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Employees' Manual
Title 8
Chapter D

MEDICAID

RESOURCES



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Overview

This chapter describes Medicaid resource requirements. Resource policies that apply to all coverage groups are described in the first part of the chapter:

- ◆ [Attribution of resources between an institutionalized spouse and a community spouse.](#)
- ◆ [Estate recovery for members who are over age 55 or and in a medical institution.](#)
- ◆ [Transfers of assets.](#)
- ◆ [Trusts.](#)

These sections are followed by sections on resource requirements that are specific to either:

- ◆ [People whose eligibility is based on their relationship to the Family Medical Assistance Program \(FMAP-related coverage groups\), including dependent children and their families;](#) or
- ◆ [People whose eligibility is based on their relationship to the Supplemental Security Income program \(SSI-related coverage groups\), including persons who are aged, blind, or disabled;](#) or
- ◆ [Children in certain coverage groups, whether FMAP-related or SSI-related.](#)

Attribution of Resources

Legal reference: 441 IAC 75.5(3)

When one spouse enters a medical institution or applies for a home- and community-based services (HCBS) waiver or Programs for All-Inclusive Care for the Elderly (PACE) services, resources are “attributed” to the “community spouse” to protect sufficient resources for the community spouse’s maintenance.

A “community spouse” is a person who is not in an institution but who is the spouse of a person who is in an institution or applying for or receiving PACE or waiver services. The community spouse could live:

- ◆ In the couple’s own home.
- ◆ In a custodial home, such as a residential care facility.
- ◆ In an apartment.
- ◆ With relatives.
- ◆ In another nonfacility or noninstitutional setting.

Complete the attribution using the resources the couple had as of the first day of the month that:

- ◆ The institutionalized spouse enters a medical institution (on or after September 30, 1989) expecting to stay 30 consecutive days or more, or
- ◆ The Medical Services Unit at the Iowa Medicaid Enterprise (IME) determines that the Medicaid HCBS waiver or PACE applicant meets level of care.

Information needed to attribute resources is included on the Medicaid application forms. Use form 470-2577, *Resources Upon Entering a Medical Institution*, to attribute resources when:

- ◆ The month of entry to the institution and the month of application are different, or
- ◆ A married Medicaid member requests home- and community-based waiver or PACE services, or
- ◆ Either the institutionalized spouse or the community spouse requests attribution but does not apply for Medicaid.

When a Medicaid application is filed, complete the attribution within:

- ◆ 30 calendar days after the application is filed; **or**
- ◆ 30 calendar days after the applicant was:
 - Institutionalized for 30 days; **or**
 - Met institutional level of care (for HCBS waiver programs or PACE).

Do not approve Medicaid until the attribution is completed. If attribution is requested without a Medicaid application, complete the attribution within 45 calendar days.

Complete only one attribution per community spouse per case. After an attribution has been completed, do not complete a new attribution if:

- ◆ The institutionalized spouse is discharged after the 30 days but later reenters a medical institution.
- ◆ The attribution was completed for a waiver or PACE application but the application was denied.
- ◆ The attribution was completed for waiver or PACE services and the waiver or PACE spouse later enters a medical facility.
- ◆ A person whose attribution was completed in another state applies for institutional care in Iowa. However, if that state has a lower minimum community spouse resource allowance, recalculate the attribution and assign Iowa's minimum.

In specific circumstances, attribution guidelines may be different:

- ◆ If both spouses entered an institution but one goes home, complete an attribution for the month the spouse who remains institutionalized entered the institution.
- ◆ If the previously institutionalized spouse goes home and then the community spouse enters a medical institution expecting to stay for 30 days or more, complete a new attribution for the new institutionalized spouse.
- ◆ If either spouse dies in the month of application or died in the retroactive period, attribute resources for the month of entry to the institution. Use the attributed resources to determine eligibility for months the spouse was living.
- ◆ If the applicant marries **after** entering the institution but **before** Medicaid eligibility is determined, complete an attribution of resources for the community spouse. Complete the attribution for the month of entry.
- ◆ If the a single member or a member who was widowed after the attribution marries **after** entering the institution and **after** Medicaid eligibility for institutional care has been established, do not complete an attribution. If the institutionalized spouse later becomes ineligible for Medicaid and reapplies for Medicaid benefits, complete an attribution for the month of entry.

Revise attribution results when:

- ◆ A final appeal establishes a greater amount of protected resources for the community spouse. See [If the Applicant Appeals the Attribution Amount](#).
- ◆ The member is later able to verify resources that were owned at the date of entry to the institution. See [Calculating the Amount to Attribute to the Community Spouse](#).
- ◆ The amount of resources used in the original attribution was not correct.

If a person who requests an attribution without filing a Medicaid application fails to cooperate in determining attribution, a new determination is not necessary when you receive an IRS report. (However, do complete the attribution and consider the IRS report when the person later applies for Medicaid if you receive verification and can establish what resources existed when the person entered the institution.)

Further details on the attribution procedure are organized as follows:

- ◆ [Resources excluded from attributions](#)
- ◆ [Calculating the amount to attribute the community spouse](#)
- ◆ [Processing a Medicaid application after the attribution is completed](#)
- ◆ [Summary examples of attribution situations](#)

Resources Excluded From Attribution

Legal reference: 441 IAC 75.5(3)“c”

Some resources are not considered for attribution, whether owned by one or both spouses. Resources that do not count in the attribution process also do not count when determining eligibility. Do not count for either the attribution process or eligibility:

- ◆ One vehicle regardless of value.
- ◆ Burial and related expense funds for each spouse that are separately identified and set aside for that purpose. Each spouse may have a fund or multiple funds but no more than \$1,500. Subtract from this \$1,500 limit the total face value of excluded whole life and term life insurance policies and any amounts in irrevocable trusts or arrangements available to meet burial and related expenses.
- ◆ Burial spaces held for either spouse or any other member of the immediate family.
- ◆ Disaster Relief Act Assistance and Emergency Act Assistance or other assistance provided because of a Presidential declaration of disaster. Exclude these resources and any interest earned on the funds for nine months, beginning with the date of receipt. (These funds may be excluded for a longer period, if good cause is shown.)
- ◆ Household goods and personal effects, regardless of value.
- ◆ Housing assistance paid by HUD or FMHA for housing occupied by the community spouse.
- ◆ Life insurance policies with a total face value of \$1,500 or less for each spouse.
- ◆ Property in a homestead, including the home and related land.
- ◆ Property used for self-support of either spouse if it would be excluded by SSI.
- ◆ Real property up to \$6,000 if it is earning six percent of equity.
- ◆ Relocation assistance provided by a state or local government which is comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.
- ◆ Resources of a blind or disabled person who has a Plan for Achieving Self-Support, as determined by the Division of Vocational Rehabilitation, the Department of Human Services, or the Department for the Blind.

- ◆ Resources necessary for self-employment.
- ◆ Retirement funds if the member or the member's spouse has to quit a job or claim hardship in order to withdraw them.
- ◆ Shares of stock held by natives of Alaska in a regional or village corporation. Exclude for the 20 years in which the stock is inalienable, as provided in Sections 7(h) and 8(c) of the Alaska Native Claim Settlement Act.
- ◆ **Underpayment of SSI or Social Security** that is due either spouse for any month before the month it is received. Exclude for six months after receipt.
- ◆ **Victim's compensation** from a fund established by a state for victims of crime. Do not count the assistance for nine months from receipt. The applicant must prove that the payment was for expenses incurred or losses suffered as a result of a crime.

See [Specific SSI-Related Resources](#) for more descriptive information about these excluded resources. (Note that there are other types of resources described under that heading that are excluded for determining eligibility, but not for attribution.)

Resources affected by a prenuptial or antenuptial agreement are countable as resources unless excluded under the criteria listed above.

Calculating the Amount to Attribute to the Community Spouse

Legal reference: 441 IAC 75.5(3) "c," "d," and "f"; 76.5(2) "b," P. L. 100-365, P. L. 100-485

Use SSI-related resource policies when determining which resources to count in completing an attribution. To calculate how much to attribute to each spouse:

1. Determine what resources the couple owned as of the first moment of the first day of the month of entry into the medical institution (or the month the HCBS waiver or PACE applicant meets the institutional level).

Count all resources not listed under [Specific SSI-Related Resources](#) that are owned by either spouse. It does not matter which spouse owns the resource. Include the value of resources that are for sale.

The applicant must provide verification of the value of the resources. Count **only** those resources that can be verified. If the applicant provides partial verification, use that documentation to determine the attribution.

Mr. and Mrs. G claimed resources of \$60,000 on the application for attribution. However, they could provide verification for only \$50,000. The attribution was based on the verified resources of \$50,000.

Count the uncompensated value of any divested resources owned by either spouse if the resource was owned on the first moment of the first day of the month. "Uncompensated value" is the fair market value of the asset minus the amount that was received for the asset.

NOTE: If either spouse transferred resources at less than fair market value to attain eligibility, see [Transfer of Assets](#) for procedures to handle such transfers when determining eligibility.

2. Add together all resources of both spouses.
3. Attribute one-half of the documented resources to each spouse. If necessary, adjust the division so that the community spouse will receive no less than \$24,000 (if there is that much) but no more than \$119,220.

Value of Combined Resources	\$0 - \$47,999	\$48,000 - \$238,439	\$238,440 or more
Amount attributed to:			
Community spouse	\$24,000	One-half	\$119,220
Institutionalized spouse	Remainder	One-half	Remainder

After the attribution is complete, send each spouse the results on form 470-2588, *Notice of Attribution of Resources*, with copies of the resource documents. The notice includes an explanation of the spouses' appeal rights. (See [If the Applicant Appeals the Attribution Amount.](#))

If a court or administrative appeal decision has ordered an amount greater than half the resources for the community spouse, or more than \$119,220, attribute the amount ordered.

1. Mr. A enters a medical institution and his wife remains at home. Mr. and Mrs. A furnish verification of a total of \$69,500 in resources. One-half of this is \$34,750. Mrs. A is attributed \$34,750 and Mr. A is attributed \$34,750.

2. Mr. B enters skilled care expecting to stay indefinitely. His wife remains at home. Their total resources are \$24,792. One-half of this is \$12,396. Since this result is less than \$24,000, the minimum amount of \$24,000 is attributed to Mrs. B. \$792 is attributed to Mr. B.

3. Mrs. D enters a hospital and is expected to stay over 30 days. Her husband remains at home. Their total resources are \$300,000. One-half of this is \$150,000.

The community spouse cannot be attributed more than \$119,220 without a court order or final appeal decision. Therefore, \$180,780 is attributed to Mrs. D and \$119,220 is attributed to Mr. D ($\$300,000 - \$119,220 = \$180,780$).

4. Mr. M enters a nursing facility and Mrs. M remains at home. The total value of their resources is \$40,000. However, the court has ordered that \$30,000 be transferred to Mrs. M for support. In this case, \$30,000 is attributed to Mrs. M, even though this amount exceeds the \$24,000 minimum; \$10,000 is attributed to Mr. M.

If the Applicant Appeals the Attribution Amount

Legal reference: 441 IAC 75.5(3)"f"

The current minimum monthly maintenance needs allowance (MMMNA) for a community spouse is \$2,980.50. If the income available to the community spouse is less than the MMMNA, the applicant or the community spouse may file an appeal to set aside additional resources that would generate income equal to the difference between the income available to the community spouse and the MMMNA.

The appeal request must be filed within 90 days of the *Notice of Attribution of Resources* (NOA) or any *Notice of Decision* (NOD) regarding medical assistance. If the applicant does not file an appeal within 90 days of an NOA or NOD, the applicant loses the right to a hearing on the attribution for that application. If requested, help the applicant to complete form 470-0487 or 470-0487(S), *Appeal and Request for Hearing*.

If the appeal is filed after one or more applications has been denied, and the appeal allows a substitution of resources that result in the institutionalized spouse now being eligible, the date of approval begins with the most recent application. Only one appeal to allow a substitution of resources will be conducted.

1. Mr. Q enters a facility in January 2002. Mrs. Q remains at home. The Qs file an application for medical assistance in March 2002. An attribution of resources is completed, and the application is denied in April 2002. Another application is filed for Mr. Q in February 2003.

The worker totals all of the household resources and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in March 2003.

A third application is filed for Mr. Q in March 2004. The worker again totals all of the household resources and subtracts the community spouse resource allowance assigned in the attribution process. Again the remaining resources continue to exceed the resource limit. The worker issues an NOD denying benefits in March 2004.

Mr. Q files an appeal in April 2004 regarding the March 2004 NOD. A hearing is granted. Mrs. Q's income is low enough that the cost of an annuity is used to set aside additional resources for Mrs. Q. The final appeal decision attributes additional resources to Mrs. Q.

The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. Q. The March 2004 application decision is reversed. The prior decisions on the March 2002 and March 2003 applications stand as issued.

2. Mrs. Z enters a facility in August 2003. Mr. Z remains at home. The Zs file an application for medical assistance for Mrs. Z in August 2003. An attribution of resources is completed, and the application is denied in September 2003. Another application is filed for Mrs. Z in June 2004.

The worker totals all of the household resources, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in July 2004.

Mrs. Z appeals the NOD in July 2004. A hearing is granted. Mr. and Mrs. Z are unable to obtain an annuity quote. The worker assists them in getting the quote. The administrative law judge issues a decision upholding the original attribution. Once this decision becomes final, no other hearings regarding the attribution will be granted, as the Zs were granted a hearing on the attribution of resources.

3. Mr. M enters a facility in January 2005. Mrs. M remains at home. The Ms file an application for medical assistance for Mr. M in August 2005. An attribution of resources is completed. Mrs. M is attributed \$24,000. The Ms have \$6,000 in resources. The application is approved.

The review form is sent out in January 2006 and not returned. The case is canceled effective February 1, 2006. Another application is filed in February 2006. The Ms now have \$42,000 in resources.

The worker subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources exceed the resource limit.

The worker issues an NOD denying the application in February 2006. Mr. M files an appeal regarding the NOD. A hearing is granted. The final appeal decision attributes additional resources to Mrs. M. The couple's income is low enough that the average of the annuities, \$99,424, is used to set aside additional resources for Mrs. M.

The new community spouse resource allowance exceeds the current resources owned by Mr. and Mrs. M. The February 2006 decision to deny the application based on excess resources is reversed.

Verify the couple's available gross monthly income. Do not count income that is earned by resources used in the attribution process.

When determining gross monthly income, include any income the community spouse or institutionalized spouse may be entitled to but is not receiving. When the community spouse works only part of the year and received income only during the time worked, annualize the income as directed in [8-E, Determining Income from Self-Employment](#).

For couples where one spouse entered an institution before February 8, 2006, county only the community spouse's income.

For couples where one spouse entered an institution on or after February 8, 2006, consider the institutionalized spouse's income that can be made available to the community spouse according to the facility client participation calculation. See [8-I, Deductions From Client Participation](#). Allow a \$50 personal needs allowance deduction from the gross countable income of the institutionalized spouse for facility, HCBS waiver, **or** PACE applicants.

1. Mrs. B enters a facility in January 2006. Mr. B remains at home. The Bs file an application for medical assistance for Mrs. B in March 2006. An attribution of resources is completed. The worker totals all of the household resources as of January 1, 2006, and subtracts the community spouse resource allowance assigned in the attribution process. The remaining resources continue to exceed the resource limit. The worker issues an NOD denying the application in April 2006.

Mrs. B files an appeal regarding the NOD. A hearing is granted. Since Mrs. B entered the facility before February 8, 2006, only Mr. B's income is used when the Bs provide a quote for the cost of an annuity to set aside additional resources for Mr. B.

2. Mr. C enters a facility on April 19 and files an application on April 21. Mr. C has a community spouse, Mrs. C. The Cs have combined total resources that are counted in the attribution, in the amount of \$27,000. \$24,000 was attributed to Mrs. C and that left \$3,000 for Mr. C.

Mr. C has \$1,410.90 Social Security and \$700 pension with a total income of \$2,110.90. Mr. C has Medicare and a Medicare supplement with a monthly premium of \$150. Mr. C has total unmet medical deductions in the amount of \$254.90 (\$104.90 Medicare premium + \$150 Medicare supplement = \$254.90). Mrs. C has \$1,100.90 Social Security.

The April application was denied since Mr. C's resources exceed the \$2,000 resource limit. Mr. C appealed the attribution and the denial.

Since Mr. C became institutionalized after February 8, 2006, Mrs. C's income, plus the income that will be made available from Mr. C is used when determining the shortfall of income between the MMMNA and Mrs. C's available income for the attribution process.

\$ 1,410.90	Social Security
+ <u>700.00</u>	Pension
\$ 2,110.90	
- <u>50.00</u>	Personal needs allowance
\$ 2,060.90	Total of Mr. C's income available to Mrs. C
+ <u>1,100.90</u>	Mrs. C's income
\$ 3,161.80	Total income available to Mrs. C when determining her shortfall for the annuity quote
\$ 2,980.50	MMMNA
- <u>3,161.80</u>	Total income available to Mrs. C
\$.00	Shortfall of income used to determine the cost of an annuity for the attribution

Since there is not a shortfall of income for Mrs. C, additional resources cannot be attributed to Mrs. C. Mr. C remains ineligible until he spends down his resources to \$2,000.

If Mr. C is determined eligible, calculate the CP as follows:

\$ 1,410.90	Social Security
+ <u>700.00</u>	Pension
\$ 2,110.90	
- 50.00	Personal needs allowance
- <u>1,879.60</u>	Mrs. C's deficit
\$ 181.30	Client participation

\$ 2,980.50	MMMNA
- <u>1,100.90</u>	Mrs. C's Social Security
\$ 1,879.60	Mrs. C's deficit of income

Since Mr. C has income left after the spousal diversion, this is when you will allow other deductions in the CP calculation, such as unmet medical needs (Medicare and health insurance premiums). Since there is only \$181.30 left, Mr. C will have \$181.30 that he can use to pay towards his Medicare premium or health insurance premium.

3. Mr. D applied for waiver services in April and meets level of care for waiver services on May 5. Mr. D has a community spouse, Mrs. D. The Ds have combined total resources that are counted in the attribution, in the amount of \$78,000. \$39,000 was attributed to each spouse ($\$78,000 \div 2 = \$39,000$).

Mr. D has \$1,390.90 Social Security and \$233 pension with a total income of \$1,623.90. Mr. D has Medicare and a Medicare supplement with a monthly premium of \$100. Mr. D has total unmet medical deductions in the amount of \$204.90 (\$104.90 Medicare premium + \$100 Medicare supplement = \$204.90). Mrs. D has \$535.90 Social Security.

The April application was denied since Mr. D's resources exceed the \$2,000 resource limit. Mr. D appealed the attribution and the denial.

Since Mr. D became institutionalized after February 8, 2006, Mrs. D's income, plus the income that will be made available from Mr. D is used when determining the shortfall of income between the MMMNA and Mrs. D's available income for the attribution process.

