CHAPTER 71

MEDICAID ONLY

Authority

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

Source and Effective Date

R.2012 d.025, effective December 29, 2011.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).

Chapter Expiration Date

Chapter 71, Medicaid Only, expires on December 29, 2018.

Chapter Historical Note

Chapter 71, Medicaid Only, was originally codified in Title 10 as Chapter 94, Medicaid Only Manual. Chapter 94, was adopted as R.1976 d.157, effective July 1, 1976. See: 7 N.J.R. 464(d), 8 N.J.R. 287(d).

Subchapter 3, Eligibility Factors, was readopted as R.1983 d.317, effective July 20, 1983. See: 15 N.J.R. 948(a), 15 N.J.R. 1382(a).

Subchapter 4, Resources, and Subchapter 5, Income, were readopted as R.1983 d. 373, effective August 22, 1983. See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a).

Subchapter 7, Other Payments, Subchapter 8, Responsibilities, and Subchapter 9, Medical Assistance for the Aged Continuation, were readopted as R.1986 d.5, effective January 6, 1986. See: 17 N.J.R. 2340(a), 18 N.J.R. 276(a).

Chapter 94, Medicaid Only Manual, was recodified as N.J.A.C. 10:71, effective March 16, 1987. See: 19 N.J.R. 466(e).

Pursuant to Executive Order No. 66(1978), Chapter 71, Medicaid Only Manual, was readopted as R.1991 d.33, effective December 24, 1990. See: 22 N.J.R. 3357(a), 23 N.J.R. 215(a).

Pursuant to Executive Order No. 66(1978), Chapter 71, Medicaid Only Manual, was readopted as R.1995 d.651, effective November 17, 1995. See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).

Pursuant to Executive Order No. 66(1978), Chapter 71, Medicaid Only Manual, was readopted as R.2000 d.415, effective September 15, 2000. As a part of R.2000 d.415, Chapter 71, Medicaid Only Manual, was renamed Medicaid Only, effective October 16, 2000. See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).

Chapter 71, Medicaid Only, was readopted as R.2006 d.133, effective March 14, 2006. See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 71, Medicaid Only, was scheduled to expire on September 10, 2013. See: 43 N.J.R. 1203(a).

Chapter 71, Medicaid Only, was readopted as R.2012 d.025, effective December 29, 2011. See: Source and Effective Date. See, also, section annotations.

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).

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. INTRODUCTION

10:71-1.1 General introduction
10:71-1.2 Choice of program by applicant
10:71-1.3 Living arrangements
10:71-1.4 Information on the chapter
10:71-1.5 Administrative organization
10:71-1.6 Basic principles of administration
10:71-1.7 Examination or review of chapter
10:71-1.8 County welfare agency responsibility; chapter
10:71-1.9 Providing chapter material in adverse action situations
10:71-1.10 Revisions of the chapter
10:71-1.11 Availability of chapter

SUBCHAPTER 2. THE APPLICATION PROCESS

10:71-2.1 Definitions
10:71-2.2 Responsibilities in the application process
10:71-2.3 Policy and procedure on prompt disposition
10:71-2.4 Intake policy and procedure
10:71-2.5 Application policy and procedure
10:71-2.6 Registration procedures and record of inquiries
10:71-2.7 Reports to the Commission for the Blind and Visually Impaired under specified circumstances
10:71-2.8 Assignment of pending application for completion of eligibility determination
10:71-2.9 Process of establishing eligibility
10:71-2.10 Collateral investigation
10:71-2.11 Case recording
10:71-2.12 Recommendation for agency decision
10:71-2.13 Supervisory review and approval
10:71-2.14 Disposition of application
10:71-2.15 Notice of agency decision
10:71-2.16 Retroactive eligibility for Medicaid

SUBCHAPTER 3. ELIGIBILITY FACTORS

10:71-3.1 General provisions
10:71-3.2 Citizenship; requirements
10:71-3.3 Citizenship; alien status-documentation requirements
10:71-3.4 Residence requirement
10:71-3.5 Resident defined
10:71-3.6 Change of county residence
10:71-3.7 Eligibility of beneficiaries who leave New Jersey
10:71-3.8 Medicaid eligibility for individuals who enter New Jersey in order to secure medical care
10:71-3.9 Age
10:71-3.10 Disability and blindness factors
10:71-3.11 Determination of disability and blindness eligibility; a State function
10:71-3.12 Disability; definitions
10:71-3.13 County welfare agency responsibility and procedures
10:71-3.14 Institutional eligibility
10:71-3.15 County welfare agency responsibility and procedures; eligibility factors
10:71-3.16 Medical assistance units

SUBCHAPTER 4. RESOURCES

10:71-4.1 Financial eligibility standards; resources
10:71-4.2 Countable resources
10:71-4.3 (Reserved)
10:71-4.4 Excludable resources
10:71-4.5 Resource eligibility standards
10:71-4.6 Deeming of resources
10:71-4.7 (Reserved)
10:71-4.8 Institutional eligibility; resources of a couple
10:71-4.9 Resource assessment
10:71-4.10 Transfer of assets
10:71-4.11 Trusts

New Jersey State Library

SUBCHAPTER 5. INCOME

10:71-5.1 Income; financial eligibility standards
10:71-5.2 Determination of countable income
10:71-5.3 Income exclusions
10:71-5.4 Includable income
10:71-5.5 Deeming of income
10:71-5.6 Income eligibility standards
10:71-5.7 Post-eligibility treatment of income; institutionalized individuals
10:71-5.8 Eligibility under life care and pay-as-you-go agreements
10:71-5.9 Deeming from sponsor to alien

SUBCHAPTER 6. CASE RECORDS AND FILES

10:71-6.1 Purpose of case records
10:71-6.2 Contents of the case record
10:71-6.3 Forms applicable to the Medicaid Only program
10:71-6.4 Maintenance and custody of case records
10:71-6.5 Movement of case records
10:71-6.6 Retention and destruction of records

SUBCHAPTER 7. OTHER PAYMENTS

10:71-7.1 General provisions
10:71-7.2 Services and service payments
10:71-7.3 Other service payments
10:71-7.4 Emergency assistance payments
10:71-7.5 Payment of burial and funeral expenses

SUBCHAPTER 8. RESPONSIBILITIES

10:71-8.1 Other agency responsibilities
10:71-8.2 Redetermination of medical eligibility
10:71-8.3 Notice of county welfare agency decision
10:71-8.4 Complaints and fair hearings
10:71-8.5 Fraudulent receipt of assistance
10:71-8.6 Reporting criminal offenses to law enforcement authorities
10:71-8.7 Safeguarding information
10:71-8.8 Nondiscrimination in public assistance programs

SUBCHAPTER 9. MEDICAL ASSISTANCE FOR THE AGED CONTINUATION

10:71-9.1 General statement
10:71-9.2 Initial certification
10:71-9.3 Termination
10:71-9.4 Continuation of medical need
10:71-9.5 Eligibility for other programs

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 agency for the Medicaid Only program under Title XIX.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "board of social services" for "welfare board".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "welfare agency" for "board of social services".

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 chapter.

(b) Persons who are neither aged, blind nor disabled qualify for Medicaid benefits when they are determined by the county welfare agency to be eligible for AFDC-related Medicaid 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 AFDC-related Medicaid chapter (N.J.A.C. 10:69).

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "chapter" for "manual"; and rewrote (b).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (b), substituted "welfare agency" for "board of social services".

Case Notes

County Board of Social Services (CBSS) acted properly when it determined that an applicant was not eligible for institutional Medicaid for the months of December 2013 and January and February 2014 due to the fact that she possessed resources that exceeded $2000. The applicant argued that $10,524 cash value of a life insurance policy was not a resource within the meaning of the relevant regulations because it was used to reimburse her son for funds he expended to purchase a cemetery plot for the applicant and to fund an irrevocable funeral trust. However, such resources were countable because they exceeded the limits on such life insurance policies and burial funds. In sum, because the applicant had countable resources in excess of $2000 and had received the maximum allowed credit of $1500 for burial expenses, the CBSS had acted properly in determining that the applicant was ineligible in the cited months. L.H. v. Hudson Cty. Bd. of Social Servs., OAL DKT. NO. HMA 05597-14, 2015 N.J. AGEN LEXIS 167, Initial Decision (March 24, 2015).

Agency determination denying the application of a disabled adult for enrollment in the Community Care Waiver/Medicaid Only (CCW) on the ground that her resources exceeded the ceiling imposed by N.J.A.C. 10:71-1.2(a) and N.J.A.C. 10:71-4.1 was reversed. The disabled adult owned life insurance policies, one of which had a cash surrender value of $2,065, and her ownership thereof meant that her resources exceeded the eligibility standard of $2,000. However, resources which are not accessible to an individual through no fault of his or her own are excluded per N.J.A.C. 10:71-4.4(b)(6). Thus, though the cash value was "available" to the disabled adult in the sense that she had the right to liquidate the policy, the circumstances presented by these facts, which included that the adult has Down's Syndrome and had been declared incompetent by reason thereof, the adult lacked the capacity to deal with the insurance, and its value should not have been considered when evaluating the adult's resources. Once the value thereof was excluded, the adult was eligible for Medicaid as of the proposed date of September 1, 2013. P.M. v. DMAHS, OAL DKT. NO. HMA18597-13, AGENCY REF. NO. 9020032129-01, 2014 N.J. AGEN LEXIS 291, Initial Decision (May 12, 2014).

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 chapter

This chapter 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.

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

10:71-1.5 Administrative organization

The Medicaid Only program is administered by the county welfare agencies (CWAs) of the State of New Jersey through the Division of Medical Assistance and Health Services in the Department of Human Services. The CWAs contract with the Division of Medical Assistance and Health Services for the purpose of providing Medicaid Only benefits to eligible persons.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to county boards of social services for references to County Welfare Agencies throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (b), substituted "welfare agencies (CWAs)" for "boards of social services (CBOSS)" and the second occurrence of "CWAs" for "CBOSSs".

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

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

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

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

i. An application for Medicaid Only is denied;

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

iii. Medicaid Only is terminated.

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

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

Amended by R.1986 d.71, effective March 17, 1986.
See: 17 N.J.R. 2522(a), 18 N.J.R. 564(b).
(a)3 amended.
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted references to beneficiaries for references to recipients throughout.

Case Notes

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546, Final Decision (June 11, 2007).

10:71-1.7 Examination or review of chapter

This chapter is a public document. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each CWA office for examination or review during regular office hours on regular work days. An electronic rendition of the sections in this chapter can be

viewed at http://www.lexisnexis.com/njoal/. However, it should be noted that the electronic rendition is not the official version of the chapter; only the printed pages contained in the published hardcopy of the New Jersey Administrative Code is the official version.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted a reference to this chapter for a reference to this manual, and substituted a reference to CBOSS offices for a reference to CWA offices.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA" for "CBOSS" and inserted the second and third sentences.

10:71-1.8 County welfare agency responsibility; chapter

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted a reference to the CBOSS for a reference to the CWA, and substituted a reference to this chapter for a reference to this manual.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Section was "County board of social services responsibility; chapter" Substituted "CWA" for "CBOSS" and deleted a comma following "correctly".

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

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

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted a reference to chapter material for a reference to policy material, and substituted a reference to beneficiaries for a reference to recipients.

10:71-1.10 Revisions of the chapter

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

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to this chapter for references to this manual throughout.

10:71-1.11 Availability of chapter

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

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

(c) Each legal services office will be furnished with a copy of this chapter free of charge if they do not have access to the internet and are unable to view the electronic rendition of the sections of the chapter as discussed at N.J.A.C. 10:71-1.7.

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

(e) All supplementary State policy directives will routinely be sent to those who have been supplied with the chapter. A mailing list will be maintained by the Division. Supplemental directives will also be posted on the DMAHS website and made available for free download. See http://www.state.nj.us/humanservices/dmahs/home/index.html.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to this chapter for references to this manual throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Rewrote (c); and in (e), inserted the last two sentences.

SUBCHAPTER 2. THE APPLICATION PROCESS

10:71-2.1 Definitions

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

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

"Applicant," in Medicaid Only, means the aged, disabled or blind individual or his/her authorized agent who executes the formal written application (PA-1G).

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

"County welfare agency (CWA)" means that agency of county government, that is charged with the responsibility for determining eligibility for public assistance programs, including AFDC-Related Medicaid, Temporary Assistance to Needy Families (TANF), the Food Stamp Program, NJ FamilyCare and Medicaid. Depending on the county, the CWA might be identified as the board of social services, the welfare board, the division of welfare or the division of social services.

"Department of Human Services (DHS)" means the New Jersey Department of Human Services.

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

"DRA" means the Federal Deficit Reduction Act of 2005, P.L. 109-171.

"MRT" means Medical Review Team.

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

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

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

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

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

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

1. Denied means that the applicant has been determined to be ineligible for assistance for a specific reason.

2. Dismissed means official recognition that eligibility need not be considered further because:

i. The applicant died (however, if there were unpaid medical bills incurred subsequent to inquiry or application, whichever occurred first, the application process is to be completed); or

ii. The applicant cannot be located; or

iii. The application was registered in error; or

iv. The applicant moved to another county in New Jersey during the application process.

3. Withdrawn means that the applicant decided not to pursue the application further.

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

"State Verification Exchange System (SVES)" means the Social Security Administration's database, which provides states with a standardized method of Social Security number verification and uniform data response.

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Inserted "CBOSS" and "MRT"; substituted references to CBOSS for references to CWA throughout; and in "Reopened application", substituted a reference to beneficiaries for a reference to recipients.
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).
Added "Poverty guidelines".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Deleted definition "CBOSS"; added definitions "County welfare agency (CWA)", "Department of Human Services (DHS)", "DRA" and "State Verification Exchange System (SVES)"; and in definitions "Disposition of the application", "Registration" and "Transfer application", substituted "CWA" for "CBOSS".

Case Notes

Denial of Medicaid eligibility under N.J.A.C. 10:71-2.1 was reversed and a reassessment of the case ordered. The Division of Medical Assistance and Health Services and the Passaic County Board of Social Services (agency) failed to provide notification of documents needed for eligibility approval to the applicant's husband, who took care of her affairs after she was admitted to a nursing home due to the her dementia, and instead sent those letters to the nursing home, which did not forward them. The agency failed to comply with the administrative law judge's letter ordering it to provide a specific list of remaining documents needed for Medicaid eligibility to the husband. N.L. (Deceased) v. Div. of Med. Assistance and Health Serv. and the Passaic Cnty. Bd. of Social Serv., OAL DKT. No. HMA 16199-12, 2014 N.J. AGEN LEXIS 310, Initial Decision (June 5, 2014).

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

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

10:71-2.2 Responsibilities in the application process

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

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

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

1. Inform the applicants about the purpose and eligibility requirements for Medicaid Only, inform them of their rights and responsibilities under its provisions and inform applicants of their right to a fair hearing;

2. Receive applications;

3. Assist the applicants in exploring their eligibility for assistance;

4. Make known to the applicants the appropriate resources and services both within the agency and the community, and, if necessary, assist in their use; and

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.

(d) The CWAs shall also provide supportive social services, which will enhance cure and rehabilitation of beneficiaries of Medicaid Only.

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

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

2. Assist the CWA in securing evidence that corroborates his or her statements; and

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA" throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWAs" for "CBOSSs" and "CWA" for "CBOSS" throughout; in (a), substituted "that" for "which"; in (c)4, inserted "and" at the end; in (c)5, substituted a period for a semicolon at the end; recodified former (c)6 as (d) and former (d) as (e); and in (e)2, substituted "his or her" for "his/her" and inserted "and" at the end.

Case Notes

Son's failure to obtain and provide, to a county board of social services, true copies of agreements and related documents concerning a trust of which his father, an elderly man who was disabled due to Alzheimers, dementia and Parkinson's disease, was the sole trustee afforded grounds for a denial of Medicaid benefits. This was notwithstanding the fact that the son had demonstrated that the documents were not provided because the son simply could not obtain them from the bank where the trust was established. A.T., Petitioner, v. Division of Medical Assistance & Health Services and Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 20582-15, 2016 N.J. AGEN LEXIS 156, Initial Decision (March 28, 2016).

Because a county board of social services was entitled to establish a cut-off date for submission, by an applicant, of information requested by the board and needed to determine whether the applicant was eligible for Medicaid, the determination that the applicant had failed to submit needed materials was properly affirmed. While a county board had the option to afford additional time to an applicant, it nonetheless was entitled to determine when sufficient time was allowed and to make a decision based on the information in its possession on the deadline. N.V. v. DMAHS and Gloucester Cnty. Bd. of Social Servs.,OAL DKT. NO. HMA 01201-16, 2016 N.J. AGEN LEXIS 140, Initial Decision (March 17, 2016).

County board of social services did not comply with required deadlines in governing regulations when it considered whether a petitioner's eligibility for "Medicaid Only" Institutional Medicaid, with the result that the eligibility date of July 1, 2015 that was granted by the board was incorrect and the petitioner was entitled to an eligibility date of May 1, 2015. Among other failures, the board did not comply with its duty to write to the petitioner and explain the reasons for delay and failed to inform the petitioner of the need for a Qualified Income Trust (QIT) in a timely manner. Because the manner in which the board processed the application was improper, an earlier eligibility date was appropriately granted. J.E., Petitioner, v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15778-15, 2016 N.J. AGEN LEXIS 120, Initial Decision (March 10, 2016).

County social services board was justified in denying an application for Medicaid on the ground that the applicant had failed to provide verification of resources per governing regulations. The board gave the applicant more than two months to provide closing statements from certain investment accounts. On these facts, the board took reasonable steps and gave adequate time for the applicant to submit the required verification. M.B. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 14682-15, 2015 N.J. AGEN LEXIS 758, Initial Decision (December 22, 2015).

Failure on the part of an applicant seeking Medicaid benefits for the Adult Medicaid Nursing Home program to submit required documentation and to otherwise cooperate with the agency in determining eligibility justified the agency in denying the application, which denial was sustained following a fair hearing. Though the facility in which the applicant resided claimed to have submitted the requested documents via facsimile, the facility offered no substantiation such as a fax transmittal confirmation. Because the requested documents were not submitted until the day of the hearing, which was well after they were required to be submitted, the agency's denial of the application was properly approved. A.B. v. Essex Cty. Bd. of Social Servs., OAL DKT. NO. HMA 03840-15, 2015 N.J. AGEN LEXIS 234, Initial Decision (May 4, 2015).

Medicaid eligibility of a recipient was properly terminated on a finding that an absent parent of the recipient's younger minor child in fact lived with the recipient notwithstanding the recipient's denial that

the absent parent in fact resided with her and two children. The recipient's testimony relative to where the absent parent was living was unworthy of belief in the face of other evidence that established that the recipient in fact currently was in a romantic relationship with the absent parent and that the latter's last known address was that at which the recipient currently resided. Nor had the recipient provided the agency with adequate information establishing that the absent parent in fact resided elsewhere. K.B. v. Gloucester Cty. Bd. of Social Servs., OAL DKT. NO. HMA 02927-15, 2015 N.J. AGEN LEXIS 233, Initial Decision (April 30, 2015).

An Administrative Law Judge (ALJ) concluded that an applicant was eligible for Medicaid and that denial of his application was improper. The grounds for the denial was that the agency was not satisfied with the applicant's explanation that numerous $9000 deposits made into his checking account reflected cash that he had squirreled away over many years. The agency believed that the funds had been derived from other assets that had not been adequately disclosed. However, the applicant's testimony relative to the source of the funds was fully corroborated by the former executive director of an assisted living complex in which the applicant had resided, who testified that she had first-hand knowledge that the applicant had nearly $80,000 in cash, funds that he had retained in cash because he did not trust banks. Because the corroboration of the source of funds that was required by the regulations had been provided, the ALJ concluded that the applicant should not have been denied Medicaid eligibility. W.F. v. Monmouth Cty. Bd. of Social Servs., OAL DKT. NO. HMA 16564-14, 2015 N.J. AGEN LEXIS 264, Initial Decision (April 17, 2015).

Determinations of the Division of Medical Assistance and Health Services (DMAHS) twice denying Medicaid benefits on behalf of an applicant who died during the pendency of the application denying the application on the ground that the applicant's wife (and, later, widow) had not produced two insurance policies was rejected by an administrative law judge (ALJ). Though the policies were ultimately produced after having been located by an attorney retained by the widow to assist her in handling her deceased spouse's estate, the widow's age, infirmities and mental and emotional status during the application period rendered her incapable of assisting DMAHS and providing the necessary documents. Those conditions constituted "exceptional circumstances" within the meaning of relevant regulations that warranted an extension of time to provide the documents. The ALJ noted in so finding that the purpose of the regulatory scheme was to facilitate disposition of a Medicaid application on the merits. So long as there was good reason for a failure to provide all documentation, the better practice would be to extend the deadline, obtain all relevant information, and make a determination of the merits. J.F. v. DMAHS and Cumberland Cty. Bd. of Social Servs., OAL DKT. NO. HMA 9678-14 and HMA 17109-14 (CONSOLIDATED), 2015 N.J. AGEN LEXIS 189, Initial Decision (March 6, 2015).

Determination by a county board of social services (BSS) denying an application for Medicaid eligibility filed by a nursing home on behalf of a resident therein was not supported by the record because the evidence showed that the resident's condition was such that she could not assist the home in collecting the bank statements that the BSS had requested and the home had made substantial efforts to gather and provide the information requested. Though agreeing that all of the documentation had not been provided, the administrative law judge (ALJ) found that given the resident's inability to assist in assembling the materials and the efforts made to date by the home, denial of eligibility at this time was not appropriate and the home should be afforded additional time within which to try and gather the remaining materials. S.H. v. Essex Cty. Bd. of Social Servs., OAL DKT. NO. HMA 16991-14, 2015 N.J. AGEN LEXIS 188, Initial Decision (March 6, 2015).

Determination by a county Board of Social Services (CBSS) denying Medicaid benefits to an applicant on the ground that the applicant had failed to provide required verification and had failed to assist the CBSS in securing relevant documentation was rejected by an administrative law judge. The applicant was a 71 year old who suffered from both psychiatric and physical conditions, and his application had been filed by his estranged wife, from whom he had been separated for 10 years. The testimonial and documentary evidence in the record supported the wife's position that she had responded to the best of her ability to the requests made by the caseworker and was attempting to cooperate with the agency to the extent that she could. A fair reading of the governing regulations showed that there were circumstances where the processing of an application would be delayed beyond the time that was normally essential and that the circumstances of this case were such that the agency should have afforded more time to the wife to address documentation requests made by the caseworker. On that basis, the application was properly reinstated. R.C. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13064-2014, 2015 N.J. AGEN LEXIS 205, Initial Decision (February 12, 2015).

Determination that a former resident of a nursing home located in Burlington County was not eligible for Medicaid on account of his failure to provide a verification of his wife's resources or a letter indicating that she had no assets was properly sustained. The original notice to the nursing home, which had filed the application on behalf of the resident while the resident was still residing in its facility, advised that such documents had to be provided no later than October 26, 2013. When the nursing home contacted the Burlington County Board of Social Services (BCBSS) in August of 2014, it advised BCBSS that the resident had left the facility in February 2014 and had been approved for Medicaid in a different county. Given the record as of that date, denial of Medicaid eligibility for failure to provide the requested verification was proper. M.P. v. Burlington Cty. Bd. of Social Servs., OAL DKT. NO. HMA 12429-14, 2015 N.J. AGEN LEXIS 114, Initial Decision (February 11, 2015).

Although no Medicaid statute or regulation specifically refers to a "spousal waiver," New Jersey's Medicaid program informally recognizes the existence of such a waiver, and in appropriate cases an applicant is properly exempted from the requirement of a spousal resource assessment. Such a waiver was properly found here, where the applicant and her spouse had been formally separated since 2004. Other facts that were relevant to the determination included that while the spouse had repeatedly promised to provide such records, he had failed to do so and in fact had asserted that he was not subject to court orders requiring him to submit financial records in connection with the applicant's divorce petition; that the husband had been unfailingly recalcitrant and decidedly deceptive in his dealings with the applicant and the court; and that the applicant should not be penalized on account of the husband's conduct. That meant that the applicant was entitled to have her application for benefits evaluated without regard to the husband's financial condition. N.O. v. Morris Cty. Bd. of Social Servs., OAL DKT. NO. HMA 10246-14, 2015 N.J. AGEN LEXIS 110, Initial Decision (February 11, 2015).

Determination by a county Board of Social Services (CBSS) denying Medicaid benefits to an applicant on the ground that the applicant had failed to provide required information was rejected by an Administrative Law Judge (ALJ) on findings that the agency had ignored applicable regulations. Because the applicant had Alzheimer's and was confined to a nursing home, she was unable to assist her daughters, who filed the application on her behalf. To the extent that the application was denied on the ground that the daughters had not cooperated, the record did not support that position because that provision concerns cases where an applicant or her representative did not cooperate. Here, the daughters clearly were cooperating to the best of their ability. Moreover, there could be a basis for concluding that the failure to obtain verification of a single item in the amount of $45.88 was the fault of the agency, which might have had more success in dealing with the insurance company that had issued it. Finally, though there was authority for the agency's proposition that the normal deadline for compliance had passed, the regulation also recognized that there were circumstances where the processing of an application would be delayed beyond the time that was normally utilized and the agency should have allowed additional time. On that basis, the matter was properly remanded to the agency for a disposition on the merits. M.D. v. DMAHS and Atlantic Cty. Bd. of Social Servs., OAL DKT. NO. HMA 14997-14, 2015 N.J. AGEN LEXIS 210, Initial Decision (February 10, 2015).

Nursing home resident's application for Medicaid benefits was not properly denied on the basis claimed by the agency, which was that the resident had not provided sufficient verification of factors related to eligibility, including sources of income and resources. Though the agency claimed that there were three items that had not been provided

and that the denial was based on that omission, the resident in fact demonstrated that all documents with the exception of one account verification had been provided to the agency and that telephone calls to the agency to confirm that the documents as provided were sufficient were not returned. On these facts, the agency's demand, on May 23, 2014, for additional documentation after it had had no contact with the resident for five months and its cognate refusal to respond to the resident's request for additional time to provide that last item was arbitrary and unreasonable. R.D. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 9056-14, 2015 N.J. AGEN LEXIS 127, Initial Decision (January 29, 2015).

Department of Medical Assistance and Health Services and the Atlantic County Board of Social Services appropriately denied an application for Medicaid benefits for failure to provide required documentation pursuant to N.J.A.C. 10:71-2.2(e). Contrary to the applicant's assertion, the denial determination provided adequate notice regarding the required documentation. To require that the Medicaid denial determination provide the specific documents the agency alleged were not provided would be to unnecessarily broaden the definition of adequate notice found in the case law or federal regulations. This was particularly true in this matter where it was clear that the applicant's attorney acknowledged the request for specific information only one week before the Medicaid denial determination. R.P. v. Div. of Med. Assistance and Health Serv. and Atlantic County Bd. of Social Serv., OAL DKT. NO. HMA 07818-14, 2014 N.J. AGEN LEXIS 778, Initial Decision (November 25, 2014).

When an applicant failed to provide timely and sufficient verification to be considered for Medicaid eligibility as required by N.J.A.C. 10:71-2.2(e)(2), the county welfare office properly denied the application. Although the applicant argued that his estranged spouse was uncooperative and hindered his ability to provide the requested documents and spend down verification, he did not request any additional extensions or do anything about the uncooperative spouse until several months after the application was filed. There was no evidence that the applicant advised the board of these exceptional circumstances or that he requested additional extensions as a result of the uncooperative spouse pursuant to N.J.A.C. 10:71-2.3(c). Camden County Bd. of Social Serv., OAL DKT. NO. HMA 6383-14, 2014 N.J. AGEN LEXIS 759, Initial Decision (November 20, 2014).

Denial by the Sussex County Board of Social Services (Agency) of an application for Medicaid benefits by the long-term care facility from which the applicant received care was unreasonable because the facility did not fail to provide the Agency with verification information under N.J.A.C. 10:71-2.2(e). The facility submitted the requested documentation concerning the disability retirement, health benefits, or early reduced benefits from the Motion Picture Industry that were applied for, and the problem presented was that the denial letter from Motion Picture Industry was not clear. This confusion very easily could have been clarified if the Agency had persisted in its attempts to speak to a representative of the Motion Picture Industry. H.M. v. Sussex County Bd. of Social Serv., OAL DKT. NO. HMA 04381-14, 2014 N.J. AGEN LEXIS 739, Initial Decision (November 14, 2014).

Hudson County Board of Social Services properly terminated a Medicaid recipient pursuant to N.J.A.C. 10:71-2.2(d). Her failure to provide the agency with an address where she could be contacted and her failure to provide the post office with a forwarding address resulted in her not being able to be located. F.H. v. Hudson County Bd. of Social Serv., OAL DKT. NO. HMA09702-14, 2014 N.J. AGEN LEXIS 534, Initial Decision (November 2, 2014).

When an applicant did not provide sufficient verification documentation for the Union County Board of Social Services to consider her application as required by N.J.A.C. 10:71-2.2(e)(1) and N.J.A.C. 10:71-3.1(b), she could not be considered eligible for Medicaid benefits. The Board notified the applicant by letter on at least two occasions of the verification documentation that was needed to establish her eligibility, but she failed to prove the entire PA-5 report. N.R. v. Union Cnty. Bd. of Social Serv., OAL DKT. No. HMA 07734-14, 2014 N.J. AGEN LEXIS 449, Initial Decision (July 30, 2014).

When an applicant failed to provide the Camden County Board of Social Services with verification documentation that was appropriately requested, the Board properly denied his application for Medicaid Only benefits pursuant to N.J.A.C. 10:71-2.2(e)(2). He had not provided documentation indicating that he had not applied for retirement benefits or that he was not eligible for same. Also, he had not supplied sufficient documentation informing the Board how he covered his daily expenses. Thus, the Board was not effectively able to determine financial eligibility. R.E. v. Camdenn Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 4310-14, 2014 N.J. AGEN LEXIS 373, Initial Decision (June 30, 2014).

Denial of an application for Medicaid was affirmed when the applicant failed to provide verification of his address in the form requested pursuant to N.J.A.C. 10:70-2.3(a)1, N.J.A.C. 10:71-2.2(e)2, and N.J.A.C. 10:72-2.3(b). A letter from the landlord that was almost a year old was too old to verify the applicant's current address. A.M. v. Union Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 07033-14, 2014 N.J. AGEN LEXIS 346, Initial Decision (July 16, 2014).

When an applicant failed to provide sufficient verification pursuant to N.J.A.C. 10:71-2.2(e)2 for the Camden County Board of Social Services (CCBSS) to consider her application, she could not be considered eligible for Medicaid benefits. CCBSS notified the applicant's Power of Attorney (POA) several times of the verification documentation that was needed in order to establish eligibility, and the POA conceded that the requested documentation had not been provided. M.D. v. Camden Cnty. Bd. Social Serv., OAL Dkt. No. HMA 1459-14, 2014 N.J. AGEN LEXIS 281, Initial Decision (May 22, 2014).

An Administrative Law Judge (ALJ) concluded that a county board of social services acted properly when it denied an application for Medicaid eligibility made by an applicant on a finding that the applicant had failed to provide the required verification. The applicant admitted that there were several outstanding requests for documents to which she had not responded. Because the board was required by N.J.A.C. 10:72-2.3(a) and N.J.A.C. 10:71-2.9 to verify all factors related to eligibility, including sources of income and resources, the applicant's conceded failure to comply with those requests per N.J.A.C. 10:71-2.2(e)(1) and N.J.A.C. 10:71-3.1(b) to provide the requested items foreclosed a determination that she was eligible for Medicaid. M.D. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 1459-14, AGENCY DKT. NO. 410052818-01, 2014 N.J. AGEN LEXIS 273, Initial Decision (May 22, 2014).

Applicant was not eligible for Medicaid benefits after failing to provide sufficient verification pursuant to N.J.A.C. 10:71-2.2(e)2. Although a request for certain bank statements was made on three separate occasions, the applicant produced no documents evidencing compliance with the request. Although he testified that the account might not have existed at the time in question, he produced no evidence of this fact. G.W. v. Camden Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 15781-13, 2014 N.J. AGEN LEXIS 264, Initial Decision (May 12, 2014).

Camden County Board of Social Services appropriately denied an application for Medicaid under N.J.A.C. 10:71-2.2(e)(2) when the applicant failed to establish by a preponderance of credible evidence that he provided all of the information necessary to complete his application for benefits. The Board twice notified the applicant of verification documentation that was needed in order for him to establish eligibility. Though he did provide some bank statements as well as handwritten notations on the Board's notice, the applicant did not submit all of the requested information. He admitted as much to a Board worker during a telephone conversation after he received the Board's denial notice. W.B. v. Div. of Medical Assistance and Health Serv. and Camden Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 8393-13, 2014 N.J. AGEN LEXIS 252, Initial Decision (May 6, 2014).

An Administrative Law Judge concluded that even though an elderly woman's application for Medicaid's Global Options Assisted Living Waiver Program was not processed in accordance with the requirements in N.J.A.C. 10:71-2.2 and N.J.A.C. 10:71-2.3(c), the fact was that the applicant was not financially eligible for participation in the program. That is, the processing agencies' failure to comply with those requirements, including the 45-day processing requirement, did not provide a

basis for an award of benefits to an otherwise ineligible applicant as such a retroactive award would be in contravention of N.J.A.C. 10:49-22.1(b). A.H. v. Div. of Med. Assistance & Health Servs. and Morris Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 00531-13, 2014 N.J. AGEN LEXIS 91, Initial Decision (January 27, 2014).

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546, Final Decision (June 11, 2007).

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

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

10:71-2.3 Policy and procedure on prompt disposition

(a) The maximum period of time normally essential to process an application for the aged is 45 days; for the disabled or blind, 90 days.

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

1. In the case of an approved application, the effective date of the application. (Either the date of application, or the date of form PA-1C, whichever is earlier);

2. In the case of a denied application, the date on which written notification informing the applicant of his or her lack of eligibility and the reason therefor is sent to him or her;

3. In the case of a withdrawn application, the date on which written notification confirming to the client that the agency has taken cognizance of his or her voluntary withdrawal is sent to him or her; or

4. In the case of a dismissed application, the date on which written notification informing the applicant of the dismissal and the reasons therefor is sent to him or her.

(c) It is recognized that there will be exceptional cases where the proper processing of an application cannot be completed within the 45/90-day period. Where substantially reliable evidence of eligibility is still lacking at the end of the designated period, the application may be continued in pending status. In each such case, the CWA shall be prepared to demonstrate that the delay resulted from one of the following:

1. Circumstances wholly within the applicant's control;

2. A determination to afford the applicant, whose proof of eligibility has been inconclusive, a further opportunity to develop additional evidence of eligibility before final action on his or her application;

3. An administrative or other emergency that could not reasonably have been avoided; or

4. Circumstances wholly outside the control of both the applicant and CWA.

(d) When the complete processing of an application is delayed beyond 45 days for the aged or 90 days for the blind or disabled, written notification shall be sent to the applicant on or before the expiration of such period, setting forth the specific reasons for delay.

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

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (c) and (f), substituted "CBOSS" for "CWA" throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (a) and (d), substituted "45" for "30" and "90" for "60"; in the introductory paragraph of (c), and in (c)4 and (f), substituted "CWA" for "CBOSS"; in the introductory paragraph of (c), substituted "45/90" for "30/60"; in (c)1 and (c)2, deleted "or" from the end; and in (f), substituted "that" for "which" and "therefor" for "therefore".

Case Notes

County board of social services did not comply with required deadlines in governing regulations when it considered whether a petitioner's eligibility for "Medicaid Only" Institutional Medicaid, with the result that the eligibility date of July 1, 2015 that was granted by the board was incorrect and the petitioner was entitled to an eligibility date of May 1, 2015. Among other failures, the board did not comply with its duty to write to the petitioner and explain the reasons for delay and failed to inform the petitioner of the need for a Qualified Income Trust (QIT) in a timely manner. Because the manner in which the board processed the application was improper, an earlier eligibility date was appropriately granted. J.E., Petitioner, v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15778-15, 2016 N.J. AGEN LEXIS 120, Initial Decision (March 10, 2016).

Applicant for Medicaid was not entitled to a retroactive date of eligibility based on the date of application because a delay on the part of the board of social services in acting on the application was due to the failure on the part of the applicant's wife to submit required documentation. The mere fact that the board did not complete the processing within the 45-day period described in governing regulations did not provide a basis for retroactivity. H.F. v. Morris Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00044-15, 2016 N.J. AGEN LEXIS 62, Initial Decision (February 16, 2016).

Board of social services erred when it denied Medicaid benefits to an applicant who had suffered from dementia for several years on the grounds that she had failed to provide the information and documents requested by the agency and because her "available" resources exceeded

the maximum allowable under regulations. The evidence made it quite clear that the applicant did not and could not have participated in the liquidation of her personal and marital assets and that the assets at issue were neither "accessible" nor "countable" in relation to the applicant. A.F. v. Hudson Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02986-15, 2016 N.J. AGEN LEXIS 63, Initial Decision (February 12, 2016).

Applicant was properly denied Medicaid eligibility based on his failure to comply with regulations requiring applicants to produce documentation reflecting his finances over the prior five years. Since it ultimately appeared that the applicant's attorney in fact possessed the information that was needed to complete the application and because the agency had already granted several extensions to the regulatory deadline for submission of such documents, there was merit to the agency's claim that the only available recourse was against the attorney, not the agency. P.S. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 17263-15, 2016 N.J. AGEN LEXIS 50, Initial Decision (February 8, 2016).

Even though the Medicaid application filed on behalf of a married woman who was residing in a rehabilitation facility was not processed within the regulatory time limits, the application was properly belatedly denied because financial information for the applicant's husband was never provided as requested. C.H. v. Essex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 20004-15, 2016 N.J. AGEN LEXIS 6, Initial Decision (January 6, 2016).

County social services board was justified in denying an application for Medicaid on the ground that the applicant had failed to provide verification of resources per governing regulations. The board gave the applicant more than two months to provide closing statements from certain investment accounts. On these facts, the board took reasonable steps and gave adequate time for the applicant to submit the required verification. M.B. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 14682-15, 2015 N.J. AGEN LEXIS 758, Initial Decision (December 22, 2015).

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Determinations of the Division of Medical Assistance and Health Services (DMAHS) twice denying Medicaid benefits on behalf of an applicant who died during the pendency of the application denying the application on the ground that the applicant's wife (and, later, widow) had not produced two insurance policies was rejected by an administrative law judge (ALJ). Though the policies were ultimately produced after having been located by an attorney retained by the widow to assist her in handling her deceased spouse's estate, the widow's age, infirmities and mental and emotional status during the application period rendered her incapable of assisting DMAHS and providing the necessary documents. Those conditions constituted "exceptional circumstances" within the meaning of relevant regulations that warranted an extension of time to provide the documents. The ALJ noted in so finding that the purpose of the regulatory scheme was to facilitate disposition of a Medicaid application on the merits. So long as there was good reason for a failure to provide all documentation, the better practice would be to extend the deadline, obtain all relevant information, and make a determination of the merits. J.F. v. DMAHS and Cumberland Cty. Bd. of Social Servs., OAL DKT. NO. HMA 9678-14 and HMA 17109-14 (CONSOLIDATED), 2015 N.J. AGEN LEXIS 189, Initial Decision (March 6, 2015).

Determination by a county board of social services (BSS) denying an application for Medicaid eligibility filed by a nursing home on behalf of a resident therein was not supported by the record because the evidence showed that the resident's condition was such that she could not assist the home in collecting the bank statements that the BSS had requested and the home had made substantial efforts to gather and provide the information requested. Though agreeing that all of the documentation had not been provided, the administrative law judge (ALJ) found that given the resident's inability to assist in assembling the materials and the efforts made to date by the home, denial of eligibility at this time was not appropriate and the home should be afforded additional time within which to try and gather the remaining materials. S.H. v. Essex Cty. Bd. of Social Servs., OAL DKT. NO. HMA 16991-14, 2015 N.J. AGEN LEXIS 188, Initial Decision (March 6, 2015).

Determination by a county Board of Social Services (CBSS) denying Medicaid benefits to an applicant on the ground that the applicant had failed to provide required verification and had failed to assist the CBSS in securing relevant documentation was rejected by an administrative law judge. The applicant was a 71 year old who suffered from both psychiatric and physical conditions, and his application had been filed by his estranged wife, from whom he had been separated for 10 years. The testimonial and documentary evidence in the record supported the wife's position that she had responded to the best of her ability to the requests made by the caseworker and was attempting to cooperate with the agency to the extent that she could. A fair reading of the governing regulations showed that there were circumstances where the processing of an application would be delayed beyond the time that was normally essential and that the circumstances of this case were such that the agency should have afforded more time to the wife to address documentation requests made by the caseworker. On that basis, the application was properly reinstated. R.C. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13064-2014, 2015 N.J. AGEN LEXIS 205, Initial Decision (February 12, 2015).

