Indiana Health Coverage Program Policy Manual
Chapter 2600 RESOURCES Sections 2600.00.00 – 2640.10.40

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2600.00.00 RESOURCES

This chapter presents requirements for determining eligibility based on resources. The chapter contains the following main sections:

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2605.00.00 PRINCIPLES OF RESOURCES

This entire chapter is inapplicable to MED 3 and TMA (MA F).

The resources owned by specific individuals must be identified and evaluated according to the requirements of each program. A distinction between resources and income must always be made so that proper consideration is given to each. Section 2605 outlines principles which apply to the consideration of resources in the determination of eligibility for assistance.

All property not specifically exempted in the following sections is countable as a resource. When there is an agreement to offer to dispose of real property, the agreement should be considered to be effective for the purposes of the application (see 2620.20.10).

2605.05.00 DEFINITION OF RESOURCES

Resources are real or personal property that is owned solely or jointly by an individual.

Real property is land, including buildings or immovable objects attached permanently to the land. Real property also includes life estates, remainder interests, and mineral rights. (Refer to Sections 2605.25.10 and 2620.00.00).

Personal property includes all property that is not real property. The eligibility system resource screens identify the following types of personal property as liquid resources:

Cash on hand (including balances on a pay card).

Checking accounts.

Savings accounts, including Christmas Club.

Savings certificates.

Trust funds.

Individual retirement accounts.

Keogh plans.

Credit union accounts.

Prepaid funeral agreements.

Stocks.

Bonds.

Virtual currency is also known as cryptocurrency, such as Bitcoin.

Nursing home accounts.

2605.10.00 OWNERSHIP OF RESOURCES

The owner of a resource is any individual who has the ability to liquidate or dispose of the resource. A resource can be solely or jointly owned.

2605.10.05 JOINT OWNERSHIP OF RESOURCES

Joint ownership of resources, consisting of real or personal property, exists when the right to liquidate or dispose of the property is shared by more than one individual. Joint ownership is indicated by entering "Y" on the Liquid Asset-Details page. The full amount is entered for each individual in the case who owns part of the resource. Then the joint ownership screen comes up for each joint owner. If the resource is jointly owned by a married couple, one-half of the resource is to be entered for each spouse on the jointly owned resources screen. Otherwise, the entry on the screen depends on the type of resource, as explained below.

When any type of account held in a financial institution is jointly owned, the worker is to presume that all of the funds belong to each owner. The individuals are to be advised of this presumption and given the opportunity to rebut it. If an applicant/recipient rebuts, they are responsible for providing proof of ownership of the funds, which includes a record of deposits and withdrawals from the account.

Following a successful rebuttal, the funds must be separated and placed in separate accounts. Only the funds actually belonging to the applicant/recipient will then be counted as a resource to them and entered on the Liquid Resources screen. This procedure applies whether or not the joint owners are all applying for or receiving assistance. If the funds are not separated, the balance is counted in its entirety by each joint owner.

In addition to bank accounts, other real and personal property may be jointly owned. If an applicant/recipient owns real property or non-liquid personal property with another applicant/recipient of any assistance program, the real/personal property resources screen is to be completed for EACH owner. Then proportionate shares of the property are to be assigned to the joint owners on the Jointly Owned Resources screen. The percentage amount of the share owned by each individual is entered on the screen. Refer to Section 2605.10.10 regarding the availability determination for jointly owned vehicles.

When a non-recipient is one of the joint owners of real or personal property, the availability of the applicant's/recipient's proportionate share must be determined. If the individual has the unrestricted right, authority, or legal ability to liquidate or dispose of the property, or their share of it, the proportionate share would be available to them.

If the joint owners do not have unrestricted rights to sell their interest in real property according to the title or other legal document, statements must be obtained from all joint owners to determine if they are all willing to sell the property.

If all joint owners are willing to sell, then the property will be considered available. The AV (available) question on the Real/Personal Property Resources screen is answered "Y", and the Jointly Owned Resources screen will come up. The percentage amount of their share is to be entered on the screen.

2605.10.10 JOINT OWNERSHIP OF VEHICLES

This section addresses the determination of "availability" of jointly owned vehicles. If a vehicle is found to be available, refer to Section 2605.10.05 to determine how to complete the Jointly Owned Resources screen.

A jointly owned vehicle is considered an available resource to the Assistance Group (AG) when:

It is jointly owned with another, (one or more) applicant/recipient who may or may not be in the same AG or living at the same address

It is jointly owned by a non-recipient who lives with the AG and either owner has physical possession and/or use of the vehicle and the non-recipient owner agrees to sell the vehicle

It is jointly owned with a non-recipient who does not reside with the AG, but the AG has physical possession or use of the vehicle and the non-recipient owner agrees to sell the vehicle

It is jointly owned with a non-recipient who does not live with the AG and the AG does not have physical possession or use of the vehicle but, the joint owner is willing to sell the vehicle, thus enabling the client to obtain his share of the vehicle's value.

If the client cannot legally sell the vehicle or take action to remove their name from the title (for example a pending lawsuit prohibits this action) the vehicle will not be considered to be available even in the situations listed above. The client must provide proof that the vehicle is not legally available by presenting court or BMV documents.

Therefore, when a vehicle is found to be jointly owned with a non-recipient, the AG must be asked if the non-recipient is willing to sell the vehicle. If the non-recipient is not willing to sell, verification of the non-recipient's statement must be obtained. The recipient must cooperate in locating and obtaining verification from the non-recipient.

2605.15.00 AVAILABILITY OF RESOURCES

Resources are available if the owner has unrestricted right, authority, or legal ability to liquidate or dispose of the property or his share of the property. Resources must be available in order to be counted in the eligibility determination.[1] Refer to Section 2605.10.10 regarding the availability determination of jointly owned vehicles. Refer to Section 2615.45 regarding the availability determination of savings bonds for MED 1.

2605.20.00 RESOURCE ELIGIBILITY DATE

The resource eligibility determination is based on resources owned as of the first day of a month. Ownership of excess resources on the first day of the month renders an applicant or recipient ineligible for medical assistance for the entire month. The first day of the month means the first moment of the first day. Therefore, a financial transaction occurring on the first day does not affect the first of the month resource amount.

For applicants, resources must be verified as of the first day of each retroactive month and the month of application. For a redetermination or a resource review, verification of the most current value of resources must be obtained. The value is then used to project resource eligibility for the following month.

For liquid resources, the worker must enter on the Liquid Resources screen the resource information for each retroactive month and the month of application, including a "begin date" and an "end date" if the amount differs on the first day of each of the months. Subsequent changes in the amounts during the application processing period must be entered accordingly.

Income is considered income in the month received, and a resource the month following. All income received in the previous month that was intended for that month counts as a resource in the following month. The only exception to this is early payments. For example, social security deposited the check on 01/03, but then deposited the February check early on 01/31. The

second social security check should be deducted from the 02/01 bank balance. If a member routinely gets income at the end of the month, it is considered income in the month received and a resource the month after. If there are questions, submit to PAL.

2605.25.00 DETERMINING RESOURCE VALUE

The value of a resource must be determined in order to establish the amount that must be counted toward the resource limit. With a few exceptions, the amount of any resource to be counted is the equity value. Equity value is the current fair market value minus the total amount of liens against the property.[2] The exceptions to this procedure are vehicles (Section 2605.25.05) and, in certain instances, real property. (See section 2605.25.10.)

2605.25.05 VEHICLE VALUATIONS

The fair market value of a vehicle is the lowest "wholesale" value as listed in publications written for the purpose of providing guidance to automobile dealers and loan companies. The Kelly Blue Book vehicle value guide may be used. If the Kelly Blue Book vehicle value guide is not available, any vehicle value guide which provides guidance to automobile dealers and loan companies may be used provided they have been updated within the last six months. If the applicant/recipient disputes the value amount, a written statement must be obtained from a licensed automobile dealer.

The AG should be asked to acquire verification of the value of antique, custom made, or classic vehicles, if the worker is unable to make an accurate appraisal.

If a vehicle is especially equipped with apparatus for the handicapped, the book value is to be assigned as if the vehicle were not so equipped.

If a vehicle is no longer listed in a book due to the age of the vehicle, the AG's estimate of the value of vehicle is to be accepted, unless there is reason to believe that the estimate is incorrect.

A written statement must be obtained from a licensed automobile dealer.

Vehicle verification must include verification of all of the following:

Ownership

License status

Fair market value

Amount owed.

Workers must keep in mind that equity value will increase with each monthly loan payment.

Also, the fair market value may decrease whenever the publication used to establish the value is published. For those recipients who are very close to the resource limit, the value of nonexempt vehicles may have to be verified monthly to ensure that the recipient does not have excess resources as of the first day of a month.[3]

2605.25.10 REAL PROPERTY VALUE

Fair market value is the reasonable price that real property can be expected to sell for on the open market in the particular geographic area involved. (Refer to 2605.05.00 for definition of real property and to 2620.)

The fair market (FMV) value of real property can be obtained through tax records or from an estimate by a knowledgeable source. When tax records are used, the most recent property tax assessment must be obtained. The fair market value is the assessed value divided by the assessment ratio. The tax assessment cannot be used if:

It is more than one year old

It is under appeal

It is based on a fixed rate per acre method

The taxing authority does not provide an assessment ratio, or only provides a range, for example, between 50% and 75%.

If the worker questions an estimate from a knowledgeable source, one or more additional estimates are to be obtained and averaged in order to establish the fair market value.

If the lesser value is accepted, it must be entered on the Real/Personal Property resources screen in the Equity field. Since the eligibility system calculates the equity based on the worker entered FMV of property, the equity override (EO) field must be answered "Y" to enable the lesser equity to be entered and used by the system in the eligibility determination.

2605.25.10.05 LIFE ESTATE/REMAINDER VALUE

Life Estate: A life estate conveys to an individual certain rights in property for his lifetime. The owner of a life estate generally has the right of possession and use of the property, as well as the right to obtain profits from the property and to sell his life estate interest.

Remainder Interest: When an individual conveys property to one person for life (life estate holder) and to a second person (the remainderman) upon the death of the life estate holder, both a life estate interest and a remainder interest are created in the property. A remainderman cannot sell his interest in the property while the life estate holder is alive unless otherwise specified in the deed. At the death of the life estate holder, the remainderman will hold full title.

The fair market value of a life estate or remainder interest is determined as follows:

Determine the fair market value of the property (Section 2605.25.10) in the usual manner

Refer to the Life Estate and Remainder Interest Tables in Section 2605.25.10.10

Using the individual's age as of his last birthday, multiply the figure in the Life Estate or Remainder Interest column for that age by the fair market value of the property to obtain the value of the life estate or remainder interest.

Advise the individual or person acting on their behalf of the presumed value of the life estate obtained from the table and provide him the opportunity to submit documentation of a lesser value. Such documentation will be acceptable only if it is provided by a knowledgeable source based on an evaluation of the specific life estate in question.

If the lesser value is accepted, it must be entered on the Real/Personal Property Resources screen in the Equity field. Since the eligibility system calculates the equity based on the worker entered FMV of property, the equity override (EO) field must be answered "Y" to enable the lesser equity to be entered and used by the system in the eligibility determination.

2605.25.10.10 LIFE ESTATE/REMAINDER TABLES

AGE	LIFE ESTATE	REMAINDER
0	0.97188	0.02812
2	0.99017	0.00983
4	0.98981	0.01019
6	0.98884	0.01116
8	0.98748	0.01252

AGE	LIFE ESTATE	REMAINDER
1	0.98988	0.01012
3	0.99008	0.00992
5	0.98938	0.01062
7	0.98822	0.01178
9	0.98663	0.01337

10	0.98565	0.01435	11	0.98453	0.01547
12	0.98329	0.01671	13	0.98198	0.01802
14	0.98066	0.01934	15	0.97937	0.02063
16	0.97815	0.02185	17	0.977	0.023
18	0.9759	0.0241	19	0.9748	0.0252
20	0.97365	0.02635	21	0.97245	0.02755
22	0.9712	0.0288	23	0.96986	0.03014
24	0.96841	0.03159	25	0.96678	0.03322
26	0.96495	0.03505	27	0.9629	0.0371
28	0.96062	0.03938	29	0.95813	0.04187
30	0.95543	0.04457	31	0.95254	0.04746
32	0.94942	0.05058	33	0.94608	0.05392
34	0.9425	0.0575	35	0.93868	0.06132
36	0.9346	0.0654	37	0.93026	0.06974
38	0.92567	0.07433	39	0.92083	0.07917
40	0.91571	0.08429	41	0.90457	0.09543

42	0.90457	0.09543	43	0.89855	0.10145
44	0.89221	0.10779	45	0.88558	0.11442
46	0.87863	0.12137	47	0.87137	0.12863
48	0.86374	0.13626	49	0.85578	0.14422
50	0.84743	0.15257	51	0.83674	0.16126
52	0.82969	0.17031	53	0.82028	0.17972
54	0.81054	0.18946	55	0.80046	0.19954
56	0.79006	0.20994	57	0.77931	0.22069
58	0.76822	0.23178	59	0.75675	0.24325
60	0.74491	0.25509	61	0.73267	0.26733
62	0.72002	0.27998	63	0.70696	0.29304
64	0.69352	0.30648	65	0.6797	0.3203
66	0.66551	0.33449	67	0.65098	0.34902
68	0.6361	0.3639	69	0.62086	0.37914
70	0.60522	0.39478	71	0.58914	0.41086
72	0.57261	0.42739	73	0.55571	0.44429

74	0.53862	0.46138	75	0.52149	0.47851
76	0.50441	0.49559	77	0.48742	0.51258
78	0.47049	0.52951	79	0.45357	0.54643
80	0.43659	0.56341	81	0.41967	0.58033
82	0.40295	0.59705	83	0.38642	0.61358
84	0.36998	0.63002	85	0.35359	0.64641
86	0.33764	0.66236	87	0.32262	0.67738
88	0.30859	0.69141	89	0.29526	0.70474
90	0.28221	0.71779	91	0.26955	0.73045
92	0.25771	0.74229	93	0.24692	0.75308
94	0.23728	0.76272	95	0.22887	0.77113
96	0.22181	0.77819	97	0.2155	0.7845
98	0.21	0.79	99	0.20486	0.79514
100	0.19975	0.80025	101	0.19532	0.80468
102	0.80025	0.80946	103	0.18437	0.81563
104	0.17856	0.82144	105	0.16962	0.16962

106	0.15488	0.84512
108	0.10068	0.89932

107	0.13409	0.86591
109	0.04545	0.95455

2605.25.10.15 MINERAL RIGHTS VALUE

A mineral right is an ownership interest in certain natural resources such as coal, sulphur, petroleum, sand, natural gas, and others which are usually obtained from the ground. If the individual owns the land to which the mineral rights pertain, the fair market value of the land can be assumed to include the value of the mineral rights. If the individual does not own the land to which the mineral rights pertain, a fair market value must be obtained from a knowledgeable source such as: the Bureau of Land Management, the U. S. Geological Survey, or any mining company that holds leases.

2605.30.00 CONVERSION OF RESOURCES

Whenever a resource is sold or converted from one form to another resource, the proceeds remain a resource rather than income.[4] Verification concerning the new resource must be obtained.

Example 1:

An applicant/recipient has an IRA valued at $100,000. The applicant/recipient cashed in the policy and deposits the proceeds into a bank account. Because the IRA was converted to a bank account (from one resource to another resource), it is considered a conversion of resources and remains a countable resource.

Example 2:

An applicant/recipient has an IRA valued at $100,000. The applicant/recipient annuitizes the IRA and payments in the amount of $500 a month. The resource has been converted to income. This is a conversion of a resource to income making the IRA no longer a countable resource but the distributions countable as income. The IRA should be updated in the eligibility system as not available and the payments of $500 are considered income.

2605.35.00 VERIFICATION OF RESOURCES

All verification of resources must be obtained from the source (for example, by the bank where the account is held) or through a source document. Verification of resources is required in all programs; however, the individual's signed statement as to the amount of cash on hand is sufficient (Refer to Section 2615.05.00). When resources are jointly owned, the portion belonging to the individual must be identified and verified.

2605.40.00 MONITORING OF RESOURCES

Each applicant/recipient must be advised of the resource limits of the assistance programs and their responsibility to report any changes in the resource amounts which may affect their eligibility for assistance.

Resources are verified at each redetermination and must be monitored more frequently if changes are anticipated, or resources are close to the limit. When payments are being made on real property or vehicles, the equity value may require monitoring as each payment will increase the property's equity.

Special emphasis must be placed on the need for the recipient to keep their resources within the program's limits in order for assistance to continue. Additionally, workers are responsible for monitoring resources between redeterminations.

In cases where resources are close to the resource limits, the cases must be flagged to alert the workers to check resources frequently or on a monthly basis when necessary. The Expected Changes Screen should be used for this purpose. Monthly monitoring of the value of resources is not required.

2605.45.00 THEFT OF FUNDS

When a member, or their authorized representative, claims that the member’s income or resources have been stolen or misused it must be sent to PAL for review.

To avoid imposition of a transfer of property penalty when claiming stolen or misused funds, the following actions are required:

The member must cooperate in the filing of an official police report detailing the alleged theft or misuse, and

The member must actively cooperate with law enforcement in the pursuit of charges against the alleged perpetrator.

In situations where the member claims their authorized representative, power of attorney, legal guardian or other legal representative has misused or stolen their income or resources, the member must cooperate in the required actions outlined above and must also:

Remove the accused individual as their representative, and

Report the accused representative to Adult Protective Services (APS).

In all cases involving a claim of stolen or misused assets, documentation verifying the member's active cooperation in all required actions must be requested and sent to PAL for review.

If funds are returned or ~~if~~ restitution is paid to the member, then the resources should be reviewed to verify that the member meets the eligibility criteria.

If a member claims that theft or misuse of assets has occurred but fails to cooperate with any of the requirements listed above, then a transfer of property penalty should be invoked.

In the event of the member's death, estate recovery will be pursued.

2610.00.00 RESOURCE LIMITS

The resource limit is the maximum value of nonexempt resources that the AG may retain without affecting eligibility. It is dependent on the composition and living arrangement of the AG and the specific rules that govern each program. An AG with countable resources in excess of the applicable resource limit is ineligible for benefits. Refer to Section 3005.00 for the specific resource limits.

2612.00.00 ASSET VERIFICATION SYSTEM (AVS)

Federal regulations require that all States have an AVS in place to verify the resources of individuals when determining Medicaid eligibility for categories that require an asset/resource test[5]. The AVS is an automated system that obtains electronic resource verification and includes all MED 1 and MED 4 categories. AVS also applies to those whose resources are counted for household members on a Medicaid resource category for new applications, redeterminations, and category change from a non-resource Medicaid category to a resource required category. Submissions for the AVS are processed through the Eligibility System and responses are received electronically in the case file.

AVS completes a lookback period for gathering resources of the member and any other members that would be included in the resource test (such as a spouse). Depending on the application lifecycle, the below lookback occurs:

For new applications, including category changes from MAGI to non-MAGI categories, the AVS completes a 5 year look back period.

At redetermination, AVS reviews resources for 1 month prior to redetermination date.

For reapplications, AVS completes a 4-month lookback period.

AVS requests can be made every 90 days, however, if an AVS exchange is required prior to the 90 days, this must be sent to PAL, and if determined necessary, PAL can request a new AVS ping. Unless necessary, AVS pings should not occur more than once a year.

Resource verifications returned from the AVS are obtained from Experian, Bureau of Motor Vehicles, and real property searches. Matches are made using the members' name and Social Security Number. If a member does not have an SSN, then an AVS data match can't be completed.

For liquid resources including bank accounts, a search within 65 miles of the members' address listed in the case is completed. While the AVS ping will return verifications from most of the larger banks, some of the smaller banks may not return information.

Some liquid resource that may return results includes:

Checking accounts

Savings accounts

Money markets

Stocks balances if affiliated with a bank account

IRA's and retirement fund balances

Miller Trust balances

Trust fund amounts, but not the actual legal Trust document

Vehicles registered in the members' name and listed address in the eligibility system

Real property in the member's name.

When the worker completes the wrap-up in the Eligibility system, this will ping the AVS system, and AVS will return the electronic verification in 13 days. A 2032 Request for Verifications form must also be sent to the member with the 13-day deadline pending all unverified resources.

If the member's resources are verified via hard copy before the 13 days, the worker should not send it to SRED or authorize the case until the AVS electronic verification is returned or on the 13th day that the verifications are due. Unless the member is failing (such as being over income), no case action should be taken until the 13th day.

With the exception of issuing continued benefits due to an appeal, workers should not override AVS pings prior to the 13th day without PAL approval.

If an unreported or unverified resource by the member is found by AVS, then the AVS information should be entered to continue the eligibility determination process. At no time should a case be closed or denied for failure to verify a resource if the resource has been verified by AVS.

In the case that a member returns the verifications, and they do not match the AVS documentation, then the higher balance will be used as the verified resource amount. The only exception to this is if there is a successful rebuttal verified by a hard copy verification, then AVS will not be used. There is an option for certain DFR workers to override AVS if there is verification that hard copy verification is the lower resource amount. If this occurs, it must be thoroughly documented in case notes.

Documenting AVS returns:

If after the due date, no hard copy verifications are received but AVS is returned, then AVS verification is to be used.

If the member fails for a Medicaid resource category due to AVS, an AVS discrepancy notice must be generated and sent to the member notifying them that the application is denied based on AVS data exchange.

The member can send a rebuttal to the AVS information, such as but not limited to:

Verification that the resource is jointly owned with another person, therefore a reduced countable value should be used.

Proof of the amount that is still owed.

Verification that the resource is no longer in their name (normal transfer of property rules apply). If the member has a reason to believe the AVS data is incorrect, they will need to dispute with the consumer reporting agency in writing or by calling the toll-free number and address located at the bottom of the AVS discrepancy notice.

Blue book value is used for vehicles. Default to the fair purchase price listed for a base model of the same make, model, and year, unless other verification is received.

If the 13 days have passed and the case has been authorized, then the AVS returns additional verifications, this should be treated as a case change and the verification should be updated accordingly.

If the member fails for a Medicaid resource category (MA A, MA B, MA D, MADI, MADW, MA L, MA J, MA I, MA G, MA R) due to AVS resource data, an AVS discrepancy notice must be generated and sent out to the applicant member notifying them that the application is denied based on AVS data exchange. If the member has a reason to believe the AVS data is incorrect, they will need to contact the number at the bottom of the discrepancy notice.

