CHAPTER 71

MEDICAID ONLY MANUAL

Authority

N.J.S.A. 30:4D–3; 30:4D–7, 7a, b and c.

Source and Effective Date

R.1991 d.33, effective December 24, 1990.
See: 22 N.J.R. 3357(a), 23 N.J.R. 215(a).

Executive Order 66(1978) Expiration Date

Chapter 71, Medicaid Only Manual, expires on December 24, 1995.

Chapter Historical Note

All provisions of this chapter became effective July 1, 1976 as R.1976 d.157. See: 7 N.J.R. 464(d), 8 N.J.R. 287(d). Amendments became effective April 1, 1977 as R.1977 d.57. See: 8 N.J.R. 556(b), 9 N.J.R. 126(b). Further amendments became effective October 1, 1977 as R.1977 d.336. See: 9 N.J.R. 341(a), 9 N.J.R. 479(c).

Revisions for 1978: Revisions became effective April 1, 1978 as R.1978 d.73. See: 10 N.J.R. 13(c), 10 N.J.R. 153(a). Further amendments became effective June 22, 1978 as R.1978 d.212. See: 10 N.J.R. 190(c), 10 N.J.R. 344(c). Further amendments became effective August 23, 1978 as R.1978 d.296. See: 10 N.J.R. 106(a), 10 N.J.R. 443(a).

Revisions for 1979: Revisions became effective May 17, 1979 as R.1979 d.198. See: 11 N.J.R. 193(a), 11 N.J.R. 283(d). Further revisions became effective July 1, 1979 as R.1979 d.257. See: 11 N.J.R. 282(b), 11 N.J.R. 382(b). Further amendments became effective November 1, 1979 as R.1979 d.364. See: 11 N.J.R. 379(b), 11 N.J.R. 519(e). Further amendments became effective November 13, 1979 as R.1979 d.449. See: 11 N.J.R. 518(a), 11 N.J.R. 527(d).

Revisions for 1980: Revisions became effective January 16, 1980 as R.1980 d.27. See: 11 N.J.R. 557(b), 12 N.J.R. 86(b). Further revisions became effective May 1, 1980 as R.1980 d.187 and d.188. See: 12 N.J.R. 125(a), 12 N.J.R. 322(b). Further revisions became effective July 1, 1980 as R.1980 d.223. See: 12 N.J.R. 324(b).

Revisions for 1981: The text of subchapters 4 and 5 was completely replaced effective June 4, 1981 as R.1981 d.177. See: 12 N.J.R. 663(a), 13 N.J.R. 364(b). An emergency amendment and concurrent proposal became effective July 1, 1981 as R.1981 d.276. See: 13 N.J.R. 501(a). This emergency amendment and concurrent proposal was adopted effective September 24, 1981 as R.1981 d.385. See: 13 N.J.R. 773(a).

Revisions for 1982: Amendments became effective August 31, 1982 as R.1982 d.314. See: 14 N.J.R. 758(a), 14 N.J.R. 1058(a). Further amendments became effective October 18, 1982 as R.1982 d.354. See: 14 N.J.R. 816(a), 14 N.J.R. 1162(c).

Revisions for 1983: Amendments became effective June 6, 1983 as R.1983 d.167. See: 15 N.J.R. 422(a), 15 N.J.R. 925(b). Subchapter 3 was readopted effective July 20, 1983 as R.1983 d.317. See: 15 N.J.R. 948(a), 15 N.J.R. 1382(a). Subchapters 4 and 5 were readopted effective August 22, 1983 as R.1983 d.373. See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a). Further amendments became effective August 30, 1983 as R.1983 d.381. See: 15 N.J.R. 1187(a), 15 N.J.R. 1585(a). Further amendments became effective September 6, 1983 as R.1983 d.373. See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a). An emergency rule and concurrent proposal became effective December 19, 1983 (operative January 1, 1983). See: 15 N.J.R. 1733(a), 15 N.J.R. 2171(a).

Revisions for 1984: Amendments became effective June 18, 1984 as R.1984 d.244. See: 16 N.J.R. 684(a), 16 N.J.R. 1611(a). Emergency adoption and concurrent proposal became effective September 28, 1984 (operative October 1, 1984) as R.1984 d.467. Readopted November 28, 1984 (with amendments effective January 1, 1985) as R.1984 d.566. See: 16 N.J.R. 2845(a), 16 N.J.R. 3451(a).

Revisions for 1985: Amendments became effective April 15, 1985 (operative May 1, 1985) as R.1985 d.169. See: 17 N.J.R. 39(a), 17 N.J.R. 969(b). Amendments became effective September 16, 1985 as R.1985 d.474. See: 17 N.J.R. 1525(a), 17 N.J.R. 2274(a). Emergency amendment became effective December 27, 1985 (operative January 1, 1986, expires February 24, 1986) as R.1985 d.714. See: 18 N.J.R. 215(a).

Revisions for 1986: Subchapters 7, 8 and 9 were readopted effective January 6, 1986 with amendments effective February 3, 1986 as R.1986 d.5. See: 17 N.J.R. 2340(a), 18 N.J.R. 276(a). Further amendments became effective February 24, 1986 as R.1986 d.74. See: 18 N.J.R. 215(a), 18 N.J.R. 565(a). Further amendments became effective March 3, 1986 as R.1986 d.53. See: 17 N.J.R. 2732(a), 18 N.J.R. 484(a). Further amendments became effective March 17, 1986 as R.1986 d.71. See: 17 N.J.R. 2522(a), 18 N.J.R. 564(b). Further amendments became effective April 7, 1986 (operative May 1, 1986) as R.1986 d.97. See: 17 N.J.R. 2954(a), 18 N.J.R. 691(a). Further amendments became effective May 5, 1986 (operative June 2, 1986) as R.1986 d.165. See: 17 N.J.R. 2524(a), 18 N.J.R. 985(b). Amendment to 4.2 and repeal of 4.3 became effective December 15, 1986 as R.1986 d.481. See: 18 N.J.R. 542(a), 18 N.J.R. 2457(a).

Pursuant to Executive Order No. 66(1978), Chapter 71 was readopted as R.1991 d.33, effective December 24, 1990. See: Source and Effective Date. See section annotations for specific rulemaking activity.

Law Review and Journal Commentaries

Healthy Financial Planning for Nursing Home Care. Michael K. Feinberg, 138 N.J.Law. 33 (Mag.) (Jan./Feb. 1991).

Nursing Homes in the Garden State: A Legal Perspective. Janice Chapin, 141 N.J.Law. 38 (Mag.) (July/August 1991).

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SUBCHAPTER 1. INTRODUCTION

10:71-1.1 General introduction

On January 1, 1974, Title XVI of the Social Security Act replaced previous Titles I (Old Age Assistance), X (Aid to the Blind) and XIV (Aid to the Disabled), which were repealed. The Social Security Administration administers Title XVI, Supplemental Security Income (SSI), which provides cash payments to the aged, blind and disabled. Individuals who desire medical care only apply through the county welfare board for the Medicaid Only program under Title XIX.

10:71-1.2 Choice of program by applicant

(a) An aged, blind or disabled person who desires Medicaid and does not wish to receive a money payment may apply for the Medicaid Only program. To qualify for this program, he/she must have financial eligibility as determined by the regulations and procedures set forth in this manual.

(b) Persons who are neither aged, blind nor disabled qualify for Medicaid benefits when they are determined by the county welfare board to be eligible for Title IV-A payments (Aid to Families with Dependent Children) or assistance to the families of the working poor (a State program). Persons whose eligibility is thus established may choose to receive Medicaid Only benefits without accepting money payments. Regulations governing these programs are set forth in the public assistance manual and assistance standards handbook.

10:71-1.3 Living arrangements

(a) Aged, blind and disabled persons who are living in the community and meet the requirements of the SSI program may receive Medicaid Only.

(b) Aged, blind and disabled persons who are receiving care in an eligible medical institution and, because of income or resources, do not qualify for SSI may be eligible for Medicaid Only.

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 boards of the State of New Jersey through the Division of Medical Assistance and Health Services in the Department of Human Services. The county welfare boards contract with the Division of Medical Assistance and Health Services for the purpose of providing Medicaid Only benefits to eligible persons.

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 county welfare board office for examination or review during regular office hours on regular work days.

10:71-1.8 County welfare board responsibility; manual

The director of the county welfare board 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.

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.

"Applicants," 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 by the CWB 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 CWB in assigning a control number to an application.

"Rejected" is an inclusive term (for statistic 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 decides 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 their 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 welfare board of another county from which they moved.

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 county welfare boards 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 county welfare board 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 county welfare boards 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 has responsibility to:

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

2. Assist the CWB in securing evidence that corroborates his/her statements;

3. Report promptly any change affecting his/her circumstances.

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/her lack of eligibility and the reason therefor is sent to him/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/her voluntary withdrawal is sent to him/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/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 CWB 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/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 CWB.

(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/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 welfare board or the Division of Medical Assistance and Health Services.

10:71–2.4 Intake policy and procedure

(a) "Intake" is a term applied to the county welfare boards' 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.

10:71–2.5 Application policy and procedure

(a) Application for Medicaid Only may be taken by the county welfare board 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/her own behalf. Consequently, the CWB 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.

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 CWB 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.

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

By law, the CWB 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 pertinent information shall be registered with the commission in the prescribed form.

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

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

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 CWB will be unable to certify entitlement to Medicaid Only.

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 income maintenance (IM) worker is initially responsible for the recommendation for approval or denial. The IM worker will complete the work sheet and authorization for public assistance (PA-3A) 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 (PA-3L) will be completed in appropriate cases.

10:71-2.13 Supervisory review and approval

(a) In most cases an IM 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.

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 are to 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 public assistance). The intake worker will not be responsible for making a financial determination of eligibility for the three-month period in question.

(b) The applicant will be required to 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

CN–712

Trenton, New Jersey 08625

(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 the local medical assistance unit.