Determination by a county Board of Social Services (CBSS) denying Medicaid benefits to an applicant on the ground that the applicant had failed to provide required information was rejected by an Administrative Law Judge (ALJ) on findings that the agency had ignored applicable regulations. Because the applicant had Alzheimer's and was confined to a nursing home, she was unable to assist her daughters, who filed the application on her behalf. To the extent that the application was denied on the ground that the daughters had not cooperated, the record did not support that position because that provision concerns cases where an applicant or her representative did not cooperate. Here, the daughters clearly were cooperating to the best of their ability. Moreover, there could be a basis for concluding that the failure to obtain verification of a single item in the amount of $45.88 was the fault of the agency, which might have had more success in dealing with the insurance company that had issued it. Finally, though there was authority for the agency's proposition that the normal deadline for compliance had passed, the regulation also recognized that there were circumstances where the processing of an application would be delayed beyond the time that was normally utilized and the agency should have allowed additional time. On that basis, the matter was properly remanded to the agency for a disposition on the merits. M.D. v. DMAHS and Atlantic Cty. Bd. of Social Servs., OAL DKT. NO. HMA 14997-14, 2015 N.J. AGEN LEXIS 210, Initial Decision (February 10, 2015).

Division of Medical Assistance and Health Services and Cape May County Board of Social Services (agency) improperly denied an application for Medicaid benefits for failure to timely provide documentation under N.J.A.C. 10:71-2.3(a). The purpose of that regulation is not to fix a deadline for an applicant to produce documents, but rather to set a deadline for the agency to process the application. It was the agency, not the applicant, that delayed action for large periods of time, and then, after demanding a veritable mountain of additional documents, the agency summarily denied the application 32 days after the final request letter. In addition, the inability of the applicant to elicit four- and five-year old records from large financial institutions within a 30-day window was wholly understandable, and N.J.A.C. 10:71-2.3(c) makes allowance for such a situation. The agency denial was reversed and the case remanded for further analysis. Div. of Medical Assistance and Health Serv. and Cape May County Bd. of Social Serv., OAL DKT. NO. HMA 11078-14, 2014 N.J. AGEN LEXIS 758, Initial Decision (November 21, 2014).

When an applicant failed to provide timely and sufficient verification to be considered for Medicaid eligibility as required by N.J.A.C. 10:71-2.2(e)(2), the county welfare office properly denied the application. Although the applicant argued that his estranged spouse was uncooperative and hindered his ability to provide the requested documents and spend down verification, he did not request any additional extensions or do anything about the uncooperative spouse until several months after the application was filed. There was no evidence that the applicant advised the board of these exceptional circumstances or that he requested additional extensions as a result of the uncooperative spouse pursuant to N.J.A.C. 10:71-2.3(c). Camden County Bd. of Social Serv., OAL DKT. NO. HMA 6383-14, 2014 N.J. AGEN LEXIS 759, Initial Decision (November 20, 2014).

Medicaid applicant met the exceptional circumstances set forth in N.J.A.C. 10:71-2.3(c) concerning timeliness. The applicant was physically and mentally disabled with no family support. Considering his disabilities related to his stroke, the doctrine of subjective impossibility or impossibility of performance were analogous and applied. The applicant could not complete the Medicaid application due to his Medical inability. Therefore, the Medicaid application could not be denied as it would be punitive to a severely disabled individual and financially prejudicial to the nursing facility (NF). Rather the NF as the applicant's agent and the Cumberland County Medicaid Unit would work together to obtain answers to the remaining questions. Cumberland County Bd. of Social Serv. and Div. of Medical Assistance and Health Serv., OAL DKT. NO. HMA 5565-1, 2014 N.J. AGEN LEXIS 740, Initial Decision (November 18, 2014).

Denial of application for Medicaid benefits under N.J.A.C. 10:71-2.3(a) was reversed and the matter remanded for further consideration. The applicant's daughter acted diligently in her efforts to obtain the required records. The desultory conduct of two financial institutions was in no way her fault, and certainly no fault of the applicant, who was helpless in her bed. Therefore, an extension of time to provide documents was warranted. D.C. v. Div. of Medical Assistance and Health Serv. and Cumberland County Bd. of Social Serv., OAL DKT. NO. HMA10898-14, 2014 N.J. AGEN LEXIS 535, Initial Decision (October 29, 2014).

Determination of the Gloucester County Medicaid Long-Term Care Unit (CWA) denying an application for Medicaid eligibility was reversed because the applicant met the exceptional circumstances set forth in N.J.A.C. 10:71-2.3(c). The applicant was physically and mentally disabled with no family support. The initial Medicaid application was completed by the CWA staff, and the applicant was thereafter left to her own devices. Considering her disabilities including dementia, broken ribs, a concussion, COPD, colon cancer, and a pulmonary embolism the doctrine of subjective impossibility or impossibility of performance were analogous and applied. The applicant could not complete the Medicaid application due to her Medical inability. I.M. v. Gloucester County Bd. of Social Serv. and Div. of Medical Assistance and Health Serv., OAL DKT. NO. HMA 9838-14, 2014 N.J. AGEN LEXIS 706, Initial Decision (October 16, 2014).

Administrative law judge reversed the denial of an application for Medicaid benefits on the grounds that the applicant's income allegedly exceeded the maximum allowable amount and remanded the matter to the Division of Medical Assistance and Health Services (agency). The agency was well aware of the desultory manner in which the Veteran's Administration responded to requests for information and should have delayed action on the application pursuant to N.J.A.C. 10:71-2.3(c) until the requested Award Letter was received. S.F. v. Div. of Medical Assistance and Gloucester County Bd. of Social Serv., OAL DKT. NO. HMA9985-14, 2014 N.J. AGEN LEXIS 546, Initial Decision (October 15, 2014).

Cape May County Board of Social Services and Division of Medical Assistance and Health Services (Agency) properly denied an application for Medicaid benefits. The Agency extended the applicant's time to provide asset documentation far beyond the 60-day maximum in N.J.A.C. 10-71-2.3(a), but notwithstanding the Agency's generosity in affording the applicant nearly six months to provide the documentation, the applicant failed to do so by the deadline. The Agency was within its rights to set the deadline and hold the applicant to that date. J.B. v. Cape May Cnty. Bd. of Social Serv. and Div. of Med. Assistance and Health Serv., OAL DKT. No. HMA 6942-14, 2014 N.J. AGEN LEXIS 506, Initial Decision (August 22, 2014).

Passaic County Board of Social Services (PCBSS) incorrectly determined an applicant's Medicaid effective date pursuant to N.J.A.C. 10:71-2.3(b). Because of the applicant's dementia she was unable to place her house on the market or instruct her disabled son on what to and was in a situation prior to the appointment of a guardian, due to no fault of her own, that prevented her from making the property available and accessible to her. In addition, her property should have been excluded when counting resources to determine Medicaid eligibility under N.J.A.C. 10:71-4.4(b)(6). The law excluded the house, based on the unavailability and inaccessibility of the asset at the time she entered the nursing home and applied for Medicaid and because of the legal rights of her disabled son who could reside in or sell the home, with proceeds from the sale placed in a Special Needs Trust for his care and upkeep. Because PCBSS accepted the application, processed it and determined eligibility, it should be equitably estopped from claiming the application was invalid. B.S. v. Div. of Med. Assistance and Health Serv. and Passaic Cnty. Bd. of Social Serv., OAK Dkt. No. HMA 09208-12, 2014 N.J. AGEN LEXIS 428, Initial Decision (July 23, 2014).

Determination by a county board of social services (CBSS) denying a petitioner's request that she be found eligible for nursing home disabled benefits per N.J.A.C. 10:70-1.1 et seq. was affirmed. CBSS took the position that ineligibility was the proper outcome because petitioner not only failed to provide all documents requested by CBSS within the 45-day period described in N.J.A.C. 10:71-2.3 but that petitioner's submission was still incomplete on December 9, 2013, which was more than four months after the 45 day period had expired and more than six months after the date of the application. Moreover, the fact was that petitioner effectively had produced little to no information until she received the denial letter on December 9, 2009 and was inspired to make a real effort to provide the documents only after the denial was received. Such facts did not establish exceptional circumstances that would justify an extension of the applicable time limits. G.G. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 1127-14, AGENCY DKT. NO. 1510041726-01, 2014 N.J. AGEN LEXIS 377, Initial Decision (June 27, 2014).

A county board of social services (CBSS) had no alternative but to deny Medicaid eligibility to an adult who had severe dementia for whom an application for Medicaid have been made by the Office of the Public Guardian for Elderly Adults (OPG). Though it was quite clear that the adult's impairment was such that she could not help and that the guardian's efforts to elicit assistance from her family members had been unsuccessful, the fact was that the agency had already afforded OPG additional time beyond that prescribed by N.J.A.C. 10:71-2.3(a), which called for an application processing period of 60 days. Since adequate evidence had not been marshalled within the extended period, the Medicaid application was properly denied. J.D. v. DMAHS and Atlantic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 3564-14, 2014 N.J. AGEN LEXIS 381, Initial Decision (June 26, 2014).

A county board of social services and community development had no alternative but to deny Medicaid eligibility to an adult who had severe dementia for whom an application for Medicaid have been made by Senior Planning Services (SPS). Though it was quite clear that the adult's impairment was such that she could not help and that SPS's efforts to elicit assistance from her family members had been unsuccessful, the fact was that the agency had already afforded SPS substantial additional time beyond that prescribed by N.J.A.C. 10:71-2.3(a), which called for an application processing period of 60 days. Since adequate evidence had not been marshalled within the extended period, the Medicaid application was properly denied. C.S. v. DMAHS and Atlantic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 4549-14, 2014 N.J. AGEN LEXIS 378, Initial Decision (June 25, 2014).

A county board of social services (CBSS) acted properly in denying Medicaid eligibility to an adult for whom her son had made an application for Medicaid benefits. The application was still incomplete despite the fact that it had been pending for 230 days and despite the fact that CBSS had made two written requests for additional documents, neither of which had been satisfied. Because N.J.A.C. 10:72-2.3(e)

provided that the applicant or her representative (here, her son) were required to provide credible verification of all eligibility factors and the same had not been accomplished in this case, denial of Medicaid eligibility was proper. S.W. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 4508-14, AGENCY DKT. NO. 0415004449-01, 2014 N.J. AGEN LEXIS 365, Initial Decision (June 23, 2014).

Determination that an applicant was not eligible for Medicaid was affirmed by an administrative law judge because the applicant did not meet the exceptional circumstances set forth in N.J.A.C. 10:71-2.3(c). He was physically but not mentally disabled. He engaged a professional Medicaid planner and had the capacity to assist that planner in obtaining the five-year look back material needed for his Medicaid application. It was uncontested that the applicant's wife was uncooperative in helping him complete his application. However, he had the matrimonial forum and the Office of Administrative Law forum to issue subpoenas as a means to compel production of the required banking documents for the look back analysis. A.V. v. Atlantic Cnty. Bd. of Social Serv. and Division of Med. Assistance and Health Serv., OAL Dkt. No. HMA 5641-14, 2014 N.J. AGEN LEXIS 353, Initial Decision (July 18, 2014).

Denial of an application for Medicaid was affirmed when the applicant failed to provide verification of his address in the form requested pursuant to N.J.A.C. 10:70-2.3(a)1, N.J.A.C. 10:71-2.2(e)2, and N.J.A.C. 10:72-2.3(b). A letter from the landlord that was almost a year old was too old to verify the applicant's current address. A.M. v. Union Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 07033-14, 2014 N.J. AGEN LEXIS 346, Initial Decision (July 16, 2014).

Board of Social Services' delay in processing a Medicaid application was not improper under N.J.A.C. 10:71-2.3(c). Throughout the 21 months between the filing of initial application and its amended disposition, the information, including duplicates, was supplied on several occasions in response to the verifications sought. A transfer penalty was properly assessed pursuant to N.J.A.C. 10:71-4.10(i) arising from the transfer to her niece of the applicant's interest in a limited liability company that owned her home in exchange for a promissory note. While it was undisputed that the niece took the applicant into her home, sound proof did not exist concerning that arrangement. The fair market value documents did not provide an adequate market analysis of the home because they primarily reflected later values, and they clearly stated that the figures are not guaranteed. E.B. v. Bergen Cnty. Bd. of Social Serv., OAL DKT. NO. HMA 667-14, 2014 N.J. AGEN LEXIS 327, Initial Decision (June 9, 2014).

An Administrative Law Judge (ALJ) concluded that a county board of social services had acted improperly in denying an application for Medicaid eligibility filed by an applicant because the review of that application was not concluded within the period in N.J.A.C. 10:71-2.3(a) and that no extension of the review period was proper under N.J.A.C. 10:71-2.3(c) and (d). The evidence clearly showed that the application was mishandled and ignored and that the reasons given for the denial were farcical. Moreover, the letter advising the applicant of the denial incorrectly stated that the application had expired. Such misconduct warranted a determination reversing the agency's decision to deny the application. M.B. v. DMAHS and Essex Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 18796-13, AGENCY Dkt. No. No. 0710482949-01, 2014 N.J. AGEN LEXIS 182, Initial Decision (April 8, 2014).

An Administrative Law Judge concluded that even though an elderly woman's application for Medicaid's Global Options Assisted Living Waiver Program was not processed in accordance with the requirements in N.J.A.C. 10:71-2.2 and N.J.A.C. 10:71-2.3(c), the fact was that the applicant was not financially eligible for participation in the program. That is, the processing agencies' failure to comply with those requirements, including the 45-day processing requirement, did not provide a basis for an award of benefits to an otherwise ineligible applicant as such a retroactive award would be in contravention of N.J.A.C. 10:49-22.1(b). A.H. v. Div. of Med. Assistance & Health Servs. and Morris Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 00531-13, 2014 N.J. AGEN LEXIS 91, Initial Decision (January 27, 2014).

Administrative law judge (ALJ) recommended a revision of the approval of a Medicaid application to reflect an earlier effective date. The preponderance of the credible evidence clearly established that the DHAHS and County Board of Social Services (agency) failed to process the application in a timely manner pursuant to N.J.A.C. 10:71-2.3(a), allowing the ALJ to afford minimal deference to the agency's witness, and no evidence existed to establish that the applicant's available assets exceeded the $2,000 threshold at the time of the application as required by N.J.A.C. 10-71-4.5(b). The undisputed credible evidence demonstrated that the all funds that were in the applicant's bank accounts were not accessible to him through his sole temporary guardian. Once his permanent guardian was appointed and the applicant's assets were transferred, the Office of the Public Guardian took immediate steps to ensure that those funds were used to pay the nursing home facility for the applicant's costs of care, pharmacy and pre-paid burial. J.T. v. DMAHS and Hudson Cnty. Bd. Of Social Servs., OAL Dkt. No. HMA 15301-12, 2014 N.J. AGEN LEXIS 52, Initial Decision (March 7, 2014).

10:71-2.4 Intake policy and procedure

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

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

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

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "CBOSS's" for "CWA's".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (a), substituted "CWA's" for "CBOSS's".

10:71-2.5 Application policy and procedure

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

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

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

1. A relative by blood or marriage;

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

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

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a) and (c), substituted "CBOSS" for "CWA".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (a) and the introductory paragraph of (c), substituted "CWA" for "CBOSS"; and in (c)3, inserted "or" at the end.

Case Notes

First application for Medicaid eligibility filed by a guardian on behalf of an incapacitated person was properly denied when the guardian was unwilling to provide the verification that was requested of her pursuant to N.J.A.C. 10:71-2.5(b). The administrative law judge (ALJ) remanded a second application filed by the Public Guardian for Elderly Adults of New Jersey (OPG). The OPG was making a substantial effort to provide verification concerning the bank accounts in question but would probably not know the reasons for various withdrawals by the first guardian. The ALJ recommended that the Union County Board of Social Services deny the application for failure to provide verification only in situations where the OPG was able but unwilling to do so. F.F. v. Union Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 16307-13, 2014 N.J. AGEN LEXIS 422, Initial Decision (July 18, 2014).

Administrative law judge reversed the Union County Board of Social Services' determination that an applicant was ineligible for Medicaid benefits. The applicant suffered from advanced Alzheimer's disease, and his son, on behalf of the applicant under N.J.A.C. 10:71-2.5(c)1, truthfully stated that he did not have any information about the source of four deposits as reflected in a submission of two years of bank statements. The application, as submitted and explained to the best of his ability and knowledge by his son, met the prudent test of credibility pursuant to N.J.A.C. 10:71-3.1(b). S.Q. v. Union Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 04202-14, 2014 N.J. AGEN LEXIS 419, Initial Decision (July 21, 2014).

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; and

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 of the CWA office, registration shall be completed within three working days.

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

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b), substituted "CBOSS" for "CWA".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (a)2, inserted "and" at the end; and in (b), substituted "of the CWA" for "the CBOSS".

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

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA" for "CBOSS".

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

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA" for "CBOSS" and inserted "a" preceding "pending".

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.

Case Notes

County board of social services did not comply with required deadlines in governing regulations when it considered whether a petitioner's eligibility for "Medicaid Only" Institutional Medicaid, with the result that the eligibility date of July 1, 2015 that was granted by the board was incorrect and the petitioner was entitled to an eligibility date of May 1, 2015. Among other failures, the board did not comply with its duty to write to the petitioner and explain the reasons for delay and failed to inform the petitioner of the need for a Qualified Income Trust (QIT) in a timely manner. Because the manner in which the board processed the application was improper, an earlier eligibility date was appropriately granted. J.E., Petitioner, v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15778-15, 2016 N.J. AGEN LEXIS 120, Initial Decision (March 10, 2016).

An Administrative Law Judge (ALJ) concluded that a county board of social services acted properly when it denied an application for Medicaid eligibility made by an applicant on a finding that the applicant had failed to provide the required verification. The applicant admitted that there were several outstanding requests for documents to which she had not responded. Because the board was required by N.J.A.C. 10:72-2.3(a) and N.J.A.C. 10:71-2.9 to verify all factors related to eligibility, including sources of income and resources, the applicant's conceded failure to comply with those requests per N.J.A.C. 10:71-2.2(e)(1) and N.J.A.C. 10:71-3.1(b) to provide the requested items foreclosed a determination that she was eligible for Medicaid. M.D. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 1459-14, AGENCY DKT. NO. 410052818-01, 2014 N.J. AGEN LEXIS 273, Initial Decision (May 22, 2014).

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 CWA will be unable to certify entitlement to Medicaid Only.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (c), substituted "CBOSS" for "CWA".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (c), substituted "CWA" for "CBOSS".

Case Notes

Determination by a county Board of Social Services (CBSS) denying Medicaid benefits to an applicant on the ground that the applicant had failed to provide required information was rejected by an Administrative Law Judge (ALJ) on findings that the agency had ignored applicable regulations. Because the applicant had Alzheimer's and was confined to a nursing home, she was unable to assist her daughters, who filed the application on her behalf. To the extent that the application was denied on the ground that the daughters had not cooperated, the record did not support that position because that provision concerns cases where an applicant or her representative did not cooperate. Here, the daughters clearly were cooperating to the best of their ability. Moreover, there could be a basis for concluding that the failure to obtain verification of a single item in the amount of $45.88 was the fault of the agency, which might have had more success in dealing with the insurance company that had issued it. Finally, though there was authority for the agency's proposition that the normal deadline for compliance had passed, the regulation also recognized that there were circumstances where the processing of an application would be delayed beyond the time that was normally utilized and the agency should have allowed additional time. On that basis, the matter was properly remanded to the agency for a disposition on the merits. M.D. v. DMAHS and Atlantic Cty. Bd. of Social Servs., OAL DKT. NO. HMA 14997-14, 2015 N.J. AGEN LEXIS 210, Initial Decision (February 10, 2015).

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546, Final Decision (June 11, 2007).

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

10:71-2.11 Case recording

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

10:71-2.12 Recommendation for agency decision

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

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to eligibility workers for income maintenance workers throughout, substituted "medical assistance PR-1" for "public assistance (PA-3A)" in the second sentence, and substituted "PR-1 (formerly PA-3L)" for "(PA-3L)" in the third sentence.

10:71-2.13 Supervisory review and approval

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

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

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

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

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "eligibility worker" for "IM worker".

10:71-2.14 Disposition of application

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

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

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

1. Those where immediate medical need is not indicated; or

2. Those where the director believes that there is valid cause to question the available evidence on any point of eligibility, or where the case presents a special problem;

3. If so held, the application shall be identified in the narrative portion of the minutes, and in each instance shall include a brief statement of the question or special problem involved and the decision of the board.

10:71-2.15 Notice of agency decision

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

10:71-2.16 Retroactive eligibility for Medicaid

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

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

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

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

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

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "Medicaid" for "public assistance" in the third sentence.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (d), substituted "a Medical Assistance Customer Center" for "the Medicaid District Office."

Case Notes

County board of social services did not comply with required deadlines in governing regulations when it considered whether a petitioner's eligibility for "Medicaid Only" Institutional Medicaid, with the result that the eligibility date of July 1, 2015 that was granted by the board was incorrect and the petitioner was entitled to an eligibility date of May 1, 2015. Among other failures, the board did not comply with its duty to write to the petitioner and explain the reasons for delay and failed to inform the petitioner of the need for a Qualified Income Trust (QIT) in a timely manner. Because the manner in which the board processed the application was improper, an earlier eligibility date was appropriately granted. J.E., Petitioner, v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15778-15, 2016 N.J. AGEN LEXIS 120, Initial Decision (March 10, 2016).

Third application for Medicaid eligibility filed by a representative of an elderly nursing home resident who was suffering from dementia was properly granted retroactive to a date that was three months prior to the date of filing in accord with governing law over claims that it should have been retroactive to the date on which the resident had been admitted to the nursing home because there was no causal relationship between the resident being admitted to the nursing home and his access to countable resources for establishing eligibility. E.M. v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 13935-15, 2016 N.J. AGEN LEXIS 49, Initial Decision (February 10, 2016).

Applicant, through his widow, failed to prove by a preponderance of the credible evidence that there were grounds for retroactive Medicaid in excess of the three months that she was already awarded by the agency under N.J.A.C. 10:71-2.16. Although the widow argued that she was in enormous debt since the death of her husband and that she needed assistance, there were no grounds for additional Medicaid Only retroactive payments, and there was no provision for any retroactive application under the Medically Needy program. J.O. v. Bergen County Bd. of Social Serv., OAL DKT. NO. HMA05530-14, 2014 N.J. AGEN LEXIS 594, Initial Decision (November 5, 2014).

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

SUBCHAPTER 3. ELIGIBILITY FACTORS

Law Review and Journal Commentaries

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

10:71-3.1 General provisions

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

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

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

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

Case Notes

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

Failure on the part of an applicant for Medicaid only to submit verifications requested by a county social services board afforded grounds to deny the application because there was no evidence that the applicant or her representative made any effort to obtain the requested verifications or that they were unavailable. It was not necessary for the agency to show that the applicant or her representative had refused to obtain the information or had refused to allow the board to obtain it. To be sure, the applicant's failure to respond to the request for verifications in any manner meant that the agency had no knowledge as to whether the applicant was in the process of obtaining the verifications, required assistance in doing so or was simply refusing to cooperate. G.C. v. Bergen Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 08504-15, 2015 N.J. AGEN LEXIS 706, Initial Decision (September 22, 2015).

When an applicant did not provide sufficient verification documentation for the Union County Board of Social Services to consider her application as required by N.J.A.C. 10:71-2.2(e)(1) and N.J.A.C. 10:71-3.1(b), she could not be considered eligible for Medicaid benefits. The Board notified the applicant by letter on at least two occasions of the verification documentation that was needed to establish her eligibility, but she failed to prove the entire PA-5 report. N.R. v. Union Cnty. Bd. of Social Serv., OAL DKT. No. HMA 07734-14, 2014 N.J. AGEN LEXIS 449, Initial Decision (July 30, 2014).

Administrative law judge reversed the Union County Board of Social Services' determination that an applicant was ineligible for Medicaid benefits. The applicant suffered from advanced Alzheimer's disease, and his son, on behalf of the applicant under N.J.A.C. 10:71-2.5(c)1, truthfully stated that he did not have any information about the source of four deposits as reflected in a submission of two years of bank statements. The application, as submitted and explained to the best of his ability and knowledge by his son, met the prudent test of credibility pursuant to N.J.A.C. 10:71-3.1(b). S.Q. v. Union Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 04202-14, 2014 N.J. AGEN LEXIS 419, Initial Decision (July 21, 2014).

An Administrative Law Judge (ALJ) concluded that a county board of social services acted properly when it denied an application for Medicaid eligibility made by an applicant on a finding that the applicant had failed to provide the required verification. The applicant admitted that there were several outstanding requests for documents to which she had not responded. Because the board was required by N.J.A.C. 10:72-2.3(a) and N.J.A.C. 10:71-2.9 to verify all factors related to eligibility, including sources of income and resources, the applicant's conceded failure to comply with those requests per N.J.A.C. 10:71-2.2(e)(1) and N.J.A.C. 10:71-3.1(b) to provide the requested items foreclosed a determination that she was eligible for Medicaid. M.D. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 1459-14, AGENCY DKT. NO. 410052818-01, 2014 N.J. AGEN LEXIS 273, Initial Decision (May 22, 2014).

10:71-3.2 Citizenship; requirements

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

1. An individual who cannot be classified as an eligible alien in accordance with this subchapter due to changes mandated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) but who was residing in a Medicaid-certified nursing facility prior to January 29, 1997, will continue to be eligible for medical assistance until the individual is no longer eligible for long-term care services.

Amended by R.1999 d.253, effective August 2, 1999.
See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).
Rewrote (a).

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; alien status-documentation requirements

(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, Swains Island and the Northern Mariana Islands are also regarded as citizens of the United States. Additionally, persons recognized as citizens of the United States pursuant to 8 U.S.C. §1401 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 U.S. Citizenship and Immigration Services 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 or her naturalization certificate as proof of citizenship. If the applicant does not have this document, the county welfare board should contact the nearest U.S. Citizenship and Immigration Services (USCIS) district office to verify that the applicant meets the requirements of a naturalized citizen.

(c) The following aliens, if present in the United States prior to August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to full Medicaid benefits:

1. An alien lawfully admitted for permanent residence;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the U.S. Citizenship and Immigration Services pursuant to section 212(d)(5) of the Immigration and Nationality Act;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty in the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain legal aliens who are victims of domestic violence and when there is a substantial connection between the battery or cruelty suffered by an alien and his or her need for Medicaid benefits, subject to certain conditions described below:

i. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent;

ii. The alien has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household of the alien and the spouse or parent acquiesced to such battery or cruelty;

iii. The alien's child has been battered or subjected to extreme cruelty in the United States by the spouse or the parent of the alien (without the active participation of the alien in the battery or cruelty);

iv. The alien's child has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household as the alien and the spouse or parent acquiesced to and the alien did not actively take part in such battery or cruelty;

v. In addition to the conditions described in (c)12i through iv above, if the individual responsible for the battery or cruelty continues to reside in the same household as the individual who was subjected to such battery or cruelty, then the alien shall be ineligible for full Medicaid benefits under this chapter;

vi. The county welfare agency shall apply the definitions "battery" and "extreme cruelty" and the standards for determining whether a substantial connection exists between the battery or cruelty and the need for Medicaid as issued by the Attorney General of the United States under his or her sole and unreviewable discretion, in accordance with 8 U.S.C. §1641.

(d) The following aliens entering the United States on or after August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to Medicaid benefits:

1. An alien lawfully admitted for permanent residence, but only after having been present in the United States for five years;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)5 of the Immigration and Nationality Act, but only after the alien has been present in the United States for five years;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980, but only after the alien has been present in the United States for five years;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty with the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain aliens who are victims of domestic violence as specified in (c)12 above, but only after the alien has been present in the United States for five years.

(e) Any alien who is not an eligible alien as specified in (c) and (d) above is ineligible for full Medicaid benefits. Any such alien, if a resident of New Jersey and if he or she meets all other Medicaid eligibility requirements, is entitled to Medicaid coverage for the treatment of an emergency medical condition only.

1. An emergency medical condition is one of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the patient's health in serious jeopardy;

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

2. An emergency medical condition includes all labor and delivery for a pregnant woman. It does not include routine prenatal or post-partum care.

3. Services related to an organ transplant procedure are not covered under services available for treatment of an emergency medical condition.

(f) Persons claiming to be citizens and eligible aliens shall provide the county welfare agency with documentation of citizenship or alien status.

(g) As a condition of eligibility, all applicants for Medicaid (except for those applying solely for services related to the treatment of an emergency medical condition) shall sign a declaration under penalty of perjury that they are a citizen of the United States or an alien in a satisfactory immigration status. In the case of a child or incompetent applicant, another individual on the applicant's behalf shall complete the same written declaration under penalty of perjury.

1. The following are acceptable documentation of United States citizenship:

i. A birth certificate;

ii. A religious record of birth recorded in the United States or its territories within three months of birth. The document must show either the date of birth or the individual's age at the time the record was created;

iii. A United States passport (not including limited passports which are issued for periods of less than five years);

iv. A Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);

v. A U.S. Citizen I.D. Card (USCIS Form-197, Nationality Certificate (USCIS Form N-550 or N-570);

vi. A Certificate of Citizenship (USCIS Form N-560 or N-561);

vii. A Northern Mariana Identification Card (issued by the USCIS to a collectively naturalized citizen of the United States who was born in the United States before November 3, 1986);

viii. An American Indian Card with a classification code "KIC" (issued by the USCIS to identify U.S. citizen members of the Texas Band of Kickapoos);

ix. A contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swains Island or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in any of these jurisdictions); or

x. Other documentation allowed through regulation by the Secretary of the U.S. Department of Health and Human Services in compliance with 42 U.S.C. §§1396b(x).

2. If an applicant presents an expired USCIS document or is unable to present any document demonstrating his or her immigration status, the county welfare agency shall refer the applicant to the local INS district office to obtain evidence of status. If, however, the applicant provides an alien registration number, but no documentation, the county welfare agency shall file USCIS Form G-845 along with the alien registration number with the local INS district office to verify status.

3. The following sets forth acceptable documentation for eligible aliens:

i. Lawful Permanent Resident—USCIS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

ii. Refugee—USCIS Form I-94 annotated with stamp showing entry as refugee under section 207 of the Immigration and Nationality Act and date of entry into the United States; USCIS Form I-688B annotated "274a. 12(a)(3)," I-766 annotated "A3" or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the United States, but for purposes of determining Medicaid eligibility they are considered refugees. Refugees whose status has been adjusted will have USCIS Form I-551 annotated "RE-6," "RE-7," "RE-8" or "RE-9."

iii. Asylees—USCIS Form I-94 annotated with a stamp showing grant of asylum under section 208 of the Immigration and Nationality Act, a grant letter from the Asylum Office of the U.S. Citizenship and Immigration Services, Forms 688B annotated "274a. 12(a)(5)" or I-766 annotated "A5."

iv. Deportation Withheld—Order of an Immigration Judge showing deportation withheld under section 243(h) of the Immigration and Nationality Act and the date of the grant, or USCIS Form I-688B annotated "274a. 12(a)(10)" or I-766 annotated "A10."

v. Parole for at Least a Year—USCIS Form I-94 annotated with stamp showing grant of parole under section 212(d)(5) of the Immigration and Nationality Act and a date showing granting of parole for at least a year.

vi. Conditional Entry under Law in Effect before April 1, 1980—USCIS Form I-94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or USCIS Forms I-688B annotated "274a. 12(a)(3)" or I-766 annotated "A3."

vii. Cuban Haitian Entrant—USCIS Form I-94 stamped "Cuban/Haitian Entrant under section 212(d)(5) of the INA."

viii. An American Indian born in Canada—USCIS Form I-551 with code S13 or an unexpired temporary I-551 stamp (with code S13) in a Canadian passport or on Form I-94.

ix. A member of certain Federally recognized Indian tribes—Membership card or other tribal document showing membership in tribe is acceptable documentation.

x. Amerasian Immigrant—USCIS Form I-551 with the code AM1, AM2 or AM3 or passport stamped with an unexpired temporary I-551 showing a code AN6, AM7 or AM8.

4. For aliens subject to the five-year waiting period before eligibility for Medicaid can be established, the date of entry into the United States shall be determined as follows:

i. On USCIS Form I-94, the date of admission should be found on the refugee stamp. If missing, the county welfare agency should contact the USCIS local district office by filing Form G-845, attaching a copy of the document;

ii. If the alien presents USCIS Form I-688B (Employment Authorization Document), I-766 or I-571 (Refugee Travel Document), the county welfare agency shall ask the alien to present Form I-94. If that form is not available, the county welfare agency shall contact the USCIS via the submission of Form G-845, attaching a copy of the documentation presented;

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the county welfare agency shall contact the USCIS by submitting a Form G-845, attaching a copy of the document presented.

5. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following serve as documentation:

i. For discharge status, an original or notarized copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original or notarized copy, of the applicant's current orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self-declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

(h) An applicant who declares that he or she is a United States citizen (or national) or otherwise eligible non-citizen and who meets all other eligibility requirements will be approved immediately for benefits.

1. An applicant who makes such a declaration shall be afforded a reasonable opportunity to provide documentary evidence of citizenship or qualified immigration status. Reasonable opportunity is defined as 90 days from the time that the applicant is informed of the need to provide the necessary documentary evidence of the declared citizenship or qualified alien status.

i. The applicant shall provide documentation as described in (g) above; or

ii. The applicant shall provide a valid Social Security number, so that the Division can access the State Verification Exchange System (SVES) to obtain/confirm information related to the applicant. Any inconsistencies between the information provided by the applicant and the information obtained from SVES shall be reported to the applicant for resolution.

2. If the applicant has not submitted the required documentary evidence or resolved any inconsistencies by the end of the 90th day of the reasonable opportunity period, a termination notice shall be sent informing the applicant of termination of benefits. The termination date shall be effective no later than 30 days after the end of the 90-day reasonable opportunity period and will clearly identify which household member(s) have not complied and are being terminated from the program. Terminated applicants may re-apply for benefits once they have secured the required documentary evidence of citizenship or qualified alien immigration status.

(i) Medicaid applicants who are Medicare beneficiaries and who can provide an original and valid Medicare Identification Card are not required to provide additional proof of identity and citizenship. A copy of the beneficiary's Medicare card shall be retained in the case record as evidence that additional documentation was not required.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.1999 d.253, effective August 2, 1999.
See: 31 N.J.R. 97(a), 31 N.J.R. 2203(b).
Rewrote (c); and added (d) through (g).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "September 22, 1922" for "September 22, 1992" in the introductory paragraph; and substituted "board of social services" for "welfare agency" throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Rewrote (a), (b), and (g); in (c)5, substituted "U.S. Citizenship and Immigration Services" for "Immigration and Naturalization Service"; in (c)12vi and (f), substituted "welfare agency" for "board of social services"; in (c)12vi, substituted "§1641" for "§ 1641"; and added (h) and (i).

10:71-3.4 Residence requirement

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

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

Case Notes

Initial Decision (2009 N.J. AGEN LEXIS 312) adopted, which found that petitioner met the residency requirement for Medicaid because, although she and her husband had been out of the country for two years, they did not leave New Jersey with the intent to establish a permanent residence in Uruguay; rather, the couple left New Jersey for a temporary visit or vacation in Uruguay, which was unexpectedly elongated due to sudden illness and treatment. The convergence of the couple's return from Uruguay and the need to apply for Medicaid was due to a coincidence of calamity, and the record was bereft of any evidence that they flew to New Jersey for a temporary visit or to secure health care funded by Medicaid. M.M. v. DMAHS, OAL Dkt. No. HMA 13911-08, 2009 N.J. AGEN LEXIS 670, Final Decision (August 24, 2009).

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 CWA charged by law with responsibility for the official receipts, registration and processing of applications. The CWA 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.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b), substituted "CBOSS" for "CWA" throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (b), substituted "CWA" for "CBOSS" twice, and deleted a comma following "registration" and "facilities".

10:71-3.6 Change of county residence

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

(b) A temporary visit by the beneficiary 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 beneficiary whose application has not been validated has changed or is planning to change his or her residence from one county to another, the CWA 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 (b)2 below. If the CWA 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 beneficiary whose application has been validated is planning to change his or her residence from one county to another, it shall be the responsibility of the CWA 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 CWA directors mutually so arranged.

5. The welfare of the client shall not be adversely affected and his or 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.

i. Since the Medicaid Only client retains the same Medicaid number when he or 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) Beneficiaries: Beneficiaries 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 beneficiary's new address in the receiving county, and form PR-1 (formerly PA-3L), 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).
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted the references to CBOSS for references to CWA and references to beneficiaries for references to recipients throughout; and in (e)1i, substituted "PR-1 (formerly PA-3L)" for "(PA-3L).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In the introductory paragraph of (b), substituted "three-month" for "three month"; and in (b)1, (b)2 and (b)4, substituted "CWA" for "CBOSS" throughout.

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

(a) Whenever a beneficiary wishes to leave New Jersey either to establish a permanent residence or for a temporary visit, he or she shall be advised of the effect of this plan on his or her eligibility for continued medical assistance. Particular care should be taken to advise the beneficiary how to present his or her New Jersey Medicaid validation stub and instruct the provider where to send the bill, should the beneficiary 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 beneficiary 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 or she decides to remain indefinitely in the place outside New Jersey to which he or she had gone for a temporary visit, he or she ceases to be eligible to receive Medicaid.

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

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b), substituted references to beneficiaries for references to recipients throughout; and in (b), substituted a reference to Medicaid for a reference to assistance.

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

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; or

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 beneficiary 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 beneficiary;

2. That a disabled child beneficiary 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; and

3. That a disabled child beneficiary 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).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (c), substituted "CBOSSs" for "CWAs" in the introductory paragraph, and substituted "beneficiary" for "recipient" throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (a)1, substituted a semicolon for a period at the end; in (a)2, substituted "; or" for a period at the end; and in the introductory paragraph of (c), substituted "CWAs" for "CBOSSs".

Case Notes

Applicant was denied Medicaid eligibility for failure to provide information to establish his identity under N.J.A.C. 10:71-3.9 because there was no proof on the record sufficient to establish that any of the acceptable documents was provided to the agency in a timely manner. The sole evidence on this issue came from a nursing home's representative who had no personal knowledge that the applicant's medical records reflecting his age and identity were sent to the agency in a timely manner. The representative's testimony was based exclusively on hearsay, which could not form the sole basis for a decision under N.J.A.C. 1:1-15.5. C.C. v. Cape May Cnty. Bd. of Social Serv. and Div. of Med. Assistance and Health Serv., OAL Dkt. No. HMA 5372-14, 2014 N.J. AGEN LEXIS 349, Initial Decision (July 8, 2014).

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.

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. 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 CWAs.

(b) In situations where an applicant's disability or blindness appears to meet the definition in N.J.A.C. 10:71-3.12, presumptive eligibility for either of these factors can be granted with the approval of the Medical Review Team.

(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 Medical Review Team 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 Medical Review Team 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 Medical Review Team 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).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to CBOSSs for references to CWAs and substituted references to the Medical Review Team for references to the Medical Review Team in the Disability Review Unit throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (a), substituted "Medical Review Team" for "medical review team" once and "CWAs" for "CBOSSs" twice; in (b) and the introductory paragraph of (c), deleted "(MRT)" following "Team"; in (b), substituted "N.J.A.C. 10:71-3.12" for "section 12 of this subchapter"; in the introductory paragraph of (c) and in (c)1, substituted "CWA" for "CBOSS"; and in (c)1 and (c)2, substituted "Medical Review Team" for "(MRT)".

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.

Case Notes

As evidenced by his RSDI status, a recipient was Medicaid eligible from January through August 31, 2014 due to his disability under N.J.A.C. 10:71-3.12, and he was noticed to that effect. His Medicaid was valid and continued until August 31, 2014, and there was no authority for the Bergen County Board of Social Services to recoup Medicaid benefits for that period. J.C. v. Bergen Cnty. Bd. of Social Serv., OAL DKT. NO. HMA 09134-14, 2014 N.J. AGEN LEXIS 520, Initial Decision (August 28, 2014).