\$ 1,390.90	Social Security
+ <u>233.00</u>	Pension
\$ 1,623.90	
- <u>50.00</u>	Personal needs allowance
\$ 1,573.90	Total of Mr. D's income available to Mrs. D
+ <u>535.90</u>	Mrs. D's income
\$ 2,109.80	Total income available to Mrs. D when determining her shortfall for the annuity quote
\$ 2,980.50	MMMNA
- <u>2,109.80</u>	Total income available to Mrs. D
\$ 870.70	Shortfall of income used to determine the cost of an annuity for the attribution

If Mr. D is determined eligible, calculate the CP as follows:

\$ 1,390.90	Social Security
+ <u>233.00</u>	Pension
\$ 1,623.90	
- <u>2,199.00</u>	Mr. D's maintenance needs
\$.00	Client participation
\$ 483.00	MNIL for one-person household
- <u>535.90</u>	Mrs. D's Social Security
\$.00	Mrs. D's deficit of income

In this situation for client participation, Mrs. D does not have a deficit of income and Mr. D has no income left to allow any other deductions. If Mr. D had income left after the spousal diversion, this is when you would allow other deductions in the CP calculation, such as unmet medical needs (Medicare and health insurance premiums).

NOTE: Do not annualize the community spouse's income when determining the diversion to the community spouse in the client participation calculation.

The appellant must obtain one estimate of the cost of a single-premium lifetime annuity, based on the community spouse's age at the time of appeal, that would generate income equal to the difference between:

- ◆ The couple's available gross income and
- ◆ The MMMNA in effect when the appeal was filed.

Neither the applicant nor the community spouse has to purchase an annuity as a condition of Medicaid eligibility.

If the applicant is unable to obtain one estimate, assist the couple by contacting financial institutions. If the institution requires the identity of the applicant, obtain a release of information from the applicant.

If the financial institution is unable to provide an estimate, determine the shortfall between the couple's available gross income and the MMMNA. Multiply the shortfall by 12. Multiply this amount by the community spouse's "Life Expectancy in Years" row from the *Table for an Annuity for Life* from the Mortality Table issued by the Iowa Department of Revenue. (See next page.)

Formula: $(\text{MMMNA} - \text{couple's available gross monthly income}) \times 12 \times \text{community spouse's life expectancy in years} = \text{single-premium lifetime annuity quote}$.

Complete *Attribution of Resources Appeal Summary*, Form 470-3144, according to instructions in [6-Appendix](#). Report the verified available income of the couple. Note and estimate the amount of any benefits for which the community spouse is eligible but is not receiving. Attach copies of the annuity bid to the form.

Send the form to the Appeals Section, 1305 E Walnut Street, 5th Floor, Des Moines, Iowa 50319-0114.

If the annuity quote is greater than the original attribution amount, the administrative law judge will order that the annuity quote be used instead of the original amount. Send a new *Notice of Attribution of Resources* reflecting the revised amount. (The 90-day transfer policy applies as of the date of Medicaid approval. See [Transfers to Establish Ongoing Eligibility](#).)

If the annuity quote is equal to or less than the original attribution amount, the original attribution is left as is.

TABLE FOR AN ANNUITY FOR LIFE

2001 CSO-D mortality table based on blending 50% male-50% female (pivotal age 45)
 age nearest birthday **Source:** Iowa Department of Revenue

Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years	Age In Years	Life Expectancy In Years
0	78.65	41	39.22	82	7.84
1	77.73	42	38.28	83	7.38
2	76.78	43	37.35	84	6.94
3	75.81	44	36.42	85	6.52
4	74.84	45	35.49	86	6.13
5	73.86	46	34.57	87	5.75
6	72.87	47	33.65	88	5.41
7	71.89	48	32.74	89	5.09
8	70.91	49	31.84	90	4.79
9	69.92	50	30.94	91	4.51
10	68.94	51	30.04	92	4.23
11	67.95	52	29.15	93	3.94
12	66.97	53	28.27	94	3.67
13	65.99	54	27.40	95	3.43
14	65.01	55	26.54	96	3.21
15	64.04	56	25.68	97	3.03
16	63.07	57	24.84	98	2.88
17	62.11	58	24.01	99	2.71
18	61.15	59	23.19	100	2.53
19	60.19	60	22.38	101	2.35
20	59.23	61	21.57	102	2.18
21	58.27	62	20.78	103	2.02
22	57.32	63	20.00	104	1.87
23	56.36	64	19.24	105	1.72
24	55.40	65	18.49	106	1.59
25	54.45	66	17.75	107	1.47
26	53.49	67	17.02	108	1.35
27	52.53	68	16.31	109	1.25
28	51.58	69	15.60	110	1.16
29	50.63	70	14.91	111	1.08
30	49.67	71	14.23	112	1.00
31	48.72	72	13.56	113	0.93
32	47.76	73	12.91	114	0.86
33	46.81	74	12.28	115	0.79
34	45.85	75	11.66	116	0.73
35	44.90	76	11.06	117	0.67
36	43.95	77	10.47	118	0.61
37	43.00	78	9.91	119	0.56
38	42.05	79	9.36	120	0.50
39	41.11	80	8.83		
40	40.16	81	8.32		

Increase in Maximum Allowance for Community Spouse

The maximum resource allowance for the community spouse increases each year. This fact is noted on form 470-2588, *Notice of Attribution of Resources*. No further notice or action is necessary unless the household applies for Medicaid or requests a revision of the attribution based on the increase in the maximum allowance.

When a household with the maximum community spouse attribution files an application or requests a revision of the attribution, assess the case to determine if the revised maximum must be attributed to the community spouse. (You do not need to increase attributed resources if the institutionalized spouse's eligibility is already established.)

If the new maximum applies, complete a revision and send a written statement. Do not send a *Notice of Attribution*. Suggested wording is as follows:

The Department of Human Services completed an attribution of resources for your household in (**month, year**). At that time, the community spouse was attributed the maximum resource allowance of (**amount**). You have (filed an application *or* requested a revision of the attribution).

We have revised the attribution, based on an increase in the maximum community spouse resource allowance to (**amount**). As of (**date**), the community spouse is attributed (**current maximum**).

We subtract this amount from your household's total resources at the time of the Medicaid application to determine the institutionalized spouse's countable resources.

If you have questions, please contact me.

Processing a Medicaid Application After Attribution

Legal reference: 441 IAC 75.5(4)“a”(1), P. L. 100-360, P. L. 100-485

When determining eligibility for the institutionalized spouse, the amount of resources to count is the difference between the couple’s total resources at the time of application and the amount attributed to the community spouse.

Follow the requirements of [8-B](#) to process a Medicaid application. However, do not approve Medicaid before completing an attribution of resources.

If the couple does not have an attribution, total the countable resources of both spouses at the first moment of the month of entry. Exempt only those resources listed under [Resources Excluded From Attribution](#). Complete the attribution as directed under [Calculating the Amount to Attribute to the Community Spouse](#).

Determine and verify countable resources of both spouses as of the first moment of the first day of the month for which application is being made (if this is a different month). Subtract the amount of resources attributed to the community spouse as of the date of entry to the facility from the couple’s total resources in the month of application. Count the remaining balance towards the Medicaid resource limit for the institutionalized spouse.

Mr. Z enters a nursing facility on May 22, 1994. Mrs. Z files a Medicaid application for him in September 1995. She lists resources of their homestead, one car, a \$20,000 CD, a checking account of \$55,000, and \$5,000 in a savings account.

When Mr. Z entered the facility, the Zs owned the following resources: their homestead, one car, \$60,000 in CDs, a checking account of \$65,000, and \$15,000 in a savings account. Of these resources, the following items are used in completing the attribution:

\$ 60,000	CDs
65,000	Checking account
+ 15,000	Savings account
\$ 140,000	Total resources

The worker divides \$140,000 by two, which equals \$70,000. This amount is attributed to each spouse.

When determining Mr. Z's eligibility, the worker uses the Zs' resources at the time of application:

\$ 20,000	CD
55,000	Checking account
+ 5,000	Savings account
\$ 80,000	Total resources

The worker then subtracts the community spouse resource allowance (\$70,000 for Mrs. Z) from the total resources. This leaves \$10,000 available for Mr. Z. He is not resource-eligible for Medicaid payment of nursing facility care.

The attributed amount protected for the community spouse is maintained from the month of entry through the initial determination of the institutionalized spouse's Medicaid eligibility. Even if the total resources have increased or decreased by the time the spouse applied for Medicaid, the amount protected for the community spouse is the value of the resources attributed when the other spouse entered the institution.

However, if resources attributed to the community spouse are below the minimum allowance, and the couple later acquires resources that were not counted for attribution, these resources can be transferred to the community spouse to bring that spouse's resources up to the minimum.

1. When Mr. H enters a medical institution, the resources attributed to Mrs. H are \$24,000. When Mr. H applies for Medicaid, the resources of Mr. and Mrs. H are \$25,000 as of the first moment of the first day of the month of application.

The worker subtracts the \$24,000 attributed to Mrs. H from the total. Mr. H has \$1,000. He is resource-eligible under any Medicaid coverage group.

2. Mr. and Mrs. J are SSI-eligible. When Mrs. J enters a medical institution in November, Mr. and Mrs. J have \$2,997 in resources. All of the resources are attributed to Mr. J to meet the minimum protection of \$24,000. Mrs. J is resource-eligible for Medicaid payment of nursing facility care.
3. Mr. and Mrs. K are eligible for Medically Needy. Their resources are \$9,800 when Mr. K enters skilled care in December. All of the resources are attributed to Mrs. K to meet the minimum protection of \$24,000. Mr. K is resource-eligible for Medicaid payment of nursing facility care.

4. Mr. I enters a nursing facility in December. At that time, resources attributed to Mrs. I are \$25,000. Mr. I applies for Medicaid six months later. He reports that his resources have increased. The total is \$75,000 at the time of application. However, only \$25,000 can be attributed to Mrs. I. The other \$50,000 is countable to Mr. I.

If the institutionalized spouse's resources exceed limits for nursing facility coverage groups, check eligibility under the qualified Medicare beneficiary (QMB) group or Medically Needy coverage group. Review resources eligibility at redetermination to ensure that coverage group continues to be correct.

Mr. D enters a nursing facility in November. Mrs. D remains at home. Their resources total \$28,950 in November. Mrs. D is attributed \$24,000 and \$4,950 is attributed to Mr. D. He is resource-eligible for Medically Needy coverage.

Mrs. D asks that the resources be reevaluated in February, since their resources have decreased. As of the first moment of the first day of the month, the combined resources of both spouses are \$24,784. Subtracting the \$24,000 attributed to Mrs. D, Mr. D has \$784 in resources. Mr. D is resource-eligible under any Medicaid coverage group.

When Spouses Are Estranged

Legal reference: 441 IAC 75.5(4)"a"(3)

Attribute resources for estranged couples. "Estrangement" means a breakdown to the point that the spouses would not be living together if one was not institutionalized or were not living together before one spouse entered the institution. Determine estrangement by talking with the applicant.

If the institutionalized spouse is estranged from the community spouse, do not deny eligibility because of excess resources or failure to provide verification if the applicant can show hardship. To prove hardship, the applicant must demonstrate that:

- ◆ The applicant cannot get information about the community spouse's resources after exploring all legal means.
- ◆ The applicant is unable to access the estranged community spouse's resources after exploring all legal means, even though the community spouse's resources cause the applicant to be ineligible.

Assignment of Support Rights

Legal reference: 441 IAC 75.5(4)"a"(4)

Do not deny Medicaid for the institutionalized spouse if the resources owned by the institutionalized spouse are less than eligibility limits and the institutionalized spouse either:

- ◆ Has assigned any rights to support from the community spouse to the state, **or**
- ◆ Lacks the ability to execute an assignment because of physical or mental impairment.

To decide if the applicant lacks the ability to assign support rights, determine if the applicant has a guardian or conservator. If the applicant did not voluntarily choose to have a guardian or conservator, the client lacks the ability to assign support rights. No further verification is required.

If the applicant chose to have a guardian or conservator but it is alleged that the applicant lacks the ability to assign support rights, verify the lack of assignment ability with a physician's statement.

If you approve eligibility for an applicant who voluntarily or involuntarily has a guardian or conservator, send the following information to the Bureau of Financial, Health and Work Supports:

- ◆ The names and addresses of both spouses.
- ◆ The amount of the community spouse resource allowance.
- ◆ The amount of resources owned by the community spouse.

The Department will pursue support from the community spouse on a case-by-case basis. The state has the right to bring a support proceeding against a community spouse without an assignment.

The applicant is ineligible if the applicant owns resources that exceed limits, even if the applicant assigns support rights or lacks the ability to assign support rights.

Transfers to Establish Ongoing Eligibility

Legal reference: 441 IAC 75.5(4)"a"(2)

After the month the institutionalized spouse is determined eligible, do not consider the resources **owned** by the community spouse to be available to the institutionalized spouse.

Resources that are owned wholly or in part by the institutionalized spouse and are not transferred to the community spouse **are** counted when determining ongoing eligibility.

However, do not consider these resources if the institutionalized spouse has declared, in writing, the intent to transfer ownership of the resources to the community spouse. Issue form 470-4888, *Institutional Spouse Intent to Transfer Resources*, to document the member's intent. The member can choose to sign and return the form or can provide a written statement.

If the institutionalized spouse does not intend to transfer resources, establish eligibility for the month of application only. Deny ongoing eligibility at the end of that month.

1. Mr. W, the institutionalized spouse, has \$1,900 in resources attributed to him and is eligible for Medicaid. He jointly owns a CD valued at \$20,000. To remain eligible for Medicaid payment to the nursing facility, he must transfer \$18,000 of the CD to reduce his ownership down to \$2,000. He may transfer the total value if he wishes.

2. Mr. J is determined eligible for Medicaid in a medical institution. The amount of resources attributed to Mrs. J (the community spouse) and owned by Mrs. J is \$7,000, which is under the \$24,000 minimum.

A year later, Mr. J receives an inheritance of \$5,000. The IM worker verifies that when Mr. J received the inheritance, Mrs. J's resources were \$6,000. Mr. J intends to transfer \$4,000 to Mrs. J since her resources are under the \$24,000 minimum. He signs a statement to this effect.

Mr. J's remaining resources are \$1,000 ($\$5,000 - \$4,000 = \$1,000$). He is below resource limits for Medicaid and continues to be eligible.

When the member intends to transfer the resource, monitor the progress of the transfer. The transfer must take place within 90 days. The member must provide verification of the transfer. Send a notice similar to the following:

Medicaid has been approved effective _____, since your intent is to transfer resources to your spouse within 90 days of the date of this eligibility determination.

Failure to transfer the resource within 90 days will result in cancellation of Medicaid benefits unless unusual circumstances exist. Please notify this office when the resource is transferred and provide proof that the resource was transferred. 8-D, Transfers to Establish Ongoing Eligibility.

Contact the member or authorized representative within 45 days of the notice to check the status of the transfer. Contact the member at the end of 90 days to see if the resources were transferred.

If the institutionalized spouse is not able to transfer excess resources because of circumstances beyond the member's control, you can allow another 90 days. If, at the end of this extended 90-day period, the resources have not been transferred, cancel the case.

In some cases, the transfer of resources may cause Medicaid ineligibility for the community spouse. After the transfer has been made, examine the effect of the transfer on the community spouse's Medicaid eligibility.

Mr. and Mrs. K are eligible for SSI-related 503 program at home. Mrs. K enters a nursing facility in January. All \$2,900 of their resources are attributed to Mr. K, who actually owns them. Mr. K is ineligible for the 503 program if he retains the \$2,900 resources. However, he is eligible for the Medically Needy program.

Summary Examples

1. When Mr. R enters a nursing facility, Mrs. R files form 470-2577, *Resources Upon Entering a Medical Facility*. The Rs list resources of a farm that includes their homestead, \$4,000 in bonds, \$20,000 in stock, two cars, and \$3,000 in a checking account.

Completing the Attribution

The following items are used to complete the attribution:

\$	4,000	Bonds
	20,000	Stocks
	1,500	One car
+	<u>3,000</u>	Checking account
\$	28,500	Total resources

The worker divides \$28,500 by 2, which equals \$14,250. Because this is less than \$24,000, the amount attributed to Mrs. R (the community spouse) is \$24,000. The remaining amount of \$4,500 is attributed to Mr. R.

Appealing an Attribution

After the attribution is complete, Mrs. R files an appeal to set aside additional resources that would generate income equal to the difference between the couple's available income and the MMMNA. The deficit in income is \$1,622.

The cost of an annuity to generate \$1,622 per month is \$103,119. Because \$103,119 is more than the \$24,000 attributed to Mrs. R, the attribution will be modified to substitute \$103,119 for the \$24,000 previously attributed to Mrs. R. No resources are attributed to Mr. R.

Determining Eligibility After the Appeal

After the appeal, Mrs. R applies for Medicaid for Mr. R. The worker subtracts the community spouse allowance of \$103,119 from the couple's resources. This leaves no resources available to Mr. R. He is resource-eligible for Medicaid payment for nursing facility care. Mr. R has 90 days to transfer resources to Mrs. R to maintain his eligibility.

2. Mrs. J enters a nursing facility and files form 470-2577, *Resources Upon Entering a Medical Facility*. The Js list resources of a \$150,000 farm, a homestead, \$10,000 in bonds, \$100,000 in CDs, one car, \$10,000 in a checking account, and \$35,000 in a savings account.

Completing the Attribution

The following items are used to complete the attribution:

\$ 150,000	Farm
10,000	Bonds
100,000	CDs
10,000	Checking account
+ 35,000	Savings account
\$ 305,000	Total resources

\$119,220 is attributed to Mr. J. \$185,780 is attributed to Mrs. J.

Appealing an Attribution

After the attribution is complete, Mr. J files an appeal to set aside additional resources to generate income equal to the difference between the couple's income and the MMMNA. The couple's available income is \$1,844 per month. $\$2,980.50 - \$1,844 = \$1,136.50$ unmet need.

The average estimate of the cost of an annuity to generate \$1,136 per month is \$45,000, which is less than the \$119,220 attributed to Mr. J. The attribution remains the same.

Determining Eligibility After the Appeal

After the appeal, Mr. J files an application for medical assistance for Mrs. J. The Js have the following resources at the time of application:

\$ 61,920	CDs
50,000	Bonds
10,000	Checking account
+ 35,000	Savings account
\$ 156,920	Total resources

The worker subtracts the community spouse allowance of \$119,220. This leaves \$37,700 in resources available to Mrs. J. She is ineligible for Medicaid payment for nursing facility care, because she is over the resource limit.

Estate Recovery

Legal reference: 441 IAC 75.28(7)

The cost of medical assistance is subject to recovery from the estate of certain Medicaid members. Members affected by the estate recovery policy are those who:

- ◆ Are 55 years of age or older, regardless of where they are living; or
- ◆ Are under age 55 and:
 - Reside in a nursing facility, an intermediate care facility for persons with an intellectually disability, or a mental health institute, and
 - Cannot reasonably be expected to be discharged and return home. See [Establishing Whether a Member Under Age 55 Can Return Home](#).

Give a copy of Comm. 123 or Comm. 123(S), *Important Information for You and Your Family Members About the Estate Recovery Program*, to all Medicaid applicants at the time of the application.

An "estate" includes all real property, personal property, or any other asset in which the member had any legal title to or interest in at the time of the death of the member, to the extent of such interest. This includes, but is not limited to, interest in jointly held property, interest in trusts and retained life estates.

