

10:71-1.4 Information on the manual

This manual sets forth the policies and procedures necessary for the orderly and equitable administration of the Medicaid Only program as it relates to the aged, blind and disabled. It is a statement of policy and procedures separate from all other assistance programs, and is applicable to "Medicaid Only". The criteria for determination of eligibility are based on SSI policy and procedure which do not necessarily coincide with standards for other public assistance programs and therefore require separate instructions.

10:71-1.5 Administrative organization

The Medicaid Only program is administered by the County Welfare Agency(ies) (CWA(s)) of the State of New Jersey through the Division of Medical Assistance and Health Services in the Department of Human Services. The CWAs contract with the Division of Medical Assistance and Health Services for the purpose of providing Medicaid Only benefits to eligible persons.

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

10:71-1.6 Basic principles of administration

(a) The following principles of administration shall apply to the Medicaid Only program.

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 recipients 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 recipient 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 recipients 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 recipients 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.

10:71-1.7 Examination of review of manual

This manual is a public document. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each CWA 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).

10:71-1.8 County Welfare Agency responsibility; manual

The director of the CWA shall assign copies of this manual 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).

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

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

10:71-1.10 Revisions of the manual

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

10:71-1.11 Availability of manual

(a) A current up-to-date copy of the manual 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 manual up-to-date will have a copy available under their regulations.

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

(d) Welfare, social service and other non-profit organizations will be furnished with a copy of the manual 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 manual. A mailing list will be maintained by the Division.

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-1G).

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

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

“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.

“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 CWA 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 recipient in any county in the State for reconsideration of his/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 CWA of another county from which he/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).

Case Notes

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 CWAs 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 CWA exercised 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 CWAs shall also provide supportive social services which will enhance cure and rehabilitation of recipients of Medicaid Only.

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

1. Complete, with assistance from the CWA if needed, any forms required by the CWA as a part of the application process;
2. Assist the CWA 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).

Case Notes

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 CWA 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 CWA.

(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 therefor. 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 CWA 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).

10:71-2.4 Intake policy and procedure

(a) "Intake" is a term applied to the CWA'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).

10:71-2.5 Application policy and procedure

(a) Application for Medicaid Only may be taken by the CWA 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 CWA 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).

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 CWA 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).

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

By law, the CWA 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).

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

Each CWA 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).

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.

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 comingled 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.

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).

Law Review and Journal Commentaries

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

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.

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 the limit below:

before January 1, 1986	\$2,400
January 1, 1986—December 31, 1986	\$2,550
January 1, 1987—December 31, 1987	\$2,700
January 1, 1988—December 31, 1988	\$2,850
January 1, 1989 and thereafter	\$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 the limits below:

before January 1, 1986	\$1,600
January 1, 1986—December 31, 1986	\$1,700
January 1, 1987—December 31, 1987	\$1,800
January 1, 1988—December 31, 1988	\$1,900
January 1, 1989 and thereafter	\$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.

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).

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.

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/recipient is an adult residing in the same household with his/her ineligible spouse or is a child residing in the same household with his/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/recipient, whether or not it is actually available, is termed deemed resources.

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

(c) Applicant/recipient couple: In the case of an applicant/recipient 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/recipient living with ineligible spouse: If the applicant/recipient lives with an ineligible spouse, all countable resources of the ineligible spouse are deemed to the applicant/recipient. 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/recipient unmarried and under 18 years of age, living with parents: If the applicant/recipient 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.

10:71-4.7 Transfer of resources

(a) The provisions of this section apply only to persons who are receiving an institutional level of services or who are seeking that level of services. 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 30 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 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 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;
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 recipients

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(b), 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.

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 Martz. 164 N.J.Law 34(Mag.) (Oct. 1994).

Case Notes

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, 95N.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 Medicaid 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 welfare agency 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 a 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 CWA 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.)