Severe physical impairment constitutes disability for New Jersey Care eligibility. D.K. v. Division of Medical Assistance and Health Services and Ocean County Board of Social Services, 97 N.J.A.R.2d (DMA) 25.

Insufficient finding of disability defeats Medicaid benefits application for blindness. BP. v. Division of Medical Assistance and Health Services and Middlesex County Board of Social Services, 97 N.J.A.R.2d (DMA) 1.

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 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; or

5. When the applicant states that he or she is blind or that visual impairment is his or 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 Medical Review Team 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 Medical Review Team.

(c) Other evidence, such as education, training, work experience and daily living activities, shall be submitted to the Medical Review Team 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 or her disability, the application for Medicaid Only shall be referred to the Medical Review Team 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 Medical Review Team. It shall be clearly indicated on the PA-6 that this is a Medicaid Only case. Records transmitted by the Medical Review Team 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 CWA control.

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

(g) Upon receipt of records from the Medical Review Team, 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 CWA 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 or her physical and mental adjustment.

(i) The following procedures shall be observed in respect to the Medical Review Team 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 CWA shall establish and maintain a control file for "approved" cases in order that the date for determination review by the Medical Review Team will be observed and considered according to N.J.A.C. 10:71-5.

iv. The Medical Review Team (MRT) shall also maintain a control file in order to ensure appropriate and timely reevaluation by the MRT. The MRT will notify CWA 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 CWA.

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 admin-

istrative 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 subsection 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 CWA 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, effective October 1, 1977.
See: 9 N.J.R. 340(a), 9 N.J.R. 479(c).
As amended, R.1978 d.212, effective June 22, 1978.
See: 10 N.J.R. 190(c), 10 N.J.R. 344(c).
As amended, R.1979 d.364, effective November 1, 1979.
See: 11 N.J.R. 379(b), 11 N.J.R. 519(e).
As amended, R.1979 d.449, effective November 13, 1979.
See: 11 N.J.R. 518(a), 11 N.J.R. 527(d).
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to CBOSSs for references to CWAs and substituted references to the Medical Review Team for the Disability Review Unit throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Section was "County board of social services responsibility and procedures". Rewrote the section.

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 provided 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, intermediate care facilities, or Class B and C special hospitals. These facilities must be licensed by the Department of Health and Senior Services licensing authority, and approved by the Department of Human Services for provider participation in the Title XIX Medicaid program. When a

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 licensed by the Department of Health and Senior Services in accordance with N.J.A.C. 8:43. 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).
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (e)2, deleted "(skilled nursing facilities)" following "homes".

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

(a) The CWA shall be responsible for determining income and resource eligibility, as outlined in N.J.A.C. 10:71-4 and 5, for Medicaid Only when the applicant is receiving care in institutions defined in N.J.A.C. 10:71-3.14(d). This does not include residents of the State psychiatric hospitals, the State schools for persons with intellectual disabilities, 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 (MRT). The CWA 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 CWA will complete and process a Medicaid Status File Transaction, Form MAP-1, within 10 working days from the date of such determination. The CWA will issue and distribute Medicaid validation stubs to Medicaid Only beneficiaries who are not in long-term care facilities. The CWA will complete the statement of income available for nursing home payment (PR-1) (formerly PA-3L) when appropriate.

(d) A determination of continuing eligibility shall be made in accordance with N.J.A.C. 10:71-5.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to CBOSSs for references to CWAs throughout; and in (c), substituted "beneficiaries" for "recipients" in the second sentence, and substituted "(PR-1) (formerly PA-3L)" for "(PA-3L)" in the third sentence.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Section was "County board of social services responsibility and procedures; eligibility factors". Rewrote the section.

10:71-3.16 Medical assistance units

(a) Medical Assistance Customer Centers: The Division of Medical Assistance and Health Services has local medical offices throughout the State, known as Medical Assistance Customer Centers (MACCs). The role of these MACCs is to: provide liaison with providers of health services; provide information about Medicaid to beneficiaries 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 MACC as listed at N.J.A.C. 10:49, Appendix, Form #13, or on the DMAHS website: http://www.state.nj.us/humanservices/dmahs/home/index.html.

Amended by R.1985 d.291, effective June 3, 1985.
See: 17 N.J.R. 38(a), 17 N.J.R. 1415(a).
Addresses to MDO have been changed.
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "beneficiaries" for "recipients" in the second sentence.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (a), substituted "Medical Assistance Customer Centers" for "Medicaid District Office (MDO)", "Medical Assistance Customer Centers (MACCs)" for "Medicaid District Office (MDO's)" and "MACCs" for "offices"; and in (b), substituted "MACC" for "MDO" and "#14" for "#17".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (b), deleted a comma following "regulations", and substituted "13, or on the DMAHS website: http://www.state.nj.us/humanservices/dmahs/home/index.html" for "14".

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 beneficiaries.

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

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

1. The person has the right, authority or power to liquidate real or personal property or his or her share of it;

2. Resources have been deemed available to the applicant (see N.J.A.C. 10:71-4.6 regarding deeming of resources); or

3. Resources arising from a third-party claim or action are considered available from the date of receipt by the applicant/beneficiaries, his or her legal representative or other individual acting on his or her legal behalf in accordance with the following definition and provisions.

i. Definition of "availability of resources in third-party situations": In third-party situations in which applicants/beneficiaries have brought an action or made a claim against a third party who is or may be liable for payment of medical expenses related to the cause of the action or claim, funds are considered available or countable at the moment of receipt by the applicant/beneficiary, his or her legal representative, guardian, relative or any person acting on the applicant's/beneficiary's behalf. Such funds should be considered available or countable at the earliest date of receipt by any of the aforementioned entities.

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

(2) If a bona fide lien or judgment exists against such funds, making all or some portion of the funds inaccessible to the applicant/beneficiary, 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/beneficiary 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 (that is, its equity value).

1. Real property:

i. Sole ownership: When the eligible individual is sole owner and has the right to dispose of the property, the total equity value (see (d)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 shall be divided by the number of owners and the eligible individual's share counted toward the resource maximum.

iii. Ownership by the entirety: Ownership by the entirety (or tenancy by the entirety) refers to property owned by a husband and wife whereby each member has ownership interest in the whole property which is indivisible. When a married couple (either one or both are eligible) is living together, the total equity value of all nonexempt property shall be counted toward the resource maximum. The same policy shall apply to an eligible couple who have been separated less than six months. If the eligible couple has been separated for six months or more, one half of the value represents a resource to each individual. If one spouse is institutionalized and the other spouse resides in the community, the extent to which either spouse has ownership of the property shall be included pursuant to N.J.A.C. 10:71-4.8.

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

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

v. Substantial equity value: Individuals seeking benefits with respect to nursing facility services or other long-term care services who have an equity interest in their home that exceeds $750,000 (as indexed) shall not be eligible for benefits.

(1) Effective January 1, 2011, the home equity limits shall be indexed to the Consumer Price Index – Urban (CPIU) annually and rounded to the nearest thousand. The annual adjustment shall be published as a notice of administrative change in the New Jersey Register. As of January 1, 2011 the excess home equity limit is $758,000.

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

3. Verification of value: The CWA shall verify the equity value of resources through appropriate and credible sources. Additionally, the CWA shall evaluate the applicant's past circumstances and present living standards in order to ascertain the existence of resources that 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 beneficiary has drawn a check (or equivalent instrument) on a checking or similar account, the amount of such check shall reduce the value of the account. The value of such accounts shall not be reduced by any unpaid obligations for which funds have not already been committed by the drafting of a check.

i. When checks have been drawn on an account, the 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.

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

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

Amended by R.1986 d.97, effective April 7, 1986 (operative May 1, 1986).
See: 17 N.J.R. 2954(a), 18 N.J.R. 691(a).
(c)3 added.
Amended by R.1986 d.165, effective May 5, 1986 (operative June 2, 1986).
See: 17 N.J.R. 2524(a), 18 N.J.R. 985(b).
(e) added.
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to beneficiaries for references to recipients and substituted references to CBOSSs for references to CWAs throughout.
Amended by R.2001 d.199, effective June 18, 2001.
See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).
In (d)1i, substituted "(d)1iv" for "(d)iv" preceding "below"; in (d)1ii, substituted "shall" for "must"; in (d)1iii, added the last sentence.
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Added (f).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (b), substituted "him or her" for "him/her" and "his or her" for "his/her"; in (c)1, deleted a comma following "authority", and substituted a semi-colon for a colon at the end; in (c)3i(2) and (c)3i(3), substituted "CWA" for "CBOSS"; added (d)1v; in (d)2, inserted a comma following the second occurrence of "individual", and substituted "CWA" for "CBOSS"; rewrote (c)3; and in (e)2i, substituted "CWA" for "CBOSS".

Case Notes

Though the income of an applicant for Medicaid fluctuated seasonally, his income in the month in which he and his wife sought recertification of eligibility exceeded the ceiling and afforded good grounds to deny the application. J.M. v. DMAHS, OAL DKT. NO. HMA 17572-15, 2016 N.J. AGEN LEXIS 143, Initial Decision (March 21, 2016).

Sufficient evidence supported the determination of a county board of social services that the funds in a bank account in the names of the applicant and her daughter were a resource of the applicant and were properly counted in determining the applicant's resources for the purposes of qualifying for participation in the Medicaid Only Program. Since those funds well exceeded the ceiling for eligibility, the applicant was properly found to be ineligible. M.H. v. Mercer Cnty., Bd. of Social Servs., OAL DKT. NO. HMA 16444-15, 2016 N.J. AGEN LEXIS 142, Initial Decision (March 17, 2016).

Determination of a county board of social services that an elderly woman's countable resources exceeded the eligibility resource limit, though originally sustained by an ALJ, was approved after remand and further proceedings on findings that the woman's access to an account that held $5,658 at the time of the application was unrestricted. Though the parties had stipulated that the account at issue was jointly held by the woman and her daughter, the ALJ noted that the woman did not submit any documentation proving that her access to those funds in fact was restricted and that there was evidence suggesting that each account owner could act independently with regard to transactions therein. F.J. v. Camden Bd. of Social Servs., OAL DKT. NO. HMA 9451-15 (On Remand HMA 15125-14), 2016 N.J. AGEN LEXIS 119, Decision on Remand (March 14, 2016).

Board of social services erred when it denied Medicaid benefits to an applicant who had suffered from dementia for several years on the grounds that she had failed to provide the information and documents requested by the agency and because her "available" resources exceeded the maximum allowable under regulations. The evidence made it quite clear that the applicant did not and could not have participated in the liquidation of her personal and marital assets and that the assets at issue were neither "accessible" nor "countable" in relation to the applicant. A.F. v. Hudson Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02986-15, 2016 N.J. AGEN LEXIS 63, Initial Decision (February 12, 2016).

Pension and disability benefits paid by a qualified pension plan that was governed by ERISA and that were deposited into a bona fide special needs trust established per 42 U.S.C.S. § 1396p(d)(4)(A) and governing state law were "available" to the disabled payee for purposes of determining her Medicaid eligibility because, as a matter of law, such payments could not be assigned to the special needs trust. That being so, such payments constituted "available income" that was countable in determining the payee's income for the purpose of eligibility for the Medically Needy Program. P.R. v. DMAHS and Hunterdon Cnty. Div. of Social Servs., OAL DKT. NO. HMA 05481-12, 2015 N.J. AGEN LEXIS 766, Initial Decision (December 15, 2015).

County board of social services was right to conclude that the countable resources of a 78 year old widow included a checking account that contained more than $70,000 even though her son, who was a co-owner of the checking account, insisted that nearly $60,000 of those funds were the proceeds from the sale of his house in which his mother had no legal interest. The widow was not under any disability or guardianship and the manner in which the account was titled – as an "or" account – meant that the widow had unrestricted access to all of the funds contained therein. S.M. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 04755-15, 2015 N.J. AGEN LEXIS 456, Initial Decision (November 20, 2015).

Funds held in an escrow account on which the N.J. Office of the Public Guardian held a lien were not "available" to an applicant who was seeking eligibility for the Medicaid Only program within the meaning of governing rules and was not properly included in the "countable resources" on which an eligibility decision was properly based. C.H. v. Essex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 08484-15, 2015 N.J. AGEN LEXIS 604, Initial Decision (September 24, 2015).

Determination by the Division of Medical Assistance and Services (DMAHS) and a county Board of Social Services denying an application for Medicaid filed on behalf of an elderly women who had dementia and resided in a nursing home based on her joint ownership, with an adult son who was permanently disabled, of stock valued at $89,309.28 was unsupported by the evidence and properly rejected. The son, a permanently incapacitated adult who permanently resided in a VA hospital, was totally blind, had no recollection of his mother being alive, and refused to sign any documents relating to the stock. Given the son's condition, it could not be said that the assets at issue were accessible to the mother because she had no power to liquidate them without her son's approval, and thus the stocks could not be included as countable resources of the applicant according to governing regulations. To the extent that the determination of ineligibility relied on the existence of the stocks, it was incorrect, and the applicant was entitled to an order granting her application for Medicaid. F.F. v. DMAHS and Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 00793-15, 2015 N.J. AGEN LEXIS 318, Initial Decision (June 3, 2015).

County Board of Social Services (CBSS) correctly set an applicant's Medicaid-eligibility date as March 1, 2015. At the time applicant's brother filed his Medicaid application seeking Medical Long Term Services and Support, the applicant's resources, which included Social Security benefits and a very small pension, exceeded the eligibility standards. Thereafter, however, applicant established a Qualified Income Trust (QIT) for the de minimus amounts which put applicant over the resource threshold, and eligibility as of March 1 was established. Applicant's claim for an earlier eligibility date lacked basis because the CBSS was neither authorized nor obligated to provide legal advice to applicant as to the availability of a QIT. Moreover, the use of a QIT was not even approved until December 2014. That meant that the March 1, 2015 date was proper. R.K. v. Burlington Cty. Bd. of Social Servs., OAL DKT. NO. HMA 04457-15, 2015 N.J. AGEN LEXIS 301, Initial Decision (May 21, 2015).

Applicant for Nursing Home Medicaid (NHM) was improperly denied eligibility on the ground that her resources of $6,725.44 from several bank accounts exceeded the $2,000 Medicaid eligibility limit. Specifically, an investment account holding $5,658.88 should not have been counted as a resource of the applicant notwithstanding that her name was listed as a joint tenant thereon because the applicant's daughter, who was the source of all deposits into that account, credibly testified that she had added her mother's name to the account at a time when she was residing with her mother; and that her mother was currently an "incapacitated" person and the daughter had been appointed as her mother's temporary guardian. The daughter's testimony was forthright, sincere and uncontroverted. Given that fact and given the further fact that the mother's incapacity foreclosed her from independently accessing the investment account, the funds held therein should not have been counted as the mother's resources for purposes of NHM eligibility. F.J. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 15125-14, 2015 N.J. AGEN LEXIS 261, Initial Decision (April 30, 2015).

Decision of a county Board of Social Services (CBSS) imposing a $127,751.71 transfer penalty due to uncompensated transfers within the look-back period upon the Medicaid eligibility of a 91 year old woman was modified in part based on evidence relative to the use of a substantial portion of those funds for the applicant's care. The undisputed evidence established that $60,000 was returned to the applicant and $53,360.92 was used exclusively for her care. That meant that the transfer penalty was properly reduced by the amount shown to have been legitimate payments for the applicant's care. M.M. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 9251-14, 2015 N.J. AGEN LEXIS 155, Initial Decision (March 9, 2015).

Determination by a county board of social services (CBSS) that a 42-day transfer penalty was properly imposed on the eligibility of an applicant for Medicaid was incorrect because the preponderance of the credible evidence showed that the applicant's daughter, who was generally responsible for her care, made some of the challenged transfers for a reason other than to qualify for Medicaid eligibility. Because the daughter convincingly rebutted the presumption that the transfers were made to establish Medicaid eligibility, the transfers on which a penalty was properly imposed totaled $12,437.33. B.J.H. v. Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13823-14, 2015 N.J. AGEN LEXIS 208, Initial Decision (February 13, 2015).

Medicaid applicant failed to rebut the presumption that a substantial portion of the assets that she transferred during the "look-back" period were transferred for the purpose of qualifying for Medicaid. Moreover, the applicant continued to transfer large sums of money to her children and grandchildren as her health slowly deteriorated and as she could anticipate the need for long-term care services. Thus, she was entitled to a small reduction in the penalty period based on her showing that about $10,000 of those funds was spent on her own living expenses and care needs. However, she was not entitled to any reduction in the penalty period due to partial returns of improperly-transferred assets because the transfer penalty may only be adjusted if all assets transferred for less than FMV have been returned. Finally, the record supports a conclusion that the Board of Social Services had incorrectly calculated the penalty in the first place because it did not use the then-current year's divisor in the calculation, an error that should be corrected on recalculation of the penalty to be based on $130,028.64. M.D. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 345-14, 2014 N.J. AGEN LEXIS 824, Initial Decision (December 15, 2014).

Administrative law judge reversed a determination of the Atlantic County Board of Social Services, Medicaid Unit (CWA), denying a Medicaid application based on excess resources under N.J.A.C. 10:71-4.5(c). Pursuant to provisions of N.J.A.C. 10:71-4.1 et seq., the applicant, a person that was adjudicated as incapacitated by the Superior Court on May 10, 2013, did not have access to probate assets (bank account) held by the (intestate) estate of his deceased wife. Nor did the Public Guardian have access to the assets of the estate of the deceased wife at this time. If and when the assets of the estate of deceased wife were subject to probate, the Public Guardian was ordered to inform the CWA and resource eligibly might be re-evaluated, subject to the priorities established by the probate laws. E.C. v. Atlantic County Bd. of Social Serv. and Div. of Medical Assistance and Health Serv., 3 OAL DKT. NO. HMA 9751-14, 2014 N.J. AGEN LEXIS 542, Initial Decision (October 24, 2014).

Administrative law judge affirmed the termination of a recipient's Medicaid case by the Bergen County Board of Social Services and its attempt to recover Medicaid benefits expended on his behalf because he failed to disclose all resources as defined by N.J.A.C. 10:71-4.1(b) on his Medicaid application and subsequent redetermination applications. Irrespective of the recipient's state of mind at the time of the initial application or subsequent redeterminations, it was undisputed that he was the owner of a TD Ameritrade account, the value of which at all relevant times exceeded the resource eligibility limit of N.J.A.C. 10:71-4.5(c). J.V. v. Bergen County Bd. of Social Serv., OAL DKT. NO. HMA 09843-14, 2014 N.J. AGEN LEXIS 717, Initial Decision (October 15, 2014).

Determination by a county board of social services (CBSS) denying a petitioner's request for Medically Needy Nursing Home Medicaid per N.J.A.C. 10:70-1.1 et seq. was reversed. That determination had been based on a CBSS calculation of amounts held in four bank accounts, two of which were in the name of a business that the applicant had owned. However, the applicant established that the business had stopped operations, would not be reopening for the next school year, had no employees, owed amounts to former employees, to a landlord and to some trade vendors. That being so, a recalculation of the applicant's resources in accord with N.J.A.C. 10:71-5.1(b) and N.J.A.C. 10:71-4.1 was appropriate, and eligibility thus established. F.P. v. Middlesex Cnty. Bd. of Social Servs., OAL DKT. NOS. HMA 03183-14 and HMA 05622-14, AGENCY DKT. NO. 1215061428 (Consolidated), 2014 N.J. AGEN LEXIS 475, Initial Decision (August 6, 2014).

Although a nursing home could not access all of a Medicaid applicant's funds through a judgment arising from the applicant's unpaid bills, that levy was immaterial for purposes of N.J.A.C. 10:71-4.1(c)(3)(i)(2). While the judgment encumbered funds in her account unrelated to her social security direct deposits, it did not make her social security checks inaccessible to her pursuant to 42 U.S.C.S. § 407(a). Therefore, the administrative law judge affirmed the medical eligibility date calculated by the Board of Social Services. D.W. v. Passaic Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 15245-13, 2014 N.J. AGEN LEXIS 447, Initial Decision (July 28, 2014).

County board of social services (CBSS) and Division of Medical Assistance and Health Services (DMAHS) did not err in imposing a transfer penalty on the Medicaid eligibility of an applicant on the ground that the transfer, to the applicant's daughter, of $18,555.64 of the proceeds of a CD owned by the applicant was made for less than fair value. Though the daughter insisted that the entire amount actually represented rent paid by her mother to her over a five year period and though the daughter submitted uncashed checks that totaled $18,048, there was no evidence that they actually were written when they were purported to have been written and were no longer negotiable on the date on which funds were transferred from the applicant's CD to her daughter. Since the presumption was that the amount had been transferred to allow the applicant to qualify for Medicaid benefits within the meaning of N.J.A.C. 10:71-4.1(d)2, was not rebutted, the applicant was properly rendered ineligible per N.J.A.C. 10:71-4.10 and a transfer penalty imposed. C.D. v. Camden Cnty. Bd. of Social Servs. and Div. of Medical Assistance & Health Servs., OAL DKT. NO. HMA 4606-14, AGENCY DKT. NO. 0410052983, 2014 N.J. AGEN LEXIS 444, Initial Decision, August 1, 2014.

County board of social services (CBSS) erred when it imposed a transfer penalty on the Medicaid eligibility of an applicant on the ground that the withdrawal, by the applicant's sister, of approximately $17,000 from a bank account that belonged to the applicant and his sister was a transfer to facilitate qualification for Medicaid. Though CBSS took the position that the amount was transferred to allow the applicant to qualify for Medicaid benefits within the meaning of N.J.A.C. 10:71-4.1(d)2 and that the applicant was thus rendered ineligible per N.J.A.C. 10:71-4.10, the sister established that the funds that she withdrew in fact belonged to her as they were the proceeds from the settlement of a personal injury case. That showing provided adequate grounds per N.J.A.C. 10:71-4.10(e)6ii for a determination that the funds had been transferred for a purpose other than to facilitate the applicant's qualification for Medicaid benefits, thus eliminating the basis on which the CBSS had relied in imposing a transfer penalty on the applicant. L.B. v. Atlantic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 4147-14, AGENCY DKT. NO. 0120009439-01, 2014 N.J. AGEN LEXIS 399, Initial Decision, June 17, 2014.

DMAHS's imposition of a 35 month, 10 day penalty against the eligibility of an incapacitated husband on account of the value of real estate that he and his wife had owned and which had an assessed value of $312,069 after applying the equalization ratio. An Administrative Law Judge (ALJ) so concluded despite an unrebutted showing that the building had fallen into significant disrepair; that the third floor had collapsed into the second floor; that a flood had resulted from broken pipes; that a city health inspector had ordered his wife to either renovate the premises or face demolition; and that the property in fact had just been sold to a third party for $37,000. Given the specific language of N.J.A.C. 10:71-4.1(d), the use of the tax-assessed value was mandatory. Because the calculation of the value of the property complied with governing law, the penalty on eligibility was proper. J.R. v. Atlantic Cnty. Bd. of Social Servs., and Div. of Medical Assistance & Health Servs., OAL DKT. NOS. HMA 17331-13 and OAL DKT. NO. HMA 2125-14 (Consolidated), AGENCY DKT. NO. 32710, 2014 N.J. AGEN LEXIS 374, Initial Decision, June 26, 2014.

Agency determination denying the application of a disabled adult for enrollment in the Community Care Waiver/Medicaid Only (CCW) on the ground that her resources exceeded the ceiling imposed by N.J.A.C. 10:71-1.2(a) and N.J.A.C. 10:71-4.1 was reversed. The disabled adult owned life insurance policies, one of which had a cash surrender value of $2065, and her ownership thereof meant that her resources exceeded the eligibility standard of $2,000. However, resources which are not accessible to an individual through no fault of his or her own are excluded per N.J.A.C. 10:71-4.4(b)(6). Thus, though the cash value was "available" to the disabled adult in the sense that she had the right to liquidate the policy, the circumstances presented by these facts, which included that the adult has Down's Syndrome and had been declared incompetent by reason thereof, the adult lacked the capacity to deal with the insurance, and its value should not have been considered when evaluating the adult's resources. Once the value thereof was excluded, the adult was eligible for Medicaid as of the proposed date of September 1, 2013. P.M. v. DMAHS, OAL DKT. NO. HMA18597-13, AGENCY

REF. NO. 9020032129-01, 2014 N.J. AGEN LEXIS 291, Initial Decision (May 12, 2014).

Burlington County Board of Social Services' termination of Medicaid eligibility was affirmed when the resources of the recipient exceeded the amount permitted under N.J.A.C. 10:71-4.1. He owned two life insurance policies but failed to disclose them, and there was no legal precedent to waive this requirement when a recipient either did not know or failed to do proper diligence in the discovery or reporting of such resources. His argument of a transfer to a disabled child failed because the child was not disabled at the time of the application and the transfer was not made properly. S.B. v. Burlington Cnty. Bd. Social Serv., OAL Dkt. No. HMA 16743-13, 2014 N.J. AGEN LEXIS 286, Initial Decision (May 22, 2014).

Action of the Division of Medical Assistance and Health Services and the Camden County Board of Social Services denying an application for Nursing Home Medicaid was reversed. An irrevocable trust was created before the sixty month Medicaid long back period began. The checks written to the nursing home from the trust during the look back period were made payable to the nursing home, obviously for the applicant's care and for her benefit. The remaining checks written during the look back period appeared to be for the maintenance of the property that was contained in the trust and for taxes. These payments were for the benefit of the applicant with the exception of one check written payable to cash, which was considered not to be for her benefit under N.J.A.C. 10:71-4.11(e)1iii. Thus, the applicant's resources were under $2,000 pursuant to N.J.A.C. 10:71-4.5(c). J.S. v. Camden Cnty. Bd. Social Serv. and Div. of Medical Assistance and Health Serv., OAL Dkt. No. HMA 11618-13, 2014 N.J. AGEN LEXIS 280, Initial Decision (May 20, 2014).

An Administrative Law Judge (ALJ) concluded that neither an elderly woman nor her guardian received a November 7, 2012 letter from the county agency denying her Medicaid application and that the elderly woman thus was entitled to be granted Medicaid eligibility effective February 1, 2013. The denial was predicated on the fact that the agency had not received the woman's Social Security and Medicare cards nor information that had been requested relative to the value of assets including life insurance policies and the woman's residence. However, despite the fact that the guardian continued to respond to those and other requests on the part of the agency, the agency received that information without ever advising the guardian that the application had already been denied. Moreover, if the agency, as required by N.J.A.C. 10:71-4.1(c)3(i)2, had deducted from the woman's countable assets the amounts awarded by a court to the guardian on account of fees, the eligibility requirements would have been met no later than the requested February 1, 2013 date. M.S. v. Burlington Cnty. Bd. of Soc. Servs. & Div. of Med. Assistance & Health Servs., OAL Dkt. No. HMA 8060-13, AGENCY Dkt. No. 0310030326, 2014 N.J. AGEN LEXIS 174, Initial Decision, April 10, 2014.

An Administrative Law Judge (ALJ) concluded that the Bergen County Board of Social Services erred when, relying on N.J.A.C. 10:72-4.5(b)(3), it denied a Medicaid application filed by an elderly husband (Husband) and imposed a transfer penalty of 17 months and 20 days, making Husband's eligibility date September 21, 2014, based on its finding that the assets represented by three certificate of deposit (CDs) accounts titled to his wife (Wife) and Wife's sister (Sister) constituted resources within the meaning of N.J.A.C. 10:71-4.6 that were "available" to Husband within the meaning of N.J.A.C. 10:71-4.1(c) and could be converted to cash and used for the Husband's support and maintenance. Wife and Sister's submission on that issue, which included a statement from the financial institution where the accounts were held, established that the funds used to obtain the CDs were owned in toto by Sister, who was elderly, had no children, and lived alone; and that Sister's intention, in titling the accounts as she did, was to assure that Wife would have access to the funds in the event that Sister became incapacitated or to pay for her funeral expenses. Because the submission met the standards in N.J.A.C. 10:71-4.10(*o*)3 and established that the funds were not a resource of Husband, the ALJ concluded that there was no basis for the imposition of a transfer penalty. W.Z. v. Bergen Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 16767-13, AGENCY Dkt. No. 021016511201, 2014 N.J. AGEN LEXIS 99, Initial Decision (February 7, 2014).

Petitioner should have been granted Medicaid Only Nursing Home benefits effective June 1, 2008, instead of October 1, 2008, because petitioner did not have resources of $50,000.00, an amount due him in accordance with the property settlement in a divorce action, where the attorney who held the $50,000.00 in his trust account was his wife's attorney, not his; additionally, all parties agreed that no payment was ever made directly to petitioner from this fund. C.S.J. v. DMAHS, OAL Dkt. No. HMA 12214-08, 2009 N.J. AGEN LEXIS 736, Final Decision (July 16, 2009).

Initial Decision (2008 N.J. AGEN LEXIS 868) adopted, which found that the effective date of eligibility for a Medicaid program account began March 22, 2008, instead of on petitioner's requested date of October 22, 2007, because the petitioner had received $7,500.20 in June of 2007, and $38,000 in November of 2007, from a reverse mortgage loan; although the monies were ostensibly taken for home improvement repairs, the monies were placed, not in an escrow account or any kind of account with specific instructions limiting how the proceeds were to be spent, but were placed in petitioner's account and were under his direct dominion and control. As a result, petitioner was resource ineligible because those funds in his bank account were still available to him and well exceeded the $2,000 resource limitation. F.R. v. DMAHS, OAL Dkt. No. HMA 09322-08, 2008 N.J. AGEN LEXIS 1112, Final Decision (October 29, 2008).

Expert testimony demonstrated that an annuity could be converted to cash and thus was an available resource for purposes of a nursing facility resident's application for Medicaid benefits under the Medically Needy program; the annuity, purchased by the applicant, a widow, for $195,710, was to pay the applicant $1,740.85 per month for 10 years and stated on its face that it was non-assignable (adopting 2007 N.J. AGEN LEXIS 209). D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546, Final Decision (June 11, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546, Final Decision (June 11, 2007).

Medicaid applicant's irrevocable trust arrangement was void because it violated New Jersey's public policy against shielding assets to become Medicaid eligible, pursuant to N.J.S.A. 30:4D-6(f), and therefore the trust res was considered an available resource. Because public policy considered the trust null and void, it was as if the trust assets were available to the applicant throughout the duration of the trust and at the time of the Medicaid application made on February 8, 2006; thus, the transfer of assets did not occur until February 8, 2006, pursuant to N.J.A.C. 10:71-4.10(m)1, and the penalty period for the transfer began on that date. J.S. v. DMAHS, OAL Dkt. No. HMA 4896-06, 2006 N.J. AGEN LEXIS 1054, Initial Decision (December 19, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 456) adopted, which concluded that a special needs trust, of which petitioner was a beneficiary, was an excludable resource under N.J.A.C. 10:71-4.4(b)6 for purposes of determining Medicaid Only eligibility because petitioner was not the grantor, the trust was not funded by any of petitioner's assets, a trustee other than petitioner had sole discretion to disburse trust funds, petitioner could not compel the distribution of the corpus or income, and petitioner was not the beneficiary of any remaining funds upon the trust's termination. A.M. v. DMAHS, OAL Dkt. No. HMA 8525-05, 2006 N.J. AGEN LEXIS 586, Final Decision (June 26, 2006).

Custodial bank accounts of Medicaid applicant's children were not available to applicant or her husband and thus were not countable resources in determining applicant's eligibility for the Nursing Home Medicaid program for the year in question; the accounts, created years before applicant's entry into the nursing home, were governed by the New Jersey Uniform Transfers to Minors Act, N.J.S.A. 46:38A-1 et seq.

L.A.S. v. Union County Div. of Soc. Servs., OAL Dkt. No. HMA 1215-05, 2006 N.J. AGEN LEXIS 348, Initial Decision (April 26, 2006).

Initial Decision (2005 N.J. AGEN LEXIS 669) adopted, which concluded that a July 7, 1993 irrevocable trust, which had entitled the Medicaid applicant to payments at the discretion of the trustee and terminated that discretion upon the applicant becoming a nursing home resident, had to be counted as an available resource notwithstanding that the trust was a pre-August 11, 1993 trust. L.C. v. DMAHS, OAL Dkt. No. HMA 3857-05, 2005 N.J. AGEN LEXIS 1475, Final Decision (December 7, 2005).

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

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

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

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

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

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

10:71-4.2 Countable resources

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

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

(b) Verification of resources: If verification is required in accordance with the provisions of N.J.A.C. 10:71-4.1(d)3, the 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).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b), substituted "CBOSS" for "CWA" throughout.
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Added (a)1.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In the introductory paragraph of (b), and in (b)1, (b)2 and (b)3, substituted "CWA" for "CBOSS"; in (b)1, deleted a comma following "assessors"; and in (b)3, substituted the second occurrence of "or" for the second occurrence of "of", and deleted a comma following "receivable" and "firms".

Law Review and Journal Commentaries

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

Case Notes

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

Though the income of an applicant for Medicaid fluctuated seasonally, his income in the month in which he and his wife sought recertification of eligibility exceeded the ceiling and afforded good grounds to deny the application. J.M. v. DMAHS, OAL DKT. NO. HMA 17572-15, 2016 N.J. AGEN LEXIS 143, Initial Decision (March 21, 2016).

Determination of a county board of social services that an elderly woman's countable resources exceeded the eligibility resource limit, though originally sustained by an ALJ, was approved after remand and further proceedings on findings that the woman's access to an account that held $5,658 at the time of the application was unrestricted. Though the parties had stipulated that the account at issue was jointly held by the woman and her daughter, the ALJ noted that the woman did not submit any documentation proving that her access to those funds in fact was restricted and that there was evidence suggesting that each account

owner could act independently with regard to transactions therein. F.J. v. Camden Bd. of Social Servs., OAL DKT. NO. HMA 9451-15 (On Remand HMA 15125-14), 2016 N.J. AGEN LEXIS 119, Decision on Remand (March 14, 2016).

Applicant for Medicaid was not entitled to a retroactive date of eligibility based on the date of application because a delay on the part of the board of social services in acting on the application was due to the failure on the part of the applicant's wife to submit required documentation. The mere fact that the board did not complete the processing within the 45-day period described in governing regulations did not provide a basis for retroactivity. H.F. v. Morris Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00044-15, 2016 N.J. AGEN LEXIS 62, Initial Decision (February 16, 2016).

Board of social services erred when it denied Medicaid benefits to an applicant who had suffered from dementia for several years on the grounds that she had failed to provide the information and documents requested by the agency and because her "available" resources exceeded the maximum allowable under regulations. The evidence made it quite clear that the applicant did not and could not have participated in the liquidation of her personal and marital assets and that the assets at issue were neither "accessible" nor "countable" in relation to the applicant. A.F. v. Hudson Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02986-15, 2016 N.J. AGEN LEXIS 63, Initial Decision (February 12, 2016).

County board of social services was right to conclude that the countable resources of a 78 year old widow included a checking account that contained more than $70,000 even though her son, who was a co-owner of the checking account, insisted that nearly $60,000 of those funds were the proceeds from the sale of his house in which his mother had no legal interest. The widow was not under any disability or guardianship and the manner in which the account was titled – as an "or" account – meant that the widow had unrestricted access to all of the funds contained therein. S.M. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 04755-15, 2015 N.J. AGEN LEXIS 456, Initial Decision (November 20, 2015).

Applicant for Nursing Home Medicaid (NHM) was improperly denied eligibility on the ground that her resources of $6,725.44 from several bank accounts exceeded the $2,000 Medicaid eligibility limit. Specifically, an investment account holding $5,658.88 should not have been counted as a resource of the applicant notwithstanding that her name was listed as a joint tenant thereon because the applicant's daughter, who was the source of all deposits into that account, credibly testified that she had added her mother's name to the account at a time when she was residing with her mother; and that her mother was currently an "incapacitated" person and the daughter had been appointed as her mother's temporary guardian. The daughter's testimony was forthright, sincere and uncontroverted. Given that fact and given the further fact that the mother's incapacity foreclosed her from independently accessing the investment account, the funds held therein should not have been counted as the mother's resources for purposes of NHM eligibility. F.J. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 15125-14, 2015 N.J. AGEN LEXIS 261, Initial Decision (April 30, 2015).

Morris County Board of Social Services correctly determined that a Medicaid applicant's entrance fee to a continuing care retirement community (CCRC) constituted a countable resource under N.J.A.C. 10:71-4.2 and that his countable resources exceeded the amount of exempt assets available to his community spouse. The provisions of the CCRC contract satisfied the Centers for Medicaid and Medicare Services' interpretation of 42 U.S.C.S. § 1396p(g)(2)(B). Thus, the Board of Social Services appropriately denied the Medicaid application. M.G. v. DMAHS and Morris Cnty. Bd. of Social Serv., OAL DKT. No. HMA 13509-13, 2014 N.J. AGEN LEXIS 98, Initial Decision (February 26, 2014).

Determination by a county board of social services imposing a penalty period of five months and 17 days before a 97-year-old woman could receive Medicaid Only benefits based on a finding that $479 in monthly income was properly imputed to her by reason of her life estate in a family home was reversed because the governing regulations, including N.J.A.C. 10:71-5.4(a) and N.J.A.C. 10:71-4.2(b)1, did not authorize the board to find that the applicant could obtain rental income from a life estate or that such theoretical rental income must be or could be counted as "available income" within the meaning of N.J.A.C. 10:71-5.1(b)1. Given that such an interpretation of existing rules would have a significant impact upon the public at large and given the need for uniformity throughout the state, the status of such theoretical rental income was properly the subject of formal rule-making in compliance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. H.S. v. DMAHS and Atlantic Cty. Bd. of Soc. Servs., OAL Dkt. NO. HMA 10450-12, 2013 N.J. AGEN LEXIS 12, Initial Decision (January 23, 2013).

Initial Decision (2005 N.J. AGEN LEXIS 669) adopted, which concluded that a July 7, 1993 irrevocable trust, which had entitled the Medicaid applicant to payments at the discretion of the trustee and terminated that discretion upon the applicant becoming a nursing home resident, had to be counted as an available resource notwithstanding that the trust was a pre-August 11, 1993 trust. L.C. v. DMAHS, OAL Dkt. No. HMA 3857-05, 2005 N.J. AGEN LEXIS 1475, Final Decision (December 7, 2005).

10:71-4.3 (Reserved)

10:71-4.4 Excludable resources

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

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

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

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

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

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

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

(1) The equity value of an automobile is the value of the vehicle as indicated by the "Average Wholesale Value" in the most recent April or October edition of

the Red Book; Official Used Car Valuations minus any encumbrances.

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

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

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

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

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

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

5. Nonhome property that is used in a business or nonbusiness self-support activity that is essential to the means of self-support of an individual and/or spouse, is excluded from resources.

i. Tools, equipment or other items that are used for trade or business and required for employment, including, but not limited to, the machinery and livestock of a farmer, are assumed to be of a reasonable value and producing a reasonable rate of return and are, therefore, excluded from resources.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Immediate family includes an individual's minor and adult children, stepchildren and adopted children, brothers, sisters, parents, adopted parents and spouses of those persons. Dependency and living-in-the-same household are not factors. Immediate

family does not include the members of an ineligible spouse's family unless they meet this definition.

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

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

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

(B) In order for burial funds to be excluded, the funds must be separately identifiable (that is, not 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.

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

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

As amended, R.1983 d.167, effective June 6, 1983.
See: 15 N.J.R. 422(a), 15 N.J.R. 925(b).
(a)9., Burial spaces and funds added as excludable resources.
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b)2ii, substituted "beneficiary" for "recipient" in the introductory paragraph.
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Added (b)10.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
Rewrote (b)2i; in (b)2ii, rewrote the introductory paragraph; in (b)2ii(1), substituted "equity value" for "CMB" and inserted "minus any encumbrances"; deleted (b)2iii.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (b)1, substituted "his or her" for "his/her"; and rewrote (b)5.

Law Review and Journal Commentaries

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

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

Case Notes

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

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

Though an applicant who was seeking an award of Medicaid benefits provided a letter from her bank containing certain needed information, the letter did not address the balance in the account on the first of the month, which was the critical date under applicable regulations, and that failure provided grounds for a denial. A.A-G. v. Somerset Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00912-16, 2016 N.J. AGEN LEXIS 174, Initial Decision (April 11, 2016).

Though the income of an applicant for Medicaid fluctuated seasonally, his income in the month in which he and his wife sought recertification of eligibility exceeded the ceiling and afforded good grounds to deny the application. J.M. v. DMAHS, OAL DKT. NO. HMA 17572-15, 2016 N.J. AGEN LEXIS 143, Initial Decision (March 21, 2016).