All assets included in the Medicaid member's estate are subject to probate for the purpose of estate recovery. NOTE: It is not allowable for assets of a deceased member to be used to pay for travel expenses of family members of the deceased at the time of the member's death.

Refer questions from members about estate recovery to the Iowa Medicaid Enterprise (IME) Estate Recovery Unit at the toll-free number 1-888-513-5186 or in the Des Moines area, at (515) 246-9841. You may also give members Comm. 266, *Iowa's Estate Recovery Law*, which gives detailed information about estate recovery procedures.

Establishing Whether a Member Under Age 55 Can Return Home

Legal reference: 441 IAC 75.28(7)

Presume that a member in a medical institution who is under age 55 is **unable** to return home. You are required to inform members of this policy by manually issuing form 470-2980, *Estate Recovery Notice for New Approvals*, to all members who are **under age 55 and a resident of a medical institution** at the time of Medicaid approval.

If a member under age 55 is discharged before six months has elapsed, no further action is necessary. Estate recovery will not be pursued because the member was not permanently institutionalized.

A member in a medical institution who is under age 55 has the right to rebut this presumption. To do so, the member must make a written request to the Department after being in the institution for six months.

If a member dies before six consecutive months of institutionalization, the family or another interested party may submit a written request to the Department to rebut the presumption that the member could not have been reasonably expected to be discharged.

Inform members who are under age 55 of their rebuttal rights by manually issuing them form 470-3209, *Estate Recovery Six-Month Follow-Up*, six months after their admission into the medical institution. If the member dies in the medical institution after a stay of less than six months, issue the form to the family or someone acting on the member's behalf.

Send all rebuttal requests to the Medical Services Unit at the Iowa Medicaid Enterprise (IME) either by using the local mail or by U.S. mail to PO Box 36478, Des Moines, Iowa 50315. The IME Medical Services Unit determines whether the member can reasonably be expected to return home and sends a copy of its decision to you and to the member.

If the IME Medical Services Unit determines that the member cannot reasonably expect to return home, the Unit will provide information to the member and to you about whether the member was ever able to return home within the first six months of institutionalization and the date the expectation and ability to return home ceased. File a copy of the determination in the case record.

A member may appeal an adverse decision. The member first appeals through the IME Medical Services Unit for reconsideration. If the member disagrees with the reconsideration decision, the member or someone acting responsibly for the member can appeal an adverse reconsideration decision by IME Medical Services Unit through normal DHS appeal procedures.

Requests for the IME Medical Services Unit determination are timely when filed within 30 calendar days from the date form 470-3209, *Estate Recovery Six-Month Follow-Up*, is issued. The member may still make a request later. However, if the decision then is that the member is reasonably able to return home, assistance received before the date the request was submitted to DHS is still subject to estate recovery.

Estate Recovery Agent

Estate recovery activities are conducted by the Revenue Collection Unit at the Iowa Medicaid Enterprise (IME). Refer the names of all deceased Medicaid members to the IME Revenue Collection Unit by entering information on the referral to estate recovery screens on the Automated Benefit Calculation (ABC) system. You must complete all known information on these screens when making a referral for estate recovery.

Referrals may be done on the form 470-4122, *Estate Recovery Program Referral*, only when the Medicaid member did not have an ABC case. Send the completed form via the e-mail address on the form.

The IME Revenue Collection Unit may request a copy of the member's first and last application or review form to determine if there are resources that could be subject to estate recovery. When sending a copy of the requested forms, record the member's name, state identification number, social security number, and case number on each sheet.

Additionally, the IME Revenue Collection Unit compares monthly Medicaid eligibility files against Vital Statistics records on reported deaths in Iowa to determine when estate recovery can be initiated for an individual.

Amount Due

Legal reference: 441 IAC 75.28(7) "d" and "f"

The debt due the Department from the member's estate is equal to all medical assistance provided on the member's behalf on or after:

- ◆ The date the person attained age 55, or
- ◆ The date a person under age 55 entered a medical institution with no reasonable expectation of returning home.

However, no debt is due for assistance provided before July 1, 1994 (the beginning of the estate recovery program). Effective January 1, 2010, Medicaid payments for Medicare cost-sharing benefits are excluded from estate recovery for the following members:

- ◆ Qualified Medicare Beneficiaries (QMB)
- ◆ Specified Low-Income Medicare Beneficiaries (SLMB)
- ◆ Expanded Specified Low-Income Medicare Beneficiaries (E-SLMB)
- ◆ Qualified Disabled Working People (QDWP)
- ◆ Dually eligible for a full Medicaid coverage group and QMB
- ◆ Dually eligible for a full Medicaid coverage group and SLMB

Medicare cost-sharing benefits include Medicaid payments for Medicare Part A and Part B premiums, copayments, coinsurance, and deductibles.

If a member under the age of 55 is discharged from the facility and returns home before six consecutive months, no debt is assessed for Medicaid payments made on the member's behalf for the time of the institutionalization.

A claim against the estate of a member who was eligible for Medicaid because resources were disregarded under the Long-Term Care Asset Preservation program is computed differently. The amount of the assets disregarded under this program is not subject to estate recovery. EXCEPTION: Medicaid paid before the member attained eligibility due to long-term care asset preservation is still recovered from the estate.

Interest accrues on a debt due beginning six months after the death of a Medicaid member, surviving spouse, or surviving child, or upon the minor child reaching age 21. The Department does not use liens in the estate recovery program.

When Estate Recovery Is Waived

Legal reference: 441 IAC 75.28(7) "b," "c," and "g"

Waiver of collection from the estate based on undue hardship is determined on a case-by-case basis. Collection of the debt from the estate of a Medicaid member is waived when collection of the debt would result in:

- ◆ Reduction in the amount received from the member's estate by a surviving spouse, or by a surviving child who is under age 21, blind, or permanently and totally disabled at the time of the member's death, or
- ◆ Other undue hardship. Undue hardship exists when all of the following are true:
 - The household that claims hardship has gross monthly income, as defined by Family Investment Program (FIP) policy, of less than 200% of the poverty level for a household of the same size.
 - The household that claims hardship has total resources, as defined by FIP policy, that do not exceed \$10,000.
 - Application of estate recovery would deprive a person of food, clothing, shelter, or medical care such that the person's life or health would be endangered.

When a person claims undue hardship, refer the person to the program manager for Estate Recovery at the Iowa Medicaid Enterprise.

If collection of all or part of a debt is waived for a surviving spouse or child, or for hardship, the amount waived creates a debt due from:

- ◆ The estate of the member's surviving spouse or blind or disabled child, upon the death of the spouse or child,
- ◆ A surviving child who was under 21 years of age at the time of the member's death, or upon the child reaching age 21,
- ◆ The estate of a surviving child who was under age 21 at the time of the member's death, if the child dies before reaching age 21, or
- ◆ The person who received the hardship waiver if the hardship no longer exists or from the estate of the person, whichever is first.

The debt owed by the surviving spouse, child, or person who received the hardship waiver will not exceed the amount in which recovery was waived.

Transfer of Assets

Legal reference: 441 IAC 75.23(249A), P. L. 100-360

“Transfer of assets” occurs when a person transfers resources or countable income for less than fair market value in order to become eligible or maintain eligibility for Medicaid. Transfer of assets includes, but is not limited to:

- ◆ Giving away property to someone else.
- ◆ Establishing a trust for the benefit of someone else.
- ◆ Removing a name from an asset.
- ◆ Disclaiming an inheritance on or after July 1, 2000.
- ◆ Failure to “take” against a deceased spouse’s will on or after July 1, 2000.
- ◆ Reducing ownership interest in an asset.
- ◆ Transferring or disclaiming the right to income not yet received.
- ◆ Use of funds to purchase some annuities.
- ◆ Use of funds to purchase some promissory notes, loans, and mortgages.
- ◆ Use of funds to purchase some life estates.

See [Determining the Value of a Resource](#) when establishing the fair market value or equity value of a resource. Assume that a person who transfers assets does so to become eligible for Medicaid unless they prove otherwise. See [Rebuttal of Transfer of Assets](#).

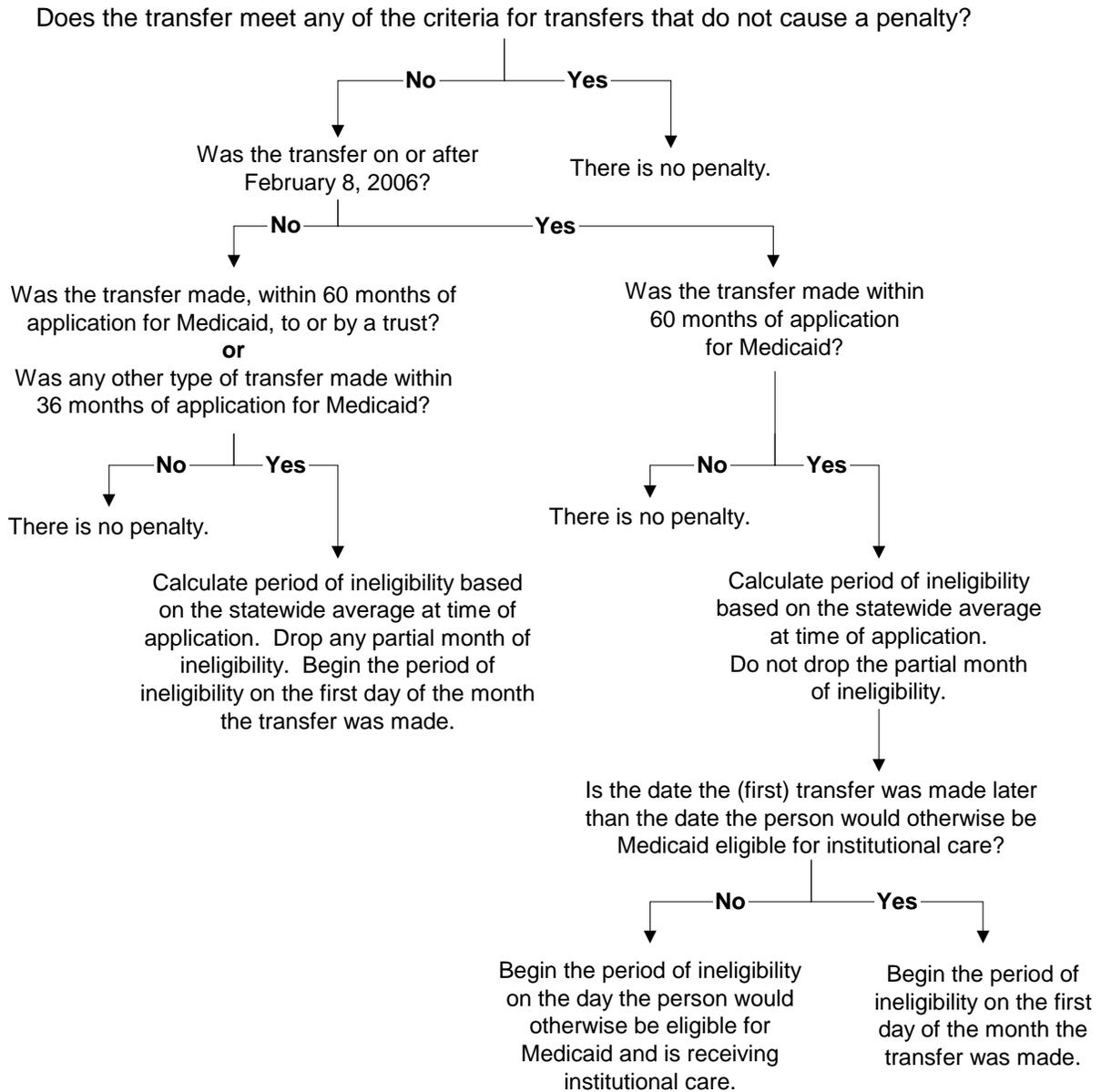
Some transfers do not result in a penalty. These are listed under [Transfers That Do Not a Cause Penalty](#). The penalty for transferring assets depends upon:

- ◆ The date the transfer occurred,
- ◆ To whom the assets were transferred, and
- ◆ How much the assets were worth at the time of the transfer.

The transfer of assets penalty affects Medicaid coverage of certain long-term care services for persons under FMAP-related and SSI-related Medicaid coverage groups. See [Penalties for Transferring Assets](#).

A claim may need to be established against a person who received the transferred assets, as explained under [Claim Against a Person Who Receives Transferred Assets](#).

Transfer of Assets Flow Chart



Transfers That Cause a Medicaid Penalty

Legal reference: 441 IAC 75.6(249A), 75.15(249A), 75.23(249A), P. L. 100-360

Transfers that currently may result in a Medicaid penalty being applied are:

- ◆ Transfers by an applicant or an applicant's spouse to someone other than a spouse that are made on or after February 8, 2006, and within 60 months before the Medicaid application is filed or on or after the date of application. This includes:
 - The disclaimer of an inheritance, and
 - Failure to take a share of an estate as a surviving spouse (also known as "taking against a will") if the value received by taking against the will would exceed the inheritance received under the will
- ◆ Transfers by an applicant or an applicant's spouse involving funds in a trust that are made after August 10, 1993, and during the 60 months before the Medicaid application is filed and after institutionalization.

Transfers of assets that do not meet these criteria do not result in a penalty being applied to current Medicaid eligibility. However, if the transfer was after July 1, 1993, and was within 60 months before the Medicaid application date, a claim against the person who received the transferred assets may still be applicable. See [Claim Against a Person Who Receives Transferred Assets](#).

Purchases Considered Transfers for Less Than Fair Market Value

Legal reference: 441 IAC 75.23(9), (10), and (11)

A transfer of assets for less than fair market value includes, but is not limited to, the following actions:

- ◆ Purchase of an annuity **before** February 8, 2006, if the expected return on the annuity is not commensurate with a reasonable estimate of life expectancy, also referred to as "actuarially sound."

When an annuity purchased before February 8, 2006, is "actuarially sound," then it is not considered a transfer of assets for less than fair market value. The annuitant has just converted the resources to income.

To determine whether the annuity is "actuarially sound," use the life expectancy tables compiled from information published by the Office of the Chief Actuary of the Social Security Administration. These tables may be accessed at <http://www.ssa.gov/OACT/STATS/table4c6.html>.

The average number of years of expected life remaining for the annuitant must coincide with the life of the annuity. If the annuitant is not reasonably expected to live as long as or longer than the guarantee period of the annuity, the annuitant will not receive fair market value for the annuity based on the projected return.

In that case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place. The penalty is assessed based on a transfer of assets that is considered to have occurred at the time the annuity was purchased or the date the annuity became available as a countable resource, whichever is later.

1. Mr. W, at age 65, purchases a \$10,000 annuity to be paid over the course of ten years. His life expectancy according to the table is 17.19 years. Thus, the annuity is actuarially sound.
2. Mr. A, at the age of 80, purchases a \$10,000 annuity to be paid over the course of ten years. His life expectancy is only 7.9 years. Thus, a payout of the annuity for approximately three years is considered a transfer of assets for less than fair market value and the amount is subject to penalty.

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- ◆ Purchase of an annuity on or after February 8, 2006, by a **Medicaid applicant or member as the annuitant**, unless the annuity also meets **one** of first three conditions **and** the fourth condition described below:
 - The annuity is an annuity described in subsection (b) or (q) of section 408 of the United States Internal Revenue Code of 1986, or
 - The annuity is purchased with proceeds from:
 - An account or trust described in subsection (a), (c), or (p) of section 408 of the United States Internal Revenue Code of 1986;
 - A simplified employee pension (within the meaning of section 408(k) of the United States Internal Revenue Code of 1986); or
 - A Roth IRA described in section 408A of the United States Internal Revenue Code of 1986; or
 - The annuity:
 - Is irrevocable and nonassignable;
 - Is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration (see [Annuities](#)); and
 - Provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made;

and

- The annuity has the state of Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is currently institutionalized. Iowa may be named as either:
 - The remainder beneficiary in the first position, or
 - The remainder a beneficiary in the second position, after the community spouse, minor child or disabled child, and in the first position if the spouse or a representative of the child does dispose of the remainder for less than fair market value.

NOTE: When an annuity has the state of Iowa named as a remainder beneficiary, complete form 470-4382, *Notification Regarding Annuity Benefits*, and send it to the annuity company.

- Purchase of an annuity on or after February 8, 2006, by **the spouse of a Medicaid applicant or member as the annuitant**, unless the annuity has the state of Iowa named as the remainder beneficiary for at least the total amount of medical assistance paid on behalf of the annuitant or the annuitant's spouse, if either is currently institutionalized. Iowa may be named as either:
 - The remainder beneficiary in the first position, or
 - The remainder a beneficiary in the second position, after the community spouse, minor child or disabled child, and in the first position if the spouse or a representative of the child does dispose of the remainder for less than fair market value.

NOTE: When an annuity has the state of Iowa named as a remainder beneficiary, complete form 470-4382, *Notification Regarding Annuity Benefits*, and send it to the annuity company.

- ◆ Any purchase of a promissory note, loan, or mortgage made on or after February 8, 2006, unless the note, loan, or mortgage meets all of the following criteria:
 - It has a repayment term that is actuarially sound, as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration (see [Loans and Promissory Notes](#));
 - It provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
 - It prohibits the cancellation of the balance upon the death of the lender.
- ◆ Purchase of a life estate in another person's home for more than its fair market value, regardless of whether the life estate was:
 - Purchased before February 8, 2006; or
 - Purchased on or after February 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

Transfers That Do Not Cause a Penalty

Legal reference: 441 IAC 75.23(5)

In the following situations, the transfer is exempt and does not cause a penalty:

- ◆ A joint account is divided into separate accounts that reflect separate ownership, as long as the funds are divided equally in proportion of ownership. Funds not equally divided in proportion of ownership may be considered transferred and subject to penalty.

Mr. J and Ms. H have \$8,000 in a joint account (A) and \$3,000 in another joint account (B) that they cannot separate. Ms. H also has an account of \$500 in her name alone.

Mr. J enters a nursing home and applies for Medicaid. Ms. H has spent \$5,000 from account A and \$1,000 from account B on Mr. J's nursing home care. At that point, she removes Mr. J's name from the accounts.

Since Ms. H spent more than half of the accounts on Mr. J's care (\$6,000 out of \$11,000), she has rebutted the presumption of divesting. The account owned by Ms. H does not enter into the rebuttal of divesting.

- ◆ A transfer is made to the institutionalized person's child or adult child who is disabled as defined by Social Security Administration. The child is considered disabled if the child is:
 - Receiving SSI, Social Security disability benefits, or Railroad Retirement benefits as a disabled child, or
 - Declared disabled by a Department disability determination. See [8-C, When the Department Determines Disability](#).

Ms. E applies for Medicaid while living in a skilled nursing facility. She has transferred \$10,000 to her son. She says her son is disabled, but he is not receiving any disability benefits. The Department refers the son to apply for SSI, because he has no income.

Ms. E's application is approved for other medical services but is pended for facility payments due to the need to determine her son's disability. If the son does not apply for SSI, the Department determines disability. If the son is not determined to be disabled, transfer of asset penalties are applied.

