

1. Any aged, blind or disabled person who believes he/she is eligible shall be assured an opportunity to make application (including reapplication) for Medicaid Only by completing the appropriate application form.

2. The applicants or beneficiaries are the primary source of information. However, it is the responsibility of the agency to make the determination of eligibility and to use secondary sources when necessary, with the applicant's knowledge and consent.

3. No duplication of assistance: No beneficiary of Medicaid Only shall receive, during the same period, any other medical assistance from the State or any political subdivision thereof with respect to any maintenance requirements or other need for which allowance is made in the Medicaid Only program (see N.J.A.C. 10:71-3.14 regarding inmates of correctional institutions). The food stamp program is not considered a duplication of public assistance.

4. There shall be strict adherence to law and complete conformity with administrative policies. Requirements other than those established by law or regulations shall not be imposed on any person as a condition of receiving medical assistance.

5. The applicants or beneficiaries shall have the right to request appeal on the action or inaction of the agency whenever they believe that they have not been given full consideration under the law. A fair hearing shall be conducted by an impartial official of the Department of Human Services in accordance with prescribed procedure when:

- i. An application for Medicaid Only is denied;
- ii. An application for Medicaid Only is not acted upon by the county welfare board within 30 days for the aged and 60 for the disabled or blind; or
- iii. Medicaid Only is terminated.

6. Information about applicants and beneficiaries and their circumstances shall not be disclosed except as required for the proper and efficient administration of the program and only to those agencies involved in the lawful administration or operation of public welfare functions or services.

7. There shall be no discrimination on grounds of race, color, religion, sex, national origin or marital, parental or birth status by state or local agencies in the administration of any public assistance program.

Amended by R.1986 d.71, effective March 17, 1986.

See: 17 N.J.R. 2522(a), 18 N.J.R. 564(b).

(a)3 amended.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a), substituted references to beneficiaries for references to recipients throughout.

10:71-1.7 Examination or review of chapter

This chapter is a public document. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each CBOSS office for examination or review during regular office hours on regular work days.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted a reference to this chapter for a reference to this manual, and substituted a reference to CBOSS offices for a reference to CWA offices.

10:71-1.8 County board of social services responsibility; chapter

The director of the CBOSS shall assign copies of this chapter to staff members as appropriate and shall ensure that such persons are thoroughly familiar with its contents, apply the required policy and procedures correctly, and keep up-to-date on all policy changes.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted a reference to the CBOSS for a reference to the CWA, and substituted a reference to this chapter for a reference to this manual.

10:71-1.9 Providing chapter material in adverse action situations

Specific chapter material necessary for an applicant or beneficiary or his or her representative to determine whether a hearing should be requested or to prepare for a hearing shall be provided to such persons without charge.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 25265(a), 32 N.J.R. 3488(a).

Substituted a reference to chapter material for a reference to policy material, and substituted a reference to beneficiaries for a reference to recipients.

10:71-1.10 Revisions of the chapter

The Division of Medical Assistance and Health Services shall issue revisions and changes to this chapter as necessary. It is the responsibility of each holder of the chapter to maintain its accuracy by inserting new material and removing obsolete pages promptly.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3488(a).

Substituted references to this chapter for references to this manual throughout.

10:71-1.11 Availability of chapter

(a) A current up-to-date copy of the chapter or any part of it is available from the Division of Medical Assistance and Health Services at the cost of printing and mailing to anyone who requests it in writing.

(b) All public and university libraries which have agreed to keep the chapter up-to-date will have a copy available under their regulations.

(c) Each legal services office will be furnished with a copy of this chapter free of charge.

(d) Welfare, social service and other non-profit organizations will be furnished with a copy of the chapter at no cost by an official written request to the Division of Medical Assistance and Health Services.

(e) All supplementary State policy directives will routinely be sent to those who have been supplied with the chapter. A mailing list will be maintained by the Division.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3488(a).

Substituted references to this chapter for references to this manual throughout.

SUBCHAPTER 2. THE APPLICATION PROCESS

10:71-2.1 Definitions

The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise:

"Application process" means all activity performed by the Income Maintenance Section relating to a request for medical assistance payments. The application process is primarily geared toward the determination of basic eligibility. However, since intake by its very nature involves a combination of services and income maintenance functions, a service worker shall be available as required during such process.

"Applicant," in Medicaid Only, means the aged, disabled or blind individual or his/her authorized agent who executes the formal written application (PA-IG).

"Approved" means that the applicant has been determined to be eligible for Medicaid Only.

"CBOSS" means county board of social services.

"Disposition of the application" means the official determination of the CBOSS that one of the following actions is appropriate: approval or rejection as defined in the section.

"MRT" means Medical Review Team.

"New application" means a written request for assistance from an individual or his/her agent who has never previously requested assistance in any county in the State under the Medicaid Only program.

"Pending application" means the general term for application, reapplication, reopened application or transfer application prior to official disposition.

"Poverty guidelines" means, with respect to a household, the income poverty line as prescribed and revised at least annually pursuant to 42 U.S.C. § 9902(2). The poverty guidelines are a simplified version of the Federal Government's statistical poverty thresholds used by the Census Bureau to prepare its statistical estimates of the number of persons and families in poverty. The poverty guidelines issued by the Department of Health and Human Services pursuant to 42 U.S.C. § 9902(2) are used for administrative purposes, for example, for determining whether a person or family is financially eligible for assistance or services under a particular Federal program.

"Reapplication" means a written request for assistance by the individual whose previous application was rejected in any county in the State and who requests reconsideration of his/her current eligibility for Medicaid Only.

"Registration" means the action of the CBOSS in assigning a control number to an application.

"Rejected" is an inclusive term (for statistical purposes) for the following actions:

1. Denied means that the applicant has been determined to be ineligible for assistance for a specific reason.
2. Dismissed means official recognition that eligibility need not be considered further because:
 - i. The applicant died (however, if there were unpaid medical bills incurred subsequent to inquiry or application, whichever occurred first, the application process is to be completed); or
 - ii. The applicant cannot be located; or
 - iii. The application was registered in error; or
 - iv. The applicant moved to another county in New Jersey during the application process.
3. Withdrawn means that the applicant decided not to pursue the application further.

"Reopened application" means a written request by a former beneficiary in any county in the State for reconsideration of his or her current eligibility for the program.

"Transfer application" means a written request for assistance by the individual who at the time of registration is still receiving assistance through the CBOSS of another county from which he or she moved.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Inserted "CBOSS" and "MRT"; substituted references to CBOSS for references to CWA throughout; and in "Reopened application", substituted a reference to beneficiaries for a reference to recipients. Amended by R.2004 d.401, effective November 1, 2004.

See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).

Added "Poverty guidelines".

Case Notes

Nursing home entitled to reimbursement for claims in process during suspension of patient's eligibility. Atlantic Coast Rehabilitation Center v. Department of Health and Senior Services, 97 N.J.A.R.2d (HLT) 25.

Medicaid-only applicant entitled to funeral expenses. B.F. v. Monmouth County Board of Social Services, 92 N.J.A.R.2d (DMA) 45.

10:71-2.2 Responsibilities in the application process

(a) The Division of Medical Assistance and Health Services is the administrative unit of the Department of Human Services responsible for coordinating the administration of Medicaid Only with the Supplemental Security Income program. This Division provides for payment of claims for, and evaluation of health services rendered under, Medicaid Only; maintains administrative liaison with other departmental divisions; and provides professional, medical and paramedical staff which is advisory to this Division in all matters of health care relevant to the administration of Medicaid Only. This Division contracts with CBOSSs for reimbursement of costs of administering the Medicaid Only program.

(b) The Division of Medical Assistance and Health Services and the Commissioner of the Department of Human Services shall establish policy and procedures for the application process and supervise the operation of and compliance with the policy and procedures so established.

(c) The CBOSS exercises direct responsibility in the application process to:

1. Inform the applicants about the purpose and eligibility requirements for Medicaid Only, inform them of their rights and responsibilities under its provisions and inform applicants of their right to a fair hearing;
2. Receive applications;
3. Assist the applicants in exploring their eligibility for assistance;
4. Make known to the applicants the appropriate resources and services both within the agency and the community, and, if necessary, assist in their use;
5. Assure the prompt and accurate submission of eligibility data to the Medicaid status files for eligible persons and prompt notification to ineligible persons of the reason(s) for their ineligibility;
6. The CBOSSs shall also provide supportive social services which will enhance cure and rehabilitation of beneficiaries of Medicaid Only.

(d) As a participant in the application process, an applicant shall:

1. Complete, with assistance from the CBOSS if needed, any forms required by the CBOSS as a part of the application process;
2. Assist the CBOSS in securing evidence that corroborates his/her statements;
3. Report promptly any change affecting his or her circumstances.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA" throughout.

Case Notes

Medicaid benefits properly provided despite non-compliance; status letter was lost in mail. B.W. v. Division of Medical Assistance and Health Services, 95 N.J.A.R.2d (DMA) 2.

Patient not ineligible for Medicaid benefits when status letter containing necessary information from Medicaid office on eligibility was lost in mail. B.W. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 2.

10:71-2.3 Policy and procedure on prompt disposition

(a) The maximum period of time normally essential to process an application for the aged is 30 days; for the disabled or blind, 60 days.

(b) "Date of effective disposition" based upon either administrative or board action means:

1. In the case of an approved application, the effective date of the application. (Either the date of application, or the date of form PA-1C, whichever is earlier);
2. In the case of a denied application, the date on which written notification informing the applicant of his or her lack of eligibility and the reason therefor is sent to him or her;
3. In the case of a withdrawn application, the date on which written notification confirming to the client that the agency has taken cognizance of his or her voluntary withdrawal is sent to him or her; or
4. In the case of a dismissed application, the date on which written notification informing the applicant of the dismissal and the reasons therefor is sent to him or her.

(c) It is recognized that there will be exceptional cases where the proper processing of an application cannot be completed within the 30/60 day period. Where substantially reliable evidence of eligibility is still lacking at the end of the designated period, the application may be continued in pending status. In each such case, the CBOSS shall be prepared to demonstrate that the delay resulted from one of the following:

1. Circumstances wholly within the applicant's control; or
2. A determination to afford the applicant, whose proof of eligibility has been inconclusive, a further opportunity to develop additional evidence of eligibility before final action on his or her application; or
3. An administrative or other emergency that could not reasonably have been avoided; or
4. Circumstances wholly outside the control of both the applicant and CBOSS.

(d) When the complete processing of an application is delayed beyond 30 days for the aged or 60 days for the blind

or disabled, written notification shall be sent to the applicant on or before the expiration of such period, setting forth the specific reasons for delay.

(e) Each county director of welfare shall arrange operational procedures and establish appropriate operational controls within his or her staff organization to expedite the processing of applications and assure the maximum possible compliance with these standards.

(f) Control records on the exceptional cases shall disclose at any time the identity of all applications which have been in pending status beyond normal limits for processing and the reason therefore. Such record shall be adequate to make possible the preparation of a report of such information at any time it might be requested by the CBOSS or the Division of Medical Assistance and Health Services.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (c) and (f), substituted "CBOSS" for "CWA" throughout.

10:71-2.4 Intake policy and procedure

(a) "Intake" is a term applied to the CBOSS's activities in relation to requests for information pertaining to or requests for Medicaid Only.

(b) When a client or a representative of a client inquires, for Medicaid Only, an appointment for an interview with the client shall be arranged promptly. Such inquiries shall be recorded as inquiries unless and until there is an interview which results in a decision to make application for assistance.

(c) When the inquiry is by letter or telephone, an appointment, if requested, shall be arranged promptly. An application for Medicaid Only is not to be taken if applicant plans to or has applied for SSI.

(d) All inquiries and referrals shall be cleared with the State Data Exchange (SDX) and any previous information on file shall be made available to the worker for the initial interview.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a), substituted "CBOSS's" for "CWA's".

10:71-2.5 Application policy and procedure

(a) Application for Medicaid Only may be taken by the CBOSS where the applicant resides or is institutionalized at the time of making application.

(b) A legally appointed guardian shall always be recognized as an authorized agent to initiate an application to establish eligibility for Medicaid Only.

(c) In Medicaid Only, an individual who wishes to apply may be confined at home or at an institution, or may be subject to a critical illness or injury which impedes action on his or her own behalf. Consequently, the CBOSS shall accept any one of the following, in order of priority as listed, as an authorized agent for the purpose of initiating an application:

1. A relative by blood or marriage;

2. A staff member of a public or private welfare agency of which the person is a client, who has been designated by the agency to so act;

3. A physician or attorney of whom the person is respectively a patient or client;

4. A staff member of an institution or facility in which a person is receiving care, who has been designated by the institutional facility to so act.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a) and (c), substituted "CBOSS" for "CWA".

10:71-2.6 Registration procedures and record of inquiries

(a) Official registration of an application consists of the following steps:

1. Entry in application register under appropriate classification as new, reapplication, reopened application or transfer;

2. Assignment of case control number (registration number) to a new application, or reassignment of previous number to a reapplication or reopened application;

3. Preparation of appropriate form PA-9, registration card.

(b) So far as possible, registration shall be completed on the same day that application for assistance is made. If the application is made outside the CBOSS office, registration shall be completed within three working days.

(c) An inquiry is any request for information about assistance programs which is not a request for an application. A record is necessary only when the inquiry requires follow-up action.

(d) The Institutional Services Section makes Medicaid Only referrals for adults contemplating discharge from specific state and county institutions. These cases are to be registered within two working days.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b), substituted "CBOSS" for "CWA".

10:71-2.7 Reports to the Commission for the Blind and Visually Impaired under specified circumstances

By law, the CBOSS is required to report to the Commission for the Blind and Visually Impaired, every individual coming to its attention who is known to be, or who is believed likely to become, permanently blind. The permanent information shall be registered with the Commission in the prescribed form.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA".

10:71-2.8 Assignment of pending application for completion of eligibility determination

Each CBOSS shall provide a method to assure assignment of pending application to a worker within three working days and establish a follow-up tickler system.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA".

10:71-2.9 Process of establishing eligibility

The process of establishing eligibility involves a review of the application for completeness, consistency, and reasonableness. A personal face to face interview with the applicant or his/her authorized agent is required.

Cross References

Determination of continuing eligibility, see N.J.A.C. 10:71-8.1.

10:71-2.10 Collateral investigation

(a) "Collateral investigation" shall refer to contacts with individuals other than members of applicant's immediate household, made with the knowledge and consent of the applicant(s).

(b) The primary purpose of collateral contacts is to verify, supplement or clarify essential information.

(c) The applicants will usually be able to help select the most likely sources of information about themselves. If they are unwilling to have the necessary inquiries made and are unwilling to secure the required information from such sources themselves, then it shall be explained that the CBOSS will be unable to certify entitlement to Medicaid Only.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (c), substituted "CBOSS" for "CWA".

Case Notes

Home was non-liquid resource excluded from determining Medicaid eligibility as long as applicant agreed to liquidate within six months of application date. J.N. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 55.

10:71-2.11 Case recording

All pertinent information relating to the eligible applicant shall be recorded.

10:71-2.12 Recommendation for agency decision

The eligibility worker is initially responsible for the recommendation for approval or denial. The eligibility worker will complete the work sheet and authorization for medical assistance PR-1 and a copy will be sent to the Medicaid unit for preparation of the MAP-1. The statement of income available for nursing home payment PR-1 (formerly PA-3L) will be completed in appropriate cases.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted references to eligibility workers for income maintenance workers throughout, substituted "medical assistance PR-1" for "public assistance (PA-3A)" in the second sentence, and substituted "PR-1 (formerly PA-3L)" for "(PA-3L)" in the third sentence.

10:71-2.13 Supervisory review and approval

(a) In most cases an eligibility worker will complete the investigation and processing of the application.

(b) All records shall be reviewed by a supervisory staff member prior to final disposition.

(c) Any difference of opinion between worker and supervisor shall be resolved by a conference, and, if necessary, the issue shall be referred to a higher administrative level for disposition.

(d) All records of application shall be approved in writing by the supervisor following review, either by signature or initialed transcript signature.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a), substituted "eligibility worker" for "IM worker".

10:71-2.14 Disposition of application

(a) It is the intent of State law and policy that the normal method for disposing of applications recommended for approval shall be by the authority vested in the director of welfare to make decisions on eligibility for Medicaid Only. The director of welfare has the same authority to make case decisions other than approvals.

(b) The director may delegate such authority to any staff member or members as he/she may determine. He/she shall exercise this right of delegation in such a way as to assure the available at all times of some staff member possessing the requisite authority to make decisions and to authorize

payment by the Division of Medical Assistance and Health Services.

(c) Applications which may be held for the welfare board are:

1. Those where immediate medical need is not indicated; or
2. Those where the director believes that there is valid cause to question the available evidence on any point of eligibility, or where the case presents a special problem;
3. If so held, the application shall be identified in the narrative portion of the minutes, and in each instance shall include a brief statement of the question or special problem involved and the decision of the board.

10:71-2.15 Notice of agency decision

Designation of personnel responsible for preparation of decision notices shall be at the discretion of the agency.

10:71-2.16 Retroactive eligibility for Medicaid

(a) All applicants for Medicaid Only shall be queried as to whether or not they have outstanding unpaid medical bills incurred within the three month period prior to the month of application for Medicaid Only. Those indicating the existence of such bills are to be supplied with an "Application for payment of unpaid medical bills," form FD-74, for completion. The intake worker will be responsible for assisting the applicant, where necessary, in the interpretation and completion of the application form (regardless of whether the individual is eventually determined to be eligible for Medicaid). The intake worker will not be responsible for making a financial determination of eligibility for the three-month period in question.

(b) The applicant shall attach all outstanding unpaid medical bills to the FD-74 form and forward it to the:

Division of Medical Assistance and Health
Services
Retroactive Eligibility Unit
PO Box 712 Mail Code 10
Trenton, NJ 08625-0712

(c) For individuals who are incapable of acting on their own behalf, an authorized agent can make application for retroactive Medicaid eligibility when there are outstanding medical bills. Such persons, at the time of application, should be provided with a form FD-74 for completion and submission to the retroactive eligibility unit with the unpaid medical bills attached.

(d) In the case of an individual who is deceased, an authorized agent, as defined above, may make application for retroactive Medicaid eligibility by obtaining an application form FD-74 from either the county welfare board or a Medical Assistance Customer Center.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a), substituted "Medicaid" for "public assistance" in the third sentence.

Amended by R.2006 d.133, effective November 6, 2006.

See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

In (d), substituted "a Medical Assistance Customer Center" for "the Medicaid District Office."

Case Notes

Untimely application for three months retroactive benefits under Medicaid program was not waived and was properly denied. Estate of G.K. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 27.

SUBCHAPTER 3. ELIGIBILITY FACTORS

Law Review and Journal Commentaries

Protecting the Home in Government Benefits Planning. Gary Mazart, 164 N.J.Law. 34 (Mag.) (Oct. 1994).

10:71-3.1 General provisions

(a) Eligibility must be established in relation to each legal requirement to provide a valid basis for granting or denying medical assistance.

(b) The applicant's statements regarding his/her eligibility, as set forth in the application form, are evidence. The statements must be consistent and meet prudent tests of credibility. Incomplete or questionable statements shall be supplemented and substantiated by corroborative evidence from other pertinent sources, either documentary or nondocumentary:

1. Documentary sources of evidence present factual information recorded at some previous date by a disinterested party and filed as part of a record. Examples: certificates, legal papers, insurance policies, licenses, bills, receipts, notices of RSDI benefits, and so forth.

2. Nondocumentary sources of evidence are factual oral statements which appear to be reliable by individuals, based on the observation and personal knowledge of applicant's circumstances.

Case Notes

Comparison of Medicaid monthly income eligibility limits to those for the Medical Assistance to the Aged program; Medicaid income eligibility depends on participants' living arrangements (citing former N.J.A.C. 10:94-4.33 Table A). *Texter v. Dept. of Human Services*, 88 N.J. 376, 443 A.2d 178 (1982).