Sufficient evidence supported the determination of a county board of social services that the funds in a bank account in the names of the applicant and her daughter were a resource of the applicant and were properly counted in determining the applicant's resources for the purposes of qualifying for participation in the Medicaid Only Program. Since those funds well exceeded the ceiling for eligibility, the applicant was properly found to be ineligible. M.H. v. Mercer Cnty., Bd. of Social Servs., OAL DKT. NO. HMA 16444-15, 2016 N.J. AGEN LEXIS 142, Initial Decision (March 17, 2016).

Determination of a county board of social services that an elderly woman's countable resources exceeded the eligibility resource limit, though originally sustained by an ALJ, was approved after remand and further proceedings on findings that the woman's access to an account that held $5,658 at the time of the application was unrestricted. Though the parties had stipulated that the account at issue was jointly held by the woman and her daughter, the ALJ noted that the woman did not submit

any documentation proving that her access to those funds in fact was restricted and that there was evidence suggesting that each account owner could act independently with regard to transactions therein. F.J. v. Camden Bd. of Social Servs., OAL DKT. NO. HMA 9451-15 (On Remand HMA 15125-14), 2016 N.J. AGEN LEXIS 119, Decision on Remand (March 14, 2016).

Income stream that was available from a testamentary trust benefiting, inter alia, an applicant for Medicaid constituted a "resource" for the applicant that exceeded the resource ceiling in governing law and thus disqualified the applicant from qualifying for Medicaid. There was no merit to the applicant's claim that the trustee of the trust had validly determined to not invade the corpus of the trust for her nursing home care on the ground that it was not an "emergency" within the meaning of the trust because, in reality, the applicant herself had full discretion to approve or disapprove any proposed payment. S.V. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02069-15, 2016 N.J. AGEN LEXIS 78, Initial Decision (February 23, 2016).

Third application for Medicaid eligibility filed by a representative of an elderly nursing home resident who was suffering from dementia was properly granted retroactive to a date that was three months prior to the date of filing in accord with governing law over claims that it should have been retroactive to the date on which the resident had been admitted to the nursing home because there was no causal relationship between the resident being admitted to the nursing home and his access to countable resources for establishing eligibility. E.M. v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 13935-15, 2016 N.J. AGEN LEXIS 49, Initial Decision (February 10, 2016).

County board of social services was right to conclude that the countable resources of a 78 year old widow included a checking account that contained more than $70,000 even though her son, who was a co-owner of the checking account, insisted that nearly $60,000 of those funds were the proceeds from the sale of his house in which his mother had no legal interest. The widow was not under any disability or guardianship and the manner in which the account was titled – as an "or" account – meant that the widow had unrestricted access to all of the funds contained therein. S.M. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 04755-15, 2015 N.J. AGEN LEXIS 456, Initial Decision (November 20, 2015).

Determination by the Division of Medical Assistance and Services (DMAHS) and a county Board of Social Services denying an application for Medicaid filed on behalf of an elderly women who had dementia and resided in a nursing home based on her joint ownership, with an adult son who was permanently disabled, of stock valued at $89,309.28 was unsupported by the evidence and properly rejected. The son, a permanently incapacitated adult who permanently resided in a VA hospital, was totally blind, had no recollection of his mother being alive, and refused to sign any documents relating to the stock. Given the son's condition, it could not be said that the assets at issue were accessible to the mother because she had no power to liquidate them without her son's approval, and thus the stocks could not be included as countable resources of the applicant according to governing regulations. To the extent that the determination of ineligibility relied on the existence of the stocks, it was incorrect, and the applicant was entitled to an order granting her application for Medicaid. F.F. v. DMAHS and Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 00793-15, 2015 N.J. AGEN LEXIS 318, Initial Decision (June 3, 2015).

Applicant for Nursing Home Medicaid (NHM) was improperly denied eligibility on the ground that her resources of $6,725.44 from several bank accounts exceeded the $2,000 Medicaid eligibility limit. Specifically, an investment account holding $5,658.88 should not have been counted as a resource of the applicant notwithstanding that her name was listed as a joint tenant thereon because the applicant's daughter, who was the source of all deposits into that account, credibly testified that she had added her mother's name to the account at a time when she was residing with her mother; and that her mother was currently an "incapacitated" person and the daughter had been appointed as her mother's temporary guardian. The daughter's testimony was forthright, sincere and uncontroverted. Given that fact and given the further fact that the mother's incapacity foreclosed her from independently accessing the investment account, the funds held therein should not have been counted as the mother's resources for purposes of NHM eligibility. F.J. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 15125-14, 2015 N.J. AGEN LEXIS 261, Initial Decision (April 30, 2015).

County Board of Social Services (CBSS) acted properly when it determined that an applicant was not eligible for institutional Medicaid for the months of December 2013 and January and February 2014 due to the fact that she possessed resources that exceeded $2000. The applicant argued that $10,524 cash value of a life insurance policy was not a resource within the meaning of the relevant regulations because it was used to reimburse her son for funds he expended to purchase a cemetery plot for the applicant and to fund an irrevocable funeral trust. However, such resources were countable because they exceeded the limits on such life insurance policies and burial funds. In sum, because the applicant had countable resources in excess of $2000 and had received the maximum allowed credit of $1500 for burial expenses, the CBSS had acted properly in determining that the applicant was ineligible in the cited months. L.H. v. Hudson Cty. Bd. of Social Servs., OAL DKT. NO. HMA 05597-14, 2015 N.J. AGEN LEXIS 167, Initial Decision (March 24, 2015).

Passaic County Board of Social Services (PCBSS) incorrectly determined an applicant's Medicaid effective date pursuant to N.J.A.C. 10:71-2.3(b). Because of the applicant's dementia she was unable to place her house on the market or instruct her disabled son on what to and was in a situation prior to the appointment of a guardian, due to no fault of her own, that prevented her from making the property available and accessible to her. In addition, her property should have been excluded when counting resources to determine Medicaid eligibility under N.J.A.C. 10:71-4.4(b)(6). The law excluded the house, based on the unavailability and inaccessibility of the asset at the time she entered the nursing home and applied for Medicaid and because of the legal rights of her disabled son who could reside in or sell the home, with proceeds from the sale placed in a Special Needs Trust for his care and upkeep. Because PCBSS accepted the application, processed it and determined eligibility, it should be equitably estopped from claiming the application was invalid. B.S. v. Div. of Med. Assistance and Health Serv. and Passaic Cnty. Bd. of Social Serv., OAK Dkt. No. HMA 09208-12, 2014 N.J. AGEN LEXIS 428, Initial Decision (July 23, 2014).

After the Burlington County Board of Social Services (BCBSS) improperly failed to characterized a trust as an excludable resource under N.J.A.C. 10:71-4.4 and denied a Medicaid application, an administrative law judge reversed the BCBSS decision. The BCBSS provided no credible evidence to support their conclusion that the trust was revocable. On the contrary, the preponderance of the credible evidence clearly indicated that this was not a revocable trust and that the applicant had no access to these funds, through no fault of her own. E.M. v. Burlington Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 363-14, 2014 N.J. AGEN LEXIS 388, Initial Decision (June 30, 2014).

Agency determination denying the application of a disabled adult for enrollment in the Community Care Waiver/Medicaid Only (CCW) on the ground that her resources exceeded the ceiling imposed by N.J.A.C. 10:71-1.2(a) and N.J.A.C. 10:71-4.1 was reversed. The disabled adult owned life insurance policies, one of which had a cash surrender value of $2065, and her ownership thereof meant that her resources exceeded the eligibility standard of $2,000. However, resources which are not accessible to an individual through no fault of his or her own are excluded per N.J.A.C. 10:71-4.4(b)(6). Thus, though the cash value was "available" to the disabled adult in the sense that she had the right to liquidate the policy, the circumstances presented by these facts, which included that the adult has Down's Syndrome and had been declared incompetent by reason thereof, the adult lacked the capacity to deal with the insurance, and its value should not have been considered when evaluating the adult's resources. Once the value thereof was excluded, the adult was eligible for Medicaid as of the proposed date of September 1, 2013. P.M. v. DMAHS, OAL DKT. NO. HMA18597-13, AGENCY REF. NO. 9020032129-01, 2014 N.J. AGEN LEXIS 291, Initial Decision (May 12, 2014).

Medicaid applicant's irrevocable trust arrangement was void because it violated New Jersey's public policy against shielding assets to become Medicaid eligible, pursuant to N.J.S.A. 30:4D-6(f), and therefore the trust res was considered an available resource. Because public policy considered the trust null and void, it was as if the trust assets were available to the applicant throughout the duration of the trust and at the time of the Medicaid application made on February 8, 2006; thus, the transfer of assets did not occur until February 8, 2006, pursuant to N.J.A.C. 10:71-4.10(m)1, and the penalty period for the transfer began on that date. J.S. v. DMAHS, OAL Dkt. No. HMA 4896-06, 2006 N.J. AGEN LEXIS 1054, Initial Decision (December 19, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 456) adopted, which concluded that a special needs trust, of which petitioner was a beneficiary, was an excludable resource under N.J.A.C. 10:71-4.4(b)6 for purposes of determining Medicaid Only eligibility because petitioner was not the grantor, the trust was not funded by any of petitioner's assets, a trustee other than petitioner had sole discretion to disburse trust funds, petitioner could not compel the distribution of the corpus or income, and petitioner was not the beneficiary of any remaining funds upon the trust's termination. A.M. v. DMAHS, OAL Dkt. No. HMA 8525-05, 2006 N.J. AGEN LEXIS 586, Final Decision (June 26, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 456) adopted, which concluded that a special needs trust established by a Medicaid recipient's father did not run afoul of N.J.S.A. 30:4D-6(f)2 by its provision that the trust was to supplement rather than supplant public assistance; the provision acknowledged receipt of public assistance to reinforce the grantor's intent that the trust was not for basic needs and it did not direct the trustee not to pay for health care if the recipient qualified for Medicaid. A.M. v. DMAHS, OAL Dkt. No. HMA 8525-05, 2006 N.J. AGEN LEXIS 586, Final Decision (June 26, 2006).

Custodial bank accounts of Medicaid applicant's children were not available to applicant or her husband and thus were not countable resources in determining applicant's eligibility for the Nursing Home Medicaid program for the year in question; the accounts, created years before applicant's entry into the nursing home, were governed by the New Jersey Uniform Transfers to Minors Act, N.J.S.A. 46:38A-1 et seq. L.A.S. v. Union County Div. of Soc. Servs., OAL Dkt. No. HMA 1215-05, 2006 N.J. AGEN LEXIS 348, Initial Decision (April 26, 2006).

Initial Decision (2005 N.J. AGEN LEXIS 669) adopted, which concluded that a July 7, 1993 irrevocable trust, which had entitled the Medicaid applicant to payments at the discretion of the trustee and terminated that discretion upon the applicant becoming a nursing home resident, had to be counted as an available resource notwithstanding that the trust was a pre-August 11, 1993 trust. L.C. v. DMAHS, OAL Dkt. No. HMA 3857-05, 2005 N.J. AGEN LEXIS 1475, Final Decision (December 7, 2005).

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

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

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

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

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

10:71-4.5 Resource eligibility standards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Amended by R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Added text to reference N.J.A.C. 10:71-4.8 to (a) and (d).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b), rewrote introductory paragraph; rewrote (c).
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Added (f).

Case Notes

Claimant was not eligible for Medicaid Only Benefits for nursing home costs because, as of the first day of the month of the current period of institutionalization, his resources exceeded the maximum amount permitted by N.J.A.C. 10:71-4.5(c). N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

Income subject to transfer from an institutionalized spouse was not limited to the income he was earning as of the date when the couple's resources were allocated for purposes of determining Medicaid Only eligibility. The other spouse's minimum monthly maintenance needs allowance deficit could be made up with the Social Security disability income the institutionalized spouse was reasonably expected to earn thereafter. N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

Though an applicant who was seeking an award of Medicaid benefits provided a letter from her bank containing certain needed information, the letter did not address the balance in the account on the first of the month, which was the critical date under applicable regulations, and that failure provided grounds for a denial. A.A-G. v. Somerset Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00912-16, 2016 N.J. AGEN LEXIS 174, Initial Decision (April 11, 2016).

Sufficient evidence supported the determination of a county board of social services that the funds in a bank account in the names of the applicant and her daughter were a resource of the applicant and were properly counted in determining the applicant's resources for the purposes of qualifying for participation in the Medicaid Only Program. Since those funds well exceeded the ceiling for eligibility, the applicant was properly found to be ineligible. M.H. v. Mercer Cnty., Bd. of Social Servs., OAL DKT. NO. HMA 16444-15, 2016 N.J. AGEN LEXIS 142, Initial Decision (March 17, 2016).

Medicaid Only Institutional benefits were properly denied by a county board of social services to an elderly applicant on the ground that her countable resources exceeded the eligibility ceiling. Though the applicant's caregiver/daughter claimed that the execution by the applicant of a power of attorney giving the daughter total power over all of the applicant's affairs, including her financial affairs, combined with the purported existence of a signed deed to the applicant's house, was sufficient to render the property "inaccessible," the applicant remained the owner of the property and its value was such that she was ineligible for the program. E.C. v. Passaic Bd. of Social Servs., OAL DKT. NO. HMA 16475-15, 2016 N.J. AGEN LEXIS 121, Initial Decision (March 14, 2016).

Income stream that was available from a testamentary trust benefiting, inter alia, an applicant for Medicaid constituted a "resource" for the applicant that exceeded the resource ceiling in governing law and thus disqualified the applicant from qualifying for Medicaid. There was no merit to the applicant's claim that the trustee of the trust had validly determined to not invade the corpus of the trust for her nursing home care on the ground that it was not an "emergency" within the meaning of the trust because, in reality, the applicant herself had full discretion to approve or disapprove any proposed payment. S.V. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02069-15, 2016 N.J. AGEN LEXIS 78, Initial Decision (February 23, 2016).

County board of social services was right to conclude that the countable resources of a 78 year old widow included a checking account that contained more than $70,000 even though her son, who was a co-owner of the checking account, insisted that nearly $60,000 of those funds were the proceeds from the sale of his house in which his mother had no legal interest. The widow was not under any disability or guardianship and the manner in which the account was titled – as an "or" account – meant that the widow had unrestricted access to all of the funds contained therein. S.M. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 04755-15, 2015 N.J. AGEN LEXIS 456, Initial Decision (November 20, 2015).

Funds held in an escrow account on which the N.J. Office of the Public Guardian held a lien were not "available" to an applicant who was seeking eligibility for the Medicaid Only program within the meaning of governing rules and was not properly included in the "countable resources" on which an eligibility decision was properly based. C.H. v. Essex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 08484-15, 2015 N.J. AGEN LEXIS 604, Initial Decision (September 24, 2015).

Applicant for Nursing Home Medicaid (NHM) was improperly denied eligibility on the ground that her resources of $6,725.44 from several bank accounts exceeded the $2,000 Medicaid eligibility limit. Specifically, an investment account holding $5,658.88 should not have been counted as a resource of the applicant notwithstanding that her name was listed as a joint tenant thereon because the applicant's daughter, who was the source of all deposits into that account, credibly testified that she had added her mother's name to the account at a time when she was residing with her mother; and that her mother was currently an "incapacitated" person and the daughter had been appointed as her mother's temporary guardian. The daughter's testimony was forthright, sincere and uncontroverted. Given that fact and given the further fact that the mother's incapacity foreclosed her from independently accessing the investment account, the funds held therein should not have been counted as the mother's resources for purposes of NHM eligibility. F.J. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 15125-14, 2015 N.J. AGEN LEXIS 261, Initial Decision (April 30, 2015).

Administrative Law Judge (ALJ) agreed with DMAHS that an applicant for Medicaid was properly subjected to a ten month penalty on her benefits by reason of her transfer, during the look-back period, of $78,000. By the time of the hearing, the applicant was deceased, but her son, on behalf of the estate, claimed that the $78,000 reflected six gifts of $13,000 each that she had made to family members purportedly to pay for her granddaughter's wedding and her grandchildren's college expenses and that at the time such gifts were made, the applicant was living wholly independently and that Medicaid eligibility was not a consideration at the time the gifts were made. However, there was no supporting evidence because none of the payments was made directly for wedding expenses or to a college or university. Rather, each check was made out for $13,000 without any indication of how the applicant intended for it to be spent. Each check was simply a gift in accordance with the maximum allowed without penalty under the tax laws. Since the gifts were properly considered to be transfers for "love and affection," such transfers reflected funds that could have been used for the applicant's care and a penalty was properly imposed on account thereof. M.V. v. DMAHS and Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 15653-14, 2015 N.J. AGEN LEXIS 263, Initial Decision (April 20, 2015).

Though the documents establishing a special needs trust for a disabled adult satisfied all regulatory requirements, the funds held there were properly considered assets of the beneficiary for the purposes of the application of the rules governing eligibility for Social Security and Medicaid benefits because the trust assets were actually utilized for a whole variety of purposes that were beyond the narrow confines of federal and state law such that it no longer qualified as a special-needs trust. The evidence established that at least $8,000 of the original $60,329.44 deposited had been given to relatives of the beneficiary for one purpose or another. Leaving aside many other expenditures that arguably yielded some benefit to others besides the beneficiary, this meant that at least 13% of the funds had been used in a way that benefited family members. Since the trust thus was not used for the sole benefit of the beneficiary, it no longer qualified as a special needs trust, and the Division of Medical Assistance and Health Services properly considered those assets in determining that the beneficiary's assets exceeded the statutory limit. D.C. v. DMAHS, OAL DKT. NO. HMA 10265-14, 2015 N.J. AGEN LEXIS 111, Initial Decision (February 20, 2015).

Determination by a county board of social services (CBSS) that a 42-day transfer penalty was properly imposed on the eligibility of an applicant for Medicaid was incorrect because the preponderance of the credible evidence showed that the applicant's daughter, who was generally responsible for her care, made some of the challenged transfers for a reason other than to qualify for Medicaid eligibility. Because the daughter convincingly rebutted the presumption that the transfers were made to establish Medicaid eligibility, the transfers on which a penalty was properly imposed totaled $12,437.33. B.J.H. v. Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13823-14, 2015 N.J. AGEN LEXIS 208, Initial Decision (February 13, 2015).

Administrative law judge reversed a determination of the Atlantic County Board of Social Services, Medicaid Unit (CWA), denying a Medicaid application based on excess resources under N.J.A.C. 10:71-4.5(c). Pursuant to provisions of N.J.A.C. 10:71-4.1 et seq., the applicant, a person that was adjudicated as incapacitated by the Superior Court on May 10, 2013, did not have access to probate assets (bank account) held by the (intestate) estate of his deceased wife. Nor did the Public Guardian have access to the assets of the estate of the deceased wife at this time. If and when the assets of the estate of deceased wife were subject to probate, the Public Guardian was ordered to inform the CWA and resource eligibly might be re-evaluated, subject to the priorities established by the probate laws. E.C. v. Atlantic County Bd. of Social Serv. and Div. of Medical Assistance and Health Serv., 3 OAL DKT. NO. HMA 9751-14, 2014 N.J. AGEN LEXIS 542, Initial Decision (October 24, 2014).

Administrative law judge affirmed the termination of a recipient's Medicaid case by the Bergen County Board of Social Services and its attempt to recover Medicaid benefits expended on his behalf because he failed to disclose all resources as defined by N.J.A.C. 10:71-4.1(b) on his Medicaid application and subsequent redetermination applications. Irrespective of the recipient's state of mind at the time of the initial application or subsequent redeterminations, it was undisputed that he was the owner of a TD Ameritrade account, the value of which at all relevant times exceeded the resource eligibility limit of N.J.A.C. 10:71-4.5(c). J.V. v. Bergen County Bd. of Social Serv., OAL DKT. NO. HMA 09843-14, 2014 N.J. AGEN LEXIS 717, Initial Decision (October 15, 2014).

DMAHS properly denied an application for the Medicaid Only/ Community Care Waiver program made on behalf of a disabled adult on the ground that the adult had excess resources and that significant assets had been transferred within 6 months of the application. Leaving aside other assets on which evidence was received, the adult had nearly $50,000 in a trust account on the date of the application and thus her resources exceeded the $2,000 ceiling in N.J.A.C. 10:71-4.5(c). Second, as for the transfers, which included a transfer of a condominium and transfers in the amounts of $52,863.39 and $46,108.86, per N.J.A.C. 10:71-4.10(*l*)1, the determination of whether the transfer was made to qualify for Medicaid does not include a consideration of the merits of the transfer, but whether the applicant has proven that the asset was transferred exclusively for some other purpose, the only circumstance in which presumption is successfully rebutted. In the absence of evidence rebutting that presumption, the existence of such transfers afforded grounds for denial of the application. S.M. v. DMAHS, OAL DKT. NO. HMA 11842-12, 2014 N.J. AGEN LEXIS 338, Initial Decision (June 20, 2014).

Action of the Division of Medical Assistance and Health Services and the Camden County Board of Social Services denying an application for Nursing Home Medicaid was reversed. An irrevocable trust was created before the sixty month Medicaid long back period began. The checks written to the nursing home from the trust during the look back period were made payable to the nursing home, obviously for the applicant's care and for her benefit. The remaining checks written during the look back period appeared to be for the maintenance of the property that was contained in the trust and for taxes. These payments were for the benefit of the applicant with the exception of one check written payable to cash, which was considered not to be for her benefit under N.J.A.C. 10:71-4.11(e)1iii. Thus, the applicant's resources were under $2,000 pursuant to N.J.A.C. 10:71-4.5(c). J.S. v. Camden Cnty. Bd. Social Serv. and Div. of Medical Assistance and Health Serv., OAL Dkt. No. HMA 11618-13, 2014 N.J. AGEN LEXIS 280, Initial Decision (May 20, 2014).

Camden County Board of Social Services and Division of Medical Assistance and Health Services improperly denied an application for Nursing Home Medicaid. The administrative law judge concluded that the applicant's trust was irrevocable and the only payment from the trust that was not made to or for her benefit under N.J.A.C. 10:71-4.11(e)1iii was a payment for cash in the amount of $500. As a result, her assets at the time of her application for Medicaid placed her resources at under $2,000 pursuant to N.J.A.C. 10:71-4.5(c). Camden Cnty. Bd. of Social Serv. and Div. of Medical Assistance and Health Serv., OAL Dkt. No. HMA 11618-13, 2014 N.J. AGEN LEXIS 272, Initial Decision (May 20, 2014).

Division of Medical Assistance and Health Services improperly denied Medicaid eligibility to an applicant on the grounds that her resources exceeded the Community Care Waiver/Medicaid Only resource eligibility standard pursuant to N.J.A.C. 10:71-4.5. Although the applicant owned two life insurance policies with cash value that was available to her in the sense that she had the right to liquidate those policies, she had Down's Syndrome and lacked the capacity to deal with the policies. Because the policies were not accessible to the applicant through no fault of her own, they were excludable and should not have been counted as a resource. P.M. v. Div. of Med. Assistance and Health Serv., OAL Dkt. No. HMA 18597-13, 2014 N.J. AGEN LEXIS 266, Initial Decision (May 12, 2014).

Administrative law judge (ALJ) recommended a revision of the approval of a Medicaid application to reflect an earlier effective date. The preponderance of the credible evidence clearly established that the DHAHS and County Board of Social Services (agency) failed to process the application in a timely manner pursuant to N.J.A.C. 10:71-2.3(a),

allowing the ALJ to afford minimal deference to the agency's witness, and no evidence existed to establish that the applicant's available assets exceeded the $2,000 threshold at the time of the application as required by N.J.A.C. 10-71-4.5(b). The undisputed credible evidence demonstrated that the all funds that were in the applicant's bank accounts were not accessible to him through his sole temporary guardian. Once his permanent guardian was appointed and the applicant's assets were transferred, the Office of the Public Guardian took immediate steps to ensure that those funds were used to pay the nursing home facility for the applicant's costs of care, pharmacy and pre-paid burial. J.T. v. DMAHS and Hudson Cnty. Bd. Of Social Servs., OAL Dkt. No. HMA 15301-12, 2014 N.J. AGEN LEXIS 52, Initial Decision (March 7, 2014).

Camden County Board of Social Services and the Division of Medical Assistance and Health Services incorrectly denied Medicaid eligibility to applicants pursuant to N.J.A.C. 10:71-4.5 and assessed a transfer penalty based upon the sale of their home within five years before applying for Medicaid pursuant to N.J.A.C. 10:71-4.10(a) and -4.10(b)(9)(iv). The last tax assessment for the applicants' home was done before the decline of the housing market, and by the date of the transfer, the property was outdated, had termite and structural damage, and needed substantial renovation. W.S. v. Div. of Medical Assistance and Health Serv. and Camden Cnty. Bd. Of Social Serv., J.S. v. Div. of Medical Assistance and Health Serv. and Camden Cnty. Bd. Of Social Serv., OAL Dkt. Nos. HMA 10521-13, HMA 10523-13, 2014 N.J. AGEN LEXIS 50, Initial Decision (March 6, 2014).

Expert testimony demonstrated that an annuity could be converted to cash and thus was an available resource for purposes of a nursing facility resident's application for Medicaid benefits under the Medically Needy program; the annuity, purchased by the applicant, a widow, for $195,710, was to pay the applicant $1,740.85 per month for 10 years and stated on its face that it was non-assignable (adopting 2007 N.J. AGEN LEXIS 209). D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546, Final Decision (June 11, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546, Final Decision (June 11, 2007).

Custodial bank accounts of Medicaid applicant's children were not available to applicant or her husband and thus were not countable resources in determining applicant's eligibility for the Nursing Home Medicaid program for the year in question; the accounts, created years before applicant's entry into the nursing home, were governed by the New Jersey Uniform Transfers to Minors Act, N.J.S.A. 46:38A-1 et seq. L.A.S. v. Union County Div. of Soc. Servs., OAL Dkt. No. HMA 1215-05, 2006 N.J. AGEN LEXIS 348, Initial Decision (April 26, 2006).

Where trust property was described, in testimony, as the family home, and under the Trust Agreement co-trustees could in their sole discretion distribute all or any part of the trust principal reasonably necessary for the Settlor's care, support, and maintenance, and where a provision requiring the trustee to take into account any funds that may be available to the Settlor to meet those needs from any source other than the trust, which would presumably include Medicaid funds, flew in the face of the law and public policy, the applicant and his wife had resources in excess of the maximum permitted under the regulation. J.C. v. DMAHS, OAL Dkt. No. HMA 7550-05, 2006 N.J. AGEN LEXIS 349, Initial Decision (April 25, 2006).

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

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

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

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

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

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

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

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

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

10:71-4.6 Deeming of resources

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

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

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

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

(d) Applicant/beneficiary living with ineligible spouse: If the applicant/beneficiary lives with an ineligible spouse, all countable resources of the ineligible spouse are deemed to the applicant/beneficiary. The value of the total countable resources is compared to the resource maximum for a couple.

Such individuals will continue to have resources treated in this manner until they have been separated for one full calendar month. At such time, the individuals will be considered to be living alone.

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

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

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

2. Parental resource maximums (including stepparents):

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

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

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

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

As amended, R.1983 d.373, effective September 6, 1983.
See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a).
Added, deeming resources of alien's sponsor.
Amended by R.1985 d.474, effective September 16, 1985.
See: 17 N.J.R. 1525(a), 17 N.J.R. 2274(a).
Substantially amended.
Amended by R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Added (c)1. Deleted statement regarding physician's certification and added text establishing resources counted when one member of a couple is institutionalized.
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiary" for "recipient" throughout.

Case Notes

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

Sufficient evidence supported the determination of a county board of social services that the funds in a bank account in the names of the applicant and her daughter were a resource of the applicant and were properly counted in determining the applicant's resources for the purposes of qualifying for participation in the Medicaid Only Program. Since those funds well exceeded the ceiling for eligibility, the applicant was properly found to be ineligible. M.H. v. Mercer Cnty., Bd. of Social Servs., OAL DKT. NO. HMA 16444-15, 2016 N.J. AGEN LEXIS 142, Initial Decision (March 17, 2016).

Determination by the Division of Medical Assistance and Services (DMAHS) and a county Board of Social Services denying an application for Medicaid filed on behalf of an elderly women who had dementia and resided in a nursing home based on her joint ownership, with an adult son who was permanently disabled, of stock valued at $89,309.28 was unsupported by the evidence and properly rejected. The son, a permanently incapacitated adult who permanently resided in a VA hospital, was totally blind, had no recollection of his mother being alive, and refused to sign any documents relating to the stock. Given the son's condition, it could not be said that the assets at issue were accessible to the mother because she had no power to liquidate them without her son's approval, and thus the stocks could not be included as countable resources of the applicant according to governing regulations. To the extent that the determination of ineligibility relied on the existence of the stocks, it was incorrect, and the applicant was entitled to an order granting her application for Medicaid. F.F. v. DMAHS and Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 00793-15, 2015 N.J. AGEN LEXIS 318, Initial Decision (June 3, 2015).

Applicant for Nursing Home Medicaid (NHM) was improperly denied eligibility on the ground that her resources of $6,725.44 from several bank accounts exceeded the $2,000 Medicaid eligibility limit. Specifically, an investment account holding $5,658.88 should not have been counted as a resource of the applicant notwithstanding that her name was listed as a joint tenant thereon because the applicant's daughter, who was the source of all deposits into that account, credibly testified that she had added her mother's name to the account at a time when she was residing with her mother; and that her mother was currently an "incapacitated" person and the daughter had been appointed as her mother's temporary guardian. The daughter's testimony was forthright, sincere and uncontroverted. Given that fact and given the further fact that the mother's incapacity foreclosed her from independently accessing the investment account, the funds held therein should not have been counted as the mother's resources for purposes of NHM eligibility. F.J. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 15125-14, 2015 N.J. AGEN LEXIS 261, Initial Decision (April 30, 2015).

An Administrative Law Judge (ALJ) concluded that the Bergen County Board of Social Services erred when, relying on N.J.A.C. 10:72-4.5(b)3, it denied a Medicaid application filed by an elderly husband (Husband) and imposed a transfer penalty of 17 months and 20 days, making Husband's eligibility date September 21, 2014, based on its finding that the assets represented by three certificate of deposit (CDs) accounts titled to his wife (Wife) and Wife's sister (Sister) constituted resources within the meaning of N.J.A.C. 10:71-4.6 that were "available" to Husband within the meaning of N.J.A.C. 10:71-4.1(c) and could be converted to cash and used for the Husband's support and maintenance. Wife and Sister's submission on that issue, which included a statement from the financial institution where the accounts were held, established that the funds used to obtain the CDs were owned in toto by Sister, who was elderly, had no children, and lived alone; and that Sister's intention, in titling the accounts as she did, was to assure that Wife would have access to the funds in the event that Sister became incapacitated or to pay for her funeral expenses. Because the submission met the standards in N.J.A.C. 10:71-4.10(*o*)3 and established that the funds were not a resource of Husband, the ALJ concluded that there was no basis for the imposition of a transfer penalty. W.Z. v. Bergen Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 16767-13, AGENCY Dkt. No. 021016511201, 2014 N.J. AGEN LEXIS 99, Initial Decision (February 7, 2014).

Custodial bank accounts of Medicaid applicant's children were not available to applicant or her husband and thus were not countable resources in determining applicant's eligibility for the Nursing Home Medicaid program for the year in question. L.A.S. v. Union County Div. of Soc. Servs., OAL Dkt. No. HMA 1215-05, 2006 N.J. AGEN LEXIS 348, Initial Decision (April 26, 2006).

10:71-4.7 (Reserved)

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.
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (d)2, substituted "Medical Review Team" for "Disability Review Section"; in (i), substituted "beneficiaries" for "recipients".
Amended by R.2001 d.199, effective June 18, 2001.
See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).
In (a), rewrote the introductory paragraph; in (b), inserted "shall" preceding "apply" in the introductory paragraph.
Petition for Rulemaking.
See: 39 N.J.R. 2157(a), 2660(a), 4453(a).
Petition for Rulemaking.
See: 42 N.J.R. 1434(a), 1918(a), 2645(a).
Repealed by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Section was "Transfer of resources".

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 request for a resource assessment in accordance with N.J.A.C. 10:71-4.9 or at the time of application for Medicaid benefits. The total countable resources of the couple shall include all resources owned by either member of the couple individually or together. The county welfare agency 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 $117,240, as indexed annually in accordance with 42 U.S.C. § 1396r-5(g) and published as a notice in the New Jersey Register, and unless authorized in (a)4 or 5 below. The community spouse's share of the couple's resources shall be the greater of:

i. $23,448, as indexed annually in accordance with 42 U.S.C. § 1396r-5(g) and published as a notice in the New Jersey Register; or

ii. One half of the couple's combined countable resources.

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

i. In the case of an individual whose eligibility for institutional care is determined in accordance with the rules applicable for New Jersey Care (see N.J.A.C. 10:72), 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. 10:71-4.10.

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. 10:71-4.10.

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

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

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

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

New Rule, R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Emergency Amendment, R.1992 d.84, effective January 22, 1992, operative January 1, 1992, (expires March 22, 1992).
See: 24 N.J.R. 651(a).
Resource eligibility revised upward.
Adopted concurrent amendment, R.1992 d.191, effective April 20, 1992.
See: 24 N.J.R. 651(a), 24 N.J.R. 1498(b).
Provisions of emergency amendment, R.1992 d.84, readopted without change.
Amended by R.1993 d.402, effective August 16, 1993.
See: 25 N.J.R. 1818(a), 25 N.J.R. 3786(a).
Amended by R.1994 d.428, effective August 15, 1994.
See: 26 N.J.R. 1754(a), 26 N.J.R. 3478(a).
Amended by R.1996 d.46, effective January 16, 1996.
See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).
In (a)1 and (a)1i resource eligibility revised upward.
Amended by R.1996 d.466, effective October 7, 1996.
See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "board of social services" for "welfare agency" in the introductory paragraph, substituted "$84,120" for "$76,740" in the introductory paragraph of 1, substituted "$16,824" for "$15,348" in 1i, and substituted "CBOSS" for "CWA" throughout.
Amended by R.2001 d.199, effective June 18, 2001.
See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).
In (a), rewrote the third and fourth sentences of the introductory paragraph, substituted "$84,120, as indexed annually in accordance with 42 U.S.C. § 1396r-5(g) and published as a notice in the New Jersey Register, and" for "$74,740" in 1, and rewrote 1i.
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).
In (a)1, substituted "$92,760" for "$84,120" in the introductory paragraph, and substituted "$18,552" for "$16,824" in i.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (a)1, substituted "$95,100" for "$92,760"; and in (a)1i, substituted "$19,020" for "$18,552".
Public Notice: Notice of Increase in the Community Spouse's Share of a Couple's Combined Countable Resources.
See: 39 N.J.R. 705(b).
Public Notice: Notice of Increase in the Community Spouse's Share of a Couple's Combined Countable Resources.
See: 40 N.J.R. 2295(a).
Public Notice: Notice of Increase in the Community Spouse's Share of a Couple's Combined Countable Resources.
See: 41 N.J.R. 2507(a).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In the introductory paragraph of (a), substituted "welfare agency" for "board of social services" twice; in (a)1, substituted "$109,560" for "$95,100"; in (a)1i, substituted "$21,912" for "$19,020"; in (a)2i, deleted "et seq." following the N.J.A.C. reference; in the introductory paragraph of (a)3, substituted "CWA" for "CBOSS"; and in (a)4 and (a)5, updated the N.J.A.C. reference.
Administrative change.
See: 44 N.J.R. 1780(b).
Administrative change.
See: 45 N.J.R. 1960(b).
Administrative change.
See: 47 N.J.R. 115(a).

Case Notes

Income subject to transfer from an institutionalized spouse was not limited to the income he was earning as of the date when the couple's resources were allocated for purposes of determining Medicaid Only eligibility. The other spouse's minimum monthly maintenance needs allowance deficit could be made up with the Social Security disability income the institutionalized spouse was reasonably expected to earn

thereafter. N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

Claimant was not eligible for Medicaid Only Benefits for nursing home costs because, as of the first day of the month of the current period of institutionalization, his resources exceeded the maximum amount permitted by N.J.A.C. 10:71-4.5(c). N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

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

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

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

VA benefits payable to an institutionalized spouse that resulted from unusual medical expenses (UMEs) incurred by the institutionalized spouse were properly excluded as income in determining whether, per N.J.A.C. 10:71-4.8 and N.J.A.C. 10:71-5.7, the community spouse was entitled to an increased community spouse resource allowance. R.B. v. DMAHS and Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15134-12, 2016 N.J. AGEN LEXIS 210, Initial Decision (April 15, 2016).

Community spouse was entitled to an additional allowance to be made as a part of her minimum monthly maintenance needs allowance (MMMNA) due to her deteriorating medical condition so that the spouse had funds to defray the costs of prescriptions and therapy. However, her MMMNA was not properly increased on account of other expenses such as utilities, credit card payments or lawn care nor could the MMMNA be increased to fund the retrofitting of the community spouse's existing home, which was estimated to cost more than $40,000. R.B. v. Warren Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 04303-15, 2015 N.J. AGEN LEXIS 688, Initial Decision (August 27, 2015).

Spouse of a terminally ill husband met the "exceptional circumstances" standard of proof and was entitled to an increased Minimum Monthly Maintenance Needs Allowance equal to her spouse's net income after deduction for his personal-needs allowance, his medical insurance premiums, and any funds already paid to the spouse. "Exceptional circumstances" resulting in financial duress pursuant to 42 U.S.C.S. § 1396r-5(e)(2)(B) and cognate state law included the substantial debt she had already incurred to care for her husband and for her now-deceased minor child, who died from the same disease that now afflicted her husband, the fact that the facility in which her husband lived (and where he now was receiving hospice care) was suing her for $63,000, her limited earning opportunities, her own medical and dental problems. Under these circumstances, the amount otherwise allocable to the spouse as the "community spouse resource allowance" was demonstrably insufficient. R.L.W. v. DMAHS and Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 8511-10, 2014 N.J. AGEN LEXIS 825, Initial Decision (December 15, 2014).

A county board of social services (CBSS) acted properly in denying Medicaid eligibility to a husband who was already a resident of a care center because the husband, who bore the burden of proof per N.J.A.C. 10:71-4.10(j), did not establish that sufficient verification of spend-down had been provided to CBSS. Moreover, the couple's resource assessment as determined per the criteria in N.J.A.C. 10:71-4.8(a) indicated total resources of $414,458.15, far in excess of the maximum for the husband, which was $211,229. R.K. v. Burlington Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 16823-13, AGENCY DKT. NO. 0310030815, 2014 N.J. AGEN LEXIS 341, Initial Decision (June 18, 2014).

Resources of a Medicaid applicant's ex-wife that were acquired during the couple's 23-year separation but prior to their Pennsylvania divorce could not be considered as available to the applicant for the purpose of determining the countable resources of the couple pursuant to N.J.A.C. 10:71-4.8; the applicant's rights to those resources were determined by Pennsylvania law, and a valid Pennsylvania divorce decree was issued indicating that the applicant had no legal rights to those resources. S.P. v. DMAHS, OAL Dkt. No. HMA 10019-07, 2008 N.J. AGEN LEXIS 304, Initial Decision (April 14, 2008).

Initial Decision (2007 N.J. AGEN LEXIS 189) adopted, which concluded that in calculating the Community Spouse Resource Allowance, repayments on home equity loans or lines of credit are not deductible as a shelter expense unless there is a direct relationship to preserving the marital home, such as when the loan proceeds are used for major repairs or capital improvements necessary to protect the home. A.F. v. DMAHS, OAL Dkt. No. HMA 12301-06, 2007 N.J. AGEN LEXIS 330, Final Decision (May 24, 2007).

Custodial bank accounts of Medicaid applicant's children were not available to applicant or her husband and thus were not countable resources in determining applicant's eligibility for the Nursing Home Medicaid program for the year in question. L.A.S. v. Union County Div. of Soc. Servs., OAL Dkt. No. HMA 1215-05, 2006 N.J. AGEN LEXIS 348, Initial Decision (April 26, 2006).

Where trust property was described, in testimony, as the family home, and under the Trust Agreement co-trustees could in their sole discretion distribute all or any part of the trust principal reasonably necessary for the Settlor's care, support, and maintenance, and where a provision requiring the trustee to take into account any funds that may be available to the Settlor to meet those needs from any source other than the trust, which would presumably include Medicaid funds, flew in the face of the law and public policy, the applicant and his wife had resources in excess of the maximum permitted under the regulation. J.C. v. DMAHS, OAL Dkt. No. HMA 7550-05, 2006 N.J. AGEN LEXIS 349, Initial Decision (April 25, 2006).