- ◆ The applicant or member or the applicant or member's spouse transfers an asset that would have been exempt as a resource at the time of transfer.

Mr. and Mrs. D have \$11,000 in total assets in March. On April 14, they gave away \$5,000 in certificates of deposit to their daughter. Mrs. D enters a medical institution to stay on April 30.

Since the Ds owned total assets of less than \$24,000, the minimum protected amount for the community spouse in the month before the month of entry and attribution, the transfer is not for the purpose of qualifying for Medicaid.

EXCEPTION: Transfers of a home and surrounding property (including the transfer of a life estate interest only) are not exempt from transfer penalties.

- ◆ A transfer was made into a trust established solely for the benefit of:
 - The person's child or adult child who is blind or disabled, as defined by the Social Security Administration.
 - A person under 65 years of age who is disabled, as defined by the Social Security Administration.
- ◆ A transfer made between spouses or to another person for the sole benefit and support of the community spouse.

1. Mr. Q transfers his half of a \$25,000 certificate of deposit to his daughter on May 14, 2005, for Mrs. Q's benefit. Mr. Q then applies for Medicaid on May 20, 2005. On June 1, 2005, he enters a skilled nursing facility. Mr. Q furnishes a statement that the money was transferred because Mrs. Q is handicapped, and the daughter will be handling Mrs. Q's finances.

This transfer does not disqualify Mr. Q for payment of nursing facility services because the transfer was for the benefit of his spouse.

2. Mr. W transfers his car, valued at \$25,000, to Mrs. W while living at home. Mr. W applies for Medicaid. This is not a disqualifying transfer, since the car was transferred to the spouse, and the spouse did not transfer it.

- ◆ A transfer is made in response to a court order that the institutionalized spouse provide support for the community spouse, and the assets are transferred for:
 - The support of the community spouse, or
 - The support of a minor or dependent child, dependent parent, or dependent sibling of the institutionalized spouse or community spouse who lives with the community spouse.

When Mr. P enters a nursing facility, there is a court order stating that Mr. P should transfer \$10,000 to First National Bank for the support of his son, Pat, who lives with Mrs. P. Since Pat lives with Mrs. P, and there is a court order requiring this transfer, it is not a disqualifying transfer. Mr. P is eligible for payment for nursing facility services.

- ◆ The transfer results in denial of eligibility that causes an undue hardship to the applicant or member. Undue hardship exists only when all of the following conditions are met:
 - Application of the transfer of asset penalty would deprive the applicant or member of food, clothing, shelter, medical care, or other necessities of life, such that the applicant's or member's health or life would be endangered.
 - The client who transferred the resource or the client's spouse has exhausted all means to recover the resource, including legal remedies and consultation with an attorney.
 - The client's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay-resident, counting the value of all resources except for:
 - The home, if occupied by a dependent relative or if a licensed physician verifies that the person is expected to return home.
 - Household goods.
 - A vehicle required by the applicant or member for transportation.
 - Funds for burial of \$4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates that payments cannot be obtained from the funds of the person who handled the financial affairs to pay for nursing facility services.

Mr. C transfers his home, with an equity value of \$75,000, to his nephew and applies for Medicaid payments in a nursing home. The IM worker determines that Mr. C is ineligible for Medicaid for 30 months.

Mr. C replies that he does not have the money to pay for care. He goes to his lawyer, who writes to the nephew requesting that the nephew return the home. The nephew refuses to return the home, and the attorney advises that no further legal recourse is available.

Mr. C has met the requirement of exhausting legal means. Mr. C has the following assets: \$500 cash and a burial fund of \$1,500. The \$500 is countable because it is available. Since the \$1,500 is earmarked for burial and under \$4,000, it is not available.

Because Mr. C's available assets are less than the average statewide cost of nursing facility services, he also meets the second requirement and a hardship exception is granted.

Because the transfer of asset penalty will not be applied and Mr. C is otherwise eligible, Medicaid nursing facility payments are approved from the date of entry.

- ◆ The applicant or member who transferred the asset makes a satisfactory showing that the applicant or member intended to dispose of the asset either at fair market value or for other valuable consideration equal to the fair market value. The client must verify the attempts to sell the asset for fair market value through an independent source.
- ◆ The applicant or member who transferred the asset makes a satisfactory showing that the asset was transferred exclusively for another purpose other than to establish eligibility for Medicaid. See [Rebuttal of Transfer of Assets](#).
- ◆ The applicant or member who transferred the asset makes a satisfactory showing that all assets transferred for less than fair market value have been returned to the applicant or member.

- ◆ The applicant's or member's home is transferred to one of the following:
 - The spouse of the institutionalized applicant or member.
 - A child of the institutionalized person who is under age 21, or who is blind or totally disabled as defined by the Social Security Administration. The child is considered disabled if the child is:
 - Receiving SSI or Social Security benefits or Railroad Retirement benefits as a blind or disabled person, or
 - Declared disabled by a Department disability determination. See [8-C, When the Department Determines Disability](#).
 - A sibling of the institutionalized applicant or member who has an equity interest in the home and who lived in the home at least one year immediately before the applicant or member became institutionalized or eligible for HCBS waiver or PACE services.

Verify that the sibling has an equity interest and lived in the home for the required period of time.

- A son or daughter who was living in the parent's home for at least two years immediately before the date the parent became institutionalized, and who provided care to the parent that allowed the parent to live at home rather than in a medical institution. The parent can be either a biological parent or stepparent.

Verify with a third party the length of time that the parent was able to stay home due to the care of the son or daughter.

1. On September 17, while Mr. W is living at home on his farm, he transfers his farm to his son, age 51. Mr. W enters a nursing facility on September 29. His son is not disabled, and did not provide care to Mr. W while Mr. W was at home.

The worker determines Mr. W is subject to a penalty, because the son to whom the farm was transferred did not meet the criteria for exempting the transfer.

2. Ms. O has a 32-year-old daughter who has always lived with her, but does not provide care to Ms. O to enable her to stay at home rather than in a medical institution. She wants her daughter to have the home and transfers it after her entry to the skilled nursing facility.

The daughter does not receive SSI, Social Security, or Railroad Retirement, but alleges a disability. Disability Determination Services determines that the daughter is disabled. The transfer of the home is not a disqualifying transfer.

3. Mr. E, who lives in a skilled nursing facility, transfers his share of his home to his brother. They inherited the home from their father and had lived there together for 20 years.

This transfer does not disqualify Mr. E for payment of nursing facility services, since the brother had an equity interest and they had lived together more than one year before Mr. E's entry to a nursing facility.

Rebuttal of Transfer of Assets

Legal reference: 20 CFR 416.1246, IAC 75.23(5) "c" (249A)

Assume all applicants or members who transfer assets do so to become eligible for Medicaid unless the applicant or member proves otherwise. The burden of proof is on the applicant or member to prove assets were **not** transferred to meet eligibility requirements. The applicant or member must:

- ◆ Explain why the asset was transferred.
- ◆ Explain the applicant's or member's relationship to the person who received the transferred asset.
- ◆ Establish the fair market value and the equity value of the resource.
- ◆ Verify an attempt to dispose of the asset for a fair market value.
- ◆ Explain why less than the fair market value was accepted.
- ◆ Establish that an agreement, contract, or expectation was created at the time of transfer stating the applicant or member received or will receive compensation for the value of the transfer. Compensation is money, real or personal property, food, shelter, or services received by an owner in exchange for an asset.
- ◆ Explain how the applicant or member planned for self-support after the asset was transferred.

Include in the case record documents or letters made at the time of the transfer as evidence to verify that a transfer was not done to qualify for Medicaid.

Certain factors **may** indicate that a transfer was done for some reason other than to obtain Medicaid eligibility, such as:

- ◆ The transfer was made before the applicant or member was diagnosed with a previously undetected disabling condition or became suddenly traumatically disabled (for example, due to a car accident).

- ◆ The transfer that would have prevented eligibility was made before the applicant or member unexpectedly lost other assets or income. For example, at the time the assets were transferred, the applicant or member had enough income or assets to meet the applicant's or member's own needs without the use of Medicaid but then unexpectedly lost that income or asset.

In July, Mr. J sells property valued at \$8,000 for \$5,000. He applies for Medicaid in October. Mr. J explains that he sold the property to pay medical bills of \$3,900 incurred by his recently deceased wife. Although he was asking \$8,000 for the property, he accepted less than fair market value because he needed the money quickly.

At the time of the sale, Mr. J was receiving \$1,000 in Social Security, \$200 from a private pension, \$200 in dividends from a company in which he owned stock, and \$1,000 monthly cash support from his son.

But in August, Mr. J's son died and the cash support payments ceased. In September, the company from which he had been drawing dividends went bankrupt, rendering his stock worthless, and removing that source of income.

Mr. J presents as evidence copies of paid medical bills, a March agreement with a realtor to sell the property, copies of canceled checks showing monthly \$500 payments to Mr. J, a copy of his son's death certificate, and newspaper clippings regarding the bankruptcy of the dividend-paying company.

Mr. J has established that he sold the property exclusively for some other purpose than establishing Medicaid eligibility. The transfer does not affect Medicaid eligibility.

The rationale for this determination is that Mr. J attempted to sell the property at fair market value and at the time of the sale had income that would have made him ineligible to receive Medicaid. He could not reasonably have expected to become entitled to Medicaid as a result of the sale.

- ◆ The transfer was of an asset that was excluded on the date of transfer and would continue to be excluded even if retained. Property that was excluded as a homestead property is considered an asset for this purpose. (See 42 U.S.C. sec. 1396p(e)(5)).

If an excluded home is transferred for less than fair market value, the fact that it was excluded on the date of transfer and would continue to be excluded even if retained is not sufficient to establish that the transfer was done for some reason other than to obtain Medicaid eligibility.

- ◆ The transfer was a gift and a pattern has been established of giving gifts or contributing to a charity.

Mr. Z applies for Medicaid on November 6. He has given his son \$500 for Christmas every year since the son was born. Mr. Z shows convincing evidence that he made such gifts to his son every year at Christmas. The presumption that the assets were transferred to qualify for Medicaid is rebutted.

- ◆ The transfer was in exchange for support, maintenance, or services provided to the applicant or member as part of binding agreement at the time of transfer. Determine the fair market value of the services received and the length of time the services will be provided.

Mrs. H transferred her savings account of \$5,000 to her son in July 1996, pursuant to a written agreement they made in October 1995 for him to provide her care until she went in the nursing home.

The \$5,000 was determined by the son charging \$500 a month for 10 months of care. She rebutted the presumption that the transfer was made to attain eligibility.

If services will be provided for the client's lifetime, use the table of Average Number of Years of Life Remaining under [Purchases Considered Transfers for Less Than Fair Market Value](#) to determine if the resources were transferred for less than they are worth. This table comes from the Social Security Administration Office of the Actuary.

To determine the total value of support and maintenance for the client, multiply the current market value of the support and maintenance by the figure for average years of life remaining opposite the client's age. If the client's age is not on the chart, use the next lowest age on the chart.

If the value of the service is equal to or more than the asset, there is no transfer of assets.

Penalties for Transferring Assets

Legal reference: 441 IAC 75.23(1)

Transfer of assets after August 10, 1993, for less than fair market value by either a Medicaid applicant or member or the applicant or member's spouse disqualifies the applicant or member for Medicaid payment for:

- ◆ Nursing facility services.
- ◆ Level of care in a medical institution equivalent to that of nursing facility services.
- ◆ Home- and community-based (HCBS) waiver services. (A person receiving HCBS waiver services is considered as an institutionalized person.)
- ◆ Program for All-Inclusive Care for the Elderly (PACE) services. (A person receiving PACE services is considered as an institutionalized person.)
- ◆ Home health care services.
- ◆ Home and community care for functionally disabled elderly people.
- ◆ Personal care services.
- ◆ Other long-term care services.

The penalty period for transferring assets depends on when the assets were transferred and how much the assets were worth at the time the transfer occurred.

The value of the assets transferred is divided by the statewide average cost of nursing facility services at the time of application.

Time of Application	Average Monthly Statewide Cost of Nursing Facility Services	Average Daily Cost of Nursing Facility Services
July 1, 2016 – June 30, 2017	\$5,809.13	\$191.09
July 1, 2015 – June 30, 2016	\$5,407.24	\$177.87
July 1, 2014 – June 30, 2015	\$5,103.24	\$167.87
July 1, 2013 – June 30, 2014	\$5,057.65	\$166.37
July 1, 2012 – June 30, 2013	\$5,131.82	\$168.81
July 1, 2011 – June 30, 2012	\$4,853.36	\$159.65
July 1, 2010 – June 30, 2011	\$4,842.72	\$159.30
July 1, 2009 – June 30, 2010	\$4,598.61	\$151.27
July 1, 2008 – June 30, 2009	\$4,342.03	\$142.83
July 1, 2007 – June 30, 2008	\$4,173.92	\$137.30
July 1, 2006 – June 30, 2007	\$4,021.31	\$132.28
July 1, 2005 – June 30, 2006	\$3,697.55	\$121.63
July 1, 2004 – June 30, 2005	\$3,597.84	NA
July 1, 2003 – June 30, 2004	\$3,575.34	NA
July 1, 2002 – June 30, 2003	\$3,111.69	NA
July 1, 2001 – June 30, 2002	\$3,024.00	NA
July 1, 2000 – June 30, 2001	\$2,933.07	NA

To establish the penalty period for transfers made **before** February 8, 2006:

1. Determine the equity value of all assets transferred in the 36 months before the client applied for Medicaid, other than those transferred to or by a trust.
2. Determine the equity value of all assets transferred into or by a trust in the 60 months before the client applied for Medicaid.
3. Divide the total equity value of the transferred assets by the average monthly cost of nursing services at the time of application to determine the number of months of penalty. Drop any fraction remaining, so the result is in whole months.

4. Start the penalty on the first day of the month assets were transferred.

1. Mr. T transfers \$100,000 to his next-door neighbor on April 11, 2005. He enters a nursing facility and applies for Medicaid on June 3, 2006. The worker determines that the transfer was made to qualify for Medicaid. The penalty period is figured by dividing \$100,000 by \$3,697.55, with a result of 27.05 months.

Since the transfer was made before February 8, 2006, the partial month of ineligibility is rounded down to 27 months. Also, the penalty period begins on the first day of the month the transfer was made. Mr. T's period of ineligibility begins April 1, 2005, and lasts through June 30, 2007. He can reapply for Medicaid nursing facility payment and, if he is otherwise eligible, be approved on July 1, 2007.

2. Mrs. A transfers \$3,000 to her daughter on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on June 9, 2006.

The worker determines that the transfer was made in order to qualify for Medicaid. The penalty period is figured by dividing \$3,000 by \$3,697.55, with a result of 0.811. Since the transfer was made before February 8, 2006, the result is rounded down and there is no period of ineligibility.

To establish the penalty period for transfers made **on or after** February 8, 2006:

1. Determine the equity value of all assets transferred in the 60 months before the client applied for Medicaid.
2. Divide the amount from step 1 above by the average monthly statewide cost of nursing facility services.
3. Multiply the full number of months from step 2 by the average monthly statewide cost of nursing facility services to determine the amount of the transfer that would be used to cover the full months.
4. Subtract (result of step 3) from the total assets transferred (amount in step 1) to determine the balance or partial month amount.
5. Divide the partial month amount (result from step 4) by the daily average statewide cost of nursing facility services to come up with the number of additional days for the partial month penalty.

6. Start the penalty on:

- ◆ The date the applicant or member would otherwise be eligible for Medicaid payment of long-term care services, or
- ◆ The level of care effective date for Medicaid HCBS waiver applicants, or
- ◆ The level of care effective date for PACE enrollees, or
- ◆ The first day of the month assets were transferred, whichever is later.

1. Mr. Z transfers \$95,000 to his best friend on February 11, 2006. He enters a nursing facility on March 3, 2006, and applies for Medicaid nursing facility payment on June 9, 2006. The worker determines that the transfer was made in order to qualify for Medicaid.

Since the transfer took place after February 8, 2006, the partial month of ineligibility is not rounded down. The penalty period is figured as follows:

- a. Divide the total transferred by the statewide monthly cost of nursing facility services ($\$95,000 \div \$3,697.55 = 25.69$).
- b. Figure the amount used in the full 25 months of penalty (25 months \times $\$3,697.55 = \$92,438.75$).
- c. Subtract this from the total transferred to come up with the partial month balance ($\$95,000 - \$92,438.75 = \$2,561.25$).
- d. Take the partial month balance and divide by the statewide daily average cost of nursing facility services ($\$2,561.25 \div \$121.63 = 21$ days).

The penalty period is 25 months and 21 days.

If there were no penalty for transferring his assets for less than fair market value, Mr. Z could have been eligible for Medicaid payment of his facility care effective March 3, 2006. Since this date is later than the date he made the transfer, Mr. Z's period of ineligibility begins March 3, 2006, and lasts through April 23, 2008. He can reapply for Medicaid nursing facility payment and, if he is otherwise eligible, be approved on May 24, 2008.

2. Mrs. G transfers \$3,000 to her daughter on February 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid nursing facility payment on June 9, 2006. The worker determines that the transfer was made to qualify for Medicaid. The transfer was made after February 8, 2006, so the partial month of ineligibility is not rounded down.

The penalty period is figured and results in a penalty for 24 days ($\$3,000 \div 121.63 = 24.66$). If there were no penalty for transferring her assets for less than fair market value, Mrs. G would have been eligible for Medicaid payment of her facility care effective March 3, 2006.

Since this date is later than the date she made the transfer, Mrs. G's period of ineligibility begins March 3, 2006, and lasts through March 26, 2006. If she is otherwise eligible, she can be approved effective March 27, 2006.

If the transfer period is determined and the community spouse later becomes eligible for Medicaid payment of facility care, divide the remaining period of ineligibility in half and apply one-half of the penalty period to each spouse. When the transfer was made before February 8, 2006, combine the two partial months of ineligibility to equal one month and apply that month to the spouse that initiated the transfer.

If one spouse dies before the penalty period is completed, apply the remaining period of ineligibility to the living spouse.

1. Mrs. L transfers \$71,000 in January 2005. Mr. L enters a nursing facility in March 2006, and files an application for nursing facility care. A 19-month period of ineligibility is determined ($\$71,000 \div \$3,697.55 = 19.2$). Since the transfer was made before February 8, 2006, the period of ineligibility begins on the first day of the month the transfer was made. Mr. L is ineligible from January 1, 2005, through July 31, 2006.

Mrs. L enters the facility on April 3, 2006. Sixteen months of the period of ineligibility have passed. The worker divides the remaining three months between the couple ($3 \text{ months} \div 2 = 1.5$). Because Mrs. L initiated the transfer, she is ineligible for two months and Mr. L is ineligible for one month. Mrs. L is ineligible for nursing facility care beginning April 1, 2006, through May 31, 2006. Mr. L's period of ineligibility is shortened to end May 31, 2006.

2. Mrs. S transfers \$71,000 on March 2, 2006. Both enter a nursing facility on April 1, 2006, and file an application for nursing facility care in June 2006. A 19-month period of ineligibility is determined ($\$71,000 \div \$3,697.55 = 19.2$, or 19 months + 6 days). The total period of ineligibility is divided between Mr. and Mrs. S ($19 \text{ months} + 6 \text{ days} \div 2 = 9 \text{ months} + 18 \text{ days}$ each).