2612.05.00 AVS TIMEFRAMES

AVS completes a lookback period for gathering resources of the applicant/member and any other members that would be included in the resource test (such as a spouse). Depending on the application lifecycle, the following is the process for lookback occurs:

For new applications, including category changes from MAGI to non-MAGI categories, the AVS completes a five-year look back period

At redetermination, AVS reviews resources for one month prior to redetermination processing date (90 days before redetermination is due)

For reapplications, AVS completes a four-month lookback period.

AVS requests can be made every 90 days, however, if another AVS exchange is required prior to the 90 days, this must be sent to PAL, and if determined necessary, PAL can request a new AVS ping. Unless necessary, AVS pings should not occur more than once a year.

When the worker completes the wrap-up in the eligibility system, this will ping the AVS system, and AVS will return initial findings from electronic verification in 13 days. A 2032 Request for Verifications form must also be sent to the applicant member and authorized representative with the 13-day deadline pending all unverified resources.

Even if the individual's resources are verified via hard copy before the 13 days, the worker cannot authorize the case until the 13th day after AVS electronic verification was requested. Unless the applicant/member is failing (such as being over income or over resources based on information they provided), no case action should be taken until after the 13th day. If no AVS information is returned by the 13th day, the worker should process as normal based on what the applicant/member has verified or failed to verify.

If an unreported or unverified resource by the applicant member is found by AVS, then the AVS information should be entered to continue the eligibility determination process. At no time should a case be closed or denied for failure to verify a resource if the resource has been verified by AVS.

If AVS finds additional information between days 13 and 30, and the case has already been authorized, any changes based on the newer AVS information should be treated as verified change. (See 2215.00.00.) After 30 days, AVS will not return any further information.

If an asset is returned by AVS but was not reported by the applicant/member, the AVS value should be used. In the case that an applicant/member or their authorized representative returns verifications and they do not match the AVS documentation, then the higher balance will be used as the verified resource amount. The only exception to this is if there is a successful

rebuttal verified by a hard copy verification, then AVS will not be used. (See IHCPPM 2612.10.00.)

2612.10.00 AVS AND ANNUAL MEDICAID REDETERMINATION

Ninety (90) days prior to the redetermination due date for individuals in categories that require a resource test, the AVS will be pinged for information. If no discrepant information or information which makes the member fail resources is returned, the member may qualify for auto-renewal based on existing rules. However, if AVS returns discrepant information or shows the member is over resources, the member will receive a mailer which they will be required to return with needed verifications to determine ongoing eligibility.

For all members who are required to return a signed mailer and verifications, their AR will receive a full copy of the mailer and may complete and return it with verifications and signature on the member's behalf, if desired.

If after the mailer is returned the member for whom we pinged AVS is failing due to excess resources, a discrepancy notice will be mailed (see IHCPPM 2612.15.00).

2612.15.00 THE AVS DISCREPANCY NOTICE AND REBUTTAL PROCESS

If AVS information was returned and the applicant/member fails for a Medicaid resource category (MA A, MA B, MA D, MADI, MADW, MA L, MA J, MA I, MA G, MA R), a discrepancy notice will be sent. The AVS discrepancy notice tells the applicant/member and AR that Medicaid is currently set to be denied or closed based on information provided fully or partially by the AVS data exchange.

This notice will display both the resources reported by the applicant or member and/or their authorized representative and also the details on what AVS has returned. They will be given 13 days to return hard copy documentation to verify a reduction in the countable amount of the asset.

The applicant or member and/or their authorized representative can send a rebuttal to the countable value returned by AVS, such as but not limited to:

Bank statements that show amounts that should be deducted from the first of the month balance. (See 2615.10.05.)

Verification that the resource is jointly owned with another person, therefore a reduced countable value should be used

Proof of the amount that is still owed on it which reduces the equity value

Verification that the resource is no longer in their name (normal transfer of property rules apply).

If the applicant/member or authorized representative believes the AVS data is incorrect, they will need to dispute with the consumer reporting agency in writing or by contacting the toll-free number and address located at the bottom of the AVS discrepancy notice. This process would be external to the Medicaid determination and workers should continue to use the AVS or hard copy verified information, as appropriate.

There is an option for certain DFR workers to override AVS if hard copy verification proves a lower countable amount for the resource/s. If this occurs, it must be thoroughly documented in case notes.

NOTE ABOUT FIRST OF THE MONTH BANK BALANCES: The applicant/member will still be requested to provide monthly statements for bank accounts on a 2032 Request for Verifications. If bank statements are returned, use the existing policy to determine any allowable deductions from the first of the month balance. If the first of the month balance/s match what was returned by AVS (AVS only returns 1st of the month balance), the worker can consider this a successful rebuttal without sending a discrepancy notice and use the lower hard copy value for that account.

If no successful rebuttal is received:

For applicants, the application will be denied after the discrepancy notice due date, and a separate denial notice will be mailed with normal appeal rights.

For ongoing eligibility, Medicaid will be closed after the discrepancy notice due date (using normal adverse timing) and separate notice will be mailed with normal appeal rights.

Documenting AVS returns:

If after the 2032 Request for Verifications due date, no hard copy verifications are received but AVS is returned, then AVS verification is to be used.

For items where AVS returns information but there are not enough details to determine countable value (for example, we learn about a trust but need the actual trust document for Policy review as to availability), the applicant/member will have to provide separate documentation with the needed details.

Assets which were disposed of during the lookback period should be reviewed for potential transfer penalties.

Blue book value is used for vehicles. Default to the fair purchase price listed for a base model of the same make, model, and year, unless other verification is received.

If the 13 days have passed and the case has been authorized, then the AVS returns additional verifications, this should be treated as a case change and the verification should be updated accordingly.

2615.00.00 TYPES AND VALUE OF PERSONAL PROPERTY RESOURCES

This section describes the policy for determining the value of personal property resources. The different types of such resources and their consideration are discussed.

2615.05.00 CASH

Cash that is not part of a current month's income is counted as a resource. Cash includes money the individual owns, no matter where it is located.[6] Cash on hand includes:

Amounts carried by the individual

Amounts the individual has at home

Amounts being held for the individual elsewhere.

A signed statement from the individual owning the cash is sufficient verification.

2615.05.05 PRE-PAID DEBIT CARDS

Pre-paid debit cards are considered an available resource and must be verified. Any balance remaining on a pre-paid debit card is considered a liquid asset beginning the month following the month the funds were deposited.

Exceptions to this rule include:

Direct Express debit cards - Direct Express cards only allow deposits from federal agencies, such as Social Security Administration, therefore, these accounts don't need verified.

Debit cards issued by a government-sponsored medical benefit – (such as Medicare Advantage or Medicaid Managed Care Program) Assistance provided in cash or in kind (including food or shelter) under a Federal, State, or local government program whose purpose is to provide medical care or medical services (including vocational rehabilitation). 7

2615.10.00 BANK AND OTHER ACCOUNTS

Bank accounts refer to funds in a bank, credit union, savings and loan association, or any other financial institution that are usually payable on demand. Bank accounts may be solely or jointly owned. Joint ownership exists when the right to liquidate the account is shared by more than one individual.

This section provides information on:

Checking and savings accounts

Time deposits, including IRAs and Keogh Plans

Guardianship accounts.

2615.10.05 SAVINGS AND CHECKING ACCOUNTS

It is assumed that all of the funds in a savings or checking account are owned by and available to the individual designated as owner in the account title.

If the account is jointly owned, it is to be presumed that all of the funds belong to each owner. [8] The individuals are to be advised of this presumption and given the opportunity to rebut it. If an applicant/recipient rebuts, they are responsible for providing proof of ownership of the funds, which includes a record of deposits and withdrawals from the account.[9] Following a successful rebuttal, the funds must be separated and placed in separate accounts. Only the funds actually belonging to the applicant/recipient will then be counted as a resource to the applicant/recipient.

The resource value of savings and checking accounts is the balance in the account as of the first moment of the first day in which eligibility is being determined (see IHCPPM 2605.20.00).When determining the balance of a checking account for resource eligibility purposes, any checks that have not cleared the bank as of the date on which eligibility is determined are to be subtracted from the balance.

Income is considered income in the month received, and a resource the month following. All income received in the previous month that was intended for that month counts as a resource in the following month. The only exception to this is early payments. For example, social security deposited the check on 01/03, but then deposited the February check early on 01/31. The second social security check should be deducted from the 02/01 bank balance. <u>If a member routinely gets income at the end of the month, it is considered income in the month received and a resource the month after.</u> If there are questions, submit to PAL.

Example 1:

The RSDI (Social Security) check is deposited on May 31st, but this is a June payment. Because it was deposited a day early, then it is considered as income for the month of June and will not become a resource until July. The RSDI deposit should be subtracted from the June 1st bank balance.

Example 2:

As of the first moment of the first of January, the bank balance is $3,800. The member received a deposit of $1,000 on 01/03.

A second deposit from the same company is made on January 31st. The last payment was deposited early and is considered income in the month of February.

No income can be deducted from the bank balance in January. The beginning bank balance did not include the $1,000 deposit and the last deposit had no impact on the January budget.

This member is over resources as of January 1st.

01/01 balance $3,800

01/31 deposit (early deposit) $1,000

January balance total $3,800

The member is over resources for the month of January.

Example 3:

Using the same case example as above, the bank balance on February 1st is $2,300 (the member spent the other $1,500). The unearned income direct deposit was made on 01/31, so this should be subtracted from the February budget.

01/31 deposit $1,000

02/01 balance $2,300

Subtract 01/31 deposit - $1,000

02/01 balance $1,300

This member is resource eligible for Medicaid in February.

Example 4:

On May 15th, a new application is submitted. On the February 1st bank statement (retro month), the first moment of the first day of the month has a bank balance of $10,000. The member/authorized representative included copies of checks that were dated/written on January 31st.

The member receives Social Security income in the amount of $1,500. One deposit was made on January 3rd, and a second deposit was made on January 31st. The second deposit is an early deposit intended for the month of February. The second deposit of $1,500 should be subtracted from the February 1st budget as it is income for the month of February and is not considered a resource.

The checks that are dated prior to February 1st but not yet cleared need subtracted from the February bank statement. The second and early Social Security check that was deposited on January 31st also needs subtracted from the February 1st bank balance.

05/15 Application date

02/01 First retro month with a bank balance of $10,000

Subtract checks written:

01/31 $2,000

01/31 $5,500

Total = $7,500

02/01 balance: $10,000-$7,500 = $2,500

Subtract the early Social Security deposit of $1,500

Balance $2,500-$1,500 (SS) = $1,000

The 02/01 bank balance is $1,000.

The member is passing resource eligibility for the month of February.

The total value of all bank accounts must be verified at the time of application and at each redetermination. Bank accounts must be verified by documentation obtained directly from the financial institution. In addition to using a bank collateral form, monthly account statements can be utilized to verify bank account balances.

2615.10.05.05 BUSINESS ACCOUNTS (MED 1, 4)

When funds are in a bank account that has been properly identified as a business account, it is assumed that the funds are being used for the operation of the business and are not counted as a resource. If a business account is not clearly distinguishable from personal resources, such funds must be considered personal resources when determining resource eligibility.

2615.10.05.10 DEDICATED ACCOUNTS FOR INDIVIDUALS UNDER 18 (MED 1, 4)

When past-due SSI benefit payments are paid into a separate dedicated account established solely for the payment of past-due SSI benefits for an individual under 18, these benefits are to be excluded as a resource until all funds in the dedicated account are depleted or until the individual no longer receives benefits from the Social Security Administration (SSA), whichever occurs first. This exclusion continues in any of the following situations:[10]

When the child turns 18 years of age and continues to receive benefit payments from the SSA

If the individual receives a new representative payee for the dedicated account

During periods when benefits from the SSA have been temporarily suspended.

A dedicated account may be a checking, savings, or money market account.

A dedicated account cannot be in the form of certificates of deposit, mutual funds, stocks, bonds, or trusts. However, if the lump sum(s) of past due benefits are deposited into either a Special Needs Trust or a Pooled Trust described in section 2615.75.15, the resources in that trust would be exempt.

2615.10.05.15 VIRTUAL CURRENCY

For MED 1 and 4 budgeting, virtual currency, otherwise known as cryptocurrency, is a not exempt and is a countable resource in the Medicaid budget.[11] While it is not considered legal tender, it can be used to purchase goods and services. Some virtual currency, such as Bitcoin or Litecoin, can be exchanged for real currency. The current market value (CMV) of the virtual currency is counted as a resource.

For the purposes of determining Medicaid eligibility, at the time of the interview or redetermination, the applicant/member needs to provide a current account statement showing the number of virtual coins owned.

All virtual currencies for which are listed on the exchange should be determined using that exchange. If the virtual currency is not held on an exchange, utilize “Coinbase” at the following web address: https: www.coinbase.com to determine the value. The exchange website and the exact exchange rate at the time of verification must be documented in case notes.

2615.10.05.20 PAYMENT PROCESSING APPS

Applications such as Venmo, Cash App and others of the same nature may be used as a pass through for the purpose of transferring funds from one account to another. If used solely for that purpose, it would not be considered its own resource.

The account to which it is attached must be evaluated for resources and income just as any bank account.

Some of these applications offer banking accounts within the application. In that case, the account(s) would be evaluated for resources and income just as any bank account. It would be important to take note of whether the account within the application is also attached to another bank account, which would also need to be evaluated for resources and income. Eligibility staff must determine how the account is being used at the time of the eligibility interview and identify the account accordingly.

2615.10.10 TIME DEPOSITS

Time deposits held by financial institutions may be solely or jointly owned. If a time deposit is solely owned, the availability of funds is the deciding factor in determining if the time deposit is a resource. A time deposit such as a savings certificate or certificate of deposit usually is available to the individual and is counted as a resource.[12]

Verification is to be obtained from the financial institution involved.

When a time deposit is jointly owned and available, the worker is to presume that all of the funds belong to each owner. The individuals are to be advised of this presumption and given the opportunity to rebut it. If an applicant/recipient rebuts, then the member is responsible for providing proof of ownership of the funds, which includes a record of deposits and withdrawals from the time deposit account. Immediately following a successful rebuttal, the funds must be separated and placed in separate accounts. Only the funds actually belonging to the applicant/recipient will then be counted as a resource. If funds are not separated, the balance is counted in its entirety by each joint owner.

Any interest penalties imposed for withdrawing the time deposit funds prior to maturity are deducted from the total amount when determining the value of the time deposit resource. Interest penalties may involve a reduction in the interest rate and/or loss of interest for a short period of time.

In rare instances time deposits cannot be withdrawn prior to maturity under any circumstances. Funds in this type of account are not included as an asset until they reach maturity and become available.

Verification of a time deposit certificate from the financial institution must include information on when the funds can be withdrawn and any penalties for early withdrawal.

2615.10.15 SAFETY DEPOSIT BOX

The applicant/recipient must present to the worker a signed statement listing all of the contents of a safety deposit box. The contents must then be evaluated in terms of their count ability as a resource.[13]

2615.10.20 COLLEGE SAVINGS ACCOUNTS

Effective 07/01/2017 College Savings Accounts, such as 529 College Savings Plans, are exempt as a resource. Student funds used for educational expenses are not counted as income.[14]

2615.10.30 ABLE ACCOUNTS

ABLE (Achieving a Better Life Experience) accounts are tax-favored savings accounts established on behalf of designated beneficiaries. ABLE accounts are established to provide secure funding for disability-related expenses and are exempt as a resource for Medicaid. As if 01/01/2026, those who were deemed disabled before age 24, are eligible.[15] Prior to 01/01/26, the age limit was 26.

ABLE accounts are only recoverable under estate recovery at a member's passing for those that meet the estate recovery criteria outlined in State rule and federal law.[16]

2615.15.00 RETIREMENT ACCOUNTS

The below policy applies to new applications filed on or after 07/26/2024.

Retirement accounts as defined in 405 IAC 2-1-1 (13) are financial plans for providing income when employment ends. They may be in the form of Individual Retirement Accounts (IRAs), Keogh Plans, 401K Plans, pensions, annuities, and work-related plans. Some profit-sharing plans may qualify as retirement accounts. Savings accounts, checking accounts and certificates of deposits held at banks or credit unions are not retirement accounts.

Except in the three situations listed below, a retirement account is an available resource to an individual if there is an option of withdrawing an amount for any reason, even though the member is not yet eligible for periodic payments. However, a retirement account is NOT considered an available resource if an individual must terminate employment in order to obtain any payment.

Exceptions:

• Funds held in an Individual Retirement Account or work-related pension plan, including Keogh Plans, by a ineligible spouse are not counted as resources[17]. Ineligible spouse means someone who lives with you as your husband or wife and is not eligible for SSI benefits.[18]

• For M.E.D. Works (MADW and MADI), all retirement accounts are exempt including those owned by the M.E.D. Works applicant/recipient. This exemption applies to such funds held by the member as well as by the spouse.

• When the Retirement Account has been annuitized and the member begins to receive regular, periodic payments are being received on a retirement account, the account is no longer a countable resource, and the payments are considered unearned income. If the IRA has sporadic withdrawals, then this is a conversion of resources and is not income but remains a resource.[19]

The value of a retirement account is the amount that the individual can currently withdraw less any penalty for early withdrawal. Taxes due are not deducted from the retirement account's value. Verification is to be obtained from the administrator of the retirement plan. If there is a delay in payment due to reasons beyond the individual's control because of the financial organization processing timeframe, it would affect the availability of the resource.

The retirement account is presumed available unless there is evidence showing the processing timeframe for a request to withdraw funds. If the timeframe is equal to or less than twenty working days, the account is considered available in all months. If the timeframe is more than twenty working days, the account is considered available after the individual agrees to withdraw the funds from the account and the documented timeframe has passed. If the individual refuses to withdraw the funds, the account is considered available upon the refusal.

The value of the retirement account/s of both spouses will be used in the initial calculation of the resource assessment for MCCA (Medicare Catastrophic Coverage Act) budgeting. After the 90-day transfer period as outlined in IHCPPM 2635.10.10.15, an account which is only in the community spouse's name will no longer be included in the eligibility or post-eligibility (liability calculation) budget. Retirement accounts of both spouses will count in regular budgeting. [20,21]

For married couples where both spouses are in an institution, a PACE member or on an HCBS waiver, see IHCPPM 2635.10.10.05 and 2635.10.10.10 for budgeting rules. MCCA budgeting supersedes all other budgeting types.[22]

Retirement accounts are not counted in the MED 4 budget.

Another type of retirement account is intended for self-employed individuals and is often referred to as a Keogh Plan. Funds on deposit in Keogh Plans are counted as resources if the plan does not involve a contractual obligation with anyone who is not an AG member. If the plan includes a contractual obligation with a non-AG member, the money may not be accessible to

the AG member and, therefore, is an unavailable resource. The value is the total amount of Keogh, less any withdrawal penalty.

If there are any questions regarding the retirement account, please send it to PAL for review.

2615.20.00 BURIAL RELATED RESOURCES

Burial related resources include various methods for reserving funds for burial such as prepaid funeral agreements, funeral trusts, life insurance, and burial accounts on deposit in financial institutions. Each assistance program has specific requirements in regard to burial related resources.

2615.20.05 BURIAL ACCOUNTS (MED 1, 4)

A burial account refers to a revocable account in which funds are identified to be used for burial purposes. In order for funds or assets to be considered set aside for burial, the account titling must indicate such, or there must be a signed statement by the owner or guardian of the purpose for the funds and the date on which they were set aside. This type of account is available to the owner. If a burial arrangement is irrevocable, it is not to be identified as a burial account. Refer to the following sections on funeral trusts and prepaid funeral agreements which are irrevocable.

The policies contained in this paragraph apply to the MA A, MA B, and MA D categories of assistance, in the circumstance of an individual or an institutionalized spouse/community spouse. For each individual or spouse, up to $1,500 of any separately identifiable funds set aside and earmarked for burial in a revocable account are exempt, regardless of beneficiary designation.[23] The $1,500 maximum must be reduced by the amount in an irrevocable burial trust or by the face value of any life insurance policies whose cash surrender value (CSV) has been exempted because the face value is $10,000 or less and the beneficiary is the estate or funeral home.

Example:

Mr. Jones is in a nursing facility. Mr. and Mrs. Jones each have a burial account valued at $1,500. Mrs. Jones also has a life insurance policy with a face value of $1,000. Only $500 of Mrs. Jones' burial account can be exempted.

For QMB (MA L), QDW (MA G), SLMB (MA J), and QI (MA I) up to $1,500 of any separately identifiable funds in a burial account are exempt. The exemption applies to the applicant/recipient and to his spouse. The $1,500 maximum must be reduced by the amount in an irrevocable burial trust or any irrevocable prepaid funeral agreement. It must also be reduced

by the face value of any life insurance policies whose cash surrender value has been exempted because the face value does not exceed $1,500 regardless of the beneficiary designation.

2615.20.10 FUNERAL PLANNING PROGRAMS (MED 1, 4)

There are various methods by which an individual may reserve funds for burial, such as burial accounts, prepaid funeral agreements, funeral trusts, and life insurance. In evaluating any of these entities as resources, workers must carefully apply resource eligibility principles applicable to each program. In most situations, the determination of availability of funds reserved by any type of prepaid funeral arrangement will be based on whether the contract is revocable or irrevocable.

However, a prepaid funeral agreement does not become irrevocable until 30 days after the contract is signed by the purchaser and seller, unless the 30-day period is waived as described below. During the 30-day waiting period the contract can be revoked, and a revocable contract is a countable resource except in the circumstances explained in the previous section. If the funeral agreement was established on or after July 1, 1997, and includes a waiver of the 30-day waiting period or similar language making the trust immediately irrevocable, the funds in the trust are unavailable and exempt beginning on the date the agreement is signed. When necessary, an FSSA attorney should be consulted.

Example:

Client signs a prepaid funeral agreement on 7/12. The contract is revocable for 30 days, so the value of the agreement is a countable resource for 8/1. The contract becomes irrevocable 30 days after signing, so the value is unavailable and, therefore, not a countable resource for 9/1.

When an irrevocable assignment of life insurance (an action which eliminates the owner's right to obtain the cash surrender value) is involved as a means of funding an irrevocable funeral trust, the worker must verify two dates:

The date of the assignment

The date the insurance company accepted the assignment.