10:71-3.2 Citizenship; requirements

(a) The applicant must be a resident of the United States who is either a citizen or an alien who can be classified as an eligible alien in accordance with this subchapter.

Case Notes

No Medicaid eligibility for trustor entitled to receive funds under irrevocable trust. *Dickson v. Division of Medical Assistance and Health Services and Bergen County Board of Social Services*, 97 N.J.A.R.2d (DMA) 33.

Medicaid benefits were properly denied where applicant had excess resources despite incurring large debt to nursing home. *Estate of L.L. v. Essex County Department of Citizens Services*, 96 N.J.A.R.2d (DMA) 41.

Transfer of real property for less than true value raised presumption of transfer to obtain Medicaid benefits. *P.V. v. Camden County Board*, 95 N.J.A.R.2d (DMA) 38.

Ceremonial marriage required; medicaid resource eligibility. *P.M. v. Morris County Board of Social Services*, 94 N.J.A.R.2d (DMA) 8.

Combined countable resources included unsecured promissory notes. *H.H. v. New Jersey Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 58.

Husband's estate funds were available to pay wife's nursing home costs. *L.S. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 7.

10:71-4.2 Countable resources

(a) Any resource which is not specifically excludable under the provisions of N.J.A.C. 10:71-4.4 shall be considered a countable resource for the purpose of determining Medicaid Only eligibility.

1. No portion of a cash reward offered by the Division to an individual for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of resources for financial eligibility purposes, if the resource is maintained in a separate account, in accordance with N.J.A.C. 10:71-4.4(b).

(b) Verification of resources: If verification is required in accordance with the provisions of N.J.A.C. 10:71-4.1(d)3, the CBOSS shall proceed in the following manner:

1. Real property which produces income: If the CBOSS determines that it is necessary to establish whether or not real property is producing income consistent with its current market value (see N.J.A.C. 10:71-4.4(b)5), inquiry shall be made of local real estate brokers, tax assessors, or other persons knowledgeable of the prevailing rate of return on real property in the community.

2. Nonexcludable household goods and/or personal effects: If the CBOSS determines that certain household goods and/or personal effects are not excludable (see N.J.A.C. 10:71-4.4), inquiry shall be made of one or more local merchants who deal in used household goods or personal goods in order to determine the current market value of the resource.

3. The CBOSS shall verify the existence or nonexistence of any cash, savings of checking accounts, time or demand deposits, stocks, bonds, notes receivable, or any other financial instrument or interest. Verification shall be

accomplished through contact with financial institutions, such as banks, credit unions, brokerage firms, and savings and loan associations. Minimally, the CBOSS shall contact those financial institutions in close proximity to the residence of the applicant or the applicant's relatives and those institutions which currently provide or previously provided services to the applicant.

(c) Documentation of verification: Any verification which occurs in connection with the determination or evaluation of resources shall be fully documented in the case record.

Amended by R.1986 d.481, effective December 15, 1986 (operative January 1, 1987).

See: 18 N.J.R. 542(a), 18 N.J.R. 2457(a).

Old (b) and (c) deleted; (c)1 renumbered (b); (b)3 added; (d) renumbered to (c).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b), substituted "CBOSS" for "CWA" throughout.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (a)1.

Law Review and Journal Commentaries

Protecting the Home in Government Benefits Planning. Gary Mazart. 164 N.J.Law. 34(Mag.) (Oct. 1994).

Case Notes

Federal Medicaid statute requiring that state's methodology for determining resource eligibility of medically needy person be no more restrictive than for categorically needy person required exclusion of husband's individual retirement account from computation of wife's resources for purposes of determining eligibility. *Mistrick v. Division of Medical Assistance and Health Services*, 299 N.J.Super. 76, 690 A.2d 651 (A.D.1997).

10:71-4.3 (Reserved)

10:71-4.4 Excludable resources

(a) A resource which is classified as excludable shall not be considered either in the deeming of resources or in the determination of eligibility for participation in the Medicaid Only Program.

(b) The following resources shall be classified as excludable:

1. A house occupied by the individual as his/her place of principal residence, and the land appertaining thereto, shall be excluded:

- i. Short temporary absences from home such as trips, visits, and hospitalizations do not affect this exclusion so long as the individual intends, and may reasonably be expected, to return home. An absence of more than six months is assumed to indicate that the home no longer serves as a principal residence. However, if the home is used by a spouse or there is evidence that the absence from the house is temporary, the home may continue to be excluded. With that exception, the CWA shall extend the period only with

approval from the Division of Medical Assistance and Health Services.

2. In the determination of resources of an individual (and spouse, if any), an automobile shall be excluded or counted as follows:

i. One automobile is totally excluded regardless of value if it is used for transportation for the individual or a member of the individual's household.

ii. Any other automobiles shall be considered to be non-liquid resources. Equity in all such automobiles is counted as a resource.

(1) The equity value of an automobile is the value of the vehicle as indicated by the "Average Wholesale Value" in the most recent April or October edition of the Red Book; Official Used Car Valuations minus any encumbrances.

3. Personal effects and household goods, to the extent that the total equity value of such resources does not exceed \$2,000:

i. The amount by which the equity value of such resources exceeds \$2,000 shall be countable toward the appropriate resource maximum.

ii. In determining the value of household goods and personal effects of an individual (and spouse), there shall be excluded a wedding ring and an engagement ring.

iii. Prosthetic devices, dialysis machines, hospital beds, wheel chairs, and similar equipment shall not be considered in the evaluation of personal effects, unless such items are used extensively and primarily by other members of the household, as well as by the person whose physical condition requires them.

4. The cash surrender value of all life insurance policies owned and in the control of the individual, if the total face value of such policies does not exceed \$1,500 (see also (b)9 below):

i. If the total face value of such policies exceeds \$1,500, the total cash surrender value of all policies shall be included as a resource, countable toward the appropriate resource maximum.

5. Nonhome property that is used in a business or non-business self-support activity is excluded from resources when the equity does not exceed \$6,000 and the activity produces a net annual return of at least six percent of the excludable equity value. If a net return of six percent on \$6,000 equity is shown, but the equity value of the property exceeds \$6,000, the excess equity (property value less \$6,000) is a countable resource and applied to the resource standards in N.J.A.C. 10:71-4.5. If such property is not excludable because the net annual return is less than 6 percent of the equity value (with exceptions below), the total equity value is an includable resource.

i. A rate of return of less than six percent is considered acceptable when all the following conditions are met:

(1) The property is used in a business income-producing operation; and

(2) Unusual or untoward circumstances cause a temporary reduction in the net rate of return; and

(3) The usual net rate of return is six percent of equity value; and

(4) The individual expects the property to again produce a return of six percent of equity value within 18 months of the end of the taxable year in which the unusual incident which caused the reduction in the rate of return occurred.

ii. Tools and equipment required for employment are assumed to be of a reasonable value and producing a reasonable rate of return and are, therefore, excluded from resources.

6. The value of resources which are not accessible to an individual through no fault of his or her own.

i. Such resources include, but are not limited to, irrevocable trust funds, property in probate, and real property which cannot be sold because of the refusal of a co-owner to liquidate.

ii. Inaccessible resources shall be reevaluated (regarding their accessibility) at every redetermination.

7. In the case of a blind or otherwise disabled person, resources which have been accumulated in connection with a plan to achieve self-support.

To qualify for this exclusion, an individual's plan to achieve self-support shall have been approved by the Division of Vocational Rehabilitation Services or the Commission for the Blind and Visually Impaired, and must be current as of the date of the exemption.

8. The replacement value of excludable resources shall be considered as follows:

i. For insurance proceeds, the amount received from an insurance company for the purpose of replacing or repairing an originally excludable resource, if repair or replacement of such resource occurs within nine months.

(1) The initial nine month period shall be extended for a reasonable period up to an additional nine months when it is determined that the individual had good cause for not replacing or repairing the resource. An individual will be found to have good cause when circumstances beyond his or her control prevented the repair or replacement or the contracting for the repair or replacement.

ii. The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent that they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within three months of the date of the proceeds. If the proceeds are not used in the above manner they shall be counted toward the resource maximum.

9. Burial spaces intended for the use of the individual, his or her spouse, or any other member of his or her immediate family and funds which are set aside for the burial expenses of the individual or spouse, subject to the limits specified below.

i. The following definitions apply in regard to burial spaces or funds:

(1) Burial spaces are conventional grave sites, crypts, mausoleums, urns, or other repositories which are customarily and traditionally used for the remains of deceased persons.

(2) Funds set aside for burial include revocable burial contracts, burial trusts, and any separately identifiable assets which are clearly designated as set aside for the expenses connected with an individual's burial, cremation or other funeral arrangements.

(3) Funds in an irrevocable trust or other irrevocable arrangement which are available for burial are funds held in an irrevocable burial contract and irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified for burial expenses.

(4) Immediate family includes an individual's minor and adult children, stepchildren and adopted children, brothers, sisters, parents, adopted parents and spouses of those persons. Dependency and living-in-the-same household are not factors. Immediate family does not include the members of an ineligible spouse's family unless they meet this definition.

ii. The exclusion from resources of funds set aside for burial applies only when counting any portion of the funds toward the resource limit would cause ineligibility due to excess resources.

(1) If the individual or couple would otherwise be ineligible and could be eligible with the application of this exclusion and the individual or couple alleges that funds are set aside for the burial of the eligible individual or his or her spouse, an affidavit indicating such must be obtained.

(A) The amount of funds that may be excluded shall be determined and may not exceed the maximum limit of \$1,500 each for the individual and his or her spouse. The maximum limit for each individual is reduced by an amount equal to the amount of funds held in an irrevocable burial trust,

an irrevocable burial contract, or other irrevocable arrangement which is available to meet that individual's burial expenses. Each individual's maximum limit is further reduced by the face value of any insurance policy on that individual's life owned by him or her or his or her spouse if the cash surrender value of the policy was excluded in determining the resources of the individual.

(B) In order for burial funds to be excluded, the funds must be separately identifiable (that is, not commingled with other funds or assets which are not set aside for burial). Additionally, the funds must be already designated as set aside for burial. If the funds are not so designated, the funds may be excluded if the individual attests in writing, that he or she intends to use the funds for his or her burial and agrees to submit within 30 days, documentary evidence that the funds have been designated as set aside for burial.

(C) Any increase in the value of excluded burial funds due to interest on such funds which were left to accumulate or appreciation of such funds after establishment of Medicaid eligibility shall be excluded.

10. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes;

i. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

As amended, R.1983 d.167, effective June 6, 1983.

See: 15 N.J.R. 422(a), 15 N.J.R. 925(b).

(a)9., Burial spaces and funds added as excludable resources.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b)2ii, substituted "beneficiary" for "recipient" in the introductory paragraph.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (b)10.

Amended by R.2006 d.133, effective November 6, 2006.

See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

Rewrote (b)2i; in (b)2ii, rewrote the introductory paragraph; in (b)2ii(1), substituted "equity value" for "CMB" and inserted "minus any encumbrances"; deleted (b)2iii.

Law Review and Journal Commentaries

Protecting the Home in Government Benefits Planning. Gary Mazart. 164 N.J.Law. 34 (Mag.) (Oct. 1994).

Healthy Financial Planning for Nursing Home Care. Michael K. Feinberg, 138 N.J.L.J. 33 (1991).

Case Notes

Federal Medicaid statute requiring that state's methodology for determining resource eligibility of medically needy person be no more restrictive than for categorically needy person required exclusion of husband's individual retirement account from computation of wife's resources for purposes of determining eligibility. *Mistrick v. Division of Medical Assistance and Health Services*, 299 N.J.Super. 76, 690 A.2d 651 (A.D.1997).

Proceeds from judgment or settlement transferred by individual into irrevocable trust are still available resources, for purposes of determining Medicaid eligibility. *In re Lennon*, 294 N.J.Super. 303, 683 A.2d 239 (Ch.1996).

Testamentary trust income not includable as income in determining Medicaid eligibility. *McKenna v. Division of Medical Assistance and Health Services and Essex County Department of Citizen Services*, 97 N.J.A.R.2d (DMA) 42.

Trust which terminated benefits upon institutionalization counted as eligible resource for Medicaid eligibility purposes. *P.J. v. Division of Medical Services and Health Services*, 97 N.J.A.R.2d (DMA) 9.

Home was non-liquid resource excluded from determining Medicaid eligibility as long as applicant agreed to liquidate within six months of application date. *J.N. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 55.

Securities transferred by recipient were not a resource for Medicaid eligibility when solely for purpose of repaying a loan. *W.B. v. Dmahs & Atlantic County*, 95 N.J.A.R.2d (DMA) 17.

Proceeds from sale of residence were not "available" to nursing facility resident for Medicaid purposes. *N.P. v. DMAHS*, 93 N.J.A.R.2d (DMA) 103.

10:71-4.5 Resource eligibility standards

(a) For eligibility in the Medicaid Only Program, total countable resources are subject to the following limits. (See N.J.A.C. 10:71-4.1(b) regarding definition of resources, N.J.A.C. 10:71-4.2 regarding countable resources, and N.J.A.C. 10:71-4.8 regarding resources of a couple when one member is applying for Medicaid for institutional services.)

1. Resource eligibility is determined as of the first moment of the first day of the month. Changes in the amount of countable resources subsequent to the first moment of the first day of the month shall not affect eligibility.

2. In the case of checking accounts, the balance as of the first moment of the first day of the month shall be reduced by the amount of any checks which have been drawn on the account but which have not yet cleared the financial institution.

(b) Resource maximum for a couple: Participation in the program shall be denied or terminated if the total value of a couple's countable resources exceeds \$3,000.

1. Definition of a couple: A couple shall be defined as a man and a woman who are legally married, or who have

been determined to be a couple by the Social Security Administration for receipt of RSDI benefits, or who are living together in the same household and presenting themselves to the community in which they live as husband and wife.

(c) Resource maximum for an individual: participation in the program shall be denied or terminated if the total value of an individual's resources exceeds \$2,000.

(d) Resource maximum (institutionalized individuals): The resource maximum for an individual in (c) above applies equally to individuals institutionalized in a Title XIX approved facility. Countable resources held in the institution (for example, trust funds, personal needs accounts) together with those held outside the institution, are to be applied toward the resource maximum. If the resource maximum is exceeded, Medicaid eligibility will cease. (See also N.J.A.C. 10:71-4.8 regarding resource eligibility for institutionalized individuals.)

(e) The grandfather clause: An individual who satisfied the following criteria may have his/her resource eligibility determined in accordance with procedures formerly used in New Jersey's OAA, AB, and DA programs if it is more advantageous to the individual (see Financial Assistance Manual, Chapter 300, for regulations in effect prior to January 1, 1974):

1. The individual was participating in the Medicaid program during December 1973 under one of New Jersey's Federal programs for the aged, blind, or disabled;

2. The individual has, since December 1973, continuously resided in New Jersey;

3. The individual has, since December 31, 1973, continuously been an eligible individual, an eligible spouse, or an essential person participating in the Medicaid program.

- i. Essential person status (refers to spouse only): A spouse who received Medicaid coverage in December 1973 because of his/her status as a person "essential" to the existence of an eligible person is also considered eligible for receipt of Medicaid Only benefits under the provision of the grandfather clause. Such spouse must continue to reside with the eligible individual alone in order to retain his/her essential person status.

- ii. Once an individual's essential person status is terminated, he/she must again apply for benefits and be determined eligible or ineligible on the basis of criteria used for other newly applying aged, blind, or disabled individuals.

(b) Any questions with respect to policy, regulations, or procedures of the Medicaid program should be directed to the appropriate MDO as listed at N.J.A.C. 10:49, Appendix, Form #17.

Amended by R.1985 d.291, effective June 3, 1985.

See: 17 N.J.R. 38(a), 17 N.J.R. 1415(a).

Addresses to MDO have been changed.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a), substituted "beneficiaries" for "recipients" in the second sentence.

SUBCHAPTER 4. RESOURCES

Law Review and Journal Commentaries

Marital Status and 60+ Crowd. Elizabeth Brody, 164 N.J.Law. 39 (Mag.) (Oct. 1994).

Protecting the Home in Government Benefits Planning. Gary Mazar, 164 N.J.Law. 34 (Mag.) (Oct. 1994).

10:71-4.1 Financial eligibility standards; resources

(a) The resources criteria and eligibility standards of this section apply to all applicants and beneficiaries.

(b) Resources defined: For the purpose of this program a resource shall be defined as any real or personal property which is owned by the applicant (or by those persons whose resources are deemed available to him/her, as described in N.J.A.C. 10:71-4.6) and which could be converted to cash to be used for his/her support and maintenance. Both liquid and nonliquid resources shall be considered in the determination of eligibility, unless such resources are specifically excluded under the provisions of N.J.A.C. 10:71-4.4(b).

(c) Availability of resources: In order to be considered in the determination of eligibility, a resource must be "available." A resource shall be considered available to an individual when:

1. The person has the right, authority, or power to liquidate real or personal property, or his or her share of it;
2. Resources have been deemed available to the applicant (see N.J.A.C. 10:71-4.6 regarding deeming of resources); or
3. Resources arising from a third-party claim or action are considered available from the date of receipt by the applicant/beneficiaries, his or her legal representative or other individual acting on his or her legal behalf in accordance with the following definition and provisions.
 - i. Definition of "availability of resources in third-party situations": In third-party situations in which applicants/beneficiaries have brought an action or made a claim against a third party who is or may be

liable for payment of medical expenses related to the cause of the action or claim, funds are considered available or countable at the moment of receipt by the applicant/beneficiary, his or her legal representative, guardian, relative or any person acting on the applicant's/beneficiary's behalf. Such funds should be considered available or countable at the earliest date of receipt by any of the aforementioned entities.

(1) In determining resource eligibility in accordance with N.J.A.C. 10:71-4.5(a), those funds actually available to the applicant/beneficiary or any person acting on his or her behalf as of the first day of the month subsequent to the month of receipt shall be considered a countable resource, unless otherwise excluded (see N.J.A.C. 10:71-4.4).

(2) If a bona fide lien or judgment exists against such funds, making all or some portion of the funds inaccessible to the applicant/beneficiary, CBOSSs shall deduct the encumbrances and consider the remaining amount as a countable resource.

(3) If between the date of receipt of such moneys and the first day of the subsequent month the applicant/beneficiary pays outstanding medical expenses and/or other expenses, the CBOSS shall consider only the funds remaining after such payment as a countable resource.

(d) Evaluation of resources: The value of a resource shall be defined as the price that the resource can reasonably be expected to sell for on the open market in the particular geographic area minus any encumbrances (that is, its equity value).

1. Real property:

i. Sole ownership: When the eligible individual is sole owner and has the right to dispose of the property, the total equity value (see (d)iv below) shall be counted toward the resource maximum.

ii. Joint ownership or ownership in common: Under joint ownership or ownership in common, the equity value of the property shall be divided by the number of owners and the eligible individual's share counted toward the resource maximum.

iii. Ownership by the entirety: Ownership by the entirety (or tenancy by the entirety) refers to property owned by a husband and wife whereby each member has ownership interest in the whole property which is indivisible. When a married couple (either one or both are eligible) is living together, the total equity value of all nonexempt property shall be counted toward the resource maximum. The same policy shall apply to an eligible couple who have been separated less than six months. If the eligible couple has been separated for six months or more, one half of the value represents a resource to each individual. If one spouse is institutionalized and the other spouse resides in the community,

the extent to which either spouse has ownership of the property shall be included pursuant to N.J.A.C. 10:71-4.8.

(1) When an eligible individual and an ineligible spouse own nonexempt property by the entirety and the couple is separated for a full calendar month, the cooperation of both owners is necessary to ascertain resource value. If the ineligible owner expresses willingness to dispose of the property, then its value is divided by the number of owners. If there is no such willingness by the ineligible owner, then no value may be assigned to the property. (See also N.J.A.C. 10:71-4.4(b)6 regarding situations in which a co-owner refuses to liquidate.)

iv. Equity value: The equity value of real property is the tax assessed value of the property multiplied by the reciprocal of the assessment ratio as recorded in the most recently issued State Table of Equalized Valuations, less encumbrance, if any. The Table is available from the State of New Jersey, Department of the Treasury, Trenton, New Jersey 08625.