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).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b) and (c), substituted "board of social services" for "welfare agency" throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "welfare agency" for "board of social services" throughout; and in (b)1, substituted "third-party" for "third party".

10:71-4.10 Transfer of assets

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

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

1. Individual means:

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

ii. The individual's spouse;

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

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

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

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

i. Irrevocably waiving pension income;

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

iii. Not accepting or accessing injury settlements;

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

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

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

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

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

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

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

iii. Under a life estate, an individual who owns property transfers the ownership of that property to another individual, while retaining for the rest of his or her life, or the life of another person, certain rights to that property. A life estate entitles the owner of the life estate to possess, use and obtain profits from the property, as long as he or she lives, although actual ownership of the property has passed to another individual. In a transaction involving a life estate, a transfer of assets is involved. In determining whether a penalty shall be assessed in the case of a transfer involving a life estate, the value of the asset transferred and the value of the life estate shall be computed. The value of the asset transferred is computed by determining the fair market value. The value of the life estate is calculated in accordance with the life estate table published by the Centers for Medicare and Medicaid Services (CMS) at 49 FR Vol. 49 No. 93, 5-11-84 and 26 CFR 20.2031-7. The value of the life estate is determined by multiplying the current market value of the property by the life estate factor that corresponds to the grantor's age. The value of the life estate is then subtracted from the value of the asset transferred to determine the portion of the asset that was transferred for less than fair market value. If only the value of the transferred portion is needed, the current market value of the asset is multiplied by the remainder factor. The transfer in which a life estate is retained shall be considered a transfer for less than fair market value whenever the value of the asset transferred is greater than the value of the rights conferred by the life estate. The purchase of a life estate interest shall be treated as a transfer of assets for less than fair market value unless the purchaser actually lives in the home for at least one full year after the date of purchase.

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

8. In order for a transfer of assets to be considered to be for the sole benefit of a spouse, disabled child or disabled individual under the age of 65, for the purposes of this subchapter, the transfer shall have been arranged in such a way that no individual except the spouse, disabled child or disabled individual under age 65 can, in any way, benefit from the assets transferred either at the time of the transfer, or at any time in the future. For the purpose of this subchapter, the person administering the funds shall only be compensated for the reasonable costs that can be directly attributable to the administration of the funds and for compensation for that administration. In no event shall such compensation exceed the amounts allowed by law for the administration of trusts. The transfer of asset penalty exemption for transfers made for the sole benefit of the spouse, disabled child or disabled individual under the age of 65 does not impact the treatment of a trust pursuant to N.J.A.C. 10:71-4.11.

i. If the transfer instrument provides that there are beneficiaries other than a blind or disabled child, or a disabled individual under the age of 65, the sole benefit requirement shall not have been met if the instrument fails to provide that the State shall be the first remaining beneficiary of residual funds prior to disbursement to any other beneficiary.

9. The look-back period shall be 60 months.

i. In the case of an individual who is already eligible for Medicaid benefits, the look-back period shall be the 60-month period prior to the date the individual becomes institutionalized.

ii. In the case of an individual not already eligible for Medicaid benefits, the look-back period shall be the 60-month period prior to the date the individual applied for Medicaid as an institutionalized individual.

iii. When a portion of a trust is treated as a transfer, the look-back period shall be 60 months from the date the individual applied for Medicaid as an institutionalized individual, or for a non-institutionalized individual, the date the individual applied for Medicaid, or, if the date the transfer was made is later, then the date the transfer was made (see N.J.A.C. 10:71-4.11(e)1iii).

iv. Penalties of ineligibility shall be assessed for transfers which take place during or after the look-back period. Periods of ineligibility cannot be imposed for resource transfers which take place prior to the look-back period.

(c) 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 assets (including any interest in an asset or future rights to an asset) within the look-back period, the following steps shall be taken and shall be fully documented in the case record:

1. The fair market value (FMV) of the asset shall be ascertained;

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

3. The amount of the UV, if any, shall be added to the amount of the other countable resources;

4. The period of ineligibility for institutional level services that would result from the asset transfer shall be determined (see N.J.A.C. 10:71-4.10(*l*));

5. In all cases where the amount of uncompensated value would result in a period of ineligibility, the applicant shall be notified of the determination via Form PA-13. The Form PA-13 shall advise the applicant that he or she may rebut the presumption that an asset was transferred at less than fair market value in order to qualify for Medicaid coverage for institutional level care (see (i) below).

(d) The provisions of this section shall apply whether or not the asset would have been considered excluded or exempt 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 legally married spouse of the individual;

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. 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 Team of the Division of Medical Assistance and Health Services, in accordance with 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 for the purposes of this subchapter shall have exceeded normal personal support activities (for example, routine transportation and shopping). The individual's physical or mental condition shall have been such as to require special attention and care. The care provided by the son or daughter shall have been essential to the health and safety of the individual and shall have 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 application of a transfer penalty as set forth in this section shall not apply when:

1. The assets were transferred to a trust established for the sole benefit of an individual under 65 years of age who is disabled as defined by the Social Security Administration;

2. The assets were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse;

3. The assets were transferred from the individual's spouse to another for the sole benefit of the individual's spouse (see N.J.A.C. 10:71-4.10(b) 7);

4. The assets 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;

5. The assets were transferred from the individual or individual's spouse to the 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 Unit of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13; or

6. A satisfactory showing is made, to the State that:

i. The individual intended to dispose of the assets at either fair market value or for other valuable consideration;

ii. The assets were transferred exclusively for a purpose other than to qualify for medical assistance; or

iii. All assets transferred for less than fair market value have been returned to the individual.

(f) In determining whether an asset was transferred for the sole benefit of a spouse, child or disabled individual as defined in N.J.A.C. 10:71-4.10(b) 8, the transfer shall be accomplished via a written instrument of transfer, such as a trust document, which legally binds the parties to a specific course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. Moreover, the written instrument shall state that the State of New Jersey shall be the first remaining beneficiary. A transfer without such a document shall not be considered to have been made for the sole benefit of the spouse, child or disabled individual.

(g) When the asset was transferred at fair market value, the application shall be processed as usual. No special procedure shall be required.

(h) When the uncompensated value of transferred assets would result in no period of ineligibility for long-term care level services, the application shall be processed as usual.

(i) When the uncompensated value of transferred assets results in a period of ineligibility for long-term care level services, eligibility for long-term care services shall be denied and the procedures below shall be followed:

1. The applicant shall be notified via Form PA-13 that there has been a transfer of assets for less than fair market value, the amount of the uncompensated value and the length of the penalty period. The Form PA-13 shall state that the law presumes that a transfer of assets at less than fair market value is for the purpose of establishing Medicaid eligibility for long-term level care services.

2. The applicant shall be advised that he or she may rebut the presumption that the transfer of assets was for the purpose of establishing Medicaid eligibility (see (j) below).

(j) Any applicant or beneficiary may rebut the presumption that assets were transferred to establish Medicaid eligibility by presenting convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose. The applicant shall be assisted in obtaining information when necessary. However, the burden of proof shall rest with the applicant. When the applicant expresses the desire to rebut the presumption that he or she transferred assets to establish Medicaid eligibility, the procedures below shall be followed.

1. The applicant's statement concerning the circumstances of the transfer shall be included in the case record. The statement shall include, but need not be limited to, the following:

i. The applicant's stated purpose for transferring the asset;

ii. The applicant's attempt to dispose of the asset at fair market value;

iii. The applicant's reasons for accepting less than the fair market value for the asset;

iv. The applicant's means of and plans for, supporting himself or herself after the transfer; and

v. The applicant's relationship, if any, to the person(s) to whom the asset was transferred.

2. The applicant shall be asked to submit any pertinent evidence (for example, legal documents, realtor agreements, and relevant correspondence) with regard to the transfer.

3. Statements shall be taken from other individuals, if such statements are material to the decision. The statement shall indicate if such individual has or had a relationship with the applicant and the extent of the relationship (that is, related by blood or marriage, friendship).

(k) The presence of one or more of the following factors, while not conclusive, may indicate that the assets were transferred exclusively for some purpose other than establishing Medicaid eligibility for long term care services:

1. The occurrence after transfer of the asset of:

i. Traumatic onset of disability;

ii. Unexpected loss of other assets which would have precluded Medicaid eligibility; or

iii. Unexpected loss of income which would have precluded Medicaid eligibility;

2. Court-ordered transfer (when the court is not acting on behalf of, or at the direction of, the individual or the individual's spouse); or

3. Evidence of good faith effort to transfer the asset at fair market value.

(*l*) Agency determination pursuant to client rebuttal shall be as follows:

1. The presumption that assets were transferred to establish Medicaid eligibility shall be considered successfully rebutted only if the applicant demonstrates that the asset was transferred exclusively for some other purpose.

2. If the applicant had some other purpose for transferring the asset, but establishing Medicaid eligibility appears to have been a factor in his or her decision to transfer, the presumption shall not be considered successfully rebutted.

3. The agency's determination shall not include an evaluation of the merits of the applicant's stated purpose of transferring assets. The determination shall 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 at the county welfare agency and shall be documented in the case record.

5. The applicant shall be sent a notice of the decision, which shall include information on his or her right to a fair hearing in accordance with N.J.A.C. 10:49-10.

(m) For the purposes of this subchapter, the penalty period shall be the period of time during which payment for long-term care level services is denied. An institutionalized individual who is ineligible for payment of long-term care services as a result of an asset transfer shall be precluded from eligibility, but shall be entitled to ancillary services if otherwise eligible.

1. In accordance with 42 U.S.C. §1396p(c)(1)(E), the penalty period for asset transfer shall be the number of months equal to the total, cumulative uncompensated value of all assets transferred by the individual, on or after the look-back date, divided by the average monthly cost of nursing home services in the State of New Jersey adjusted annually in accordance with the change in the Consumer Price Index-All Urban Consumers, rounded up to the nearest dollar. The annual adjustment to the average cost of nursing home services in New Jersey shall be published as a notice of administrative change in the New Jersey Register. As of November 2009, the average monthly cost is $7,282. The penalty period shall begin with the date of the resource transfer. As of November 2009, the current daily divisor is $239.41. A penalty shall be calculated for partial months of ineligibility. There shall be no limit on the length of the penalty period.

i. For the purpose of determining a penalty period, the transfer of real property shall be considered to have occurred the date the title is recorded or registered with the appropriate office.

ii. When calculating the penalty period, all of the whole months are calculated first, using the monthly average in (m)1 above; then remaining days are calculated using the daily divisor. The resulting figures will provide the length of the penalty period in months and days.

2. In the case of an asset transfer which occurs during an existing asset transfer penalty period, the penalty for the subsequent transfer shall not begin until the expiration of the previous penalty period.

3. When assets have been transferred in amounts and/or frequencies that would make the calculated penalty periods overlap or structured to run consecutively, the uncompensated value of all the asset transfers shall be added together and divided by the average cost of nursing home care. This will result in a single penalty period, beginning on the first day of the month in which the first transfer was made. For example: An individual transfers $15,000 in January, $15,000 in February, and $15,000 in March. Calculated individually, the penalty periods would overlap. Because the three penalty periods overlap, each of the asset transfers shall be added together and divided by the average cost of nursing home care creating a single penalty period beginning on January 1.

4. When assets have been transferred in such a way that the penalty periods would not overlap, or are not structured to run consecutively, each asset transfer shall be treated as a separate event, each with its own penalty period. For example: An individual transfers $15,000 in January, $15,000 in November and $15,000 in March of the following year. The penalty period for the January transfer would be January and February. The penalty for the November transfer would be November and December. The penalty period for the March transfer would be March and April of the following year.

(n) When an individual's income is given or assigned in some manner, such gift or assignment shall be considered an asset transfer. The following standards shall be used to determine the penalty period:

1. Income, in order to be considered transferred, shall have been irrevocably assigned or otherwise unavailable to the individual. If income has been waived or deferred and that waiver or deferral can be reversed, the waived or deferred income shall be considered available to the individual, regardless of whether the income is actually received, and shall be counted in the determination of eligibility.

2. In the event an individual gives up his or her rights to receive a lump sum payment or transfers a lump sum payment in the month it is received, the period of ineligibility shall be based on the amount of the lump sum payment to which he or she was otherwise entitled.

3. In the event a stream of income (that is, income received on a regular basis), such as a pension, is transferred, the county welfare agency shall make a determination of the total projected amount of income that has been transferred, based on the individual's life expectancy. This determination shall be based on the most recent life expectancy tables published by the Centers for Medicare and Medicaid Services. In determining the projected amount, the county welfare agency shall strictly adhere to the life expectancy tables without adjustment for the individual's medical condition or other factors. The projection shall be based on the value of the income at the time of transfer and there shall be no attempt to account for future cost-of-living adjustments over the life expectancy of the individual.

4. In determining if there has been a transfer of income, the county welfare agency need not ascertain the individual's spending habits over the appropriate look-back period. Unless there is a reason to believe otherwise, the county welfare agency shall assume that the individual's income was legitimately spent on the normal costs of living. The county welfare agency may ask questions of the applicant and/or the applicant's representative concerning past and present sources and levels of income and whether the individual has transferred income to others.

(*o*) When an asset is held by an individual in common with another person or persons via joint tenancy, tenancy in common, joint ownership, or similar arrangements, the asset (or the affected share of the asset) shall be considered to be transferred by the individual when any action is taken, either by the individual or any other person, that reduces or eliminates the individual's ownership or control of the asset.

1. If the addition of another name to the ownership of an asset does not change the individual's ownership interest, the action does not constitute a resource transfer. For instance, if another name is added to an individual's account with the term "or," the individual shall not be considered to have transferred assets since he or she continues to have unrestricted access to the funds. In the event the newly added owner subsequently withdraws the funds from the account, that action shall be considered to be a transfer by the individual. The transfer shall be considered to have occurred on the date that the funds are withdrawn from the account.

2. If the addition of another name to the ownership of an asset restricts the individual's access, right to sell or otherwise dispose of the asset (for example, the addition of another name requires that the new co-owner(s) agree to the sale or disposal of the asset where no such agreement was necessary before), the addition of the name shall constitute a transfer of assets. The transfer shall be considered to have occurred on the date that the additional name was added to the account. In the case of real property for the purpose of this chapter, if another name is added to a deed, the transfer shall be considered to have occurred the date the new deed is recorded.

3. N.J.A.C. 10:71-4.1 shall apply to determine what portion of a jointly owned resource is presumed to belong to the individual. Any portion belonging to the individual that is withdrawn by another owner shall be considered a transfer of assets. If the individual can satisfactorily establish that the withdrawn funds were, in fact, the sole property of, and were contributed to the account by the other owner, and thus never belonged to the individual, the withdrawal of those funds shall not result in the imposition of an asset transfer penalty.

(p) Annuity provisions shall be as follows:

1. Any annuity purchase in which the entity issuing the annuity is not a commercial financial institution shall be considered to be a transfer of an asset in order to qualify for Medicaid benefits, regardless of the terms of the annuity payout. The entire amount transferred into such an annuity shall be the amount considered in determining eligibility.

2. Any commercial annuity purchased which is not actuarially sound, based on the life expectancy of the individual (as set forth in life expectancy tables published by the Centers for Medicare and Medicaid Services) or term certain (the length of payout is specified and payment does not terminate upon the death of the annuitant) shall be considered to be a transfer of an asset in order to qualify for Medicaid benefits. In the event that an annuity is not actuarially sound at the time of purchase, the amount that shall be considered to have been transferred at less than fair market value shall be that proportion of the annuity purchase price which is not actuarially sound. This shall be the same proportion as the amount by which the pay-out period exceeds the life expectancy of the individual at the time of the annuity purchase. (Life expectancy divided by the payout period of the annuity multiplied by the purchase amount of the annuity is subtracted from the total amount of the annuity to determine the uncompensated value.)

(q) Upon imposition of a period of ineligibility for long-term care level services because of an asset transfer, the county welfare agency shall notify the applicant/beneficiary of his or her right to request an undue hardship exception. An applicant/beneficiary may apply for an exception to the transfer of asset penalty if he or she can show that the penalty will cause an undue hardship to him- or herself. The applicant/beneficiary shall provide sufficient documentation to support the request for an undue hardship waiver to the county welfare agency within 20 days of notification of the transfer penalty. Within 30 days of receipt of such documentation, the CWA shall issue notice to the applicant/beneficiary of its determination.

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

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

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

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

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

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

New Rule, R.2001 d.199, effective June 18, 2001.
See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).
Petition for Rulemaking.
See: 35 N.J.R. 1456(a), 2532(b).
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).
In (m), rewrote 1, and substituted "$15,000" for "$12,000" throughout 4.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (m)1, substituted "2005" for "2003" and substituted "$6,525" for "$6,050"; and deleted (p)2i.
Petition for Rulemaking.
See: 39 N.J.R. 2157(a), 2660(a), 4453(a).
Petition for Rulemaking.
See: 42 N.J.R. 1434(a), 1918(a), 2645(a).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Rewrote the section.

Law Review and Journal Commentaries

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

Case Notes

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

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

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

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

Eligibility penalty was properly imposed on an elderly man's application for skilled nursing home Medicaid benefits based on $247,104 in transfers during the look-back period. Though the applicant's representative claimed that the bulk of those payments was made to compensate a woman who provided care to the applicant, there was no evidence whatever that the recipient of those payments actually rendered services to the applicant and it thus was properly presumed that they were transfers for less than fair market value for the purpose of establishing Medicaid eligibility. A.M. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 17835-2015, 2016 N.J. AGEN LEXIS 200, Initial Decision (April 15, 2016).

Use of funds belonging to an applicant for Medicaid to purchase an immediate, irrevocable, non-transferrable, actuarially sound annuity, which named the State of New Jersey as the first remainder beneficiary, did not provide a basis for the imposition of a transfer penalty by a county division of social services. Proceeds of the annuity were clearly intended to pay for the applicant's nursing home bills during the 536.25 day penalty period imposed on account of the applicant having made a gift to her children in the amount of $ 178,353.51. Because the annuity met the criteria in 42 U.S.C.S. § 1396p(c)(1), the funds used to purchase it were not countable as a resource for eligibility purposes. M.N. v. Hunterdon Cnty. Div. of Social Servs., OAL DKT. NO. HMA 00688-16, 2016 N.J. AGEN LEXIS 198, Initial Decision (April 14, 2016).

Medicaid Only Institutional benefits were properly denied by a county board of social services to an elderly applicant on the ground that her countable resources exceeded the eligibility ceiling. Though the applicant's caregiver/daughter claimed that the execution by the applicant of a power of attorney giving the daughter total power over all of the applicant's affairs, including her financial affairs, combined with the purported existence of a signed deed to the applicant's house, was sufficient to render the property "inaccessible," the applicant remained the owner of the property and its value was such that she was ineligible for the program. E.C. v. Passaic Bd. of Social Servs., OAL DKT. NO. HMA 16475-15, 2016 N.J. AGEN LEXIS 121, Initial Decision (March 14, 2016).

Applicant was properly denied Medicaid eligibility based on his failure to comply with regulations requiring applicants to produce documentation reflecting his finances over the prior five years. Since it ultimately appeared that the applicant's attorney in fact possessed the information that was needed to complete the application and because the agency had already granted several extensions to the regulatory deadline for submission of such documents, there was merit to the agency's claim

that the only available recourse was against the attorney, not the agency. P.S. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 17263-15, 2016 N.J. AGEN LEXIS 50, Initial Decision (February 8, 2016).

Decision of County Board of Social Services imposing a 34 day transfer penalty on the Medicaid benefits to which an elderly nursing home resident was entitled was rejected by an ALJ because the fair market value of the rent, utilities, food and other expenses that the resident was receiving from her daughter, with whom she lived, completely accounted for the amounts that the resident had paid to her daughter. Because those amounts represented the FMV of what the resident was receiving, no transfer penalty should have been imposed. L.S. v. Morris Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 09660-15, 2016 N.J. AGEN LEXIS 48, Initial Decision (February 5, 2016).

A 99-year old Medicaid applicant failed to rebut the presumption that transfers of her property with an FMV of $30,300 were made in an effort to qualify for Medicaid, and an order imposing a 97 day transfer penalty was approved by an administrative law judge. While the majority of the payments made to a son who claimed that the funds were used for his mother's benefit while she was living with him, there was no rebuttal relating to payments made to petitioner's other son, who was not providing any care to his mother. A.M. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 13679-2015, 2016 N.J. AGEN LEXIS 31, Initial Decision (January 26, 2016).

County agency did not err in determining that the penalty period imposed in connection with an elderly Medicaid claimant's eligibility was not properly reduced due to the existence of a judgment won by the Office of the Public Guardian on behalf of the claimant against his claimant's daughter, who was believed to have wrongfully retained funds belonging to her father. Even if the entire amount of the judgment was collected, which was doubtful, that sum represented only a partial return of the claimant's assets and thus did not afford a basis for any reduction per 42 U.S.C.S. § 1396p(2)(c). R.R. v. Morris Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 03644-15, 2015 N.J. AGEN LEXIS 756, Initial Decision (December 30, 2015).

Son of an elderly Alzheimer's patient qualified as his mother's "caregiver" within the meaning of the "Caregiver's Exemption" in governing regulations because the evidence amply established that the son provided care to his mother that included medication supervision, monitoring of her meals and nutrition, and insuring her safety, which care exceeded "normal personal support activities;" that the mother's condition required special attention and care; and that the care provided by the son was essential to his mother's health and safety. S.E. v. Bergen Cnty., Bd. of Social Servs., OAL DKT. NO. HMA 15582-15 (On remand), 2015 N.J. AGEN LEXIS 723, Initial Decision (December 15, 2015).

Undue hardship exception to the application of a transfer penalty did not apply to a nursing home resident whose guardian was pursuing a claim against the resident's son for allegedly having taken nearly $300,000 of the resident's money and used it on himself and his sister. Although the resident demonstrated that the transferred assets were presently beyond her control and that she had undertaken good faith efforts to recover the assets, she did not irrefutably demonstrate that the assets cannot be recovered or that all remedies had been exhausted because the resident's guardian was currently pursuing legal proceedings against the son. J.K. v. Bergen Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 09932-14, 2015 N.J. AGEN LEXIS 722, Initial Decision (October 26, 2015).

Medicaid applicant successfully rebutted presumption that she had transferred a total of $100,000 in November 2008 for the purpose of qualifying for Medicaid in 2013. The transfers were made as gifts to her other adult children so as to equalize amounts that had been loaned to the daughter with whom she resided. At the time of the gifts, the applicant was still living with her daughter and she intended to live out the remainder of her life in the daughter's home, and her transfer to a nursing home occurred only because she became acutely ill several years after the transfers were made and was no longer able to reside with her daughter. M.M. v. Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 00526-15, 2015 N.J. AGEN LEXIS 686, Initial Decision (October 20, 2015).

ALJ concluded that a board of social services should not have imposed a transfer penalty on the Medicaid eligibility of an applicant based on expenditures equaling $ 114,917 because the applicant's family established that all such funds actually went to pay caregivers who were providing around-the-clock care to the applicant in her home, thereby rebutting the presumption that such funds were transferred for less than fair value in order to qualify the applicant for Medicaid. M.G. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 07800-15 (on remand HMA 13067-14), 2015 N.J. AGEN LEXIS 691, Initial Decision (October 5, 2015).

Because title to a residence owned by an elderly nursing home residence never had been transferred to her son, N.J.A.C. 10:71-4.10(d)4 was inapplicable and there was no reason to consider whether care allegedly provided by the son to his mother exceeded normal personal support activities; whether her condition required special attention and care; or whether the care provided by the son was essential to the mother's health and safety and consisted of required activities. S.E. v. Bergen Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02656-15, 2015 N.J. AGEN LEXIS 721, Initial Decision (August 7, 2015).

Determination by a county board of social services (CBSS) that a penalty of two months and 12 days was properly imposed on the eligibility of an applicant for Medicaid was correct because applicant had transferred $24,034 for less than fair value during the five year look back period. Those funds were principally spent on wedding reception expenses for a granddaughter, pharmacy school tuition and graduation gifts for a granddaughter, and some traditional gifting to family members for Christmas, birthdays and similar events. Though the applicant insisted that these expenditures were consistent with her past practices and were not properly included in an eligibility penalty, the Administrative Law Judge (ALJ) reasoned that once applicant's health took a turn for the worse and she required institutionalization, it no longer remained credible that applicant did not anticipate seeking public assistance at some point in the future. It was untenable for her to argue that she did not in part know that spending monies on her granddaughter's education or wedding or for family gifts that would in earlier times have been perfectly normal meant that she would not have funds to pay for her medical care and might thus qualify for public assistance. D.B. v. Warren Cty. Bd. of Social Servs., OAL DKT. NO. HMA 00529-15, AGENCY REF. NO.W-13781 (Slip Opinion), Initial Decision (May 18, 2015).

Medicaid eligibility of an applicant was properly penalized on account of the uncompensated transfer of $130,945 of the applicant's funds because the applicant failed to prove that the bulk of the funds were used for the applicant's care or that, as also alleged, the remaining funds were used to care for a disabled grandchild. The grandchild, a young adult who suffered from anxiety and related conditions, was never declared to be disabled for any purpose, including for the purposes of Social Security entitlement. Moreover, the grandchild's claim that a substantial part of the funds were spent on the applicant due to the sudden onset of a disability. The state of the evidence was such that the presumption that the transfer of the funds occurred for the purpose of qualifying the applicant for Medicaid was not rebutted. That being so, the applicant's eligibility was properly subjected to a transfer penalty. A.T. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 06961-2014, 2015 N.J. AGEN LEXIS 235, Initial Decision (May 4, 2015).

Administrative Law Judge (ALJ) rejected a claim by DMAHS that an applicant for Medicaid was properly subjected to a four month, fourteen-day penalty on her benefits by reason of her transfer, during the look-back period, of $41,775.97. The largest expenditures that were included in that amount were two checks of $15,000 each which, it was undisputed, were gifts to assist two granddaughters in paying for their weddings. The ALJ concluded that the contributions to the weddings were the acts of a normal, affectionate grandparent and were not gifts representing a concerted effort by the applicant to pauperize herself. They were not gifts without a purpose made only for love and affection. Rather, they were made in the ordinary course of living a normal human

life. The applicant was not properly penalized for making such contributions just because she was old. Similar logic applied to the two $1000 checks that were given to the same relatives as wedding presents. The regulations create a presumption that all transfers for less than fair market value were made to establish Medicaid eligibility, but that presumption can be rebutted, and the ALJ found that it had been rebutted in this case. Once the amounts as to which the presumption had been rebutted were subtracted from the total amount on which the penalty was based, the total amount of unexplained expenditures was $3600 and justified the imposition of an 11-day penalty. F.P. v. Atlantic Cty. Bd. of Social Servs. and DMAHS, OAL DKT. NO. HMA 17211-14, 2015 N.J. AGEN LEXIS 265, Initial Decision (April 30, 2015)

Administrative Law Judge (ALJ) agreed with DMAHS that an applicant for Medicaid was properly subjected to a ten month penalty on her benefits by reason of her transfer, during the look-back period, of $78,000. By the time of the hearing, the applicant was deceased, but her son, on behalf of the estate, claimed that the $78,000 reflected six gifts of $13,000 each that she had made to family members purportedly to pay for her granddaughter's wedding and her grandchildren's college expenses and that at the time such gifts were made, the applicant was living wholly independently and that Medicaid eligibility was not a consideration at the time the gifts were made. However, there was no supporting evidence because none of the payments was made directly for wedding expenses or to a college or university. Rather, each check was made out for $13,000 without any indication of how the applicant intended for it to be spent. Each check was simply a gift in accordance with the maximum allowed without penalty under the tax laws. Since the gifts were properly considered to be transfers for "love and affection," such transfers reflected funds that could have been used for the applicant's care and a penalty was properly imposed on account thereof. M.V. v. DMAHS and Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 15653-14, 2015 N.J. AGEN LEXIS 263, Initial Decision (April 20, 2015).

A transfer penalty of 12 months and 21 days was properly imposed on the Medicaid eligibility of an applicant who was found to have transferred $119,580 for less than fair market value during the relevant look-back period. Though the applicant's representative, her daughter, insisted that the majority of the transfers should not have been included in the penalty amount, the daughter had no documentation establishing that the funds were used for the purposes that the daughter had identified and she thus failed to rebut the presumption that the funds were transferred exclusively for the purpose of qualifying for Medicaid. J.M. v. Bergen Cty. Bd. of Social Servs., OAL DKT. NO. HMA 07591-14, 2015 N.J. AGEN LEXIS 259, Initial Decision (April 8, 2015).

Decision of a county Board of Social Services (CBSS) imposing a $127,751.71 transfer penalty due to uncompensated transfers within the look-back period upon the Medicaid eligibility of a 91 year old woman was modified in part based on evidence relative to the use of a substantial portion of those funds for the applicant's care. The undisputed evidence established that $60,000 was returned to the applicant and $53,360.92 was used exclusively for her care. That meant that the transfer penalty was properly reduced by the amount shown to have been legitimate payments for the applicant's care. M.M. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 9251-14, 2015 N.J. AGEN LEXIS 155, Initial Decision (March 9, 2015).

Determination by a county board of social services (CBSS) that a 42-day transfer penalty was properly imposed on the eligibility of an applicant for Medicaid was incorrect because the preponderance of the credible evidence showed that the applicant's daughter, who was generally responsible for her care, made some of the challenged transfers for a reason other than to qualify for Medicaid eligibility. Because the daughter convincingly rebutted the presumption that the transfers were made to establish Medicaid eligibility, the transfers on which a penalty was properly imposed totaled $12,437.33. B.J.H. v. Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13823-14, 2015 N.J. AGEN LEXIS 208, Initial Decision (February 13, 2015).

County Board of Social Services (CBSS) correctly imposed a penalty on an applicant's Medicaid eligibility based on her having transferred a large sum of money for less than fair market value within the five-year look back period. The source of the funds at issue was an amount that the applicant inherited from her sister. Though the applicant was the sole beneficiary of the sister's estate, the applicant believed that it was fair to share it with other relatives, and somewhat more than $20,000 was either distributed to other relatives or used for other non-exempt purposes. The amount of the funds that the applicant distributed to other relatives was the basis of the eligibility penalty. However, the amount transferred was reduced by several items that the administrative law judge found to have been adequately explained, with the result that the penalty that was originally imposed, which was two months and 29 days, was reduced to two months and 17 days. J.C. v. DMAHS and Atlantic Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13872-14, 2015 N.J. AGEN LEXIS 209, Initial Decision (February 12, 2015).

Transfer penalty of two months and two days on a Medicaid applicant's benefits was properly imposed on account of transfers made from the applicant's accounts to various members of her family, which transfers were found to have been made for less than fair market value during the sixty-month look back period. Though some of the payments that originally were included in the gross amount of transfers on which a penalty was imposed, the applicant's daughter did not present clear and convincing evidence to rebut the presumption that the remaining payments, which totaled $16,200, were made for less than fair market value to qualify for Medicaid. C.M. v. Burlington Cty. Bd. of Social Servs., OAL DKT. NO. HMA 11783-14, 2015 N.J. AGEN LEXIS 113, Initial Decision (February 11, 2015).

Determination by a county board of social services (CBSS) that an applicant's Medicaid eligibility was properly penalized based on transfers totaling $114,917 was rejected by an administrative law judge (ALJ) who concluded that the applicant had rebutted the presumption that such transfers were made to establish Medicaid eligibility. The applicant, who was diagnosed with Alzheimer's disease in 2006, had lived at home with round-the-clock care for some seven years before she became a nursing home resident. Though the applicant's family had demonstrated that the applicant had paid $500 weekly for her in-home care over those years, the agency had rejected the applicant's claims that the payments had not been made to establish eligibility and had imposed a penalty of 14 months and 22 days. The ALJ found that while there was no written contract between the caregiver and the family, the weekly payments were regular and consistent and there was no question that the caregiver was employed by the family to care for the applicant. The documentation from the applicant's doctors regarding her need for live-in assistance was credible and undisputed. That being so, the assets at issue were not more than the fair market value of the services provided by the caregiver and the agency should not have based a penalty thereon. M.G. v. Camden Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13067-14, 2015 N.J. AGEN LEXIS 207, Initial Decision (February 3, 2015).

County agency acted properly in imposing a transfer penalty period upon an applicant on a finding that he had transferred $17,266.24 in resources for the purpose of establishing Medicaid eligibility. The first challenged transfer occurred soon after the applicant's son, his caregiver, learned about Medicaid's financial eligibility requirements. The first transfer ostensibly represented amounts that were owed to the son on account of care that he had rendered in his home to his father and to his recently-deceased mother, and was made shortly after his mother's death. The son admitted that the second transfer was made for the purpose of establishing Medicaid eligibility for his father. Given the lack of any evidence that the transfers were made for any other purpose, the agency's determination that they were made to establish eligibility was amply supported by the record. J.B. v. Morris Cty. Office of Temp. Assistance, OAL DKT. NO. HMA 12835-14, 2015 N.J. AGEN LEXIS 122, Initial Decision (January 29, 2015).

Applicant failed to rebut the presumption that the transfer of assets for a home repair and renovation project was for the purpose of establishing

Medicaid eligibility pursuant to N.J.A.C. 10:71-4.10(j). The credible evidence established that the applicant would not be returning home from the nursing home facility to live in the refurbished home. In fact, her disability was severe enough that her son lived with her and served as her caregiver for at least two years before her institutionalization. M.A.M. v. Morris County Bd. of Social Serv., OAL DKT. NO. HMA 13089-14, 2015 N.J. AGEN LEXIS 38, Initial Decision (January 20, 2015).

Medicaid applicant successfully rebutted the presumption that certain assets subject to a transfer penalty were transferred for the purpose of establishing Medicaid eligibility pursuant to N.J.A.C. 10:71-4.10(j). She employed a live-in for the benefit of her husband, who suffered from Alzheimer's disease, and paid for those services by writing checks payable to "cash." The applicant utilized the balance of the transferred funds to support herself and the household, and the administrative law judge found that this amount was both reasonable and credible. Thus, the transfer penalty was reversed and the applicant was deemed eligible for the Medicaid Only Program for institutional level care. N.K. v. Gergen County Bd. of Social Serv., OAL DKT. NO. HMA 11328-14, 2014 N.J. AGEN LEXIS 792, Initial Decision (December 30, 2014).

Transfer penalty was properly imposed on an applicant based on her transfer of $148,081 to her son and daughter-in-law, which funds were taken from the $250,000 proceeds received by the applicant from a reverse mortgage. Though the applicant, who was 93 years old, suffered from dementia, and was residing with her son and daughter-in-law, claimed that the funds were transferred to compensate her family members for care they had provided to her, there was no written agreement that established the services to be rendered and the costs to be incurred thereby nor was there any other credible documentary evidence supporting the applicant's claims. At best, the applicant had a loose arrangement to compensate her family members from the proceeds of the reverse mortgage for services and care that they provided. That being so, the applicant was not entitled to relief from the transfer penalty. E.D. v. Atlantic Cnty. Bd. of Social Servs. and DMAHS, SERVICES, OAL DKT. NO. HMA 13364-14, 2014 N.J. AGEN LEXIS 822, Initial Decision (December 17, 2014).

County board of social services acted improperly when it denied the application for an undue hardship exception made on behalf of a 96-year old woman who suffered from dementia and required 24-hour care. The record established that while the woman had inherited $246,371.62, it was more likely than not that the funds had been gambled away by her husband, who now was deceased. Neither the woman nor her adult children had any of the funds and the adult children were in no position to provide the care that the woman required due to her advanced age and her dementia. Denial of the waiver would deprive the woman of food, clothing, shelter and other necessities of life and the harm that would come to the woman if she was to be discharged from the facility in which she resided make it clear that an undue hardship waiver was appropriately granted. M.Y. v. Union Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 05391-14, 2014 N.J. AGEN LEXIS 821, Initial Decision (December 17, 2014).

Medicaid applicant failed to rebut the presumption that a substantial portion of the assets that she transferred during the "look-back" period were transferred for the purpose of qualifying for Medicaid. Moreover, the applicant continued to transfer large sums of money to her children and grandchildren as her health slowly deteriorated and as she could anticipate the need for long-term care services. Thus, she was entitled to a small reduction in the penalty period based on her showing that about $10,000 of those funds was spent on her own living expenses and care needs. However, she was not entitled to any reduction in the penalty period due to partial returns of improperly-transferred assets because the transfer penalty may only be adjusted if all assets transferred for less than FMV have been returned. Finally, the record supports a conclusion that the Board of Social Services had incorrectly calculated the penalty in the first place because it did not use the then-current year's divisor in the calculation, an error that should be corrected on recalculation of the penalty to be based on $130,028.64. M.D. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 345-14, 2014 N.J. AGEN LEXIS 824, Initial Decision (December 15, 2014).

Administrative law judge ordered that the denial of Medicaid eligibility and application of a penalty by the Bergen County Board of Social Services be reversed. The applicant met her burden to establish by convincing evidence that assets were transferred exclusively for purposes other than Medicaid eligibility pursuant to N.J.A.C. 10:71-4.10(l)(1). Her son's credible testimony, coupled with the documents in the record, established that the applicant was unable to manage her own finances and that her son had been spending her pension payments from August 2009 until August 2013 on her behalf. It was evident that her son was handling her finances for an extended period of time, including paying her rent and grocery bills. Given the duration of time, it was not unreasonable that her son did not have a receipt for every dollar that was spent on behalf of the applicant. E.W. v. Bergen County Bd. of Social Serv., OAL DKT. NO. HMA 05984-14, 2014 N.J. AGEN LEXIS 777, Initial Decision (December 5, 2014).

Imposition of a transfer penalty by the Camden County Board of Social Services pursuant to N.J.A.C. 10:71-4.10(a) and -4.10(b)9iv was affirmed. There was no preponderance of credible evidence that the purpose of the subject $10,000 transfer was unrelated to Medicaid. It was logical, reasonable and probable that Medicaid was contemplated to some degree by the applicant who, at age 94, moved in with her daughter but returned to her own condominium and perhaps then had some stage of dementia. The applicant did not convincingly rebutted the presumption that the transfer was made to establish Medicaid eligibility under N.J.A.C. 10:71-4.10(*l*)2. V.B. v. Camden County Bd. of Social Serv., OAL DKT. NO. HMA 10897-14, 2014 N.J. AGEN LEXIS 563, Initial Decision (November 10, 2014).

Ocean County Board of Social Services and the Division of Medical Assistance and Health Services improperly denied an applicant Medicaid benefits on the grounds that she was over-resourced pursuant to N.J.A.C. 10:70-5.1(a). The resource value of the asset in question, a restaurant, less the encumbrances against it resulted in a negative value. However, her transfer of assets for less than fair market value triggered a Medicaid-eligibility penalty period pursuant to N.J.A.C. 10:71-4.10(c)4. The applicant essentially made a gift of the property at issue to her son by transferring it for one dollar consideration and then encumbering it with close to $3 million in liens to build a business that her son and his wife owned through their limited liability company (LLC). The transfer was a gift to her son for which his LLC was the sole beneficiary. The applicant did not meet her burden of rebutting the presumption that the purpose of this transfer was for reasons other than Medicaid planning. She presented no explanation as to why she would give away her valuable interest in the property to her son's LLC for profit, leaving her with nothing but millions of dollars in debt. C.S. v. Div. of Med. Assistance and Health Serv. and Ocean County Bd. of Social Serv., OAL DKT. NO. HMA 5957-14, 2014 N.J. AGEN LEXIS 584, Initial Decision (November 6, 2014).

Administrative law judge reversed a determination of the Cape May County Board of Social Services, Medicaid Unit, imposing a transfer penalty of three months and five days on an applicant. The payments to the applicant's daughter were not made in contemplation of Medicaid eligibility pursuant to N.J.A.C. 10:71-4.10(j). All of her resources were transferred to a trust in 2004. She had no need to spend down her income to make herself Medicaid eligible because she had a monthly assisted living facility debt that exceeded her nominal monthly income. C.S. v. Cape May County Bd. of Social Serv. and Div. of Medical Assistance and Health Serv., 3 OAL DKT. NO. HMA 9473-14, 2014 N.J. AGEN LEXIS 541, Initial Decision (October 24, 2014).

Administrative law judge (ALJ) modified the penalty period imposed upon a Medicaid applicant. It was an unauthorized transfer of assets pursuant to N.J.A.C. 10:71-4.10(e) to spend the applicant's funds so that her grandson could attend private schools when those funds were needed for the applicant's own institutional care needs. However, the ALJ found that certain transfers were made to help the applicant's family with usual financial problems and were not made with the intent, even partially, to qualify for Medicaid and thus were exempt transfers. A.R. v. Morris Cnty. Bd. of Social Serv, OAL DKT. NO. HMA 04663-14, 2014 N.J. AGEN LEXIS 531, Initial Decision (August 29, 2014).