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

The applicant must be a resident of the United States who is either a citizen or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

Case Notes

Medicaid regulation excluding illegal aliens from coverage not offensive to constitutional equal protection guarantee. Monmouth Medical Center v. Kwok, 183 N.J.Super. 494, 444 A.2d 610 (App.Div.1982).

10:71-3.3 Citizenship; definitions

(a) A person born in the United States is, by definition, a United States citizen. The United States is defined as the Continental United States, Alaska, Hawaii, Puerto Rico, Guam, and the Virgin Islands of the United States. Native-born persons of American Samoa and Swain's Island are also regarded as citizens of the United States.

(b) Naturalized citizens are those persons upon whom United States citizenship is conferred after birth. This may be accomplished through individual or collective naturalization or, under certain conditions, citizenship may be derived from a naturalized parent. Thus a child(ren) of a naturalized parent(s) is automatically considered a naturalized citizen(s). Women who themselves could be lawfully naturalized and, prior to September 22, 1922, were married to citizens, or were married to aliens who became citizens before that date, automatically became citizens. On and after that date, standard immigration and naturalization service conditions have to be met before any person can become a naturalized citizen:

1. A naturalized citizen, unless automatically naturalized as outlined above, should have his/her naturalization certificate as proof of citizenship. If the applicant does not have this document, the county welfare board should contact the nearest immigration and naturalization service district office to verify that the applicant meets the requirements of a naturalized citizen.

(c) The status of an alien shall be verified by means of one of the following:

1. An alien who is legally in the United States should have documentation to that effect since he/she is required by law to carry it. The alien should have in his/her possession a form I-151, Alien Registration Receipt Card, or an older form AR-3 and AR-3a, Alien Registration Receipt Card, or a reentry permit. Any of those cards can be accepted as verification that the alien has been lawfully admitted to the United States for permanent residence. If the applicant does not have one of these documents, the county welfare board should contact the nearest immigration and naturalization service district office to verify that the applicant is lawfully admitted to the United States.

2. There are special sections of the Immigration and Nationality Act which allow the Attorney General discretion in allowing conditional entry into the United States. Entry into the United States may be for reasons of national catastrophe, persecution or fear of persecution on account of race, religion, or political opinion, and so forth. Individuals in these categories will have form I-94, Arrival-Departure Record, citing the section of the Immigration and Nationality Act under which admitted. This form will be acceptable evidence of permanent residence.

3. An alien who is lawfully admitted for a specific period of time only will be in possession of one of the following documents: Arrival-Departure Record (I-94) for aliens other than parolees or refugees; Canadian border crossing guard (I-185); Mexican border visitors permit (SW-434); crewman's landing permit (I-95A); crewman's landing permit and identification card (I-184). Such persons are not eligible for participation in the Medicaid Only program.

10:71-3.4 Residence requirement

An applicant for or recipient of Medicaid Only shall be a resident of the State of New Jersey.

10:71-3.5 Resident defined

(a) The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

(b) County residence is not an eligibility requirement and relates only to identification of the welfare board charged by law with responsibility for the official receipt, registration, and processing of applications. The county welfare board is responsible for institutionalized (including nursing homes, intermediate care facilities, and sheltered boarding homes) applicants and recipients within its county regardless of previous county of residence.

10:71-3.6 Change of county residence

(a) Responsibility for case management shall be transferred from one county to the other when a recipient moves to another county.

(b) A temporary visit by the recipient shall not be considered to be a change of county residence until that visit has continued for more than a three month period.

1. Whenever it is determined that a recipient whose application has not been validated has changed or is planning to change his/her residence from one county to another, the CWB of origin shall continue medical assistance while completing validation, subject to the time limits set forth in the application process, then transfer the case without delay to the receiving county in accordance with the next paragraph. If the CWB of origin is in the process of obtaining medical records, it shall complete the process and forward the medical records to the receiving county.

2. Whenever it is determined that a recipient whose application has been validated is planning to change his/her residence from one county to another, it shall be the responsibility of the county welfare board of directors of the two counties concerned to effect the transfer without interruption of medical assistance.

3. The county of origin shall initiate and the receiving county shall, on request, immediately cooperate in accomplishing a full investigation of the circumstances surrounding the move.

4. If the move is permanent and the case warrants continued medical assistance, transfer of the case shall be accomplished expeditiously by discontinuance of medical assistance in the county of origin and award of medical assistance in the receiving county, to occur simultaneously in the first month for which the county welfare board of directors mutually so arrange.

5. The welfare of the client shall not be adversely affected and his/her right to uninterrupted medical assistance if in need shall not be prejudiced by disagreement or other administrative difficulty between the counties. Any adverse change in grant resulting from transfer requires timely notice.

NOTE: Since the Medicaid Only client retains the same Medicaid number when he/she moves from one county to another, the county of origin shall not terminate the client from the Medicaid status file, but only from its own register.

(c) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with (d) and (e) below.

(d) Applicants: Applicants are those individuals applying for Medicaid in the county of origin who move to the receiving county before the eligibility determination has been completed.

1. County of origin: The county of origin has the responsibility to:

i. Complete the eligibility determination process;

ii. Accrete the individual to the Medicaid Status File (MSF) with the correct effective date of Medicaid eligibility and the new address (in the receiving county); and

iii. Within five working days of the eligibility determination, transfer the case record material to the receiving county in accordance with (e)1i through iv below.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative upon receipt of the case material to advise of the continued receipt of medical assistance; and

ii. Notify immediately in writing the county of origin of the date the case material was received.

(e) Recipients: Recipients include all individuals determined eligible for Medicaid Only.

1. County of origin: The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent PA–1G form (including all verification), Social Security numbers, the recipient's new address in the receiving county, and PA–3L form, completed with the individual's circumstances current as of the month of the transfer;

ii. Send with the above case material a cover letter specifying that the case is being transferred and requesting written acknowledgment of receipt;

iii. Forward promptly to the receiving county copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any case material described in (e)1i or iii above.

2. Receiving county: The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative when case material is received. Such communication shall arrange for the client and/or the client's authorized representative to make application within 10 working days of the contact to ensure uninterrupted receipt of medical assistance;

ii. Notify immediately in writing the county of origin of the date the initial case material was received;

iii. Determine eligibility for the individual. Identify and resolve questions of the eligibility determination made by the county of origin and receiving county. Advise the county of origin of any discrepancies in the eligibility determinations between the two counties;

iv. Certify eligibility for medical assistance (provided application to transfer has been made) effective for the next month if the initial case material has been received before the 10th of the month;

v. Certify eligibility for medical assistance (provided application to transfer has been made) for the second month after the month of receipt of initial case material when such material is received on or after the 10th of the month;

vi. Update the Medicaid Status File (MSF), if necessary. If the individual is determined eligible for Medicaid Only in the receiving county, there shall be no interruption of Medicaid eligibility and no change to the MSF is necessary. If the individual is determined ineligible for Medicaid Only in the receiving county, Medicaid eligibility shall be terminated, subject to timely and adequate notice, and the individual deleted from the MSF; and

vii. Notify the county of origin of the date eligibility for medical assistance will begin or will be terminated in the receiving county.

(f) Any case for which transfer procedures in (c) through (e) above are not begun within 30 days of the date of original referral, shall be promptly reported by the county of origin to the Division of Medical Assistance and Health Services by letter, setting forth the pertinent available facts. This does not mean that the actual transfer must be completed within 30 days, but rather that the procedures shall be commenced within that time.

Amended by R.1986 d.8, effective February 3, 1986.
See: 17 N.J.R. 2523(a), 18 N.J.R. 275(a).
Old (c) deleted; new (c)—(e) added; old (d) recodified to (f).

10:71-3.7 Eligibility of recipients who leave New Jersey

(a) Whenever a recipient wishes to leave New Jersey either to establish a permanent residence or for a temporary visit, he/she shall be advised of the effect of this plan on his/her eligibility for continued assistance. Particular care should be taken to advise the recipient how to present his/her New Jersey Medicaid validation stub and instruct the provider where to send the bill, should the recipient need medical care or hospitalization while out of the State on an approved temporary visit.

(b) It shall be the policy of this State that if a recipient leaves New Jersey with intent to establish a permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, or if he/she decides to remain indefinitely in the place outside New Jersey to which he/she had gone for a temporary visit, he/she ceases to be eligible to receive assistance.

(c) Visits by a recipient for a period of not more than 30 days will be permitted without affecting the recipient's eligibility. Absence for longer periods of time must be approved by the Division of Medical Assistance and Health Services.

10:71-3.8 Medicaid eligibility for individuals who enter New Jersey in order to secure medical care

(a) Federal and State statute and regulations expressly bar a duration-of-residence requirement as a condition of eligibility. The New Jersey Medical Assistance and Health Services Act authorizes a grant of medical assistance to a qualified applicant who is a resident of the State which " ... means a person living, other than temporarily, within the State."

(b) When an individual enters this State in order to receive medical care, and applies for Medicaid to meet all or a portion of the costs of such care, the fact that the immediate purpose of the move was to secure medical care does not, in and of itself, have the effect of making this person ineligible for the medical assistance program. It is the responsibility of the county welfare board to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

1. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;

2. Whether the move is part of a carefully conceived social service plan which would serve to meet other requirements of the individual in addition to purely physical needs, for example, a person moves to a nursing home in order to be closer to relatives who are interested in the person's welfare;

3. Whether there is a clear expression of intent on the part of the individual to remain permanently in this State;

4. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he/she came;

5. Whether the State in which the individual previously resided recognizes him/her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

(c) If, after full consideration of these factors, the county welfare board is satisfied that the individual has become a resident of this State, then eligibility for medical assistance is established if the person is otherwise eligible.

10:71-3.9 Age

(a) Age requirements are:

1. The applicant must be 65 years of age or older to be eligible based on age alone.

2. A disabled or blind child must be under 18 years of age, or under 22 years of age and a student regularly attending school and neither married nor the head of the household.