2. Savings and checking accounts: When a savings or checking account is held by the eligible individual with other parties, all funds in the account are resources to the individual so long as he or she has unrestricted access to the funds (that is, an "or" account) regardless of their source. When the individual's access to the account is restricted (that is, an "and" account), the CBOSS shall consider a pro rata share of the account toward the appropriate resource maximum, unless the client and the other owner demonstrate that actual ownership of the funds is in a different proportion. If it can be demonstrated that the funds are totally inaccessible to the client, such funds shall not be counted toward the resource maximum. Any question concerning access to funds should be verified through the financial institution holding the account.

3. Verification of value: The CBOSS shall verify the equity value of resources through appropriate and credible sources. Additionally, the CBOSS shall evaluate applicant's past circumstances and present living standards in order to ascertain the existence of resources which may not have been reported. If the applicant's resource statements are questionable, or there is reason to believe the identification of resources is incomplete, the CBOSS shall verify the applicant's resource statements through one or more third parties.

i. Responsibility of applicant: If the third party contact is required in accordance with the provisions above, the applicant shall cooperate fully with the verification process. If necessary, the applicant shall provide written authorization allowing the CBOSS to secure the appropriate information.

(e) Resource eligibility: Resource eligibility is determined as of the first moment of the first day of each month. If an individual or couple is resource ineligible as of the first moment of the first day of the month, subsequent changes within that month in the amount of countable resources will not affect the original determination of ineligibility. If resource eligibility is established as of the first moment of the first day of the month, resource eligibility is established for the entire month regardless of any increase in the amount of countable resources.

1. This policy applies equally to individuals and couples in the month of application. Regardless of the date of application, resource eligibility is determined as of the first moment of the first day of that month.

2. If, prior to the first moment of the first day of the month, the applicant or beneficiary has drawn a check (or equivalent instrument) on a checking or similar account, the amount of such check shall reduce the value of the account. The value of such accounts shall not be reduced by any unpaid obligations for which funds have not already been committed by the drafting of a check.

i. When checks have been drawn on an account, the CBOSS shall review the appropriate account registers or check stubs to ascertain the actual balance as of the first moment of the first day of the month. Full documentation of such circumstances is required.

(f) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

Amended by R.1986 d.97, effective April 7, 1986 (operative May 1, 1986).

See: 17 N.J.R. 2954(a), 18 N.J.R. 691(a).

(c)3 added.

Amended by R.1986 d.165, effective May 5, 1986 (operative June 2, 1986).

See: 17 N.J.R. 2524(a), 18 N.J.R. 985(b).

(e) added.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted references to beneficiaries for references to recipients and substituted references to CBOSSs for references to CWAs throughout.

Amended by R.2001 d.199, effective June 18, 2001.

See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).

In (d)li, substituted "(d)liv" for "(d)iv" preceding "below"; in (d)lii, substituted "shall" for "must"; in (d)liii, added the last sentence.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (f).

Case Notes

No Medicaid eligibility for trustor entitled to receive funds under irrevocable trust. *Dickson v. Division of Medical Assistance and Health Services and Bergen County Board of Social Services*, 97 N.J.A.R.2d (DMA) 33.

Medicaid benefits were properly denied where applicant had excess resources despite incurring large debt to nursing home. *Estate of L.L. v. Essex County Department of Citizens Services*, 96 N.J.A.R.2d (DMA) 41.

Transfer of real property for less than true value raised presumption of transfer to obtain Medicaid benefits. *P.V. v. Camden County Board*, 95 N.J.A.R.2d (DMA) 38.

Ceremonial marriage required; medicaid resource eligibility. *P.M. v. Morris County Board of Social Services*, 94 N.J.A.R.2d (DMA) 8.

Combined countable resources included unsecured promissory notes. *H.H. v. New Jersey Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 58.

Husband's estate funds were available to pay wife's nursing home costs. *L.S. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 7.

10:71-4.2 Countable resources

(a) Any resource which is not specifically excludable under the provisions of N.J.A.C. 10:71-4.4 shall be considered a countable resource for the purpose of determining Medicaid Only eligibility.

1. No portion of a cash reward offered by the Division to an individual for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of resources for financial eligibility purposes, if the resource is maintained in a separate account, in accordance with N.J.A.C. 10:71-4.4(b).

(b) Verification of resources: If verification is required in accordance with the provisions of N.J.A.C. 10:71-4.1(d)3, the CBOSS shall proceed in the following manner:

1. Real property which produces income: If the CBOSS determines that it is necessary to establish whether or not real property is producing income consistent with its current market value (see N.J.A.C. 10:71-4.4(b)5), inquiry shall be made of local real estate brokers, tax assessors, or other persons knowledgeable of the prevailing rate of return on real property in the community.

2. Nonexcludable household goods and/or personal effects: If the CBOSS determines that certain household goods and/or personal effects are not excludable (see N.J.A.C. 10:71-4.4), inquiry shall be made of one or more local merchants who deal in used household goods or personal goods in order to determine the current market value of the resource.

3. The CBOSS shall verify the existence or nonexistence of any cash, savings of checking accounts, time or demand deposits, stocks, bonds, notes receivable, or any other financial instrument or interest. Verification shall be accomplished through contact with financial institutions, such as banks, credit unions, brokerage firms, and

savings and loan associations. Minimally, the CBOSS shall contact those financial institutions in close proximity to the residence of the applicant or the applicant's relatives and those institutions which currently provide or previously provided services to the applicant.

(c) Documentation of verification: Any verification which occurs in connection with the determination or evaluation of resources shall be fully documented in the case record.

Amended by R.1986 d.481, effective December 15, 1986 (operative January 1, 1987).

See: 18 N.J.R. 542(a), 18 N.J.R. 2457(a).

Old (b) and (c) deleted; (c)1 renumbered (b); (b)3 added; (d) renumbered to (c).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b), substituted "CBOSS" for "CWA" throughout.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (a)1.

Law Review and Journal Commentaries

Protecting the Home in Government Benefits Planning. Gary Martz. 164 N.J.Law. 34(Mag.) (Oct. 1994).

Case Notes

Federal Medicaid statute requiring that state's methodology for determining resource eligibility of medically needy person be no more restrictive than for categorically needy person required exclusion of husband's individual retirement account from computation of wife's resources for purposes of determining eligibility. *Mistrick v. Division of Medical Assistance and Health Services*, 299 N.J.Super. 76, 690 A.2d 651 (A.D.1997).

10:71-4.3 (Reserved)

10:71-4.4 Excludable resources

(a) A resource which is classified as excludable shall not be considered either in the deeming of resources or in the determination of eligibility for participation in the Medicaid Only Program.

(b) The following resources shall be classified as excludable:

1. A house occupied by the individual as his/her place of principal residence, and the land appertaining thereto, shall be excluded:

i. Short temporary absences from home such as trips, visits, and hospitalizations do not affect this exclusion so long as the individual intends, and may reasonably be expected, to return home. An absence of more than six months is assumed to indicate that the home no longer serves as a principal residence. However, if the home is used by a spouse or there is evidence that the absence from the house is temporary, the home may continue to be excluded. With that exception, the CWA shall extend the period only with approval from the Division of Medical Assistance and Health Services.

2. In the determination of resources of an individual (and spouse, if any), an automobile shall be excluded or counted as follows:

i. One automobile is totally excluded regardless of value if, for the individual or a member of the individual's household:

(1) It is necessary for employment; or

(2) It is necessary as a means of transportation for the medical treatment of a specific or regular medical problem; or

(3) It is modified for operation by, or transportation of, a handicapped person.

ii. If no automobile is excluded under (b)2i above, one automobile is excluded as a resource to the extent that its current market value (CMV) does not exceed \$4,500. The CMV in excess of \$4,500 is counted against the resource limit. Where more than one automobile is involved, the car of highest value may be excluded for use if it is to the advantage of the applicant/beneficiary.

(1) The CMB of an automobile is the value of the vehicle as indicated by the "Average Wholesale Value" in the most recent April or October edition of the Red Book; Official Used Car Valuations.

iii. Other automobiles: Any other automobiles are treated as non-liquid resources and counted to the extent of their equity value.

3. Personal effects and household goods, to the extent that the total equity value of such resources does not exceed \$2,000:

i. The amount by which the equity value of such resources exceeds \$2,000 shall be countable toward the appropriate resource maximum.

ii. In determining the value of household goods and personal effects of an individual (and spouse), there shall be excluded a wedding ring and an engagement ring.

iii. Prosthetic devices, dialysis machines, hospital beds, wheel chairs, and similar equipment shall not be considered in the evaluation of personal effects, unless such items are used extensively and primarily by other members of the household, as well as by the person whose physical condition requires them.

4. The cash surrender value of all life insurance policies owned and in the control of the individual, if the total face value of such policies does not exceed \$1,500 (see also (b)9 below):

i. If the total face value of such policies exceeds \$1,500, the total cash surrender value of all policies shall be included as a resource, countable toward the appropriate resource maximum.

5. Nonhome property that is used in a business or nonbusiness self-support activity is excluded from resources when the equity does not exceed \$6,000 and the activity produces a net annual return of at least six percent of the excludable equity value. If a net return of six percent on \$6,000 equity is shown, but the equity value of the property exceeds \$6,000, the excess equity (property value less \$6,000) is a countable resource and applied to the resource standards in N.J.A.C. 10:71-4.5. If such property is not excludable because the net annual return is less than 6 percent of the equity value (with exceptions below), the total equity value is an includable resource.

i. A rate of return of less than six percent is considered acceptable when all the following conditions are met:

(1) The property is used in a business income-producing operation; and

(2) Unusual or untoward circumstances cause a temporary reduction in the net rate of return; and

(3) The usual net rate of return is six percent of equity value; and

(4) The individual expects the property to again produce a return of six percent of equity value within 18 months of the end of the taxable year in which the unusual incident which caused the reduction in the rate of return occurred.

ii. Tools and equipment required for employment are assumed to be of a reasonable value and producing a reasonable rate of return and are, therefore, excluded from resources.

6. The value of resources which are not accessible to an individual through no fault of his or her own.

i. Such resources include, but are not limited to, irrevocable trust funds, property in probate, and real property which cannot be sold because of the refusal of a co-owner to liquidate.

ii. Inaccessible resources shall be reevaluated (regarding their accessibility) at every redetermination.

7. In the case of a blind or otherwise disabled person, resources which have been accumulated in connection with a plan to achieve self-support.

To qualify for this exclusion, an individual's plan to achieve self-support shall have been approved by the Division of Vocational Rehabilitation Services or the Commission for the Blind and Visually Impaired, and must be current as of the date of the exemption.

8. The replacement value of excludable resources shall be considered as follows:

i. For insurance proceeds, the amount received from an insurance company for the purpose of replacing or repairing an originally excludable resource, if repair or replacement of such resource occurs within nine months.

(1) The initial nine month period shall be extended for a reasonable period up to an additional nine months when it is determined that the individual had good cause for not replacing or repairing the resource. An individual will be found to have good cause when circumstances beyond his or her control prevented the repair or replacement or the contracting for the repair or replacement.

ii. The proceeds from the sale of a home which is excluded from the individual's resources will also be excluded from resources to the extent that they are intended to be used and are, in fact, used to purchase another home, which is similarly excluded, within three months of the date of the proceeds. If the proceeds are not used in the above manner they shall be counted toward the resource maximum.

9. Burial spaces intended for the use of the individual, his or her spouse, or any other member of his or her immediate family and funds which are set aside for the burial expenses of the individual or spouse, subject to the limits specified below.

i. The following definitions apply in regard to burial spaces or funds:

(1) Burial spaces are conventional grave sites, crypts, mausoleums, urns, or other repositories which are customarily and traditionally used for the remains of deceased persons.

(2) Funds set aside for burial include revocable burial contracts, burial trusts, and any separately identifiable assets which are clearly designated as set aside for the expenses connected with an individual's burial, cremation or other funeral arrangements.

(3) Funds in an irrevocable trust or other irrevocable arrangement which are available for burial are funds held in an irrevocable burial contract and irrevocable burial trust, or an amount in an irrevocable trust which is specifically identified for burial expenses.

(4) Immediate family includes an individual's minor and adult children, stepchildren and adopted children, brothers, sisters, parents, adopted parents and spouses of those persons. Dependency and living-in-the-same household are not factors. Immediate family does not include the members of an ineligible spouse's family unless they meet this definition.

ii. The exclusion from resources of funds set aside for burial applies only when counting any portion of the

funds toward the resource limit would cause ineligibility due to excess resources.

(1) If the individual or couple would otherwise be ineligible and could be eligible with the application of this exclusion and the individual or couple alleges that funds are set aside for the burial of the eligible individual or his or her spouse, an affidavit indicating such must be obtained.

(A) The amount of funds that may be excluded shall be determined and may not exceed the maximum limit of \$1,500 each for the individual and his or her spouse. The maximum limit for each individual is reduced by an amount equal to the amount of funds held in an irrevocable burial trust, an irrevocable burial contract, or other irrevocable arrangement which is available to meet that individual's burial expenses. Each individual's maximum limit is further reduced by the face value of any insurance policy on that individual's life owned by him or her or his or her spouse if the cash surrender value of the policy was excluded in determining the resources of the individual.

(B) In order for burial funds to be excluded, the funds must be separately identifiable (that is, not commingled with other funds or assets which are not set aside for burial). Additionally, the funds must be already designated as set aside for burial. If the funds are not so designated, the funds may be excluded if the individual attests in writing, that he or she intends to use the funds for his or her burial and agrees to submit within 30 days, documentary evidence that the funds have been designated as set aside for burial.

(C) Any increase in the value of excluded burial funds due to interest on such funds which were left to accumulate or appreciation of such funds after establishment of Medicaid eligibility shall be excluded.

10. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes;

i. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

As amended, R.1983 d.167, effective June 6, 1983.

See: 15 N.J.R. 422(a), 15 N.J.R. 925(b).

(a)9., Burial spaces and funds added as excludable resources.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b)2ii, substituted "beneficiary" for "recipient" in the introductory paragraph.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (b)10.

Law Review and Journal Commentaries

Protecting the Home in Government Benefits Planning. Gary Martz. 164 N.J.Law. 34 (Mag.) (Oct. 1994).

Healthy Financial Planning for Nursing Home Care. Michael K. Feinberg. 138 N.J.L.J. 33 (1991).

Case Notes

Federal Medicaid statute requiring that state's methodology for determining resource eligibility of medically needy person be no more restrictive than for categorically needy person required exclusion of husband's individual retirement account from computation of wife's resources for purposes of determining eligibility. *Mistrick v. Division of Medical Assistance and Health Services*, 299 N.J.Super. 76, 690 A.2d 651 (A.D.1997).

Proceeds from judgment or settlement transferred by individual into irrevocable trust are still available resources, for purposes of determining Medicaid eligibility. *In re Lennon*, 294 N.J.Super. 303, 683 A.2d 239 (Ch.1996).

Testamentary trust income not includable as income in determining Medicaid eligibility. *McKenna v. Division of Medical Assistance and Health Services and Essex County Department of Citizen Services*, 97 N.J.A.R.2d (DMA) 42.

Trust which terminated benefits upon institutionalization counted as eligible resource for Medicaid eligibility purposes. *P.J. v. Division of Medical Services and Health Services*, 97 N.J.A.R.2d (DMA) 9.

Home was non-liquid resource excluded from determining Medicaid eligibility as long as applicant agreed to liquidate within six months of application date. *J.N. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 55.

Securities transferred by recipient were not a resource for Medicaid eligibility when solely for purpose of repaying a loan. *W.B. v. Dmahs & Atlantic County*, 95 N.J.A.R.2d (DMA) 17.

Proceeds from sale of residence were not "available" to nursing facility resident for Medicaid purposes. *N.P. v. DMAHS*, 93 N.J.A.R.2d (DMA) 103.

10:71-4.5 Resource eligibility standards

(a) For eligibility in the Medicaid Only Program, total countable resources are subject to the following limits. (See N.J.A.C. 10:71-4.1(b) regarding definition of resources, N.J.A.C. 10:71-4.2 regarding countable resources, and N.J.A.C. 10:71-4.8 regarding resources of a couple when one member is applying for Medicaid for institutional services.)

1. Resource eligibility is determined as of the first moment of the first day of the month. Changes in the amount of countable resources subsequent to the first moment of the first day of the month shall not affect eligibility.

2. In the case of checking accounts, the balance as of the first moment of the first day of the month shall be reduced by the amount of any checks which have been drawn on the account but which have not yet cleared the financial institution.

(b) Resource maximum for a couple: Participation in the program shall be denied or terminated if the total value of a couple's countable resources exceeds \$3,000.

1. Definition of a couple: A couple shall be defined as a man and a woman who are legally married, or who have been determined to be a couple by the Social Security Administration for receipt of RSDI benefits, or who are living together in the same household and presenting themselves to the community in which they live as husband and wife.

(c) Resource maximum for an individual: participation in the program shall be denied or terminated if the total value of an individual's resources exceeds \$2,000.

(d) Resource maximum (institutionalized individuals): The resource maximum for an individual in (c) above applies equally to individuals institutionalized in a Title XIX approved facility. Countable resources held in the institution (for example, trust funds, personal needs accounts) together with those held outside the institution, are to be applied toward the resource maximum. If the resource maximum is exceeded, Medicaid eligibility will cease. (See also N.J.A.C. 10:71-4.8 regarding resource eligibility for institutionalized individuals.)

(e) The grandfather clause: An individual who satisfied the following criteria may have his/her resource eligibility determined in accordance with procedures formerly used in New Jersey's OAA, AB, and DA programs if it is more advantageous to the individual (see Financial Assistance Manual, Chapter 300, for regulations in effect prior to January 1, 1974):

1. The individual was participating in the Medicaid program during December 1973 under one of New Jersey's Federal programs for the aged, blind, or disabled;

2. The individual has, since December 1973, continuously resided in New Jersey;

3. The individual has, since December 31, 1973, continuously been an eligible individual, an eligible spouse, or an essential person participating in the Medicaid program.

i. Essential person status (refers to spouse only): A spouse who received Medicaid coverage in December 1973 because of his/her status as a person "essential" to the existence of an eligible person is also considered eligible for receipt of Medicaid Only benefits under the provision of the grandfather clause. Such spouse must continue to reside with the eligible individual alone in order to retain his/her essential person status.

ii. Once an individual's essential person status is terminated, he/she must again apply for benefits and be determined eligible or ineligible on the basis of criteria used for other newly applying aged, blind, or disabled individuals.

(f) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

Amended by R.1991 d.32, effective January 22, 1991.

See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

Added text to reference N.J.A.C. 10:71-4.8 to (a) and (d).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b), rewrote introductory paragraph; rewrote (c).

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (f).

Case Notes

Irrevocable trust would not be included in resources determination for Medicaid benefits where applicant was not grantor. *M.M. v. Division of Medical Assistance and Health Services*, 96 N.J.A.R.2d (DMA) 34.

Applicant ineligible for Medicaid for time period his checking account exceeded \$2,000 resource limit. *E.N. v. Division of Medical Assistance and Health Services*, 96 N.J.A.R.2d (DMA) 1.

Home was non-liquid resource excluded from determining Medicaid eligibility as long as applicant agreed to liquidate within six months of application date. *J.N. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 55.

Transfer of real property for less than true value raised presumption of transfer to obtain Medicaid benefits. *P.V. v. Camden County Board*, 95 N.J.A.R.2d (DMA) 38.

Patient not ineligible for Medicaid benefits when status letter containing necessary information from Medicaid office on eligibility was lost in mail. *B.W. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 2.

Termination of New Jersey care benefits was inappropriate; applicant and live-in friend were not a "couple". *C. G. v. Division of Medical Assistance and Health Services*, 94 N.J.A.R.2d (DMA) 37.