Division of Medical Assistance and Health Services and Camden County Board of Social Services properly imposed a transfer penalty on a Medicaid applicant arising from transfers to her daughter during the sixty-month look back period. Although the daughter's testimony was quite earnest, the administrative law judge concluded that she did not rebut the presumption that these assets were transferred solely for some other purpose than to establish Medicaid eligibility. Although she provided copies of bills and pictures of her renovated home, the bills were all prior to 2006, and the transfers occurred during the sixty-month look back. S.B. v. Camden Cnty. Bd. of Social Serv. and Div. of Med. Assistance Health Serv., OAL DKT. NO. HMA 6303-14, 2014 N.J. AGEN LEXIS 516, Initial Decision (August 27, 2014).

County board of social services (CBSS) acted improperly when, pursuant to N.J.A.C. 10:71-4.10(a), it imposed a one month, nine day penalty on the eligibility of a Medicaid applicant on account of what the CBSS claimed was an uncompensated transfer of assets. The assets at issue were funds belonging to the applicant which were used by the applicant's daughter to repair smoke damage caused by the applicant, a heavy smoker, to a condominium that the applicant had rented from the daughter. Because it was shown that the assets were not transferred to establish Medicaid eligibility but in fact were transferred exclusively to fund repairs for which the applicant was legally liable under a lease, the applicant's eligibility was not properly subjected to a penalty. R.M. v. Burlington Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 7521-14, AGENCY DKT. NO. 0315002712, 2014 N.J. AGEN LEXIS 492, Initial Decision (August 18, 2014).

County board of social services (CBSS) acted improperly when, pursuant to N.J.A.C. 10:71-4.10(a), it penalized the eligibility of a Medicaid applicant on account of what the CBSS claimed to be transfers of funds for which no accounting had been made. One transfer, for $5000, was shown to have been used to install a chairlift in the home of the applicant's son, where the applicant lived and received care from her son. Given that showing, the applicant's eligibility should not have been penalized on account thereof. However, there was no documentation submitted to establish the purpose for which the second transfer, a $2,500 check, was made, and a ten-day penalty against the applicant's eligibility was properly imposed. I.M. v. Atlantic Cnty. Bd. of Social Servs. & DMAHS, OAL DKT. NO. HMA 4710-14, AGENCY DKT. NO. 0110032695, 2014 N.J. AGEN LEXIS 491, Initial Decision (August 14, 2014).

Application for long term nursing care Medicaid eligibility was denied for the period August 2, 2013, through January 21, 2014, not through July 19, 2015 as calculated by the Hunterdon County Board of Social Services (HCBSS). Although the HCBSS completely discounted amounts paid under a caregiver agreement as arising from transfers for less than adequate consideration pursuant to N.J.A.C. 10:71-4.10(*l*), the administrative law judge found that the applicant's daughter transferred a value (the use of a residence to the applicant for a portion of the amount at issue. The caregiver agreement only served to memorialize the pre-existing actions of the parties for the applicant to contribute the fair market value rental obligation for her use of the separate apartment. There was no indication that the transfers occurred for the applicant to become Medicaid eligible. Div. of Med. Assistance and Health Serv. and Hunterdon Cnty. Bd. of Social Serv., OAL DKT. NO. HMA 4558-14, 2014 N.J. AGEN LEXIS 461, Initial Decision (August 12, 2014).

County board of social services (CBSS) acted properly when it imposed a transfer penalty of 104 days on the Medicaid eligibility of an applicant and determined that the penalty period was to begin on the date on which the applicant became eligible for Medicaid. While the parties agreed that the penalty was 104 days, the applicant challenged the determination based on her claim that the period of ineligibility described in N.J.A.C. 10:71-4.10(m)(1)(i) should begin on November 4, 2013, the date on which the applicant transferred a share of the interest in her home to her son for less than market value. However, because N.J.A.C. 10:71-4.10(m) and 42 U.S.C.S. § 1396p(c) were in conflict, the federal statute governed and the penalty period for transferring assets at less than fair market value was properly calculated as beginning on the latter of: (1) the month of the transfer; (2) the month after the transfer; or (3) the date upon which the individual became Medicaid eligible and would be receiving institutional level of services if not for the penalty period. Since the applicant was not Medicaid-eligible due to her receipt of $65,000 on account of her share of proceeds from the sale of the house, the penalty period had not begun to run and would not run until she again became Medicaid-eligible. I.L. v. Passaic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 01465-14, AGENCY DKT NO. 1620362403, 2014 N.J. AGEN LEXIS 476, Initial Decision (August 6, 2014).

County board of social services (CBSS) and Division of Medical Assistance and Health Services (DMAHS) did not err in imposing a transfer penalty on the Medicaid eligibility of an applicant on the ground that the transfer, to the applicant's daughter, of $18,555.64 of the proceeds of a CD owned by the applicant was made for less than fair value. Though the daughter insisted that the entire amount actually represented rent paid by her mother to her over a five year period and though the daughter submitted uncashed checks that totaled $18,048, there was no evidence that they actually were written when they were purported to have been written and were no longer negotiable on the date on which funds were transferred from the applicant's CD to her daughter. Since the presumption was that the amount had been transferred to allow the applicant to qualify for Medicaid benefits within the meaning of N.J.A.C. 10:71-4.1(d)2, was not rebutted, the applicant was properly rendered ineligible per N.J.A.C. 10:71-4.10 and a transfer penalty imposed. C.D. v. Camden Cnty. Bd. of Social Servs. and Div. of Medical Assistance & Health Servs., OAL DKT. NO. HMA 4606-14, AGENCY DKT. NO. 0410052983, 2014 N.J. AGEN LEXIS 444, Initial Decision (August 1, 2014).

Decision to deny Medicaid eligibility and to impose a transfer penalty was affirmed by an administrative law judge. The amount paid by the applicant to her son and daughter-in-law for her life interest in her home was a transfer for less than fair market value under N.J.A.C. 10:71-4.10(b)6iii and subject to the transfer penalty. The additional amount she paid to them for renovations also represented a transfer for less than fair market value. While some of the costs were directly related to modifying the property for the applicant to live there, insufficient information remained in the record as to whether the entire amount was for her benefit. H.D. v. Burlington Cnty. Bd. of Social Serv. and the Division of Med. Assistance and Health Serv., OAL Dkt. No. HMA 3495-14, 2014 N.J. AGEN LEXIS 421, Initial Decision (July 22, 2014).

County board of social services (CBSS) acted properly in denying an application for Medically Needy Nursing Home Medicaid filed on behalf of an applicant based on its finding that she had transferred assets at an unfair market value within the meaning of N.J.A.C. 10:71-4.10. The applicant and her now-deceased husband were joint owners of their residence. Though the couple, in 2006, had executed a quit claim deed conveying the property to their granddaughter, neither of them changed their wills, which purported to leave the property to a group of descendants rather than just the granddaughter named on the quit claim deed, to remove references to the residence therein. Moreover, the granddaughter, as the putative grantee, never assumed any responsibility for taxes or other expenses relating to upkeep of the property. Finally, the deed was not filed until March 26, 2013. All of these factors, taken together, supported CBSS's conclusion that the applicant was the sole owner of the property on the date on which she applied for Medicaid, and that it had been transferred for less than market value. M.H. v. Burlington Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15923-13, ON REMAND HMA 8129-13, AGENCY DKT. NO. Case No. 0315002570, 2014 N.J. AGEN LEXIS 405, Initial Decision (June 16, 2014).

County board of social services (CBSS) erred when it imposed a transfer penalty on the Medicaid eligibility of an applicant on the ground that the withdrawal, by the applicant's sister, of approximately $17,000 from a bank account that belonged to the applicant and his sister was a transfer to facilitate qualification for Medicaid. Though CBSS took the position that the amount was transferred to allow the applicant to qualify for Medicaid benefits within the meaning of N.J.A.C. 10:71-4.1(d)2 and that the applicant was thus rendered ineligible per N.J.A.C. 10:71-4.10, the sister established that the funds that she withdrew in fact belonged to her as they were the proceeds from the settlement of a personal injury case. That showing provided adequate grounds per N.J.A.C. 10:71-4.10(e)6ii for a determination that the funds had been transferred for a

purpose other than to facilitate the applicant's qualification for Medicaid benefits, thus eliminating the basis on which the CBSS had relied in imposing a transfer penalty on the applicant. L.B. v. Atlantic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 4147-14, AGENCY DKT. NO. 0120009439-01, 2014 N.J. AGEN LEXIS 399, Initial Decision (June 17, 2014).

Determination by the Atlantic County Board of Social Services assessing a penalty against a Medicaid applicant arising from the transfer of her half-interest in her home was reversed by an administrative law judge pursuant N.J.A.C. 10:71-4.10(j). The applicant offered convincing proofs that the transfer was in an effort to protect the home from bankruptcy proceedings and was thus for some other purpose than Medicaid eligibility. L.L. v. Division of Med. Assistance and health Serv. and Atlantic Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 4146-14, 2014 N.J. AGEN LEXIS 383, Initial Decision (June 30, 2014).

Denial of an 82-year old woman's application for Global Options (GO) Medicaid was appropriate. The applicant previously was receiving $2055 a month from her husband under a Limited Judgment of Divorce from Bed and Board, which payment was claimed to be the applicant's share of the ratable portion of a former marital asset, not alimony. Prior to making the GO Medicaid application, however, the applicant applied for and was awarded a consent order decreasing the $2055 monthly payment to $1500. Though an Administrative Law Judge (ALJ) agreed with the applicant that those payments did not constitute alimony, she also concluded that they were not excludable as income under any provision of N.J.A.C. 10:71-5.3. Moreover, because the applicant's action to reduce the payments was admittedly taken to enable the applicant to remain in an assisted living setting, the facts triggered the application of N.J.A.C. 10:71-4.10(b)3. That is, her monthly income would be deemed to include the entire $2055 rather than the reduced amount because the reduction was a result of action on the part of the applicant to meet eligibility guidelines. G.D. v. Burlington Cnty. Bd. of Social Servs. & DMAHS, OAL DKT. NO. HMA 2840-14, AGENCY DKT. NO. 0310031084, 2014 N.J. AGEN LEXIS 361, Initial Decision (June 20, 2014).

A county board of social services (CBSS) acted properly in denying Medicaid eligibility to a husband who was already a resident of a care center because the husband, who bore the burden of proof per N.J.A.C. 10:71-4.10(j), did not establish that sufficient verification of spend-down had been provided to CBSS. Moreover, the couple's resource assessment as determined per the criteria in N.J.A.C. 10:71-4.8(a) indicated total resources of $414,458.15, far in excess of the maximum for the husband, which was $211,229. R.K. v. Burlington Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 16823-13, AGENCY DKT. NO. 0310030815, 2014 N.J. AGEN LEXIS 341, Initial Decision (June 18, 2014).

DMAHS properly denied an application for the Medicaid Only/ Community Care Waiver program made on behalf of a disabled adult on the ground that the adult had excess resources and that significant assets had been transferred within 6 months of the application. Leaving aside other assets on which evidence was received, the adult had nearly $50,000 in a trust account on the date of the application and thus her resources exceeded the $2,000 ceiling in N.J.A.C. 10:71-4.5(c). Second, as for the transfers, which included a transfer of a condominium and transfers in the amounts of $52,863.39 and $46,108.86, per N.J.A.C. 10:71-4.10(*l*)1, the determination of whether the transfer was made to qualify for Medicaid does not include a consideration of the merits of the transfer, but whether the applicant has proven that the asset was transferred exclusively for some other purpose, the only circumstance in which presumption is successfully rebutted. In the absence of evidence rebutting that presumption, the existence of such transfers afforded grounds for denial of the application. S.M. v. DMAHS, OAL DKT. NO. HMA 11842-12, 2014 N.J. AGEN LEXIS 338, Initial Decision (June 20, 2014).

Board of Social Services' delay in processing a Medicaid application was not improper under N.J.A.C. 10:71-2.3(c). Throughout the 21 months between the filing of initial application and its amended disposition, the information, including duplicates, was supplied on several occasions in response to the verifications sought. A transfer penalty was properly assessed pursuant to N.J.A.C. 10:71-4.10(i) arising from the transfer to her niece of the applicant's interest in a limited liability company that owned her home in exchange for a promissory note. While it was undisputed that the niece took the applicant into her home, sound proof did not exist concerning that arrangement. The fair market value documents did not provide an adequate market analysis of the home because they primarily reflected later values, and they clearly stated that the figures are not guaranteed. E.B. v. Bergen Cnty. Bd. of Social Serv., OAL DKT. NO. HMA 667-14, 2014 N.J. AGEN LEXIS 327, Initial Decision (June 9, 2014).

An Administrative Law Judge (ALJ) concluded that the majority of expenditures made to a residence in the six or seven months before a Medicaid applicant actually entered a nursing home were not transfers of resources within the meaning of N.J.A.C. 10:71-4.10(a) and thus could not form the basis of a determination that the applicant's Medicaid eligibility was properly delayed. The applicant owned a life estate in the residence at issue and while the county board of social services took the position that all of the expenditures were made to benefit the applicant's son, with whom the applicant shared a two-family house, the ALJ determined that only such funds as were used to improve and repair the third floor, which was where the son was now living, were expenditures for which a penalty was properly imposed. The ALJ reasoned that the applicant, as the owner of a life estate, had certain responsibilities, including the responsibility to keep the property in good repair and that expenses that benefited the entire residence were not properly made the basis of an eligibility penalty. T.B., v. DMAHS and Hudson Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 13009-13, 2014 N.J. AGEN LEXIS 299, Initial Decision (May 22, 2014).

Atlantic County Board of Social Services properly calculated the penalty for the transfer of assets during the look back period pursuant to N.J.A.C. 10:71-4.10 in determining the date of Medicaid eligibility. Petitioner did not dispute any of the transfers made. She simply testified that her terminally ill husband required full-time care, which she provided. She quit her job and used a majority of the funds to pay for their living expenses. Additionally, she used funds to assist her son with saving his house. She was a co-mortgagee on the home until she executed a quit claim deed to her son in full. Unfortunately, petitioner could not account for any of the funds because as she simply executed checks to her son, who converted them and then paid the mortgage. R.P. v. Atlantic Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 03151-14, 2014 N.J. AGEN LEXIS 282, Initial Decision (May 21, 2014).

Determination of the effective date of Medicaid eligibility and imposition of transfer penalty by the Camden County Board of Social Services (CCBSS) was affirmed. The CCBSS was correct in not including a re-gifting from the applicant to her grandson back to the applicant pursuant to N.J.A.C. 10:71-4.10(e)6iii, but the applicant was not entitled to a hardship waiver under N.J.A.C. 10:71-4.10(q) for the remainder of the transfer. She made no showing that she filed a request for an undue hardship exception, and while she provided a great deal of evidence of her current medical state and the care she needed, no evidence was provided that the recovery transferred assets were beyond her control. A.B. v. Camden Cnty. Bd. Social Serv. and Div. of Medical Assistance and Health Serv., OAL Dkt. No. HMA 965-14, 2014 N.J. AGEN LEXIS 277, Initial Decision (May 21, 2014).

An Administrative Law Judge (ALJ) concluded that a county board of social services acted properly when it denied an application for Medicaid eligibility made by an applicant on behalf of her deceased husband on a finding that a penalty period of one year and 12 day was properly imposed per N.J.A.C. 10:71-4.10 on account of transfers in the amount of $96,420.38 that were made within the relevant look-back period. Though the applicant claimed that the resources were used to care for the decedent during his final, terminal illness, she was unable to account for the funds as most of them were reflected in checks made payable to her son. R.P. v. Atlantic Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 03151-14, State of New Jersey 2014 N.J. AGEN LEXIS 274, Initial Decision (May 21, 2014).

An Administrative Law Judge (ALJ) concluded that an applicant for Nursing Home Medicaid was not entitled to a hardship waiver under N.J.A.C. 10:71-4.10(q) from the period of ineligibility based on an asset transfer. The asset transfer involved $222,909.28 in resources that the

county board of social services determined had been transferred for less than fair market value, including substantial assets that had been transferred to the applicant's grandson. Though the applicant adequately established her current medical state and her need for care, she did not offer any evidence tending to show that the recovery of transferred assets was beyond her control and that she had made good faith efforts, including the exhaustion of remedies available at law or in equity, to recover the transferred assets. A.B. v. Camden Cnty. Bd. of Social Servs., and Div. of Medical Assistance and Health Servs., OAL DKT. NO. HMA 965-14, AGENCY DKT. NO. 0410052140, 2014 N.J. AGEN LEXIS 269, Initial Decision (May 21, 2014).

Agency erred in determining that an elderly woman's Global Option Medicaid eligibility was subject to a penalty period per N.J.A.C. 10:71-4.10 due to $151,300 in transfers made between October 2006 and October 2011, which transfers were cash gifts. The agency had used a five-year look-back period beginning in 2011 when, in fact, the application at issue had been made on June 21, 2013 for an eligibility date of June 1, 2013. If the proper look-back period was used, the transfer amount that would properly apply was $21,378.00, or an approximately three month penalty period, not the nineteen month and fifteen day period that the agency originally had imposed. A.D. v. Union Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 2670-14, AGENCY REF. NO. 2010048756, 2014 N.J. AGEN LEXIS 259, Initial Decision (May 19, 2014).

No transfer penalty should have been applied by a county board of social services upon the Medicaid eligibility of an elderly woman (now deceased) because her daughter was properly compensated for services rendered to her mother under a personal services contract. The evidence established that the daughter provided services in excess of 20 hours a day because her mother, who had Alzheimer's disease, required constant supervision, and that those services were provided at fair market value. That being so, there was no basis for imposition of the transfer penalty described in N.J.A.C. 10:71-4.10. E.B. v. DMAHS and Cumberland Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 2809-14, ON REMAND HMA 12812-13, AGENCY DKT. NO. 0610096253, 2014 N.J. AGEN LEXIS 245, Initial Decision (May 28, 2014).

An Administrative Law Judge (ALJ) concluded that an elderly woman's January 2011 transfer, to her daughter, of the woman's home was a transfer for less than market value within the meaning of N.J.A.C. 10:71-4.10 and provided grounds for the imposition of a penalty of 25 months and 3 days against the elderly woman's Medicaid entitlement, meaning that her eligibility date would be February 3, 2014. Nor did the "caregiver" exception to the fair market rule apply. That was because the evidence showed that the elderly woman needed an institutional level of care as of March 2011, and that the elderly woman was not residing with the daughter for that entire period nor was the daughter her mother's caregiver for a full two years prior to March 2011. M.K. v. DMAHS and Burlington Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 8099-13 (On remand HMA 5791-12), 2014 N.J. AGEN LEXIS 243, Initial Decision (May 30, 2014).

An Administrative Law Judge (ALJ) concluded that a county board of social services had acted lawfully when it had imposed a penalty of ten months and 13 days against an elderly woman's Medicaid eligibility by reason of three transfers made from the woman's checking account to her grandson within the 60 month "look-back period" in N.J.A.C. 10:71-4.10. Though the grandson had claimed that the largest of the three transfers – which was for $75,000 – was repayment of a loan that he made to his grandmother, there was no documentary evidence whatsoever that such was the case and the surrounding facts and circumstances strongly suggested that the grandson's claim was untrue. As for the other payments, claimed by the grandson to represent compensation for care that he rendered to his grandmother, the presumption that such services would have been provided without compensation was not rebutted. E.M. v. Bergen Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15670-13, AGENCY DKT. NO. 021516716501, 2014 N.J. AGEN LEXIS 237, Initial Decision (May 30, 2014).

Transfer penalty incurred pursuant N.J.A.C. 10:71-4.10(a) was reduced when documented medical expenses and legal bills paid by the sister of a Medicaid were legitimate reimbursements of expenses paid for solely for the applicant's health and wellbeing and not in anticipation of Medicaid eligibility. Had the applicant paid the legal bills directly, even if for legal advice regarding Medicaid planning, they would not have been included transfer/penalty analysis. D.P. v. Atlantic Cnty. Bd. of Social Serv., OAL DKT. No. HMA 1080-14, 2014 N.J. AGEN LEXIS 209, Initial Decision (April 29, 2014).

An Administrative Law Judge concluded that a 15 day eligibility penalty provided by N.J.A.C. 10:71-4.10 should not have been imposed upon an applicant for benefits under the Medically Needy Nursing Home Program. The penalty was based on the agency's finding that she had transferred resources valued at $4000 to a caretaker. The caretaker, who actually was a member of the applicant's church who was providing her with care through a church program, testified that the applicant had loaned her $4000 but that she in fact had repaid $2,000 of that amount. Since that amount had been repaid, it should not have been characterized as a transfer for less than fair market value and the agency was properly required to recalculate the penalty based on a transfer of $2,000. J.O. v. Morris Cnty. Bd. of Soc. Servs, OAL Dkt. No. HMA 16304-13, 2014 N.J. AGEN LEXIS 169, Initial Decision (April 4, 2014).

Spouse's transfers to her children and grandchildren of a portion of her Community Spouse Resource Allowance (CSRA) for less than fair market value did not result in a penalty period because she rebutted the presumption that the resource was transferred to establish Medicaid eligibility for her husband pursuant to N.J.A.C. 10:71-4.10(*l*)1. She mistakenly believed that the she was permitted to transfer her CSRA assets after that amount was calculated at the time of institutionalization but before eligibility was determined at the time of application. Poong Cha v. Morris County Bd. of Social Serv., OAL DKT. No. HMA 00267-14, 2014 N.J. AGEN LEXIS 141, Initial Decision (March 31, 2014).

An Administrative Law Judge (ALJ) concluded that a direct transfer of $430,183.52 made by a 95-year-old parent who was a Medicaid recipient to the parent's totally disabled adult child came within an exception to the rule in 42 U.S.C.S. § 1396p(c)(1) and N.J.A.C. 10:71-4.10(a) generally requiring the imposition of a "transfer penalty" on the Medicaid recipient who made such a transfer. That was because the transfer met the criteria in § 1396p(c)(2)(B)(iii) and a determination that the challenged transfer did not trigger the penalty was also consistent with prior rulings of the Division of Medical Assistance and Health Services. M.C. v. Div. of Med. Assistance and Health Servs. & Union Cnty. Div. of Soc. Servs., OAL Dkt. No. HMA 08967-13, AGENCY Dkt. No. 2010050139-01, 2014 N.J. AGEN LEXIS 95, Initial Decision (February 10, 2014).

An Administrative Law Judge (ALJ) concluded that the Bergen County Board of Social Services erred when, relying on N.J.A.C. 10:72-4.5(b)(3), it denied a Medicaid application filed by an elderly husband (Husband) and imposed a transfer penalty of 17 months and 20 days, making Husband's eligibility date September 21, 2014, based on its finding that the assets represented by three certificate of deposit (CDs) accounts titled to his wife (Wife) and Wife's sister (Sister) constituted resources within the meaning of N.J.A.C. 10:71-4.6 that were "available" to Husband within the meaning of N.J.A.C. 10:71-4.1(c) and could be converted to cash and used for the Husband's support and maintenance. Wife and Sister's submission on that issue, which included a statement from the financial institution where the accounts were held, established that the funds used to obtain the CDs were owned in toto by Sister, who was elderly, had no children, and lived alone; and that Sister's intention, in titling the accounts as she did, was to assure that Wife would have access to the funds in the event that Sister became incapacitated or to pay for her funeral expenses. Because the submission met the standards in N.J.A.C. 10:71-4.10(*o*)3 and established that the funds were not a resource of Husband, the ALJ concluded that there was no basis for the imposition of a transfer penalty. W.Z. v. Bergen Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 16767-13, AGENCY Dkt. No. 021016511201, 2014 N.J. AGEN LEXIS 99, Initial Decision (February 7, 2014).

An Administrative Law Judge concluded that the determination of two agencies (the New Jersey Division of Medical Assistance and Health Services and the Union County Board of Social Services) in imposing a N.J.A.C. 10:71-4.10 transfer penalty on an elderly Medicaid

recipient on account of her transfer, to two relatives, of compensation for care that they rendered to her, which compensation was calculated based on an hourly rate of $25. Though both of the relatives had some relevant expertise, neither was a licensed home health care provider and thus should not have been paid at a rate exceeding the Department of Labor rate for unlicensed care, which was $10.10. E.H. v. Div. of Med. Assistance and Health Servs. & the Union Cnty. Bd. of Soc. Servs., OAL Dkt. No. HMA 09604-13, Case No. 2010049231-01, 2014 N.J. AGEN LEXIS 96, Initial Decision (January 28, 2014).

An Administrative Law Judge (ALJ) concluded that a direct transfer of $430,183.52 made by a 95 year old parent who was a Medicaid recipient to the parent's totally disabled adult child came within an exception to the rule in 42 U.S.C.S. § 1396p(c)(1) and N.J.A.C. 10:71-4.10(a) generally requiring the imposition of a "transfer penalty" on the Medicaid recipient who made such a transfer. That was because the transfer met the criteria in § 1396p(c)(2)(B)(iii) and a determination that the challenged transfer did not trigger the penalty was also consistent with prior rulings of the Division of Medical Assistance and Health Services. M.C. v. Div. of Med. Assistance and Health Servs. & Union Cnty. Div. of Soc. Servs., OAL Dkt. No. HMA 08967-13, AGENCY Dkt. No. 2010050139-01, 2014 N.J. AGEN LEXIS 95, Initial Decision (February 10, 2014).

Medicaid applicant was subject to a penalty due to an improper transfer of assets and that penalty could not be reduced pursuant to 42 U.S.C.S. § 1396p(c)(2)(C) and N.J.A.C. 10:71-4.10(e)(6). Only a portion of the proceeds from the sale of the marital home that the applicant gave to her nephews was returned. C.C. v. Div. of Medical Assistance and Health Serv. And Ocean Cnty. Bd. of Social Serv., OAL DKT. No. HMA 4752-13, 2014 N.J. AGEN LEXIS 93, Initial Decision (February 12, 2014).

Bergen County Board of Social Services did not err in imposing a penalty under N.J.A.C. 10:71-4.10(c) arising from unaccounted transfers after an application for Medicaid was filed on behalf of an elderly woman (applicant). The applicant did not sustain her burden in proving that transfers used to make reverse-mortgage payments were made not circumvent Medicaid eligibility. There was no sound proof that the payment of the mortgage would make the home salvageable for the family because the property was on the market, and it was evident that the applicant would not return to the residence due to her deteriorating health. The timing of the transfer of the home to her son in relation to one month later applying for institutional Medicaid questioned the soundness of the conveyance. L.M. v. Bergen Cnty. Bd. of Social Servs, OAL Dkt. No. HMA 18618-13, 2014 N.J. AGEN LEXIS 53, Initial Decision (March 10, 2014).

Administrative law judge recommended the affirmation of a penalty imposed on an applicant's Medicaid eligibility pursuant to N.J.A.C. 10-71-4.10(c). She transferred her share of the proceeds from the sale of her house to her son one year and three days prior to the date of her application., which was during the lookback period. Thus, those funds must be included when calculating her assets. The funds were expended to build an addition on her son's home, which created a gift from the applicant to her son that warranted a penalty. T.W. v. Atlantic Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 13126-13, 2014 N.J. AGEN LEXIS 51, Initial Decision (March 6, 2014).

Camden County Board of Social Services and the Division of Medical Assistance and Health Services incorrectly denied Medicaid eligibility to applicants pursuant to N.J.A.C. 10:71-4.5 and assessed a transfer penalty based upon the sale of their home within five years before applying for Medicaid pursuant to N.J.A.C. 10:71-4.10(a) and -4.10(b)(9)(iv). The last tax assessment for the applicants' home was done before the decline of the housing market, and by the date of the transfer, the property was outdated, had termite and structural damage, and needed substantial renovation. W.S. v. Div. of Medical Assistance and Health Serv. and Camden Cnty. Bd. Of Social Serv., J.S. v. Div. of Medical Assistance and Health Serv. and Camden Cnty. Bd. Of Social Serv., OAL Dkt. Nos. HMA 10521-13, HMA 10523-13, 2014 N.J. AGEN LEXIS 50, Initial Decision (March 6, 2014).

Penalty for transfer of resources during the "look back" period should not have applied to petitioner because, although she transferred $50,000 in 2006, the gifts were not made for the purpose of establishing Medicaid eligibility; rather, the record revealed that petitioner sustained a traumatic onset of disability approximately two years after giving the gifts to her two daughters. M.M. v. DMAHS, OAL Dkt. No. HMA 13911-08, 2009 N.J. AGEN LEXIS 670, Final Decision (August 24, 2009).

Petitioner was subject to a transfer penalty since petitioner's nephew did not meet the transfer exception for a home conveyed to a son or daughter who staved off institutionalization by at least two years. Congress clearly only applied exceptions to the penalty when the transfer was to a son or daughter who resided in the home for at least two years and provided care to the applicant, and there was no room for an interpretation that would lend itself to expand the exemption to other relatives. V.D. v. DMAHS, OAL Dkt. No. HMA 4044-08, 2008 N.J. AGEN LEXIS 1111, Final Decision (December 9, 2008).

Initial Decision (2008 N.J. AGEN LEXIS 1405) adopted, which found that Medicaid applicants' prepayment of a large sum of money, pursuant to Life Care Contracts, to family members for personal-care services to be performed in the future constituted a transfer of assets for less than fair market value, subjecting the applicants to the imposition of a penalty period. C.S. v. DMAHS, OAL Dkt. No. HMA 1036-08, HMA 1122-08 and HMA 3499-08, 2008 N.J. AGEN LEXIS 1428, Final Decision (December 4, 2008).

Penalty period imposed by federal law (42 U.S.C.A. 1396p(c)(1)(D)), effective Feb. 8, 2006, and not that imposed by prior law, applied to institutionalized Medicaid applicant's gift transfers because sufficient funds to cover the gift checks, allegedly written before Feb. 8, 2006, were not in the account on which the checks were drawn until Feb. 13, 2006; thus, the penalty period expired Sept. 15, 2008, rather than Nov. 1, 2007, despite petitioner's contention that another bank's alleged delay in liquidating CDs to cover the checks rendered the funds outside her control. M.M. v. DMAHS, OAL Dkt. No. HMA 929-08, 2008 N.J. AGEN LEXIS 1017, Final Decision (July 18, 2008).

Transfer of petitioner's principal residence to her child, who resided with her for at least two years immediately prior to the date on which petitioner became institutionalized and who provided care to her during that time, was an exempt transfer pursuant to the caregiver child exception to the Medicaid penalty rules where the activities and the actions of petitioner's son were outside of the normal personal support activities, including preparing meals, bathing, helping her take her medication, and, most importantly, making sure she was safe by assisting her with walking and negotiating the stairs. The only evidence to the contrary was hearsay testimony from an adult protective services worker who testified as to what other workers reported; her hearsay testimony was without a residuum of competent legal evidence to support it. M.J. v. DMAHS, OAL Dkt. No. HMA 2512-07, 2008 N.J. AGEN LEXIS 1317, Final Decision (June 23, 2008).

Transfer of petitioner's principal residence to her child, who resided with her for at least two years immediately prior to the date on which petitioner became institutionalized and who provided care to her during that time, was an exempt transfer pursuant to the caregiver child exception to the Medicaid penalty rules where petitioner was continuously institutionalized from the time she was hospitalized and then transferred to Burlington Woods on September 20, 2005; her brief return home in December 2005 did not change the date of her designation as an institutionalized individual. M.J. v. DMAHS, OAL Dkt. No. HMA 2512-07, 2008 N.J. AGEN LEXIS 1317, Final Decision (June 23, 2008).

Applicant was not entitled to Medicaid assistance where she voluntarily reduced her pension income but remained able to rescind the reduction; thus, the original monthly pension benefit of $556.34 was available to the applicant and was properly counted in the determination of Medicaid eligibility. J.C. v. DMAHS, OAL Dkt. No. HMA 6950-07, 2008 N.J. AGEN LEXIS 39, Initial Decision (January 17, 2008).

There is a clear conflict between federal law (42 U.S.C.A. 1396p(c)) and the New Jersey regulation (N.J.A.C. 10:71-4.10(m)) because the regulation begins the penalty period for a transfer of assets for less than fair market value with the month of the transfer, whereas federal law imposes the penalty at either the month of the transfer, the month after the transfer, or the date upon which the individual becomes eligible, whichever is later. The Division correctly applied the current federal law to petitioner's Medicaid Only application because the courts have held that states participating in a federal entitlement program must conform to federal statutes and regulations. E.B. v. DMAHS, OAL Dkt. No. HMA 2289-07, 2007 N.J. AGEN LEXIS 605, Initial Decision (August 23, 2007).

Medicaid applicant's irrevocable trust arrangement was void because it violated New Jersey's public policy against shielding assets to become Medicaid eligible, pursuant to N.J.S.A. 30:4D-6(f), and therefore the trust res was considered an available resource. Because public policy considered the trust null and void, it was as if the trust assets were available to the applicant throughout the duration of the trust and at the time of the Medicaid application made on February 8, 2006; thus, the transfer of assets did not occur until February 8, 2006, pursuant to N.J.A.C. 10:71-4.10(m)1, and the penalty period for the transfer began on that date. J.S. v. DMAHS, OAL Dkt. No. HMA 4896-06, 2006 N.J. AGEN LEXIS 1054, Initial Decision (December 19, 2006).

10:71-4.11 Trusts

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

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

1. The purposes for which the trust is established;

2. Whether the trustee(s) has discretion or exercises such discretion under the trust;

3. Any restrictions on when or whether distribution can be made from the trust; or

4. Any restrictions on the use of distributions from the trust.

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

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

i. The individual;

ii. The individual's spouse;

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

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

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

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

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

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

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

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

2. When the corpus of a trust includes assets of either an institutionalized spouse as defined in N.J.A.C. 10:71-4.10(b)2 or a community spouse, this section shall apply to the portion of the trust attributable to either spouse for the purposes of determining eligibility for the institutionalized spouse.

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

1. In the case of a revocable trust:

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

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

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

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

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

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

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

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

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

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

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

4. Payments made from a revocable or irrevocable trust to or on behalf of the individual shall include payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment. For example, such payments may include purchase of clothing or other items, such as a radio or television, for the individual. Such payments may also include payment for services the individual may require, or care, whether medical or personal, that the individual may need. Payments to maintain a home shall also be considered payments for the benefit of the individual.

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

5. In determining whether payments can or cannot be made from a trust to or for an individual, the county welfare agency shall take into account any restrictions on payments, such as use restrictions, exculpatory clauses or limits on trustee discretion that may be included in the trust. Any amount in a trust for which payment can be made, no matter how unlikely the circumstance of payment might be or how distant in the future, shall be considered a payment that can be made under some circumstances.

i. For example, if an irrevocable trust provides that the trustee can disburse only $1,000 to or for the individual out of a $20,000 trust, only the $1,000 is treated as a payment that could be made. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the individual and may be subject to a transfer penalty. On the other hand, if a trust contains $50,000 that the trustee can pay to the grantor only in the event that the grantor needs, for example, a heart transplant, this full amount is considered as payment that could be made under some circumstances, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances and the funds are included.

6. Placement of excluded assets in trust, with the exception of a home, shall not result in a penalty of ineligibility because the transferred asset is not an asset for transfer purposes. However, a home, whether excluded or not, when transferred into a trust shall be presumed to have

been transferred for the purposes of qualifying for Medicaid.

(f) Transfer to a trust (or similar instrument, including an annuitized trust) for the sole benefit of a community spouse shall be treated in accordance with the provisions of (e) above. If the trust is established by either member of the couple (using at least some of the couple's assets), the trust shall be reviewed by the county welfare agency for availability of resources, in accordance with (e) above. If the payment from such a trust shall be considered an available resource to either spouse, the trust shall be included as a countable resource in determining Medicaid eligibility for the institutionalized spouse pursuant to N.J.A.C. 10:71-4.8.

(g) The trust provisions shall not apply to the following trusts so long as the trust document meets all the requirements set forth in this chapter:

1. A special needs trust, that is, a trust containing the assets of a disabled individual and which is established prior to the time the disabled individual reaches the age of 65 and which is established for the sole benefit of the disabled individual by a parent, grandparent, legal guardian of the disabled individual or a court, may be excluded from the rules regarding the treatment of a trust. To qualify for the exclusion, the trust shall contain the following provisions:

i. The trust shall be identified as an OBRA '93 trust established pursuant to 42 U.S.C. §1396p(d)(4)(A).

(1) The trust shall not contain any provisions intended to give anyone or a court the power to alter the form of the trust from an individual trust to a "pooled trust" under 42 U.S.C. §1396p(d)(4)(C). Notwithstanding amendments to the trust solely to conform to the requirements of this subsection and/or 42 U.S.C. §1396p(d)(4), there shall be no provisions permitting the trust to be altered for any other reasons.

ii. The trust shall specifically state that the trust is for the sole benefit of the trust beneficiary.

(1) Only trusts which are intended for the sole benefit of the disabled individual are special needs trusts. Any trust which provides benefits to other persons shall not be considered an individual special needs trust. If expenditures are made from the trust which shall also incidentally provide an ongoing and continuing benefit to other persons, those other persons who also benefit shall contribute a prorata share to the trust for the subsequent expenses associated with their use of the acquisition,

(A) For example, if the trust acquires housing for the benefit of the trust beneficiary, and other family members also live in that house, the trust document shall provide that the trustee shall require and collect a pro rata contribution for the expenses of uses incurred, and shall return such contribution to the trust. Such collections shall be reflected in the annual required trust accounting. Any property acquired by the trust shall be titled solely in the trust's name. In addition, unless the trust is given equity in any improvements to real property, the trust shall not pay for upkeep, property taxes or other expenses associated with the property or any additions to the existing property.

iii. The trust shall specifically state that its purpose is to permit the use of trust assets to supplement, and not to supplant, impair or diminish, any benefits or assistance of any Federal, State or other governmental entity for which the beneficiary may otherwise be eligible or which the beneficiary may be receiving.

(1) If the trust provides for food, clothing or shelter, such expenditures shall be considered income under Social Security and Medicaid eligibility rules.

(2) It may be permissible for the trust to acquire property which is used to provide shelter for the trust beneficiary, but the trustee shall take care to ensure that such acquisitions do not create unintended problems (such as disqualifying someone for Federal benefits). Additionally, parents shall not be relieved of their duty to support their minor child, if they are capable of doing so. A minor's funds in a trust shall not be expended on routine support, unless the parents' income is insufficient for these expenses. N.J.S.A. 3B:12-43.

iv. The trust shall specifically state the age of the trust beneficiary, that the trust beneficiary is disabled within the definition of 42 U.S.C. §1382c(a)(3) and whether the trust beneficiary is competent at the time the trust is established.

(1) If the trust beneficiary is a minor, the trustee shall execute a bond to protect the child's funds or shall get a court's permission not to do so.

(2) If there is some question about the trust beneficiary's disability, independent proof may be required.

(3) If the trust beneficiary is a minor, the trust shall state whether the trust beneficiary is expected to be competent at his or her majority.

v. The trust shall specifically identify, in an attached schedule, the source of the initial trust property and all assets of the trust. If the trust is being established with funds from the proceeds of a settlement or judgement subsequent to the bringing of a legal cause of action, Medicaid's claim for its expenditures that are related to the cause of action shall be repaid immediately upon the receipt of such proceeds and prior to the establishment of the trust.

(1) Subsequent additions made to the trust corpus shall be reported to the appropriate eligibility deter-

mination agency. Subsequent additions to the trust (other than interest on the corpus) shall cease when the trust beneficiary reaches age 65, or shall be subject to transfer provisions.

(2) If subsequent additions are to be made to the trust corpus with funds not belonging to the trust beneficiary, it shall be understood that those funds are a gift to the trust beneficiary and cannot be reclaimed by the donor.

vi. If the trust makes provisions which are intended to limit invasion by creditors or to insulate the trust from liens or encumbrances, the trust shall state that such provisions are not intended to limit the State's right to reimbursement or to recoup incorrectly paid benefits.

vii. The special needs trust shall state that it is established by a parent, grandparent, or legal guardian of the trust beneficiary, or by a court.

(1) The trust shall identify the grantor/settlor by name and as the parent, grandparent, legal guardian, or court. A court can be named as the grantor, if the trust is established pursuant to a settlement of a case before it, or if the court is otherwise involved in the creation of the trust.

viii. The trust shall specifically state that it is irrevocable. Neither the grantor, the trustee(s), nor the beneficiary shall have any right or power, whether alone or in conjunction with others, in whatever capacity, to alter, amend, revoke or terminate the trust or any of its terms or to designate the persons who shall possess or enjoy the trust estate during his or her lifetime.