The date of a legally executed irrevocable assignment of a life insurance policy which will fund a funeral trust is the date that the cash surrender value is considered to be unavailable, provided that the home office of the insurance company subsequently accepts the assignment.[24]

2615.20.10.05 PREPAID FUNERAL AGREEMENTS (MED 2)

The cash value of a prepaid funeral agreement with a funeral home is exempt as a resource, up to a maximum of $1,500. One such exemption is allowable for each member of the AG. The amount of cash value exceeding $1,500 must be counted as a resource.[25]

However, any prepaid funeral agreement must be reviewed to verify not only its value, but its terms. A determination must be made as to whether the agreement is revocable or irrevocable. Per Indiana statute, a prepaid funeral agreement does not become irrevocable until 30 days after the contract is signed by the purchaser and seller.[26]

During the 30-day waiting period the contract can be revoked. An FSSA attorney may be consulted in the determination of whether an agreement is revocable or irrevocable. The value of any type of prepaid funeral agreement is considered available to the individual if the contract is revocable, however, the $1,500 exemption explained above is applicable. Refer to Section 2615.20.15 for information regarding funeral trusts.

Funds set aside in a financial institution and designated for burial are counted as a resource to the individual.

2615.20.15 FUNERAL TRUSTS

A valid irrevocable Indiana funeral trust is an exempt resource regardless of the value of the trust.

Indiana's funeral trust statute is found at I.C. 30-2-10 et seq. and applies to funeral trusts established on or after July 1, 1982. I.C. 30-2-9 et seq. is applicable to funeral trusts established after June 30, 1978, but before July 1, 1982.

A funeral trust may be valid if there is written evidence of the terms of the trust bearing the signature of the settlor or the settlor’s authorized agent.

All funeral trusts must be reviewed to determine that it is valid and irrevocable in accordance with the criteria specified in the applicable statute. The value of the trust must also be verified. If questionable, the funeral trusts can be submitted to PAL for review.

If an irrevocable trust is created but is not exempt per policy, then it should be reviewed for a potential transfer of property penalty (see IHCPPM 2640.10.05).

Interest earned on an irrevocable trust is also exempt if the interest accrues to the principal of the trust.

A funeral trust established in a state other than Indiana must be evaluated in terms of that state's laws.

2615.20.21 DEATH BENEFITS (MED 1, 4)

Death benefits, including gifts and inheritances, received by an individual, to the extent that they are not income because they are to be spent on costs resulting from the last illness and burial of the deceased, are not resources for the calendar month following the month of receipt. However, such death benefits retained until the first moment of the second calendar month following their receipt are resources at that time.[27]

2615.20.20.05 BURIAL PLOTS (MED 2)

A burial plot for each participating member of the AG is exempt. This includes a conventional gravesite, crypt, mausoleum, or any other type of repository.

2615.20.20.10 BURIAL PLOTS OR SPACES (MED 1, 4)

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an exempt resource, regardless of value. This includes a conventional gravesite, crypt, mausoleum, urn, or any other type of repository.

2615.25.00 INSURANCE

Insurance policies owned by an individual may affect his eligibility and must be identified and evaluated. Types of insurance that may be taken into consideration include:

Life insurance

Casualty insurance

Indiana Long Term Care Insurance

Sections 2615.25.05.05 through 2615.25.15 discuss how these types of insurance are treated in the eligibility determinations for the different assistance programs.

2615.25.05 LIFE INSURANCE

The following definitions are pertinent in the consideration of life insurance as a resource:

The insured is the individual whose life is covered by the policy.

The beneficiary is the individual or entity named in the contract to receive the proceeds of the policy upon the death of the insured.

The owner is the individual who has all rights and privileges of the contract and has the absolute right to liquidate the policy, exercise policy loans, change beneficiary, elect settlement options, determine the manner in which dividends will be treated, or any other rights and privileges granted in the policy.

The face value is the amount stated as such on the face of the policy.

The cash surrender value (CSV) is the amount which the insurer will pay upon cancellation of the policy before death or maturity. This value usually increases as more premiums are paid toward the policy.

There are various types of life insurance. However, not all types of life insurance have cash value (for example, term insurance). Policies which have no cash value prior to payment of the death benefit, do not count in the resource determination. The presumption is that the cash value of a life insurance policy is a liquid resource.[28]

The CSV of insurance is available to the owner unless assigned or in some other manner transferred on the records of the insurance company to the insured or another person.

Therefore, insurance is to be considered a resource to the owner and not to the insured if the specific assistance program takes the CSV into consideration.

2615.25.05.10 LIFE INSURANCE VALUE

The CSV of a life insurance policy is counted as a resource if the owner is the applicant/recipient or a person whose resources are deemed to the AG.

The owner of a life insurance policy may be indicated on the policy; however, verification of the CSV must be obtained from the insurance company. As this will usually take several weeks, workers must be sure to follow up and, whenever possible, should enlist the assistance of the applicant/recipient and the local insurance office or agent. Awaiting verification of the cash surrender value is a valid extenuating circumstance for pending a case beyond the time standard. If there is no possibility that the CSV will cause excess resources (for example, the policy has been in force a short time and the person's other resources are minimal), the application can be approved prior to receipt of verification of the CSV. Efforts to obtain the CSV, however, must be continued.

The CSV must be verified at each redetermination. In cases where resources are close to the resource limits, the cases must be flagged to alert the worker to check resources frequently, at a minimum, on a monthly basis. The Expected Changes screen should be used for this purpose. It is recommended that, at the time of application, workers request that the insurance company verify future cash surrender values as well as the current CSV.

2615.25.05.15 LIFE INSURANCE EXEMPTION (MED 1)

The cash surrender value (CSV) of life insurance is exempt when the total face value (FV) of all policies owned by the applicant/member and their spouse (except term insurance and burial insurance) does not exceed $1,500, regardless of the beneficiary designation. If the total face value of any or all polices exceeds $1,500, the CSV is a countable resource. The spouse of the

member/recipient is also entitled to have the CSV of life insurance exempted under this provision.[29]

In order for a trust, an escrow~~,~~ or a life insurance policy, with a FV that exceeds $1,500 to be exempt as a resource in determining an applicant's or a recipient's eligibility for Medicaid, the applicant or recipient must:

Irrevocably assign the asset to a funeral trust or prepaid funeral agreement, and

Designate to the State of Indiana or the applicant's or recipient's estate to receive any remaining amounts after delivery of all services and merchandise under the contract as reimbursement for Medicaid assistance provided to the applicant or recipient after fifty-five (55) years of age.

Once the life insurance policy has been irrevocably assigned to funeral planning (i.e., irrevocable funeral trust or an irrevocable prepaid funeral agreement), only then can it be exempted if it designates the state or the applicant's/recipient's estate is to receive any remaining amounts after the goods and services are paid for. If questionable, send it to PAL for review.

Example 1:

Sally has a life insurance policy with a face value of $30,000. The policy was properly transferred over to the funeral home and created an irrevocable funeral agreement which designates the state or Sally's estate to receive any remaining funds after all services and merchandise have been paid. The life insurance cash surrender would be exempt on the date the funeral agreement is irrevocable.

Example 2:

A member has a life insurance policy with a face value of $20,000. The policy was transferred over to the funeral home and created an irrevocable funeral agreement which did not designate the State or the estate to receive any remaining funds after all services have been paid. Because the life insurance was transferred to an irrevocable funeral agreement, then it is no longer an available resource. However, the funeral agreement did not designate the State or estate to receive remaining funds after the services have been paid, therefore a violative transfer has occurred. A transfer of property penalty should be imposed.

Before the CSV over $1,500 can be exempt, the worker must verify the face value, the owner, the beneficiary, and the insured.

Policies which ensure the non-recipient spouse or parent of the applicant/recipient cannot be exempt under this provision.

2615.25.05.20 LIFE INSURANCE EXEMPTION (MED 4)

The CSV of life insurance is exempt when the total face value (FV) of all policies (except term policies) does not exceed $1,500, regardless of the beneficiary designation. If the total face value exceeds $1,500, the CSV is a countable resource. Both spouses are entitled to have the CSV of life insurance exempted under this provision, whether or not they are both applicants/recipients.

2615.25.10 INDEMNITY HEALTH INSURANCE, VA AID AND ATTENDANCE PAYMENTS, AND CASUALTY INSURANCE

Payments made to covered persons under an indemnity health insurance plan intended to cover costs associated with health care costs incurred by the applicant/recipient are exempt as resources the month the payments are received and the following month. Any payments from the insurance policy that are not spent on health services during the exempted timeframe are deemed countable once this timeframe has passed. This resource exclusion applies to income received for VA Aid and Attendance payments made to the applicant/recipient.

The proceeds (including interest earned) of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property are not to be counted as a resource if the applicant/recipient demonstrates that the proceeds are being used to repair or replace the property. For MED 1 and 4 only, the resource is exempt for a period not to exceed nine months from the date of receipt. If the proceeds from casualty insurance are retained by the applicant/recipient or his spouse or parent after the nine-month period, they must be counted as a resource.[30]

2615.25.15 LONG TERM CARE PROGRAM-RESOURCE DISREGARD (MED 1, 4)

This section applies to all MED 1. Within MED 4, it applies only to QMB (MA L).

The Indiana Long Term Care Program (ILTCP) is jointly administered by the Family and Social Services Administration and the Department of Insurance. An applicant/member and their spouse, who purchases a long-term care policy that is a qualifying policy under the ILTCP, as determined by the Department of Insurance, is allowed a special resource disregard in his Medicaid eligibility determination once policy benefits have been utilized.

The amount of the disregard for the applicant and their spouse depends on the type of "asset protection" earned by the qualifying policy. There are two types of disregards depending on the policy: 1) total asset protection; and 2) dollar-for-dollar asset protection. The available policy disregard is in effect for the lifetime of the member and their spouse.

Total Asset Protection is available to the individual who purchased a policy or certificate that includes a maximum benefit equal to or greater than the State-Set dollar amount in force on the original effective date of the policy (i.e., when there was a policy agreement). To view the State Set dollar amounts for certain years, please, see the Total Asset Chart here: http://www.in.gov/iltcp/2358.htm.

Dollar-for-Dollar Protection is available when the individual does not have Total Asset Protection. The amount of the resource disregard is applicable up to the limit on the policy.

Policy benefits are payable for long-term care services provided in a long-term care facility or in the home.

Not all long-term care insurance policies qualify for this "asset protection". Workers must verify that a policy is qualified under the ILTCP. Insurance companies who sell qualified ILTCP policies are responsible for documenting the number of benefits paid on behalf of their clients. The first page of the policy will have boxed language stating the policy qualifies for Medicaid asset protection. The insurer must provide a quarterly report to the insured individual summarizing the amount of benefits paid during the quarter and cumulatively since benefits were first paid under the policy, as well as the amount of asset protection earned.[31] When an insured individual applies for Medicaid, the insurance company is required to provide the client with a service summary report.[32] This service summary is the required documentation that workers will need in order to verify that a policy is qualified under the ILTCP and the amount of the resource disregard to be applied in the Medicaid eligibility determination of an applicant/recipient.

Example 1: Dollar for Dollar Policy:

An individual purchases a dollar-for-dollar ILTCP policy which provides initial policy benefits of 100,000. She enters a nursing facility, and the policy pays out a total of $109,000 (benefits increase due to inflation provision). She then applies to Medicaid and her resources are as follows:

Irrevocable funeral trust $4,000 (exempt)

Certificate of deposit $50,000

Life insurance cash value $15,000

Stocks $25,500

Mutual Funds $20,000

Total Resources $110,500

ILTCP disregard $109,000

Countable resources $1,500

Resource Limit $2,000.

The applicant is resource eligible.

Example 2: Dollar for Dollar Policy:

An individual purchases a dollar-for-dollar ILTCP policy which provides initial policy benefits of $100,000. She enters a nursing facility, and the policy pays out a total of $109,000 (benefits increase due to Inflation provision). She then applies to Medicaid and her resources are as follows:

Irrevocable funeral trust $ 4,000 (exempt)

Certificate of deposit $50,000

Life insurance cash value $18,000

Stocks $25,500

Mutual Funds $20,000

Total Resources $113,500

ILTCP disregard $109,000

Countable resources $4,500

Resource Limit $2,000.

Applicant has excess resources, so the application is denied.

Example 3: Total Asset Policy:

An Individual purchased a total asset ILTCP which provides an initial policy benefit of $200,000 in 2005. Thereafter, she enters a nursing facility, and the insurance pays out the maximum benefits, which will be more than the initial benefits depending on when she entered the facility. She then applies to Medicaid and her resources are as follows:

Irrevocable funeral trust $4,000 (exempt)

Certificate of deposit $120,000

Life insurance cash value $15,000

Stocks $25,5000

Mutual Funds $120,000

Total Resources $280,500

ILTPC disregard $225,000

Countable resources $55,5000

Resource Limit $2,000

Applicant has excess resources, but all excess resources are disregarded with a total asset policy, because $200,000 is greater than the State-Set amount in 2005, which was $196,994.

2615.30.00 HOUSEHOLD GOODS AND PERSONAL EFFECTS

Household goods and personal effects are exempt as resources.[33] Household goods are items of personal property customarily found in the home and used in connection with the maintenance and occupancy of the home. They include (but are not limited to) furniture, appliances, kitchen utensils, linens, and television sets.

Personal effects are those items of personal property which are worn or carried by an individual. Some examples are clothing, jewelry, and hobby items.

2615.35.00 INCOME-PRODUCING PERSONAL PROPERTY

Income-producing personal property consists of items such as farm machinery, livestock, tools, equipment, a vehicle used in a business, business inventory, and furnishings and appliances included with a rental unit.

Such personal property may be solely or jointly owned. If an applicant/recipient jointly owns personal property with another applicant/recipient of any assistance group (AG), for any program, proportionate shares of the property are to be assigned to the joint owners and considered as a resource in accordance with the program requirements. (Refer to Section 2605.10.05)

When a non-recipient is one of the joint owners of real or personal property, the availability of the applicant's/recipient's proportionate share must be determined. If the applicant's/recipient's proportionate share is available to them, it is to be considered a resource as required by the specific assistance category, as discussed in the following sections.

2615.35.10 INCOME-PRODUCING PERSONAL PROPERTY (MED 2)

The equity value of farm or business equipment is a countable resource.

2615.35.15 INCOME-PRODUCING PERSONAL PROPERTY (MED 1, 4)

Items of personal property utilized in the production of income are exempt resources.[34] Examples of such are farm machinery, livestock, tools, equipment, a vehicle used in a business inventory, furnishings, and appliances included with a rental unit. This exemption does not, however, include income-producing financial assets such as certificates of deposit, other interest-bearing bank accounts, stocks, bonds, IRA’s and so forth.

2615.40.00 PERSONAL PROPERTY USED TO PRODUCE FOOD

Personal property necessary for the production of food for home consumption is also exempt as a resource.[35] This would include such things as garden equipment, farm implements, chickens, and livestock.

2615.45.00 STOCKS, BONDS, AND MUTUAL FUND SHARES

Stocks, mutual fund shares, and bonds may be solely or jointly owned. If jointly owned, refer to Section 2605.10.05 for instructions regarding jointly owned real or personal property. Stocks, mutual fund shares, and bonds are considered in the eligibility determination as follows:

Stocks and Mutual Fund Shares: The current market value of shares of stock and mutual fund shares can be verified by reviewing the closing or "bid" price listed in the financial section of the newspaper, or by contacting a brokerage firm. The value to be considered as a resource is the current market value less the legitimate expenses related to the sale of the shares.

Municipal, Corporate, and Government Bonds: A bond is a written obligation to pay a sum of money at a future specified date. It is a negotiable instrument and is transferable. The worker must verify the current market value of bonds by contacting a securities dealer. As with stocks and mutual fund shares, expenses related to the sale of a bond must be deducted from the current market value in order to determine the cash value to be counted as a resource.

United States Savings Bonds: A United States Savings Bond is an obligation of the federal government but, unlike other government bonds, it is not transferable in that it can only be sold back to the government.

Although many bonds have a table of values on the reverse side of the bond, it is often inaccurate because the interest rate may have changed since the bond was issued. Therefore, the worker should contact a bank to verify the current value. Also, the Department of Treasury's website can be used to calculate the value of bonds. www.publicdebt.treas.gov/

For determining eligibility under a MED 1 category for a month prior to June 1, 2014, savings bonds are considered immediately available if purchased on or after November 9, 2002.[36] This includes, but is not limited to, Series I and Series EE bonds. During the 6-month period following the date of issuance, bonds issued for face value are counted as a resource in the amount of the face value. Bonds issued at face value include Series I and Series HH bonds. Bonds such as Series EE which are issued at less than face value count as a resource in the amount of the purchase price. Bonds which were purchased prior to November 9, 2002, and are in the 6-month post-issuance period, become a countable resource in the sixth month after purchase. For example, a bond with an issue date in August becomes a countable resource in February; if the value of the bond causes excess resources for the recipient, the worker would discontinue Medicaid effective February 1.

Series EE U.S. Savings Bonds and I Bonds purchased after February 1, 2003, are not deemed to be available until the 13th month after the date of purchase.[37]

2615.50.00 MORTGAGES, LOANS, AND PROMISSORY NOTES

A negotiable mortgage, loan, or promissory note held by an individual is a countable resource. Such items are negotiable when they can be sold (there is no legal barrier to the transfer of ownership). The value counted as a resource is the amount of the outstanding principal balance. Also, any payment received from the principal is a resource. The interest portion of any such payment is unearned income.

If the mortgage loan or note is non-negotiable, it is not a resource. In that case, only the interest payments received are counted as unearned income.

A mortgage, loan, or promissory note should be reviewed by FSSA Legal to resolve questions of negotiability. All promissory notes must be sent to PAL for review.

2615.55.00 LAND SALES CONTRACT

A land contract must be evaluated according to the requirements of each assistance category. Property which is being sold on contract is to be entered on the real/personal property resource screen.

2615.55.10 LAND SALES CONTRACT (MED 2)

When an applicant/recipient is the owner of a contract for the sale of real property, the equity value of the contract is counted toward the resource limit of the AG.

The equity value is equal to the principal balance remaining to be paid on the contract, which is referred to as a land contract or installment contract.

Example:

A Refugee applicant contracted to sell a piece of real estate for $15,000. To date, $8700 has been paid on the principal. The remainder, $6300, is considered a resource to the applicant.

The equity value of a contract is to be considered a resource.

Except when the contract contains a clause that prohibits the owner from selling or transferring the contract. In such an instance, the equity value is exempt. However, the portion of the periodic payment that represents payment toward the principal is counted as a resource.

2615.55.15 LAND SALES CONTRACT (MED 1, 4)

Land contracts or property agreements must meet the following criteria:

The repayment term must be actuarially sound (it cannot be set up in terms which exceed the applicant/recipient's life expectancy). See the Life Expectancy Table included at the end of section 2640.10.25.10.

Payments must be made in equal amounts during the term with no deferral of payments and no balloon payments.

The land contract or property agreement must prohibit the cancellation of the balance upon the death of the lender. If a balance remains upon the death of the lender, it must be designated to the estate of the deceased in order to be considered valid.

If the criteria above are not met, the land contract or property agreement must be treated as a prohibited transfer of resources. Ineligibility periods must be determined and applied. The value of the contract to be considered an improper transfer will be the outstanding balance due as of the date of the individual's application for Medicaid or date of LTC admission, whichever is later. In the case of HCBS, the balance to be used is the amount as of the date of the cost comparison Budget approval.

Income and resources in the Medicaid budget for the seller should be handled as follows:

For all land contracts and property agreements:

The down payment is counted as a resource

Only the interest portion of the payment/s is counted as income[38]

It is considered a conversion of resources (see IHCPPM 2605.30.00).

For land contracts or property agreements meeting the criteria listed in this section:

The principal portion of payments/s is not income.

Amounts paid towards the principle are therefore a countable resource as soon as received.

Principal amounts should not be deducted from bank balances or reports of cash on hand or put into a Miller Trust.

Excess accumulation of these amounts could make the member over resources and may need to be monitored by the worker as explained in 2605.40.00.

The property itself is not a countable resource because the seller cannot legally convert it to cash while it is encumbered by the non-negotiable agreement.

The property agreement or promissory note has an assumed resource value based on the outstanding principal balance unless the individual furnishes evidence that it has a lower cash value.

For land contracts which do not meet the criteria in this section, the outstanding principal on the negotiable agreement is considered a countable resource.

2615.60.00 VEHICLES

MED 1 & 4 have different requirements for considering vehicles than MED 2. Requirements may differ between the Medicaid categories. The following sections describe how to determine the resource value of vehicles.

2615.60.05 DEFINITION OF VEHICLE

A vehicle is any conveyance that provides transportation of persons or goods from place to place. Automobiles, trucks, vans, motorcycles, mopeds, boats, snowmobiles, and so forth are classified as vehicles.[39]

2615.60.15 TREATMENT OF VEHICLES (MED 2)

Each AG is allowed an exclusion of $5000 of the equity in one vehicle. Equity is the vehicle's fair market value less any liens.

If more than one vehicle is owned, the equity in each vehicle is to be determined. Since the $5000 disregard can be applied to only one vehicle, it is to be applied to the vehicle with the highest equity value. No amount is excluded from the equity value of the remaining vehicle even if the value of the first vehicle is less than the $5000 disregard.

2615.60.20 TREATMENT OF VEHICLES PRIOR TO JUNE 1, 2014 (MED 1, 4)

As of June 1, 2014, this section no longer applies.

2615.60.20.05 TREATMENT OF VEHICLES

This section explains the treatment of vehicles.

One vehicle is exempt regardless of its value if it’s used for transportation of the applicant/member or a member of their household.[40] If the applicant/member transfers a vehicle out of their name and it is not considered an allowable transfer of property, then it should be evaluated for a transfer penalty (see IHCPPM 2640.10.15).

If there is more than one vehicle, the one with the highest equity should always be the one that is exempt. The equity value of other vehicles is counted as a resource. If the other vehicle is

being used for production of self-employment income, and there is question if it is an available resource, please contact PAL.

The equity value is the fair market value minus total liens.

2615.60.25 RECREATIONAL VEHICLES AND EQUIPMENT

Recreational vehicles such as campers, trailers, and boats must be counted according to their current equity value. If the recreational or other vehicle serves as the AG's home, it should be evaluated according to the guidelines in IHCPPM 2620.15.10.

2615.65.00 NON-RECURRING LUMP SUM PAYMENTS

A lump sum payment may include retroactive benefits such as SSI, Social Security, and VA benefits. A lump sum may also be a refund of Medicare Part B premiums, an insurance settlement, an inheritance, or other such nonrecurring payment.