Grant of first priority lien to State on property owned by Medicaid benefits petitioner was proper. *C.P. v. Passaic County Board of Health and Social Services*, 94 N.J.A.R.2d (DMA) 34.

Savings were excess resources. *Estate of E.B. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 85.

Applicant was ineligible for "Medicaid Only" benefits. *R.A. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 63.

10:71-4.6 Deeming of resources

(a) When an applicant/beneficiary is an adult residing in the same household with his or her ineligible spouse or is a child residing in the same household with his or her parent(s) or spouse of parent, the resources of the ineligible spouse or parent(s) is considered in the determination of eligibility. The amount included as resources to the applicant/beneficiary, whether or not it is actually available, is termed deemed resources.

(b) Applicant/beneficiary living alone: If the applicant/beneficiary lives alone, only his or her countable resources shall be applied to the resource maximum for an individual.

(c) Applicant/beneficiary couple: In the case of an applicant/beneficiary couple, the total amount of the husband's and wife's combined countable resources shall be applied to the resource maximum for a couple. Such individuals will continue to have resources treated in this manner until they have been separated for one calendar month. At such time, the individuals will be considered to be living alone.

1. If one member of an eligible couple enters a Title XIX institution, only the resources of the institutionalized individual will be counted in the determination of his or her eligibility beginning with the date of admission except as provided in N.J.A.C. 10:71-4.8.

(d) Applicant/beneficiary living with ineligible spouse: If the applicant/beneficiary lives with an ineligible spouse, all countable resources of the ineligible spouse are deemed to the applicant/beneficiary. The value of the total countable resources is compared to the resource maximum for a couple. Such individuals will continue to have resources treated in this manner until they have been separated for one full calendar month. At such time, the individuals will be considered to be living alone.

1. Separation due to institutionalization: If one member of the couple enters a Title XIX institution, only the resources of the institutionalized individual will be counted in the determination of his or her eligibility beginning with the date of admission except as provided in N.J.A.C. 10:71-4.8.

(e) Applicant/beneficiary unmarried and under 18 years of age, living with parents: If the applicant/beneficiary is an unmarried child under the age of 18 years of age who lives with his or her parents (including stepparents), the total value of all countable resources in excess of the appropriate parental resource maximum, cited in (e)2 below, shall be applied toward the resource maximum for an individual (see N.J.A.C. 10:71-4.5). A child will be considered to be not living with his or her parents when he or she has ceased living with them for a period of one calendar month.

1. Child not living with parents due to institutionalization: If a physician has certified that the child's duration of stay in a Title XIX facility (or a combination of such facilities) is expected to be 30 consecutive days or more, such child shall be considered to be not living with his/her parents at the time of such certification. In such circumstances, only the child's own countable resources shall be applied to the resource maximum for an individual.

2. Parental resource maximums (including stepparents):

i. One parent: The total value of countable resources in excess of the source limit for an individual

(see N.J.A.C. 10:71-4.5) shall be applied toward the eligible child's resource maximum.

ii. Two parents: The total value of countable resources in excess of the resource limit for a couple (see N.J.A.C. 10:71-4.5) shall be applied toward the eligible child's resource maximum.

3. More than one eligible child: If there is more than one eligible child in the household, the total value of countable resources in excess of the appropriate parental maximum shall be equally divided among such children. In cases of this nature, no part of the value of such resources shall be allocated to ineligible children residing in the household.

(f) Deeming resources of an alien's sponsor: When the sponsor of an alien is subject to deeming provisions (see N.J.A.C. 10:71-5.7) any countable resources of the sponsor in excess of the appropriate resource limit (the resource limit for an individual or the resource limit for a couple if the sponsor resides with his or her spouse) shall be considered to be resources of the alien in addition to whatever resources the alien has.

As amended, R.1983 d.373, effective September 6, 1983.

See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a).

Added, deeming resources of alien's sponsor.

Amended by R.1985 d.474, effective September 16, 1985.

See: 17 N.J.R. 1525(a), 17 N.J.R. 2274(a).

Substantially amended.

Amended by R.1991 d.32, effective January 22, 1991.

See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

Added (c)1. Deleted statement regarding physician's certification and added text establishing resources counted when one member of a couple is institutionalized.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted "beneficiary" for "recipient" throughout.

Case Notes

Federal Medicaid statute requiring that state's methodology for determining resource eligibility of medically needy person be no more restrictive than for categorically needy person required exclusion of husband's individual retirement account from computation of wife's resources for purposes of determining eligibility. *Mistrick v. Division of Medical Assistance and Health Services*, 299 N.J.Super. 76, 690 A.2d 651 (A.D.1997).

10:71-4.7 Transfer of resources

(a) The provisions of this section shall apply only to persons who are receiving an institutional level of services, including individuals who are receiving services under a 42 U.S.C. § 1915(c) home and community care waiver under Medicaid, or who are seeking that level of services and who have transferred resources, except as specified in N.J.A.C. 10:71-4.10. An individual shall be ineligible for institutional level services through the Medicaid program if he or she (or his or her spouse) has disposed of resources at less than fair market value at any time during or after the 36 month period immediately before:

1. In the case of an individual who is already eligible for Medicaid benefits, the date the individual becomes an institutionalized individual; or

2. In the case of an individual not already eligible for Medicaid benefits, the date that the individual applies for Medicaid as an institutionalized individual.

(b) The following definitions shall apply in situations regarding the transfer of resources:

1. Fair market value: The fair market value (FMV) is equal to the current market value at the time of resource disposal. The FMV shall be determined in accordance with the evaluation instructions set forth in N.J.A.C. 10:71-4.1(d).

2. Uncompensated value: The uncompensated value (UV) is the difference between the FMV of a nonexcludable resource (less any encumbrances) and the compensation received by the individual. If the resource was jointly owned before disposal, the UV considered is only the individual's share of that value (see N.J.A.C. 10:71-4.1(d)).

3. Institutionalized individual: An institutionalized individual for the purposes of this section is a person who is receiving care in a Medicaid certified skilled nursing facility, intermediate care facility (level A or B and ICFMR) and licensed special hospital (Class B or C) or Title XIX psychiatric hospital (if under the age of 21 or age 65 and over). Effective October 1, 1990, an institutionalized individual shall include an individual receiving care in a Medicaid certified nursing facility (NF). For the purposes of this section, an institutionalized individual shall include a person seeking benefits under a home or community care waiver program, not including the Home Care Expansion Program. An institutionalized individual shall not include a person who is receiving care in an acute care general hospital.

4. Penalty period: The penalty period is the period of ineligibility for Medicaid coverage for institutional level care established for an individual as a result of the transfer of a resource for less than fair market value. The penalty period begins with the month of the resource transfer and is the lesser of:

i. 30 months; or

ii. The number of months resulting from dividing the uncompensated value of the transferred resource by statewide monthly average lowest semi-private room rate for Medicaid certified nursing facilities as calculated annually. The current average through December 31, 1990 is \$3,376.

(c) General procedures: If an individual or his or her spouse described in (a) above (including any person acting with power of attorney or as a guardian for such individual) has sold, given away, or otherwise transferred any resources (including any interest in a resource or future rights to a resource) within the 30 months preceding the date of application or entry into institutional care, the following steps shall be taken and fully documented in the case record:

1. Ascertain and document the FMV of the resource.
2. Document the amount of compensation received by the individual for the transfer.
3. Determine the UV, if any.
4. Add the amount of the UV, if any, to the amount of other countable resources.
5. Notify the applicant, in all cases when any amount of UV is established, of the determination via Form PA-13 before the application is approved or denied.
6. Advise the applicant that he or she may rebut the presumption that a resource was transferred at less than FMV in order to qualify for Medicaid coverage for institutional care (see (i) below).

(d) The provisions of this section apply whether or not the resource would have been considered an excluded resource at the time of its disposal or transfer. However, an individual shall not be ineligible for an institutional level of care because of the transfer of his or her equity interest in a home which serves (or served immediately prior to entry into institutional care) as the individual's principal place of residence and the title to the home was transferred to:

1. The institutionalized individual's spouse;
2. A child of the institutionalized individual who is under the age of 21 or a child of any age who is blind or totally and permanently disabled;
 - i. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability shall be evaluated by the Medical Review Team of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13;
3. A brother or sister of the institutionalized individual who already had an equity interest in the home prior to the transfer and who was residing in the home for a period of at least one year immediately before the individual becomes an institutionalized individual; or
4. A son or daughter of the institutionalized individual (other than described in (d)2 above) who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual and who has provided care to such individual which permitted the individual to reside at home rather than in an institution or facility.
 - i. The care provided by the individual's son or daughter must have exceeded normal personal support activities (for example, routine transportation and shopping). The individual's physical or mental condition must have been such as to require special attention and care. The care provided by the son or daughter must have been essential to the health and safety of the individual and consisted of activities such as, but not limited to, supervision of medication, monitoring of

nutritional status, and insuring the safety of the individual.

(e) The provisions of this section do not apply to the following resource transfer situations:

1. The resources were transferred to the community spouse (or to another individual for the sole benefit of the community spouse) prior to the entry into institutional care so long as the resources were not subsequently transferred by the community spouse;
 - i. If funds were transferred to another individual for the sole benefit of the community spouse prior to entry into institutional care, in order that the transfer not be considered to have been for the purposes of qualifying for Medicaid, the funds must have been transferred in the form of a legally binding trust document specifying that the trustee(s) may use the funds solely for the benefit of the community spouse. Should the transferred funds not be so designated, the transfer shall be presumed to be for the purpose of qualifying for Medicaid in accordance with the provisions of this section;
2. The resources were transferred to the community spouse subsequent to the application for Medicaid in accordance with N.J.A.C. 10:71-4.8(a)3; or
3. The resources were transferred from the institutionalized individual or the community spouse to the institutionalized individual's child who is blind or permanently and totally disabled.
 - i. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability will be evaluated by the Disability Review Section of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13.

(f) Resource transferred at fair market value: When the resource was transferred at FMV, the application shall be processed as usual. No special procedure is required.

(g) Resource transferred, resource limit not exceeded: When the UV of a transferred resource, combined with other countable resources does not exceed the applicable resource limit, the application shall be processed as usual.

(h) Resource transferred, resource limit exceeded: When the UV of a transferred resource, combined with other countable resources, exceeds the resource limit, eligibility for institutional level services shall be denied and the procedures below followed:

1. Notify the applicant via Form PA-13 that he or she has transferred a resource at less than FMV, the amount of the UV and the length of the penalty period. Explain that the law states that transfer of a resource at less than FMV is presumed to be for the purpose of establishing Medicaid eligibility for institutional services.

2. Advise the applicant that he or she may rebut the presumption (see (i) below).

3. Prepare a list of such cases for control purposes. The control list shall include the case number, client's name, Social Security number, date of resource disposal, FMV of the resource, amount of UV, and the start and end dates of the period of ineligibility for institutional level services.

(i) Rebuttal of presumption that the resource was transferred to establish eligibility: All applicants or beneficiaries may rebut the presumption that a resource was transferred to establish Medicaid eligibility. If the individual wishes to rebut such presumption, explain that it will be his or her responsibility to present convincing evidence that the resource was transferred exclusively (that is, solely) for some other purpose. The applicant should be assisted in obtaining information when necessary. However, the burden of proof rests with the applicant. Accordingly, when the applicant expresses the desire to rebut the agency's presumption that he or she transferred a nonexcludable resource to establish Medicaid eligibility, the procedures below shall be followed.

1. The applicant's statement concerning the circumstances of the transfer shall be recorded. The statement should include, but need not be limited to, the following:

- i. The applicant's stated purpose for transferring the resource;
- ii. The applicant's attempt to dispose of the resource at FMV;
- iii. The applicant's reasons for accepting less than FMV for the resource;
- iv. The applicant's means of, or plans for, supporting himself or herself after the transfer;
- v. The applicant's relationship, if any, to the person(s) to whom the resource was transferred.

2. Request the applicant to submit any pertinent documentary evidence (for example, legal documents, realtor agreements, relevant correspondence).

3. Take statements from other individuals if material to the decision.

(j) Factors which may indicate that the transfer was for some other purpose: The presence of one or more of the following factors, while not conclusive, may indicate that resources were transferred exclusively for some purpose other than establishing Medicaid eligibility.

1. The occurrence after transfer of the resource of:
 - i. Traumatic onset of disability;
 - ii. Unexpected loss of other resources which would have precluded Medicaid eligibility;
 - iii. Unexpected loss of income which would have precluded Medicaid eligibility.

2. Resources that would have been below the resource limit during each of the preceding 30 months if the transferred resource has been retained.

3. Court-ordered transfer.

4. Evidence of good faith effort to transfer the resource at FMV.

(k) Agency determination pursuant to client rebuttal:

1. The presumption that a resource was transferred to establish Medicaid eligibility is successfully rebutted only if the applicant demonstrates that the resource was transferred exclusively for some other purpose.

2. If the applicant had some other purpose for transferring the resource, but establishing Medicaid eligibility seems to have been a factor in his or her decision to transfer, the presumption is not successfully rebutted.

3. The determination will not include an evaluation of the merits of the applicant's stated purpose of transferring a resource. The determination will only deal with whether or not the applicant has proven that the transfer was solely for some purpose other than establishing Medicaid eligibility.

4. The final determination regarding the purpose of the transfer shall be made at a supervisory level and documented in the case record.

5. The applicant shall be sent a notice of the decision which shall include his or her right to a fair hearing.

(l) In the case of any resource transfer which occurred between April 1, 1990 and August 20, 1990 and which would otherwise be subject to the provisions of this section, the period of ineligibility for institutional services shall be the lesser of:

1. 24 months; or
2. The number of months resulting from the application of the calculation at N.J.A.C. 10:71-4.7(b)4ii.

R.1983 d.373, effective September 6, 1983.

See: 15 N.J.R. 999(h), 15 N.J.R. 1477(a).

Amended by R.1985 d.474, effective September 16, 1985.

See: 17 N.J.R. 1525(a), 17 N.J.R. 2274(a).

Other resources changed from "\$600.00" to "\$1,100" and the total changed from "\$1,600" to "\$2,100."

Emergency amendment, R.1990 d.424, effective July 30, 1990 (expires September 28, 1990).

See: 22 N.J.R. 2604(a).

Revised resource transfer provisions based on Medicare Catastrophic Coverage Act of 1988. Added new (a), recodifying (a)-(c) as (b)-(d), and deleting old (c) on "excluded resources". Added new (e), recodifying old (d)-(i) as (f)-(k). Added new (l). Adopted concurrent proposal, R.1990 d.524, effective September 27, 1990.

See: 22 N.J.R. 2604(a), 22 N.J.R. 3372(b).

Provisions of emergency amendment R.1990 d.424 readopted without change.

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (d)2, substituted "Medical Review Team" for "Disability Review Section"; in (i), substituted "beneficiaries" for "recipients". Amended by R.2001 d.199, effective June 18, 2001.

See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).

In (a), rewrote the introductory paragraph; in (b), inserted "shall" preceding "apply" in the introductory paragraph. Petition for Rulemaking.

See: 39 N.J.R. 2157(a), 2660(a), 4453(a).

Law Review and Journal Commentaries

Marital Status and The 60+ Crowd. Elizabeth Brody. 164 N.J.Law 39 (Mag.) (Oct.1994).

Protecting the Home In Government Benefits Planning. Gary Mazart, 164 N.J.L.J. 34 (1994).

Case Notes

Since federal and state Medicaid laws permit interspousal transfers of the marital home, a guardian may execute such a transfer provided that it complies with the best interest of the ward inclusive of his desire to benefit the natural objects of his bounty. Matter of Labis, 314 N.J.Super. 140, 714 A.2d 335 (N.J. 1998).

House sale made exclusively for purpose other than to qualify for Medicaid prior to traumatic onset of unforeseen disability. M.M. v. Division of Medical Assistance and Health Services and the Bergen County Board of Social Services, 97 N.J.A.R.2d (DMA) 39.

Reimbursement of Medicaid benefits ordered where recipient transferred his interest in former residence for less than fair market value. J.K. v. Division of Medical Assistance and Health Services, 97 N.J.A.R.2d (DMA) 12.

Nursing home applicant entitled to Medicaid benefits after transferring property to adult children who lived in home longer than two years and provided personal services to applicant. M.M. v. Department of Medical Assistance and Health Services and Burlington County Welfare Board, 97 N.J.A.R.2d (DMA) 6.

1990 transfer of property was effective for purposes of Medicaid eligibility despite delayed recording of deed. L.A. v. Bergen County Board of Social Services, 96 N.J.A.R.2d (DMA) 92.

Medicaid applicant's transfer of home to son for less than fair market value did not disqualify her for benefits. L.S. v. DMAHS and Burlington County Board of Social Services, 96 N.J.A.R.2d (DMA) 11.

Son's long-term care of disabled parents supports exemption for Medicaid eligibility purposes of transfer of their house to him. J.L. v. Medical Assistance and Health Services Division, 96 N.J.A.R.2d (DMA) 5.

Funds in fixed annuity and family trust were not countable or accessible resources for purpose of determining Medicaid eligibility. F.E. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 67.

Transfer of real property for less than true value raised presumption of transfer to obtain Medicaid benefits. P.V. v. Camden County Board, 95 N.J.A.R.2d (DMA) 38.

Presumption of transfer of assets for less than fair market value in order to establish applicant's Medicaid eligibility was not rebutted. S.G. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 33.

Transfer by applicant of his interest in a mortgage within 24 months of application did not preclude his eligibility for Medicaid benefits. A.R. v. Passaic County, 95 N.J.A.R.2d (DMA) 21.

Securities transferred by recipient were not a resource for Medicaid eligibility when solely for purpose of repaying a loan. W.B. v. DMAHS & Atlantic County, 95 N.J.A.R.2d (DMA) 17.

Transfer of a resource, a mortgage, held on a condominium for less than fair market value operated to render applicant ineligible for Medi-

caid benefits. C.M. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 14.

Transfer of securities was not a countable resource in determining Medicaid eligibility. Applewood Estates v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 1.

Institutional level services Medicaid eligibility; penalty period of 30 months; couple sold house to children at less than fair market value. G.A. v. Ocean County Board of Social Services, 94 N.J.A.R.2d (DMA) 45.

Trust was Medicaid qualifying trust, and application for Medicaid was properly denied. C.C. v. Bergen County Board of Social Services, 94 N.J.A.R.2d (INS) 31.

Presumption that transfer of home was made solely to qualify for Medicaid rebutted. A.W. v. Morris County Board of Social Services, 94 N.J.A.R.2d (DMA) 22.

There was failure to rebut presumption that marital assets were transferred for less than fair market value in order to contravene eligibility guidelines. S.G. v. Union County Division of Social Services, 94 N.J.A.R.2d (DMA) 13.

Medicaid eligibility denied; presumption that property was transferred to establish eligibility. M.C. v. DMAHS, 94 N.J.A.R.2d (DMA) 1.

Transfer of property to children preserving life estate was prohibited transfer of resources. C.D. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 91.

Reduction in alimony pursuant to consent order was transfer of resources. B.S. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 35.

Husband's estate funds were available to pay wife's nursing home costs. L.S. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 7.

Presumption that transfer of three-family building was for purpose other than to establish Medicaid eligibility was not rebutted. E.B. v. Hudson County Board of Social Services, 92 N.J.A.R.2d (DMA) 13.

Penalty period for transfer of resources governed by regulations in effect on date of transfer. H.P. v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 7.

10:71-4.8 Institutional eligibility; resources of a couple

(a) In the determination of resource eligibility for an individual requiring long-term care, the county board of social services shall establish the combined countable resources of a couple as of the first period of continuous institutionalization beginning on or after September 30, 1989. This determination shall be made upon request for a resource assessment in accordance with N.J.A.C. 10:71-4.9 or at the time of application for Medicaid benefits. The total countable resources of the couple shall include all resources owned by either member of the couple individually or together. The county board of social services shall establish a share of the resources to be attributed to the community spouse in accordance with this section. (No community spouse's share of resources may be established if the institutionalized individual's current continuous period of institutionalization began at any time before September 30, 1989.)