Since the transfer was made after February 8, 2006, the period of ineligibility begins on the first day that both would otherwise have been eligible for Medicaid payment of their facility care. The partial month of ineligibility is not rounded down. A period of ineligibility is imposed for both Mr. and Mrs. S beginning on March 1, 2006, through December 18, 2006.

Mrs. S passed away on April 3, 2006. One month and 2 days of her period of ineligibility have passed. The remaining 8 months and 16 days of ineligibility are imposed on Mr. S's period of ineligibility and is now extended to September 2, 2007.

Do not put a penalized member in a facility aid type. If the member has been receiving Medicaid under another coverage group, leave the aid type the same as it was before the member person entered the facility. If the person is a Medicaid applicant who is eligible under a coverage group not contingent on living in a medical institution, use the nonfacility aid type for that coverage group.

Code the COPAY field on TD03 to reflect the penalty period. (See instructions in [14-B-Appendix](#).) Put a tickler in the system for the month before the end of the penalty period, and redetermine eligibility at that time.

Multiple Transfers

Transfers Before February 8, 2006

When an applicant or member makes more than one transfer of assets for less than fair market value before February 8, 2006, determine ineligibility as follows:

- ◆ If the penalty periods would not overlap, consider each transfer separately. Drop the partial month of ineligibility and begin each period of ineligibility on the first day of the month when the transfer was made.
- ◆ If the penalty periods would overlap, consider the total uncompensated value as one transfer. Drop the partial month of ineligibility and begin the period of ineligibility on the first day of the month when the first transfer was made.

Transfers on or After February 8, 2006

When there are multiple transfers made on or after February 8, 2006, total all of the transfers made on or after February 8, 2006, and within the 60 months before application. Consider the total uncompensated value as one transfer.

Begin the period of ineligibility in the month of the first transfer or in the month the person would otherwise have been eligible for Medicaid payment of facility care, whichever is later.

- ◆ When the date the applicant or member would otherwise have been eligible for Medicaid facility payment is later than the date the transfer was made, the period of ineligibility begins on the date the applicant or member would have been eligible.
- ◆ When the date the applicant or member would otherwise have been eligible for Medicaid facility payment is earlier than the date the first transfer was made, the period of ineligibility begins on the date the first transfer was made.

1. Mrs. B transfers \$3,000 to her daughter on November 25, 2005, and another \$3,500 to her son on January 11, 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid payment of her nursing facility care on March 9, 2006.

The worker determines that the transfers were made in order to qualify for Medicaid. Since the transfers were made before February 8, 2006, partial months of ineligibility are rounded down. No penalty is imposed because the amounts transferred are less than the statewide average cost of nursing facility services and the penalty is less than one month.

2. Mrs. M gave her granddaughter \$60,000 in January 2005 and another \$60,000 in January 2006. She enters a nursing facility on March 3, 2006, and applies for Medicaid in June 2006.

The penalty period is figured by dividing \$60,000 by \$3,697.55, with a result of 16.23. The 16-month-period of ineligibility for the transfer made in 2005 would overlap the date of the next transfer made in 2006. The transfers were made before February 8, 2006. Total the two transfers and treat them as one transfer.

The penalty period is figured by dividing \$120,000 by \$3697.55, with a result of 32.45. The partial month of ineligibility is rounded down and the period of ineligibility is started on the first day of the month of the first transfer. The period of ineligibility begins on January 1, 2005, and runs through August 31, 2007. Mrs. M can reapply and, if otherwise eligible, be approved effective September 1, 2007.

3. Mrs. D gave her daughter \$6,000 on February 1, 2006, and another \$6,000 in March 2006. Mrs. D entered a nursing facility on March 3, 2006, and applied for Medicaid in June 2006. The worker determined the transfers were made in order to qualify for Medicaid. The first transfer was made before February 8, 2006, and the second one was made after February 8, 2006.

The penalty period for the first transfer is one month. The partial month of ineligibility is rounded down ($\$6,000 \div \$3,697.55 = 1.62$ or 1 month). This period of ineligibility is started on the first day of the month of the transfer (February 2006).

Mrs. D's period of ineligibility for the second transfer is determined to be 1 month and 19 days. It is started on March 3, 2006, and runs through April 20, 2006. If otherwise eligible, Mrs. D can be approved effective April 21, 2006.

4. Mrs. C transfers \$3,000 to her daughter on February 25, 2006. She enters a nursing facility on March 3, 2006. On April 3, 2006, Mrs. C inherits \$3,500 and transfers it to her son. On June 10, 2006, she applies for Medicaid payment of her nursing facility care.

The worker determines that the transfers were made in order to qualify for Medicaid. Since the transfers were made after February 8, 2006, the worker totals the two transfers and treats them as one transfer.

The penalty period is figured by dividing the total of \$6,500 by \$3,697.55, with a result of 1.76 months or 1 month and 23 days. If there were no penalty for transferring her assets, Mrs. C would have been eligible for Medicaid payment of her facility care effective March 3, 2006.

Since the date the first transfer was made is earlier than the date she would otherwise have been eligible, Mrs. C's period of ineligibility begins on March 3, 2006 (the day she would have been eligible). The penalty period lasts through April 25, 2006. If Mrs. C is otherwise eligible, she can be approved effective April 26, 2006.

Return of the Transferred Asset

Legal reference: 42 USC 1396p(c)(2)(c)

If the transferred asset is returned, there is a change in the period that the uncompensated value of the asset affects eligibility. If the asset is returned in its entirety, the transfer penalty is expunged as of the first moment of the first day of the month after the return.

If the asset is partly returned, there will be no adjustment in the transfer penalty period.

The increase or decrease in value of the property transferred that may have occurred due to inflation or deflation from the time of transfer to the time of return does not affect the length of the period of ineligibility.

Changing the disqualification period does not necessarily establish eligibility.

Assets returned are not considered income, but are a countable resource if retained in the month following the month they were returned. Remember to report any returned assets to DIA if a claim has been filed.

Claim Against a Person Who Receives Transferred Assets

Legal reference: 441 IAC 89.1(249F), 89.2(1), 89.3(249F), 89.4(249A)

The Department may file a claim against a person who received transferred assets. When an applicant or a member transfers assets for less than fair market value a claim may be filed against the person who received the transferred assets, when the following occurs:

- ◆ A transfer was within 60 months of application or while on Medicaid, and
- ◆ There is intent on the part of the person who received the assets to gain Medicaid eligibility for the applicant or member who transferred the asset.

NOTE: The claim is for reimbursement for all Medicaid services paid on behalf of the member (transferor) but not greater than the uncompensated value of the assets transferred.

Establish a claim if the asset transfer for less than fair market value was made:

- ◆ While the person who transferred the asset is receiving Medicaid or within 60 months before an application for Medicaid, and
- ◆ With the intent, on the part of the person who received the asset and the person making the transfer, of enabling the person making the transfer to obtain or maintain eligibility for Medicaid. A transfer is presumed to be for the purpose of obtaining Medicaid eligibility unless clear and convincing evidence is provided showing that Medicaid was not part of the reason for accepting the transferred assets.

This policy does **not** affect an applicant's or a member's Medicaid eligibility, **nor** is it related to the Estate Recovery Program.

Estate recovery is separate and should be determined separately. However, if the member is now deceased, it is helpful to let the Department of Inspections and Appeals (DIA) know that, so that DIA is aware that the estate recovery unit will be involved. It is also helpful to let the estate recovery contractor know that a DIA referral for transfer of assets has been made.

Do not establish a claim if the transfer involved:

- ◆ Assets (other than a homestead) that would have been exempt from consideration if the Medicaid applicant or member had retained them.
- ◆ Resources transferred for the sole benefit of a spouse.
- ◆ Resources transferred for the sole benefit of a disabled or blind child.
- ◆ A dwelling that serves as the home for one of the following:
 - A child under age 21.
 - A son or daughter who was residing in the dwelling for a period of at least two years immediately before the date the applicant or member was institutionalized and who provided care that kept the parent from earlier admission to the nursing facility.
 - A sibling who has equity interest in the home and was residing in the dwelling for a period of at least one year immediately before the applicant or member entered the medical institution.
- ◆ Transfer to a trust established solely for the benefit of a person under 65 years of age who is disabled, as defined by the Social Security Administration.

The following table shows the exemptions in place on or after July 1, 2000. When the table indicates that a transfer made during the stated period was an exempt transfer, a DIA referral is not appropriate.

Asset Transferred	On or After July 1, 2000
Transfer of a homestead	Yes, DIA referral is appropriate unless the transfer meets one of the other exemptions.
Resources transferred for the sole benefit of a child	Yes, DIA referral is appropriate, unless the transfer meets one of the other exemptions.
Transfer of a dwelling that serves as the home to the spouse	DIA referral is not appropriate.
Transfer of a dwelling that serves as the home to the disabled child	DIA referral is not appropriate.
Transfers to a trust solely for the benefit of the person's child who is blind or disabled as defined by the Social Security Administration	DIA referral is not appropriate.
Transfers of less than \$2,000	DIA referral is not appropriate when less than \$2,000 was transferred in the five years before application.

Establishing a Claim

Legal reference: 441 IAC 89.3(249F)

To establish a claim against a person who has received transferred assets for less than fair market value:

1. List all items transferred for less than fair market value after July 1, 1993, and within the 60 months before a Medicaid application was filed.
2. Review the exemptions listed in the previous section, based on the date of the transfer, to check if the transferred items are exempt.
3. Determine the uncompensated value of all countable assets transferred for less than the fair market value. Uncompensated value is the equity value of the asset minus the amount that was received for the asset. The uncompensated value cannot exceed the amount that would have been counted toward the income or resource limit if the asset had been retained.
4. Complete form 470-3159, *DIA Referral for Transfer of Assets*, for all countable assets transferred for less than fair market value.
5. Send form 470-3159 as instructed in the forms appendix. Send all other written requests for information, conferences, or hearings, to the Department of Inspections and Appeals (DIA) within five working days of receipt.

1. Mr. W applies for Medicaid in a nursing facility on June 26, 2000. Mr. W transferred \$160,500 to his son on May 11, 1999. The worker determines that the transfer is not exempt and that the transfer was made with the intent to qualify for Medicaid.

Mr. W is ineligible for nursing facility care for 60 months from the date of the transfer (\$160,500 divided by \$2,673). His period of ineligibility is May 1, 1999, through April 30, 2004. Mr. W is approved for other Medicaid services under a non-facility aid type. Because the transfer is not exempt, the worker prepares form 470-3159, and sends it to DIA for further action.

2. Mrs. M files an application for nursing facility care on May 30, 1998. Mrs. M has transferred the following assets for the purpose of qualifying for Medicaid:

- \$ 8,000 to her daughter on Oct. 2, 1997
- \$25,000 a non-homestead farm property to her son on Dec. 1, 1997
- \$25,000 to her niece on Jan. 5, 1998
- \$15,000 to another daughter on April 10, 1998

The worker determines the period of ineligibility for Medicaid payment to the nursing facility. Mrs. M's period of ineligibility is 30 months. The period of ineligibility is October 1, 1997, through April 30, 2000.

Because the transfer is not exempt, the worker prepares form 470-3159 for all transfers and sends the form to DIA.

3. Ms. Z transfers \$10,000 to her daughter on April 11, 1994. Ms. Z establishes an irrevocable trust of \$150,000 on April 30, 1994. Both transfers are for the purpose of qualifying for Medicaid.

Ms. Z applies for Medicaid nursing facility payment in December 1996. The worker determines the period of ineligibility for Medicaid payment for certain services by dividing the transfers by the statewide average private pay rate.

The worker also establishes a referral and sends form 470-3159 to DIA.

4. Mrs. Q files an application for FMAP-related Medicaid. Five months previously, she transferred \$10,000 to her mother with the purpose of qualifying for Medicaid. The four-month period of ineligibility for this transfer has expired. The worker establishes a referral and sends form 470-3159 to DIA.

Trusts

Legal reference: 441 IAC 75.23(8), 20 CFR 416.1201

Treatment of resources in a trust depends on:

- ◆ When the trust was established.
- ◆ Whether the trust was established with the member's assets or with someone else's assets.
- ◆ What use of the trust income and principal is allowed by the terms of the trust.
- ◆ The member's role in relation to the trust.
- ◆ Whether the trust is revocable or irrevocable.
- ◆ The coverage group under which eligibility is being explored or established when a child is the grantor or beneficiary of the trust. (See [Resource Eligibility of Children](#) later in this chapter, and 8-F, [COVERAGE GROUPS](#), for more information.)

A person is considered to have "established" a trust if:

- ◆ The person's assets were used to form all or part of the principal of the trust, **and**
- ◆ The trust was set up by any of the following:
 - That person,
 - That person's spouse, or
 - A person, court, or administrative body with legal authority to act in place of, on behalf of, at the direction of, or upon the request of that person or that person's spouse.

"Assets" means all income and resources of the person and the person's spouse. This includes any income or resources that the person or the person's spouse is entitled to but does not receive, because of action taken by:

- ◆ The person or the person's spouse.
- ◆ Another person, court, or administrative body acting at the direction or upon the request of the person or the person's spouse.
- ◆ Another person, court or administrative body with legal authority to act in place of or on behalf of the person or the person's spouse.

Trusts established with assets not owned by the beneficiary include testamentary trusts (established by a will) and inter vivos trusts (established by one living person to another).

Policy on trusts is organized as follows:

- ◆ [Definitions of the basic terms used in describing trusts.](#)
- ◆ [How to evaluate a trust, depending on a client's roles in relation to the trust.](#)
- ◆ [Treatment of assets in a trust, including a comparison the major kinds of trusts.](#)
- ◆ [More information on specific kinds of trusts.](#)

Trusts established with assets owned by the beneficiary are treated differently depending on whether they are revocable or irrevocable and whether they were established after August 10, 1993. Irrevocable trusts established on or before August 10, 1993, are known as "Medicaid qualifying trusts."

Certain kinds of irrevocable trusts established after August 10, 1993, provide that the assets go to reimburse the state for the member's Medicaid expenses after the member's death. Trusts that are subject to different treatment because of these provisions are:

- ◆ [Medical assistance income \(Miller\) trusts.](#)
- ◆ [Special needs trusts for persons under 65.](#)
- ◆ [Special needs trusts with no age limit.](#)

Trust Definitions

A **trust** is an arrangement whereby one or more persons (the trustees) hold property for the benefit of one or more others (the beneficiaries). Trusts include two types of assets:

- ◆ **Trust principal** is the property placed in trust by the grantor that the trustee holds, subject to the rights of the beneficiary, plus any trust earnings paid into the trust and left to accumulate the month following the month of receipt.
- ◆ **Trust earnings or income** are amounts earned by trust principal, such as interest, dividends, royalties, or rents. These amounts are unearned income to the beneficiary if the beneficiary is legally able to use them for personal support and maintenance.

A trust can be established by a written document, including a will. A trust can also be established by a verbal understanding between the grantor and the trustee when the property has been transferred to the trustee.

No court involvement is necessary to establish a trust. The grantor and the beneficiary can be the same person, and the grantor can be the trustee, but the trustee and the beneficiary cannot be identical. If the trustee and the beneficiary are identical, the trustee/beneficiary owns the property outright.

NOTE: The trustee and the beneficiary are not identical if the state is a residuary beneficiary. The trustee and the life-time beneficiary may be the same person on a qualifying special needs or Miller trust where the state is a residuary beneficiary.

A **grantor** is a person who sets up a trust. A person may be a grantor if an agent or someone legally empowered to act on behalf of the person or the person's spouse (such as a legal guardian, representative payee, person acting under a power of attorney, or conservator) establishes the trust with the person's funds or property. The terms grantor, trustor, and settlor may be used interchangeably.

A **trustee** is a person or entity who holds legal title to property for the use or benefit of another person. In most instances, the trustee has no legal right to revoke the trust or use the property for the trustee's own benefit. However, if the member is a trustee and has the legal ability to revoke the trust and use the money for the member's own benefit, the trust is a resource to the member.

A **beneficiary** is a person who benefits from the principal or income. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it. A trust may have more than one beneficiary.

A **residual or residuary beneficiary** benefits from the income and principal after the primary beneficiary is no longer involved, for example, due to the death of the primary beneficiary. The residuary beneficiary receives no benefit from the trust until certain conditions are met.

