(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 CWA 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.

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

10:71–3.9 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) CWAs shall maintain administrative controls to assure:

1. That a disabled or blind recipient who becomes 65 years of age continues to have his or 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.

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

10:71–3.10 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.

Case Notes

Medicaid Only applicant failed to demonstrate disability which prevented her from working. E.N. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 89.

Applicant with injury to right leg and polio in left leg was not disabled in sense necessary for Medicaid benefits. A.G. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 9.

New Jersey State Library

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 Medical Assistance and Health Services, Disability Review Unit. Determination of all other factors of eligibility is the responsibility of the CWAs. The medical review team is composed of a medical consultant; and a medical social work consultant; it reviews Medicaid Only applications submitted by the CWA.

(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 Disability Review Unit.

(c) If an individual has been determined disabled for Social Security purposes (that is, he or she is currently receiving Disability Insurance Benefits), the CWA shall not refer the individual to the Disability Review Unit 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 Disability Review Unit 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 Disability Review Unit will make an independent determination of disability.

As amended, R.1979 d.364, effective November 1, 1979.
See: 11 N.J.R. 379(b), 11 N.J.R. 519(e).
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

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) The CWA shall 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 or 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 or 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 or 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 Disability Review Unit.

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

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

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

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

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

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

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

10:71–4.6 Deeming of resources

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

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

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

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

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

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

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

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

2. Parental resource maximums (including stepparents):

i. One parent: The total value of countable resources in excess of the source limit for an individual (see N.J.A.C. 10:71–4.5) shall be applied toward the eligible child's resource maximum.

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

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

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

As amended, R.1983 d.373, effective September 6, 1983.
See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a).
Added, deeming resources of alien's sponsor.
Amended by R.1985 d.474, effective September 16, 1985.
See: 17 N.J.R. 1525(a), 17 N.J.R. 2274(a).

Substantially amended.
Amended by R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Added (c)1. Deleted statement regarding physician's certification and added text establishing resources counted when one member of a couple is institutionalized.

Case Notes

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

10:71–4.7 Transfer of resources

(a) The provisions of this section 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).

Case Notes

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

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

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

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

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

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

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

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

Transfer of a resource, a mortgage, held on a condominium for less than fair market value operated to render applicant ineligible for Medicaid benefits. C.M. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 14.

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

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

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

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

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

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

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

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

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

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

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

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

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

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 $76,740 unless authorized in (a)4 or 5 below. The community spouse's share of the couple's resources shall be the greater of:

i. $15,348; 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).
Amended by R.1996 d.46, effective January 16, 1996.
See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).
In (a)1 and (a)1i resource eligibility revised upward.
Amended by R.1996 d.466, effective October 7, 1996.
See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).

Case Notes

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

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

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

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

10:71–4.9 Resource assessment

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

(b) The county 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).