3. A disabled or blind adult must be over 21 years of age and under 65 years of age or between 18 years of age and 22 years of age if not a full-time student.

(b) The applicant must present acceptable proof of age. Among acceptable sources of verification of age are:

1. Birth certificate;

2. Marriage certificate;

3. Church records—baptismal, confirmation membership;

4. Immigration or naturalization papers;

5. Census records;
6. School records;
7. Military service records;
8. Court records;
9. Employment records;
10. Records of public or private welfare agencies;
11. Voting records;
12. Medical records;
13. Affidavit from disinterested persons;
14. Driver's licenses; or
15. Insurance policies.

(c) County welfare boards shall maintain administrative controls to assure:

1. That a disabled or blind recipient who become 65 years of age continues to have his/her eligibility determined on the basis of disability or blindness if it appears more advantageous to the recipient;

2. That a disabled child recipient is processed as a disabled adult when reaching 18 years of age, or 22 years of age and a student regularly attending school and neither married nor the head of the household;

3. That a disabled child recipient is processed as a disabled adult when reaching 18 years of age and a student regularly attending school and either married or the head of a household.

10:71–3.10 Disability and blindness factors

For purposes of determining medical eligibility for the Medicaid Only program, the disability and blindness standards shall be the same as for the Supplemental Security Income program under Title XVI of the Social Security Act, as amended by Public Law 92–603.

10:71–3.11 Determination of disability and blindness eligibility; a State function

(a) The determination of disability and blindness eligibility for the Medicaid Only program is a direct responsibility of the medical review team in the Division of Public Welfare, Bureau of Medical Affairs. Determination of all other factors of eligibility is the responsibility of the county welfare boards. The medical review team is composed of a medical consultant and a medical social work consultant; it reviews Medicaid Only applications submitted by the county welfare board.

(b) In situations where an applicant's disability or blindness appears to meet the definition in section 12 of this subchapter, presumptive eligibility for either of these factors can be granted with the approval of the Medical Review Team (MRT) in the Bureau of Medical Affairs.

(c) If an individual has been determined disabled for Social Security purposes (i.e., he/she is currently receiving Disability Insurance Benefits), the county welfare agency shall not refer the individual to the Bureau of Medical Affairs for a determination of medical eligibility. The individual shall be considered automatically eligible, in this respect, for Medicaid Only benefits.

1. In the event the Social Security Administration determined within the 12 months prior to the application for Medicaid Only that the individual was not disabled, the Bureau of Medical Affairs will not make an independent determination of the applicant's disability but will be bound by the determination of the Social Security Administration. If an individual whose Social Security or SSI disability claim was denied within the last 12 months presents new or additional evidence to support that claim, the CWA should refer the applicant to the Social Security Administration for a reevaluation of its determination.

2. When the denial by the Social Security Administration occurred more than 12 months prior to the application for Medicaid Only, the Bureau of Medical Affairs will make an independent determination of disability.

As amended, R.1979 d.364, eff. November 1, 1979.
See: 11 N.J.R. 379(b), 11 N.J.R. 519(e).

Cross References

Redetermination of medical eligibility, see N.J.A.C. 10:71–8.2.

10:71–3.12 Disability; definitions

(a) An individual is disabled for purposes of this part if he/she is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he/she suffers from any medically determinable physical or mental impairment of comparable severity).

(b) A physical or mental impairment is an impairment which results from anatomical, physiological or psychological abnormalities which are demonstrable by medically acceptable clinic and laboratory diagnostic techniques. Statements of the applicant including his/her own description of his/her impairment (symptoms) are, alone, insufficient to establish the presence of a physical or mental impairment.

(c) An individual is "blind" for purposes of this part if he/she has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having central visual acuity of 20/200 or less.

(d) The presence of a condition diagnosed as addiction to alcohol or drugs will not itself be the basis for a finding that the individual is or is not under a disability.

10:71-3.13 County welfare agency responsibility and procedures

(a) It is the responsibility of the CWA to furnish the Medical Review Team with current, pertinent social and medical information, and to obtain any special or additional reports on request.

(b) When it appears that an applicant meets the income and resources requirements for Medicaid Only, arrangements for obtaining medical evidence should be initiated immediately by whichever of the following procedures is applicable to the applicant's situation.

1. When the applicant is currently (within three months) under the care of a private physician, he/she shall be furnished with a copy of Form PA-5 (Examining Physician's Report) to take to the physician for completion.

2. If the applicant is currently receiving treatment in a hospital clinic, public health facility (that is, tuberculosis clinic, mental health clinic or other outpatient facility) on a regular basis for the medical condition related to his/her application for Medicaid Only, a copy or abstract of the clinic record may be submitted in lieu of the PA-5.

3. If the applicant has been hospitalized within three months for a condition related to the impairment for which he/she is applying for Medicaid Only, an abstract of the hospital record may be submitted for patients in long-term care facilities.

4. In the event none of the above are applicable, the CWA should assist the applicant in choosing a physician to complete the PA-5, who is competent to determine the nature and extent or degree of disability.

5. When the applicant states that he/she is blind or that visual impairment is his/her primary disability, the CWA shall, prior to submission of the record to the Medical Review Team, obtain a Report of Eye Examination (Form PA-5A) from a qualified medical specialist in diseases of the eye (for example, ophthalmologist), or an optometrist, or from an eye clinic of a general hospital, whichever the individual may select. (The membership directory of the Medical Society of New Jersey is suggested as reference for identification of, in each municipality, physicians specializing in diseases of the eye.) Optometrists are listed in the yellow pages of local telephone directories under the heading "Optometrists—Doctors of Optometry." The Form PA-5A should be transmitted in duplicate to the MRT with any other pertinent medical evidence as outlined above. When appropriate, the Certification of Need for Patient Care in Facility Other Than Public or Private General Hospital (Form PA-4) will be submitted to the Bureau of Medical Affairs.

(c) Other evidence, such as education, training, work experience and daily living activities, shall be submitted to the MRT by completion of the PA-6 (Medical-Social Information Report). The PA-6 shall be carefully and completely filled out.

(d) If the applicant refuses to furnish medical or other evidence concerning his/her disability, the application for Medicaid Only shall be referred to the Bureau of Medical Affairs for recommendations.

(e) As soon as medical reports and the Medical-Social Information Report (PA-6) are completed, one copy of each shall be stapled together for transmittal to the Bureau of Medical Affairs. It shall be clearly indicated on the PA-6 that this is a Medicaid Only case. Records transmitted by CWB on a given date shall be listed by registration number and name on an inventory sheet, prepared in duplicate, the cases being grouped by case status. One copy shall be attached to the submittal records, the duplicate retained as CWB control.

(f) The Bureau of Medical Affairs will prepare a similar inventory and attach cases returned to the CWB on a given date. Attached to each will be Form PA-8 (Record of Action) containing the determination of eligibility by the MRT and any necessary instructions.

(g) Upon receipt of records from the Bureau of Medical Affairs, the CWA shall examine the PA-8 (Record of Action) for the action of the Medical Review Team and for specific instructions or recommendations, and to note the review date.

(h) Recommendations will be made by the medical consultant to alert the CWB to the possibilities of adequate medical care for the client, and to provide specific pertinent questions to be raised with the attending physician. The medical social work consultant will make recommendations to help the CWA staff recognize the social problems indicated in the client's situation and the relationship between these problems and his/her physical and mental adjustment.

(i) The following procedures shall be observed in respect to MRT actions:

1. "Approved" cases:

i. CWA shall complete, as necessary, determination of eligibility in respect to other factors and, if applicant is eligible, take the necessary action to obtain Medicaid benefits.

ii. When an applicant is not eligible in respect to any other factor, although "approved" for the disability or blindness factor, the application shall be denied.

iii. The county welfare board shall establish and maintain a control file for "approved" cases in order that the date for determination review by the MRT will be observed and considered according to instruction in subchapter 5 of this chapter.

iv. The Bureau of Medical Affairs shall also maintain a control file in order to ensure appropriate and timely reevaluation by the MRT. The Bureau of Medical Affairs will notify county welfare boards one month in advance of cases scheduled for such review. Cases also for reevaluation will be listed on Form PA–655.

2. "Undetermined" cases:

i. If further medical and/or social information is required by the MRT for the initial determination of eligibility, the CWA shall obtain the information promptly and resubmit the case. Reports from medical specialists shall be submitted on their own letterheads.

ii. If the applicant fails or refuses to present himself/herself for required examinations or tests, the application shall be referred to the MRT for recommendations.

3. "Disapproved" cases:

i. Any case determined as not medically eligible for "Medicaid Only" by the MRT shall be denied Medicaid Only by the country welfare board.

ii. Appropriate notification shall be given to the applicant as well as any specific recommendations for follow-up care and treatment.

(j) When page 5 of Form PA–5 carries the signature of the medical consultant approving the payment of the examining physician, such payment shall be forwarded to the physician from administrative funds, regardless of whether the action on the record of action is "approved", "disapproved" or "undetermined". (In an "undetermined" case, if the request for additional information relates to an incomplete report from the examining physician, approval for payment will not appear on page 5 of the PA–5.)

(k) Payment for special diagnostic reports shall likewise be forwarded to the medical specialist or clinic from administrative funds regardless of whether the case is "approved", "disapproved", or "undetermined".

(*l*) Maximum allowances for examining physician (completion of PA–5) are as follows.

1. Examination at office or hospital: $20.00.

2. Examination at patient's home: $30.00.

3. Examination at public institution: No fee.

(m) Diagnostic examination services rules are:

1. This section is concerned with medical specialty consultant evaluation services and diagnostic studies (that is, clinical laboratory, diagnostic x-ray and special diagnostic examinations) incident thereto, authorized by a county welfare board upon recommendation of the MRT, when deemed essential as part of the initial determination of medical eligibility.

2. These examinations and procedures are exclusively for diagnostic eligibility, are chargeable as matchable administrative costs and a medical vendor payment should be promptly made upon approval of the consultant's report by the reviewing physician employed by the State agency.