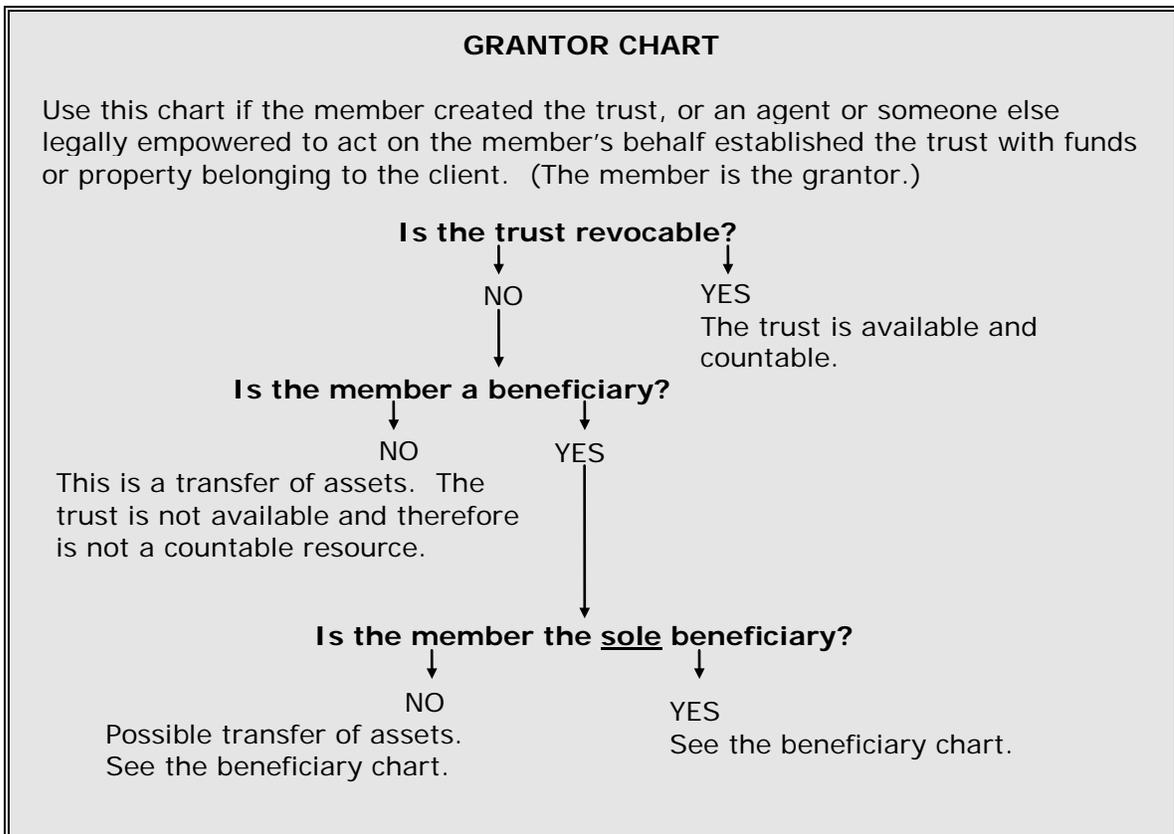
A **Totten trust** is a tentative trust in which a grantor makes himself or herself trustee of the grantor's own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Therefore, consider the principal and income of a Totten trust available to the member. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

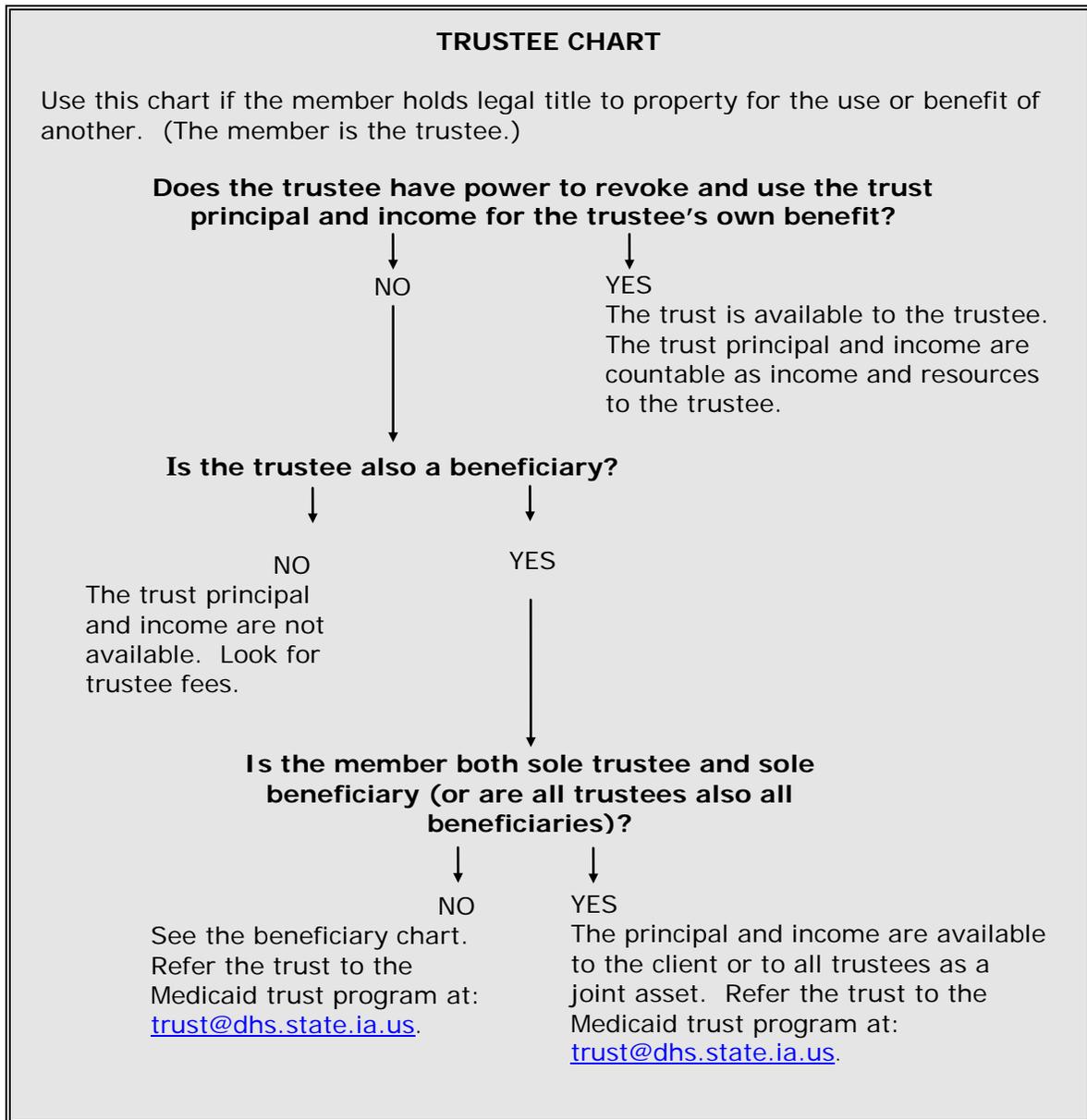
A **conservatorship** is similar to a trust. A conservatorship is always established by a court, which explicitly appoints a conservator to act on the ward's behalf for the ward's financial affairs. Treat a conservatorship established on or after February 9, 1994, as a trust. See [Revocable Trusts](#) and [Irrevocable Trusts](#) to determine availability and whether transfer of asset policies apply.

Evaluating a Trust

The following charts provide a guide to understanding trusts. Use the appropriate chart depending on whether the member is the grantor, the trustee, or the beneficiary. The member may occupy more than one role.

1. Mr. J is the grantor and also the beneficiary of a trust. Use the grantor and the beneficiary trust charts to determine availability and accessibility of the trust principal and income when determining Medicaid eligibility.
2. Mr. D is the grantor and trustee of a trust that names his niece as the beneficiary. Use the grantor and trustee charts to determine the availability of the trust principal and income when determining Mr. D's Medicaid eligibility.
3. Ms. M is the beneficiary of a trust. Use the beneficiary chart to determine the availability of the trust principal and income when determining her eligibility.





	Testamentary and Inter Vivos Trusts	Medicaid Qualifying Trust (set up before 8/10/93)	Irrevocable Trust (set up after 8/10/93)	Revocable Trust (set up after 8/10/93)
Established by:	Someone other than the member is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.	Member or someone acting on member's behalf is the grantor of the trust.
Established with:	Funds not owned by the beneficiary before trust was established.	Funds owned by the grantor or funds that the grantor is entitled to.	Funds owned by the grantor or funds that the grantor is entitled to.	Funds owned by the grantor or funds that the grantor is entitled to.
Availability of principal and income	<p>Discretionary: Principal and income are not necessarily available to the beneficiary.</p> <p>Principal and income available to the beneficiary for basic needs is countable as resources and income when determining eligibility, client participation, and spenddown.</p> <p>Principal and income available for nonbasic needs only are not countable as resources and income.</p>	<p>Discretionary: The maximum amount that may be made available by the trustee under the terms of the trust, assuming the trustee exercises full discretion in the distribution of the income and principal is countable in determining eligibility, client participation, and spenddown.</p> <p>See Transfer of Assets for any principal or income not available to the grantor.</p>	<p>The principal and income are considered available and countable to the extent they could be made available, under any circumstances or for any purpose, according to the terms of the trust.</p> <p>See Transfer of Assets for any principal or income not available to the grantor.</p>	<p>Principal and income are available and countable to the beneficiary when determining eligibility, client participation, and spenddown.</p> <p>See Transfer of Assets Any payments from the trust not for the benefit of the client are assets transferred for less than fair market value.</p>

	Testamentary and Inter Vivos Trusts	Medicaid Qualifying Trust (set up before 8/10/93)	Irrevocable Trust (set up after 8/10/93)	Revocable Trust (set up after 8/10/93)
Use in Medicaid and State Supplementary Assistance	Count amounts available according to the terms of the trust.	Amounts that count toward FIP, SSI, or SSA cash payments are not used in determining Medicaid eligibility.	Any available principal or income counts toward resource limits. If not available, see transfer of asset policy.	Count principle and income as available.

Procedure:

Refer trusts and conservatorships to the Medicaid Trust Program when:

You need help understanding the terms of the trust;

- ◆ An inaccessible trust is held by an active member;
- ◆ The trustee is not abiding by the terms of the trust; or
- ◆ The trustee has the authority to use the principal of the trust for medical expenses but has not done so. This is a third-party liability referral.

Make the referral for initial review by sending form 470-0116, *Clarification Request*, to trust@dhs.state.ia.us. (See [1-B-Appendix](#) for form instructions.)

In the clarification request:

- ◆ Identify the client by name, social security number, date of birth and state identification number. (This information is essential because program staff do not have access to the ABC system, Online Narrative, or electronic case files.)
- ◆ Indicate what program the client is applying for or is eligible under.
- ◆ Indicate whether this referral concerns a trust for third-party liability for medical expenses.
- ◆ Include the email address for the scanning center that handles your service area.
- ◆ Attach a copy of the legal document or trust agreement to the request.

Trust Program staff will first review each submitted document to determine whether it is a “pay-back” trust (defined as a special needs trust, an income trust, or a pooled trust).

- ◆ Trusts that are not “pay-back” trusts are returned to the Bureau of Financial, Health, and Work Supports for review. (See procedures below.)
- ◆ “Pay-back” trusts are kept for review by trust program staff. Of these, income trusts will be the priority for review.

Review procedure for income trusts:

1. The Trust Program will:
 - ◆ Determine whether the document meets the criteria for a medical assistance income trust; and
 - ◆ Send a response indicating whether the trust was approved or denied directly to the scanning center indicated on the *Clarification Request*. (If the request does not contain a case number, the response will be emailed to the requesting worker.)
2. When the trust is **approved**, the worker issues form 470-4488, *Medical Assistance Income Trust*, to the client or the payee.
3. When the trust is **denied**, the Trust Program will:
 - ◆ Prepare a checklist indicating why the trust does not meet the criteria; and
 - ◆ Email the checklist to the scanning center indicated on the *Clarification Request*, where it will be received in the electronic case file process list.

Review procedure for other “pay-back” trusts:

When the trust has been **approved**:

1. The Trust Program will:
 - ◆ Forward the request to the Bureau of Financial, Health, and Work Supports for eligibility review; and
 - ◆ Email a status update to alert the worker that the trust is now at central office.

2. The worker should make a note in the on-line narrative in case another worker has questions.
3. Bureau staff will:
 - ◆ Review the trust for eligibility;
 - ◆ Respond to the *Clarification Request* indicating how the trust will affect eligibility; and
 - ◆ Send the response to the scanning center indicated on the *Clarification Request*, where it will be received in the electronic case file process list.

When the trust has been **denied**, the Trust Program will:

1. Send a letter to the attorney or trustee explaining that the trust does not meet the criteria for a medical assistance trust; and
2. Email a copy of the letter to the scanning center indicated on the *Clarification Request*, where it will be received in the electronic case file process list. (If the request does not contain a case number, the response will be emailed to the requesting worker.)

Review procedure for non-“pay-back” trusts:

1. The Trust Program will:
 - ◆ Forward the request to the Bureau of Financial, Health, and Work Supports for review; and
 - ◆ Email a status update to alert the worker that the trust is now at central office.
2. The worker should make a note in the on-line narrative in case another worker has questions.
3. Bureau staff will:
 - ◆ Review the trust for eligibility;
 - ◆ Respond to the *Clarification Request* indicating how the trust will affect eligibility; and
 - ◆ Send the response to the scanning center indicated on the *Clarification Request*, where it will be received in the electronic case file process list.

Trusts Established With Assets Not Owned by Beneficiary

Legal reference: 441 IAC 75.13(2), P. L. 99-272, P. L. 99-500

If the applicant or member is the beneficiary but not the grantor of a trust, Medicaid eligibility is determined by the terms of the trust. These trusts may be testamentary trusts or inter vivos trusts.

Examine the terms of the trust to determine if it is countable. Under both SSI and FMAP-related policy, income and resources **are** available to an applicant or member who is the beneficiary as follows:

- ◆ Trust principal and income are countable resources and income to the beneficiary when the terms of the trust **require the trustee** to pay or to make available to the beneficiary trust principal and income for the beneficiary's basic needs.
- ◆ Trust principal and income are countable income, but not a countable resource, to the beneficiary when the terms of the trust allow the trustee to make income or principal available to the beneficiary for basic needs, and the trustee makes either trust principal or income available to the beneficiary for basic needs.
- ◆ Trust principal and income are countable resources and income to the beneficiary when the terms of the trust **allow the beneficiary** to withdraw trust principal and income for basic needs.

Income and resources are **not** available to the beneficiary under both SSI-related and FMAP-related policy if:

- ◆ The terms of the trust **prohibit** the trustee from making either trust principal or income available for the beneficiary's basic needs.
- ◆ The terms of the trust allow the trustee, at the trustee's discretion, to make income or principal available to the beneficiary for basic needs, but the trustee does not make either income or resources available for basic needs.

In both cases, any payments from either trust principal or trust income that are made to the applicant or member or made for the applicant's or member's basic needs are countable income in the period of intended use and a resource thereafter. If payments are made to vendors for basic needs, see policies in [8-E](#), SSI-RELATED IN-KIND INCOME or In-Kind Unearned Income.

Medicaid Qualifying Trusts

Legal reference: 441 IAC 75.9(249A), P. L. 99-272, P. L. 99-509, section 9435(c)

A Medicaid qualifying trust is a trust or similar legal device which:

- ◆ Was established on or before August 10, 1993.
- ◆ Is not established by a last will and testament.
- ◆ Is established by an applicant or member, the applicant's or member's spouse, or someone acting for them.
- ◆ Is established from funds belonging to the applicant or member or the spouse.
- ◆ Allows or names the applicant or member to be the beneficiary of payments from the trust.
- ◆ Has one or more trustees determine the distribution of payments.
- ◆ Permits the trustees to exercise discretion with respect to the distribution of trust principal and income to the beneficiary.

When someone with power of attorney, a conservator, a guardian, a lawyer, or a court acts on behalf of the applicant or member to set up the trust, treat it as though the applicant or member set up the trust.

The amount of income and principal from a Medicaid qualifying trust that is considered available is the maximum amount that may be permitted under the terms of the trust, assuming the trustees exercise full discretion in the distribution of the income and principal.

EXCEPTION: Trusts or initial trust decrees established before April 7, 1986, solely for the benefit of a person with an intellectual disability who lives in an intermediate care facility for persons with an intellectual disability are exempt.

Evaluate an irrevocable trust established on or before August 10, 1993, under this policy. The terms of the trust that specify the available income and principal determine the amount counted as available to the applicant or member, regardless of whether any payments are actually being made. Treat a trust established for medical payments as a third-party resource.

1. Miss T established a trust in July 1985 as the result of a settlement of a malpractice suit. Since she has an intellectual disability and lives in an intermediate care facility for persons with an intellectual disability (ICF/ID), and since the trust was established before April 7, 1986, this is not a Medicaid qualifying trust.

2. Mr. D established a trust for himself and his wife in 1972. Mrs. D applies for Medicaid and she is a co-beneficiary of the trust. This is a Medicaid qualifying trust.

A trust established by the last will and testament of a spouse is not a Medicaid qualifying trust. Trusts set up with funds not owned by the member or spouse are not Medicaid qualifying trusts. Burial trusts set up by a member or spouse, are not Medicaid qualifying trusts when the funds are available only upon death, and the member is not the beneficiary of the trust.

Trusts set up by charity or a fund-raising activity are not Medicaid qualifying trusts unless the money is given to the member, who then creates the trust. NOTE: If the charity or fund-raising present the proceeds to the person and the receiver sets up a trust on or before August 10, 1993, this is a Medicaid qualifying trust.

Counting Income or Resources

Legal reference: 441 IAC 75.9(2)

Consider trust income available as specified by the terms of the trust, even if the trustees do not actually pay the income according to the terms of the trust.

Count trust principal (including accumulated income) available to the member as a resource.

EXCEPTION: If the terms of the trust explicitly limit the amount of principal that is made available on an annual (or specified less frequent) basis, the principal is countable income beginning the month it becomes available. Prorate it for the period of accessibility and intended use.

Trust principal and income available for daily living expenses (food, clothing or shelter), including things not thought of as essential to daily living, are countable as resources and income.

Income and principal available only for non-basic-needs vendor payments are considered not available as income to the client when determining eligibility.

Trusts established for medical payments are a third-party resource. Do not count trust principal and income if the terms of the trust specify that they are available only for medical care. The principal and income for these trusts are not countable as income and resources in determining eligibility.

For trust established for educational benefits, deduct the expenses of education depending on what the related FIP or SSI standards allow. If the trust is to be used for education but is totally available at any time, count the trust as a resource.

To establish eligibility for FIP, SSI, or State Supplementary Assistance, use the countable income from the trust according to the related policy. Then apply the income from the Medicaid qualifying trust and other income of a FIP or FMAP-related member, exclusive of FIP, SSI, or State Supplementary Assistance, to the FIP Schedule of Basic Needs for the family group.

Trust income and principal already counted toward FIP, SSI, or State Supplementary Assistance eligibility are not counted a second time for determining Medicaid eligibility. However, if the person is ineligible for FIP and is eligible for Medicaid, then the income is countable according to the FMAP- or SSI-related policy.

To establish eligibility for an SSI-related Medicaid person, add together the income from the Medicaid qualifying trust and other income, exclusive of FIP, SSI, or State Supplementary Assistance, and compare the total income to the limit for the number of people in the SSI-related Medicaid case.

Once the resources of the person are compared to FIP, SSI, or State Supplementary Assistance standards, count the principal of the trust as a resource for Medicaid to the fullest extent allowed by the trust, unless the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis.

Compare the total countable resources, including the amount from the trust, to the resource limit of the coverage group under which the applicant seeks assistance.

Determining Eligibility

Legal reference: 441 IAC 76.11(249A)

When the applicant who has a Medicaid qualifying trust is applying for a money payment (FIP, SSI or SSA benefits) determine financial assistance first. (This determination may involve income or resources from the trust.) The applicant may be eligible for FIP, SSI, or State Supplementary Assistance but be ineligible for Medicaid.

After the financial assistance is determined, add the income and resources from the Medicaid qualifying trust that were **not** used in the determination of the financial assistance amount to other income and resources for determining Medicaid eligibility.

If the income or resources exceed Medicaid limits, deny Medicaid even when the applicant receives FIP, SSI, or State Supplementary Assistance.

If the applicant is ineligible by counting income and resources of a Medicaid qualifying trust according to the policies of the coverage group, determine whether the applicant is eligible under any other coverage group.

If the required filing unit is eligible for FMAP-related Medicaid, and a sibling or child in the filing unit has a Medicaid qualifying trust that makes the family ineligible for Medicaid, the filing unit may exclude the sibling or child. However, an excluded person is ineligible for all Medicaid coverage groups.

1. Ms. P receives SSI. She has a Medicaid qualifying trust that provides for "care and keep." Any of the principal of \$12,000 can be used to meet her living expenses, but no money is currently provided for her.

\$12,000 is added to Ms. P's other countable resources. Ms. P is not eligible for Medicaid since \$12,000 is greater than any resource limit.

2. Ms. W, a CMAP applicant, has a Medicaid qualifying trust set up as the result of a malpractice suit. The trust pays only for medical care. There is \$100,000 in the trust. Since the trust provides for medical care only, it is not a resource. It is a third party medical resource.

Ms. W is evaluated for resources based on her other resources of \$500. She is income- and resource-eligible for Medicaid, based on the CMAP coverage group. The worker prepares and sends a memo to TPL stating the basic trust provisions and the name and address of the trustees.

3. Mr. N, a 503 applicant, has a Medicaid qualifying trust that provides payments of \$100 a month from trust income. No principal can be used. The trustee has not made the income available.