Retroactive lump sum payments from Social Security (i.e., SSI, RSDI, or SSDI) are exempt as resources for nine (9) months.[41]

2615.70.00 LIFE CARE CONTRACT (MED 1, 4)

An individual may have entered into an agreement with an institution in which the individual transferred their available assets to the institution in exchange for full maintenance and medical care in the institution for life. Such individual would normally be ineligible for assistance, as the institution has a legal responsibility to provide care even if the individual's resources are exhausted.

However, in the event the facility claims that the conditions of the contract are no longer applicable because the facility is financially unable to fulfill its legal responsibilities under the contract, the facility must prove this allegation.

The DFR must require an accounting from the facility as to:

The amount of income and resources the individual assigned to the facility upon admission

The cost of the individual's care as paid by the facility

Amount of assets refunded to the individual

Amount of assets retained by the individual.

If such documentation proves the facility's allegation that the individual's funds have been expended on their care, then the individual can be eligible for Medicaid.[42]

2615.75.00 TRUST FUNDS

All trusts which involve a member of the AG must be carefully evaluated to determine whether or not the trust principal will be counted as a resource.

2615.75.05 TRUST FUNDS ESTABLISHED PRIOR TO AUGUST 11, 1993

The date on which a trust fund was established is a determining factor as to how the trust will be treated for Medicaid eligibility purposes. A change in federal law (OBRA-93) governs the treatment of trusts established on and after August 11, 1993 and is explained in next Section 2615.75.20.

A trust which was established prior to 8-11-93 by the applicant/recipient or his/her spouse as grantor with the applicant/recipient or spouse as the beneficiary is referred to as a "Medicaid qualifying trust". Unless such a trust was created in a will (i.e., a testamentary trust) or was created prior to 4-7-86 solely for the benefit of an intellectually disabled individual residing in an ICF/IID, the principal of the trust is a countable resource. The amount to be counted as a resource is the maximum amount available to the beneficiary if the trustee were to exercise full discretion for distribution of the funds according to the terms of the trust. The trust is counted as a resource regardless of whether it is revocable or irrevocable, and whether or not the trustee actually exercises their full discretionary authority as allowed by the trust. A trust established by the individual's guardian or legal representative, who is acting on behalf of the individual, falls under the definition of a Medicaid qualifying trust.

In reviewing trust funds established prior to August 11, 1993, which do not meet the definition of a Medicaid qualifying trust, including testamentary trusts and those created prior to 4-7-86 for an intellectually disabled individual residing in an ICF/IID, the DFR must determine the "availability" of the trust. Refer to Section 2605.15.00 for the definition of availability.

2615.75.10 TRUST FUNDS ESTABLISHED ON AND AFTER AUGUST 11, 1993

The policies in this section are applicable to trust funds established, other than by a will, on and after August 11, 1993, and are effective October 1, 1993.[43]

A trust fund is subject to the provision in this section if the trust is funded with assets of the applicant/recipient or spouse and is established by:

The applicant/recipient

The spouse of the applicant/recipient

Anyone, including a court or administrative body, with legal authority to act on behalf of the applicant/recipient or spouse

Anyone, including a court or administrative body, who is acting at the direction or request of the applicant/recipient or spouse.

Refer to Section 2615.75.15 which explains the types of trust funds which are exempt from these provisions.

These provisions apply if assets of the applicant/recipient were used to fund all or part of the trust. If other person(s)' assets are included, the portion of the trust representing the individual's assets will be evaluated for resource eligibility purposes.

A revocable trust is considered as follows:

The entire trust principal is an available countable resource.

Any payments made from the trust to or for the benefit of the individual are counted as income.

Any payments from the trust which are not made to or for the benefit of the individual must be evaluated as a transfer of property. The look-back period for a transfer in this circumstance is 60 months.

An irrevocable trust is considered in the following manner. If the terms of the trust allow for payments to or for the benefit of the individual, under any circumstances, the following rules apply to that portion of the trust:

Payments from trust income or principal are treated as income.

Trust income which could be paid (but isn't being paid) is treated as an available resource.

The portion of the trust principal which could be paid (but isn't being paid) is treated as an available resource.

Payments made from the trust income or principal to another individual (and not for the benefit of the applicant/recipient or spouse) must be evaluated as a transfer of property. The look-back period for a transfer in this circumstance is 60 months.

If the terms of the trust do not allow part or all of the trust income or principal to be paid to or for the benefit of the individual under any circumstance, the value of that portion of the trust must be evaluated as a transfer of property. The look-back period in this situation is 60 months.

Payments made from revocable or irrevocable trusts are considered as being paid to the individual if such payments are paid directly to the individual or to someone acting on their behalf such as a guardian.

A payment for the benefit of the individual is one from which the individual derives a distinguishable benefit. Some examples include the purchase of clothing and items for personal

use such as a radio or television, and payment of the individual's utilities or rent. These payments are counted as income to the extent that they would ordinarily be counted as income for eligibility purposes. For example, if a trust pays the individual's medical expenses, the payment made directly to the medical provider is not countable income. Similarly, a payment to a utility company is income-in-kind, but only countable income-in-kind in accordance with Section 2815.15.00.

2615.75.15 CERTAIN TRUSTS RECEIVING SPECIAL CONSIDERATION

The trust provisions explained in the preceding Section 2615.75.10 do not apply to certain special needs trusts and pooled trusts as well as Miller trusts defined below. The following trusts should not be considered countable resources.

Special Needs Trust: This is a trust containing the assets of a disabled applicant/recipient under age 65, which is set up by the applicant's/recipient's parent, grandparent, legal guardian or by a court, and is established for the sole benefit of the applicant/recipient. A trust established on or after December 13, 2016, by an individual with a disability under age 65 for his or her own benefit can qualify as a special needs trust, conferring the same benefits as a special needs trust set up by a parent, grandparent, legal guardian, or court.[44] The individual must be disabled according to SSI criteria. Such a trust must contain a provision specifying that, upon the death of the individual, the State will receive all amounts remaining in the trust up to the total amount of Medicaid benefits paid on the individual's behalf.[45]

Pooled Trusts: A pooled trust is a trust containing the assets of a disabled applicant/recipient (disabled according to SSI criteria) which meets the following conditions:[46]

The trust is established and maintained by a non-profit association

A separate account is maintained for each of the beneficiaries, but for investment and management purposes the funds are commingled

The trust account is established by the applicant/recipient or their parent, grandparent, legal guardian or by a court for the sole benefit of the applicant/recipient

There is a provision which specifies that upon the death of the beneficiary, any funds not retained by the trust will be paid to the State up to the total amount of Medicaid benefits paid on the individual's behalf.

Miller Trust (Qualified Income Trusts): A Miller Trust (or Qualified Income Trust (QIT)) is a unique trust that allows persons residing in long-term care facilities, PACE members or receiving home-and-community-based-services through a 1915(c) waiver (see IHCPPM sections 3305.00.00 and 3320.10.00) who have personal income above the Special Income Level (SIL) (see IHCPPM sections 3455.14.00 and 3010.20.15) to be considered Medicaid eligible. A Miller Trust may be established for a Medicaid applicant/recipient who is a beneficiary of the trust by the

applicant/recipient's Authorized Representative for Medicaid eligibility purposes, legal guardian, power-of-attorney (POA), or family member if the applicant/recipient is incapacitated as shown with documentation from a licensed physician.[47]

A Miller Trust is one that:

Is funded only by the income of the beneficiary including accumulated interest on that income. The trust will not be funded with the beneficiary's resources, nor income or resources of other people.

Upon the death of the beneficiary, the State of Indiana will receive all remaining funds in the trust up to the amount of Medicaid expenditures paid on the individual's behalf.

A transfer of resource penalty does not apply to a Miller trust if the trust is:

Established for the benefit of an individual; and

Funded solely by the income of an individual, including accumulated interest.

The Miller trust described in this subsection can be revocable or irrevocable.

Under 42 U.S.C. 1396p(d)(4)(B)(ii), upon the death of a beneficiary, the state of Indiana receives the remaining funds in a Miller trust up to the amount of Medicaid expenditures paid on the member's behalf.

Allowable distributions from a Miller Trust may include the following:

A monthly personal needs allowance for a primary beneficiary if they are depositing their entire income into the trust.

A monthly amount to the spouse of a primary beneficiary sufficient to provide but not exceed the minimum monthly maintenance needs allowance for the spouse, as provided by Title XIX of the Social Security Act.

Incurred medical expenses of a primary beneficiary.

The cost of medical assistance provided to a primary beneficiary, such as the patient liability.

A Miller trust must be funded at least each month in the amount of the beneficiary's monthly income exceeding the SIL.

Funds in a Miller trust must:

Be maintained in a separate account from any other account; and

Not be commingled with other accounts.[48]

With the exception of funeral trusts and Miller trusts, trusts should be sent to OMPP through the PAL system to make a determination of validity and exemption.

2615.75.20 OTHER TRUSTS NOT GOVERNED BY OBRA-93

Trusts established on or after August 11, 1993, that are not governed by OBRA-93 must be reviewed for the purpose of determining the "availability" of the trust. Some examples are trusts created by a will (testamentary trust) or by a third party other than a spouse or someone acting on behalf of the applicant/recipient and funded with the assets of another person(s).

2615.80.00 LEGAL GUARDIANSHIP/REPRESENTATIVE PAYEE (MED)

An individual who serves as legal guardian/representative payee for another person is responsible for administering that person's funds and will be listed in bank records as having access to their bank accounts.

Resources that are managed by an individual's legal guardian, representative payee, or other person acting as an agent on behalf of the applicant/recipient are counted as resources to the individual. The resources are not counted as being available to the guardian/payee for their own use. However, the resources must be held in a form that clearly shows they belong to another individual. For example, a bank account that is held by the guardian/payee must be clearly designated as being administered by the guardian/payee on another person's behalf.

2615.90.00 PRORATED INCOME

Income that is prorated (educational income, self-employment income) cannot be counted as a resource for any month during the prorated period.

2615.95.00 PRESUMPTION OF LIQUIDITY (MED 1)

Resources are explained as real property or personal property that is owned solely or jointly by an individual (refer to Section 2605.05.00).

These property types are generally broken down into two categories: liquid and non-liquid.

Liquid resources consist of personal property which can be converted to cash within 20 working days. See Section 2605.05.00 for examples of resources which are ordinarily liquid. Liquid resources, other than cash, are evaluated according to the individual's equity in the resources. [49]

Non-liquid resources consist of all real property and some personal properties which cannot be converted to cash within 20 working days.

For treatment of non-exempt real property, refer to Section 2620.20.00.

For purposes of this section, it is assumed that the following types of personal property are non-liquid:

loan agreements

automobiles,

machinery,

livestock,

noncash business property,

It is presumed that all other types of personal property not contained in the list are liquid, can be converted to cash within 20 workdays and are countable as resources.

A person may overcome this presumption with documentary evidence. For example, if a presumed liquid asset cannot be converted to cash within 20 working days from the date the person requests the funds from the account, there must be documentary evidence**,** from the financial institution**,** showing that the request has been received and at what point such funds will be available to the individual. Such requests must be submitted to PAL for review.

Once the funds are withdrawn, if retained, they will be considered countable upon the first moment of the first day of the following month. In this situation, if verification from the financial institution is received clearly displaying that a member is unable to liquidate a resource within 20 days, send to PAL for review.

2620.00.00 TYPES AND VALUE OF REAL PROPERTY RESOURCES

Real property consisting of land, which includes buildings or immovable objects attached permanently to the land, is to be evaluated as a resource according to the requirements of each assistance category.[50]

2620.05.00 REAL PROPERTY OWNERSHIP

Real property is to be considered as a resource according to the requirements of each assistance category and the type of ownership of the property. (Refer to Sections 2605.05.00 and 2605.25.10.) Ownership of real property can consist of an interest in the title as follows:

Sole Ownership: When property is solely owned by one individual, only the individual or their legal guardian may sell the ownership interest without conditions imposed by others. The individual is legally entitled to all income which may be generated from the property.

Joint Ownership: Joint ownership is the holding of property by two or more people who have an equal interest in the whole property. At the death of one of two joint owners, the survivor

usually becomes the sole owner. At the death of one of three or more joint owners, the survivors become joint owners.

If an applicant/recipient jointly owns real property with another applicant/recipient of any assistance program, proportionate shares of the property are to be assigned to the joint owners and considered as a resource in accordance with the program requirements.

When a non-recipient is one of the joint owners of real property, the availability of the applicant's/recipient's proportionate share must be determined. (Refer to Section 2605.15.00.) If the applicant's/recipient's proportionate share is available to them, it is to be considered a resource as required by the specific assistance program. If the applicant's/recipient's proportionate share is not available to them, the resource is exempt.

Ownership in Common: An ownership in common is the holding by two or more persons of separate titles in the same real estate. Each owner has a divided interest in the whole property. There is no right of survivorship to ownership in common. It is *not* joint ownership.

Ownership by Entirety: Ownership 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. Upon the death of one, the survivor becomes sole owner. When a marriage has been legally dissolved, the former spouses become owners in common of the property.

Ownership of real property can also consist of a legal right to the use of property without having title to it, as follows:

Life Estate: A life estate conveys to an individual certain rights in property for their lifetime. The owner of a life estate generally has the right of possession and use the property, as well as the right to obtain profits from the property, and to sell their life estate interest. However, the deed establishing the life estate may restrict one or more rights of the individual. Ownership of a life estate interest may affect eligibility for certain assistance programs. (Refer to Section 2605.25.10.05.)

Remainder Interest: When an individual conveys property to one person for life (life estate holder) and to a second person (the remainderman) upon the death of the life estate holder, both a life estate interest and a remainder interest are created in the property. A remainderman cannot sell their interest in the property while the life estate holder is alive, unless otherwise specified in the deed. At the death of the life estate holder, the remainderman will hold full title. (Refer to Section 2605.25.10.05.)

Reversion Interest: When an individual owner conveys property to another person for life (life estate holder) and to themselves (the reversioner) upon the death of the life estate holder, both a life estate interest and a reversion interest are created in the property. A reversioner cannot sell the property while the life estate holder is alive. At the death of the life estate holder, the reversioner would hold full title. (Refer to Section 2605.25.10.05.)

2620.10.00 VERIFICATION OF REAL PROPERTY OWNERSHIP

Ownership of real property can be verified from one or more of the following sources:

Deed

Mortgage

Property tax receipts (current only)

County treasurer's records, or

Title search.

2620.15.00 EXEMPT REAL PROPERTY RESOURCES

Certain real property is exempt from being considered as a resource. This determination is program specific so that the exemption or non-exemption of real property must be in accordance with program requirements as explained in the following passages.

2620.15.10 THE HOME (MED 1, 4)

A home is exempt when it is the principal residence of any of the following:

The applicant/recipient

The spouse of the applicant/recipient

The parent of an applicant/recipient under age 18

The biological or adoptive child under age 18 of the applicant/recipient

The biological or adoptive disabled or blind child age 18 or older of the applicant/recipient.[51]

The home is defined as the shelter in which the individual resides, the land on which the shelter is located, and related outbuildings. In order to be considered part of the home, the surrounding land must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others. (A road does not separate land.)

Such property remains exempt until it is verified that none of the people listed above intends to reside there or is physically able to reside there.[52] Whenever there is a conflict between an individual's stated intent to return home and their apparent physical capability to do so, the worker is to obtain documentation from the individual's physician.

2620.15.10.05 HOME REPLACEMENT (MED 1, 4)

The proceeds from the sale of an exempt home can also be exempt from consideration under certain conditions. If, within a specified time period, the proceeds are used (or obligated to be used) to purchase a replacement home and cover the costs incurred in occupying it, the proceeds can be disregarded. The individual must be committed to the transactions within the "home replacement period", the time period beginning with the date of the receipt of the proceeds and ending on the last day of the third full month following receipt of the funds.

2620.15.20 INCOME-PRODUCING REAL PROPERTY (MED 1, 4)

Income-producing property is exempt if the income from it is greater than the expenses of ownership. This exemption also applies to property being sold on land contract. The ownership of income-producing property must be verified to determine who is legally entitled to the income from the property.

2620.15.25 FOOD-PRODUCING REAL PROPERTY (MED 1, 4)

Real property used for producing food for home consumption is exempt.[53] An example of such property would be a garden plot.

2620.15.30 REAL PROPERTY OWNED BY A COMMUNITY SPOUSE (MED 1)

For purposes of Medicaid eligibility, when the resources of an institutionalized spouse and a community spouse are assessed to establish the amount of combined resources for spousal share determination, the equity value of real property owned solely by the community spouse (or jointly with someone other than the institutionalized spouse) is not included. Additionally, such property is not considered in the resource eligibility determination of the institutionalized spouse.

2620.20.00 TREATMENT OF NON-EXEMPT REAL PROPERTY

Real property that is not classified as exempt is taken into consideration in the resource eligibility determination. Nonexempt real property must be considered under the requirements of each assistance program as explained in the following passages.

2620.20.10 OFFERING REAL PROPERTY FOR SALE OR RENT (MED 1)

If non-exempt real property causes an applicant/recipient to be over resources for Medicaid and it is available, it must be offered for sale or rent at fair market value (FMV), unless the applicant/recipient is in a long-term care facility and has a community spouse.[54] (For the definition of real property, see 2605.05.00.) This requirement is also applied to ownership of a life or remainder interest in the property and to a life or remainder interest in mineral rights. For policy regarding exempt real property, see 2620.15.10.

When it is determined that the applicant/recipient or their financially responsible relative's own property which is not exempt and is available, the owner of the property must sign the form, FI 0118, *Agreement to Offer Property for Sale or Rent and Repayment Agreement.* If the owner of the property refuses to sign the form, the applicant/recipient is ineligible for Medicaid.

If the property owner complies and signs the form, FI 0118, they have 30 days from the date they signed the form or from the date the notice of eligibility is mailed, whichever is later, to offer the property for sale or rent at CMV. When the form is signed, it is effective "for the purposes of the application", that is, inclusive of retroactive months for that application date. To be considered offered for sale or rent, a sign must be placed at a conspicuous location on the property, stating clearly that the property is for sale (or for rent) and giving the individual's name and address (or telephone number), or listing the property with a realtor.

When the AG owns property that is not exempt and is available, enter a "?" on screen real/personal property resource in the "agree to sell" and "agree to rent" fields, unless the nonexempt property is currently for sale or rent. If the eligibility system determines that it must be offered for sale or rent, the case will be pended and indicated on the Resource Eligibility Determination/Transfer Results screen.

When the property owner is contacted and signs the Form 0118, *Agreement to Offer Property for Sale or Rent and Repayment Agreement,* access the Real/Personal Property Resources screen, change the "?" to "Y" and enter the date it was signed. (If the owner refuses to sign it, enter "N" in the appropriate fields.) If "Y" was entered, the resource eligibility determination/transfer results screen will then indicate the client has passed resource eligibility.

The eligibility system will monitor the 30-day period that is allowed to offer the property for sale or rent, and the system will generate an alert. When the property owner signs the Form 0118A, *Report on Property for Sale or Rent*, access the real/personal property resource screen and enter "Y" in the appropriate field. If the owner does not offer the property for sale or rent, enter "N" in the appropriate field and assistance will be discontinued.[55]

2620.20.10.05 OFFERING REAL PROPERTY FOR SALE OR RENT (MED 4)

The provision requiring nonexempt real property to be offered for sale or rent as is explained in the preceding passage, 2620.20.10, can be invoked only if the equity value of the real property causes excess resources. If the applicant/recipient is within the applicable resource limitation when the equity value of nonexempt real property is counted, the property owner is not required to agree to offer it for sale or rent. If the equity value does cause excess resources, the agreement to offer the real property for sale or rent must be signed.

When the AG owns nonexempt real property, enter a "?" on the real/personal property resource screen in the "agree to sell" and "agree to rent" fields, unless the nonexempt property is currently for sale or rent. If the eligibility system determines that it must be offered for sale or rent, the resource eligibility determination/transfer results screen will display the number of

excess resources in the "sale/rent" field, and the case will be pended. Follow instructions in Section 2620.20.10 regarding compliance with the requirement to offer the property for sale or rent.

2625.00.00 PLAN FOR ACHIEVING SELF-SUPPORT

There are two kinds of Plans for Achieving Self-Support (PASS). One is an SSI PASS which is approved by the Social Security Administration for SSI eligibility purposes. The other is a Medicaid PASS which is approved by the Division of Family and Resources, Central Office, for Medicaid eligibility purposes. MED 1 and MED 4 have provisions to exempt resources specified in a PASS under certain circumstances as explained in the following two sections. Med 2 has no provisions to exempt a PASS.

2625.10.00 PLAN FOR ACHIEVING SELF-SUPPORT (MED 1, 4)

The policies explained in this section apply only to the MA B, MA G, MA L, SLMB (MA J), and QI (MA I) categories of assistance.

A PASS can be developed for an individual who needs to set aside a part of their resources for a specified period of time necessary to achieve an occupational objective. The resources could be used for current expenditures or saved for a later planned expenditure to achieve a work-related goal such as education, vocational training, starting a business, or purchasing work-related equipment.

For individuals in the MA B category (SSI recipients and non-SSI recipients) as well as non-SSI recipients in the MA L, MA G, MA J, and MA I categories, a PASS must be approved by the Office of Medicaid Policy and Planning (OMPP).[56] In order for a PASS to be approved, the DFR must submit a letter to the OMPP containing:

The description and objectives of the plan as discussed with the applicant/recipient

The source and amount of all income and/or resources and the amounts of each that are to be used in the plan

The length of time the plan is to operate

Any other pertinent information including documentation from the Social Security Administration of an SSI recipient's approved PASS.

This letter is to be recorded in the case record with one copy being given to the applicant/recipient, one copy being sent to the OMPP Eligibility Unit at 402 W. Washington Street, MS 07, W374, Indianapolis, IN, 46204, and one copy being retained in the case record. The OMPP will forward a copy to the Blind and Visually Impaired Section of the DMHA for their recommendation. OMPP will then review the self-support plan and recommendation from the Blind and Visually Impaired Section of the Division of DMHA and notify the DFR by letter of

approval or disapproval. The DFR will then notify the applicant/recipient. If the plan is approved, the amount of income and resources disregarded and time period for the disregard, must be documented in the case record. A Medicaid approved PASS is coded in the eligibility system as PM.