3. The following schedule of fees is exclusive to laboratory, x-ray and other special diagnostic studies which may be required.

i. Diagnostic Consultation and Report (ophthalmologic includes refraction: otological includes audiometric screening) other than psychiatric or neurologic: $45.00.

ii. Diagnostic Consultation requiring complete psychiatric or complete neurological examination or complete neuropsychiatric examination, with detailed report: $50.00.

iii. Electrocardiogram with interpretation and report: $25.00.

(n) Payment of the above allowance is to be approved only when the specialist has received prior authorization to perform the diagnostic evaluation and when the examination is performed by a qualified specialist (that is, eligible for or certified by the appropriate American board; or recognized by hospital, community and peers as a specialist, and practice is limited to the specialty). See current membership directory of the Medical Society of New Jersey.

(*o*) The fee(s) listed in fees for professional and diagnostic services issued by the Medical–Surgical Plan of New Jersey (Revised 6–1–73) shall be approved when diagnostic x-ray or radioisotope studies, laboratory and/or special diagnostic studies are deemed essential by the medical specialist authorized to perform the diagnostic consultant evaluation. Payment based on the allowances listed by the Medical–Surgical Plan, Series 575, shall be limited to medical specialists as defined in the section.

As amended, R.1977 d.334, eff. October 1, 1977.
See: 9 N.J.R. 340(a), 9 N.J.R. 479(c).
As amended, R.1978 d.212, eff. June 22, 1978.
See: 10 N.J.R. 190(c), 10 N.J.R. 344(c).
As amended, R.1979 d.364, eff. November 1, 1979.
See: 11 N.J.R. 379(b), 11 N.J.R. 519(e).
As amended, R.1979 d.449, eff. November 13, 1979.
See: 11 N.J.R. 518(a), 11 N.J.R. 527(d).

10:71–3.14 Institutional eligibility

(a) Persons who are otherwise eligible for Medicaid Only receive medical coverage while receiving patient care in eligible medical institutions. Such coverage shall be provid-

ed through the appropriate payment mechanism of the Division of Medical Assistance and Health Services. The Medicaid "CAP" income standard is applied only to certain institutions.

(b) Individuals who are inmates of public institutions are not eligible for Medicaid coverage, unless they are receiving care in a Title XIX approved section of such facility.

(c) Individuals incarcerated in a Federal, State or local correctional facility (prison, jail, detention center, reformatory, etc.) are not eligible for Medicaid coverage. The needs of such individuals (inmates) are met through another agency of the Federal or State government or political subdivision thereof (see N.J.A.C. 10:71-1.6(a)3).

(d) An "institution" is any group living arrangement in which food, shelter and personal care (other than nursing care) are furnished on a continuous basis to four or more persons unrelated to the operator or in which food, shelter and personal care, including nursing care, are furnished on a continuous basis to four or more persons unrelated to the operator; or any establishment or facility licensed or approved by the State of New Jersey.

(e) Application of Medicaid "CAP" rules are:

1. General or Class A special hospitals: When a person is confined to such a hospital, the Medicaid "CAP" standard does not apply; eligibility will be determined according to the applicable living arrangement in Table B (see N.J.A.C. 10:71-5.6(c)5).

2. Long term care facilities (eligible private medical institutions): This may include licensed nursing homes (skilled nursing facilities), intermediate care facilities, or Class B and C special hospitals. These facilities must be licensed by the Department of Health licensing authority, and approved by the Department of Human Services for provider participation in the Title XIX Medicaid program. When person is confined to a long term care facility, the Medicaid "CAP" standard is used.

3. Licensed boarding homes for sheltered care (including nonprofit incorporate homes for the aged): These homes must be approved by the Department of Health. When the person is in a facility of this type, the income standard for licensed boarding home is used.

(f) An "eligible medical institution" outside New Jersey is a public or voluntary medical institution which is licensed, certified or approved by the proper authority of the jurisdiction in which the institution is located, so that the costs of care and services provided therein may be paid. Evidence of such license, certification or approval shall be obtained from the Department of Welfare or similar authority of the jurisdiction in which the institution is located.

1. Use of out-of-state facilities shall be restricted to temporary emergency situations where it is established that there is no eligibility for coverage under a welfare or nonwelfare program in the other state.

Amended by R.1986 d.71, effective March 17, 1986.
See: 17 N.J.R. 2522(a), 18 N.J.R. 564(b).
New (b) and (c) added; old (b)-(d) now (d)-(f).

10:71-3.15 County welfare board responsibility and procedures; eligibility factors

(a) The CWB shall be responsible for determining income and resource eligibility, as outlined in subchapter 4 of this chapter, for Medicaid Only when applicant is receiving care in institutions defined above. This does not include residents of the State psychiatric hospitals, the State schools for the mentally retarded, Bergen Pines County Psychiatric Hospital, and Essex County Hospital Center, which are the responsibility of the institutional services section of the Division of Medical Assistance and Health Services.

(b) When eligibility depends upon the disability or blindness factor, the determination of medical eligibility shall be the responsibility of the medical review team. The CWB shall furnish the MRT with current, pertinent social and medical information as outlined in this subchapter.

(c) When eligibility for Medicaid Only has been determined, the county welfare board will complete and process a Medicaid Status File Transaction, form MAP-1, within ten working days from the date of such determination. The county welfare board will issue and distribute medicaid validation stubs to Medicaid Only recipients who are not in long term care facilities. The CWB will complete the statement of income available for nursing home payment (PA-3L) when appropriate.

(d) A determination of continuing eligibility shall be made in accordance with subchapter 5 of this chapter.

10:71-3.16 Medical assistance units

(a) Medicaid district office (MDO): The Division of Medical Assistance and Health Services has local medical offices throughout the State, known as Medicaid district offices (MDOs). The role of these offices is to provide liaison with providers of health services; provide information about Medicaid to recipients and members of the community; provide utilization review in determining the medical need for certain covered services requiring prior authorization; and provide information about Medicaid to, and cooperate with, appropriate agencies in order to ensure maximum utilization of the services available through the Medicaid program.

(b) Any questions with respect to policy, regulations, or procedures of the Medicaid program should be directed to the appropriate MDO as listed below:

Atlantic 1 S. New York Avenue

	Atlantic City, NJ 08401 (609) 441–3620
Bergen	50 Main Street, 1st floor Hackensack, NJ 07601 (201) 488–5667
Burlington	50 Rancocas Road Mt. Holly, NJ 08060 (609) 261–0448
Camden	Parkade Building, Room 207 519 Federal Street Camden, NJ 08101 (609) 757–2870
Cape May	108 Landis Avenue Vineland, NJ 08360 (609) 696–6560
Cumberland	108 Landis Avenue Vineland, NJ 08360 (609) 696–6560
Essex	155 Washington Street Newark, NJ 07102 (201) 648–3700
Gloucester	Woodbury Plaza, Suite B 251 N. Delsea Drive Deptford, NJ 08096 (609) 845–7185
Hudson	2815 Kennedy Blvd., 2nd floor Jersey City, NJ 07306 (201) 433–8011
Hunterdon	84 Park Avenue, 2nd floor Flemington, NJ 08822 (201) 782–1130
Mercer	28 West State Street, Room 1105 Trenton, NJ 08608 (609) 292–7315
Middlesex	75 Paterson Street, basement New Brunswick, NJ 08903 (201) 246–0653
Monmouth	1200 Memorial Drive Asbury Park, NJ 07712 (201) 755–5700
Morris	10 Park Place, 4th floor Morristown, NJ 07960 (201) 267–1700
Ocean	1861 Hooper Avenue Toms River, NJ 08753 (201) 255–6226
Passaic	100 Hamilton Plaza, 9th floor Paterson, NJ 07505 (201) 977–4077
Salem	Woodbury Plaza, Suite B 251 N. Delsea Drive Deptford, NJ 08096 (609) 845–7185
Somerset	84 Park Avenue, 2nd floor Flemington, NJ 08822 (201) 782–1130
Sussex	10 Park Place, 4th floor Morristown, NJ 07960 (201) 267–1700
Union	125 Broad Street Hersh Towers, 6th floor Elizabeth, NJ 07201 (201) 820–3135
Warren	10 Park Place 4th floor Morristown, NJ 07960 (201) 267–1700

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.

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 Mazart, 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 recipients.

(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/recipient, 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/recipients 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/recipient, his or her legal representative, guardian, relative or any person acting on the applicant's/recipient'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/recipient 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 bonafide lien or judgment exists against such funds, making all or some portion of the funds inaccessible to the applicant/recipient, CWAs 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/recipient pays outstanding medical expenses and/or other expenses, the CWA 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 (i.e., 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)1iv. 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 must 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 applies 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.

(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/she has unrestricted access to the funds (i.e., an "or" account) regardless of their source. When the individual's access to the account is restricted (i.e., an "and" account), the CWA shall consider a pro rata share of the account toward the appropriate resource maximum, unless the client and the other owner demonstrates 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 CWA shall verify the equity value of resources through appropriate and credible sources. Additionally, the CWA 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 CWA 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 CWA 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 recipient 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 CWA 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.

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.

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.

(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 CWA shall proceed in the following manner:

1. Real property which produces income: If the CWA 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 CWA 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 CWA shall verify the existence or nonexistence of any cash, savings or 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 CWA 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).

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

10:71–4.3 (Reserved)

Repealed 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).
This section was "liquidation of resources."

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) Identification of excludable resources: The following resources shall be classified as excludable:

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

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

i. Total exclusion: 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. Exclusion of $4,500 of current market value: 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/recipient.

(1) CMV: The CMV 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 nonliquid resources and counted to the extent of their equity value.

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

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

ii. Wedding and engagement ring: 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. Certain medical items: 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. Life insurance: 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. Face value in excess of $1,500: Of 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. Certain income-producing property: 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 six percent of the equity value (with exceptions below), the total equity value is an includable resource.

i. Return is less than six percent: 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 of an employee: Tools and equipment required for employment are assumed to be of reasonable value and producing a reasonable rate of return and are, therefore, excluded from resources.