The worker determines whether Mr. N would qualify for SSI by adding all income together, including the \$100 a month, and disregarding his COLAs. His social security income at time of cancellation was \$230. He has no other income. $\$230 + \$100 - \$20 = \310 . He is eligible under the 503 group.

4. Mr. O is living in a nursing facility. He applies for SSI-related Medicaid on May 6, 1993. His gross social security and VA income is \$965.30 monthly. He has \$1,700 in savings and checking accounts as of April 30, 1993, at midnight.

He also has a trust that he set up when he went into the nursing facility in May 1990. The trust was set up four years ago, so divesting is not considered. According to the trust, money is available if he needs it, but he can have no more than one-third of the principal of the trust each year.

The trustee verifies the principal as of the first of the year to be \$99,000. Mr. O has used \$1,000 of the trust this year.

His resource from the trust is: $\$99,000 \text{ divided by } 3 = \$33,000$ that can be withdrawn minus \$1,000 used = \$32,000 remainder.

Therefore \$32,000 plus his other resources of \$1,700 is counted toward the resource limit. He is not eligible.

5. Mr. and Mrs. C and their children are eligible for FIP. Mrs. C has a Medicaid qualifying trust.

Trust income is not counted for FIP, as the trust is discretionary and nothing is paid to Mrs. C. The income that could be paid at the discretion of the trustee is \$200 per month. The \$200 that would be paid is countable for FMAP-related Medicaid programs.

6. Ms. J, an SSI recipient in a residential care facility, has a Medicaid qualifying trust for educational benefits that she set up with inheritance funds. Each year she receives \$2,500 for tuition, books, and living expenses.

Since SSI policy provides that the income for living expenses counts for eligibility and is included as income for SSI, there is no more income to count for the Medicaid qualifying trust.

Also since the only amount available from the trust is for education, the trust is not count as a resource.

7. Mr. E applies for Medically Needy. His income is \$200 Veteran's Assistance and \$350 Social Security. He also has a Medicaid qualifying trust with income of \$240 monthly for "other expenses."

His income is:

\$ 350.00	Social Security Income
200.00	Veterans Assistance
+ <u>240.00</u>	Trust income
\$ 790.00	Monthly countable income
- <u>20.00</u>	General disregard
\$ 770.00	Monthly net countable income for Medically Needy

Code people who are ineligible for Medicaid due to a Medicaid qualifying trust as denied (or canceled if the only program for which the person applied is Medicaid). NOTE: This also applies to SSI recipients. If the person or group is denied Medicaid but receives State Supplementary Assistance grant, use the fund code of 7.

Client Participation

Legal reference: 441 IAC 75.5(9)

Consider all income, including countable income from the Medicaid qualifying trust, as available when determining client participation in a medical institution, unless the income is expressly exempt income, as listed in [8-E](#).

Mrs. P, an NF resident, has social security income of \$245. She also has civil service income of \$310. She has a Medicaid qualifying trust that could pay \$120 a month for expenses if she needed the money.

Eligibility for Medicaid is determined as follows:

\$ 120.00	Trust income
245.00	Social Security Income
+ <u>310.00</u>	Civil Service income
\$ 675.00	To compare to the 300% income limit (Medicaid cap)

Her income used to determine client participation is \$675.00.

Trusts Established After August 10, 1993

When the client or someone acting on the client's behalf created a trust using the client's assets after August 10, 1993, determine whether the client is a beneficiary of the trust. If the client is not a beneficiary, investigate the trust as a transfer of assets.

If the client is a beneficiary, treatment of the trust depends on whether the trust is revocable or irrevocable. Three special kinds of irrevocable trusts (Miller trusts and two special needs trusts) also receive different treatment.

Revocable Trusts

Legal reference: 441 IAC 75.24(2)"a"

When an applicant or member establishes a revocable trust established after August 10, 1993, the **principal** of the trust is an available **resource**.

Payments from the trust to or for the benefit of the applicant or member (as beneficiary) are countable **income** to the applicant or member in the period of intended use when determining income eligibility for Medicaid.

Any payments from the trust other than those made to or for the benefit of the applicant or member (beneficiary) are assets transferred for less than fair market value.

Irrevocable Trusts

Legal reference: 441 IAC 75.24(2)"b"

If the applicant or member or that person's spouse establishes an irrevocable trust after August 10, 1993, which names the applicant or member as a beneficiary, determine what payments are allowed from the trust.

If payment could be made to or for the benefit of the applicant or member (as beneficiary) for any purpose, count the portion of the **principal** from which that payment could be made as a **resource**. Also count any income earned on the principal from which payment could be made.

Payments from the trust principal or income to or for the benefit of the applicant or member (beneficiary) are countable **income** in the period of intended use and a countable resource the following month.

Payments from trust principal or income for any other purpose are a transfer of assets for less than fair market value. Determine the period of ineligibility according to [Penalties for Transferring Assets](#).

Any portion of the trust or any income on the principal from which no payment could be made to the applicant or member (beneficiary) under any circumstances is a transfer of assets for less than fair market value. The transfer occurred on the later of the date the trust was established or the date on which payment to the beneficiary was no longer available.

Determine the value of the transfer by including the amount of any payments made from the trust after the date of foreclosure. Determine a period of ineligibility according to [Penalties for Transferring Assets](#).

Payments made on behalf of the beneficiary are countable income in the month the payment is made despite the purpose of the payment. FIP and SSI rules do not apply to irrevocable trusts established with an applicant's or a member's own assets after August 10, 1993.

Special Needs Trust for Persons Under 65 Years Old

Legal reference: 441 IAC 75.24(3)"a," Iowa Code 633C.1, 633C.2

A special needs trust for persons under 65 years old must meet the following conditions:

- ◆ The trust is an irrevocable trust.
- ◆ The trust is established after August 10, 1993.
- ◆ The trust is created with the assets of a person who is under the age of 65 and is disabled as defined by the Social Security Administration.
- ◆ The trust is established for the benefit of the beneficiary by a parent, grandparent, legal guardian of the beneficiary, or a court.
- ◆ The trust provides that the state of Iowa will receive all amounts remaining in the trust upon the death of the beneficiary, up to an amount equal to the total Medicaid paid on behalf of the beneficiary.

When the Social Security Administration or the Railroad Retirement Board has not determined a person disabled, the Department must determine disability for this policy to apply. Send a referral to the Disability Determination Services Bureau. See [8-C, When the Department Determines Disability](#).

The principal of a special needs trust is not a countable resource. Income paid into the trust is not countable. Count only the income paid from the trust or made available to the member as income. Payments from the trust follow the same rules as described in [8-E, Medical Assistance Income Trusts \(Miller-Type Trust\)](#).

When a member with a special needs trust reaches age 65, the trust retains its exempt status. However, any additions to the trust after the member reaches age 65 (other than those generated by the preexisting trust assets) are countable assets. Also:

- ◆ The income generated by any such additions is countable income.
- ◆ These additions will be considered a transfer of assets for less than fair market value.

When a member with a special needs trust dies, include information about the trust in the ABC system referral to the Estate Recovery Unit

Medical Assistance Income Trust (Miller Trust)

Legal reference: 441 IAC 75.24(3)“b,” Iowa Code 633C.1, 633C.3

A medical assistance income trust, or Miller trust, must meet the following conditions:

- ◆ The trust is an irrevocable trust established after August 10, 1993.
- ◆ Only the beneficiary's earned and unearned income is deposited into the trust.
- ◆ The state will receive the remaining balance in the trust upon the death of the beneficiary, up to the amount Medicaid paid out for the beneficiary.
- ◆ The trust may be irrevocable or revocable, if a clause is added that upon revocation or termination, the trust and income will be paid back to the state up to the amount of medical assistance paid on behalf of the beneficiary.

The principal of medical assistance income trust is not a countable resource. Determine available income as directed in [8-I, Members With a Medical Assistance Income Trust](#), and [8-E, Medical Assistance Income Trusts \(Miller-Type Trust\)](#).

When a member with a medical assistance trust dies, include information about the trust in the ABC system referral to the Estate Recovery Unit.

Special Needs Trust (Pooled Trust)

Legal reference: 441 IAC 75.24(3)“c,” Iowa Code 633C.1, 633C.2

A special needs trust or pooled trust for persons under 65 years of age is a trust that meets the following conditions:

- ◆ The trust is established after August 10, 1993, and provides that the state will receive the remainder of the trust principal and income upon the death of the beneficiary.
- ◆ The trust contains the assets of a person who is disabled as defined by Social Security Administration.
- ◆ The trust is established and managed by a nonprofit association.
- ◆ The association maintains a separate account for each beneficiary of the trust, but pools these accounts for purposes of investment and management of funds.
- ◆ Accounts in the trust are established solely for the benefit of people who are disabled (as defined by Social Security Administration).
- ◆ Accounts are established by the parent, grandparent, or legal guardian of the beneficiary or by a court.
- ◆ Upon death of the beneficiary, all amounts remaining in the beneficiary's account not retained by the trust are paid to the state of Iowa up to the amount of medical assistance paid on behalf of the beneficiary.

For this policy to apply to a person who has not been determined disabled by the Social Security Administration, the Department must determine disability. See [8-C, When the Department Determines Disability](#).

When a trust qualifies as a special needs trust, count the principal and income as available according to the terms of the trust.

| Any additions made to the trust after the trust beneficiary reaches age 65 will be considered a transfer of assets for less than fair market value.

When a member with a special needs trust dies, include information about the trust in the ABC system referral to the Estate Recovery Unit.

Resource Eligibility of Children

Legal reference: 441 IAC 75.1(7)"a"(4), 75.1(7)"b," 75.1(14)"a," 75.1(15)"a," 75.1(17), 75.1(28)"b," 75.1(35)"a"(2), 75.1(35)"a"(3), 75.1(35)"b"(1), 75.1(35)"c"(3), 75.13(2), 75.13(3), 75.56(1), 83.2(1)"c"

Disregard the resources of all household members when determining eligibility for children in certain coverage groups. Continue to count resources when determining eligibility for children in all other coverage groups according to the policies in this chapter.

The age limit for determining if a person is a child or an adult is the age limit for the coverage group under which Medicaid is being received or under which eligibility is being explored or established. See 8-F, [COVERAGE GROUPS](#), for more information.

The following chart lists all coverage groups under which children can establish eligibility and whether household resources are disregarded or counted in determining children's eligibility.

Coverage Group Name	Are Resources An Eligibility Factor For Children?
Family Medical Assistance Program (FMAP)	No
Transitional Medicaid TM	NA. Resources are not an eligibility factor for children or adults
Extended Medicaid due to receipt of support	No
Child Medical Assistance Program (CMAP)	No
Mothers and Children (MAC)	No
Ineligible for FMAP due to residence in a medical institution	No
Iowa Family Planning Network	No. Resources are not an eligibility factor for children or adults.
SSI recipients in their own homes and recipients of mandatory supplements	Yes

Coverage Group Name (Cont.)	Are Resources An Eligibility Factor For Children? (Cont.)
SSI recipients in medical institutions	Yes
People eligible for SSI benefits but not receiving them	No
Essential persons	Not applicable. A child cannot be an essential person.
Ineligible for SSI or SSA due to requirements that do not apply to Medicaid	Yes
Ineligible for SSI or SSA due to Social Security COLAs (503 medical only)	Yes
Ineligible for SSI or SSA due to Social Security benefits paid from a parent's account	Yes
Ineligible for SSI or SSA due to Social Security increase of October 1972	Yes
Ineligible for SSI due to substantial gainful Activity (1619b)	Yes
Ineligible for SSI or SSA due to actuarial change for widowed persons	Yes
Ineligible for SSI or SSA due to receipt of widow's social security benefits	Yes
Ineligible for SSI due to residence in a medical institution	Yes
People in medical institutions under 300% income level	No
Medicaid for Kids with Special Needs	No
Medically Needy	No
Qualified disabled and working persons (QDWP)	Yes

Coverage Group Name (Cont.)	Are Resources an Eligibility Factor for Children? (Cont.)
Qualified Medicare beneficiaries (QMB)	Yes
Specified low-income Medicare beneficiaries (SLMB)	Yes
Expanded specified low-income Medicare beneficiaries (expanded SLMB)	Yes
Medicaid for employed people with disabilities	Yes

1. The C family applies for the HCBS MR waiver for Child C. Child C is the grantor and beneficiary of a trust with a countable value of \$197,345. Income produced by the trust is countable, not excluded. If all other eligibility factors are met, Child C is eligible under the 300% group, since household resources are disregarded in determining children's eligibility under this group.

2. Child B, age 15, lives in an ICF/MR and is eligible for Medicaid and facility care under the coverage group for people who are ineligible for SSI due to residence in a medical institution. Child B has countable monthly income of \$100 and countable resources of \$1,800.

At the annual review, the worker determines that Child B's countable resources now total \$2,100. Since Child B is no longer eligible under this coverage group, the worker completes an automatic redetermination. Child B can be determined eligible under the 300% group, since resources are not an eligibility factor for children in the 300% group and because Child B's income exceeds the SSI maximum for a person in a medical institution (\$30).

3. Mrs. A and her two children, ages 6 and 8, apply for Medicaid. Countable income is under the FMAP limit for a three-member household. Mrs. A reports the following household resources:

Savings account of the 6-year-old	\$200
Savings account of the 8-year-old	\$300
Mrs. A's checking account	\$50
1990 Chevrolet Impala	\$3,500 equity value
1992 travel trailer	\$5,000

In determining FMAP eligibility for Mrs. A, the countable value of household resources is \$5,550. Mrs. A is not eligible under FMAP. She is eligible under Medically Needy with zero spenddown.

In determining FMAP eligibility for the children, household resources are disregarded. Mom is not resource eligible for FMAP, therefore, the children are eligible for Medicaid under CMAP.

4. The D family, composed of Mr. and Mrs. D and their child, age 10, file an application for Medicaid. Mr. D has been injured in an automobile accident and has no health insurance. He is at home and is unable to work. Child D is the grantor and beneficiary of a trust with a countable value of \$97,755. The trust is purchasing health insurance for Child D.

The Ds can choose to voluntarily exclude Child D so that the trust will not be a countable resource in determining eligibility for Mr and Mrs. D. The Ds' countable resources then total \$843. If all other eligibility factors are met, Mr. and Mrs. D are eligible for Medicaid under FMAP, since their countable resources are within FMAP limits.

General SSI-Related Resource Policies

The following sections describe SSI-related policies on:

- ◆ [Resource limits.](#)
- ◆ [What resources to count.](#)
- ◆ [Joint ownership of real property.](#)
- ◆ [Disputed ownership.](#)
- ◆ [Determining the value of a resource.](#)
- ◆ [Deeming resources from a spouse or parent.](#)
- ◆ [Eligibility while trying to sell a nonliquid resource.](#)
- ◆ [Long-term care asset protection.](#)
- ◆ [Resources exempt for Medicaid for Employed People with Disabilities.](#)

SSI-Related Resource Limits

Legal reference: 20 CFR 416.1205, 441 IAC 50.2(1), 75.1(249A), 75.1(39)“a”(5), 76.5(2)

For SSI-related Medicaid eligibility, the resource limit is:

- ◆ \$2,000 for an individual, and
- ◆ \$3,000 for a married couple living together.

The resources of the ineligible spouse must be deemed to the eligible spouse. See [Deeming From a Spouse](#). Determine which resource limit to use, based on whether or not the ineligible spouse has income to deem to the eligible spouse (according to procedures in [8-E](#)).

- ◆ Use the resource limit for an individual when no income is deemed from the ineligible spouse.
- ◆ Use the resource limit for a couple when income is deemed from the ineligible spouse.

EXCEPTIONS:

- ◆ The resource limit is \$4,000 for an individual eligible as a qualified disabled and working person.
- ◆ The resource limit is \$6,000 for a married couple living together who are eligible as qualified disabled and working persons.
- ◆ The resource limit is \$7,280 for an individual eligible under one of the following coverage groups:
 - Qualified Medicare beneficiaries
 - Specified low-income Medicare beneficiaries
 - Expanded specified low-income Medicare beneficiaries
- ◆ The resource limit is \$10,930 for a couple eligible under one of the following coverage groups:
 - Qualified Medicare beneficiaries
 - Specified low-income Medicare beneficiaries
 - Expanded specified low-income Medicare beneficiaries
- ◆ The resource limit is \$10,000 for an individual or couple in the SSI-related Medically Needy coverage group.

- ◆ The resource limit is \$12,000 for an individual in the Medicaid for employed people with disabilities coverage group.
- ◆ The resource limit is \$13,000 for a couple in the Medicaid for employed people with disabilities coverage group.
- ◆ All household resources are disregarded in the eligibility determination of children in certain coverage groups. See [Resource Eligibility of Children](#).

What Resources to Count

Legal reference: 20 CFR 416.1201

“Resources” are liquid and nonliquid assets owned by a person that the person is not legally restricted from using for support and maintenance, and that could be converted to cash to use for support and maintenance. Unless specifically exempt, all resources are considered countable.

Guardianship, conservatorship, and power of attorney are not legal restrictions on a resource. Continue to count an adult’s resources if the person has (or is waiting for) a guardian, conservator, or person with power of attorney.

An applicant or a member is not required to start a lawsuit to access or sell a resource. However, a resource is counted if they (or their conservator) have to petition the court to request access, because this action is not a lawsuit. (See [Trust Definitions](#) for more information on conservatorships.)

Include the resources of everyone who is considered part of the SSI-related household. See [8-C, Nonfinancial SSI-Related Eligibility](#), when establishing the SSI-related household. Determine countable resources and resource eligibility as of the first moment of the first day of each month, including the retroactive period. If resource values change during the month, eligibility will not be affected until the next month.

Nonliquid Resources

“Nonliquid resources” are assets that cannot be converted to cash in 20 days. Examples are:

- ◆ Homes and homesteads. See [Property in a Homestead](#).
- ◆ Nonhomestead property.
- ◆ Personal property, such as household goods, personal effects, tractors, motor vehicles, machinery, and livestock.

Liquid Resources

“Liquid resources” are assets that can be converted to cash in 20 days. Following are examples of liquid resources.

- ◆ **Annuities.** Count the salable value of an annuity or the amount the company will pay back to the applicant or member if the annuity is cashed in. Ask the client to obtain a statement from the company regarding the lump sum and the cash-in amount.

If the annuity cannot be cashed in but is assignable or can be transferred, ask three knowledgeable sources what its value is. Average the three values.

Most annuities allow benefits to be assigned or ownership sold. An applicant or a member who claims that an annuity cannot be sold or transferred must obtain verification.

- ◆ **Bonds.** The countable value of the bond is its redemptive value on the first moment of the first day of the month.
- ◆ **Cash,** unless it was counted as income for the month or specifically excluded as a resource, such as a retroactive SSI lump sum.
- ◆ **Checking and savings accounts.** Subtract verified outstanding checks and any funds included in the accounts that are specifically excluded as a resource.

If funds intended for the following month are direct deposited or deposited by the applicant or member before the intended month, do not count the funds as a resource in the month they were intended to cover. Remember to count the funds as income.

Mrs. J has \$2,000 in checking as of midnight on May 31. She receives her social security check of \$700 June 1. This check is not a factor in determining resources, because \$2,000 was countable as of the first moment of the first day of the month.