(1) Notwithstanding the irrevocability provision above, the trust can state that "the trust shall be irrevocable except that the trust may be amended as necessary to conform with the requirements of 42 U.S.C. 1396p and/or state law."

ix. The trustee shall be specifically identified by name and address. The trust shall state that the original trust beneficiary cannot be the trustee. The trust shall make provisions for naming a successor trustee in the event that any trustee is unable or unwilling to serve. The Bureau of Administrative Control, Division of Medical Assistance and Health Services, as well as the trust beneficiary and/or guardian, shall be given prior notice if there is a change in the trustee.

x. The trust shall specifically state that the trustee shall fully comply with all State laws, including the Prudent Investor Act, N.J.S.A. 3B:20-11.1 et seq. The trust shall provide that the trustee cannot take any actions not authorized by, or without regard to, State laws. If the trust gives the trustee authorization or power not provided for in the Prudent Investor Act, an accompanying letter shall provide an explanation for each such authorization or power.

xi. Except as approved by court order, after notice to the Division of Medical Assistance and Health Services, individual trustee fees shall be in accordance with N.J.S.A. 3B:18-23 et seq. or, in the case of a corporate trustee, the corporate trustee's regular fee schedule. The trustee shall not delay or defer accepting compensation or commissions more than one year from the date(s) they would otherwise be payable under the terms of the trust or of any applicable statute or rule. If the trust identifies a guardian, the trust shall specifically identify him or her by name. A guardian shall be compensated only as provided by law. The parent of a minor child shall not be compensated from the trust as the child's guardian.

(1) If an adult beneficiary is not competent, the trust shall specifically state that the "guardianship protections for the incompetent's funds which are required by New Jersey law and Court rules are incorporated by reference into this trust." The trustee shall either file a bond or shall get the Court's permission not to do so.

xii. The trust shall specifically state that, upon the death of the primary beneficiary, the State will be notified, and shall be paid all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of the beneficiary. The trust shall comply fully with this obligation under the statute to first repay the State, without requiring the State to take any action except to establish the amount to be repaid. Repayment shall be made to the Treasurer, State of New Jersey, and shall be sent to the Division of Medical Assistance and Health Services, to the attention of the Bureau of Administrative Control, PO Box 712, Trenton, New Jersey 08625-0712, or to any successor agency.

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

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

xv. No provisions in the trust shall permit the estate's representative to first repay other persons or creditors at the death of the beneficiary. Only what remains in the trust after the repayments specified in (g)1xii, xiii and xiv above have been made shall be considered available for other expenses or beneficiaries of the estate. The trust may provide for a prepaid burial plan, but shall not state that it will pay for reasonable burial expenses after the death of the trust beneficiary.

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

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

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

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

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

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

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

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

v. Funds of an individual 65 or older, which are transferred to a pooled trust shall be subject to the transfer penalty provisions contained in N.J.A.C. 10:71-4.10.

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

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

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

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

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

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

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

New Rule, R.2001 d.199, effective June 18, 2001.
See: 32 N.J.R. 2021(a), 33 N.J.R. 2195(a).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Rewrote (d) through (g) and (i).

Law Review and Journal Commentaries

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

Case Notes

Medicaid applicants challenging state's treatment of community spouse annuity trusts (CSATs) as countable assets in determining Medicaid eligibility lacked standing to challenge state's undue hardship

procedures for otherwise ineligible claimants as untimely, where, although state did not have undue hardship procedures in place before action was brought, state offered applicants the opportunity to apply for undue hardship hearings, and applicants chose not to seek such hearings, thereby suffering no injury related to lack of timeliness provision. Johnson v. Guhl, 357 F.3d 403.

Pension and disability benefits paid by a qualified pension plan that was governed by ERISA and that were deposited into a bona fide special needs trust established per 42 U.S.C.S. § 1396p(d)(4)(A) and governing state law were "available" to the disabled payee for purposes of determining her Medicaid eligibility because, as a matter of law, such payments could not be assigned to the special needs trust. That being so, such payments constituted "available income" that was countable in determining the payee's income for the purpose of eligibility for the Medically Needy Program. P.R. v. DMAHS and Hunterdon Cnty. Div. of Social Servs., OAL DKT. NO. HMA 05481-12, 2015 N.J. AGEN LEXIS 766, Initial Decision (December 15, 2015).

Though the documents establishing a special needs trust for a disabled adult satisfied all regulatory requirements, the funds held there were properly considered assets of the beneficiary for the purposes of the application of the rules governing eligibility for Social Security and Medicaid benefits because the trust assets were actually utilized for a whole variety of purposes that were beyond the narrow confines of federal and state law such that it no longer qualified as a special-needs trust. The evidence established that at least $8,000 of the original $60,329.44 deposited had been given to relatives of the beneficiary for one purpose or another. Leaving aside many other expenditures that arguably yielded some benefit to others besides the beneficiary, this meant that at least 13% of the funds had been used in a way that benefited family members. Since the trust thus was not used for the sole benefit of the beneficiary, it no longer qualified as a special needs trust, and the Division of Medical Assistance and Health Services properly considered those assets in determining that the beneficiary's assets exceeded the statutory limit. D.C. v. DMAHS, OAL DKT. NO. HMA 10265-14, 2015 N.J. AGEN LEXIS 111, Initial Decision (February 20, 2015).

Decision of the Division of Medical Assistance and Health Services to deny an applicant's eligibility for Medicaid was appropriate under N.J.A.C. 10:70-5.1. The income and corpus of a family trust was not specifically excludable for purposes of determining Medicaid eligibility and must be treated as countable assets for the purpose of determining Medicaid eligibility under N.J.A.C. 10:71-4.11(e)(2)(i). As such, the applicant's countable income exceeded the resource limit of $4,000 for the Medically Needy program. K.L. v. Div. of Medical Assistance and Health Serv. and Gloucester County Bd. of Social Serv., OAL DKT. NO. HMA 11454-2014, 2015 N.J. AGEN LEXIS 37, Initial Decision (January 13, 2015).

Camden County Board of Social Services and Division of Medical Assistance and Health Services improperly denied an application for Nursing Home Medicaid. The administrative law judge concluded that the applicant's trust was irrevocable and the only payment from the trust that was not made to or for her benefit under N.J.A.C. 10:71-4.11(e)1iii was a payment for cash in the amount of $500. As a result, her assets at the time of her application for Medicaid placed her resources at under $2,000 pursuant to N.J.A.C. 10:71-4.5(c). Camden Cnty. Bd. of Social Serv. and Div. of Medical Assistance and Health Serv., OAL Dkt. No. HMA 11618-13, 2014 N.J. AGEN LEXIS 272, Initial Decision (May 20, 2014).

Medicaid applicant's irrevocable trust arrangement was void because it violated New Jersey's public policy against shielding assets to become Medicaid eligible, pursuant to N.J.S.A. 30:4D-6(f), and therefore the trust res was considered an available resource. Because public policy considered the trust null and void, it was as if the trust assets were available to the applicant throughout the duration of the trust and at the time of the Medicaid application made on February 8, 2006; thus, the transfer of assets did not occur until February 8, 2006, pursuant to N.J.A.C. 10:71-4.10(m)1, and the penalty period for the transfer began on that date. J.S. v. DMAHS, OAL Dkt. No. HMA 4896-06, 2006 N.J. AGEN LEXIS 1054, Initial Decision (December 19, 2006).

Initial Decision (2006 N.J. AGEN LEXIS 456) adopted, which concluded that a special needs trust, of which petitioner was a beneficiary, was an excludable resource under N.J.A.C. 10:71-4.4(b)6 for purposes of determining Medicaid Only eligibility because petitioner was not the grantor, the trust was not funded by any of petitioner's assets, a trustee other than petitioner had sole discretion to disburse trust funds, petitioner could not compel the distribution of the corpus or income, and petitioner was not the beneficiary of any remaining funds upon the trust's termination. A.M. v. DMAHS, OAL Dkt. No. HMA 8525-05, 2006 N.J. AGEN LEXIS 586, Final Decision (June 26, 2006).

Where trust property was described, in testimony, as the family home, and under the Trust Agreement co-trustees could in their sole discretion distribute all or any part of the trust principal reasonably necessary for the Settlor's care, support, and maintenance, and where a provision requiring the trustee to take into account any funds that may be available to the Settlor to meet those needs from any source other than the trust, which would presumably include Medicaid funds, flew in the face of the law and public policy, the applicant and his wife had resources in excess of the maximum permitted under the regulation. J.C. v. DMAHS, OAL Dkt. No. HMA 7550-05, 2006 N.J. AGEN LEXIS 349, Initial Decision (April 25, 2006).

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 or she can apply, either directly or by sale or conversion, to meet his or her basic needs for food or shelter. 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).

Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In the introductory paragraph of (b), substituted "her or she" for "he/she", "his or her" for "his/her" and "or shelter" for ", shelter, or clothing", and inserted a period at the end.

Law Review And Journal Commentaries

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

Case Notes

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

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

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

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

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

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).

Board of Social Services erred when it included, in the "countable resources" available to a Medicaid recipient, the $209.80 per month refund of Medicare Part B premiums that the recipient had paid every month since July 1993. Even though the governing regulations appeared to characterize that refund as "income," an express statement in the Social Security Administration's Program Operations Manual that such refunds were not "income" supported the conclusion that the refund was not properly included in such resources. L.F. v. Bergen Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 16900-15, 2016 N.J. AGEN LEXIS 155, Initial Decision (March 28, 2016).

Income stream that was available from a testamentary trust benefiting, inter alia, an applicant for Medicaid constituted a "resource" for the applicant that exceeded the resource ceiling in governing law and thus disqualified the applicant from qualifying for Medicaid. There was no merit to the applicant's claim that the trustee of the trust had validly determined to not invade the corpus of the trust for her nursing home care on the ground that it was not an "emergency" within the meaning of the trust because, in reality, the applicant herself had full discretion to approve or disapprove any proposed payment. S.V. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02069-15, 2016 N.J. AGEN LEXIS 78, Initial Decision (February 23, 2016).

Pension and disability benefits paid by a qualified pension plan that was governed by ERISA and that were deposited into a bona fide special needs trust established per 42 U.S.C.S. § 1396p(d)(4)(A) and governing state law were "available" to the disabled payee for purposes of determining her Medicaid eligibility because, as a matter of law, such payments could not be assigned to the special needs trust. That being so, such payments constituted "available income" that was countable in determining the payee's income for the purpose of eligibility for the Medically Needy Program. P.R. v. DMAHS and Hunterdon Cnty. Div. of Social Servs., OAL DKT. NO. HMA 05481-12, 2015 N.J. AGEN LEXIS 766, Initial Decision (December 15, 2015).

Because the N.J. Division of Medical Assistance and Health Services (DMAHS) was not required to implement an income cap waiver that was approved by the federal government, an elderly woman's application for the Global Option waiver program was properly denied based on a finding that she had excess income. The income from her annuity placed it over the monthly Medicaid eligibility income cap of $2,130. E.M. v. Union Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 16475-13, 2014 N.J. AGEN LEXIS 823, Initial Decision (December 17, 2014).

Determination by a county board of social services (CBSS) denying a petitioner's request for Medically Needy Nursing Home Medicaid per N.J.A.C. 10:70-1.1 et seq. was reversed. That determination had been based on a CBSS calculation of amounts held in four bank accounts, two of which were in the name of a business that the applicant had owned. However, the applicant established that the business had stopped operations, would not be reopening for the next school year, had no employees, owed amounts to former employees, to a landlord and to some trade vendors. That being so, a recalculation of the applicant's resources in accord with N.J.A.C. 10:71-5.1(b) and N.J.A.C. 10:71-4.1 was appropriate, and eligibility thus established. F.P. v. Middlesex Cnty. Bd. of Social Servs., OAL DKT. NOS. HMA 03183-14 and HMA 05622-14, AGENCY DKT. NO. 1215061428 (Consolidated), 2014 N.J. AGEN LEXIS 475, Initial Decision (August 6, 2014).

An Administrative Law Judge (ALJ) concluded that the Division of Medical Assistance and Health Services had correctly determined that a disabled adult's income per N.J.A.C. 10:71-5.1 exceeded the eligibility limit of $2130 that applied to the Medicaid Only/Community Care Waiver and that the applicant thus was not entitled to benefits under that program. Applying the "countable income" regulations in N.J.A.C. 10:71-5.2(a), the ALJ determined that the applicant's gross monthly Social Security income of $1,372.90 and the applicant's gross monthly Defense Finance Accounting Service annuity of $848 were properly counted in their entirety because neither amount was excludable under N.J.A.C. 10:71-5.3. F.S. v. Div. of Med. Assistance & Health Servs.,

OAL DKT. NO. HMA 01924-14, AGENCY REF. NO. 9020032857-01, 2014 N.J. AGEN LEXIS 321, Initial Decision (June 10, 2014).

Determination by a county board of social services imposing a penalty period of five months and 17 days before a 97-year-old woman could receive Medicaid Only benefits based on a finding that $479 in monthly income was properly imputed to her by reason of her life estate in a family home was reversed because the governing regulations, including N.J.A.C. 10:71-5.4(a) and N.J.A.C. 10:71-4.2(b)1, did not authorize the board to find that the applicant could obtain rental income from a life estate or that such theoretical rental income must be or could be counted as "available income" within the meaning of N.J.A.C. 10:71-5.1(b)1. Given that such an interpretation of existing rules would have a significant impact upon the public at large and given the need for uniformity throughout the state, the status of such theoretical rental income was properly the subject of formal rule-making in compliance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. H.S. v. DMAHS and Atlantic Cty. Bd. of Soc. Servs., OAL Dkt. NO. HMA 10450-12, 2013 N.J. AGEN LEXIS 12, Initial Decision (January 23, 2013).

Applicant was not entitled to Medicaid assistance where she voluntarily reduced her pension income but remained able to rescind the reduction; thus, the original monthly pension benefit of $556.34 was available to the applicant and was properly counted in the determination of Medicaid eligibility. J.C. v. DMAHS, OAL Dkt. No. HMA 6950-07, 2008 N.J. AGEN LEXIS 39, Initial Decision (January 17, 2008).

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

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

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

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

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

10:71-5.2 Determination of countable income

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

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

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

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

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

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

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

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

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

Case Notes

Though an applicant who was seeking an award of Medicaid benefits provided a letter from her bank containing certain needed information, the letter did not address the balance in the account on the first of the month, which was the critical date under applicable regulations, and that failure provided grounds for a denial. A.A-G. v. Somerset Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00912-16, 2016 N.J. AGEN LEXIS 174, Initial Decision (April 11, 2016).

Because the N.J. Division of Medical Assistance and Health Services (DMAHS) was not required to implement an income cap waiver that was approved by the federal government, an elderly woman's application for the Global Option waiver program was properly denied based on a finding that she had excess income. The income from her annuity placed it over the monthly Medicaid eligibility income cap of $2,130. E.M. v. Union Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 16475-13, 2014 N.J. AGEN LEXIS 823, Initial Decision (December 17, 2014).

An Administrative Law Judge (ALJ) concluded that the Division of Medical Assistance and Health Services had correctly determined that a disabled adult's income per N.J.A.C. 10:71-5.1 exceeded the eligibility limit of $2130 that applied to the Medicaid Only/Community Care Waiver and that the applicant thus was not entitled to benefits under that program. Applying the "countable income" regulations in N.J.A.C. 10:71-5.2(a), the ALJ determined that the applicant's gross monthly Social Security income of $1,372.90 and the applicant's gross monthly Defense Finance Accounting Service annuity of $848 were properly

counted in their entirety because neither amount was excludable under N.J.A.C. 10:71-5.3. F.S. v. Div. of Med. Assistance & Health Servs., OAL DKT. NO. HMA 01924-14, AGENCY REF. NO. 9020032857-01, 2014 N.J. AGEN LEXIS 321, Initial Decision (June 10, 2014).

10:71-5.3 Income exclusions

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

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

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

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

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

5. The value of food stamps shall be excluded.

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

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

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

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

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

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

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

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

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

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

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

ix. Payments received from the Youth Incentive Entitlement Pilot Projects, Youth Community Conservation and Improvement Projects, and the Youth Employment and Training Programs under the Youth Employment and Demonstration Projects Act of 1978 shall be exempt. However, payments from the Adults Conservation Corps under that Act or any other payments under the Comprehensive Employment and Training Act (CETA) of 1973 (with the exception of (a)6iii above) may not be excluded.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. The first $20.00 per month of income, other than income received as a VA pension based upon need, shall be excluded. This exclusion shall be applied first to unearned income, and any remaining amount of exclusion then applied to earned income. In the determination of countable income of a couple, this $20.00 exclusion is applied to the combined income of both.

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

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

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

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

As amended, R.1983 d.167, effective June 6, 1983.
See: 15 N.J.R. 422(a), 15 N.J.R. 925(a).
17. Interest on burial funds added, 17-20 renumbered 18-21.

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

Law Review and Journal Commentaries

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Case Notes

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

Board of Social Services erred when it included, in the "countable resources" available to a Medicaid recipient, the $209.80 per month refund of Medicare Part B premiums that the recipient had paid every month since July 1993. Even though the governing regulations appeared to characterize that refund as "income," an express statement in the Social Security Administration's Program Operations Manual that such refunds were not "income" supported the conclusion that the refund was not properly included in such resources. L.F. v. Bergen Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 16900-15, 2016 N.J. AGEN LEXIS 155, Initial Decision (March 28, 2016).

Denial of an 82-year old woman's application for Global Options (GO) Medicaid was appropriate. The applicant previously was receiving $2055 a month from her husband under a Limited Judgment of Divorce from Bed and Board, which payment was claimed to be the applicant's share of the ratable portion of a former marital asset, not alimony. Prior to making the GO Medicaid application, however, the applicant applied for and was awarded a consent order decreasing the $2055 monthly payment to $1500. Though an Administrative Law Judge (ALJ) agreed with the applicant that those payments did not constitute alimony, she also concluded that they were not excludable as income under any provision of N.J.A.C. 10:71-5.3. Moreover, because the applicant's action to reduce the payments was admittedly taken to enable the applicant to remain in an assisted living setting, the facts triggered the application of N.J.A.C. 10:71-4.10(b)3. That is, her monthly income would be deemed to include the entire $2055 rather than the reduced amount because the reduction was a result of action on the part of the applicant to meet eligibility guidelines. G.D. v. Burlington Cnty. Bd. of Social Servs. & DMAHS, OAL DKT. NO. HMA 2840-14, AGENCY DKT. NO. 0310031084, 2014 N.J. AGEN LEXIS 361, Initial Decision (June 20, 2014).

An Administrative Law Judge (ALJ) concluded that the Division of Medical Assistance and Health Services had correctly determined that a disabled adult's income per N.J.A.C. 10:71-5.1 exceeded the eligibility limit of $2130 that applied to the Medicaid Only/Community Care Waiver and that the applicant thus was not entitled to benefits under that program. Applying the "countable income" regulations in N.J.A.C. 10:71-5.2(a), the ALJ determined that the applicant's gross monthly Social Security income of $1,372.90 and the applicant's gross monthly Defense Finance Accounting Service annuity of $848 were properly counted in their entirety because neither amount was excludable under N.J.A.C. 10:71-5.3. F.S. v. Div. of Med. Assistance & Health Servs., OAL DKT. NO. HMA 01924-14, AGENCY REF. NO. 9020032857-01, 2014 N.J. AGEN LEXIS 321, Initial Decision (June 10, 2014).

Adopting Initial Decision's conclusion that student loans were not includable as income for purposes of determining petitioner's Medicaid eligibility under the NJ FamilyCare program; a loan is a liability, not income, and including student loans as income defeats the purpose of the student loan program, as well as the underlying spirit and intent of assisting impoverished individuals (adopting with clarification 2007 N.J. AGEN LEXIS 188). K.F. v. DMAHS, OAL Dkt. No. HMA 12115-06, 2007 N.J. AGEN LEXIS 329, Final Decision (March 15, 2007).

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

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

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

10:71-5.4 Includable income

(a) Any income which is not specifically excluded under the provisions of N.J.A.C. 10:71-5.3 shall be includable in the determination of countable income. Such income shall include, but is not limited to, the following:

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

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

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

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

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

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

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

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

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

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

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

6. Vendor payments: Cash payments, except those for medical costs, which are made on behalf of the individual by an organization or other third party shall be included as unearned income.

7. Proceeds of life insurance policies: Payments made as the result of the settlement of a life insurance policy claim shall be included as unearned income except as provided in N.J.A.C. 10:71-5.3(a)8.

8. Prizes, gifts, and awards: Cash or in-kind payments which are received as prizes, gifts, or awards shall be included as unearned income. (Occasional gifts, such as Christmas presents, with a value of $20.00 or less, are excluded.)

i. Gift defined: A gift shall be defined as any payment which is neither given as compensation for services or other consideration, nor as satisfaction of any legal obligation to the beneficiary of the gift.

ii. Value of in-kind prizes, gifts, or awards: The value of an in-kind prize, gift, or award shall be its cash value.

9. Dividends, interest royalties: Dividends, interest, and royalties shall be included as unearned income.

10. Rental income and income from roomer-boarder: The amount remaining, after all the costs (except depreciation costs) of producing the income have been deducted, shall be included as unearned income.

11. Lump-sum payments: A lump-sum payment shall be included as income (either earned or unearned, as appropriate) either in the month in which it is received or prorated over three months when the payment exceeds the individual's monthly deficit, except as follows:

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

12. Support and maintenance furnished in-kind (community cases): Support and maintenance encompasses the provision to an individual of his or her needs for food, clothing, and shelter at no cost or reduced value. Persons determined to be "living in the household of another" in accordance with N.J.A.C. 10:71-5.6 shall not be considered to be receiving in-kind support and maintenance as the income eligibility levels have been reduced in recognition of such receipt. Persons not determined to be "living in the household of another" who receive in-kind support and maintenance shall be considered to have income in the amount of:

$260.33 for an individual

$380.67 for a couple

i. In the event the individual/couple can demonstrate that the actual value of in-kind support and maintenance is less than the assigned value, the lesser value shall be counted as unearned income.

ii. The income levels in (a)12 above shall be revised annually to reflect the annual cost-of-living adjustment to the SSI payment standard made by the Social Security Administration in accordance with 42 U.S.C. § 1382f. The income level revisions to (a)12 above will be published annually as a notice of administrative change in the New Jersey Register.

13. Support and maintenance furnished in-kind (other living situations):

i. Title XIX facilities: In-kind support and maintenance is not counted in cases in which the individual is considered institutionalized for program purposes (i.e., the individual's eligibility is determined under the Medicaid "Cap").

ii. Private nonprofit domiciliary care facility: The value of in-kind support and maintenance provided an individual in a nonprofit residential care facility is excluded when all the following conditions are met:

(1) The facility is not a public facility. A public facility is one which is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(2) The facility, or the distinct portion in which the individual resides, is neither a Title XIX in-kind nor an institution for educational or vocational training.

(3) The facility is tax-exempt under Section 501(c) or (d) of the Internal Revenue Code.

(4) The facility (or organization controlling it) provides support and maintenance to the individual but does not receive payment for that part to be excluded or receives such payment from a private nonprofit organization which is also tax exempt under Section 501(c) or (d) of the Internal Revenue Code.

(5) The nonprofit facility or nonprofit organization has not undertaken an express obligation to fur-

nish full support and maintenance to the individual. An express obligation to provide full support and maintenance exists when an institution agrees to provide lifetime care in return for a specified lump sum payment and there is no requirement for any current or future payment. An express obligation also exists if, as a result of the membership of the individual or of a relative, in an organization (fraternal or religious order, union, etc.) there exists a written document requiring the facility to provide lifetime care regardless of payment provided.

(6) If the criteria in (a)13ii(1)-(5) above are not met, the value of support and maintenance is determined in accordance with (a)13iii below.

iii. Other nonmedical facilities:

(1) Facility is proprietary (private for-profit) or private non-profit and no third party pays: The value of in-kind support and maintenance is excluded from income if it is provided by such a facility, no third party payment is made for it, and:

(A) The individual makes some payment which the facility accepts as payment in full (even though its usual charge may be higher); or

(B) The individual contracts a written indebtedness to the facility for his/her support and maintenance and the facility accepts the amount of the debt plus the individual's payment, if any, as payment in full.

(2) Facility if proprietary or private nonprofit and third party pays: When a proprietary (private for-profit) or private nonprofit facility provides support and maintenance to an individual because a third party pays the facility on that individual's behalf, that individual is receiving in-kind support and maintenance. The value of the in-kind support and maintenance is determined in accordance with (a)12 above.

(3) Other situations regardless of third-party payment: In other types of facilities, support and maintenance provided by that facility is unearned income to the individual in accordance with (a)12 above.

(b) Countable income: Income remaining after appropriate income exclusions shall be applied toward the applicable income eligibility standard. The applicant's living arrangement affects the method of treatment of income and its relationship to the standards as stated in the variations appearing below.

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

2. Applicant/beneficiary couple: In the case of an applicant/beneficiary couple, living together, the total amount of husband's and wife's countable income shall be combined and applied to the appropriate income eligibility standard for a couple. Such individuals will continue to have their countable income combined until they have been separated for a period of six months.

i. One member of couple institutionalized: When one member of an applicant/beneficiary couple is institutionalized and the other remains in the community, no income of the community spouse will be used in the determination of income eligibility beginning in the month of admission into a Title XIX facility.

ii. Institutionalized couple: When an applicant/recipient couple is institutionalized in the same facility, the gross income of each individual is combined and applied to an amount equal to two times the Medicaid "Cap." If, however, the applicant/recipient couple is institutionalized in separate facilities, the income of each is applied individually to the Medicaid "Cap."

3. Applicant/beneficiary living with ineligible spouse: if the applicant/beneficiary lives with an ineligible spouse, the income of the ineligible spouse is deemed to the applicant/beneficiary (see N.J.A.C. 10:71-5.5). Such individual's income shall continue to be deemed until the husband and wife have been separated for one month. At such time the individuals will be considered to be living alone and deeming shall cease.

i. Effect of institutionalization: Income of the community spouse shall not be considered in the determination of income eligibility of the institutionalized individual beginning with the month of admission into a Title XIX facility.

4. Applicant/beneficiary unmarried and under 18 years of age, living with parents: If the applicant/recipient is an unmarried child under 18 years of age who lives with his or her parents (including stepparents), the income of the parents is deemed to the child (see N.J.A.C. 10:71-5.5(c)3). Such deeming will cease when a child has ceased living with his/her parents for a period of one calendar month.

i. Child not living with parents due to institutionalization: If a physician has certified that the child's duration of stay in a Title XIX facility (or a combination of such facilities) is expected to be a full calendar month or more, such child shall be considered to be not living with his/her parents and deeming shall cease at the time of such certification.

Emergency Amendment, R.1981 d.276, effective July 1, 1981.
See: 13 N.J.R. 501(a).
Adopted concurrent proposal, R.1981 d.385, effective September 24, 1981.
See: 13 N.J.R. 501(a), 13 N.J.R. 773(a).
Substantially amended.
Amended by R.1982 d.314, effective August 31, 1982.
See: 14 N.J.R. 758(a), 14 N.J.R. 1058(a).
Amended by R.1983 d.381, effective August 30, 1983.
See: 15 N.J.R. 1187(a), 15 N.J.R. 1585(a).
Originally filed as an emergency rule R.1983 d.289, effective July 1, 1983.

As amended as emergency rule R. 1983 d.593, effective December 19, 1983, operative January 1, 1983.
See: 15 N.J.R. 1733(a), 15 N.J.R. 2171(a).
Readopted, R.1984 d.566, effective November 28, 1984 (amendments effective January 1, 1985).
See: 16 N.J.R. 2845(a), 16 N.J.R. 3451(a).
Previously filed as emergency rule R.1984 d.289. Raised amounts of unearned income.
Emergency Amendment R.1985 d.714, effective December 27, 1985 (operative January 1, 1986, expires February 24, 1985).
See: 18 N.J.R. 215(a).
Unearned income raised.
Amended by R.1986 d.74, effective February 24, 1986.
See: 18 N.J.R. 215(a), 18 N.J.R. 565(a).
Emergency amendment, R.1987 d.78, effective December 29, 1986 (operative January 1, 1987; expires February 27, 1987).
See: 19 N.J.R. 245(a).
Unearned income raised.
Adoption of concurrent proposal, R.1987 d.174, effective April 20, 1987.
See: 19 N.J.R. 245(a), 19 N.J.R. 646(b).
Emergency amendment, R.1988 d.55, effective January 4, 1988 (operative January 4, 1988, expires March 4, 1988).
See: 20 N.J.R. 207(a).
Unearned income raised.
Adopted concurrent proposal, R.1988 d.193, effective May 2, 1988.
See: 20 N.J.R. 207(a), 20 N.J.R. 985(a).
Previously filed as an Emergency Rule.
Emergency amendment, R.1989 d.57, effective December 29, 1988 (operative January 1, 1989, expires February 27, 1989).
See: 21 N.J.R. 207(a).
Individual raised from $138.00 to $142.67 and couple raised from $197.33 to $204.33.
Emergency amendment expired February 27, 1989. Concurrent proposal adopted February 28, 1989, as R.1989 d.174, effective March 20, 1989.
See: 21 N.J.R. 217(a), 21 N.J.R. 763(a).
Emergency provisions retained.
Emergency amendment R.1990 d.55, effective December 26, 1989, operative January 1, 1990 (expires February 24, 1990).
See: 22 N.J.R. 251(a).
Includable income limits raised at (a)12.
Adopted concurrent proposal, R.1990 d.177, effective February 23, 1990.
See: 22 N.J.R. 251(a), 22 N.J.R. 954(a).
Provisions of emergency amendment R.1990 d.55 readopted without change.
Amended by R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Deleted text in N.J.A.C. 10:71-5.4(b)2i concerning includable income when one member of a couple is institutionalized and added statement establishing new guidelines. Deleted text in N.J.A.C. 10:71-5.4(b)3i concerning physician's certification and added statement establishing new includable income standard.
Emergency amendment, R.1991 d.37, effective December 31, 1990 (operative January 1, 1991).
See: 23 N.J.R. 233(a).
Increase in Medicaid Only eligibility computation amounts at (a)12.
Adopted Concurrent Proposal, R.1991 d.169, effective March 1, 1991.
See: 23 N.J.R. 233(a), 23 N.J.R. 1007(a).
Provisions of emergency amendment R.1991 d.37 readopted without change.
Emergency Amendment, R.1992 d.84, effective January 22, 1992, operative January 1, 1992, (expires March 22, 1992).
See: 24 N.J.R. 651(a).
Increase in Medicaid Only eligibility computation amounts at (a)12.
Amended by R.1993 d.402, effective August 16, 1993.
See: 25 N.J.R. 1818(a), 25 N.J.R. 3786(a).
Amended by R.1994 d.428, effective August 15, 1994.
See: 26 N.J.R. 1754(a), 26 N.J.R. 3478(a).
Amended by R.1996 d.46, effective January 16, 1996.
See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).
In (a)12 imputed income amounts revised upward.
Amended by R.1996 d.466, effective October 7, 1996.
See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiary" for "recipient" throughout; and (a)12, increased dollar amount from $176.67 to $190.67 for an individual and $255.00 to $276.33 for a couple.
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
In (a)11, added ", except as follows" at the end of the introductory paragraph and added i.
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).
In (a)12, substituted "$208.00" for "$190.67" and "$302.00" for "$276.33" in the introductory paragraph and added ii.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (a)12, substituted "$213.00" for "$208.00" and "$309.66" for "$302.00".
Administrative change.
See: 40 N.J.R. 2276(a).
Administrative change.
See: 41 N.J.R. 2485(a).
Administrative change.
See: 44 N.J.R. 1780(c).
Administrative change.
See: 45 N.J.R. 1917(a).
Administrative change.
See: 47 N.J.R. 115(b).

Case Notes

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

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

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

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

A Social Security check received by Medicaid recipient, is not a resource for inclusion in program eligibility determination (citing former N.J.A.C. 10:94-4.19 and 4.42). Gilfone v. State, 165 N.J.Super. 186, 397 A.2d 1120 (App.Div.1979).

Pension and disability benefits paid by a qualified pension plan that was governed by ERISA and that were deposited into a bona fide special needs trust established per 42 U.S.C.S. § 1396p(d)(4)(A) and governing state law were "available" to the disabled payee for purposes of determining her Medicaid eligibility because, as a matter of law, such payments could not be assigned to the special needs trust. That being so, such payments constituted "available income" that was countable in determining the payee's income for the purpose of eligibility for the Medically Needy Program. P.R. v. DMAHS and Hunterdon Cnty. Div. of Social Servs., OAL DKT. NO. HMA 05481-12, 2015 N.J. AGEN LEXIS 766, Initial Decision (December 15, 2015).

Administrative law judge affirmed the termination of a recipient's Community Medicaid Benefits under the Medically Needy program due to excessive income. Pursuant to N.J.A.C. 10:71-5.4(a)3, the Medicare Part B premium deducted from the recipient's Social Security benefits was properly counted as income. In addition, the Medicare Part B reimbursement constituted a "retirement benefit" within the contemplation of N.J.A.C. 10:71-5.4(a)3, and, accordingly, was properly

counted as unearned income. R.C. v. Somerset County Bd. of Social Serv., OAL DKT. NO. HMA09655-14, 2014 N.J. AGEN LEXIS 597, Initial Decision (October 14, 2014).

Recipient was ineligible for Medicaid at the time of her redetermination and thus the termination of her benefit by the Morris County Department of Human Services was affirmed. Because her Social Security income and VA benefits were countable income pursuant to N.J.A.C. 10:71-5.4(a), her countable income exceeded the eligibility limit. A.R. v. Morris Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 03619-14, 2014 N.J. AGEN LEXIS 313, Initial Decision (July 3, 2014).

Morris County Board of Social Services (Agency) improperly terminated a disabled individual's participation in the Global Options Community Program on the ground that her income exceeded the maximum eligibility standard. N.J.A.C. 10:71-5.4 accounted for pensions on the basis of "payment received" rather than "gross income." Thus, the Agency overstated the individual's pension by the amount of the deductions withheld. A.D. v. Morris Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 18804-13, 2014 N.J. AGEN LEXIS 256, Initial Decision (May 7, 2014).

Atlantic County Department of Family and Community Development (CWA) improperly determined that an individual with a lifetime history of mental illness was no longer eligible for Medicaid benefits. The individual resided with his father, who provided all room and board expenses, and did not pay rent or room or board to his father. The CWA misapplied N.J.A.C. 10:71-5.4 to include the in kind support received from the individual's father with his income, which would have made his total income in excess of the maximum allowable threshold. The administrative law judge concluded that because the individual did not purchase room or board separately, the in-kind support described by both the individual and the CWA could not be designated as includable income. B.B. v. Atlantic County Dep't. of Family and Cmty. Dev., OAL DKT. No. HMA 1381-14, 2014 N.J. AGEN LEXIS 147, Initial Decision (March 31, 2014).

Determination by a county board of social services imposing a penalty period of five months and 17 days before a 97-year-old woman could receive Medicaid Only benefits based on a finding that $479 in monthly income was properly imputed to her by reason of her life estate in a family home was reversed because the governing regulations, including N.J.A.C. 10:71-5.4(a) and N.J.A.C. 10:71-4.2(b)1, did not authorize the board to find that the applicant could obtain rental income from a life estate or that such theoretical rental income must be or could be counted as "available income" within the meaning of N.J.A.C. 10:71-5.1(b)1. Given that such an interpretation of existing rules would have a significant impact upon the public at large and given the need for uniformity throughout the state, the status of such theoretical rental income was properly the subject of formal rule-making in compliance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. H.S. v. DMAHS and Atlantic Cty. Bd. of Soc. Servs., OAL Dkt. NO. HMA 10450-12, 2013 N.J. AGEN LEXIS 12, Initial Decision (January 23, 2013).

Under what were described as "unique circumstances," DMAHS adopted the decision of an Administrative Law Judge finding that an amount equal to the prevailing rent for a house that was owned by a Medicaid recipient and occupied by one of her sons was not includable in the recipient's countable income for the purposes of calculating her income for eligibility purposes. That was despite the fact that in certain circumstances the value of in-kind support and maintenance of food and shelter is included in that income determination and despite the fact that if the son who was occupying those premises were to apply for benefits, the recipient's support of the son could count as income to the son. R.G. v. DMAHS and Salem Cnty. Bd. of Soc. Servs., OAL DKT. NO. HMA 9298-11, 2011 N.J. AGEN LEXIS 906, Final Decision (December 19, 2011).

Applicant was not entitled to Medicaid assistance where she voluntarily reduced her pension income but remained able to rescind the reduction; thus, the original monthly pension benefit of $556.34 was available to the applicant and was properly counted in the determination of Medicaid eligibility. J.C. v. DMAHS, OAL Dkt. No. HMA 6950-07, 2008 N.J. AGEN LEXIS 39, Initial Decision (January 17, 2008).

Receipt of out of state unemployment insurance benefits precluded recipient from receiving medicaid extension. J.M. v. Cape May County Welfare Agency, 94 N.J.A.R.2d (DEA) 9.

10:71-5.5 Deeming of income

(a) When an applicant/beneficiary is an adult residing in the same household with his or her ineligible spouse or is a child residing in the same household with his or her parent(s) or spouse of the parent, the income of the ineligible spouse or parent(s) is considered in the determination of financial eligibility. The amount included as income to the applicant/beneficiary, whether or not it is actually available, is called deemed income and is computed as described in N.J.A.C. 10:71-5.5(c), (d), (e) and (f).

1. Child: For the purpose of this section, a child is an individual who is not married and is under the age of 18 (see N.J.A.C. 10:71-5.3(a)15i regarding earnings of a child who is a student). Additionally, deeming of parental income to a blind or disabled child ceases when the child reaches age 18.

2. Parent: A parent, for deeming purposes, is a natural or adoptive parent or stepparent living in the same household as an applicant/beneficiary child. However, death or divorce of the natural or adoptive parent terminates deeming responsibility of a stepparent.

(b) Items not included in deeming: In determining the income of an ineligible spouse, parent and/or spouse of a parent, or income of any ineligible children in the household, the following are not included as income:

1. Any assistance based on need and any income considered in the determination of the amount of such assistance;

2. That portion of any grant, scholarship, or fellowship, used to pay the cost of tuitions and fees at an educational institution or costs of vocational technical training designed to prepare the individual for gainful employment;

3. Amounts received for foster care of an ineligible child;

4. The value of food stamps or U.S. Department of Agriculture donated foods (e.g., supplemental food programs);

5. Home produce grown for personal consumption;

6. Refund of taxes paid on income, real property, or food purchased by the family;

7. Such income used to comply with the terms of court-ordered support and support payments pursuant to Title IV-D of the Social Security Act;

8. The value of in-kind support and maintenance furnished to the ineligible spouse, ineligible parent(s) or ineligible spouse of a parent, and ineligible children in the household;

9. Income and benefits received under certain Federal programs described in Section N.J.A.C. 10:71-5.3(a)7;

10. The earned income of an ineligible child who is a student (subject to the limitations of N.J.A.C. 10:71-5.3(a)15, unless the child actually makes the income available to the family);

11. Income necessary for a plan to achieve self-support but only if the spouse's or parental income is actually being used according to the plan to achieve self-support.

(c) Deeming of income from spouse to spouse: If the applicant's/beneficiary's own countable income, as determined in accordance with N.J.A.C. 10:71-5.2, less appropriate exclusions in N.J.A.C. 10:71-5.3, exceeds the applicable Medicaid Only income eligibility standard in Table B at N.J.A.C. 10:71-5.6(c)5, the applicant/beneficiary is financially ineligible for Medicaid Only based on his or her own countable income, and there is no deeming. However, if the applicant's/beneficiary's own countable income renders him or her financially eligible for Medicaid Only, the following steps shall be used to compute deemed income:

1. Step 1: Calculate separately the ineligible spouse's earned and unearned income, less any income excluded in accordance with N.J.A.C. 10:71-5.5(b). Do not combine the two totals.

2. Step 2: Determine the living allowance for each ineligible child not receiving public assistance, by subtracting the child's countable income from the amount of the living allowance for an ineligible child in Table A, Figure 1.

3. Step 3: Subtract the living allowance for each ineligible child, determined in Step 2 above, from the unearned income of the ineligible spouse. Subtract any remaining living allowance from the earned income of the ineligible spouse. For any ineligible child receiving public assistance, no living allowance may be subtracted.