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

i. Examples of inaccessible resources: 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. Periodic reevaluation of inaccessible resources: Inaccessible resources shall be reevaluated (regarding their accessibility) at every redetermination.

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

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

8. Replacement value of excludable resources:

i. 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) Extension for good cause: 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/her control prevented the repair or replacement or the contracting for the repair or replacement.

ii. Sale of a home: 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 and burial funds: 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. Definitions: The following definitions apply to this section.

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

(2) Funds set aside for burial: 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 arrangement: 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: Immediate family includes an individual's minor and adult children, stepchildren and adopted children, brothers, sisters, parents, adoptive 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. Burial funds: 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, eff. 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.

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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).

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, eff. 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 Mazart, 164 N.J.Law. 34 (Mag.) (Oct. 1994).

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.)

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 $72,660 unless authorized in (a)4 or 5 below. The community spouse's share of the couple's resources shall be the greater of:

i. $14,532; 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 CWA 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).

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 welfare agency 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 welfare agency 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 welfare agency shall establish the total countable resources of the couple. The county welfare agency 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 welfare agency.

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 welfare agency or the requesting parties request a delay.

(c) At the time of providing the couple with a copy of the resource assessment, the county welfare agency 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).

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 Nallin, 135 N.J.L.J. No. 17, 53 (1993).

Protecting the Home in Government Benefits Planning. Gary Mazart, 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

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).

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:

1. Initial income eligibility: 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. Income received other than monthly:

i. Weekly: Income received weekly 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. Quarterly, semiannual, or annual: When income received on a quarterly, semiannual, 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. Period of income eligibility: 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.)

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

ii. Irregular income: In situations where earned or unearned income is received irregularly or in irregular amounts, redeterminations shall be made as frequently as necessary. The individual shall be advised of his/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.)

10:71–5.3 Income exclusions

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

1. Monies received from the sale of a resource: 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. Certain insurance reimbursements: 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. Medical payments by a third party: 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: The value of social services (e.g., advice, training, consultation) performed by any governmental or private agency shall be excluded.

5. Value of food stamps: The value of food stamps shall be excluded.

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

i. Contributions from family members: Regular contributions to an individual by his/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 certain Federal programs: Benefits received under the following Federal programs shall be exempt:

i. Women, Infants, and Children (WIC) program benefits: The value of benefits received under the Federal WIC program shall be exempt.

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

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

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

v. Domestic volunteer service act payments: 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. Disaster assistance: Payments made by the Disaster Assistance Administration shall be exempt.

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

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

ix. Payments from certain youth projects: 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)6iii above) may not be excluded.

x. Social Security cost-of-living benefits: 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 SSI cost-of-living increases subsequent to that increase which created their SSI ineligibility.

xi. 1972 Social Security cost-of-living increase: 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. Certain proceeds of life insurance policies: 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: Last illness and burial expenses shall include related hospital, medical, funeral, burial plot, interment expenses, and related costs.

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

10. Certain school tuition and fees: 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 certain produce: The value of agricultural produce, if raised for home consumption, shall be excluded.

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

i. Unearned income: 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: 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. Foster care payments: 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/her own right, or if he/she does not reside in the home of the eligible individual(s).)

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

15. Earnings of a student under 22 years of age: 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. Student defined: A person shall be considered a student if he/she meets the following criteria:

(1) He/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) Homebound students: A student shall be considered in regular attendance if he/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) Vacation periods: A student shall be considered in regular attendance during normal vacation periods if he/she is in regular attendance in the month immediately preceding and immediately following the vacation period.

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

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

17. Interest on burial funds: 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. General exclusion: 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 exclusion: 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. Employment expenses of the blind: In the case of blind persons only, all expenses reasonably attributable to the earning of income shall be excluded.

21. Income needed to fulfill a plan of self-support: 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. Approval of plan: 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.

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

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 recipient 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.

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 at a 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 unearned income in the amount of:

$168.67 for an individual

$243.00 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.

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/recipient living alone: If the applicant/recipient lives alone, only his/her countable income shall be applied to the appropriate income standard.

2. Applicant/recipient couple: In the case of an applicant/recipient 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/recipient 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 institutionalized in separate facilities, the income of each is applied individually to the Medicaid "Cap."

3. Applicant/recipient living with ineligible spouse: if the applicant/recipient lives with an ineligible spouse, the income of the ineligible spouse is deemed to the applicant/recipient (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/recipient 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/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).

Case Notes

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).

10:71–5.5 Deeming of income

(a) When an applicant/recipient 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/recipient, 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/recipient 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/recipient'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/recipient is financially ineligible for Medicaid Only based on his or her own countable income, and there is no deeming. However, if the applicant's/recipient'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/recipient. The deeming process stops.

   i. Determine the applicant's/recipient'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/recipient 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 applicant's/recipient'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 applicant/recipient 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/recipient'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/recipient and ineligible spouse) remaining countable income is less than the amount in Table A, Figure 3, for the appropriate living arrangement, the applicant/recipient 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/recipient 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/recipient spouse and an applicant/recipient child, the following deeming procedures are used:

1. Step 1: Determine the amount of income, if any, to be deemed to the applicant/recipient 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/recipient is financially eligible for Medicaid Only, there is no income available for deeming to the applicant/recipient child(ren). The deeming process stops.

3. Step 3: If, in the process of deeming of income to the applicant/recipient 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/recipient shall be deemed to any child applicant/recipient. This income is treated as unearned income to the child.

4. Step 4: If there is more than one child applicant/recipient 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/recipient 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/recipient child, shall be available for deeming equally to any other applicant/recipient children in addition to their equal shares of the total deemable income.

(e) Deeming of income from a parent (and spouse of a parent) to a child: The computation methods for deeming of income from an ineligible parent (and spouse of a parent) to a child differ depending on the type of parental income.

1. Step 1: Determine the total monthly parental income, both earned and unearned (separately), less any income excluded in N.J.A.C. 10:71–5.5(b). Do not combine the two totals.

i. 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. No allowance may be deducted for a child receiving public assistance.

ii. Subtract the living allowance for each ineligible child, determined in (e)1i above, from the unearned income of the parent(s). Subtract any remaining living allowance from the earned income of the parent(s).

iii. The remaining parental income should be treated in accordance with the procedures of Step 2, 3, or 4 below, as appropriate.

2. Step 2: Remaining parental income is earned income only:

i. From the remaining parental earned income, subtract $85.00 ($20.00 general income exclusion plus $65.00 work expense exclusion).

ii. Next, subtract the appropriate parental living allowance for the parent (and spouse of a parent) living in the household. This parental allowance is found in Table A, Figure 4a.

iii. The remaining amount is the income deemed to the applicant/recipient child(ren). This deemed income is treated as unearned income.

iv. Combine any income deemed to the eligible child together with any countable income of the eligible child.

(1) Subtract the $20.00 general income exclusion from the child's unearned income.

v. If the child's total countable income is less than the appropriate income eligibility standard in Table B, the child is financially eligible for Medicaid Only.

3. Step 3: Remaining parental income is unearned only:

i. From the remaining parental unearned income, subtract $20.00 (general income exclusion).

ii. Next, subtract the appropriate parent living allowance for the parent (and spouse of a parent) living in the household. This parental allowance is found in Table A, Figure 4b.

iii. The remaining amount is the income deemed to the applicant/recipient child(ren). This deemed income is treated as unearned income.

iv. Combine any income deemed to the eligible child together with any countable income of the eligible child.

(1) Subtract the $20.00 general income exclusion from the child's unearned income.

v. 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.

4. Step 4: Remaining parental income is both earned and unearned:

i. First, subtract the $20.00 general income exclusion from the remaining parental unearned income. Then, subtract any unused portion of the general income exclusion from the remaining parental earned income.

ii. From the remaining earned income, subtract $65.00 (work expense allowance) and one-half of the remainder of earned income. Combine any remaining earned income with the remaining unearned income.

iii. Subtract the appropriate parental living allowance for the parent (and spouse of parent) living in the household. This parental allowance is found in Table A, Figure 4c.

iv. The remaining amount is the income deemed to the applicant/recipient child(ren). This deemed income is treated as unearned income.

v. Combine any income deemed to the eligible child together with any countable income of the eligible child.

(1) Subtract the $20.00 general income exclusion from the child's unearned income.

vi. 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.

(f) Treatment of income deemed to a child: Any income deemable to a child is treated as unearned income and thus subject to the $20.00 general income exclusion. If there is more than one applicant/recipient child in the household, the deemable income is divided equally among them. However, no income is to be deemed in excess of the amount which, when combined with the child's own countable income, creates ineligibility. That portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement, is available for deeming equally to other applicant/recipient children in the household in addition to their equal shares of the total parental deemable income. The following steps shall apply in treatment of income deemed to a child:

1. Step 1: Combine any income deemed to the eligible child together with any countable income of the eligible child.

2. Step 2: Subtract the $20.00 general income exclusion from the child's unearned income.

3. Step 3: If the child's total remaining income is less than the appropriate income eligibility standard in Table B the child is financially eligible for Medicaid Only. The child has no excess deemed income available for other applicant/recipient children.

4. Step 4: If, in the process of deeming of income to an applicant/recipient child, such child becomes financially ineligible for Medicaid Only, that portion of deemed income that exceeds the appropriate income eligibility standard in Table B shall be divided equally among other applicant/recipient children in the household, in addition to their equal shares of the total parental deemable income, and shall be counted in determining financial eligibility for Medicaid Only for such other children.