In the QMB, QDW, SLMB, and QI eligibility determinations of SSI recipients who have a PASS approved by the Social Security Administration, a separate approval from the Central Office is not required. A copy of SSA's documentation should be obtained and filed in the case record. An SSI PASS is coded in the eligibility system as PS.

A PASS under the MA B category can be approved for a period not to exceed 12 months. For MA L, MA G, MA J, and MA I the PASS exemption will be for at least 18 months and may be extended up to 36 months.

2626.00.00 INDEPENDENCE AND SELF-SUFFICIENCY ACCOUNTS (MED 1)

This section applies to MADW and MADI.

Funds that have been set aside by the applicant/recipient for "independence and self-sufficiency" are disregarded as resources in an amount up to $20,000 as approved by the Central Office of the Family and Social Services Administration.[57] The purpose of an Independence and Self-Sufficiency Account (ISSA) is to allow the MEDWorks member to save money in order to purchase goods or services that will increase or maintain their employability or independence. An ISSA will not be approved for any item or service that the person is entitled to receive under Medicaid or any other public program. Accounts for general savings or personal recreation will not be approved.

State Form 50929, *MEDWorks Request for Independence and Self-sufficiency Account,* is to be provided to any Medicaid applicant or recipient in MADW/I who answers "Y" to the question on the Disabled Worker Information screen. A 30-day due date is to be specified; however, a denial of an application or discontinuance of benefits for failure to turn in the ISSA form i.e., "failure to cooperate" is not appropriate. If the form is not submitted by the individual within 30 days, the response to the question must be changed from "Yes" to "No". The applicant can submit the form at any time while the application remains pending. Workers should provide the State Form 50929 to any applicant/recipient who asks for it or who indicates the possibility of saving for an ISSA. However, a "yes "response should be entered on the Disabled Worker Information screen only when the applicant/recipient answers the question definitively, or at some time after the interview submits a completed form.

Example 1:

Applicant #1 states in their application interview that they are saving money on a down payment for a car and they do want consideration for this as an ISSA. The worker completes the top portion of the form, enters the 30-day due date, signs and dates it, and gives it to the client. A determination of excess resources cannot be made on #1's application during the 30-day time frame or while the Central Office is reviewing the ISSA request.

Example 2:

During Recipient #2's redetermination interview, the applicant/recipient says they are thinking about how they might use an ISSA to help themselves get a better job. They don't have definitive plans and do not have excess resources at the time. The worker completes the top portion of the form but does not give a due date and enters "No" on AEDWI. Recipient #2 is determined to remain eligible and MADW is authorized. Several weeks later, the worker receives the completed Form 50929. The worker signs it, enters "yes" on the Disabled Worker Information screen, and forwards the form to Central Office.

The Central Office will review the request in accordance with state law and regulations, make a decision, and enter it on the Disabled Worker Information screen. The decision will be sent to the applicant/recipient and a copy to the worker. The eligibility system will send an alert.

An ISSA does not have to be a separate account in order to be disregarded. The disregard will be applied to the person's total liquid assets. It is applied only to resources owned by the applicant/recipient or owned jointly with the applicant's/recipient's spouse. The disregard cannot be applied to resources owned solely by the spouse.

An approved ISSA must be reviewed by the worker at each redetermination. If the estimated date that the items/services were to be purchased has passed and the item/service has not been purchased, the recipient must submit an updated request Form 50929. If the recipient does not do so within 30 days, the worker is to send an e-mail to the PAL Mailbox on Outlook. It is not necessary for these e-mails to PAL to go through the Policy Contact Person at the local DFR office. The worker can send them directly by entering in the subject field "ISSA UPDATE". Do not include the recipient's name or case number in the subject field. The Central Office will then end date the ISSA, and it will no longer be an allowable resource disregard.

MEDWorks members have an obligation to report any changes in their ISSA. If their plans or goals change, they must report this to the DFR. If a request for an ISSA is disapproved or the

amount is reduced, the individual has the right to appeal this determination. The letter of decision that Central Office issues will explain these obligations and appeal rights.

2627.00.00 HEALTH SAVINGS ACCOUNTS

Health Savings Accounts are exempt as a resource if the account is restricted to use for qualified medical expenses only. The terms of the Health Savings Account are required to be verified to determine if the account can be used for purposes other than qualified medical expenses.

2630.00.00 RESOURCES EXEMPTED UNDER FEDERAL LAW

Each program has specific resources which are exempt by federal law. These exemptions are discussed in the following sections.

2630.05.00 BENEFITS UNDER FEDERAL NUTRITION PROGRAM

Certain benefits which are intended to meet the nutritional needs of low-income individuals are exempt.[58]

2630.05.05 WIC BENEFITS

Benefits received through the Women's, Infant's, and Children's (WIC) Program is exempt. These payments are usually made through vouchers and can be used to purchase specific items for pregnant or nursing women and young children.

2630.05.10 OLDER AMERICANS ACT

Benefits received under Title VII, Nutrition Program for the Elderly of the Older Americans Act of 1965, as amended, are exempt.

2630.05.15 CHILD NUTRITION ACT

The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, is exempt.[59]

2630.05.20 NATIONAL SCHOOL LUNCH ACT

The special food service program for children under the National School Lunch Act, as amended, is exempt.[60]

2630.05.25 FOOD STAMPS/COMMODITIES

The value of food stamps and the value of United States Department of Agriculture donated foods (surplus commodities), are exempt.[61]

2630.10.00 HUD ASSISTANCE

Housing assistance paid directly or indirectly by HUD under the following is exempt:

The Housing Authorization Act of 1976 with respect to a dwelling unit under the United States Housing Act of 1937, as amended (Sections 8, 10, and 23 and the Experimental Housing Allowance Program)

The National Housing Act (loans for housing renovation, mortgage insurance, and investment insurance)

Title V of the Housing Act of 1949 (loans to elderly individuals, farmers, and developers for the construction, improvement, or replacement of farm homes and other buildings)

Section 101 of the Housing and Urban Development Act of 1965 (payments to certain mortgagors on behalf of tenants with low income who are displaced by government action, age 62 or over, physically handicapped, living in substandard housing, present or past tenants of dwellings damaged or destroyed by disaster, or whose head of the household is on active duty with the armed forces).[62]

2630.15.00 RELOCATION ASSISTANCE ACT PAYMENTS

Relocation assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is exempt.[63]

2630.20.00 HOME ENERGY ASSISTANCE PAYMENTS

Payments received through the Home Energy Assistance Program (EAP) are exempt.[64]

2630.25.00 ASSISTANCE FOR CERTAIN INDIAN TRIBES/ALASKAN NATIVES

The following Section discusses federal law pertaining to Indian tribes and Alaska natives.

P.L. 92-203, section 29, dated 1/2/76, the Alaska Native Claims Settlement Act, and Section 15 of P.L. 100-241, 2/3/88, the Alaska Native Claims Settlement Act Amendments of 1987 - All compensation (including cash, stock, partnership interest, land, interest in land, and other benefits) received under this Act are excluded from income and resources.

P.L. 93-134, the Judgment Award Authorization Act, as amended by P.L. 97-458, Section 1407, 11/12/83 and P.L. 98-64, 8/2/83, the Per Capita Distribution Act. P.L. 97-458 required the exclusion of per capita payments under the Indian Judgment Fund Act (judgment awards) of $2,000 or less from income and resources. The exclusion applies to each payment made to each individual. Initial purchases made with exempt payments distributed between 1/1/82 and 1/12/83 are excluded from resources to the extent that excluded funds were used. P.L. 98-64 extended the exclusion to cover per capita payments from funds which are held in trust by the Secretary of Interior (trust fund distributions).

P.L. 93-531, Section 22 - Relocation assistance payments to members of the Navajo and Hopi Tribes are excluded from income and resources.

P.L. 94-114, Section 6 - Income derived from certain sub-marginal land held in trust for certain Indian tribes is excluded from income and resources. The tribes that may benefit are:

Bad River Band of the Lake Superior Tribe of Chippewa Indians of Wisconsin

Blackfeet Tribe

Cherokee Nation of Oklahoma

Cheyenne River Sioux Tribe

Crow Creek Sioux Tribe

Lower Brule Sioux Tribe

Devils Lake Sioux Tribe

Fort Belknap Indian Community

Assiniboine and Sioux Tribes

Lac Courte Oreilles Band of Lake Superior Chippewa Indians

Keweenaw Bay Indian Community

Minnesota Chippewa Tribe

Navajo Tribe.

P.L. 94-189, Section 6, 12/31/75 - Funds distributed per capita to the Sac and Fox Indians or held in trust are excluded from income and resources. The funds are divided between members of the Sac and Fox Tribe of the Mississippi in Iowa. The judgments were awarded in Indian Claims Commission dockets numbered 219, 153, 135, 158, 231, 83, and 95.

P.L. 94-540 - Payments from the disposition of funds to the Grand River Band of Ottawa Indians are excluded from income and resources.

P.L. 95-433, Section 2 - Indian Claims Commission payments made pursuant to this Public Law to the Confederated Tribes and Bands of the Yakima Indian Nation, and the Apache Tribe of the Mescalero Reservation are excluded from income and resources.

P.L. 96-420, Section 9(c), 10/10/80, Maine Indian Claims Settlement Act of 1980 - Payments made to the Passamaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet are excluded from income and resources.

P.L. 97-403 - Payments to the Turtle Mountain Band of Chippewas, Arizona are excluded from income and resources.

P.L. 97-408 - Payments to the Blackfeet, Grosventre, and Assiniboine tribes, Montana, and the Papago, Arizona, are excluded from income and resources.

P.L. 98-123, Section 3, 10/13/83 - Funds distributed under this Act to members of the Red Lake Band of Chippewa Indians are excluded from income and resources. Funds were awarded in docket number 15-72 of the United States Court of Claims.

P.L. 98-124, Section 5 - Per capita and interest payments made to members of the Assiniboine Tribe of the Fort Belknap Indian Community, Montana, and the Assiniboine Tribe of the Fort Peck Indian Reservation, Montana, under this Act are excluded from income and resources. Funds were awarded in docket 10-81L.

P.L. 98-500, Section 8, 10/17/84, Old Age Assistance Claims Settlement Act, provides that funds made to heirs of deceased Indians under this Act shall not be considered as income or resources.

P.L. 99-146, Section 6(b), 11/11/85 - Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior are excluded from income and resources. Judgments were awarded in Dockets numbered 18-S, 18-U, 18-C and 18-T. Dockets 18-S and 18-U are divided among the following reservations:

Wisconsin

Bad River Reservation

Lac du Flambeau Reservation

Lac Courte Oreilles Reservation

Sokaogon Chippewa Community

Red Cliff Reservation

St. Croix Reservation.

Michigan

Keweenaw Bay Indian Community (L'Anse, Lac Vieux Desert, and Ontonagon Bands)

Minnesota

Fond du Lac Reservation

Grand Portage Reservation

Nett Lake Reservation (including Vermillion Lake and Deer Creek)

White Earth Reservation.

Under Dockets 18-C and 18-T funds are given to the Lac Courte Oreilles Band of the Lake Superior Bands of Chippewa Indians of the Lac Courte Oreilles Reservation of Wisconsin, the Bad River Band of the Lake Superior Tribe of Chippewa Indians of the Bad River Reservation, the Sokaogon Chippewa Community of the Mole Lake Band of Chippewa Indians, and the St. Croix Chippewa Indians of Wisconsin.

P.L. 99-264, White Earth Reservation Land Settlement Act of 1985, 3/24/86, Section 16 excludes money paid under this Act from income and resources. This Act involves members of the White Earth Band of Chippewa Indians in Minnesota.

P.L. 99-346, Section 6(b) (2) - Payments to the Saginaw Chippewa Indian Tribe of Michigan are excluded from income and resources.

P.L. 99-377, Section 4(b), 8/8/86 - Funds distributed per capita to the Chippewa of the Mississippi or held in trust under this Act are excluded from income and resources. The judgments were awarded in Docket Number 18-S. The funds are divided by reservation affiliation for the Mille Lac Reservation, Minnesota; White Earth Reservation, Minnesota; and Leech Lake Reservation, Minnesota.

P.L. 101-41, 6/21/89, the Puyallup Tribe of Indians Settlement Act of 1989, Section 10(b) provides that nothing in this Act shall affect the eligibility of the Tribe or any of its members for any Federal program. Section 10(c) provides that none of the funds, assets or income from the trust fund established in Section 6(b) shall at any time be used as a basis for denying or reducing funds to the Tribe or its members under any Federal, State, or local program. (The Puyallup Tribe is located in the State of Washington.)

P.L. 101-277, 4/30/90, funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73, 151 and 73-A of the Indian Claims Commission are excluded from income and resources except for per capita payments in excess of $2,000. Payments were allocated to the Seminole Nation of Oklahoma, the Seminole Tribe of Florida, the Miccosukee Tribe of Indians of Florida, and the independent Seminole Indians of Florida.

P.L. 101-503, Section 8(b), Seneca Nation Settlement Act of 1990, dated 11/3/90, provides that none of the payments, funds or distributions authorized, established, or directed by this Act, and

none of the income derived therefrom, shall affect the eligibility of the Seneca Nation or its members for, or be used as a basis for denying or reducing funds under, any Federal program.

P.L. 93-134, Section 8, 10/19/73, the Indian Tribal Judgment Fund Use or Distribution Act, as amended by P.L. 103-66, Section 13736, 10/7/93, provides that interest of individual Indians in trust or restricted lands shall not be considered a resource and up to $2,000 per year of income received by individual Indians that is derived from such interests shall not be considered income in determining eligibility for assistance under the Social Security Act or any other Federal or federally assisted program.

If other types, not on this list, are encountered, contact the Policy Answer Line for guidance.

2630.30.05 COMPENSATION TO JAPANESE/ALEUTS (MED 1, 4)

Restitution payments by the U.S. Government to individual Japanese Americans (or, if deceased, to their survivors) and Aleuts who were interned or relocated during World War II are exempt from income and resources. Also, restitution payments from the Canadian government to individual Japanese Canadians who were interned or relocated during World War II are exempt resources.[65]

2630.35.00 GERMAN REPARATION PAYMENTS (MED 1, 4)

German reparation payments are payments made by the Republic of Germany to certain survivors of the Holocaust and may be received periodically or in a lump sum. They are exempt from resources by federal law.[66]

2630.35.05 CRIME VICTIM PAYMENTS (MED 1, 4)

Any amount of assistance received from federal funds administered by any state or local government program established to aid victims of crime is excluded from resources for a period of 9 months beginning with the month following the month of receipt. To be excluded from resources under this section, the individual (or spouse) must demonstrate that any amount received was compensation for expenses incurred or losses suffered as the result of a crime.[67]

2630.40.00 DOMESTIC VOLUNTEER SERVICE ACT COMPENSATION

The following is exempt as a resource by federal law:

Compensation of any kind (including stipends, supportive services, remuneration for out-of-pocket expenses, and so forth) provided to individuals who are volunteers in programs administered directly or through sponsoring agencies by the United States action Agency under Titles I, II, and III of the Domestic Volunteer Service Act of 1973, is exempt. These programs include the Foster Grandparents Program, Retired Senior Volunteer Program (RSVP), Service Corps of Retired Executives (SCORE), Active Corps of Executives (ACE), Action Cooperative Volunteer Program

(ACV), Senior Companion Program, Volunteers in Service to America (VISTA), and University Year for Action (UYA).[68]

2630.45.00 PAYMENTS TO STUDENTS

Education grants and loans received under Title IV of the Higher Education Act, or the Bureau of Indian Affairs (BIA) programs are exempt for undergraduate students' Medicaid.[69] These exclusions are allowed for students in high school and GED programs as well as post-secondary education. Examples include:

Basic Educational Opportunity Grants (BEOG),

Supplemental Educational Opportunity Grants (SEOG),

College Work Study,

National Direct Student Loans (NDSL),

Guaranteed Student Loans,

Pell Grants, and

Federal Perkins Loans

Refer to Section 2860.05 for comprehensive listing.

2630.55.00 DISASTER ASSISTANCE PAYMENTS

Assistance received under the Disaster and Emergency Assistance Act of 1974[70] or another federal statute because of a presidentially declared major disaster is permanently exempted as a resource.

2630.60.00 RADIATION EXPOSURE ACT BENEFITS

Payments made from the Radiation Exposure Compensation Trust Fund established under the Radiation Exposure Compensation Act are exempt resources.[71]

2630.65.00 AGENT ORANGE SETTLEMENT ACT PAYMENTS

Payments made from the Agent Orange settlement fund, or any fund established as a result of the Agent Orange product liability litigation, are exempt from resource consideration.[72]

2630.70.00 FEDERAL TAX REFUND PAYMENTS

For non-MAGI (MED 1, 2, 4) AGs, federal tax refunds received after December 31, 2009, are disregarded as a resource for a period of 12 months after the month of receipt for all federal

means-tested programs including Medicaid. The resource exclusion lasts for 12 months If properly transferred within the 12-month protected period, transfer of the federal tax refund would be allowable and would not incur a transfer penalty for the member.

Example:

Sam is institutionalized in a psychiatric facility and receives a federal tax return in the amount of $8000.00. The tax refund was transferred to her brother 3 months after the receipt date. Because the transfer occurred within the 12-month period of receipt, this is allowable, and Sam would not incur a transfer penalty.

The federal tax refund is to be excluded as a resource by subtracting any tax refund received by the AG in the last 12 months from the AG's resources. If the difference between the resources and the amount of the federal tax refund is less than the resource limit, the AG meets the resource limit.

Example:

AG applies today and has total resources of $4000. AG verified receipt of a federal refund in the amount of $3287 received in January of this year. This federal refund amount would need to be deducted from the total resources and the difference of $713 would be countable as a resource.

2630.95.00 INDIVIDUAL DEVELOPMENT ACCOUNT

Individual Development Accounts (IDA) operated under the Assets for Independence Act (AFIA), Public Law 106-554, are established by or on behalf of eligible TANF recipients for the purpose of purchasing a home, attending post-secondary education, or purchasing a business.[73] Eligible individuals[74] may receive matching funds for their IDA through a community development corporation (CDC). Any funds deposited in an IDA are exempt from being counted as a resource. (See IPPM 2850.05.00)

2635.00.00 RESOURCE ELIGIBILITY DETERMINATION

Resource eligibility requirements for MED 1, 2, or 4 categories must be met for eligibility to be established. The worker is responsible for obtaining and verifying all pertinent information regarding the resources of the appropriate AG members. The consideration of resources will vary according to the age, marital status, and living arrangement of the AG members. The following sections explain the methods used in determining resource eligibility.

2635.10.00 RESOURCE ELIGIBILITY DETERMINATION (MED 1)

In addition to eligibility requirements discussed in the preceding passages of this chapter, the following principles apply to the consideration of resources in the resource eligibility determination of all persons except institutionalized individuals who entered long term care facilities on or after September 30, 1989, and who have a community spouse.

All available resources owned by the applicant/recipient and their responsible relatives must be considered regarding the resource limitations listed in Section 3005.15.00. Persons who qualify as "responsible relatives" are as follows:

The spouse of the applicant/recipient if the couple is living together or separated only for medical reasons such as nursing home placement.

For those in an institution, a PACE member or on an HCBS waiver, MCCA rules apply[75]. See section 2635.10.10 – 2635.10.10.15.

The biological or adoptive parent(s) and stepparents living with an applicant/recipient under age 18 [76], unless the child is receiving Home and Community-Based Services under any of Indiana's waivers. If the applicant/recipient child is institutionalized (including hospitalization) the parent(s)' resources are not considered in the month following the month of admission. If the non-recipient parent of the applicant/recipient child owns resources more than the resource limit, the excess is to be counted as a resource of the child However, excess resources of the child applicant/recipient cannot be counted as a resource to the parent. Also, excess resources of the recipient parent cannot be counted as a resource to the child.

Parent’s resources are considered through the month in which the child applicant/recipient reaches age 18 unless the child turns 18 on the first of the month.

When the applicant/recipient is a student between the ages of 18 and 21, the parent's resources are not counted.

Resources owned solely by the following individuals are exempt:

Non-recipient children or siblings of the applicant/recipient,

The stepparent of an applicant/recipient

Parents of an institutionalized applicant/recipient beginning in the month following the month of admission, or beginning in the month of birth if the child remains institutionalized/hospitalized in the following month[77]

Parents of a child who has been determined eligible for Home and Community-Based Services (HCBS) Waiver.[78] See Chapter 3300.

2635.10.05 QMB, QDW, SLMB, AND QI RESOURCE DETERMINATIONS (MED 4)

In addition to the eligibility requirements discussed in the preceding sections of this chapter, the following principles apply to the consideration of resources in the Qualified Medicare Beneficiary (QMB), Qualified Disabled Worker (QDW), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individual (QI) eligibility determination:

Resources owned by the following individuals must be considered:

The applicant/recipient

The spouse of the applicant/recipient if the couple is living together.

Resources owned solely by the spouse of the applicant/recipient who does not live with them are not considered.

Resource limitations listed in Section 3005.25.00 must be met before resource eligibility can be established.

2635.10.10 RESOURCES/INSTITUTIONALIZED/COMMUNITY SPOUSE (MED 1)

The policies stated in this section apply only to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

Special resource provisions apply to married individuals who are institutionalized, PACE participants or HCBS waiver members; the provisions are explained further in Sections 2635.10.10.05, 2635.10.10.10, and 2635.10.10.15.

Special resource provisions apply to an institutionalized individual who has a community spouse or to a waiver applicant/recipient who has a community spouse, and are explained further in Sections 2635.10.10.05, 2635.10.10.10, and 2635.10.10.15.

To qualify for consideration under these special provisions, an institutionalized spouse must be in a hospital, nursing facility, ICF/IID, or psychiatric facility for 30 consecutive days, or be likely to remain in such a facility for that period or longer. If an individual dies before the 30th consecutive day, the individual should be treated as though they would have resided in the institution for 30 consecutive days. The "community" spouse must be living in a setting other than one of the aforementioned facilities.

The special resource provisions apply only to individuals who are legally married to community spouses and who begin continuous periods of institutionalization on or after September 30, 1989.

An individual is in a "continuous period of institutionalization" until such continuity is broken by the absence from a hospital, nursing facility, ICF/IID, or psychiatric facility for at least 30 consecutive days.

These special resource provisions no longer apply beginning the month following the month in which circumstances change so that the couple no longer meets the criteria.

An individual living in a residential facility, such as one participating in the Room and Board Assistance (RBA) program, is not entitled to have eligibility determined under the special provisions. A resident of an RBA facility qualifies as a community spouse when the other spouse is institutionalized in a hospital, nursing facility, ICF/IID, or psychiatric facility.