4. Step 4: If the total remaining income (earned plus unearned) of the ineligible spouse is equal to or less than the appropriate remaining income amount in Table A, Figure 2, no income is available for deeming to the applicant/beneficiary. The deeming process stops.

i. Determine the beneficiary's income eligibility for Medicaid Only by comparing his or her own countable income to the appropriate Medicaid Only income eligibility standard in Table B at N.J.A.C. 10:71-5.6(c)5.

5. Step 5: If Step 4 above does not apply, and the ineligible spouse's remaining total income (earned plus unearned) exceeds the appropriate remaining income amount in Table A, Figure 2, the deeming process continues and the applicant/beneficiary and his or her ineligible spouse are treated as a couple. The following deeming steps shall be used to compute the couple's countable income:

i. Add the ineligible individual's remaining unearned income after the deduction of the living allowance for the ineligible child(ren) to all of the beneficiary's unearned income. Determine the value of in-kind support and maintenance in deeming situations, in accordance with N.J.A.C. 10:71-5.4(a)12.

(1) Do not apply the $20.00 general income exclusion to the beneficiary individual's income before combining the income.

ii. Add the ineligible individual's remaining earned income after deduction of the living allowance for the ineligible child(ren) to all of the applicant's/beneficiary's earned income.

iii. Treat the two totals of unearned and earned income in the same manner as those of an eligible couple. Apply appropriate income exclusions and compute the couple's countable income as follows:

(1) First, subtract the $20.00 general income exclusion from the total unearned income. Then, subtract any unused portion of the general income exclusion from the total earned income, if any.

(2) From the remaining earned income, subtract $65.00 (work expense allowance) and one-half of the remainder of earned income.

(3) Add the remaining earned and unearned income together to arrive at the couple's total countable income.

6. Step 6: If the couple's (applicant/beneficiary and ineligible spouse) remaining countable income is less than the amount in Table A, Figure 3, for the appropriate living arrangement, the applicant/beneficiary is financially eligible for Medicaid Only. If the couple's remaining income is equal to or greater than the amount in Table A, Figure 3, for the appropriate living arrangement, the applicant/beneficiary is financially ineligible for Medicaid Only.

(d) Deeming of income to spouse and child(ren): In situations when an ineligible individual is subject to deeming of his or her income to both an applicant/beneficiary spouse and an applicant/beneficiary child, the following deeming procedures are used:

1. Step 1: Determine the amount of income, if any, to be deemed to the applicant/beneficiary spouse in accordance with the procedures in N.J.A.C. 10:71-5.5(c).

2. Step 2: If, after deeming of income from the ineligible spouse, the adult applicant/beneficiary is financially eligible for Medicaid Only, there is no income available for deeming to the applicant/beneficiary child(ren). The deeming process stops.

3. Step 3: If, in the process of deeming of income to the applicant/beneficiary spouse, such spouse becomes financially ineligible for Medicaid Only, that portion of deemed income that exceeds the eligibility level in Table A, Figure

3, for the appropriate living arrangement for the adult applicant/beneficiary shall be deemed to any child applicant/beneficiary. This income is treated as unearned income to the child.

4. Step 4: If there is more than one child applicant/beneficiary in the household, divide the deemable income equally among them. However, income is not deemed to any child in excess of that amount which, in combination with his or her own countable income, creates financial ineligibility for the child. That portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement, shall be available for deeming equally to any other applicant/beneficiary child(ren) in the household (in accordance with Step 5 below) in addition to their equal shares of the total parental deemable income.

5. Step 5: Combine any income deemed to the eligible child together with any countable income of the eligible child.

i. First, subtract the $20.00 general income exclusion from the child's unearned income.

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

iii. If the child's total income is greater than the appropriate income eligibility standard in Table B, the child is financially ineligible for Medicaid Only, and that portion of deemed income that exceeds the eligibility level in Table B, for the appropriate living arrangement for the applicant/beneficiary child, shall be available for deeming equally to any other applicant/beneficiary children in addition to their equal shares of the total deemable income.

(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/beneficiary 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/beneficiary 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/beneficiary 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/beneficiary 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/beneficiary 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/beneficiary children.

4. Step 4: If, in the process of deeming of income to an applicant/beneficiary 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/beneficiary 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) Table A which follows shall be used in deeming computation amounts. Table A will be revised annually in accordance with Federal cost-of-living adjustments made pursuant to 42 U.S.C. §1382(f). A notice of administrative changes containing the revisions will be published annually in the New Jersey Register.

Table A

Deeming Computation Amounts

1. Living allowance for each ineligible child		$361.00
2. Remaining income amount	Head of Household	Receiving Support and Maintenance
	$360.50	$ 240.67
3. Spouse to Spouse Deeming—Eligibility Levels		
a. Residential Health Care Facility		$1,820.36
b. Eligible Individual Living Alone or with Ineligible Spouse		$1,235.00
c. Living Alone or with Others		$1,113.25
d. Living in the Household of Another		$ 814.43
4. Parental Allowance—Deeming to Children Remaining Income is:		
	One Parent	Parent and Spouse of Parent
a. Earned only	$1,442.00	$2,164.00
b. Unearned only	$ 721.00	$1,082.00
c. Both earned and unearned	$ 721.00	$1,082.00

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).
Amended by R.1996 d.46, effective January 16, 1996.
See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).
Table A amended.
Amended by R.1996 d.466, effective October 7, 1996.
See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to beneficiaries for references to recipients throughout; and in (g), increased dollar amounts throughout.
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).
Rewrote (g).
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (g), updated Table A.
Administrative change.
See: 40 N.J.R. 2276(a).
Administrative change.
See: 41 N.J.R. 2485(a).
Administrative change.
See: 44 N.J.R. 1780(c).
Administrative change.
See: 45 N.J.R. 1917(a).
Administrative change.
See: 47 N.J.R. 115(b).

Case Notes

Even though the Medicaid application filed on behalf of a married woman who was residing in a rehabilitation facility was not processed within the regulatory time limits, the application was properly belatedly denied because financial information for the applicant's husband was never provided as requested. C.H. v. Essex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 20004-15, 2016 N.J. AGEN LEXIS 6, Initial Decision (January 6, 2016).

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/beneficiaries shall be determined in accordance with the following living arrangement categories. (For cases involving the deeming of income, this section shall be used in conjunction with N.J.A.C. 10:71-5.5). The income eligibility standards in Table B which follows will be revised annually to reflect the annual cost-of-living adjustments to the SSI payment standards made by the Social Security Administration in accordance with 42 U.S.C. § 1382f. A notice of administrative changes containing the revisions will be published annually in the New Jersey Register.

(b) The income standard for Residential Health Care Facilities (RHCFs) (Table B, Figure I) shall be used for individuals/couples residing in such facilities which are licensed by the New Jersey Department of Health and Senior Services. Individuals in unlicensed facilities shall always be categorized as "living alone" (N.J.A.C. 10:71-5.6(c) and Table B, II).

(c) The following provisions apply to non-institutional living arrangements:

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

i. Living physically alone;

ii. Living in a commercial establishment, such as 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, which 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, which applies to persons living with others in a private dwelling but taking all meals elsewhere; or

vi. 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) 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 or her pro rata share of household expenses.

(A) If the eligible individual's contributions (singly) are more than his or her pro rata share of household expenses, he or 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 applicants/beneficiaries 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; and garbage removal.

2. The category "living alone with ineligible spouse" (Table B, Figure III) applies when an individual lives with his or 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 described in either N.J.A.C. 10:71-5.6(c)3 or 4.

3. The category "living with others" (see Table B, Figure II) 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. 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, 2 or 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	$ 931.05	$1,820.36
II. Living Alone or with Others	$ 752.25	$1,107.36
III. Living Alone or with Ineligible Spouse	$1,107.36	
IV. Living in Household of Another	$ 524.98	$ 814.43
V. Title XIX Approved Facility: Includes persons in acute general hospitals, nursing facilities, intermediate care facilities/mental retardation (ICFMR) 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.	$2,163.00†	

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

(d) 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 and 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 Global Options 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.

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

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).
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.1996 d.46, effective January 16, 1996.
See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).
Table B amended.
Amended by R.1996 d.466, effective October 7, 1996.
See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to beneficiaries for references to recipients throughout; and in (c)5, increased dollar amounts throughout.
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Added (e).
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).
In (a), added the fourth and fifth sentences; in (c), increased the amounts for eligibility income standards in Table B.
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (c)5, updated Table B.
Administrative change.
See: 40 N.J.R. 2276(a).
Administrative change.
See: 41 N.J.R. 2485(a).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Rewrote (c) and (d).
Administrative change.
See: 44 N.J.R. 1780(c).
Administrative change.
See: 45 N.J.R. 1917(a).
Administrative change.
See: 47 N.J.R. 115(b).

Law Review and Journal Commentaries

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

Case Notes

Denial of Medicaid eligibility based on finding that the family's monthly income of $4,984 exceeded the maximum determined in accordance with the living-arrangement categories outlined in the applicable regulations was proper given the undisputed facts before the administrative law judge. S.S. v. Middlesex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 14747-15, 2015 N.J. AGEN LEXIS 599, Initial Decision (December 7, 2015).

County Board of Social Services (CBSS) acted correctly when it terminated Medicaid benefits that were being received by a recipient who, with his spouse, lived with an adult daughter in a house owned by an adult son and his wife. The recipient currently received $1079 monthly in Social Security benefits. Because the recipient and his wife, who had no income, lived in the household of another within the meaning of governing regulations, he was only permitted to earn $814.43 a month. Since his Social Security benefits exceeded that amount, the CBSS correctly terminated his Medicaid eligibility. Z.N. v. Hudson Cty. Bd. of Social Servs., OAL DKT. NO. HMA 11891-14, 2015 N.J. AGEN LEXIS 168, Initial Decision (March 24, 2015).

Because the N.J. Division of Medical Assistance and Health Services (DMAHS) was not required to implement an income cap waiver that was approved by the federal government, an elderly woman's application for the Global Option waiver program was properly denied based on a finding that she had excess income. The income from her annuity placed it over the monthly Medicaid eligibility income cap of $2,130. E.M. v. Union Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 16475-13, 2014 N.J. AGEN LEXIS 823, Initial Decision (December 17, 2014).

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

(a) The amounts specified in (b) through (h) below 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 $1,821.25 per month. 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 $546.36 per month, the amount of that excess shall in-

crease 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 rules at N.J.A.C. 10:87-5.10(a)7iv) 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 "Limited 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 $1,821.25. One-third of the remaining amount shall be the family member deduction for that family member.

(h) If a physician has certified that the individual will be institutionalized for a temporary period only and is likely to return to the residence within six months of the date of institutionalization, a maximum of $150.00 may be deducted from the institutionalized individual's income for the maintenance of his or her home in the community. This deduction shall be limited to the actual costs of such maintenance (for example, mortgage or rent payments, taxes, insurance, and other incidental costs) or $150.00, whichever is less. This deduction may be applied against the individual's income for no longer than six months. This deduction may not be applied if a deduction has been made for the maintenance of a community spouse or other family member residing in that residence.

1. This deduction must be applied to the costs of maintaining the residence and may not be accumulated by the institutionalized individual.

(i) If the institutionalized individual has health insurance covering himself or herself, the amount of the insurance premiums shall be deducted.

1. If the premium is billed other than monthly, the amount of the premium shall be prorated and deducted accordingly.

2. If the premium covers other individuals in addition to the institutionalized individual, only that portion of the premium attributable to the institutionalized individual shall be deducted.

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

(k) Effective January 1, 2010, the following policy applies to post-eligibility medical deductions.

1. For necessary medical expenses as recognized by the Division and incurred during the three-month retroactive period or during a period of eligibility, the income adjustment is limited to the Medicaid fee in effect on the date of service.

2. If no Medicaid fee exists and the medical service is medically necessary and recognized by the Division, the income adjustment will be limited to the lesser of:

i. The billed charge;

ii. The fee under the largest commercial plan in New Jersey; or

iii. Eighty percent of the Medicare fee schedule.

3. No deduction for medical and/or remedial care expenses shall be allowed for dates of service prior to the three-month retroactive period associated with the month of the Medicaid application.

4. No deduction for medical and/or remedial care expenses that were incurred during or as the result of the imposition of a transfer of assets penalty period shall be allowed.

New Rule, R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In the introductory paragraph of (c) and (g)2, increased dollar amounts from $856.00 to $1,383; and in (c)1, increased dollar amount from $257.00 to $414.00.
Amended by R.2002 d.124, effective April 15, 2002.
See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).
Added (j).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In the introductory paragraph of (a), substituted "below" for "of this section" and "long-term" for "long term"; rewrote (c); in (g)2, substituted "$1,821.25" for "$1,383"; and added (k).

Law Review and Journal Commentaries

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

Case Notes

New Jersey did not violate Medicare Catastrophic Coverage Act by employing "income-first" approach in determining Medicaid eligibility of spouse institutionalized in long-term care facility. Cleary ex rel. Cleary v. Waldman, 167 F.3d 801 (3rd Cir. N.J. 1999).

Assets of institutionalized spouse may be diverted to cover community spouse's statutory minimum needs allowance, where community spouse's income is insufficient to meet allowance, for purposes of Medicare spend down requirements; however, resources transferred to community spouse need not be adequate to cover shortfall. Cleary v. Waldman, D.N.J.1997, 959 F.Supp. 222.

Income subject to transfer from an institutionalized spouse was not limited to the income he was earning as of the date when the couple's resources were allocated for purposes of determining Medicaid Only eligibility. The other spouse's minimum monthly maintenance needs allowance deficit could be made up with the Social Security disability income the institutionalized spouse was reasonably expected to earn thereafter. N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

Under the "income-first" approach, before any of the institutionalized spouse's share of the couple's countable resources could be allocated to the community spouse to meet the shortfall in her minimum monthly maintenance needs allowance (MMMNA), the institutionalized spouse's Social Security benefits had to be applied to that deficit. Moreover, because the monthly Social Security disability benefits were sufficient to meet the MMMNA deficit, there was no basis for increasing the community spouse's share of the couple's countable resources beyond the limits established by N.J.A.C. 10:71-4.8(a). N.E. v. New Jersey Div. of Med. Assistance & Health Servs., 399 N.J. Super. 566, 945 A.2d 109, 2008 N.J. Super. LEXIS 78 (App.Div. 2008).

VA benefits payable to an institutionalized spouse that resulted from unusual medical expenses (UMEs) incurred by the institutionalized spouse were properly excluded as income in determining whether, per N.J.A.C. 10:71-4.8 and N.J.A.C. 10:71-5.7, the community spouse was entitled to an increased community spouse resource allowance. R.B. v. DMAHS and Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15134-12, 2016 N.J. AGEN LEXIS 210, Initial Decision (April 15, 2016).

Community spouse was entitled to an additional allowance to be made as a part of her minimum monthly maintenance needs allowance (MMMNA) due to her deteriorating medical condition so that the spouse had funds to defray the costs of prescriptions and therapy. However, her MMMNA was not properly increased on account of other expenses such as utilities, credit card payments or lawn care nor could the MMMNA be increased to fund the retrofitting of the community spouse's existing home, which was estimated to cost more than $40,000. R.B. v. Warren Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 04303-15, 2015 N.J. AGEN LEXIS 688, Initial Decision (August 27, 2015).

Spouse of an institutionalized person who was granted institutional Medicaid was not entitled to an increase in the amount of income allotted to her. Agency calculations showed that the community spouse needed $2,183.37 per month for maintenance and that after accounting for the spouse's income and personal social security benefit of $835.90 monthly, she was entitled to a community spouse maintenance deduction of $317.31 from her husband's funds. While the couple's son claimed that the funds available to the spouse after shelter expenses were deducted were insufficient to meet her needs, including transportation expense incurred in her job as a home health aide, the son presented no financial records or documentation of any expenses, and the record fell short of identifying any of the expenses that he testified to as being either extraordinary or unexpected. Because the record did not support the son's claim that his mother's expenses exceed her income, that her expenses were extraordinary, or that there was financial duress, no basis for an increase in her monthly allotment was shown. I.L. v. Bergen Cty. Bd. of Social Servs., OAL DKT. NO. HMA 03796-15 (Slip Opinion), Initial Decision (May 13, 2015).

Husband of a medically-needy spouse who was residing in an institutional setting was not entitled to an increase in his spousal allowance from $1,280.47 to $1,880.47 because the husband did not demonstrate by competent evidence that his monthly income justified a change to his allowance. The facts and financial data clearly demonstrated that the husband's income, which already included a spousal

allowance, was sufficient to meet his current monthly living expenses. Though the husband expressed concern that he would be unable to fund capital-type maintenance of his home, which was an older dwelling, if the same became necessary, the husband did not show that he needed to undertake those kinds of expenditures at this time. S.M. v. DMAHS and Atlantic Cty. Bd. of Social Servs., OAL DKT. NO. HMA 9749-14, 2015 N.J. AGEN LEXIS 128, Initial Decision (January 28, 2015).

Community spouse was entitled to retain the couple's excess resources when the institutionalized spouse's income and the income generated from the community spouse's share of the couple resources was insufficient to provide the maximum authorized level. By allowing the community spouse to keep the excess resources, he had no excess resources and was therefore eligible for Medicaid. E.C. v. Union County Bd. of Social Serv., OAL DKT. NO. HMA 12002-14, 2015 N.J. AGEN LEXIS 3, Initial Decision (January 2, 2015).

Spouse of a terminally ill husband met the "exceptional circumstances" standard of proof and was entitled to an increased Minimum Monthly Maintenance Needs Allowance equal to her spouse's net income after deduction for his personal-needs allowance, his medical insurance premiums, and any funds already paid to the spouse. "Exceptional circumstances" resulting in financial duress pursuant to 42 U.S.C.S. § 1396r-5(e)(2)(B) and cognate state law included the substantial debt she had already incurred to care for her husband and for her now-deceased minor child, who died from the same disease that now afflicted her husband, the fact that the facility in which her husband lived (and where he now was receiving hospice care) was suing her for $63,000, her limited earning opportunities, her own medical and dental problems. Under these circumstances, the amount otherwise allocable to the spouse as the "community spouse resource allowance" was demonstrably insufficient. R.L.W. v. DMAHS and Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 8511-10, 2014 N.J. AGEN LEXIS 825, Initial Decision (December 15, 2014).

Community spouse maintenance calculation was affirmed. The argument for exceptional circumstances resulting in the need for a higher amount under N.J.A.C. 10:71-5.7(e) was not proven. It was undisputed that the community spouse suffered from multiple sclerosis and that there were some extra expenses associated with that condition. However, it was not unexpected that a community spouse would have expenses beyond shelter expenses, and the record fell short of identifying any of those expenses as extraordinary. It was likewise not unexpected that a community spouse residing in a single family home might not be able to perform maintenance or repairs and would incur home maintenance expenses. The record did not reflect that the community spouse's expenses exceeded her income or that any of the expenses incurred were extraordinary, and a medical condition alone was not dispositive of financial duress. T.K. V. Bergen County Bd. of Social Serv., 3 OAL DKT. NO. HMA 08533-14, 2014 N.J. AGEN LEXIS 595, Initial Decision (October 29, 2014).

Combined income of a petitioner and her spouse was so low that petitioner's spouse was entitled to retain their resources totaling $139,284.25 in order to increase his monthly income closer to his Minimum Monthly Maintenance Needs Allowance of $1,750. M.M. v. DMAHS, OAL Dkt. No. HMA 13911-08, 2009 N.J. AGEN LEXIS 670, Final Decision (August 24, 2009).

Initial Decision (2007 N.J. AGEN LEXIS 189) adopted, which concluded that in calculating the Community Spouse Resource Allowance, repayments on home equity loans or lines of credit are not deductible as a shelter expense unless there is a direct relationship to preserving the marital home, such as when the loan proceeds are used for major repairs or capital improvements necessary to protect the home. A.F. v. DMAHS, OAL Dkt. No. HMA 12301-06, 2007 N.J. AGEN LEXIS 330, Final Decision (May 24, 2007).

In an institutionalization case, although the community spouse's income clearly exceeded the minimum monthly maintenance needs allowance (MMMNA), and although rental property is not an excluded resource, sale of the couple's rental property, which was necessitated by the division of the couple's resources, would reduce her income substantially; therefore, under N.J.A.C. 10:71-5.7(d) and due to the unique circumstances, the community spouse was entitled to protect the entire value of the rental property to increase her income in an attempt to reach the MMMNA and still meet the resource standard. N.S. v. DMAHS, OAL Dkt. No. HMA 4902-06, 2007 N.J. AGEN LEXIS 331, Final Decision (March 9, 2007).

Medicaid community spouse met the "exceptional circumstances" standard of proof of 42 U.S.C.A. 1396r-5 and N.J.A.C. 10:71-5.7; therefore, the community spouse's Minimum Monthly Maintenance Needs Allowance was to be recalculated and adjusted upward, beyond the standard allowances, with the inclusion of monthly adult disability child expenses not covered by SSI, monthly bankruptcy court ordered payments, and monthly expenses of a refinance loan to prevent foreclosure. Hill v. DMAHS, OAL Dkt. No. HMA 11006-03, 2006 N.J. AGEN LEXIS 83, Initial Decision (January 12, 2006).

Community spouse was entitled to increase her community spouse resource allowance under 42 U.S.C.A. 1396r-5 and N.J.A.C. 10:71-5.7, thereby protecting additional resources and making her deceased husband, who had no income, eligible for Medicaid (adopting and modifying 2005 N.J. AGEN LEXIS 595). W.S. v. DMAHS, OAL Dkt. No. HMA 2126-05, 2005 N.J. AGEN LEXIS 1111, Final Decision (September 14, 2005).

Husband's application to recalculate his Medicaid benefit was properly denied because the husband and his wife transgressed the permissible limits of Medicaid planning by entering into a divorce from bed and board and agreeing, in a consent order without judicial fact finding, that the institutionalized husband's pension benefits would be paid to the wife as alimony. H.K. v. Division of Medical Assistance and Health Services, 379 N.J. Super. 321, 878 A.2d 16, 2005 N.J. Super. LEXIS 238 (App.Div. 2005).

Both interest and principal of community spouse's monthly annuity payments constituted income for purposes of determining minimum monthly maintenance allowance under Medically Needy Program. J.M. and E.M. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 86.

Full amount of Medicaid applicant's Social Security benefits would be included as "available income" and applied to his long-term care costs, even though applicant used portion of his benefits to satisfy pre-existing alimony obligation. L.C. v. Division of Medical Assistance and Health Services, 96 N.J.A.R.2d (DMA) 73.

Exceptional circumstances resulting in significant financial distress warranted an upward adjustment in community spouse maintenance amount. M.G. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 47.

10:71-5.8 Eligibility under life care and pay-as-you-go agreements

(a) In a contractual agreement where the individual has transferred his available assets to the facility in exchange for full medical care in the institution, the institution has a legal responsibility to provide such care and Medicaid benefits are not payable for the institutional care. However, Medicaid eligibility may exist in the following circumstances (see also N.J.A.C. 10:71-5.4(a)13):

1. When it can be determined that no enforceable contract exists (for example, because the facility is financially unable to fulfill its responsibilities under the contract and all terms of the agreement are thus void), the facility has a legal obligation to refund to the individual any assets which remain from the amount assigned at the time the contract was signed. The individual may be eligible for

Medicaid Only as long as all other eligibility criteria (including resources) are met.

2. When a contract is not actually rescinded and the individual retains his or her right under the terms of the contract but, where his or her contract rights for care in the facility are not fully met, Medicaid benefits may be available for those medical expenses not being met by this facility if the individual meets eligibility requirements.

3. When the contractual agreement for care in the facility does not include all of the medical care (for example, is limited to basic room and board), Medicaid benefits may be available for those medical expenses not covered by the contract as long as all eligibility criteria are met.

4. In those contractual situations above in which Medicaid eligibility may exist, the value of in-kind room and board is not considered income.

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

10:71-5.9 Deeming from sponsor to alien

(a) For the purposes of determining eligibility for Medicaid Only for a legal alien (applying for the first time on or after October 1, 1980), the income and resources (see N.J.A.C. 10:71-4.10) of any person who sponsored the alien's entry into the United States will be deemed to the alien. Such deeming applies for a period of three years from the month of the alien's entry into the United States. However, deeming shall not apply to any alien who is:

1. Admitted to the United States under the provisions of section 203(a)(7) of the Immigration and Nationality Act which were in effect prior to April 1, 1980;

2. Admitted to the United States under the provisions of section 207(c)(1) of such Act which became effective March 31, 1980;

3. Paroled into the United States as a refugee under section 212(d)(5) of such Act;

4. Granted political asylum by the Attorney General;

5. Determined to be blind or disabled if such blindness or disability began after the date of admission into the United States for permanent residence; or

6. Sponsored by an institutional sponsor such as an employer or a church.

(b) In the event an alien is sponsored by a person subject to the deeming rules at N.J.A.C. 10:71-5.5, those rules will be used in lieu of the sponsor-to-alien rules.

(c) No inquiry shall be made regarding a sponsor's financial circumstance unless the alien's own countable income and resources indicate potential program eligibility.

(d) Normal income exclusions do not apply in deeming of a sponsor's income to an alien. Additionally, SSI benefits, TANF payments, as well as any other public income maintenance payments are not excluded in sponsor-to-alien deeming.

(e) To determine the amount of income to be deemed to an alien, the dollar amounts in (e)2 and 3 below will be updated annually by publication of a notice of administrative changes in the New Jersey Register reflecting the Federal cost-of-living adjustment to the SSI standards established pursuant to 42 U.S.C. §1382f. The 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 $721.00 for the sponsor, $1,082 for the sponsor if living with his or her spouse, $1,442 for the sponsor if his or her spouse is a cosponsor.

3. Subtract $360.50 for any other dependent of the sponsor who is or could be claimed for Federal Income Tax purposes.

4. The remaining amount is deemed as unearned income to the alien.

(f) In the event that a sponsor has sponsored more than one alien, there is no proration of deemable income among the sponsored aliens. The income is fully charged to each alien for which the sponsor has executed an affidavit of support.

R.1983 d.373, effective September 6, 1983.
See: 15 N.J.R. 999(b), 15 N.J.R. 1477(a).
As amended on emergency basis, R.1983 d.593, effective December 19, 1983, operative January 1, 1984.
See: 15 N.J.R. 1733(a), 15 N.J.R. 2171(a).Deeming amounts increased.
Amended by R.1984 d.566, effective November 28, 1984 (amendments effective January 1, 1985).
See: 16 N.J.R. 2845(a), 16 N.J.R. 3451(a).
Previously filed as emergency rule R.1984 d.289.
(e): amounts of income substantially amended.
Emergency amendment, R.1985 d.714, effective December 27, 1985 (operative January 1, 1986, expires February 24, 1986).
See: 18 N.J.R. 215(a).
Amount of income in (e)2 and 3 raised.
Readopted R.1986 d.74, effective February 24, 1986.
See: 18 N.J.R. 215(a), 18 N.J.R. 565(a).
Emergency amendment, R.1987 d.78, effective December 29, 1986 (operative January 1, 1987, expires February 27, 1987).
See: 19 N.J.R. 245(a).
Amount of income in (e)2 and 3 raised.
Adoption of concurrent proposal, R.1987 d.174, effective April 20, 1987.
See: 19 N.J.R. 245(a), 19 N.J.R. 646(b).
Emergency amendment, R.1988 d.55, effective and operative January 4, 1988 (expires March 4, 1988).
See: 20 N.J.R. 207(a).
Amount of income in (e)2 and 3 raised.
Adopted concurrent proposal, R.1988 d.193, effective May 2, 1988.
See: 20 N.J.R. 207(a), 20 N.J.R. 985(a).
Previously filed as an Emergency Rule.
Emergency amendment, R.1989 d.57, effective December 29, 1988 (operative January 1, 1989, expires February 27, 1989).
See: 21 N.J.R. 207(a).
(e)2 and 3 raised amount to be subtracted.

Emergency amendment expired February 27, 1989. Concurrent proposed amendment adopted and filed February 28, 1989, as R.1989 d.174, effective March 20, 1989.
See: 21 N.J.R. 207(a), 21 N.J.R. 763(a).
Provisions retained.
Emergency amendment R.1990 d.55, effective December 26, 1989, operative January 1, 1990 (expires February 24, 1990).
See: 22 N.J.R. 251(a).
Deeming computation amounts raised.
Adopted concurrent proposal, R.1990 d.177, effective February 23, 1990.
See: 22 N.J.R. 251(a), 22 N.J.R. 954(a).
Provisions of emergency amendment R.1990 d.55 readopted without change.
Emergency amendment, R.1991 d.37, effective December 31, 1990 (operative January 1, 1991).
See: 23 N.J.R. 233(a).
Increase in Medicaid Only eligibility computation amounts at (e).
Amended by R.1991 d.32, effective January 22, 1991.
See: 22 N.J.R. 7(a), 23 N.J.R. 215(b).
Section recodified from 5.7.
Adopted Concurrent Proposal, R.1991 d.169, effective March 1, 1991.
See: 23 N.J.R. 233(a), 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).
Amended by R.1996 d.46, effective January 16, 1996.
See: 27 N.J.R. 3668(a), 28 N.J.R. 291(a).
Increased amounts in (e)2 and 3.
Amended by R.1996 d.466, effective October 7, 1996.
See: 28 N.J.R. 2779(c), 28 N.J.R. 4480(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (d), substituted "TANF" for "AFDC"; and in (e), substituted "CBOSS" for "CWA" in the introductory paragraph, and increased dollar amounts in 2 and 3.
Amended by R.2004 d.401, effective November 1, 2004.
See: 36 N.J.R. 922(b), 36 N.J.R. 4982(a).
Rewrote (e).
Amended by R.2006 d.133, effective November 6, 2006.
See: 37 N.J.R. 3774(a), 37 N.J.R. 4505(a), 38 N.J.R. 4712(a).
In (e)2, substituted "$579.00" for "$564.00", "$869.00" for $846.00 and "$1158" for "$1,128"; and in (e)3, substituted "$289.50" for "$282.00".
Administrative change.
See: 40 N.J.R. 2276(a).
Administrative change.
See: 41 N.J.R. 2485(a).
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In the introductory paragraph of (a), updated the N.J.A.C. reference; and in the introductory paragraph of (e), substituted "CWA" for "CBOSS".
Administrative change.
See: 44 N.J.R. 1780(c).
Administrative change.
See: 45 N.J.R. 1917(a).
Administrative change.
See: 47 N.J.R. 115(b).

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 CWA's decisions and actions for each case.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS's" for "CWA's".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA's" for "CBOSS's".

10:71-6.2 Contents of the case record

(a) The following items shall be included in the case record:

1. The narrative recording;

2. All medical reports and record of action from the MRT (appropriate cases);

3. All forms related to financial eligibility; and

4. All related correspondence, memoranda and documents except those which are required by law and regulation to be maintained in some other files.

10:71-6.3 Forms applicable to the Medicaid Only program

Forms applicable to the Medicaid Only program (aged, blind and disabled) are listed on page 1 of Appendix A; sample forms follow that list.

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 the policy and procedure on retention and destruction of case records see N.J.A.C. 10:69-7, Case Records and Files.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "N.J.A.C. 10:69" for "Public Assistance Manual 7270".

Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Inserted "the" and "-7, Case Records and Files".

SUBCHAPTER 7. OTHER PAYMENTS

10:71-7.1 General provisions

Medicaid Only beneficiaries, like Supplemental Security Income (SSI) beneficiaries, 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.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiaries" for "recipients" throughout, and substituted "board of social services" for "welfare agency" in the last sentence.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "welfare agency" for "board of social services".

10:71-7.2 Services and service payments

Eligible applicants and beneficiaries 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.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiaries" for "recipients" in the first sentence, and substituted "board of social services" for "welfare agency" in the last sentence.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "welfare agency" for "board of social services".

10:71-7.3 Other service payments

Eligible applicants and beneficiaries of Medicaid Only are also eligible to receive certain service payments as authorized at N.J.A.C. 10:69-10.22(b) and 10.23. These include payments for expenses incident to homemaker service, travel costs for health care, and childcare in certain situations.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiaries" for "recipients", and changed N.J.A.C. reference.

10:71-7.4 Emergency assistance payments

Eligible applicants and beneficiaries of Medicaid Only are not eligible to receive emergency assistance as defined in N.J.A.C. 10:69-10.23.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiaries" for "recipients", and changed N.J.A.C. reference.

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" beneficiaries, as well as former Old Age Assistance, Disability Assistance and Assistance for the Blind beneficiaries. The procedure authorizing these payments is located at N.J.A.C. 10:90-8.

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.
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiaries" for "recipients" throughout, substituted "board of social services" for "welfare agency" in the first sentence, and changed N.J.A.C. reference.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "welfare agency" for "board of social services".

Case Notes

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

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 eligibility 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/beneficiary of any agency decision that relates to his or her eligibility status in accordance with the provisions of (d) below 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. Redeterminations of eligibility require the completion of Form PA-1G-NJR2 (Redetermination Form). The CWA may require that the form be completed during a face-to-face interview. However, at the option of the CWA,

and with the approval of the beneficiary, the face-to-face interview may be eliminated. Form PA-1G-NJR2 (Redetermination Form) may be mailed to and completed by the beneficiary and mailed to the CWA. All factors of eligibility subject to change (with the exception of disability and blindness factors) must be verified or reverified.

i. When a loss of assistance will result, the face-to-face interview shall be required, unless the agency documents a clear refusal by the beneficiary to have a face-to-face meeting. Before benefits are terminated, a beneficiary shall be offered a face-to-face home visit. The visit shall not be required to be in the office, but at the beneficiary's request, in the home.

2. Redetermination of financial and resource eligibility: The eligibility 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 the Medicaid Eligibility Worksheet: It is the responsibility of the eligibility worker to complete a new Form PA-1E when eligibility is to be continued, or terminated. A PR-1 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) shall be prepared. The summary shall clearly state the basis for any termination of eligibility. Following each redetermination of eligibility, it is the responsibility of the eligibility worker to recommend that eligibility be continued or terminated.

(d) Notice of agency decision: Each applicant/beneficiary 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.

Amended by R.2000 d.396, effective October 2, 2000.
See: 32 N.J.R. 2420(a), 32 N.J.R. 3570(a).
Rewrote the section.
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Rewrote the section.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In the introductory paragraph of (b)1 and in (b)4, substituted "CWA" for "CBOSS" throughout.

Case Notes

County social services board acted improperly when it terminated Medicaid benefits being paid to a petitioner because it did not afford the petitioner the procedure that was required to be followed where, as here, the board was engaging in a redetermination of the petitioner's benefits. K.B. v. Hudson Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13862-15, 2015 N.J. AGEN LEXIS 663, Initial Decision (October 21, 2015).

An Administrative Law Judge (ALJ) concluded that an adult who had been receiving Medicaid was thereafter determined not to be disabled within the meaning of applicable definitions. That conclusion rested in part on the ALJ's finding that the adult's challenges to the manner in which a county board of social services (CBSS) had proceeded in the matter were moot even though the record established that the agency had not complied with N.J.A.C. 10:71-8.1(b)(1). Rather, the claim had become moot because the adult's application for supplemental Social Security had been denied. Nor was there any provision in the Medicaid regulations that provided for the continuation of Medicaid upon a redetermination in the face of an SSI denial even if the denial was in an appeal status or that a new SSI application had been filed. M.A. v. Div. of Medical Assistance & Health Servs. and Hudson Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 05612-14, AGENCY CASE NO. 0920911823-01, 2014 N.J. AGEN LEXIS 389, Initial Decision (June 27, 2014).

Effective date of Medicaid eligibility was not date of patient's admission to long-term care facility, but was date of her subsequent submission of Medicaid application. E.M. v. Division of Medical Assistance, 95 N.J.A.R.2d (DMA) 63.

10:71-8.2 Redetermination of medical eligibility

(a) Redetermination of disability and blindness factors shall be done for every Medicaid Only beneficiary at intervals set by the Division of Medical Assistance and Health Services, Medical Review Team (MRT), except those beneficiaries 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)).

(b) 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.

(c) 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 Medical Review Team, 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.

(d) The Medical Review Team will maintain a control file in order to ensure appropriate and timely reevaluation by the Medical Review Team. The Medical Review Team will notify the county welfare agency 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.

(e) The eligibility worker shall organize his or her caseload controls (notebooks, index, and other related materials or equipment) 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."

(f) When a case is to be submitted to the Medical Review Team for redetermination review, the eligibility 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.

(g) Medicaid coverage shall be continued, if financial and resource eligibility continues to exist, unless and until the CWA is advised by the Medical Review Team that the individual no longer meets the disability and blindness requirements or the individual withdraws voluntarily.

(h) Upon receipt of records from the Medical Review Team, the CWA shall follow the procedures as outlined in N.J.A.C. 10:71-3.13(g).

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Rewrote the section.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA" for "CBOSS" and deleted "(MRT)" following "Medical Review Team" throughout; and in (d), substituted "Medical Review Team" for "medical review team (MRT)" and substituted "the county welfare agency" for "county board of social services".

10:71-8.3 Notice of county welfare agency decision

The county welfare agency shall promptly notify, in writing, the applicant for, or beneficiary of, Medicaid Only of any agency decision.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "board of social services" for "welfare agency", and substituted "beneficiary" for "recipient".
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Section was "Notice of county board of social services decision". Substituted "welfare agency " for "board of social services" and deleted the last sentence.

10:71-8.4 Complaints and fair hearings

(a) It is the right of every applicant for, or beneficiary 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. 10:49-10 and 10:69-6, 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
Office of Legal and Regulatory Liaison
PO Box 712
Mail Code #3
Trenton, New Jersey 08625-0712

(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 Office of Legal and Regulatory Liaison.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (a), substituted "beneficiary" for "recipient", and changed N.J.A.C. reference.

Case Notes

Fair hearing barred by rule of limitations. Bridgeton Nursing Center v. Division of Medical Assistance and Health Services, 92 N.J.A.R.2d (DMA) 1.

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. 10:69-9.15 through 9.20 (fraudulent receipt of assistance) shall apply to the Medicaid Only program.

Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "N.J.A.C. 10:69-9.15 through 9.20" for "N.J.A.C. 10:81-7.40 through 7.45".

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

Investigation of new applications or investigations for redetermination or eligibility may on occasion present indications to the CWA that a crime may have been committed. In such a situation, the procedures outlined in N.J.A.C. 10:69-9.19 through 9.20 (reporting criminal offenses to law enforcement authorities) are to be followed.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA", and changed N.J.A.C. reference.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA" for "CBOSS".

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 beneficiaries to purposes directly connected with the administration of public assistance. Therefore, the policies and procedures outlined in N.J.A.C. 10:69-9.8 through 9.10 (safeguarding information) apply to the Medicaid Only program.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "beneficiaries" for "recipients", and changed N.J.A.C. reference.

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. 10:69-9.12 through 9.14 (nondiscrimination) are to be strictly observed.

Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Deleted a comma following "origin" and deleted "in public assistance programs" following "nondiscrimination", and substituted "N.J.A.C. 10:69-9.12 through 9.14" for "N.J.A.C. 10:81-7.36 through 7.38".

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 beneficiaries 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. Beneficiaries receive the full spectrum of Medicaid services.

Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to beneficiaries for references to recipients throughout.

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 DMAHS/MRT (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 DMAHS/MRT 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."
Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
In (b) and (c), substituted references to CBOSSs for references to CWAs throughout, and substituted references to MRT for references to DRU throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
In (b) and (c), substituted "CWA" for "CBOSS".

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 DMAHS/MRT: Thirty days prior to the end of each certification period, the CWA will forward to DMAHS/MRT 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 DMAHS/MRT: The DMAHS/MRT 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 DMAHS/MRT determination the CWA will, as appropriate, move to terminate or recertify the case for such periods as may be required to make the review month become the final month of the new certification period.

Amended by R.1995 d.651, effective December 18, 1995.
See: 27 N.J.R. 3543(a), 27 N.J.R. 5046(a).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted references to MRT for references to DRU and substituted references to CBOSSs for references to CWAs throughout; and in (a), substituted a reference to DMAHS/MRT for a reference to DPW/BMA.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA" for "CBOSS" throughout; in (a), deleted a comma following the second occurrence of "services".

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 Assis-

tance 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).
Amended by R.2000 d.415, effective October 16, 2000.
See: 32 N.J.R. 2565(a), 32 N.J.R. 3844(a).
Substituted "CBOSS" for "CWA" throughout.
Amended by R.2012 d.025, effective February 6, 2012.
See: 43 N.J.R. 804(a), 44 N.J.R. 230(a).
Substituted "CWA" for "CBOSS" throughout.