(g) A table for deeming computation amounts follows:

TABLE A

Deeming Computation Amounts

1. Living allowance for each ineligible child		$223.00
2. Remaining income amount	**Head of Household** $223.00	**Receiving Support and Maintenance** $148.33
3. Spouse to Spouse Deeming—Eligibility Levels		
a. Residential Health Care Facility	$1,173.36	
b. Eligible individual living alone with ineligible spouse	$ 917.36	
c. Living alone or with others	$ 700.25	
d. Living in the household of another	$ 539.09	
4. Parental Allowance—Deeming to Child(ren)		
Remaining income is:	**One Parent**	**Parent & Spouse of Parent**
a. Earned only	$892.00	$1,338.00
b. Unearned only	$446.00	$ 669.00
c. Both earned and unearned	$446.00	$ 669.00

As amended on an emergency basis, R.1981 d.276, effective July 1, 1981.
See: 13 N.J.R. 501(a). Readopted, 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).
Figures which appeared at 14 N.J.R. 758(a) were effective upon filing through September 30, 1982. The new figures became effective October 1, 1982 and represent a $2.10 increase in the optional State supplement in SSI payment level.
Amended by R.1983 d.381, effective August 30, 1983, with changes upon adoption.
See: 15 N.J.R. 1187(a), 15 N.J.R. 1585(a).
Originally filed as emergency rule R.1983 d.289 effective July 1, 1983.
Amended by 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 computation amounts increased.
As amended on an emergency basis, R.1984 d.467, effective September 28, 1984 (operative October 1, 1984).
See: 16 N.J.R. 2845(a).
Table A amended.
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.
(d): Raised computation amounts.
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).
Table A amended.
Amended by R.1986 d.53, effective March 3, 1986.
See: 17 N.J.R. 2732(a), 18 N.J.R. 484(a).
(a)1 added text "regarding earnings of ... reaches age 18". Old (c) deleted; new (c)-(e) added; old (d) recodified to (g).
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).
Table A amended.
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).
Table A amended.
Adoption of 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 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).
Table A amended.
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. 207(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).
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 (g).
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 (g).
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).

10:71-5.6 Income eligibility standards

(a) Table B, which follows shall be used to determine income eligibility for aged, blind, and disabled persons who make application for Medicaid Only benefits. The standard used for applicants/recipients shall be determined in accordance with the following living arrangement categories. (For cases involving the deeming of income, this section must be used in conjunction with N.J.A.C. 10:71-5.5).

(b) Residential Health Care Facilities: The income standard for Residential Health Care Facilities (RHCFs) (Table B, Figure I) shall be used for individuals/couples residing in

such facilities. This living arrangement is predicated on licensure by the New Jersey Department of Health. Individuals in unlicensed facilities shall always be categorized as "living alone" (N.J.A.C. 10:71-5.6(c) and Table B, Figure II).

(c) Non-institutional living arrangements:

1. Living alone: This category (Table B, Figure II) shall be used for individuals/couples who are:

i. Living physically alone;

ii. Living in a commercial establishment: A commercial establishment is a motel, hotel, rooming or boarding house (including type A, B, and C, formerly known as unlicensed boarding homes) that holds itself open to the public as such;

iii. Living in a business-like arrangement;

iv. Purchasing or preparing food separately: This classification applies to persons living with others in a private dwelling, but separately purchasing or preparing their own food. The determination is based on the person's customary food purchase and preparation habits. Occasional joint purchase or preparation of food does not preclude a person from this classification;

v. Taking of all meals elsewhere: This classification applies to persons living with others in a private dwelling but taking all meals elsewhere;

vi. Paying more than pro rata share and having ownership or rental responsibility: Persons living as members of a household but having ownership or rental responsibility and paying more than their pro rata share of the household expenses (because other members are paying less) are considered to be living alone.

(1) Eligible individual with ineligible spouse: It is assumed that a couple share rental or ownership responsibility. Therefore, the following steps are necessary to determine if the eligible individual with ineligible spouse and other household members is paying more than his/her pro rata share of household expenses.

(A) If the eligible individual's contributions (singly) are more than his/her pro rata share of household expenses, he/she will be considered living alone. If not, proceed to (c)1vi(1)(B) below.

(B) If the contributions of both the eligible individual and ineligible spouse to the household are more than their pro rata share, they shall be considered to be living alone. If their contribution is equal to or less than their pro rata share, the applicant/recipient shall be considered to be living with others (see N.J.A.C. 10:71-5.6(c)3).

(C) Household expenses are limited to: food; mortgage or rental payments; real property taxes; heating fuel; gas; electricity; water; sewer; garbage removal.

2. Living alone with ineligible spouse: This category (Table B, Figure III) applies when an individual lives with his/her ineligible spouse and there are no other persons who are part of the household. If any other persons, even minor children, are present in the same household, this category does not apply. Parents with minor children are always considered to be in the same household, therefore, the presence of minor children would result in the living arrangements in either N.J.A.C. 10:71-5.6(c)3 or 5.6(c)4.

3. Living with others: This category (see Table B, Figure IV) applies when the individual/couple resides with others and either:

i. Has ownership or rental liability and pays an amount equal to or less than pro rata share of household expenses (see N.J.A.C. 10:71-5.6(c)1vi(1)(C)); or

ii. Does not have ownership or rental liability and is sharing household expenses with other members of the household. Sharing is defined as paying a pro rata share or more of household expenses (see N.J.A.C. 10:71-5.6(c)1vi(1)(C)).

4. Living in household of another: If the individual/couple lives in a household with adults other than a spouse and the living arrangement has not already been determined in N.J.A.C. 10:71-5.6(c)1 through 5.6(c)3 above, the individual/couple may be considered to be living in the household of another (Table B, Figure IV). The specific criteria for categorization in this living arrangement is the receipt of both support and maintenance. That is, the individual/couple does not purchase either food or shelter separately in accordance with (c)4i below.

i. If meals are consumed by an individual/couple in the household and the individual/couple does not purchase either food or shelter separately, the individual/couple shall be considered living in the household of another.

(1) Separate purchase of food means that the individual/couple pays a pro rata share of the household's food or actually purchases food separately. An individual/couple receiving food stamps as a separate food stamp household shall be considered to be purchasing food separately.

(2) Separate purchase of shelter exists when the individual/couple contributes an amount equal to the pro rata share of the household's shelter expenses. Shelter expenses are limited to all items except "food" in N.J.A.C. 10:71-5.6(c)1vi(1)(C).

ii. Persons determined to be living in the household of another shall not be considered to be receiving support and maintenance in-kind pursuant to N.J.A.C. 10:71–5.4(a)12 because such in-kind income has already been taken into account in the eligibility standards.

5. Table B follows:

TABLE B

Variations in Living Arrangements	Medicaid Eligibility Income Standards Individual	Couple
I. Residential Health Care Facility	$ 596.05	$1,173.36
II. Living Alone or with Others	$ 477.25	$ 694.36
III. Living Alone with Ineligible Spouse	$ 694.36	
IV. Living in Household of Another	$ 341.65	$ 539.09
V. Title XIX Approved Facility: Includes persons in acute general hospitals, nursing facilities, intermediate care facilities/mental retardation and licensed special hospitals (Class A, B, C) and Title XIX psychiatric hospitals (for persons under age 21 and age 65 and over) or a combination of such facilities for a full calendar month.	$1,338.00†	

† Gross income (that is, income prior to any income exclusions) is applied to this Medicaid "cap."

(d) Institutional eligibility: For the purpose of the Medicaid program, Title XIX approved facilities shall include acute care general hospitals, nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR), and licensed special hospitals (Class A, B, C) and Title XIX psychiatric hospitals (for persons under age 21 and age 65 and over).

1. Persons are considered institutionalized if they enter a Title XIX approved facility and a physician has certified that the duration of stay in the Title XIX facility (or a combination of such facilities) is expected to be 30 consecutive days or more. Income eligibility shall be determined in accordance with the variations contained in N.J.A.C. 10:71–5.4(b). However, the income of the institutionalized individual shall not be reduced by any of the income exclusions found in N.J.A.C. 10:71–5.3.

2. Institutionalized individuals, identified in (d)1 above, who are found Program eligible will receive benefits as of the date of admission.

3. Persons in a facility which is not Title XIX approved or whose stay is expected to be a period of less than 30 consecutive days will have eligibility determined in accordance with the community living arrangement which existed prior to entering the facility.

4. Temporary absence from the institution: Any temporary absence, during which the individual remains a patient of the institution, does not interrupt a continuous stay in the institution.

5. Persons living in the community who do not otherwise qualify for Medicaid benefits and who elect to participate in the hospice program, or who are assigned a slot in the CCPED or other waiver programs, will have financial eligibility determined in the same manner as those who reside in an institution.

i. Such individuals who are found eligible will receive benefits on the date of the election of hospice benefits, or the date of assignment to a waiver slot, whichever is applicable.

Amended on emergency basis, R.1981 d.276, effective July 1, 1981.
See: 13 N.J.R. 501(a).
Readopted, 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).
Figures which appeared at 14 N.J.R. 758(a) were effective upon filing through September 30, 1982.
The new figures became effective October 1, 1982 and represent a $2.10 increase in the optional State Supplement in SSI payment level.
Amended by R.1983 d.381, effective August 30, 1983 with changes upon adoption.
See: 15 N.J.R. 1187(a), 15 N.J.R. 1585(a).
Originally filed as emergency rule R.1983 d.289, effective July 1, 1983.
Amended by 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).
Eligibility income standards increased.
Amended by R.1984 d.244, effective June 18, 1984.
See: 16 N.J.R. 684(a), 16 N.J.R. 1611(a).
Table B: "882.00" was "852.90."
As amended on emergency basis, R.1984 d.467, effective September 28, 1984 (operative October 1, 1984).
See: 16 N.J.R. 2845(a).
Table B eligibility Income Standards increased.
Readopted, R.1984 d.566, effective November 28, 1984 (amendment effective January 1, 1985).
See: 16 N.J.R. 2845(a), 16 N.J.R. 3451(a).
Previously filed as emergency rule R.1983 d.289.
(c)4: Table B, Figure "V" changed to "IV;" (c)5: Income standards raised in Table B.
Amended by R.1985 d.169, effective April 15, 1985 (operative May 1, 1985).
See: 17 N.J.R. 39(a), 17 N.J.R. 969(b).
(e)4 added.
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).
Table B amended.
Adopted concurrent proposal, 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).
Table B amended.
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).
Table B amended.
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).
Table B amended.
Emergency amendment expired February 27, 1989. Concurrent proposed amendments adopted and filed 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).
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).
Income eligibility standards 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.
Amended by R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Added (d)4.
Emergency amendment, R.1991 d.37, effective December 31, 1990 (operative January 1, 1991).
See: 23 N.J.R. 233(a).
Increase in income eligibility standards at (c)5.
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 income eligibility standards at (c)5.
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.1992 d.442, effective November 2, 1992.
See: 24 N.J.R. 2778(a), 24 N.J.R. 4036(a).
Revised (d).
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).