2635.10.10.05 RESOURCE ASSESSMENT AND SPOUSAL SHARE (MED 1)

The policies stated in this section apply only to the MA A, MA B, MA D, MADW, and MADI categories of assistance.

Institutionalized individuals who are married to community spouses and who meet the specific criteria in Section 2635.10.10 must have a resource assessment completed. The resource assessment is a very important process whereby the combined countable resources of the couple are determined as of the beginning (date of admission) of the institutionalized spouse's first continuous period of institutionalization which began on or after September 30, 1989.[79] From this information, a "spousal share" for the community spouse, equaling one-half of the couple's combined countable resources, is then established for use in determining the institutionalized spouse's resource eligibility.

Countable resources for assessment purposes are determined in the same manner as in regular situations with the following exceptions:

Up to $2,000 of any separately identifiable funds or assets which have been set aside for burial can be excluded. This exemption can be given to both spouses if applicable; however, the $2,000 maximum must be reduced by the face value of any life insurance policy whose cash surrender value has been exempted, or by the amount in any irrevocable burial trust. [Please, note the exempted value prior to June 1, 2014, was $1,500]. In order for funds or assets to be considered set aside for burial, the account titling must indicate such, or there must be a signed statement by the owner or guardian of the purpose for the funds and the date on which they were set aside.

One motor vehicle of any value is exempt.

The equity value of nonexempt real property owned solely or jointly by the institutionalized spouse is a countable resource. (The "agree to sell" rule is applied only to eligibility determinations, not for purposes of calculating the spousal share.) The equity value of real property owned solely by the community spouse (or jointly with someone other than the

institutionalized spouse) is not included when determining the amount of combined assets for spousal share purposes.

The resource assessment can be requested independently of an application for assistance by either spouse or their authorized representative. In that situation, the assessment request should occur promptly upon admission to the facility. DFR Offices are to provide Form 2060, *Resource Assessment Notice and Request,* to interested people upon request and should provide a supply to facilities in the county. A completed Form 2060 can be mailed to FSSA Document Center or the local DFR office.

When a request for an independent resource assessment is received, the screener is to access the independent resource assessment screen, complete the screens, and schedule an appointment for the assessment interview. The interview can be conducted in person or by telephone. During the interview the worker is to complete Form 2061, *Resource Assessment for Medical Assistance to the Aged, Blind and Disabled.* The responsibility for providing the required documentation and verification rests entirely with the couple and any representative. The Form 2060 explains this fact and also lists the type of documentation which must be provided to the DFR. Workers are to give advice and guidance to the individual as to the most effective means of obtaining verification but are not required to obtain verifications directly, although it is not prohibited when a properly signed consent has been obtained.

If the necessary documentation is not received by the DFR within 20 days of the date of the assessment request, the worker will receive an alert and is to send a reminder letter to both spouses and their representative listing the necessary documentation and asking for an update on the status of their verification process. At the end of 30 days, a second letter should be sent stating that the assessment cannot be completed until the verification is submitted.

When the necessary documentation is received, the DFR is to proceed in an expedient manner to complete the assessment and determine the spousal share. Once completed, copies of the Form 2061 and the verifications must be provided to both spouses. If a representative has acted on behalf of either spouse, the DFR must provide client with a copy also. The worker is to access the independent resource assessment screen and enter the amount of the spousal share.

A copy of all complete or incomplete assessments, as well as the documentation and any correspondence, must be retained by the DFR as the spousal share, or the inability to establish one, is crucial information in the determination of the institutionalized spouse's eligibility when an application is filed. Copies of the independent resource assessments are to be retained indefinitely.

The spousal share cannot be appealed until an application for Medicaid is filed and the eligibility determination is completed. If a mathematical or keying error is made by the worker, the independent resource assessment screen can be accessed by the supervisor who can enter the correct spousal share.

If an individual not entitled to an independent resource assessment under the special resource provisions requests an assessment via the Form 2060, the DFR must advise the individual in writing of the reason the assessment will not be completed.

If the institutionalized spouse is applying for Medicaid, the resource assessment will be an integral part of the eligibility study. Do not complete the independent resource assessment screen. When a person is applying for Medicaid and needs a resource assessment as part of member's eligibility determination, that individual will be entered into the system just like any other application. When the application is processed in AE, the resource assessment and the resource assessment-continued screens are to be completed with the resource data necessary to determine the spousal share. When resources are jointly owned by the spouses, they are to be entered once on the Resources Assessment screen and the Resource Assessment-Continued screen in the institutionalized spouse's name. Then the spousal share can be correctly calculated. Resource values for assessment purposes must be verified as of the first date of continuous institutionalization, whether it is in a hospital or a nursing facility.

When an assessment is being completed in conjunction with an application for assistance, the securing of necessary resource verification is a joint applicant/worker effort conducted in the usual manner.

2635.10.10.10 RESOURCE ELIGIBILITY/INSTITUTIONALIZED SPOUSE (MED 1)

The policies stated in this section apply only to MA A, MA B, MA D, MADW, and MADI categories of assistance and are applicable to institutionalized individuals who meet the specific criteria in Section 2635.10.10.

The community spouse resource limit is the greatest of the following:[80] (Refer to Section 3005.10.00 for current amounts.)

The minimum current state standard,

The spousal share not exceeding the current maximum,

Any number of resources ordered to be transferred by a court against the institutionalized spouse for the support of the community spouse, or

The amount established by an Administrative Law Judge as the result of an appeal.

The first of the month resource eligibility rule (refer to Section 2605.20.10) is applicable to resource eligibility determinations made under the special resource provisions for an institutionalized spouse with a community spouse. The special provisions are applicable beginning with the first month of institutionalization included in the possible Medicaid covered period (that is the three-month retro period). The institutionalized spouse's resource eligibility for any month in which the special resource provision does not apply (for example, the month

before institutionalization) is to be determined using all of the regular resource methodologies and the resource limitation for a couple.

Beginning with the first month in which the special resource provisions apply, the procedure outlined below is required. This procedure establishes the initial month of eligibility, which is the point at which the community spouse's resources are no longer considered.

The couple's combined countable resources are determined by applying all of the regular resource methodologies, except as follows:

Up to $1,500 of separately identifiable burial funds is disregarded.[81] This exemption can be given to both spouses if applicable. However, the $1,500 maximum must be reduced by the amount in an irrevocable burial trust or by the face value of any life insurance policies whose cash surrender value has been exempted because the face value is $1,500 or less and the beneficiary is the estate or funeral home

One motor vehicle is exempt regardless of value or purpose

The equity value of real property owned solely by the community spouse (or jointly with someone other than the institutionalized spouse) is exempt

Nonexempt real property owned solely or jointly by the institutionalized spouse is not subject to the requirement to offer it for sale or rent, unless the total value of the couple's countable resources, including the real property, exceeds their combined resource standards.

The total value of the couple's non-exempt resources, including real property owned by the institutionalized spouse, is compared to their combined resource limit (the community spouse limit plus the standard for a single individual). If countable resources are equal to or less than the current standard, the institutionalized spouse is eligible for assistance for that month, which is the initial month of special resource eligibility for the institutionalized spouse. For subsequent months during the continuous period of institutionalization, resources owned solely by the community spouse are exempt.

If the countable resources exceed the current standard, and ownership of real property is not involved, the institutionalized spouse is ineligible for that month.

The process is repeated for subsequent months. If a month of eligibility does not occur, the application is to be denied.

If the countable resources, including non-exempt real property, are greater than the current standard, the next step is to subtract the equity value of the real property. If there still are excess resources in personal property, the applicant is ineligible. If not, the applicant must agree to offer the real property for sale or rent as a condition of eligibility.

If, for the initial month of eligibility under this provision, resources in the name of the institutionalized spouse exceed the single individual standard, a post-eligibility transfer of resources will be required within a specified time limit as explained in Section 2635.10.10.15.

If the institutionalized spouse assigns to the State of Indiana his rights for support from the community spouse, the institutionalized spouse cannot be determined ineligible due to resources under this section.

2635.10.10.15 POST ELIGIBILITY PROTECTED PERIOD (MED 1)

The policies stated in this section apply only to the MA A, MA B, MA D, MADW, and MADI categories of assistance and are applicable only to individuals who meet the specific criteria in Section 2635.10.10.

Once initial resource eligibility has been established, any amount of the community spouse resource standard spousal share which is not already solely in the community spouse's name, can be transferred to them by the institutionalized spouse and not be counted in determining the institutionalized spouse's continuing resource eligibility.[82] The institutionalized spouse must indicate a willingness to transfer resources into the community spouse's name sufficient to reduce their resources to the allowable single individual standard.

They will have a period of 90 days in which to complete this transfer. This protected period begins with the date of the notice of eligibility which approves assistance. The worker must enter on the expected changes screen the expected date of the end of the 90-day period. During this protected period, the amount subject to transfer (the difference between the community spouse resource standard and the actual number of resources solely owned by the community spouse) will not be counted as a resource of the institutionalized spouse.

Once the DFR determines that an institutionalized spouse/applicant is resource eligible for an initial month, but that the community spouse does not actually own resources equal to the community spouse resource standard, the institutionalized spouse, community spouse, and any representative must be advised in writing of the amount to be transferred to the community spouse and the deadline for doing so. This letter will be a part of the eligibility system-generated approval notice.

The DFR must monitor the couple's resources monthly through the end of the protected period to ensure that the transfer actually takes place. When it does, this is to be documented in the case record. Should the transferor need more time than the 90-day protected period to complete the transfer, the individual should contact the DFR and report this. More time must be granted by the DFR if the transfer is being pursued but has been delayed in whole or part by circumstances beyond the institutionalized spouse's control, such as a court order requirement, uncooperative insurance company, and so forth. If the protected period is extended by the DFR, access the expected changes screen, and change the expected date of the end of the 90-day protected period. Monthly resource monitoring must continue until the transfer is completed.

If there is no extension and the 90-day period ends without the transfer having occurred, the DFR must contact the institutionalized spouse or his representative relative to the status of transfer activity. If the transfer is not being pursued or there is no good cause for an extension, the protected assets immediately become countable again as resources of the institutionalized spouse and assistance will be discontinued.

2635.10.20 RESERVED

2635.10.20.05 ENTITLEMENT TO RESOURCE SPEND-DOWN/SSI DETERMINATION

As of June 1, 2014, this no longer applies.

2635.10.20.10 RESOURCE SPEND-DOWN DETERMINATION

As of June 1, 2014, this no longer applies.

2635.10.20.15 ELIGIBILITY SYSTEM PROCEDURES WHEN RESOURCE SPEND-DOWN IS INVOLVED (MED 1)

As of June 1, 2014, this no longer applies.

2640.00.00 TRANSFERS OF PROPERTY

The transfers of certain real or personal property to another individual must be considered in relation to the law and/or regulations in effect on the date that the transfer occurred. The specific policy for transfers of property varies by program and is explained in Sections 2640.10.00 through 2640.10.35.05.

The Resource Questions screen contains the transfer of property question. When the answer is "yes", the Resource Transfer screen must be completed with the transfer information.

2640.10.00 TRANSFER OF PROPERTY LAW

The Medicaid eligibility of an individual who transfers property on or after August 11, 1993, is governed by federal law. Section 1917(c) of the Social Security Act (42 U.S.C. 1396 p-C), as amended by OBRA-93 requires a penalty period of reduced Medicaid coverage for persons found to have made a property transfer for less than fair market value and for the purpose of becoming eligible for Medicaid.

The following sections explain the procedures for consideration of transfers of property occurring on or after August 11, 1993. State regulations, as amended, at 405 IAC 2-3-1.1 and 405 IAC 2-3-1.2 are applicable to certain transfers effective June 1, 2002, regarding annuities, income transfers, and failure to take action to receive assets. Additional provisions are effective July 1, 2003, regarding the start of a transfer penalty, penalty periods for successive transfers, and transfers of income producing real property.

2640.10.05 GENERAL APPLICABILITY OF TRANSFER OF PROPERTY LAW

The transfer of property provision is applicable to applicants/recipients who are either:

Inpatients of nursing facilities or other medical institutions in which they are receiving equivalent nursing facility services, or

PACE participants, or

Receiving Home and Community-Based Services (HCBS).

If an applicant/recipient does not meet one of the above conditions a transfer penalty is not invoked. If such an individual has transferred property, the worker is to record the occurrence but will not require verifications nor attempt to determine whether the transfer was violative. However, if the individual later enters a nursing facility or begins receiving HCBS, the worker would then be required to determine whether the transfer was violative.

When a spouse transfers an asset that results in a penalty for the client, the penalty period must be apportioned between the spouses. Both spouses must be eligible for Medicaid Institutional service or home/community-based waiver services during the same time for apportionment to occur. When one spouse is no longer subject to a penalty (for example, the spouse no longer receives institutional or waiver services or the spouse dies), the remaining penalty period applicable to both spouses must be served by the remaining spouse.[83]

If the applicant/recipient claims that a theft of funds has occurred, see 2605.45.00.

Transfers are potentially violative made by the following:[84]

Applicant/recipient

The spouse of the applicant/recipient

Anyone with legal authority to act on behalf of the applicant/recipient or spouse, such as a parent or legal guardian (including a court or administrative body)

Anyone acting at the direction or request of the applicant/recipient or spouse (including a court or administrative body).

Federal law defines assets as both income and resources (real and personal property) owned by the applicant/recipient and spouse. Refer to Section 2640.10.15.05 regarding transfers of homes and income-producing real property.

Also included as an asset are income and resources, which the applicant/recipient is entitled to receive but doesn't because of their actions or those of their spouse, a person with legal authority to act on the applicant or their spouse's behalf, including a court or administrative

body, or any other person, court or administrative body acting at the direction or request of the individual.

Examples of actions which would cause income or resources not to be received are:

Irrevocably waiving pension income

Waiving the right to receive, or failing to take the necessary action to receive an inheritance

Not accepting injury settlements.

Each individual circumstance of an individual failing to take an action to obtain assets must be carefully examined, as this may not always be considered a violative transfer. A transfer of property penalty will not be imposed in the following circumstances:

The applicant/recipient, or the person with the legal authority to act on behalf of the applicant/recipient is unaware of the right to receive assets or becomes aware after the deadline for taking action has passed. If the DFR or other division of FSSA informs the individual of their right to receive assets prior to the deadline for taking action, the individual will be presumed to be aware of his rights.

A physician who is knowledgeable of the medical condition of the applicant/recipient provides a written statement that the applicant/recipient is not capable of taking the necessary action to receive the asset. A physician's statement can only be used for this purpose if the applicant or recipient has no legal guardian or other person who has the authority to act on the individual's behalf in whatever action is needed to receive the assets.

The expense of collecting the assets would exceed the value of the assets. In the case of a surviving spouse who fails to take a statutory share of a deceased spouse's estate, a penalty is not imposed if the deceased spouse made other equivalent arrangements to provide for the surviving spouse's needs, including but not limited to setting up a trust.

2640.10.10 DETERMINING THE TRANSFER REVIEW PERIOD

As stated in the preceding section, the transfer of property law is made an active consideration only by the applicant/recipient being or becoming institutionalized in a nursing facility (or receiving Home and Community-Based Services). When this factor is present in a case situation, the worker must then determine the time period that must be reviewed during which transfers made could be violative. This time period is the "review period", or "look-back" period.

The review period for looking at a transfer involving non-trust property prior to November 1, 2009, is 36 months prior to the first date when the individual was institutionalized and had applied for Medicaid and continues indefinitely thereafter.

Upon November 1, 2014, the review period for looking at a transfer involving non-trust property is 60 months prior to the first date when the individual was institutionalized and had applied for Medicaid and continues indefinitely thereafter. (This date is referred to as the baseline date.)

The review period for looking at a transfer involving non-trust property between November 1, 2009, and November 1, 2014, extends back to November 1, 2009, when the individual was institutionalized and had applied for Medicaid, and continue indefinitely thereafter.

The review period for transfers involving trust funds in the circumstances explained in Section 2615.75.15 is 60 months prior to the baseline date defined above and continues indefinitely thereafter.

When a Medicaid recipient becomes institutionalized, is a PACE member or begins receiving Home and Community-Based (HCBS) waiver services, the baseline date is the date when both conditions, i.e., an application and institutionalization, or HCBS, are met. This would be the date of institutionalization or effective date of waiver services.

Example:

Individual living at home transfers property on January 10, 1995. She applies for Medicaid on April 7, 1995, and enters a nursing facility on September 11, 1995. The baseline date is September 11. Therefore, the transfer took place within the review period.

2640.10.15 ALLOWABLE TRANSFERS OF PROPERTY

If it is determined that a transfer occurred within the review period, the next step is to determine whether the transfer automatically qualifies as allowable. No transfer of property penalty can be invoked when an individual makes a transfer to:

The applicant/recipient's spouse (or to another for the sole benefit of the spouse), or

The applicant's/recipient's child who is blind or disabled, according to SSI criteria, or to a trust fund for such a child.

The assets were transferred to a trust established solely for the benefit of an individual under sixty-five (65) years of age who is disabled.[85]

Additionally, the transfer of a home to certain individuals as explained in Section 2640.10.15.05 is allowable.

Transfers on and after 8-11-93, to certain types of trust funds, as defined in section 2615.75.15, for disabled individuals are allowable.

2640.10.15.05 TRANSFERS OF HOMES AND INCOME-PRODUCING REAL PROPERTY (MED)

There is no transfer of property penalty if a home, as defined in section 2620.15.10, is transferred to any of the following:

A spouse

Children under age 21 of the applicant/recipient

Blind or disabled (according to SSI criteria) children of the applicant/recipient

A sibling of the applicant/recipient who has equity interest in the home and who was residing in the home for at least one year prior to the individual's nursing facility admission

A child of the applicant/recipient who was living in the home at least two years prior to the individual's admission to the nursing facility and who provided care that was necessary to permit the individual to remain at home rather than be institutionalized. In these situations, documentation of the individual's condition and the extent of care provided by the child is required in the case record.

An individual who transfers their home to a person not specified above remains subject to a transfer of property penalty.

For transfers of income-producing real property on and after 7-1-03, the following rules apply:

$6,000 of the equity value can be transferred without penalty if the property produces at least $360 a year in income. [86] The uncompensated value is the equity over $6,000. If the property does not produce at least $360 per year in income, the entire equity is the uncompensated value. The transfer of the income must be evaluated based on the fair market value of the income in accordance with Section 2640.10.25.20.

If the real property has equity of less than $6,000, the property can be transferred without penalty if it produces income that is at least 6% of the equity value. If it produces income that is less than 6% of the equity, the entire equity is the uncompensated value. Refer to Section 2640.10.25.20 regarding transfer of the income.

The $6,000 transfer exemption is a single, one-time exemption that applies to the total value of all income-producing real property transferred by the individual during the individual’s lifetime.

Income producing real property that is used in a trade or business can be transferred without application of the $6,000/6% limitation. In order to qualify as a trade or business, the property must be actively managed or operated by the applicant/recipient.

Income-producing real property for which the individual owns a government permit or license, or other governmental authority to engage in income-producing activity is not subject to the

$6,000/6% limitation. Examples of this are commercial fishing permits and tobacco crop allotments issued by the USDA. (This does not include crop subsidies and soil banks.) Both of these circumstances are very uncommon in Indiana, therefore, if DFR is processing a case in which the individual claims to own such property, the Policy Answer Line must be contacted. When contacting PAL, be sure to explain what type of license or permit the individual submitted as verification.

Example 1:

A Medicaid applicant in nursing facility owned rental property with an equity value of $50,000. The applicant/recipient received $2,400 per year in rent. The month before applying for Medicaid, they gave it away to a relative with no consideration received and did not show that the transfer was made for any purpose other than qualifying for Medicaid. The uncompensated value is $44,000 plus the amount of income that was transferred based on the applicant/recipient's life expectancy at the time of the transfer.

Example 2:

A Medicaid applicant in nursing home owned farmland with an equity value of $100,000 which they cash rented to their child who paid all of the expenses and gave the member $100 a year income. The uncompensated value is $100,000 (plus the amount of income that was also transferred) because the property did not produce at least $360 annual income for member.

Example 3:

A Medicaid recipient in a nursing facility owns a 25% share as tenancy in common, in rental property valued at $200,000. Their share is $50,000 and they receive FMV rent of $2,100 per year. The applicant/recipient gave their share of the property away to their child and received no consideration. The uncompensated value is $44,000 plus the amount of income that was transferred.

2640.10.15.06 HOME EQUITY RESTRICTION

A penalty consisting of ineligibility for LTC services is invoked due to the *ownership* of the home if the applicant's equity interest or share of equity interest, in his or her home is greater than the home equity limit:

11-01-09 $500,000

01-01-11 $506,000

01-01-12 $525,000

01-01-13 $536,000

01-01-14 $543,000.

The penalty starts on the date that the applicant is otherwise eligible for Medicaid and would be receiving LTC services under Medicaid were it not for the equity restriction provision, but not before 11-01-09. The penalty continues as long as the equity value remains over the home equity limit.

The home is the applicant's principal place of residence prior to requiring LTC services. A hospitalization, visit with friends or family, or other absence from the home does not change the home designation for the purpose of this provision. Income-producing home property is subject to the equity restriction.

This restriction does not apply if the individual's spouse, dependent child under the age of twenty-one (21), or blind or disabled (per SSI standards) child of any age, is lawfully residing in the home. Additionally, the amount of equity that would fall under the asset protection of a long-term care partnership policy reduces the amount of equity in excess of the limitation.

The equity value of a home is the current fair market value (FMV) minus any encumbrance against the property. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home. The current property tax assessment must be obtained as verification of the FMV. Any such assessment other than the most current one is unacceptable. If the individual disputes the property tax assessment, a current arm's length, independent professional appraisal can be submitted and will be used in lieu of the assessment. Arm's length means that there can be no special relationship, directly or indirectly, between the appraiser and the applicant/recipient so that the interests of both are independent of each other.

If there is an encumbrance against the property such as a mortgage, home equity loan, reverses mortgage, etc., the date that the encumbrance was established must be verified for the purposes of eligibility and whether or not an improper transfer occurred. If, for example, a home equity loan was taken out within the review period, the loan transaction in and of itself may not

be a violative transfer. However, any subsequent transaction involving the proceeds from the loan must be evaluated for determination of whether an improper transfer occurred.