1. The community spouse's share of the couple's combined countable resources is based on the couple's countable resources as of the first moment of the first day of the

month of the current period of institutionalization beginning on or after September 30, 1989 and shall not exceed \$95,100, as indexed annually in accordance with 42 U.S.C. §1396r-5(g) and published as a notice in the New Jersey Register, and unless authorized in (a)4 or 5 below. The community spouse's share of the couple's resources shall be the greater of:

- i. \$19,020, as indexed annually in accordance with 42 U.S.C. §1396r-5(g) and published as a notice in the New Jersey Register; or
- ii. One half of the couple's combined countable resources.

2. In determining the resource eligibility of the institutionalized spouse, the community spouse's share of the resources is subtracted from couple's total combined resources as of the first moment of the first day of the month of application for Medicaid. If the remaining resources are less than or equal to \$2,000, the institutionalized spouse is resource eligible. If the remaining resources exceed \$2,000, eligibility may not be established.

- i. In the case of an individual whose eligibility for institutional care is determined in accordance with the rules applicable for New Jersey Care (see N.J.A.C. 10:72 et seq.), resource eligibility will exist when the couple's combined resources, less the community spouse's share of the resources, are equal to or less than \$4,000.

3. To the extent that the community spouse's share of the combined resources are not already owned by the community spouse, the ownership of the community spouse's share of the resources must be transferred to the community spouse within 90 days of a determination of eligibility for institutional Medicaid services. The CBOSS may extend the transfer period if individual circumstances warrant a longer period to affect the transfer. Resources not transferred by the end of the 90-day period (or extension) shall be counted in the determination of eligibility for the institutionalized individual.

- i. Eligibility for the institutionalized individual shall be established pending the actual transfer of the resources if he or she attests, in writing, that he or she intends to transfer the community spouse's share of the resources to the community spouse.

4. If a court of competent jurisdiction has ordered that resources be transferred to the community spouse in an amount higher than that authorized in (a)1 above, the higher court-ordered amount shall be recognized as the community spouse's share. Any resource transferred under such a court order shall not be subject to the resource transfer penalty described at N.J.A.C. 10:71-4.7.

5. If, in accordance with N.J.A.C. 10:71-5.7(d), additional resources have been authorized to be set aside for the community spouse in order to provide for a sufficient income maintenance level, such additional resources are not

subject to the limitation in this section on the community spouse's share of the couple's combined resources. Any resource transferred to the community spouse under this provision shall not be subject to the resource transfer provision described at N.J.A.C. 10:71-4.7.

6. For purposes of this section, an institutionalized individual does not include any individual who is not likely to remain in a Title XIX facility for a period of 30 consecutive days. If a physician has not certified that the individual's stay in the facility is expected to be a period of 30 or more consecutive days, that individual's Medicaid eligibility will be determined as if he or she continued to reside in the community until he or she has been in a Title XIX facility (or a combination of Title XIX facilities) for a period of 30 consecutive days.

7. For purposes of this section, a continuous period of institutionalization means 30 consecutive days of institutional care in a medical institution, and/or Medicaid funded home and community-based waiver services. Continuity is broken by absences from the institution for 30 consecutive days or the non-receipt of home or community based services for 30 consecutive days.

8. For purposes of determining the community spouse's share of the couple's resources only, countable resources of a couple shall include all resources not subject to exclusion under N.J.A.C. 10:71-4.4, except that one automobile shall be excluded without regard to the dollar limits set forth at N.J.A.C. 10:71-4.4(b)2 and personal effects and household goods shall be excluded without regard to the dollar limits set forth at N.J.A.C. 10:71-4.4(b)3.

9. In determining retroactive eligibility (the three-month period immediately preceding the month of application) based on the first Medicaid application in a continuous period of institutionalization, the community spouse's share of the resources shall be deducted from the couple's combined total resources. If the institutionalized individual subsequently files another Medicaid application for the same continuous period of institutionalization, retroactive eligibility will be based on all resources actually owned by the institutionalized individual.

New Rule, R.1991 d.32, effective January 22, 1991.

See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

Emergency Amendment, R.1992 d.84, effective January 22, 1992, operative January 1, 1992, (expires March 22, 1992).

See: 24 N.J.R. 651(a).

Resource eligibility revised upward.

Adopted concurrent amendment, R.1992 d.191, effective April 20, 1992.

See: 24 N.J.R. 651(a), 24 N.J.R. 1498(b).

Provisions of emergency amendment, R.1992 d.84, readopted without change.

Amended by R.1993 d.402, effective August 16, 1993.

See: 25 N.J.R. 1818(a), 25 N.J.R. 3786(a).

Amended by R.1994 d.428, effective August 15, 1994.

See: 26 N.J.R. 1754(a), 26 N.J.R. 3478(a).

Amended by R.1996 d.46, effective January 16, 1996.

See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).

In (a)1 and (a)1i resource eligibility revised upward.

Amended by R.1996 d.466, effective October 7, 1996.
See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (a), substituted "board of social services" for "welfare agency" in the introductory paragraph, substituted "\$84,120" for "\$76,740" in the introductory paragraph of 1, substituted "\$16,824" for "\$15,348" in 1i, and substituted "CBOSS" for "CWA" throughout.
Amended by R.2001 d.199, effective June 18, 2001.
See: 32 N.J.R. 2021(a), 32 N.J.R. 2195(a).

In (a), rewrote the third and fourth sentences of the introductory paragraph, substituted "\$84,120, as indexed annually in accordance with 42 U.S.C. § 1396r-5(g) and published as a notice in the New Jersey Register, and" for "\$74,740" in 1, and rewrote 1i.
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).

In (a)1, substituted "\$92,760" for "\$84,120" in the introductory paragraph, and substituted "\$18,552" for "\$16,824" in i.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

In (a)1, substituted "\$95,100" for "\$92,760"; and in (a)1i, substituted "\$19,020" for "\$18,552".
Public Notice: Notice of Increase in the Community Spouse's Share of a Couple's Combined Countable Resources.
See: 39 N.J.R. 705(b).
Public Notice: Notice of Increase in the Community Spouse's Share of a Couple's Combined Countable Resources.
See: 40 N.J.R. 2295(a).

Case Notes

Medicaid eligibility when one spouse is institutionalized and the other is living in the community is determined by reference to total assets owned by the couple at time of application, and amount of exempt assets attributable to community spouse that was previously established at time of institutionalization, plus \$2,000 of assets attributable to institutionalized spouse, constitute the asset cap that cannot be exceeded at the time of application, unless that cap was increased to reflect a rise in the consumer price index. *A.K. v. Div. of Med. Assistance*, 350 N.J.Super. 175, 794 A.2d 835.

Federal Medicaid statute requiring that state's methodology for determining resource eligibility of medically needy person be no more restrictive than for categorically needy person required exclusion of husband's individual retirement account from computation of wife's resources for purposes of determining eligibility. *Mistrick v. Division of Medical Assistance and Health Services*, 299 N.J.Super. 76, 690 A.2d 651 (A.D.1997).

Individual Retirement account (IRA) in husband's name is includable resource for purposes of determining a wife's Medicaid eligibility when wife enters a nursing home but husband remains in the community, despite claim that the "no more restrictive" provision excluding IRAs from supplemental security income (SSI) eligibility determinations controlled; the "no more restrictive" provision was superseded by Medicare Catastrophic Coverage Act of 1988 (MCCA). *Mistrick v. Division of Medical Assistance & Health Services*, 154 N.J. 158, 712 A.2d 188 (N.J. 1998).

Spouse's IRA must be included in calculation of institutionalized spouse's available resources for Medicaid eligibility determination. *S.M. v. Division of Medical Assistance and Health Services and Passaic County Board of Social Services*, 96 N.J.A.R.2d (DMA) 37.

Combined countable resources included unsecured promissory notes. *H.H. v. New Jersey Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 58.

Husband's estate funds were available to pay wife's nursing home costs. *L.S. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 7.

10:71-4.9 Resource assessment

(a) At the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989), the institutionalized spouse or the community spouse (or a representative of either spouse) may request an assessment of the couple's total countable resources. The purpose of the assessment is to establish the community spouse's share of the couple's total countable resources (see N.J.A.C. 10:71-4.8(a)).

(b) The county board of social services shall, upon a request for a resource assessment, advise the requesting parties of the documentation and verification necessary to make the assessment. When the necessary documentation and verification is not submitted to the county board of social services in a timely manner, the requesting parties shall be advised that the resource assessment cannot be completed. Upon receipt of all relevant documentation of resources from the couple the county board of social services shall establish the total countable resources of the couple. The county board of social services shall notify both members of the couple of the total value assigned to their combined countable resources and the community spouse's share of those resources. A copy of the notice shall be retained at the county board of social services.

1. The county shall complete the resource assessment and notify the requesting parties of its results within 45 calendar days of the request unless third party verification has not been received by the county board of social services or the requesting parties request a delay.

(c) At the time of providing the couple with a copy of the resource assessment, the county board of social services shall advise the couple that there is no immediate right to a fair hearing on the county's resource assessment, but that there will be an opportunity to appeal the findings of the assessment when and if the institutionalized spouse applies for Medicaid.

New Rule, R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (b) and (c), substituted "board of social services" for "welfare agency" throughout.

10:71-4.10 Transfer of assets

(a) The provisions of this section shall apply, effective June 18, 2001, only to persons who are receiving an institutional level of services, including individuals who are receiving services under a 42 U.S.C. § 1915(c) home and community care waiver under Medicaid, or who are seeking that level of service, and who have transferred assets on or after August 11, 1993. An individual shall be ineligible for institutional level services through the Medicaid program if he or she (or his or her spouse) has disposed of assets at less than fair market value at any time during or after the 36 month period, or the 60 month period in the case of a transfer to a trust, immediately before:

1. In the case of an individual who is already eligible for Medicaid benefits, the date the individual becomes an institutionalized individual; or

2. In the case of an individual not already eligible for Medicaid benefits, the date the individual applies for Medicaid as an institutionalized individual.

(b) The following definitions shall apply to the transfer of assets:

1. Individual means:

i. The individual him or herself who is applying for benefits;

ii. The individual's spouse;

iii. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse;

iv. Any person including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

2. An institutionalized individual, for the purposes of this chapter, is a person who is receiving care in a Medicaid certified nursing facility, intermediate care facility for the mentally retarded (ICFMR), or a licensed special hospital (Class C) or Title XIX psychiatric hospital (if under the age of 21 or age 65 and over). For purposes of this chapter, an institutionalized individual shall also include a person seeking benefits under a home or community care waiver program. An institutionalized individual shall not include a person who is receiving care in an acute care general hospital.

3. Assets shall include all income and resources of the individual and of the individual's spouse. Assets shall also include income and resources which the individual or the individual's spouse is entitled to but does not receive because of action or inaction by the individual or the individual's spouse; or by any person, including a court or administrative body with the legal authority to act in place of or on behalf of the individual or the individual's spouse; or any person, including a court or administrative body, acting at the direction of or upon the request of the individual or the individual's spouse. Examples of actions that would cause income or resources not to be received shall include, but shall not be limited to:

i. Irrevocably waiving pension income;

ii. Waiving the right to receive an inheritance, including spousal elective share pursuant to N.J.S.A. 3B:8-10;

iii. Not accepting or accessing injury settlements;

iv. Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is a plaintiff; and

v. Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

4. Resources, for the purpose of asset transfer, shall include all resources, both included and excluded, in accordance with the provisions of this chapter. For example, the transfer of a home, even if it is serving as the individual's principal place of residence, shall be subject to the transfer of assets provisions.

5. Income, for the purposes of this section, shall have the same definition as found in N.J.A.C. 10:71-5. In determining whether a transfer of assets involves countable income, the income disregards in N.J.A.C. 10:71-5 shall be applied.

6. Fair-market value shall be an estimate of the value of an asset, based on generally available market information, if sold at the prevailing price at the time it was actually transferred. Value shall be based on the criteria for evaluating assets as found in N.J.A.C. 10:71-4.1(d).

i. In determining whether or not an asset was transferred for fair-market value, only tangible compensation, with intrinsic value shall be considered. For example, a transfer for "love and affection" shall not be considered a transfer for fair market value.

ii. In regard to transfers intended to compensate a friend or relative for care or services provided in the past, care and services provided for free at the time they were delivered shall be presumed to have been intended to be delivered without compensation. In regard to transfers allegedly intended to compensate a friend or a relative for care or services that were provided in the past, care and services provided for free at the time they were delivered shall be presumed to have been intended to be delivered without compensation. Thus, a transfer of assets to a friend or relative for the alleged purpose of compensating for care or services provided free in the past shall be presumed to have been transferred for no compensation. This presumption may be rebutted by the presentation of credible documentary evidence preexisting the delivery of the care or services indicating the type and terms of compensation. Further, the amount of compensation or the fair market value of the transferred asset shall not be greater than the prevailing rates for similar care or services in the community. That portion of compensation in excess of the prevailing rate shall be considered to be uncompensated value.

iii. Under a life estate, an individual who owns property transfers the ownership of that property to another individual, while retaining for the rest of his or her life, or the life of another person, certain rights to that property. A life estate entitles the owner of the life estate to possess, use, and obtain profits from the property as long as he or she lives, although actual ownership of the property has passed to another individual. In a transaction

involving a life estate, a transfer of assets is involved. In determining whether a penalty shall be assessed in the case of a transfer involving a life estate, the value of the asset transferred and the value of the life estate shall be computed. The value of the asset transferred is computed by determining the fair market value. The value of the life estate is calculated in accordance with the life estate table published by the Health Care Financing Administration (HCFA) at 49 FR Vol. 49 No. 93, 5-11-84 and 26 C.F.R. 20.2031-7. The value of the life estate is determined by multiplying the current market value of the property by the life estate factor that corresponds to the grantor's age. The value of the life estate is then subtracted from the value of the asset transferred to determine the portion of the asset that was transferred for less than fair market value. If only the value of the transferred portion is needed, the current market value of the

asset is multiplied by the remainder factor. The transfer in which a life estate is retained shall be considered a transfer for less than fair market value whenever the value of the asset transferred is greater than the value of the rights conferred by the life estate.

7. Uncompensated value (UV) shall be the difference between the fair market value at the time of the transfer (less any outstanding loans, mortgages or other encumbrances on the asset) and the amount of consideration received for the asset. If the asset was jointly owned before disposal, the UV considered shall be only the individual's share of that value (see N.J.A.C. 10:71-4.1(d)). If the individual is seeking institutional services or applying for an institutional level of services and has a spouse residing in the community, the UV considered shall be either spouse's share of that value (see N.J.A.C. 10:71-4.8).

computed. The value of the asset transferred is computed by determining the fair market value. The value of the life estate is calculated in accordance with the life estate table published by the Health Care Financing Administration (HCFA) at 49 FR Vol. 49 No. 93, 5-11-84 and 26 C.F.R. 20.2031-7. The value of the life estate is determined by multiplying the current market value of the property by the life estate factor that corresponds to the grantor's age. The value of the life estate is then subtracted from the value of the asset transferred to determine the portion of the asset that was transferred for less than fair market value. If only the value of the transferred portion is needed, the current market value of the asset is multiplied by the remainder factor. The transfer in which a life estate is retained shall be considered a

transfer for less than fair market value whenever the value of the asset transferred is greater than the value of the rights conferred by the life estate.

7. Uncompensated value (UV) shall be the difference between the fair market value at the time of the transfer (less any outstanding loans, mortgages or other encumbrances on the asset) and the amount of consideration received for the asset. If the asset was jointly owned before disposal, the UV considered shall be only the individual's share of that value (see N.J.A.C. 10:71-4.1(d)). If the individual is seeking institutional services or applying for an institutional level of services and has a spouse residing in the community, the UV considered shall be either spouse's share of that value (see N.J.A.C. 10:71-4.8).

the county board of social services within 20 days of notification of the transfer penalty.

1. For the purposes of this chapter, undue hardship shall be considered to exist when:

i. The application of the transfer of assets provisions would deprive the applicant/beneficiary of medical care such that his or her health or his or her life would be endangered. Undue hardship may also exist when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life; and

ii. The applicant/beneficiary can irrefutably demonstrate the transferred assets are beyond his or her control and that the assets cannot be recovered. The applicant/beneficiary shall demonstrate that he or she made good faith efforts, including exhaustion of remedies available at law or in equity, to recover the assets transferred.

2. Undue hardship shall not exist when the application of a transfer penalty merely causes the applicant/beneficiary an inconvenience or restricts his or her lifestyle.

3. In the event that a waiver of undue hardship is denied, neither the Department of Human Services, the Department of Health and Senior Services, nor the county boards of social services shall have any obligation to take any action to assure that payment of services is provided during the penalty period.

4. If the request for undue hardship consideration is denied by the CBOSS, the CBOSS shall notify the applicant of the denial and that the applicant may request a fair hearing in accordance with the provisions of N.J.A.C. 10:49-10.

New Rule, R.2001 d.199, effective June 18, 2001.

See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).

Petition for Rulemaking.

See: 35 N.J.R. 1456(a), 2532(b).

Amended by R.2004 d.401, effective November 1, 2004.

See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).

In (m), rewrote 1, and substituted "\$15,000" for "\$12,000" throughout 4.

Amended by R.2006 d.133, effective November 6, 2006.

See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

In (m)1, substituted "2005" for "2003" and substituted "\$6,525" for "\$6,050"; and deleted (p)2i.

Petition for Rulemaking.

See: 39 N.J.R. 2157(a), 2660(a), 4453(a).

Law Review and Journal Commentaries

Saving the family home. Harold L. Grodberg, 164 N.J.L.J. 1166 (2001).

Case Notes

Medicaid applicants' challenge to state-payback requirement for community spouse annuity trusts (CSATs), whereby state was required to be named first beneficiary of trust assets upon death of spouse residing in community if it had paid benefits on behalf of institutionalized spouse, was moot, where, upon its decision to count CSAT assets in determining Medicaid eligibility, state no longer imposed state-payback condition. *Johnson v. Guhl*, 357 F.3d 403 (3d Cir. N.J. 2004).

Recipient of homecare assistance sold her home to her grandson, and kept a leasehold in an apartment in the house for the term of her life. As the nature of the recipient's leasehold interest was not explained by the lease or by extrinsic evidence, whether she received fair market value for her leasehold interest, and thus for the house itself, could not be determined from the record for purposes of determining her continued eligibility for homecare assistance benefits. *B.D. v. Division of Med. Assistance & Health Servs.*, 397 N.J. Super. 384, 937 A.2d 980, 2007 N.J. Super. LEXIS 366 (App.Div. 2007).

In determining a claimant's eligibility for benefits, the Director of the New Jersey Department of Human Services has the expertise to determine the significance and sufficiency of various types of asset transfers, and when the Director's findings are supported by credible evidence and correct legal principles, they are entitled to deference by a reviewing court. *B.D. v. Division of Med. Assistance & Health Servs.*, 397 N.J. Super. 384, 937 A.2d 980, 2007 N.J. Super. LEXIS 366 (App.Div. 2007).

Decision of the Director of Division of Medical Assistance and Health Services (DMAHS), which upheld the imposition of a Medicaid transfer penalty based on an unequal equitable distribution to a non-institutionalized spouse of a Medicaid applicant in a bed and board divorce action, was reversed as there existed no regulation that authorized such a decision; furthermore, the DMAHS's in-house rule imposing such a penalty for a transfer of assets as equitable distribution of more than 50 percent to the non-institutionalized spouse was contrary to both New Jersey public policy and the law of equitable distribution. *W.T. v. DMAHS*, 391 N.J. Super. 25, 916 A.2d 1066, 2007 N.J. Super. LEXIS 59 (App.Div. 2007).

10:71-4.11 Trusts

(a) For purposes of this subchapter, effective June 18, 2001, a trust is any legal instrument, device, or arrangement which is similar to a trust, in which a grantor transfers property to an individual or entity with fiduciary obligations (considered to be a trustee for purposes of this section). The grantor transfers the property with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or others. For the purposes of this chapter, a trust shall include, but not be limited to, escrow accounts, annuities, investment accounts, and other similar devices managed by an individual or entity with fiduciary obligations.