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

10:71-5.7 Post-eligibility treatment of income; institutionalized individuals

(a) The amounts specified in (b) through (h) of this section shall be deducted from the income of an institutionalized individual prior to the application of his or her income to the cost of the long term care. These deductions apply only after the individual is determined eligible for Medicaid and shall not be deducted in the determination of income eligibility.

1. Should the total deductions authorized under this section exceed the institutionalized individual's income, no assistance is available from the Medicaid program to make up the deficit. In such circumstances, available funds shall first be used to provide the institutionalized individual with his or her personal needs allowance. Any remaining deductible income may be distributed to the community spouse or other family members as decided by the institutionalized individual, not to exceed the amount authorized under this section for any individual.

2. The deductions authorized in (c) through (e) below for the maintenance of the community spouse and other family members apply only so long as there is a community spouse as defined in (c) below. Deductions for the community spouse and other family members shall cease in the first full-calendar month after the community spouse dies, becomes divorced, or is institutionalized.

(b) A personal needs allowance in the amount of $35.00 shall be deducted from the institutionalized individual's income. In addition, gross income derived from employment that is considered essential toward satisfying the individual's developmental need to achieve a certain amount of independence shall be deducted from the individual's income. The combination of these deductions shall not exceed the amount in Table B for an individual living alone as found at N.J.A.C. 10:71-5.6(c)5.

(c) There shall be deducted from the institutionalized individual's income an amount for the maintenance of the community spouse. Except as specifically provided below, the deduction for the maintenance of the community spouse shall not exceed $856.00. For purposes of this section, a community spouse shall be defined as an individual who is legally married to an institutionalized individual under the provisions of State law and who is not himself or herself institutionalized. In arriving at the amount that may be deducted for the maintenance of the community spouse, the deductions authorized by this section shall be reduced by the gross income of the community spouse. The community spouse deduction is authorized only to the extent that the income deducted is actually made available to (or for the benefit of) the community spouse. No amount of the community spouse's maintenance deduction may be retained by the institutionalized individual.

1. If the community spouse's average monthly shelter expenses for his or her principal place of residence exceed $257.00, the amount of that excess shall increase the maximum community spouse maintenance deduction. Shelter expenses are limited to rent or mortgage (including principal and interest), taxes and insurance, a utility standard for the individual's utility expenses, and in the case of a condominium or cooperative, the monthly required maintenance charge.

2. A utility allowance shall not be authorized unless the community spouse directly incurs charges for utilities. A community spouse who directly incurs charges for heating fuel (in accordance with food stamp regulations at N.J.A.C. 10:87-5.10(a)5iv) separate and apart from their rent or mortgage payments, shall be entitled to a utility allowance in the amount specified as the "Heating Utility Allowance" at N.J.A.C. 10:87-12.1. If the community spouse does not directly incur heating fuel charges but does directly incur charges for a utility other than telephone, water, sewerage, or garbage collection, a utility allowance in the amount specified as "Standard Utility Allowance" at N.J.A.C. 10:87-12.1 shall be authorized. If the only direct utility charge incurred by the community spouse separate and apart from the rent or mortgage is the telephone the amount specified at N.J.A.C. 10:87-12.1 as "Uniform Telephone Allowance" shall be added to the community spouse's monthly shelter costs. The telephone allowance shall not be used if either of the above utility allowances have been used because those standard allowances include telephone charges.

(d) When the institutionalized individual's income is insufficient to provide the maximum authorized deduction for the community spouse, either the institutionalized spouse or the community spouse can request a fair hearing in accordance with N.J.A.C. 10:71–8.4. If either member can establish at the fair hearing that the income generated from the community spouse's share of the couple's resources is inadequate to raise the community spouse's income (together with the community spouse maintenance deduction) to the maximum authorized level, additional resources (beyond the community spouse's share as established at N.J.A.C. 10:71–4.8) may be set aside for the community spouse. The amount of resources to be set aside shall be that amount that is determined sufficient to generate sufficient income to raise the community spouse's gross income to the maximum authorized level.

(e) If either the institutionalized spouse or the community spouse is dissatisfied with the determination of the amount of the community spouse maintenance deduction, he or she may request a fair hearing in accordance with N.J.A.C. 10:71–8.4. If it is established at the fair hearing that the community spouse needs income above the amount established by the community spouse maintenance deduction due to exceptional circumstances resulting in financial duress, there shall be substituted for the community spouse maintenance deduction such amount as is necessary to alleviate the financial duress and for so long as directed in the final hearing decision.

(f) If a court has entered an order against an institutionalized spouse for monthly income for the support of a community spouse and the amount of the order is greater than the amount of the community spouse deduction, the amount so ordered shall be used in place of the community spouse deduction.

(g) A family member maintenance deduction shall be calculated for each family member of the institutionalized individual.

1. For purposes of this section, family members must reside with the community spouse and shall be limited to the following persons:

i. Children of either member of the couple who are under the age of 21;

ii. Children over the age of 21 who are claimed as dependents by either member of a couple for tax purposes under the Internal Revenue Code;

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 $856.00. 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.

New Rule, R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).

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

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, AFDC 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 CWA 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 $446.00 for the sponsor, $669.00 for the sponsor if living with his or her spouse, $892.00 for the sponsor if his or her spouse is a co-sponsor.

3. Subtract $223.00 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), 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.
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).

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 county welfare board's decisions and actions for each case.

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.

10:71–6.4 Maintenance and custody of case records

All case record material relevant to each family shall be maintained under an appropriate registration number. All records shall be appropriately indexed and filed.

10:71–6.5 Movement of case records

(a) No case record or official part of such record shall be removed from its designated filing cabinet without an identifying record of the person who has custody of it.

(b) No case record or official part shall be removed from the offices of the county welfare board except at the specific authorization of the director, deputy director or duly designated representative of the director.

10:71–6.6 Retention and destruction of records

For policy and procedure on retention and destruction of case records see Public Assistance Manual 7270.

SUBCHAPTER 7. OTHER PAYMENTS

10:71–7.1 General provisions

Medicaid Only recipients, like Supplemental Security Income (SSI) recipients are eligible to receive services and related service payments for services identified at N.J.A.C. 10:71–7.2 and for payment of burial and funeral expenses as authorized by N.J.A.C. 10:71–7.5. Such payments as deemed necessary and appropriate by the county welfare agency shall be paid either directly to the vendor of the service or by a check issued to the eligible person.

10:71–7.2 Services and service payments

Eligible applicants and recipients as defined under the State Plan for Title XX of the Social Security Act may receive the services and related service payments specified in the State Plan. The Division of Youth and Family Services is responsible for providing the county welfare agency with policies and procedures regarding these service programs, including those specified in N.J.A.C. 10:71–7.3.

10:71–7.3 Other service payments

Eligible applicants and recipients of Medicaid Only are also eligible to receive certain service payments as authorized at N.J.A.C. 10:82–5.2 through 5.4. These include payments for expenses incident to homemaker service, travel costs for health care, and child care in certain situations.

10:71–7.4 Emergency assistance payments

Eligible applicants and recipients of Medicaid Only are not eligible to receive emergency assistance as defined in N.J.A.C. 10:82–5.10.

10:71–7.5 Payment of burial and funeral expenses

The county welfare agency is directed, under certain situations, to provide payments for burial and funeral expenses on behalf of Supplemental Security Income and adult "Medicaid Only" recipients, as well as former Old Age Assistance, Disability Assistance and Assistance for the Blind recipients. The procedure authorizing these payments is located at N.J.A.C. 10:100–3.3 through 3.9.

As amended, R.1982 d.354, eff. October 18, 1982.

See: 14 N.J.R. 816(a), 14 N.J.R. 1162(c).
Reference to obsolete manual deleted. Reference to new, codified handbook included.

SUBCHAPTER 8. RESPONSIBILITIES

10:71–8.1 Other agency responsibilities

(a) Determination of continuing eligibility: The eligibility of each case shall be redetermined at least once every 12 months. This redetermination provides an opportunity to evaluate the total situation and enables the Income Maintenance (IM) worker to ascertain whether the individual's eligibility has changed.

1. It shall be the agency's responsibility to review indications of ineligibility as they occur and to discontinue Medicaid Only eligibility when appropriate and without delay. The agency shall notify each applicant/recipient of any agency decision that relates to his or her eligibility status in accordance with the provisions of N.J.A.C. 10:71–8.1(e) and 8.3.

2. The individual, or his or her authorized representative, shall execute a formal written application, Form PA–1G, Application and Affidavit for Medical Assistance Only (Aged, Blind, or Disabled), for continuance of assistance at least once every 12 months.

(b) Process of redetermination:

1. Personal interview: The IM worker shall conduct a face to face interview regarding application for continuance of Medicaid Only and shall assist in the completion of the application form, Form PA–1G, if necessary.

2. Redetermination of financial and resource eligibility: The IM worker shall review all eligibility factors in accordance with the provisions set forth in N.J.A.C. 10:71–3, 4, and 5. Particular attention shall be directed to identification of any changes in resources and income.

3. Completion of Worksheet and Authorization for Public Assistance (Form PA–3A) and the Medicaid Eligibility Worksheet (Form PA–1E): It is the responsibility of the IM worker to complete a new Form PA–1E and Form PA–3A when eligibility is to be continued, or suspension of eligibility continues beyond one month or the case is terminated. A new Form PA–3L, Statement of Income Available for Long Term Care Facility Payment, should be prepared for persons in institutions only when there is a change with regard to the amount of income available for medical reimbursement.

