006</td>
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<tr>
<td>17</td>
<td>June 3, 2003</td>
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<td>18</td>
<td>June 18, 1996</td>
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<td>19 and 20</td>
<td>March 25, 2005</td>
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<tr>
<td>117</td>
<td>June 16, 2006</td>
</tr>
</tbody>
</table>

Additional Information

Refer questions about this general letter to your area income maintenance administrator.