(b) The standards set forth in this section shall apply to trusts without regard to:

1. The purposes for which the trust is established;
2. Whether the trustee(s) has discretion or exercises such discretion under the trust;
3. Any restrictions on when or whether distribution can be made from the trust; or
4. Any restrictions on the use of distributions from the trust.

(c) Definitions, for the purposes of this section, shall be as follows:

1. A grantor shall be any individual who creates a trust. This section shall apply only to situations in which the grantor is:

- i. The individual;
- ii. The individual's spouse;

iii. A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse; or

iv. A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

2. A revocable trust is a trust which can, under State law, be revoked by the grantor. A trust, which provides that the trust can be only modified or terminated by a court, is considered to be a revocable trust, since the grantor (or his or her representative) can petition the court to terminate the trust. Also, a trust that declares itself to be irrevocable, but which terminates upon conditions relating to the grantor during his or her lifetime, shall be, for the purposes of this section, considered to be revocable. For example, a trust may require a trustee to terminate a trust and disburse the funds to the grantor if the grantor leaves a nursing facility. Such a trust shall be considered to be revocable.

3. An irrevocable trust is a trust which cannot, in any way, be revoked by the grantor.

4. A beneficiary is any individual or individuals designated in the trust instrument as benefiting in some way from the trust. The term "beneficiary" shall not include the trustee or any other individual whose benefit consists only of reasonable fees or payments for managing or administering the trust. The beneficiary can be the grantor, another individual, or individuals, or any combination of any of these parties.

5. For purposes of this chapter, a payment from a trust shall be any disbursement from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use or occupy real property.

(d) Individuals to whom the trust provisions apply shall include any individual who establishes a trust and who is an applicant or beneficiary of Medicaid. An individual shall be considered to have established a trust if any of his or her assets, regardless of the amount, were used to form part or all of the corpus of the trust and if any of the parties described as a grantor in (c)1 above established the trust, other than by will.

1. When the corpus of a trust includes assets of another person or persons not described in (c)1 above, as well as assets of the individual, the rules apply only to the portion of the trust attributable to the assets of the individual. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, the county board of social services shall prorate any amounts of income and resources, based on the proportion of the individual's assets in the trust to those of other persons.

2. When the corpus of a trust includes assets of either an institutionalized spouse as defined in N.J.A.C. 10:71-

4.7(b)3 or a community spouse, this section shall apply to the portion of the trust attributable to either spouse for the purposes of determining eligibility for the institutionalized spouse.

(e) Treatment of trusts, for purposes of determining Medicaid eligibility, shall be dependent on the characteristics of the trust. The look-back period for evaluation of resource transfer shall be 60 months. The following are the rules for consideration of various kinds of trusts:

1. In the case of a revocable trust:

i. The entire corpus of the trust shall be counted as a resource available to the individual;

ii. Any payments from the trust made to or for the benefit of the individual shall be counted as income (unless otherwise excludable, see N.J.A.C. 10:71-5.3); and

iii. Any payments from the trust which are not made to or for the benefit of the individual shall be considered assets disposed of for less than fair market value (see N.J.A.C. 10:71-4.10).

2. In an irrevocable trust from which payment can be made under the terms of the trust to or for the benefit of the individual from all or a portion of the trust, the following shall apply to that trust or that portion of the trust:

i. Payments from income or from the corpus made to or for the benefit of the individual shall be treated as income to the individual unless otherwise excludable (see N.J.A.C. 10:71-5.3);

ii. Income on the corpus of the trust which could be paid to or for the benefit of the individual shall be counted as a resource available to the individual;

iii. The portion of the corpus that could be paid to or for the benefit of the individual shall be treated as a resource available to the individual; and

iv. Payments from income or from the corpus that are made, but not to or for the benefit of the individual, shall be treated as a transfer of assets for less than fair market value (see N.J.A.C. 10:71-4.10).

3. In the case of an irrevocable trust from which payments from all or a portion of the trust cannot, under any circumstances, be made to or for the benefit of the individual, all of the trust, or any such portion or income thereof, shall be treated as a transfer of assets for less than fair market value (see N.J.A.C. 10:71-4.10).

i. In treating these portions as a transfer of assets, the date of transfer shall be considered to be the date the trust was established, or, if later, the date on which the right of payment to the individual was foreclosed.

ii. For transfer of assets purposes, in determining the value of the portion of the trust which cannot be paid to the individual, amounts that have been paid, for whatever purpose, shall not be subtracted from the value of the trust on the date the trust was created or, if later, the date that payment to the individual was foreclosed. The value of the transferred amount shall be no less than the value on the date the trust is established or on the date that payment is foreclosed. If additional funds are added to this portion of the trust, those funds shall be treated as a new transfer of assets or less than fair market value.

4. Payments made from a revocable or irrevocable trust to or on behalf of the individual shall include payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the

payment. For example, such payments may include purchase of clothing or other items, such as a radio or television, for the individual. Such payments may also include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home shall also be considered payments for the benefit of the individual.

i. When a payment to or for the benefit of the individual is made which would not be considered income in the eligibility process, then the payment shall not be counted as income to the individual under this section. For example, payments made on behalf of an individual for medical care are not counted in determining income eligibility for Medicaid, and are therefore not counted as income under these trust provisions.

xiii. If there is a provision for repayment of other assistance programs, the trust shall specifically state that the Medicaid Program shall be repaid prior to making repayment to any other assistance programs.

xiv. The trust shall specifically state that if the beneficiary has received Medicaid benefits in more than one state, each state that provided Medicaid benefits shall be repaid. If there is an insufficient amount left to cover all benefits paid, then each state shall be paid its proportionate share of the amount left in the trust, based upon the amount of support provided to the beneficiary.

xv. No provisions in the trust shall permit the estate's representative to first repay other persons or creditors at the death of the beneficiary. Only what remains in the trust after the repayments specified in (g)lxii, xiii and xiv above have been made shall be considered available for other expenses or beneficiaries of the estate. The trust may provide for a prepaid burial plan, but shall not state that it will pay for reasonable burial expenses after the death of the trust beneficiary.

xvi. The trust shall specify that a formal or informal accounting of all expenditures made by the trust shall be submitted to the appropriate eligibility determination agency on an annual basis.

xvii. The State shall be given advance notice of any expenditure in excess of \$5,000, and of any amount which would substantially deplete the principal of the trust. Notice shall be given to the Division of Medical Assistance and Health Services, Bureau of Administrative Control, PO Box 712, Mail Code 6, Trenton, New Jersey 08625-0712, or any successor agency, 45 days prior to the expenditures.

xviii. New Jersey rules and laws do not permit a trust to create a will for an incompetent or a minor. The money creating the trust, any additions and/or interest accumulated, cannot be left to other parties, but shall pass by intestacy. The trust shall not create other trusts within it.

2. A pooled trust is a special needs trust, containing the assets of a disabled individual, which meets the following conditions:

i. The trust shall be established and managed by a non-profit association;

ii. A separate account shall be maintained for each beneficiary of the trust, but for purposes of investment and management of the funds, the trust may pool the funds from those accounts;

iii. Accounts in the trust shall be established solely for the benefit of the disabled individual by the individual, by a parent, grandparent, or legal guardian of the individual, or by a court;

iv. To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust shall pay to the State of New Jersey the amount remaining in the account, up to an amount equal to the total amount of medical assistance paid under Title XIX of the Social Security Act on behalf of the individual. To meet this requirement, the trust shall include a provision specifically providing for such payment; and

v. Funds of an individual 65 or older which are transferred to a pooled trust shall be subject to the transfer penalty provisions contained in N.J.A.C. 10:71-4.7.

(h) Title XIX of the Social Security Act (42 U.S.C. § 1917(d)(4)(B)) provides for an exemption from the trust provisions for qualified income trusts (also known as Miller trusts). Special provisions for this form of trust apply, under the law, only in those states which do not provide medically needy coverage for nursing facility services. Because New Jersey does cover services in nursing facilities under the medically needy component of the Medicaid program, the establishment of a qualified income trust shall be presumed to be an asset transfer for the purposes of qualifying for Medicaid. This presumption shall apply whether the individual is seeking nursing facility services or home and community based services under one of the waiver programs.

(i) Upon the denial of eligibility or the termination of long-term care level services due to the application of these trust provisions, the county board of social services shall notify the applicant/beneficiary of his or her right to request an undue hardship exception. An applicant/beneficiary may apply for an exception to these trust provisions if he or she can show that the transfer will cause an undue hardship to him or herself. The applicant/beneficiary shall provide sufficient documentation to support the request for an undue hardship waiver to the county board of social services within 20 days of notification of the denial of eligibility or termination of benefits due to these trust provisions.

1. For the purposes of this chapter, undue hardship shall be considered to exist when:

i. The application of the trust provisions would deprive the applicant/beneficiary of medical care such that his or her health or his or her life would be endangered. Undue hardship may also exist when application of the trust provisions would deprive the individual of food, clothing, shelter, or other necessities of life; and

ii. The applicant/beneficiary can irrefutably demonstrate the assets placed in trust are beyond his or her control and that the asset cannot be recovered. The applicant/beneficiary shall demonstrate that he or she made good faith efforts, including exhaustion of remedies available at law or in equity, to recover the assets placed in trust.

2. In the event that a waiver of undue hardship is denied, neither the Department of Human Services, the Department of Health and Senior Services, nor the county boards of social services shall have any obligation to take any action to assure that payment of services is provided during the penalty period.

3. If the request for undue hardship consideration is denied by the county board of social services, the county board of social services shall notify the applicant of the denial and that the applicant may request a fair hearing in accordance with the provisions of N.J.A.C. 10:49-10.

New Rule, R.2001 d.199, effective June 18, 2001.
See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).

Law Review and Journal Commentaries

Special-needs trusts can help preserve family wealth. Harold L. Grodberg, 164 N.J.L.J. 822 (2001).

Case Note

Medicaid applicants challenging state's treatment of community spouse annuity trusts (CSATs) as countable assets in determining Medicaid eligibility lacked standing to challenge state's undue hardship procedures for otherwise ineligible claimants as untimely, where, although state did not have undue hardship procedures in place before action was brought, state offered applicants the opportunity to apply for undue hardship hearings, and applicants chose not to seek such hearings, thereby suffering no injury related to lack of timeliness provision. *Johnson v. Guhl*, 357 F.3d 403.

SUBCHAPTER 5. INCOME

Law Review and Journal Commentaries

Marital Status and 60+ Crowd. Elizabeth Brody, 164 N.J.Law. 39 (Mag.) (Oct. 1994).

Medicaid—Pension Benefits, Judith Nullin, 135 N.J.L.J. No. 17, 53 (1993).

Protecting the Home in Government Benefits Planning. Gary Mazar, 164 N.J.Law. 34 (Mag.) (Oct. 1994).

10:71-5.1 Income; financial eligibility standards

(a) As a condition of eligibility for the Medicaid Only Program, applicants must comply with the income standards set forth in this subchapter (see N.J.A.C. 10:71-5.6).

(b) Income defined: For the purpose of this program, income shall be defined as receipt, by the individual, of any property or service which he/she can apply, either directly or by sale or conversion, to meet his/her basic needs for food, shelter, or clothing. All income, whether in cash or in-kind, shall be considered in the determination of eligibility, unless such income is specifically exempt under the provisions of N.J.A.C. 10:71-5.3

1. Availability of income: In order to be considered in the determination of eligibility, income must be "available." Income shall be considered available to an individual when:

i. With the exception of income from self-employment, the individual actually receives the income;

ii. With the exception of income from self-employment, the income becomes payable but is not received by the individual due to his/her preference for voluntary deferment;

iii. Income has been deemed available to the applicant (see N.J.A.C. 10:71-5.5 regarding the deeming of income);

iv. Net earnings from self-employment have been determined in accordance with N.J.A.C. 10:71-5.4(a)2.

2. Earned income: Earned income shall be defined as payment received by an individual for services performed as an employee, or the net earnings as the result of self-employment. When the individual is both employed as self-employed, earned income shall consist of gross wages (or salary, etc.) plus any net earnings from self-employment.

3. Unearned income: Unearned income shall be defined as any income which is not coincident with the provisions of (b)2 above. This definition includes deemed income (see N.J.A.C. 10:71-5.5).

(c) The grandfather clause: An individual (including an essential person) meeting the criteria delineated in N.J.A.C. 10:71-4.5(e) may have his/her income eligibility determined in accordance with the procedures formerly used in New Jersey's OAA, AB, and DA programs if it is more advantageous (see Financial Assistance Manual, Chapter 300, for regulations in effect prior to January 1, 1974).

Law Review and Journal Commentaries

Medicaid. P.R. Chenoweth, 136 N.J.L.J. No. 14, 56 (1994).

Case Notes

Wife was sole owner of pension where court in making equitable distribution of assets in divorce from bed and board directed pension's administrator to pay wife; benefits could not be considered income available to former husband. *L.M. v. State, Div. of Medical Assistance & Health Services*, 140 N.J. 480, 659 A.2d 450 (1995).

Definition of "available income" for Medicaid eligibility; valid. *Estate of G.F. v. Division of Medical Assistance and Health Services*, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Pension was "available income" for Medicaid eligibility even though payment ordered to wife. *Estate of G.E. v. Division of Medical Assistance and Health Services*, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Regulation governing when income is available did not constitute exercise by the state of its authority to adopt less restrictive income standards than federal standards. *Estate of G.E. v. Division of Medical Assistance and Health Services*, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Voluntarily waived state pension benefits would be "available income" in evaluating Medicaid eligibility. *M.R. v. State Dept. of Human Services, Div. of Medical Assistance and Health Services*, 268 N.J.Super. 586, 634 A.2d 143 (A.D.1993).

Comparison of Medicaid monthly income eligibility limits to those for the Medical Assistance to the Aged program; Medicaid income eligibility depends on participants' living arrangements. *Texter v. Dept. of Human Services*, 88 N.J. 376, 443 A.2d 178 (1982).

Court-ordered spousal support was nevertheless available income to applicant and otherwise countable toward determining Medicaid eligibility. *L.M. v. Division of Medical Assistance*, 95 N.J.A.R.2d (DMA) 51.

Pension benefits paid to former spouse under qualified domestic relations order not gross income. *E.M. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 93.

Voluntary revocable repudiation of pension was not unavailable income. *M.R. v. Division of Medical Assistance and Health Services*, 93 N.J.A.R.2d (DMA) 1.

Pension paid to wife pursuant to qualified domestic relations order was part of husband's countable income. *G.E. v. Division of Medical Assistance and Health Services*, 92 N.J.A.R.2d (DMA) 59.

Petitioner eligible for Medicaid Only program because countable income is equal to program's applicable income standard; income not required to be less than standard. *C.W. v. Middlesex Cty. Welfare Agency*, 1 N.J.A.R. 47 (1980).

10:71-5.2 Determination of countable income

(a) Countable income shall be determined by adding the applicant's nonexempt unearned income (less appropriate exclusions) to his/her earned income (less appropriate exclusions).

(b) Procedures regarding the determination of income eligibility shall be as follows:

1. Determination of initial income eligibility shall be based on all earned and unearned income which has or will be received during the month for which application is made, beginning with the first day of such month, except that quarterly, semiannual, or annual payments shall be prorated in accordance with (b)2 below. (See N.J.A.C. 10:71-5.3(a)15 regarding exclusion of student earnings.)

2. The following shall apply to income received other than monthly:

- i. Income received weekly shall be multiplied by 4.333 to determine the monthly amount; biweekly income shall be multiplied by 2.167. (If earned income is irregular, the initial determination shall be based on the average of the amounts received for any four weeks within the 10 week period which includes the five weeks immediately before and after the date of application.)

- ii. When income received on a quarterly, semi-annual, or annual basis is of sufficient amount to affect the individual's eligibility, it shall be prorated as a monthly amount and entered on the Medicaid Eligibility Worksheet (Form PA-1E) accordingly. (See also N.J.A.C. 10:71-5.4(a)11, regarding lump-sum payments.)

3. The period of income eligibility begins with the month in which application is made and continues until the scheduled redetermination, or until a change in status or income occurs which requires an earlier redetermination. (See N.J.A.C. 10:71-8.1(a), regarding determination of continuing eligibility.)

4. At the time of application, the applicant shall identify any income which he or she receives periodically (less frequently than once a month) or anticipates receiving prior to the time of redetermination.

5. In situations where earned or unearned income is received irregularly or in irregular amounts, redetermination shall be made as frequently as necessary. The individual shall be advised of his or her responsibility to report significant changes in income. (See N.J.A.C. 10:71-5.3(a)12 regarding exclusion of certain irregular income.)

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

10:71-5.3 Income exclusions

(a) Only the following income shall be excluded in the determination of countable income. Income exclusions shall be applied to unearned income first, then to earned income as appropriate. Exclusions shall be applied in the order of their appearance in this section.

1. Monies received as a result of the sale of a resource shall be excluded. These monies shall be treated as a resource (see N.J.A.C. 10:71-4.2 and N.J.A.C. 10:71-4.4(b)8ii).

2. Monies received as a result of the settlement of a casualty insurance claim, if such settlement is intended as compensation for the loss or destruction of a previously excludable resource, shall be excluded (see N.J.A.C. 10:71-4.4(b)8i).

3. Third-party payments for medical care or services, including room and board furnished during medical confinement, shall be excluded.

4. The value of social services (for example, advice, training, consultation) performed by any governmental or private agency shall be excluded.

5. The value of food stamps shall be excluded.

6. All loans which are actually repayable shall be excluded.

i. Regular contributions to an individual by his or her family, which are made over an extended period of time and which would be impossible to repay given the individual's current and/or future financial status, shall not be considered loans. Contributions of this nature shall be treated as income in accordance with N.J.A.C. 10:71-5.2.

7. Benefits received under the following Federal programs shall be exempt:

i. The value of benefits received under the Federal WIC program shall be exempt.

ii. The value of meals provided under the National School Lunch Act shall be exempt.

iii. Training incentive payments made under the Comprehensive Employment Training Act (CETA) of 1973 shall be exempt.

iv. Payments received under Title II of the Uniform Relocation and Real Property Acquisition Policies Act of 1970 shall be exempt.

v. Payments received for services performed in connection with the Domestic Volunteer Service Act of 1973 shall be exempt. Such programs include the Foster Grandparents Program, Older Americans Community Service Program, the Retired Senior Volunteer Program (RSVP), the Service Corps of Retired Executives (SCORE), Volunteers in Service to America (VISTA), the Active Cooperative Volunteer Program (AVP), the Active Corps of Executive (ACE), and other programs which are coordinated by the Federal ACTION agency.

vi. Payments made by the Disaster Assistance Administration shall be exempt.

vii. The value of assistance to children under the Child Nutrition Act of 1966 shall be exempt.

viii. Payments from Home Energy Assistance (HEA) and the Crisis Intervention Program shall be exempt.

ix. Payments received from the Youth Incentive Entitlement Pilot Projects, Youth Community Conservation and Improvement Projects, and the Youth Employment and Training Programs under the Youth Employment and Demonstration Projects Act of 1978 shall be exempt. However, payments from the Adults Conservation Corps under that Act or any other payments under the Comprehensive Employment and Training Act (CETA) of 1973 (with the exception of (a) above) may not be excluded.

x. The amount of the annual cost-of-living increase in Social Security benefits for those individuals who became ineligible for Supplemental Security Income (SSI) solely as a result of SSA cost-of-living increases after June 30, 1977 shall be exempt. Individuals eligible for this exemption are entitled to an additional exemption of the dollar amount of all SSA cost-of-living increases subsequent to that increase which created their SSI ineligibility.

xi. For certain individuals, the dollar amount of the October 1972, 20 percent cost-of-living increase in Social Security benefits shall be exempt. In order to qualify for this exemption, the individual must have been, for the month of August 1972:

(1) Eligible for or receiving cash assistance under Old Age Assistance, AFDC, Aid to the Blind, or Disability Assistance (including persons who were eligible for such assistance but not receiving such assistance because they had not applied for it or because they were residents in medical or intermediate care facilities); and

(2) Entitled to a monthly insurance benefit under Title II of the Social Security Act (RSDI).