4. Need for institutional care: Official review of this factor on a routine basis is not required, but when medical or social evidence indicates that specific determination should be made, the CWA shall institute such an investigation.

(c) Recording and recommendation: A Summary Report, Form PA–2D, concerning all pertinent information shall be completed for each contact with the individual, whenever it occurs. Whenever a change in circumstances affects any facet of eligibility, a Medicaid Eligibility Worksheet (Form PA–1E) and a Worksheet and Authorization for Public Assistance (Form PA–3A) shall be prepared. The summary shall clearly state the basis for any suspension of eligibility or termination. Following each redetermination of eligibility, it is the responsibility of the IM worker to recommend on form PA–3A that eligibility be continued, suspended, or terminated.

(d) Disposition of application for continuance: Following supervisory approval, an application for continuance shall be acted upon by one of the following methods:

1. Action by executive authority: The Director of Welfare (or his or her authorized representative) shall, by his or her legal authority, continue, suspend, or terminate eligibility when, in his or her judgment, such action should be taken in advance of welfare board action. Such cases shall thereafter be presented to the welfare board at its next meeting. In those counties not having welfare boards, the authority for final action as to the disposition to continue, suspend or terminate eligibility shall rest with the Director of Welfare and the provisions of (d)2 below shall not apply.

2. Action by the welfare board: The following applications for Medicaid Only continuation shall be routinely presented to the welfare board for decision:

i. Cases recommended for continuance;

ii. Cases recommended for suspension or termination (for ratification if acted upon by the Director).

3. Whenever a special review results in a recommendation for suspension or termination, the case shall be presented to the welfare board for initial action or ratification of the Director's action, as appropriate.

(e) Notice of agency decision: Each applicant/recipient shall receive written notice of any agency decision which relates to his or her eligibility status at least 10 days prior to any change in his or her eligibility status.

10:71–8.2 Redetermination of medical eligibility

(a) Redetermination of disability and blindness factors:

1. Requirement: There shall be redetermination of the factors of disability and blindness for every Medicaid Only recipient at intervals set by the Division of Public Welfare, Bureau of Medical Affairs, except those recipients who are currently receiving SSA Disability Insurance Benefits. The redetermination review date is designated on Form PA–8, Record of Action: Medical Eligibility Factor (see N.J.A.C. 10:71–3.13(g)).

2. Evidence of continuation of disability or statutory blindness: An individual who has been determined to be disabled or statutorily blind shall, if requested with reasonable notice, present himself or herself for and submit to examinations or tests, and shall submit medical and other evidence necessary for the purpose of determining whether he or she continues to be disabled or statutorily blind.

3. Procedures for county welfare agency:

i. Scheduling of "redetermination review" date: In Medicaid Only cases, the CWA shall take into account the redetermination review date on Form PA–8 in scheduling both the annual review and interim visits. The CWA may adjust the date for case submittal to the Bureau of Medical Affairs to coincide as closely as is practical with either the annual review or with an interim visit, but such adjustment shall assure that the case will be submitted not more than two months earlier and in no event later than the date originally set on Form PA–8.

(1) In addition, the Bureau of Medical Affairs shall maintain a control file in order to ensure appropriate and timely reevaluation by the medical review team (MRT). The Bureau of Medical Affairs will notify county welfare agencies one month in advance of cases scheduled for such review by means of Form PA–655, Cases for Medical Review Team Reevaluation Due During the Month.

ii. IM worker's control: The IM worker shall organize his or her caseload controls (notebooks, index, etc.) so that he or she will be alerted sufficiently in advance of redetermination review dates to enable him or her to obtain any specific medical information or reports requested on the last Form PA–8. The data and reports so submitted must be "current."

iii. Record material requested for review: When a case is to be submitted to the Bureau of Medical Affairs for redetermination review, the IM worker shall prepare Form PA–6A, Interim Medical–Social Report in detail. Form PA–6A shall be placed on top of all forms, reports and related data previously submitted.

iv. Case status: Medicaid coverage shall be continued, if financial and resource eligibility continues to exist, unless and until the CWA is advised by the Bureau of Medical Affairs that the individual no longer meets the disability and blindness requirements or the individual withdraws voluntarily.

v. Upon receipt of records from the Bureau of Medical Affairs, the CWA shall follow the procedures as outlined in N.J.A.C. 10:71.13(g).

10:71–8.3 Notice of county welfare agency decision

The county welfare agency shall promptly notify, in writing, the applicant for, or recipient of, Medicaid Only of any agency decision. The policies and procedures outlined in N.J.A.C. 10:87–7.1 through 7.6 shall be followed.

10:71–8.4 Complaints and fair hearings

(a) It is the right of every applicant for or recipient of Medicaid Only to be afforded the opportunity for a fair hearing in the manner established by the policies and procedures set forth in N.J.A.C. 10:81–6, regarding complaints and fair hearings (see N.J.A.C. 1:1). Complaints and fair hearings regarding Medicaid Only eligibility should be referred to:

Division of Medical Assistance and Health Services
Bureau of Research and Development
CN 712
Trenton, New Jersey 08625

(b) In situations where an applicant or recipient is denied medical services to which he or she feels that he or she is entitled, a request for a hearing and a brief explanation of the situation should likewise be sent to the Bureau of Research and Development.

10:71–8.5 Fraudulent receipt of assistance

To protect the assistance agency and the public against the commission of fraud, the policies and procedures as defined in N.J.A.C. 10:81–7.40 through 7.45 (fraudulent receipt of assistance) shall apply to the Medicaid Only program.

10:71–8.6 Reporting criminal offenses to law enforcement authorities

Investigation of new applications or investigations for redetermination of eligibility may on occasion present indications to the county welfare agency that a crime may have been committed. In such a situation, the procedures outlined in N.J.A.C. 10:81–7.46 (reporting criminal offenses to law enforcement authorities) are to be followed.

10:71–8.7 Safeguarding information

The Federal Social Security Act requires that a state must provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of public assistance. Therefore, the policies and procedures outlined in N.J.A.C. 10:81–7.30 through 7.35 (safeguarding information) apply to the Medicaid Only program.

10:71-8.8 Nondiscrimination in public assistance programs

Title VI of the Federal Civil Rights Act of 1964 (Public Law 88-352) and Section 504 of the Federal Rehabilitation Act of 1973 prohibit discrimination on the ground of race, color, national origin, or handicap in the administration of a program for which Federal funds are received. Therefore, the policies and procedures relating to those acts, as outlined in N.J.A.C. 10:81-7.36 through 7.38 (nondiscrimination in public assistance programs) are to be strictly observed.

SUBCHAPTER 9. MEDICAL ASSISTANCE FOR THE AGED CONTINUATION

10:71-9.1 General statement

The Medical Assistance for the Aged Continuation (MAAC) provides payment for the costs of medical services for certain former recipients of the program of Medical Assistance for the Aged (MAA). Eligibility is based on continued medical need and lack of eligibility for any other program through which the cost of medical care is provided. Recipients receive the full spectrum of Medicaid services.

10:71-9.2 Initial certification

(a) Certification begins for those persons and only for those persons who were in certified status in the MAA program at the close of business on June 30, 1982 and those persons that filed MAA applications on or before June 30, 1982 and whose eligibility was established in accordance with regulations and case circumstances in effect on that date. The initial certification period in MAAC consists of the remainder of the current MAA certification period (see N.J.A.C. 10:71-9.4(a)).

(b) Recertification: Eligible persons will be recertified by the CWA for such additional periods, usually for three months or as specified by DPW/BMA (see N.J.A.C. 10:71-9.4).

(c) Extension of certification periods: The CWA will extend initial or subsequent certification periods in units of one month, as may be necessary, pending receipt of a medical need determination from DPW/BMA and/or, if applicable, to comply with requirements for timely notice of adverse action (see N.J.A.C. 10:71-8.3). Extensions shall not be made for any other reasons.

Amended by R.1986 d.5, effective February 3, 1986.
See: 17 N.J.R. 2340(a), 18 N.J.R. 276(a).
Added text "and those persons ... on that date."

10:71-9.3 Termination

Once terminated for any reason, including loss of medical certifications, a case shall not be reopened under the provisions of this subchapter.

10:71-9.4 Continuation of medical need

(a) Submittal of data to DPA/BMA: Thirty days prior to the end of each certification period, the CWA will forward to DPW/BMA photocopies of all forms and reports bearing on the individual's need for continued inpatient hospital services, skilled nursing home services, or home health care services required by reason of an illness necessitating confinement at home for a prolonged period.

(b) Response by DPW/BMA: The DPW/BMA will review the submitted material and notify the CWA of its determination. The determination will specify whether continuation does or does not exist.

(c) CWA action: Upon receipt of the DPW/BMA determination the CWA will, as appropriate, move to terminate or recertify the case for such period as may be required to make the review month become the final month of the new certification period.

10:71-9.5 Eligibility for other programs

(a) Review: The CWA will review each MAAC case in accordance with (a)1 below for potential eligibility for other assistance programs through which the costs of medical care may be met. Those programs will not include General Assistance but will include such programs as SSI and Medicaid Only.

1. Review times: The CWA will conduct a review with respect to other program eligibility at time of initial certification, at the beginning of the review month, whenever any change in client income occurs and at the time of any change in standards of other appropriate programs.

(b) Referral: If eligibility is found for regular Medicaid Only, the CWA will convert the case accordingly. If potential eligibility is found for a program administered by another agency, the CWA will make referral promptly and will institute procedures for follow-up of the referral. Upon acceptance of the individual into any other program through which medical costs are met, the CWA will terminate the MAAC case.

Amended by R.1986 d.5, effective February 3, 1986.
See: 17 N.J.R. 2340(a), 18 N.J.R. 276(a).