The equity restriction works in conjunction with the existing eligibility provisions regarding the treatment of real property, not in lieu of them. Even if all other eligibility provisions are met, the home equity restriction may still be a factor in whether or not LTC services will be paid for on the individual's behalf.

Example:

A single individual entered a nursing facility on 10-15-13 and listed their home for sale with a realtor. They apply for Medicaid on 11-11-13. The home is valued at $800,000. For resource eligibility purposes, the value of the home which is up for sale at fair market value is exempt. However, the applicant is subject to the home equity restriction penalty beginning the first of the month in which she or he is otherwise eligible for LTC services under Medicaid. The first retro month is 07-13. All other eligibility requirements are met, and the application is approved with Medicaid effective 07-01-13. The LTC penalty starts 10-01-13, the month in which the applicant was otherwise eligible for LTC.

This provision applies to individuals who apply for Medicaid on and after November 1, 2009, and for these individuals, any subsequent redeterminations that occur as the result of seeking LTC services as well as the annual scheduled redeterminations.

2640.10.15.10 DE MINIMIS TRANSFER OF PROPERTY ALLOWANCE

An annual transfer amount is allowed that will not invoke a transfer penalty and will be excluded from the total uncompensated value of an improper transfer under the circumstances explained below. This is referred to as the de minimis transfer allowance; the annual amount allowed per year is $1200.

The de minimis transfer allowance is applicable if the gift is made by the applicant/recipient, during the review period directly to:

A family member who is related to the applicant by blood, adoption, or existing marriage, or

A nonprofit organization qualified under Section 501(c) of the Internal Revenue Code as amended, which gives the organization tax-exempt status, and

The de minimis allowance is subtracted after any and all transfers have been evaluated. Up to $1200 per year is deducted from the uncompensated value of transfers that are otherwise improper.

Example 1:

A member residing in a nursing facility applies for Medicaid on 10-15-09 and reports the following transfers:

$10,000 to an irrevocable funeral trust

$1,200 to the applicant's child

The purchase of the funeral trust is allowable without penalty. The gift to the child does not invoke a transfer penalty because it did not exceed the de minimis allowance and was given to a family member.

No penalty is imposed.

The de minimis allowance is an annual total for all otherwise improper transfers, regardless of how many individuals received gifts from the member.

Example 2:

Gift 1: $800 is given to member's grandchild

Gift 2: $900 is given to a non-profit charity

The 2 gifts are combined for a total of $1,700. $1,200 is subtracted from the total gifted amount, resulting in an improper transfer amount of $500.

The de minimis transfer allowance does not apply to transfers made by the member's spouse.

Example 3:

Gift 1: The member gives $400 to their son.

Gift 2: The individual's spouse gives $600 to their sister.

The de minimis transfer allowance is $400, because the de minimis allowance does not apply to the transfer made by the individual's spouse.

The year of calculation for de minimis gifting is based upon the established baseline date and each calendar year of the review period. Any excess over $1,200 in a calendar year does not carry over to a subsequent year. The de minimis allowance can be applied to more than one qualifying individual or non-profit organization each year, however, not more than $1,200 in any one calendar year is allowed.

To allow a de minimis transfer allowance, the member is required to establish the relationship of the individual being claimed to be a family member and the tax-exempt status of any organization to which a gift was made. Required Documentation in the Case File includes:

The name, date of birth, and relationship lineage of a family member must be provided by the member. Signed statements from the member and family member(s) will suffice unless contradicting information is known to the worker, in which case clarifying information must be provided.

For example, documentation of a gift to a grandchild would include a statement that the grandchild is the child of the member's child, giving the child's birth date, and the names of the child, parent, and grandparent.

Collateral documentation of the 501(c) tax exempt status of an organization must be provided by the member. It is customary practice for these organizations to give receipts for gifts so that donors will have documentation for their own tax purposes. This type of receipt is sufficient documentation. Information about the organization should reveal its status as well, if the receipt is not available, such as brochures, websites, etc. In addition, proof of payment to the organization whose status is being documented must be provided.

For example, if a gift is reported to Charity #1 and a cancelled check to Organization #2 is provided, the de minimis allowance cannot be applied until the discrepancy is reconciled.

Documentation of the proof necessary to apply a de minimis transfer allowance is the responsibility of the applicant/recipient. It is the agency's responsibility to explain what type of documentation is required and follow existing procedures for obtaining documentation.

2640.10.16 TRANSFERS OF PERSONAL EFFECTS AND HOUSEHOLD GOODS

The following items can be transferred without receipt of adequate consideration and without imposition of a transfer penalty:

Household goods and personal effects[87]

One wedding ring of the applicant/recipient and spouse

One engagement ring of the applicant/recipient and spouse

Medical equipment required due to the applicant's/recipient/s physical condition, and which is not used extensively or primarily by others.

Wedding rings and engagement rings are those purchased by one spouse for the other spouse (or intended spouse in the case of engagement ring). If a ring is purchased by someone after marriage and labeled an engagement or wedding ring upon giving it away, a violative transfer has occurred.

2640.10.20 DETERMINING ADEQUACY OF CONSIDERATION

If a transfer cannot be determined automatically non-violative in accordance with the preceding sections, the DFR must proceed to determine whether or not adequate consideration was received.

Consideration is whatever compensation the individual received in return for the transferred property. In order to determine a transfer as non-violative, the individual must have received adequate consideration. Consideration is adequate when the fair market value minus loans, mortgages, or other encumbrances, of the transferred property is equal to the consideration received. Fair market value is the current market value of the property at the time of the transfer.

The applicant/recipient is required to supply any necessary records, documentation and information which verify the fair market value and consideration received.

The value of the consideration received is based on the agreement and expectation of the parties at the time of the transfer. The value of consideration is the gross amount paid by the purchaser, and it may be paid in one or more forms such as those discussed in the following sections. (Other forms of consideration may also be possible.) The compensation received for an asset must be in a tangible form with intrinsic value. For example, love and affection does not constitute adequate consideration because there is no dollar value attributable to love and affection.

2640.10.20.05 COMPENSATION IN CASH

Compensation in the form of cash is the total amount of cash paid or agreed to be paid in exchange for the property.[88]

2640.10.20.10 COMPENSATION IN REAL OR PERSONAL PROPERTY

Compensation in the form of real or personal property is valued according to the fair market value of that property at the time of the property transfer.

2640.10.20.15 COMPENSATION BY SUPPORT/MAINTENANCE

The value of compensation in the form of support and/or maintenance provided, or agreed to be provided, is based on the fair market value and duration of the support and/or maintenance.

Example:

The applicant/recipient has transferred a sum of money to a retirement community with the expectation that they will be provided with support and maintenance for a period of time.

2640.10.20.20 COMPENSATION BY SERVICES AGREEMENT, PERSONAL NEEDS CONTRACT, PERSONAL CARE CONTRACT OR OTHER SIMILAR AGREEMENTS

The policy below applies to new applications filed on or after July 26, 2024.

For purposes of this section, "agreement" refers to a service agreement, personal needs contact, a personal care agreement, or other similar agreement where services are provided in return for compensation.

All agreements must be sent to PAL for review. If there is an agreement in place, even if it has not been paid, it must be provided at the time of application for review. The agreement and logs must clearly display the services provided, the dates and hours of services, the names of the caregiver/s, proof that the value of services is commensurate with fair market value, verification of payments made, and the total amount paid to each caregiver.

To be considered an allowable transfer of assets, an agreement must[89]:

Be in writing.

List the services provided to an applicant or member.

List the payment rate of the services provided to the applicant or member.

List the care provider or providers.

Be signed by each party.

Be notarized at the time the agreement is made.

The requirements in the above sections 1-6 are not required when documentation is submitted to the office stating payments for services were made at the time the services were rendered (such as cash checks or bank statements). The fair market value of the services provided, and the

payment made will still be reviewed for a potential transfer of property penalty. Lump sum payments or rolling credit accounts for services previously provided are not considered payments at the time of the service.

The rate of pay for care provided to an applicant or a member in an agreement must be commensurate with a reasonable wage, based on fair market value, frequency, and duration of the services.

A detailed log of the services provided to an applicant or a member in an agreement must be maintained and include the following:

The monetary value.

Frequency and duration of the services.

Description of the services provided.

An agreement must provide for services for the benefit of an applicant or a member and cannot be retroactively dated or applied before the date the contract was notarized.

Lump sum payments for future services are not valid and may result in a transfer of property penalty.

An individual care provider under an agreement cannot provide services to an applicant or a

member for more than sixteen (16) hours a day. Duplicate services cannot be provided by multiple care providers to the same applicant or member.

Valid services do not include being on call or available to provide potential services to an applicant or a member.

Services provided under an agreement for an applicant, or a member may include the following:

Preparing meals.

Managing medication.

Housekeeping.

Paying household bills.

Transportation to medical appointments.

For ongoing Medicaid members, an agreement cannot duplicate services already provided or allowable under the Medicaid program.[90]

The approval process will occur more efficiently if the logs are provided with the details below:

Name of the caregiver and the total amount paid to the caregiver/s

Date services provided

A detailed breakdown of the services provided

Total hours

Checks written are in order by date with clear documentation that the checks were written for caregiver services

Verification from the member or authorized representative that the services provided are commemorate with fair market value

Verification of payments made (such as canceled checks)

If any of the required information is missing or not clear and concise, the agreement may result in a transfer of property penalty.

2640.10.25 DETERMINING UNCOMPENSATED VALUE

If inadequate consideration is received, the DFR must determine the uncompensated value. The uncompensated value is the difference between the fair market value, minus loans, mortgages, or other encumbrances, and the consideration received by the individual.[91] When the transferred property was jointly owned, the uncompensated value is the difference between the individual's share of the fair market value and the consideration received by the individual.

2640.10.25.05 TRANSFERS INVOLVING LIFE ESTATES

When an individual who owns real property transfers ownership of the property to another person and retains a life estate, the uncompensated value must be determined. The uncompensated value is the fair market value of the property, less the amount of loans, mortgages, or other encumbrance, minus the value of the life estate and minus any other consideration received. The value of the life estate is determined in accordance with Section 2605.25.10.05.

Example:

The applicant, age 66, owned a home valued at $235,000. The applicant transferred the title to the child for $20,000 and retained a life estate. Using the Table in Section 2605.25.10.10,

the life estate value is $156,394.85 ($235,000 x .66551). The total compensation received is $176,394.85 ($156,394.85 + $20,000). The uncompensated value is $58,605.15.

When an individual purchases a life estate interest in real property in the home of another person, a transfer penalty is imposed, using the full amount of the purchase price, when an individual purchases a life estate interest in another individual's home and does not reside in that home for at least one full year after the date of the purchase.[92] The year of residence in the home begins with the month after the documented purchase and continues for 12 consecutive months. This 12-month period is not a waiting period. The individual must establish and provide documentation of residence in the property and live there for a one-year period. Otherwise, a transfer penalty will be imposed. The penalty cannot be prorated or shortened in any fashion based on fewer months of residence. The start date of the penalty and length of the penalty period is determined the same as described previously for post-11/1/09 transfers.

In addition, under the resource eligibility policy, if the purchased life estate is not producing income and is no longer the person's home, then the life estate interest will have to be offered for sale or rent at FMV as a condition of Medicaid eligibility. Any transfer or otherwise disposal of the life estate must be evaluated as a transfer of property. This provision applies to individuals who purchase a life estate in another individual's home on and after November 1, 2009.

2640.10.25.10 TRANSFERS INVOLVING ANNUITIES

An annuity is an investment product, policy, certificate, contract, or other arrangement between two or more parties. One party pays a sum of money or other valuable consideration to the other party in return for the right to receive future payments.[77] The term "annuity" includes any financial instrument that claims to be an annuity, as well as any instrument that meets the definition of an annuity. Annuities are generally purchased by individuals from financial institutions, insurance companies, or non-profit organizations. However, "private annuities" exist that are arrangements between non-commercial, non-organizational entities such as family members, friends, or other individuals.

Different companies may use slightly varied terminology for their products. However, there are basic and common definitions that apply to annuities in general:

A deferred annuity allows interest to accumulate until the purchaser elects monthly payments to begin. Income payments often start many years after purchase.

With an immediate annuity, payments start no later than one year after the premium is paid.

The annuitant is the person on whose life expectancy the annuity payments will be calculated.

Annuitize is when the accumulated value of the annuity is converted into a guaranteed stream of income. At this point, the annuitant decides how the payments will be received. The individual could choose monthly fixed or variable payments, or a balloon payment at the end of the term, for example.

The purchase of an annuity is a transfer of property and, therefore, it is necessary to determine whether adequate consideration was (will be) received.

For annuities purchased on or after June 1, 2002; or annuitized on or after June 1, 2002, regardless of the purchase date, adequate consideration (will be) received if all the following criteria are met:

The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business, or from a tax-exempt non-profit organization,

The annuity provides monthly payments of interest and principal so that, for a specific year, the total payments for the year do not differ by more than five percent from the total paid in the previous year, and

The annuity must return the full purchase price to the purchaser or the purchaser's spouse within the annuitant's life expectancy using the Life Expectancy Tables that appear later in this section. If the individual does not (will not) receive compensation in the amount of the full purchase price within their lifetime (or within the contract's specified time period if shorter than the life expectancy), the uncompensated amount is the difference between the purchase price and the amount that the annuity will pay out to the individual within the individual's life expectancy, or term of the contract if shorter than life expectancy.

If an annuity is not purchased from a company that regularly sells such financial products or not purchased from a non-profit organization, the uncompensated amount is the entire purchase price. An example is the purchase of a private annuity from a family member. The purchase of a private annuity is a violative transfer of property.

If the annuity pays (will pay) a lump sum balloon payment or if the total annual payments vary by more than five percent, then the uncompensated amount is the entire amount of the purchase price.

If an annuity does not meet any of the criteria that render it automatically a violative transfer of property, then a determination of whether adequate consideration will be received must be made by the DFR. The value of the expected income is determined by multiplying the monthly income by the individual's life expectancy (or term of the annuity, if shorter). Convert years to months using the figure for the person's age at the time of purchase. The uncompensated value is the difference between the purchase price of the annuity and the amount of income expected to be received by the purchaser or their spouse, during the lifetime of the annuitant, or term of the annuity if shorter.

Example 1:

A female applicant, age 85, purchases a $50,000 immediate annuity from a life insurance company. She elects to receive income payments of $375 per month. Per the Life Expectancy Table for females, her life expectancy is 6.63 years or 79.56 months. $375 x 79.56 = $29,835. The applicant is not expected to receive in payments what she transferred in principle. The uncompensated value is $20,165.

Example 2:

Male applicant, age 60, purchases a $100,000 annuity on June 1, 2002, from an insurance company and will receive equal income payments of $500 per month. Per the Life Expectancy Table for males, his life expectancy is 18.42 years or 221.04 months. $500 x 221.04 = $110,520. The applicant is expected to receive income greater than the purchase price. Adequate consideration will be received.

Example 3:

Male applicant, age 90, purchases a $20,000 annuity from an insurance company on July 1, 2002, and will receive 45 payments of $250 per month. Since the annuity was purchased after June 1, 2002, and the individual will receive a balloon payment, the uncompensated amount is $20,000 – the full purchase price of the annuity.

For annuities that have been annuitized prior to June 1, 2002, adequate consideration was (will be) received if the annuity will return to the individual the full purchase price within the individual's life expectancy (or within the contract's specified time period if shorter than the life expectancy). These annuities do not have to be purchased from a commercial company or a non-profit organization. The total annual payments do not have to be equal and lump sum or deferred payments toward the end of the individual's life expectancy may be made. The uncompensated amount is the difference between the purchase price and the amount that the annuity will return within the annuitant's life expectancy.

For annuities purchased, annuitized, or where certain specified changes were made on or after November 1, 2009, the following provisions apply:

The new provisions require disclosure of annuities, specify the circumstances in which a purchase or transaction involving an annuity will be treated as an improper transfer, and require the State to be beneficiary. The new provisions apply to purchases and certain transactions as described below occurring on and after November 1, 2009.

Transactions that are subject to the new provisions include any action taken by the individual that changes the course of payment to be made by the annuity, or the treatment of the income or principal of the annuity, including such actions taken on annuities purchased before November 1, 2009. These actions include:

Additions of principal

Elective withdrawals

Requests to change the distribution of the annuity

Elections to annuitize the contract

A change in ownership, or

Any other non-routine action.

The following types of changes and events would not subject an annuity purchased prior to November 1, 2009, to treatment under the new rules:

Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances.

Changes that occur based on terms of the annuity which existed prior to November 1, 2009, and which do not require a decision, election, or action to take effect, or.

Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic condition.

Any interest in an annuity must be reported. The requirement to disclose all resources when applying for Medicaid has always been in effect for LTC applicants/recipients. These new provisions specifically require disclosure of any interest that the LTC applicant/recipient and or spouse have in annuities. The failure to disclose and provide all necessary documentation will result in denial or closure due to failure to cooperate. At minimum, the applicant/recipient must provide a copy of the complete annuity contract and documentation of transactions that occur after the purchase. The application and redetermination forms have been revised to allow for annuity disclosure as required by federal law.

The State must be beneficiary. Annuities purchased and transactions made on annuities owned by the applicant/recipient and spouse must name the State as a remainder beneficiary in accordance with the rules that follow below. If these rules regarding the beneficiary assignment in the correct position are not met, the full purchase price of the annuity is considered an improper transfer, and a penalty must be imposed.

An annuity must name the State as the remainder beneficiary in the first position unless there is a community spouse and/or a minor or disabled child. A disabled child is one who meets the SSI or SSDI disability criteria.

If there is a community spouse and/or minor or disabled child, the State must be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child.

If the State has been named as a remainder beneficiary after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State must then be named beneficiary in the first position.

The requirement is waived if the individual has purchased a long-term care insurance policy that protects the annuity as approved by the Indiana Long-Term Care Partnership (ILTCP).

As remainder beneficiary, the State is entitled to receive the total amount of medical assistance paid on behalf of the applicant for medical assistance.

Additional Criteria Applicable ONLY to the person in LTC: The rules explained below do not apply to annuities owned by or transactions made by community spouses. There are 2 separate sets of criteria that, if met by the terms of the annuity, will not result in a transfer penalty. The first set will be referred to as “soundness” criteria. The second set will be referred to as “class exceptions”. The annuity does not have to meet both sets of criteria – it must meet the criteria from either set.

The purchase of an annuity or transactions completed will not result in a transfer of property penalty if the following conditions, referred to as soundness criteria, are met:

The annuity is irrevocable and non-assignable in that it cannot be cashed in, nor ownership transferred to another individual or entity, *and*

The annuity is actuarially sound in that it is expected to return full principal and interest within the institutionalized individual’s life expectancy, *and*

The annuity provides payments in approximately equal amounts with no deferred or balloon payments.

To determine actuarial soundness for promissory notes, loans and annuities use the Life Expectancy Table at the end of this document.

If the individual does not (will not) receive compensation in the amount of the full purchase price within lifetime (or within the contract's specified time period if shorter than the life expectancy), the uncompensated amount is the difference between the purchase price and the amount that the annuity will pay out to the individual within the individual's life expectancy, or term of the contract if shorter than life expectancy.

Ownership of an annuity in one of the following classes of retirement annuities will not result in a transfer of property penalty:

An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or

A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408 (q) of the IRC), or

The annuity is purchased with proceeds from a traditional IRA (IRC Sec. 408a), or

The annuity is purchased with proceeds from certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c)), or

The annuity is purchased with proceeds from a simplified retirement account (IRC Sec. 408 § (p)),

The annuity is purchased with proceeds from simplified employee pension (IRC Sec 408 § (k))

The annuity is purchased with proceeds from a Roth IRA (IRC Sec. 408A).

To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced above, rely on verification from the financial institution, the employer or the employer association that issued the annuity. The burden of proof is on the applicant or recipient (or his/her authorized representative) to produce this documentation.

The life expectancy tables for males and females are listed below and are effective for annuities purchased on or after August 1, 2023. Life expectancy is provided in years.

LIFE EXPECTANCY TABLES

TABLE 1 - MALE TABLE 2 - FEMALE

Average Number of Years	Age of Life Remaining	Age of Life Remaining
55	24.27	27.86
56	23.48	27.01
57	22.71	26.16
58	21.95	25.32
59	21.21	24.49
60	20.47	23.67
61	19.74	22.85
62	19.03	22.04
63	18.32	21.24
64	17.63	20.45
65	16.94	19.66
66	16.26	18.88
67	15.58	18.10

68	14.91	17.34
69	14.24	16.58
70	13.59	15.82
71	12.94	15.08
72	12.30	14.36
73	11.67	13.64
74	11.05	12.94
75	10.46	12.26
76	9.88	11.60
77	9.32	10.95
78	8.77	10.31
79	8.25	9.70
80	7.74	9.10
81	7.25	8.53
82	6.77	7.98
83	6.31	7.44

84	5.88	6.93
85	5.47	6.44
86	5.07	5.99
87	4.70	5.55
88	4.35	5.15
89	4.02	4.76
90	3.72	4.41
91	3.44	4.08
92	3.18	3.78
93	2.96	3.51
94	2.75	3.27
95	2.57	3.05
96	2.42	2.85
97	2.28	2.68
98	2.15	2.52
99	2.04	2.37

100	1.93	2.23
101	1.83	2.09
102	1.73	1.96
103	1.63	1.84
104	1.54	1.72
105	1.45	1.61
106	1.36	1.50
107	1.28	1.40
108	1.20	1.30
109	1.13	1.21
110	1.05	1.12
111	0.98	1.03
112	0.92	0.95
113	0.85	0.88
114	0.79	0.80
115	0.74	0.74

116	0.68	0.68
117	0.63	0.63
118	0.58	0.58
119	0.53	0.53

2640.10.25.20 ESTABLISHING JOINT OWNERSHIP (MED)

When property is converted from individual ownership to joint ownership on or after July 1, 1996, a transfer of property has occurred. The amount considered to be transferred is the proportionate value of the new owner(s) share of the property.

When evaluating this kind of transfer workers should keep in mind that the joint interests might not all be equal. The deed or contract should specify the proportionate interests of each owner, but if it is not clear or if the worker has questions, an FSSA attorney should be consulted for assistance.

Example 1:

Property value = $60,000. One equal joint owner is added. $30,000 was transferred.

Example 2:

Property value = $80,000. Two joint owners are added and all 3 have equal interests. $53,333.34 was transferred. (The 2 new owners' value of the property.)