8. That part of the proceeds of a life insurance policy which is used to pay the last illness and burial expenses of the insured shall be excluded.

i. Last illness and burial expenses shall include related hospital, medical, funeral, burial plot, interment expenses, and related costs.

9. Refunds on taxes for food, real property, or income shall be exempt.

10. That portion of a grant, scholarship, or fellowship which is to be used to pay tuition and mandatory fees (as defined by the educational institution) shall be excluded.

11. The value of agricultural produce, if raised for home consumption, shall be excluded.

12. Certain irregular and/or infrequently received income shall be excluded as follows:

i. Unearned income which totals \$60.00 or less per quarter (any consecutive three-month period), and which is received less frequently than twice per quarter or cannot be reasonably anticipated shall be excluded.

ii. Earned income which totals \$30.00 or less per quarter (any consecutive three-month period), and which is received less frequently than twice per quarter or cannot be reasonably anticipated shall be excluded.

13. Monies paid to an individual as compensation for the care of a legally assigned foster child shall be excluded. (This income is not excludable if the child is an eligible individual in his or her own right, or if he or she does not reside in the home of the eligible individual(s).)

14. One-third of the amount received as child support from an absent parent shall be excluded.

15. Income received as compensation for services performed as an employee, or from self-employment, by an unmarried student who is under 22 years of age, shall be excluded to the extent that such income does not exceed \$1,200 in a calendar quarter and/or \$1,620 per calendar year.

i. A person shall be considered a student if he or she meets the following criteria:

(1) He or she is enrolled in a course or courses of study and attends to the extent required for continued enrollment. Specifically, a person must attend:

(A) A college or university at least eight semester or quarter hours weekly; or

(B) A secondary school at least 12 clock hours weekly; or

(C) A course of vocational or technical training (other than at a secondary school, college, or university) designed to prepare the student for gainful employment involving shop practice, at least 15 clock hours a week; or without shop practice, at least 12 clock hours per week; or

(D) Less than the appropriate requirements in (a)15i(1)(A), (B), and (C) above, if it is determined that there are extenuating circumstances beyond the control of the student and he/she is pursuing a course of study comparable to the requirements of (a)15i(1)(A), (B), and (C) above.

(2) A student shall be considered in regular attendance if he or she is engaged in home study provided by a secondary school, college, university, or governmental agency, and a home visitor or tutor supervises the study or training. For purposes of this section, government-sponsored courses in the various self-improvement and anti-poverty programs are considered to be for the purposes of preparing the student for gainful employment.

(3) A student shall be considered in regular attendance during normal vacation periods if he or she is in regular attendance in the month immediately preceding and immediately following the vacation period.

(4) A student shall be considered to be in regular attendance for the month in which he or she completes or discontinues his or her school or training program.

16. Benefits provided under the State's Lifeline Utility Credit Program shall be excluded.

17. Interest on or appreciation in value of burial funds excluded from consideration as resources at N.J.A.C. 10:71-4.4(b)9 shall be excluded from income.

18. The first \$20.00 per month of income, other than income received as a VA pension based upon need, shall

be excluded. This exclusion shall be applied first to unearned income, and any remaining amount of exclusion then applied to earned income. In the determination of countable income of a couple, this \$20.00 exclusion is applied to the combined income of both.

19. Earned income, in the amount of \$65.00 per month plus one-half of the remaining sum, shall be excluded. In the determination of countable income of a couple, this exclusion applies to the combined earned income of both.

20. In the case of blind persons only, all expenses reasonably attributable to the earning of income shall be excluded.

21. In the case of blind or otherwise disabled persons, the amount of money which is needed to achieve an approved plan of self-support shall be excluded.

i. In order for this exclusion to apply, the plan of support must have been approved, in writing, by the Division of Vocational and Rehabilitation Services or the Commission for the Blind and Visually Impaired. The plan must also be current.

As amended, R.1983 d.167, effective June 6, 1983.

See: 15 N.J.R. 422(a), 15 N.J.R. 925(a).

17. Interest on burial funds added, 17-20 renumbered 18-21.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

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Medicaid. P.R. Chenoweth, 136 N.J.L.J. No. 14, 56 (1994).

Case Notes

Definition of "available income" for Medicaid eligibility; valid. Estate of G.E. v. Division of Medical Assistance and Health Services, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Pension was "available income" for Medicaid eligibility even though payment ordered to wife. Estate of G.E. v. Division of Medical Assistance and Health Services, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Regulation governing when income is available did not constitute exercise by the state of its authority to adopt less restrictive income standards than federal standards. Estate of G.E. v. Division of Medical Assistance and Health Services, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Court-ordered spousal support was nevertheless available income to applicant and otherwise countable toward determining Medicaid eligibility. L.M. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 51.

Receipt of worker's compensation benefits causing loss of AFDC eligibility did not entitle recipient to 12-month extension of Medicaid eligibility. C.S. v. Morris County Board of Social Services, 94 N.J.A.R.2d (DEA) 1.

Countable income reduced by child support. R.M. v. Division of Medical Assistance and Health Services, 93 N.J.A.R.2d (DMA) 41.

10:71-5.4 Includable income

(a) Any income which is not specifically excluded under the provisions of N.J.A.C. 10:71-5.3 shall be includable in the

determination of countable income. Such income shall include, but is not limited to, the following:

1. Wages, salaries, tips, and commissions: Any and all compensation for services performed as an employee shall be included as earned income.

2. Income from self-employment: Net adjusted income from self-employment shall be included as earned income.

i. Determination of net adjusted income from self-employment: In the determination of net adjusted income, IRS rules shall apply.

(1) Individual business: Net adjusted income shall be the amount of gross income, less all allowable deductions attributable to the trade or business.

(2) Partnership: Net adjusted income shall be the individual's distributive share of the trade or business in which he/she is a partner.

ii. Annualization of income: If income from self-employment is received on other than a monthly basis, such income shall be averaged over the most recently ended taxable year in order to determine the average monthly or quarterly income to the individual, with the following exceptions:

(1) Seasonal self-employment: An individual whose income from seasonal self-employment is supplemented by income from employment and/or other sources during the balance of the year shall not have his/her self-employment income annualized. Income from self-employment shall be averaged only over the period in which it is intended to cover.

3. Annuities, pensions, and other benefits: Payments received in an annuity, pension, retirement or disability benefits, workers or unemployment compensation, veteran's Social Security (gross income), or strike benefits shall be included as unearned income.

i. Social security income: SSA gross income shall be defined as the actual amount of the check, plus any premium deduction made under the Supplemental Medical Insurance Program (SMI on Part B Medicare).

4. Educational grants and loans: Scholarships, educational grants, fellowships, and veteran's educational benefits shall be included as unearned income, except as provided in N.J.A.C. 10:71-5.3(a)10.

5. Support, alimony, and inheritances: Support, alimony, and inheritances, in the amounts actually received, shall be included as unearned income except as provided in N.J.A.C. 10:71-5.3(a)14.

6. Vendor payments: Cash payments, except those for medical costs, which are made on behalf of the individual by an organization or other third party shall be included as unearned income.

7. Proceeds of life insurance policies: Payments made as the result of the settlement of a life insurance policy claim shall be included as unearned income except as provided in N.J.A.C. 10:71-5.3(a)8.

8. Prizes, gifts, and awards: Cash or in-kind payments which are received as prizes, gifts, or awards shall be included as unearned income. (Occasional gifts, such as Christmas presents, with a value of \$20.00 or less, are excluded.)

i. Gift defined: A gift shall be defined as any payment which is neither given as compensation for services or other consideration, nor as satisfaction of any legal obligation to the beneficiary of the gift.

ii. Value of in-kind prizes, gifts, or awards: The value of an in-kind prize, gift, or award shall be its cash value.

9. Dividends, interest royalties: Dividends, interest, and royalties shall be included as unearned income.

10. Rental income and income from roomer-boarder: The amount remaining, after all the costs (except depreciation costs) of producing the income have been deducted, shall be included as unearned income.

11. Lump-sum payments: A lump-sum payment shall be included as income (either earned or unearned, as appropriate) either in the month in which it is received or prorated over three months when the payment exceeds the individual's monthly deficit, except as follows:

i. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

12. Support and maintenance furnished in-kind (community cases): Support and maintenance encompasses the provision to an individual of his or her needs for food, clothing, and shelter at no cost or reduced value. Persons determined to be "living in the household of another" in accordance with N.J.A.C. 10:71-5.6 shall not be considered to be receiving in-kind support and maintenance as the income eligibility levels have been reduced in recognition of such receipt. Persons not determined to be "living in the household of another" who receive in-kind support and maintenance shall be considered to have income in the amount of:

\$232.33 for an individual

\$338.67 for a couple

i. In the event the individual/couple can demonstrate that the actual value of in-kind support and maintenance is less than the assigned value, the lesser value shall be counted as unearned income.

ii. The income levels in (a)12 above shall be revised annually to reflect the annual cost-of-living adjustment to the SSI payment standard made by the Social Security Administration in accordance with 42 U.S.C. § 1382f. The income level revisions to (a)12 above will be published annually as a notice of administrative change in the New Jersey Register.

13. Support and maintenance furnished in-kind (other living situations):

i. Title XIX facilities: In-kind support and maintenance is not counted in cases in which the individual is considered institutionalized for program purposes (i.e., the individual's eligibility is determined under the Medicaid "Cap").

ii. Private nonprofit domiciliary care facility: The value of in-kind support and maintenance provided an individual in a nonprofit residential care facility is excluded when all the following conditions are met:

(1) The facility is not a public facility. A public facility is one which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(2) The facility, or the distinct portion in which the individual resides, is neither a Title XIX in-kind nor an institution for educational or vocational training.

(3) The facility is tax-exempt under Section 501(c) or (d) of the Internal Revenue Code.

(4) The facility (or organization controlling it) provides support and maintenance to the individual but does not receive payment for that part to be excluded or receives such payment from a private nonprofit organization which is also tax exempt under Section 501(c) or (d) of the Internal Revenue Code.

(5) The nonprofit facility or nonprofit organization has not undertaken an express obligation to furnish full support and maintenance to the individual. An express obligation to provide full support and maintenance exists when an institution agrees to provide lifetime care in return for a specified lump sum payment and there is no requirement for any current or future payment. An express obligation also exists if, as a result of the membership of the individual or of a relative, in an organization (fraternal or religious order, union, etc.) there exists a written document requiring the facility to provide lifetime care regardless of payment provided.

(6) If the criteria in (a)13ii(1)-(5) above are not met, the value of support and maintenance is determined in accordance with (a)13iii below.

iii. Other nonmedical facilities:

(1) Facility is proprietary (private for-profit) or private non-profit and no third party pays: The value of in-kind support and maintenance is excluded from income if it is provided by such a facility, no third party payment is made for it, and:

(A) The individual makes some payment which the facility accepts as payment in full (even though its usual charge may be higher); or

(B) The individual contracts a written indebtedness to the facility for his/her support and maintenance and the facility accepts the amount of the debt plus the individual's payment, if any, as payment in full.

(2) Facility if proprietary or private nonprofit and third party pays: When a proprietary (private for-profit) or private nonprofit facility provides support and maintenance to an individual because a third party pays the facility on that individual's behalf, that individual is receiving in-kind support and maintenance. The value of the in-kind support and maintenance is determined in accordance with (a)12 above.

(3) Other situations regardless of third-party payment: In other types of facilities, support and maintenance provided by that facility is unearned income to the individual in accordance with (a)12 above.

(b) Countable income: Income remaining after appropriate income exclusions shall be applied toward the applicable income eligibility standard. The applicant's living arrangement affects the method of treatment of income and its relationship to the standards as stated in the variations appearing below.

1. Applicant/beneficiary living alone: If the applicant/beneficiary lives alone, only his or her countable income shall be applied to the appropriate income standard.

2. Applicant/beneficiary couple: In the case of an applicant/beneficiary couple, living together, the total amount of husband's and wife's countable income shall be combined and applied to the appropriate income eligibility standard for a couple. Such individuals will continue to have their countable income combined until they have been separated for a period of six months.

i. One member of couple institutionalized: When one member of an applicant/beneficiary couple is institutionalized and the other remains in the community, no income of the community spouse will be used in the determination of income eligibility beginning in the month of admission into a Title XIX facility.

ii. Institutionalized couple: When an applicant/recipient couple is institutionalized in the same facility, the gross income of each individual is combined and applied to an amount equal to two times the Medicaid "Cap." If, however, the applicant/recipient couple is in-

stitutionalized in separate facilities, the income of each is applied individually to the Medicaid "Cap."

3. Applicant/beneficiary living with ineligible spouse: if the applicant/beneficiary lives with an ineligible spouse, the income of the ineligible spouse is deemed to the applicant/beneficiary (see N.J.A.C. 10:71-5.5). Such individual's income shall continue to be deemed until the husband and wife have been separated for one month. At such time the individuals will be considered to be living alone and deeming shall cease.

i. Effect of institutionalization: Income of the community spouse shall not be considered in the determination of income eligibility of the institutionalized individual beginning with the month of admission into a Title XIX facility.

4. Applicant/beneficiary unmarried and under 18 years of age, living with parents: If the applicant/recipient is an unmarried child under 18 years of age who lives with his or her parents (including stepparents), the income of the parents is deemed to the child (see N.J.A.C. 10:71-5.5(c)3). Such deeming will cease when a child has ceased living with his/her parents for a period of one calendar month.

i. Child not living with parents due to institutionalization: If a physician has certified that the child's duration of stay in a Title XIX facility (or a combination of such facilities) is expected to be a full calendar month or more, such child shall be considered to be not living with his/her parents and deeming shall cease at the time of such certification.

Emergency Amendment, R.1981 d.276, effective July 1, 1981.

See: 13 N.J.R. 501(a).

Adopted concurrent proposal, R.1981 d.385, effective September 24, 1981.

See: 13 N.J.R. 501(a), 13 N.J.R. 773(a).

Substantially amended.

Amended by R.1982 d.314, effective August 31, 1982.

See: 14 N.J.R. 758(a), 14 N.J.R. 1058(a).

Amended by R.1983 d.381, effective August 30, 1983.

See: 15 N.J.R. 1187(a), 15 N.J.R. 1585(a).

Originally filed as an emergency rule R.1983 d.289, effective July 1, 1983.

As amended as emergency rule R. 1983 d.593, effective December 19, 1983, operative January 1, 1983.

See: 15 N.J.R. 1733(a), 15 N.J.R. 2171(a).

Readopted, R.1984 d.566, effective November 28, 1984 (amendments effective January 1, 1985).

See: 16 N.J.R. 2845(a), 16 N.J.R. 3451(a).

Previously filed as emergency rule R.1984 d.289. Raised amounts of unearned income.

Emergency Amendment R.1985 d.714, effective December 27, 1985 (operative January 1, 1986, expires February 24, 1985).

See: 18 N.J.R. 215(a).

Unearned income raised.

Amended by R.1986 d.74, effective February 24, 1986.

See: 18 N.J.R. 215(a), 18 N.J.R. 565(a).

Emergency amendment, R.1987 d.78, effective December 29, 1986 (operative January 1, 1987; expires February 27, 1987).

See: 19 N.J.R. 245(a).

Unearned income raised.

Adoption of concurrent proposal, R.1987 d.174, effective April 20, 1987.

See: 19 N.J.R. 245(a), 19 N.J.R. 646(b).

Emergency amendment, R.1988 d.55, effective January 4, 1988 (operative January 4, 1988, expires March 4, 1988).

See: 20 N.J.R. 207(a).

Unearned income raised.

Adopted concurrent proposal, R.1988 d.193, effective May 2, 1988.

See: 20 N.J.R. 207(a), 20 N.J.R. 985(a).

Previously filed as an Emergency Rule.

Emergency amendment, R.1989 d.57, effective December 29, 1988 (operative January 1, 1989, expires February 27, 1989).

See: 21 N.J.R. 207(a).

Individual raised from \$138.00 to \$142.67 and couple raised from \$197.33 to \$204.33.

Emergency amendment expired February 27, 1989. Concurrent proposal adopted February 28, 1989, as R.1989 d.174, effective March 20, 1989.

See: 21 N.J.R. 217(a), 21 N.J.R. 763(a).

Emergency provisions retained.

Emergency amendment R.1990 d.55, effective December 26, 1989, operative January 1, 1990 (expires February 24, 1990).

See: 22 N.J.R. 251(a).

Includable income limits raised at (a)12.

Adopted concurrent proposal, R.1990 d.177, effective February 23, 1990.

See: 22 N.J.R. 251(a), 22 N.J.R. 954(a).

Provisions of emergency amendment R.1990 d.55 readopted without change.

Amended by R.1991 d.32, effective January 22, 1991.

See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

Deleted text in N.J.A.C. 10:71-5.4(b)2i concerning includable income when one member of a couple is institutionalized and added statement establishing new guidelines. Deleted text in N.J.A.C. 10:71-5.4(b)3i concerning physician's certification and added statement establishing new includable income standard.

Emergency amendment, R.1991 d.37, effective December 31, 1990 (operative January 1, 1991).

See: 23 N.J.R. 233(a).

Increase in Medicaid Only eligibility computation amounts at (a)12.

Adopted Concurrent Proposal, R.1991 d.169, effective March 1, 1991.

See: 23 N.J.R. 233(a), 23 N.J.R. 1007(a).

Provisions of emergency amendment R.1991 d.37 readopted without change.

Emergency Amendment, R.1992 d.84, effective January 22, 1992, operative January 1, 1992, (expires March 22, 1992).

See: 24 N.J.R. 651(a).

Increase in Medicaid Only eligibility computation amounts at (a)12.

Amended by R.1993 d.402, effective August 16, 1993.

See: 25 N.J.R. 1818(a), 25 N.J.R. 3786(a).

Amended by R.1994 d.428, effective August 15, 1994.

See: 26 N.J.R. 1754(a), 26 N.J.R. 3478(a).

Amended by R.1996 d.46, effective January 16, 1996.

See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).

In (a)12 imputed income amounts revised upward.

Amended by R.1996 d.466, effective October 7, 1996.

See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted "beneficiary" for "recipient" throughout; and (a)12, increased dollar amount from \$176.67 to \$190.67 for an individual and \$255.00 to \$276.33 for a couple.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

In (a)11, added "except as follows" at the end of the introductory paragraph and added i.

Amended by R.2004 d.401, effective November 1, 2004.

See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).

In (a)12, substituted "\$208.00" for "\$190.67" and "\$302.00" for "\$276.33" in the introductory paragraph and added ii.

Amended by R.2006 d.133, effective November 6, 2006.

See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

In (a)12, substituted "\$213.00" for "\$208.00" and "\$309.66" for "\$302.00".

Administrative change.

See: 40 N.J.R. 2276(a).

Case Notes

Definition of "available income" for Medicaid eligibility; valid. *Estate of G.E. v. Division of Medical Assistance and Health Services*, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Pension was "available income" for Medicaid eligibility even though payment ordered to wife. *Estate of G.E. v. Division of Medical Assistance and Health Services*, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Regulation governing when income is available did not constitute exercise by the state of its authority to adopt less restrictive income standards than federal standards. *Estate of G.E. v. Division of Medical Assistance and Health Services*, 271 N.J.Super. 229, 638 A.2d 833 (A.D.1994).

Voluntarily waived state pension benefits would be "available income" in evaluating Medicaid eligibility. *M.R. v. State Dept. of Human Services, Div. of Medical Assistance and Health Services*, 268 N.J.Super. 586, 634 A.2d 143 (A.D.1993).

A Social Security check received by Medicaid recipient, is not a resource for inclusion in program eligibility determination (citing former N.J.A.C. 10:94-4.19 and 4.42). *Gilfone v. State*, 165 N.J.Super. 186, 397 A.2d 1120 (App.Div.1979).

Receipt of out of state unemployment insurance benefits precluded recipient from receiving medicaid extension. *J.M. v. Cape May County Welfare Agency*, 94 N.J.A.R.2d (DEA) 9.

10:71-5.5 Deeming of income

(a) When an applicant/beneficiary is an adult residing in the same household with his or her ineligible spouse or is a child residing in the same household with his or her parent(s) or spouse of the parent, the income of the ineligible spouse or parent(s) is considered in the determination of financial eligibility. The amount included as income to the applicant/beneficiary, whether or not it is actually available, is called deemed income and is computed as described in N.J.A.C. 10:71-5.5(c), (d), (e) and (f).

1. Child: For the purpose of this section, a child is an individual who is not married and is under the age of 18 (see N.J.A.C. 10:71-5.3(a)15i regarding earnings of a child who is a student). Additionally, deeming of parental income to a blind or disabled child ceases when the child reaches age 18.

2. Parent: A parent, for deeming purposes, is a natural or adoptive parent or stepparent living in the same household as an applicant/beneficiary child. However, death or divorce of the natural or adoptive parent terminates deeming responsibility of a stepparent.

(b) Items not included in deeming: In determining the income of an ineligible spouse, parent and/or spouse of a parent, or income of any ineligible children in the household, the following are not included as income:

1. Any assistance based on need and any income considered in the determination of the amount of such assistance;
2. That portion of any grant, scholarship, or fellowship, used to pay the cost of tuitions and fees at an educational institution or costs of vocational technical

training designed to prepare the individual for gainful employment;

3. Amounts received for foster care of an ineligible child;

4. The value of food stamps or U.S. Department of Agriculture donated foods (e.g., supplemental food programs);

5. Home produce grown for personal consumption;

6. Refund of taxes paid on income, real property, or food purchased by the family;

7. Such income used to comply with the terms of court-ordered support and support payments pursuant to Title IV-D of the Social Security Act;

8. The value of in-kind support and maintenance furnished to the ineligible spouse, ineligible parent(s) or ineligible spouse of a parent, and ineligible children in the household;

9. Income and benefits received under certain Federal programs described in Section N.J.A.C. 10:71-5.3(a)7;

10. The earned income of an ineligible child who is a student (subject to the limitations of N.J.A.C. 10:71-5.3(a)15, unless the child actually makes the income available to the family);

11. Income necessary for a plan to achieve self-support but only if the spouse's or parental income is actually being used according to the plan to achieve self-support.

(c) Deeming of income from spouse to spouse: If the applicant's/beneficiary's own countable income, as determined in accordance with N.J.A.C. 10:71-5.2, less appropriate exclusions in N.J.A.C. 10:71-5.3, exceeds the applicable Medicaid Only income eligibility standard in Table B at N.J.A.C. 10:71-5.6(c)5, the applicant/beneficiary is financially ineligible for Medicaid Only based on his or her own countable income, and there is no deeming. However, if the applicant's/beneficiary's own countable income renders him or her financially eligible for Medicaid Only, the following steps shall be used to compute deemed income:

1. Step 1: Calculate separately the ineligible spouse's earned and unearned income, less any income excluded in accordance with N.J.A.C. 10:71-5.5(b). Do not combine the two totals.

2. Step 2: Determine the living allowance for each ineligible child not receiving public assistance, by subtracting the child's countable income from the amount of the living allowance for an ineligible child in Table A, Figure 1.

3. Step 3: Subtract the living allowance for each ineligible child, determined in Step 2 above, from the unearned income of the ineligible spouse. Subtract any remaining living allowance from the earned income of the

ineligible spouse. For any ineligible child receiving public assistance, no living allowance may be subtracted.

4. Step 4: If the total remaining income (earned plus unearned) of the ineligible spouse is equal to or less than the appropriate remaining income amount in Table A, Figure 2, no income is available for deeming to the applicant/beneficiary. The deeming process stops.

i. Determine the beneficiary's income eligibility for Medicaid Only by comparing his or her own countable income to the appropriate Medicaid Only income eligibility standard in Table B at N.J.A.C. 10:71-5.6(c)5.

5. Step 5: If Step 4 above does not apply, and the ineligible spouse's remaining total income (earned plus unearned) exceeds the appropriate remaining income amount in Table A, Figure 2, the deeming process continues and the applicant/beneficiary and his or her ineligible spouse are treated as a couple. The following deeming steps shall be used to compute the couple's countable income:

i. Add the ineligible individual's remaining unearned income after the deduction of the living allowance for the ineligible child(ren) to all of the beneficiary's unearned income. Determine the value of in-kind support and maintenance in deeming situations, in accordance with N.J.A.C. 10:71-5.4(a)12.

(1) Do not apply the \$20.00 general income exclusion to the beneficiary individual's income before combining the income.

ii. Add the ineligible individual's remaining earned income after deduction of the living allowance for the ineligible child(ren) to all of the applicant's/beneficiary's earned income.

iii. Treat the two totals of unearned and earned income in the same manner as those of an eligible couple. Apply appropriate income exclusions and compute the couple's countable income as follows:

(1) First, subtract the \$20.00 general income exclusion from the total unearned income. Then, subtract any unused portion of the general income exclusion from the total earned income, if any.

(2) From the remaining earned income, subtract \$65.00 (work expense allowance) and one-half of the remainder of earned income.

(3) Add the remaining earned and unearned income together to arrive at the couple's total countable income.

6. Step 6: If the couple's (applicant/beneficiary and ineligible spouse) remaining countable income is less than the amount in Table A, Figure 3, for the appropriate living arrangement, the applicant/beneficiary is financially eligible for Medicaid Only. If the couple's remaining income is equal to or greater than the amount in Table A, Figure 3, for the appropriate living arrangement, the applicant/beneficiary is financially ineligible for Medicaid Only.

(d) Deeming of income to spouse and child(ren): In situations when an ineligible individual is subject to deeming of his or her income to both an applicant/beneficiary spouse and an applicant/beneficiary child, the following deeming procedures are used:

1. Step 1: Determine the amount of income, if any, to be deemed to the applicant/beneficiary spouse in accordance with the procedures in N.J.A.C. 10:71-5.5(c).

2. Step 2: If, after deeming of income from the ineligible spouse, the adult applicant/beneficiary is financially eligible for Medicaid Only, there is no income available for deeming to the applicant/beneficiary child(ren). The deeming process stops.

3. Step 3: If, in the process of deeming of income to the applicant/beneficiary spouse, such spouse becomes financially ineligible for Medicaid Only, that portion of deemed income that exceeds the eligibility level in Table A, Figure 3, for the appropriate living arrangement for the adult applicant/beneficiary shall be deemed to any child applicant/beneficiary. This income is treated as unearned income to the child.

4. Step 4: If there is more than one child applicant/beneficiary in the household, divide the deemable income equally among them. However, income is not deemed to any child in excess of that amount which, in combination with his or her own countable income, creates financial ineligibility for the child. That portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement, shall be available for deeming equally to any other applicant/beneficiary child(ren) in the household (in accordance with Step 5 below) in addition to their equal shares of the total parental deemable income.

5. Step 5: Combine any income deemed to the eligible child together with any countable income of the eligible child.

i. First, subtract the \$20.00 general income exclusion from the child's unearned income.

ii. If the child's total income is less than the appropriate income eligibility standard in Table B, the child is financially eligible for Medicaid Only.

iii. If the child's total income is greater than the appropriate income eligibility standard in Table B, the child is financially ineligible for Medicaid Only, and that portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement for the applicant/beneficiary child, shall be available for deeming equally to any other applicant/beneficiary children in addition to their equal shares of the total deemable income.

iii. Parents of either member of a couple who are claimed as dependents for tax purposes under the Internal Revenue Code as dependents by either spouse; or

iv. A brother or sister (including half-brothers and half-sisters and siblings gained through adoption) of either member of a couple and who are claimed as dependents for tax purposes under the Internal Revenue Code.

2. The family member deduction shall be computed as follows. The family member's gross income shall be subtracted from \$1,383. One-third of the remaining amount shall be the family member deduction for that family member.

(h) If a physician has certified that the individual will be institutionalized for a temporary period only and is likely to return to the residence within six months of the date of institutionalization, a maximum of \$150.00 may be deducted from the institutionalized individual's income for the maintenance of his or her home in the community. This deduction shall be limited to the actual costs of such maintenance (for example, mortgage or rent payments, taxes, insurance, and other incidental costs) or \$150.00, whichever is less. This deduction may be applied against the individual's income for no longer than six months. This deduction may not be applied if a deduction has been made for the maintenance of a community spouse or other family member residing in that residence.

1. This deduction must be applied to the costs of maintaining the residence and may not be accumulated by the institutionalized individual.

(i) If the institutionalized individual has health insurance covering himself or herself, the amount of the insurance premiums shall be deducted.

1. If the premium is billed other than monthly, the amount of the premium shall be prorated and deducted accordingly.

2. If the premium covers other individuals in addition to the institutionalized individual, only that portion of the premium attributable to the institutionalized individual shall be deducted.

(j) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

New Rule, R.1991 d.32, effective January 22, 1991.

See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In the introductory paragraph of (c) and (g)2, increased dollar amounts from \$856.00 to \$1,383; and in (c)1, increased dollar amount from \$257.00 to \$414.00.

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Added (j).

Law Review and Journal Commentaries

Marital Status and The 60+ Crowd. Elizabeth Brody. 164 N.J.Law 39 (Mag) (Oct. 1994).

Case Notes

New Jersey did not violate Medicare Catastrophic Coverage Act by employing "income-first" approach in determining Medicaid eligibility of spouse institutionalized in long-term care facility. Cleary ex rel. Cleary v. Waldman, 167 F.3d 801 (3rd Cir. N.J. 1999).

Assets of institutionalized spouse may be diverted to cover community spouse's statutory minimum needs allowance, where community spouse's income is insufficient to meet allowance, for purposes of Medicare spend down requirements; however, resources transferred to community spouse need not be adequate to cover shortfall. Cleary v. Waldman, D.N.J.1997, 959 F.Supp. 222.

Husband's application to recalculate his Medicaid benefit was properly denied because the husband and his wife transgressed the permissible limits of Medicaid planning by entering into a divorce from bed and board and agreeing, in a consent order without judicial fact finding, that the institutionalized husband's pension benefits would be paid to the wife as alimony. H.K. v. Division of Medical Assistance and Health Services, 379 N.J. Super. 321, 878 A.2d 16, 2005 N.J. Super. LEXIS 238 (App.Div. 2005).

Both interest and principal of community spouse's monthly annuity payments constituted income for purposes of determining minimum monthly maintenance allowance under Medically Needy Program. J.M. and E.M. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 86.

Full amount of Medicaid applicant's Social Security benefits would be included as "available income" and applied to his long-term care costs, even though applicant used portion of his benefits to satisfy pre-existing alimony obligation. L.C. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 73.

Exceptional circumstances resulting in significant financial distress warranted an upward adjustment in community spouse maintenance amount. M.G. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 47.

10:71-5.8 Eligibility under life care and pay-as-you-go agreements

(a) In a contractual agreement where the individual has transferred his available assets to the facility in exchange for full medical care in the institution, the institution has a legal responsibility to provide such care and Medicaid benefits are not payable for the institutional care. However, Medicaid eligibility may exist in the following circumstances (see also N.J.A.C. 10:71-5.4(a)13):

1. When it can be determined that no enforceable contract exists (for example, because the facility is financially unable to fulfill its responsibilities under the contract and all terms of the agreement are thus void), the facility has a legal obligation to refund to the individual any assets which remain from the amount assigned at the time the contract was signed. The individual may be eligible for Medicaid Only as long as all other eligibility criteria (including resources) are met.

2. When a contract is not actually rescinded and the individual retains his or her right under the terms of the contract but, where his or her contract rights for care in the

facility are not fully met, Medicaid benefits may be available for those medical expenses not being met by this facility if the individual meets eligibility requirements.

3. When the contractual agreement for care in the facility does not include all of the medical care (for example, is limited to basic room and board), Medicaid benefits may be available for those medical expenses not covered by the contract as long as all eligibility criteria are met.

4. In those contractual situations above in which Medicaid eligibility may exist, the value of in-kind room and board is not considered income.

New Rule, R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

10:71-5.9 Deeming from sponsor to alien

(a) For the purposes of determining eligibility for Medicaid Only for a legal alien (applying for the first time on or after October 1, 1980), the income and resources (see N.J.A.C. 10:71-4.7) of any person who sponsored the alien's entry into the United States will be deemed to the alien. Such deeming applies for a period of three years from the month of the alien's entry into the United States. However, deeming shall not apply to any alien who is:

1. Admitted to the United States under the provisions of section 203(a)(7) of the Immigration and Nationality Act which were in effect prior to April 1, 1980;

2. Admitted to the United States under the provisions of section 207(c)(1) of such Act which became effective March 31, 1980;

3. Paroled into the United States as a refugee under section 212(d)(5) of such Act;

4. Granted political asylum by the Attorney General;

5. Determined to be blind or disabled if such blindness or disability began after the date of admission into the United States for permanent residence; or

6. Sponsored by an institutional sponsor such as an employer or a church.

(b) In the event an alien is sponsored by a person subject to the deeming rules at N.J.A.C. 10:71-5.5, those rules will be used in lieu of the sponsor-to-alien rules.

(c) No inquiry shall be made regarding a sponsor's financial circumstance unless the alien's own countable income and resources indicate potential program eligibility.

(d) Normal income exclusions do not apply in deeming of a sponsor's income to an alien. Additionally, SSI benefits, TANF payments, as well as any other public income maintenance payments are not excluded in sponsor-to-alien deeming.

(e) To determine the amount of income to be deemed to an alien, the dollar amounts in (e)2 and 3 below will be updated annually by publication of a notice of administrative changes in the New Jersey Register reflecting the Federal cost-of-living adjustment to the SSI standards established pursuant to 42 U.S.C. §1382f. The CBOSS shall proceed as follows:

1. Determine the total gross earned (wages and net earnings from self employment) and gross unearned income of the sponsor (and spouse if living with the sponsor).

2. Subtract \$637.00 for the sponsor, \$956.00 for the sponsor if living with his or her spouse, \$1,274 for the sponsor if his or her spouse is a cosponsor.

3. Subtract \$318.50 for any other dependent of the sponsor who is or could be claimed for Federal Income Tax purposes.

4. The remaining amount is deemed as unearned income to the alien.

(f) In the event that a sponsor has sponsored more than one alien, there is no proration of deemable income among the sponsored aliens. The income is fully charged to each alien for which the sponsor has executed an affidavit of support.

R.1983 d.373, effective September 6, 1983.

See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a).

As amended on emergency basis, R.1983 d.593, effective December 19, 1983, operative January 1, 1984.

See: 15 N.J.R. 1733(a), 15 N.J.R. 2171(a).

Deeming amounts increased.

Amended by R.1984 d.566, effective November 28, 1984 (amendments effective January 1, 1985).

See: 16 N.J.R. 2845(a), 16 N.J.R. 3451(a).

Previously filed as emergency rule R.1984 d.289.

(e): amounts of income substantially amended.

Emergency amendment, R.1985 d.714, effective December 27, 1985 (operative January 1, 1986, expires February 24, 1986).

See: 18 N.J.R. 215(a).

Amount of income in (e)2 and 3 raised.

Readopted R.1986 d.74, effective February 24, 1986.

See: 18 N.J.R. 215(a), 18 N.J.R. 565(a).

Emergency amendment, R.1987 d.78, effective December 29, 1986 (operative January 1, 1987, expires February 27, 1987).

See: 19 N.J.R. 245(a).

Amount of income in (e)2 and 3 raised.

Adoption of concurrent proposal, R.1987 d.174, effective April 20, 1987.

See: 19 N.J.R. 245(a), 19 N.J.R. 646(b).

Emergency amendment, R.1988 d.55, effective and operative January 4, 1988 (expires March 4, 1988).

See: 20 N.J.R. 207(a).

Amount of income in (e)2 and 3 raised.

Adopted concurrent proposal, R.1988 d.193, effective May 2, 1988.

See: 20 N.J.R. 207(a), 20 N.J.R. 985(a).

Previously filed as an Emergency Rule.

Emergency amendment, R.1989 d.57, effective December 29, 1988 (operative January 1, 1989, expires February 27, 1989).

See: 21 N.J.R. 207(a).

(e)2 and 3 raised amount to be subtracted.

Emergency amendment expired February 27, 1989. Concurrent proposed amendment adopted and filed February 28, 1989, as R.1989 d.174, effective March 20, 1989.

See: 21 N.J.R. 207(a), 21 N.J.R. 763(a).

Provisions retained.

Emergency amendment R.1990 d.55, effective December 26, 1989, operative January 1, 1990 (expires February 24, 1990).

See: 22 N.J.R. 251(a).

Deeming computation amounts raised.

Adopted concurrent proposal, R.1990 d.177, effective February 23, 1990.

See: 22 N.J.R. 251(a), 22 N.J.R. 954(a).

Provisions of emergency amendment R.1990 d.55 readopted without change.

Emergency amendment, R.1991 d.37, effective December 31, 1990 (operative January 1, 1991).

See: 23 N.J.R. 233(a).

Increase in Medicaid Only eligibility computation amounts at (e).

Amended by R.1991 d.32, effective January 22, 1991.

See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

Section recodified from 5.7.

Adopted Concurrent Proposal, R.1991 d.169, effective March 1, 1991.

See: 23 N.J.R. 233(a), 24 N.J.R. 1007(a).

Provisions of emergency amendment R.1991 d.37 readopted without change.

Emergency amendment, R.1992 d.84, effective January 22, 1992, operative January 1, 1992.

See: 24 N.J.R. 651(a).

Increase in Medicaid Only eligibility computation amounts at (e).

Adopted concurrent amendment, R.1992 d.191, effective April 20, 1992.

See: 24 N.J.R. 651(a), 24 N.J.R. 1498(b).

Provisions of emergency amendment, R.1992 d.84, readopted without change.

Amended by R.1993 d.402, effective August 16, 1993.

See: 25 N.J.R. 1818(a), 25 N.J.R. 3786(a).

Amended by R.1994 d.428, effective August 15, 1994.

See: 26 N.J.R. 1754(a), 26 N.J.R. 3478(a).

Amended by R.1996 d.46, effective January 16, 1996.

See: 27 N.J.R. 3668(a), 27 N.J.R. 291(a).

Increased amounts in (e)2 and 3.

Amended by R.1996 d.466, effective October 7, 1996.

See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

In (d), substituted "TANF" for "AFDC"; and in (e), substituted "CBOSS" for "CWA" in the introductory paragraph, and increased dollar amounts in 2 and 3.

Amended by R.2004 d.401, effective November 1, 2004.

See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).

Rewrote (e).

Amended by R.2006 d.133, effective November 6, 2006.

See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

In (e)2, substituted "\$579.00" for "\$564.00", "\$869.00" for \$846.00 and "\$1158" for "\$1,128"; and in (e)3, substituted "\$289.50" for "\$282.00".

Administrative change.

See: 40 N.J.R. 2276(a).

SUBCHAPTER 6. CASE RECORDS AND FILES

10:71-6.1 Purpose of case records

The case record is a complete record in support of the CBOSS's decisions and actions for each case.

Amended by R.1995 d.651, effective December 18, 1995.

See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Amended by R.2000 d.415, effective October 16, 2000.

See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Substituted "CBOSS's" for "CWA's".

10:71-6.2 Contents of the case record

(a) The following items shall be included in the case record:

1. The narrative recording;
2. All medical reports and record of action from the MRT (appropriate cases);
3. All forms related to financial eligibility; and
4. All related correspondence, memoranda and documents except those which are required by law and regulation to be maintained in some other files.

10:71-6.3 Forms applicable to the Medicaid Only program

Forms applicable to the Medicaid Only program (aged, blind and disabled) are listed on page 1 of Appendix A; sample forms follow that list.