If property is jointly owned and additional new owners are added, the amount transferred is the difference between individual's interest before the transfer and after the transfer.

Example 3:

Property valued at $90,000 is jointly owned by the applicant and his son. His interest is $45,000. He adds his daughter as another joint owner, and all 3 have equal shares. His interest is now $30,000, so the amount transferred is $15,000. ($45,000 - $30,000).

If the property which has been converted to joint ownership has a lien or mortgage, the amount transferred is the proportionate equity value.

2640.10.25.25 TRANSFERS OF INCOME

This section applies to transfers of income that occur on and after June 1, 2002.[93]

When an individual transfers a stream of income or the right to receive income, the uncompensated value is the difference between the actual amount of income received, and the fair market value (FMV) of income that should be received. The FMV of the income that should be received is determined by multiplying the FMV by the life expectancy of the individual based on the Tables in Section 2640.10.25.10. Any income that the property was producing, or was capable of producing, is included in the definition of assets for purposes of the transfer law. The resource that was transferred may have been exempt or non-exempt.

In the situation of a transfer of income-producing, non-home real property, the value of the property in excess of $6,000 is considered an uncompensated transfer. See Section 2640.10.15.05 for instructions on calculating the uncompensated value of income-producing real property. In addition, the value of the income that the property was producing or was capable of producing is a transfer. The uncompensated value is the fair market value of the income that the property could reasonably be expected to produce multiplied by the person's life expectancy at the time of the transfer.

If an individual rents real property for less than FMV, the uncompensated amount is the difference between the FMV of the rent and the amount of rent being received, based on the person's life expectancy.

Example 1:

A 75-year-old recipient in a nursing home owns rental property with an equity value of $50,000 and is receiving $500 a month in rent. This rental amount is consistent with other similar properties in the neighborhood and is therefore considered the fair market value. After subtracting allowable rental expenses, he has $400 rental income in his Medicaid budget. Their legal guardian transfers full title of the property to member. The uncompensated value of the transfer of income is $400 x 110.88 months (9.24 years obtained from the life expectancy tables, $44,352. This is added to the uncompensated value of the property in excess of $6,000 for a total uncompensated value of $88,352. ($44,000 real property plus $44,352 income.)

Example 2:

A 70-year-old Medicaid recipient moves into a nursing home and signs the agreement to put their home up for sale or rent at fair market value. They hire a realtor who assesses the value at $95,000 with a rental value of $800 per month. Two months later, they rent the property to their child for $10 dollars a month. The child will pay the allowable expenses which amount to $150 per month. The uncompensated value is $640 ($800 - $150 - $10) x 184.20 months (15.35 years), $117,888.

2640.10.25.30 LOANS, PROMISSORY NOTES AS TRANSFERS OF ASSETS

This provision applies to loans established on and after November 1, 2009. It applies to individuals who loan money directly to another as well as those who may purchase a loan or promissory note that was originally entered into between 2 other people. The likelihood of the latter may be small, however given the concern that many private loans are merely gifts appearing to be loans, it is important to understand the possible transactions that may occur by someone trying to shelter assets to become eligible for Medicaid. All promissory notes should be sent to PAL for review.

Whenever an individual has a promissory note, loan agreement, or mortgage as presumed evidence that a transfer of money was not a gift but was made with the expectation of full repayment, the arrangement will be considered an improper transfer unless all the following criteria are met[94]:

The repayment term is actuarially sound in accordance with the Life Expectancy Table included at the end section 2640.10.25.10,

The agreement provides for payments to be made in equal amounts during the term of the loan, with no deferral of payments and no balloon payments, and

The promissory note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.[95]

In the case of a promissory note, loan, or mortgage, that does not satisfy the requirements above and is established on or after 11-1-09, the value of such contract considered as an improper transfer will be the outstanding balance due as of the date of the individual's application for Medicaid or date of LTC admission, whichever is later. In the case of HCBS, the balance to be used is the amount as of the date of the Cost Comparison Budget approval.

When determining if the loan is actuarially sound, refer to the person's age on the Life Expectancy Table as of the date the loan is established. If the loan cannot be repaid within the person's life expectancy, it is not actuarially sound and is therefore an improper transfer.

The interest amount of the loan payments is countable income.

2640.10.25.35 TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITY ENTRANCE FEES

A Continuing Care Retirement Community (CCRC) or similar life care community typically provides a variety of living arrangements, from independent living through skilled nursing care. In many cases, potential residents must provide extensive information about their finances, including their assets and income, before being accepted for admission. In addition, they must pay substantial entrance fees and sign detailed contracts before moving to the community.

Effective with contracts entered into on and after November 1, 2009, entrance fees paid by an individual to a CCRC, or similar life care community, are counted as an available non-exempt resource of the individual for Medicaid eligibility determinations when all of the following 3 conditions apply[96]:

The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for their care. It is not necessary for the CCRC to provide a full, lump sum refund of the entrance fee to the residents. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met.

The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community.

In order to meet this second condition, it is not necessary for the residents to receive a refund of the entrance fee or deposit. This second condition is met if the resident could receive a refund were the contract to be terminated or if the resident dies.

The entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

Ownership interest generally means the right to possess and convey property. Therefore, the residents will be required to verify whether or not they have an ownership interest in a CCRC or life care community by presenting documentation from the facility to that effect. If the CCRC or life care community confirms that the entrance fee does not confer an ownership interest to the residents, then the third condition described above is met.

For Medicaid eligibility determinations, all spousal impoverishment protection rules regarding income and asset allocations for a community spouse are applicable when one spouse resides in the skilled nursing care section of the facility, and the other spouse (the community spouse) resides in an independent living setting. CCRC and similar life care community contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse before determining the number of resources that a resident must spend on his or her own care.

2640.10.25.40 TRANSFERS INVOLVING BURIAL PLOTS OR SPACES FOR IMMEDIATE FAMILY MEMBERS

Pursuant to FSSA v. Culley, irrevocable burial trusts, plots or spaces purchased with assets owned by applicants or recipients that name an immediate family member as the beneficiary of the burial plots or spaces are not considered improper transfers that invoke a penalty period. See IHCPPM 2615.20.20.10.

For purposes of this section *immediate family* means an individual's minor and adult children, including adopted children and stepchildren, an individual's brothers, sisters, parents, adoptive parents, and the spouses of those individuals. Neither dependency nor living-in-the-same-household will be a factor in determining whether a person is an immediate family member.

For purposes of this section “burial spaces” include burial plots, gravesites, crypts, mausoleums, urns, niches, and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use. Additionally, the term includes necessary and reasonable improvements or additions to or upon such burial spaces including, but not limited to, vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.[97]

2640.10.30 PRESUMPTION OF INTENT IN TRANSFERRING PROPERTY

Once the uncompensated value for a transfer of property has been established, this figure will be used to determine a penalty period. DFR will presume Medicaid eligibility to be the motive unless a satisfactory showing is made to the DFR that the property was transferred exclusively for a purpose other than to qualify for Medicaid, or that the individual intended to transfer the property at fair market value.

If the individual wishes to rebut this presumption, they are responsible for presenting convincing evidence to the DFR in support of their contention that the property was transferred exclusively for some other purpose or that they intended to transfer the property at fair market value.

If the individual chooses to rebut the presumption, they must provide a statement concerning the circumstances of the transfer. The statement should cover, but need not be limited to the following:

Purpose for transferring the property

Attempts to dispose of the property at fair market value

Reason for accepting less than fair market value for the property

Means of or plans for supporting himself after the transfer

Relationship (for example: familial or business) to the person to whom the property was transferred.

In addition, the individual must submit any and all pertinent documentary evidence such as legal documents, realtor listing agreements, relevant correspondence, and so forth, to the DFR. An allegation by the individual that the property transfer was done to avoid Medicaid estate recovery will not be accepted as a satisfactory showing that the property was transferred exclusively for a purpose other than to become eligible for Medicaid. Clearly, an individual who makes this claim has the intention of becoming eligible for Medicaid, or estate recovery would not even be an issue.

Furthermore, a simple statement made by or on behalf of a recipient who has transferred property, that the transfer did not affect eligibility and is therefore allowable, does not constitute a satisfactory showing. The individual may be trying to protect all future eligibility. Again, the avoidance of estate recovery may be the intent and will not suffice.

If the DFR finds the individual has made a satisfactory showing that the resource was not transferred to attain Medicaid eligibility, or that they intended to transfer it for fair market value, a penalty period will not be established.

2640.10.35 DETERMINING THE TRANSFER PENALTY PERIOD BEGIN DATE

An unsuccessful rebuttal of the presumption of intent combined with a determination of inadequate consideration will result in the DFR invoking a penalty period. During a transfer of property penalty period, the recipient is ineligible for nursing facility services and home and community-based services.

For transfers on and after 8-11-93 but prior to July 1, 2003, the penalty period will begin with the month of the transfer (if that month is not a part of another penalty period) and continues for

the full number of penalty months determined by dividing the uncompensated value by the nursing facility private pay rate in effect as of the application month. (Refer to Section 3006.00.00 for the private pay rate). The process of rounding down the number of penalty months is no longer valid policy, and the procedure is now prohibited.

The penalty start date for transfers of property will begin on the **later** of:

The date on which the individual would be otherwise eligible for Long Term Care Services under Medicaid based on an approved application were it not for the imposition of the penalty period, or

The first day of a month during which assets have been transferred for less than fair market value (FMV), and

The penalty does not occur during any other transfer of property penalty.

NOTE: Advance notice of an adverse action is applicable for individuals who have been determined eligible for Medicaid. IHCPPM 2232.00.00. Therefore, if the calculation of the penalty period based on the criteria previous stated in this section would have any portion of the penalty period cover month(s) where the individual was previously determined eligible for and received Medicaid long-term care services, a claim for benefit recovery must be initiated to recover the portion of the nursing home per diem paid for by Medicaid during the calculated penalty period the individual incorrectly received. Please, refer to IHCPPM Chapter 4600 for Benefit Recovery. The notice of the benefit recovery action serves as the notice for advanced notice of adverse action in this instance.

If the individual residing in a long-term care facility is a new applicant whose eligibility requires a transfer penalty period, the begin date will most often be the first month the person is otherwise eligible.

Example:

10/15 Individual entered LTC facility

12/05 Gifted Money

05/10 Apply for Medicaid

The months covered by the application are February, March April and continuing. During the eligibility process it is determined that the gifting was an improper transfer, and that the applicant had excess resources for the months of February and March.

Therefore, Medicaid is effective 04/01 and a transfer penalty is imposed starting the same date, 04/01. Assume the penalty period is 5 full months. The penalty begins on 04/01 and ends on 08/31.

Under the old rules, the transfer penalty would have begun on 01/01, the month after the month of transfer and ended on 05/31.

2640.10.35.05 CALCULATION OF THE PENALTY PERIOD

All improper transfers occurring on and after 11-01-09 are accumulated into one total amount to determine the penalty period. The facility rate as of the date of application, not the date of transfer, is used in the calculation. Refer to IPPM 3006.00. The uncompensated value determination must take into consideration the de minimis transfer allowance as explained in IPPM 2640.10.15.10. Transfer penalties using the specific method explained below may end on any date in a month not just the last day of a month.

Two standard values are used in the penalty period calculation:

Monthly Standard of days in a month - 30.42 days. (365 days divided by 12).

Average Monthly Facility Private Rate - Refer to IPPM 3006.00 for the applicable rate to use based on the date of an application.

Once the final uncompensated value (UV) of all improper transfers made on and after 11-01-09 has been determined, the steps below are to be followed to determine the length of the penalty period:

Divide the UV by the facility rate as of the date of application. Round up at 2 decimal places. (For example, 2.26216807 are 2.27 months.) This result is the length of the penalty period.

If the above division happens to result in whole months, the calculation of the penalty is complete.

If the length of the penalty period as calculated above includes a fractional month, the next step is to convert the fractional month into days. Multiply the partial month by 30.42 and round up to determine the number of days in last month of the penalty period.

Example:

UV = 10,129.24 Private Rate = $4,611

$10,129.24 divided by $4,611 = 2.1967555 2.20 months

Partial month .20 x 30.42 Standard of days = 6.084 7 days

Penalty period is 2 months, 7 days.

2640.10.35.10 MULTIPLE TRANSFERS OF PROPERTY

For transfers occurring on or after November 1, 2009: If multiple transfers occurred during a person's look-back review period that require a transfer of property penalty period, there is to be one overall penalty period that is a cumulative total of all the improper transfers.

Example:

An individual admitted to Long Term Care facility on 10/08/09 with application filed 11/20/2010.

Facility Private Rate is $4,826. Refer to IHCPPM 3006.00.00.

The first month of eligibility is 10/2010. (The applicant is ineligible for August and September due to excess resources).

Transfers:

11/03/2009: $10,000 cash gift to sister

11/09/2010: $800 cash gift to son

11/14/2010: $20,000 cash to best friend

Evaluation:

All transfers are determined to be improper and subject to penalty. Because the application was filed after 10/01/2009, the $1,200 de minimis transfer allowance rule applies to each year of transfers. The $10,000 transfer is reduced to $8,800 because the gift was to a family member. $8,800 divided by $4826 = 1.823 = 1.83 months. Convert. The partial .23 months to days: 30.42 x .83 = 24.2486 days = 25 days. The penalty begins 11/01/2010 and ends 12/25/2010.

The uncompensated value of the transfer in 2010 = $20,800. Only the $800 gift to a family member is subject to the de minimis; the gift to the friend is not reduced. The uncompensated value subject to penalty is $20,000.

$20,000 divided by $4,826 = 4.1442 months = 4.15 months. Convert the .15 partial months to days: 30.42 x .15 = 4.563 days = 5 days. The penalty period is 4 months 5 days. Combined with the other penalty period, this penalty extends from 12/26/2010 and ends on 4/30/2011.

For transfers involving trusts occurring before November 1, 2009, but within the client's look-back review period, multiple transfers are handled differently. For multiple transfers involving trusts before November 1, 2009, that occur in the same month or in consecutive months, the total cumulative value of the transfers will be considered one transfer for purposes of calculating the penalty. The penalty period begins with the month following the first transfer.

Multiple transfers involving trusts before November 1, 2009, that are not made in consecutive months will result in separate penalty periods. Each penalty period will begin in the month following the month of transfer or, if that month is already part of a penalty period, in the month after the prior period ends. Penalty periods do not overlap.

2640.10.35.15 TRANSFERRED PROPERTY IS RETURNED TO THE ORIGINAL OWNER

If the transferred property is returned in its entirety, no penalty can be established. If a penalty has already been established, and then the property is returned to the individual, this transaction nullifies the penalty. It has the effect of restoring ownership of the property to the individual back to the month of the transfer. It does not necessarily restore full Medicaid coverage to the individual. The worker must redetermine Medicaid for the months in question by considering the value of the property. When only a portion of the property or its equivalent value is returned, the penalty period is to be reduced proportionately.

2640.10.35.20 BUDGETING PROCEDURES DURING A TRANSFER PENALTY PERIOD

During the penalty period, "eligibility step" budgeting is to be used. Effective June 2014, the "eligibility step" is the comparison of individual income to the Special Income Level (SIL). Refer to IHCPPM 3455.14.00. The post-eligibility step is never completed.

Once the penalty period has been served, the post-eligibility calculation to determine the liability amount is to be effective the month after the last month of the penalty period. Caseload controls must be in place to ensure that desk reviews are completed for appropriate action immediately after the penalty period expires.

2640.10.40 TRANSFER PENALTY HARDSHIP EXCEPTION

The hardship procedures explained in this section are used when a transfer penalty has been imposed on an individual for a transfer of property occurring on and after November 1, 2009, except when the penalty is due to an annuity purchase. There is no hardship exception for an annuity purchase.

POLICY: When a penalty is imposed, the eligibility system generated notice will explain that an appeal based on the merits of the penalty determination can be filed, *or* a hardship exception can be requested if the individual alleges and can document that such a hardship exists. Procedures for filing the Request for Hardship Exception-Transfer of Property directly to the FSSA Office of Medicaid Policy & Planning (OMPP) are explained in the notice. (The text of the hardship language on the eligibility notice is at the end of this section.) The request for an undue hardship exception will serve as admission by the individual that a transfer of assets for less than adequate consideration was made, and that the agency's penalty determination was correct.

The penalty will be removed or modified under a hardship exception if documentation substantiates that the recipient's health is endangered as result of the penalty or that the recipient will be deprived of food, clothing, shelter, or other necessities of life.

PROCEDURE: A hardship exception request must be filed within 30 days of the notice imposing the transfer penalty. The *Request for Hardship Exception – Transfer of Property* State Form 54167 must be submitted to:

Mail Stop 07

Family & Social Services Administration

Office of Medicaid Policy & Planning – Eligibility

405 W Washington Street

Indianapolis, IN 46204

The following people can apply for a hardship exception:

The recipient

The recipient's authorized representative, or

The nursing facility in which the recipient currently resides if written consent from the recipient or the recipient's personal representative is given for the nursing facility to file the request.

OMPP will make the decision to waive all, or a portion of the transfer penalty based solely on the evidence submitted with the request. The Notice of Decision on Transfer of Property Hardship Exception Request will be issued by OMPP to the requestor within 45 days of receiving a request for an exception. A denial of a hardship exception is subject to administrative appeal. A copy of the Notice of Decision on Transfer of Property Hardship Exception Request will be sent to the Division of Family Resources.

An approval of a hardship exception must be acted upon by the Division within 10 days (normal change processing requirements) to remove or shorten the penalty as approved.

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[1] 20 CFR 416.1201(a)(1)

[2] 20 CFR 416.1201(c)(2)

[3] 20 CFR 416.1207(b)

[4] 20 CFR 416.1103 (c)

[5] 42 U.S.C. § 1396w

[6] IC 12-15-41-2

[7] 20 CFR 416.1103(a)(3)

[8] 20 CFR 416.1208(c)

[9] 20 CFR 416.1208(c)(4)

[10] 20 CFR 416.546

[11] 20 CFR 416.1201(a) and (b)

[12] IC 12-7-2-44.6 (2) (c) (ii)

[13] IC 12-7-2-44.6

[14] IC 12-11-14

[15] 20 CFR 416.1202

[16] IC 12-11-14-1; 26 USC 529A

[17] 20 CFR 416.1202 (a)(1)

[18] 20 CFR 416.1160(d) & 405 IAC 2-1-1

[19] 20 CFR 416.1121 (a)

[20] 42 USCS 1396r-5

[21] 405 IAC 2-3-26

[22] 42 U.S.C. 1396r-5

[23] 20 CFR 416.1231 (b)

[24] IC 30-2-13-12

[25] 20 CFR 416.1231 (b)

[26] IC 30-2-13-12 (b)

[27] 20 CFR 416.1201 (4)

[28] 20 CFR 416.1201 (b)

[29] 20 CFR § 416.1230(a); 12-15-2-17(f)

[30] 20 CFR 416.12; Public Law 95-171

[31] 760 IAC 2-20-39

[32] 760 IAC 2-20-40

[33] 20 CFR 416.1216

[34] 20 CFR 416.1220

[35] 405 IAC 2-3-14(b)(1)

[36] 405 IAC 2-3-23

[37] 31 CFR 351.6, 31 CFR 359.6

[38] 20 CFR 416.1103(f)

[39] 20 CFR 416.1218(a)

[40] 20 CFR 416.1218(b)(1)(2)

[41] 20 CFR 416.1233(a)

[42] 405 IAC 2-3-2

[43] SSA Section 1917(d) as added by P.L. 103-66, OBRA-93; 405 IAC 2-3-22

[44] 42 U.S.C 1396p(d)(4)(A), 405 IAC 2-3-22(i)(2)

[45] 405 IAC 2-3-22(i)(3)(D)

[46] 405 IAC 2-3 (i)(4)

[47] 405 IAC 2-3-29

[48] 405 IAC 2-3-29

[49] 20 CFR 416.1201(b)

[50] 405 IAC 2-10-1(~~6~~7)

[51] 405 IAC 2-3-14(b)(4)

[52] 405 IAC 2-3-14(b)(4)

[53] 405 IAC 2-3-14(b)(1)

[54] 405 IAC 2-3-14(f)

[55] 405 IAC 2-3-14(f)

[56] 20 CFR Part 416.11, 405 IAC 2-3-14(3)

[57] 405 IAC 2-9-4(c)(1)

[58] 20 CFR 416.1236(a)(4)

[59] 20 CFR 416.1236(a)(6)

[60] 20 CFR 416.1236(a)(5)

[61] 20 CFR 416.1236(a)(4), 20 CFR 416.1236 (a)(11)

[62] 20 CFR 416.1238

[63] 20 CFR 416.1236(a)(1)

[64] 20 CFR 416.1236(a)(13)

[65] 20 CFR 416.1236(a)(15)

[66] SSA Section 1902(r)(1)(A) as amended by OBRA-90; P.L. 101-508

[67] 20 CFR 416.1229

[68] P.L. 93-113, Sections 404(g) and 418

[69] 20 CFR 416.1236(a)(14)

[70] P.L. 93-288; 20 CFR 416.1150

[71] P.L. 101-426 as amended by P.L. 101-510; 20 CFR 416.1236 (a)(17)

[72] 20 CFR 416.1236(a)(16)

[73] IC 4-4-28-5

[74] IC 4-4-28-6

[75] 42 U.S.C. 1396R-5

[76] 20 CFR 416.1202(b)

[77] 405 IAC 2-1.1-7(c)

[78] 405 IAC 2-1.1-7(c)

[79] SSA, Section 1924(c)(1)

[80] SSA, Section 1924(f)(2)

[81] SSA, Section 1924(c)(5)(A) as amended by OBRA-90

[82] SSA, Section 1924(f)(1) as amended by OBRA-90 (P.L. 101-508)

[83] 405 IAC 2-3-1.1

[84] 405 IAC 2-3-1.1(1)

[85] 405 IAC 2-3-1.1(k)(5)

[86] 405 IAC 2-3-1.1(8)(l)

[87] 20 CFR 416.1216

[88] 20 CFR 416.1246(c)

[89] 405 IAC 2-3-27

[90] 405 IAC 2-3-27

[91] 20 CFR 416.1246(d)(1)

[92] 405 IAC 2-3-1.1 (d)(1)(H)

[93] 405 IAC 2-3-1.2

[94] 405 IAC 2-3-1.1(d)(1)(G)

[95] **42** U.S.C 1396p(c)(1)(I)(iii)

[96] 405 IAC 2-3-2(b)

[97] 20 CFR 416.1231(a)(2)