For co-owned accounts, if two or more account holders are either Medicaid applicants or members or are people whose income and resources must be considered for Medicaid eligibility (such as spouses or parents of minor children), count an equal share of the account for each.

If only one of the account holders is a Medicaid applicant or member or a person whose income and resources must be considered for Medicaid eligibility, count the entire amount in a co-owned account unless the applicant or member can establish that they (or the deemer) cannot access the funds. See [Disputed Ownership](#).

Ms. G has \$3,000 in a joint checking account with her sister, Ms. H, and their mother, Mrs. I. Ms. G and Ms. H are both over the age of 21 and are both receiving SSI-related Medicaid. Mrs. I has not applied for and does not receive Medicaid. Countable amounts are \$1,500 for Ms. G and \$1,500 for Ms. H, unless either can establish that they do not have access to the account.

- ◆ **Individual Retirement Accounts (IRA)**. Use the value of the IRA if cashed in minus any penalties for early withdrawal. NOTE: The 10% tax penalty for early withdrawal would not be allowed as a deduction, since it is an additional tax on the income portion of the withdrawal.
- ◆ **Mutual funds**. Count the value for which the shares can be sold.
- ◆ **Oil leases**. The value must be established by a knowledgeable source, such as a brokerage firm or bank. The lease value can be excluded if it is under \$6,000 and the land earns a net income of 6% of equity, or if the land is being sold. The leasehold is the right to use the property for a specified period. It does not convey ownership of the property.
- ◆ **Promissory notes** that can be sold or discounted.
- ◆ **Stocks**. Use the closing price of the stock on the first moment of the first day of the month.

Do not count resources that have no cash value, that cannot be liquidated, or that the applicant or member does not have the right to liquidate and use for support and maintenance. NOTE: Do not count property jointly owned by spouses involved in a divorce when the property is unavailable until a decision on distribution has been made. Do not consider the terms of a prenuptial agreement when determining Medicaid eligibility.

Do not count a resource until ownership is known to the applicant or member. An applicant or a member who is not aware of owning a resource must prove that it was reasonable not to know about it. Forgetting a resource is not evidence. Count the value of the resource plus any interest as income in the month of discovery. Count it as a resource the next month.

Mr. N's grandfather had transferred land to Mr. N in October but had not told him. Mr. N was told the following May. Mr. N provides verification with a letter from his uncle establishing that there was no prior knowledge. The \$5,000 value of the land is income to Mr. N in May. The land is a resource in June unless it is sold.

If the applicant or member has the legal ability to convert a resource to cash, it is not necessary that they have possession of the resource for it to be counted. EXCEPTION: An applicant or a member must possess a savings bond for it to be counted. Savings bonds have no resource value for six months from the issue date.

Joint Ownership of Real Property

Legal reference: 20 CFR 416.1201, 416.1201(a), 416.1245(a)

If real property is owned by more than one person, assume all persons have equal shares, unless you are able to determine differently. If a client does not own an equal share in a resource, count only the portion owned by the client.

If the client jointly owns real property, evaluate the details of ownership and the particulars of the situation to determine how shared ownership affects the value of the property as a resource.

In Iowa, people who jointly own property and wish to dispose of their interest in the property may do so. The refusal of one owner does not preclude any other owners from selling their ownership interest. (After the sale of the property, the new owners can petition the court for a partition action.) So, joint ownership does not preclude the property from being a countable resource, but it may affect the countable value of the seller's interest.

If a client jointly owns real property in another state, state law there may require the co-owner to move if the property is sold. If so, exclude it as a resource if the disposal of this property would cause undue hardship to the co-owner due to lack of housing. Obtain verification of the joint ownership and the applicable state law. The co-owner must use the property as the principal place of residence and have no other housing readily available.

Mr. J owns 40% of a 100-acre farm as tenant in common with his brother. The interest is referred to as "undivided." Specific acres are not identified as belonging to Mr. J, but he could sell his 40% interest. If Mr. J dies, his ownership passes to his heirs.

"Joint tenancy" means that two or more persons own an interest in and possession of the entire property. An owner's portion can be sold. If an owner dies, the ownership passes **to the other owner**.

Mr. J owns 40% of the 100-acre farm with Mr. T in joint tenancy. His interest is undivided but he could sell his 40% interest. If Mr. J dies, his ownership interest passes to Mr. T.

"Leasehold" means the lessee has the right to the use of the property for a specified period of time. A lessee may sell that right. Verify the countable value with a statement from a knowledgeable source.

Disputed Ownership

Legal reference: 20 CFR 416.1201, 416.1201(a), 416.1245(a)

Count jointly owned resources unless the client rebuts ownership. Allow the client to rebut ownership of all or part of jointly owned liquid and nonliquid resources. To do this, the client must establish:

- ◆ That the client's money is not deposited in the resource, or the proportion of money deposited by the client in relation to the total money deposited.
- ◆ The reason for the joint ownership.
- ◆ Whether the client made any withdrawals from the resource for the client's own use, or made withdrawals proportional to the client's share of the money.
- ◆ Whether the resource was altered to reflect true ownership interest.

If the client successfully shows either no ownership or partial ownership and changes the resource to reflect this, the ownership is then established at the beginning of the financial arrangement. Count only the part that the client could not prove belonged to another person. See [Liquid Resources](#) for countable amounts of co-owned checking and savings accounts.

Mrs. N and Mr. F, who are brother and sister, jointly own a bank account. Mrs. N has her name on the account to handle Mr. F's business, since he is not able to do so. Mr. F is not a Medicaid applicant or recipient.

Mrs. N applies for Medicaid on October 11. She lists the account, which has \$6,000 as of October 1. She proves that all the deposits were Mr. F's and she did not use any of the withdrawals. She changes the name on the account to show the true ownership. This account is not countable to Mrs. N.

Determining the Value of a Resource

Legal reference: 20 CFR 416.1201

Policy:

The **countable value** of a resource is the equity value. The **equity value** is the current fair market value minus any legal debt on the item. To be considered a debt against the resource, the debt must be legally recognized as binding on the resource's owner. The **current fair market value** is the amount an item can be sold for on the open market.

Procedure:

If a client is trying to sell property:

- ◆ The client should provide verification of the fair market value of the property.
- ◆ If the client provides verification that the client has tried to sell the property at the fair market value and it did not sell, consider a lower amount to be fair market value as long as it seems reasonable.
- ◆ Use the prudent-person concept when determining if the lesser fair market value amount is reasonable.

When property is sold at an auction, the current fair market value is considered to be the highest bid, as long as the client has provided verification that both:

- ◆ Attempts to sell the property at fair market value have been unsuccessful; **and**
- ◆ The auction was advertised to the public.

If either of these criteria has not been met, assess a transfer of assets penalty for the difference between the fair market value and what the property sold for.

1. Mr. M applies for nursing facility assistance. He has listed his home on the market in January at the assessed value of \$125,000. By May, he has not had an offer. Mr. M then lowers the price of his home to \$120,000. In July there are still no offers on the home. In August, he again lowers the asking price to \$116,000. In September, the home sells for \$112,000.

As long as Mr. M can provide verification of the listings, sale of the home is not considered to be a transfer of assets, because Mr. M tried to sell the home for fair market value. The fair market value is considered to be the amount that the home sold for.

2. Ms. J applies for Medicaid. She has a home with a current assessed value of \$95,000. She lists her home for \$95,000 and after two months has not yet had an offer. Ms. J drops the listing on her home to \$45,000 and sells her home two weeks later.

The sale is considered to be a transfer of assets for less than fair market value.

When determining the equity value of a resource:

- ◆ Deduct from the current market value only the principal amount of the debt and any prepayment penalties required. Do not consider any future interest owed.
- ◆ Determine the ownership of jointly held resources, such as joint checking or savings accounts and jointly held real estate, according to the intent of the parties who created the joint interests upon the creation of the joint interest.

If the document creating the joint interests, such as a deed to real estate or a bank account signature card, specifies the shares of the parties, divide the fair market value of the entire resource between the joint owners according to the shares specified.

If the shares of the joint owners are not specified, assume equal shares for all joint owners, unless evidence of intent shows unequal shares. Examples of evidence of intent showing unequal shares include:

- The source of the funds used to purchase or create the joint resource.
 - The use made of the joint resource.
 - The inclusion of one of the joint owners as a caretaker for the convenience of the other, etc.
- ◆ If excluded funds are combined with countable resources, assume the countable resources are spent first.
 - ◆ Consider the sale or transfer of a resource as a change in the form of the resource. Do not consider the transfer or sale of a resource as income.
 - ◆ A court restriction may make all or part of the resource unavailable to the client. Consult your supervisor if you have questions about the legal restrictions. Legal restrictions on resources can be included in:
 - Liens.
 - Qualified domestic orders.
 - Divorce decrees.
 - Probate matters.
 - Bankruptcy proceedings.

Deeming Resources

Legal reference: 20 CFR 416.1160, 416.1163, 416.1202

Deeming is the process of assigning a specified amount of resources of an ineligible spouse, parent, or sponsor when determining Medicaid eligibility. An "ineligible spouse" is a spouse who is not receiving SSI-related Medicaid. See 8-L, [ALIENS](#), when deeming resources from a sponsor to an alien.

Do not apply deeming policies if the applicant's or couple's resources alone are over the resource limits after including all appropriate disregards and exclusions.

Deem resources as of the first moment of the first day of the month of eligibility.

Deeming From a Spouse

Legal reference: 20 CFR 416.1202

To determine eligibility, include resources of an ineligible spouse when:

- ◆ An eligible person was living in the same household with the ineligible spouse at any time during the month, or
- ◆ An SSI-eligible person was living with an SSI-eligible spouse during the last six months unless:
 - The spouses have divorced,
 - One of them has died, or
 - One of them moved to a medical facility.

When an applicant is living in the same household with an ineligible spouse, include the resources of the ineligible spouse in determining the application's eligibility. Do not, however, deem pension funds controlled by an employer or union, or IRA or Keogh accounts.

See [8-D, SSI-Related Resource Limits](#), to determine which resource limit to apply.

If spouses who are both eligible for Medicaid separate, including when one spouse enters a medical facility, discontinue deeming the month after the month of the separation. Separation means that the spouses are not expected to be living together for a full calendar month.

Before entering a nursing facility, Mrs. L was living at home with her spouse. She will be in the facility for less than 30 days. Their countable resources are as follows:

\$1,800	Savings account in Mr. L's name only
+ 500	Vacant lot owned by Mr. L
\$2,300	Total resources of Mr. and Mrs. L
- 3,000	Limit for a couple
\$.00	Excess resources

Since resources deemed to Mrs. L do not exceed the resource limit for a couple, eligibility exists.

Deeming From a Parent to a Child

Legal reference: 20 CFR 416.1202

Before deeming resources from a parent to a child, see 8-D, [Resource Eligibility of Children](#). If the child's eligibility is determined under a coverage group where resources are exempt, there is no need to deem resources from the parents.

A "child" is a person who is:

- ◆ Not married,
- ◆ Not the head of the household, and
- ◆ Either under age 18 or under age 22, if a student regularly attending a school, college, university, or course of vocational or technical training to prepare for gainful employment.

When an eligible child is living in the household with an ineligible parent or stepparent, include the parent's and stepparent's resources when determining the child's eligibility unless the stepparent is the only person living with the child. If the child lives with the stepparent and not the biological parent, there is no deeming.

Do not deem a parent's resources to other ineligible children. Do not count or deem resources of ineligible children to the eligible child.

The child's resources are any resources the child owns plus any resources deemed from the parents. Determine the child's resources independently of the parents' resources. Consider household goods and personal effects owned by the child separately from those owned by the parents. Do not exclude more than one home and one vehicle for the family.

To deem the parents' resources to a child:

1. Allow the parents all the exclusions for which they would be eligible if they were eligible for Medicaid. Do not deem an ineligible parent's pension funds if they are controlled by the employer or by the union or are in an IRA or Keogh account.
2. Deduct \$2,000 for an individual (if one parent) or \$3,000 for a couple (if two parents) before deeming to the child.
3. Deem the remaining countable resources to the child.

A child is not eligible if the child's own resources plus the value of the resources deemed from the parents exceeds the \$2,000 resource limit unless the child is eligible under QMB, SLMB, or Medically Needy. See [8-F](#).

Sam, age 17, was living with his parents and two brothers before entering a residential care facility (RCF). Sam has a \$50 savings account in his own name. The parent's resources are as follows:

\$ 30,000	Value of home they live in
\$ 3,200	Parent's joint savings account

The home is excluded. \$200 resources are available for deeming. (\$3,200 minus \$3,000 SSI exclusion for a couple.)

\$ 200	Deemed from parents
+ 50	Sam's own resources
\$ 250	Total resources

Since resources deemed to Sam plus Sam's own resources do not exceed the resource limit for an individual, Sam meets the resource standard.

Do not deem parents' income or resources to a child the month following the month of entry into a medical institution or RCF.

Eligibility While Trying to Sell a Nonliquid Resource

Legal reference: 20 CFR 416.1240-416.1245, 441 IAC 50.5(249A), 76.2(3)

Applicants or members who have countable nonliquid resources that exceed the applicable resource limit may not receive Medicaid under a "Medicaid only" coverage group while they are attempting to sell the resource.

However, such applicants or members may be able to receive State Supplementary Assistance (SSA) or Supplemental Security Income (SSI) benefits until the resource is sold. These benefits are called "conditional benefits." Persons who are conditionally eligible for SSI are not eligible for Medicaid but persons who are conditionally eligible for SSA may receive Medicaid in the same manner as any other SSA recipient.

If the person has been approved for conditional SSI or federally administered State Supplementary Assistance benefits, there will be a "C" code in the COND PAY CODE field on the State Data Exchange (SDX).

There is usually no retroactive Medicaid eligibility for a recipient who has been approved for conditional SSI or State Supplementary Assistance benefits. However, the recipient's countable resources, including the excess resources, may have been under the Medically Needy limits. Also, some resources may not have been countable in the retroactive period, e.g., a house in which the recipient was living.

Ms. A, a minor child, is approved for SSI effective August 1, 1996. Her parents receive 10 acres of land on August 6 as an anniversary gift. The land has a value of \$6,000. In October, her parents sign an agreement to sell the land and repay SSI.

The IM worker evaluates resources of Ms. A and her family for the Medicaid retroactive period of May, June, and July, to determine if resources were under the limit. Since they did not own the land before August, retroactive eligibility is not affected by the 10 acres. The conditional benefits period begins in November (the month the agreement was signed). For the months of September and October, the land value of \$6,000 is a countable asset.

Long-Term Care Asset Preservation

Legal reference: 441 IAC 75.5(5), Iowa Code Chapters 249G and 514H

Policy:

A person may be eligible for Medicaid when the person meets **all** of the following conditions:

- ◆ The person is aged 65 or older.
- ◆ The person:
 - Is the beneficiary of a qualified long-term-care insurance policy, or
 - Is enrolled in a prepaid health care delivery plan that provides long-term-care services.
- ◆ The person is eligible for Medicaid under one of the following coverage groups except for excess resources:
 - Ineligible for SSI or SSA due to residence in a medical institution,
 - In the 300% group, or
 - Receiving home- and community-based waiver services.
- ◆ The excess resources do not exceed the amount of long-term-care insurance benefits paid out under the person's qualified long-term-care insurance policy. (This amount is called the asset adjustment.)

The asset adjustment is exempt from estate recovery for the member and the member's spouse.

Comment:

The Long-Term Care (LTC) Partnership program is a cooperative effort between private insurers and state government to encourage people to plan ahead and provide for their long-term health needs. An LTC partnership policy:

- ◆ Must meet the minimum standards established for long-term care insurance policies and certificates as established by the Iowa Insurance Division.
- ◆ Has identifying information included in the policy or attached to the policy to indicate that it is a qualifying long-term insurance policy.

The insurer provides the beneficiary a quarterly report which includes the amount paid in the last quarter and total amount paid on behalf of the insured.

In addition, the insurer is required to report data on each partnership policy sold under the Long-Term Care Partnership program to a national database. The national database then reports this information to each state's insurance department. The information reported includes:

- ◆ Notice of when benefits are paid under the policy,
- ◆ The amount of those benefits, and
- ◆ Notice of termination of the policy.

Iowa participates in a national reciprocity agreement with other states. If a person moves to Iowa and has a partnership policy that was purchased in another state, the policy can carry over to Iowa for the person to be eligible for an asset adjustment if the person applies for Medicaid in Iowa.

Procedure:

The amount of the disregard is equal to the amount of the insurance benefits paid to or on the behalf of the person. The insurance benefits do not have to be fully exhausted before the disregard can be applied. If the person is approved for Medicaid and the policy continues to pay benefits, the asset adjustment can continue to increase.

Subtract the total amount the policy has paid on the person's behalf from the person's total resources. Compare the remaining resources to the resource limit to determine Medicaid resource eligibility. If the person's remaining resources exceed the resource limit, issue a *Notice of Decision* denying or canceling Medicaid.

1. Mr. J buys a long-term-care partnership policy. The policy provides for \$100,000 in long-term-care coverage. Several years later, Mr. J needs nursing home care. His partnership policy covers most of the costs for three years before the \$100,000 benefits are exhausted by payment for his care.

Mr. J applies for Medicaid. He is able to protect \$100,000 for his resources and still qualify for Medicaid to help pay for his long-term care if he meets the other eligibility criteria.
2. Mr. S buys a long-term care partnership policy that provides \$100,000 in coverage. Several years later, Mr. S needs long-term care services and his policy begins to pay him a monthly benefit. Eventually, Mr. S applies for Medicaid home- and community-based waiver services.

At the time of application, Mr. S has \$90,000 in countable resources. His long-term care policy has paid out \$88,000 in benefits with \$12,000 remaining. The worker calculates his resources for Medicaid as:

\$ 90,000	Mr. S's resources
88,000	Benefits paid out under the LTC policy
- 2,000	Medicaid resource limit
\$ 0	Remaining countable resources

Mr. S is eligible for Medicaid because the amount paid under his partnership policy (\$88,000) combined with the Medicaid resource limit (\$2,000) equals his total countable resources (\$90,000). If his partnership policy continues to pay benefits, Mr. S can protect additional resources.

Exempt Resources for Medicaid for Employed People With Disabilities

Legal reference: 441 IAC 75.1(39)"a"(5)

Additional resources are exempt for persons who qualify for Medicaid eligibility under Medicaid for employed people with disabilities. They are:

- ◆ **Assistive technology accounts:** Assistive technology accounts include funds in contracts, savings, trust or other financial accounts, financial instruments or other arrangements with a definite cash value that are set aside and designated for the purchase, lease or acquisition of assistive technology, assistive technology services or assistive technology devices.

These accounts must be held separate from other accounts. Funds must be used to purchase, lease, or otherwise acquire assistive technology, assistive technology services, or assistive technology devices for the working person with a disability.

"Assistive technology" is defined as the systematic application of technologies, engineering, methodologies, or scientific principles to meet the needs of and address the barriers confronted by people with disabilities in areas such as education, rehabilitation, technology devices, and assistive technology services.

An **"assistive technology device"** is any item, piece of equipment, product system, or component part (whether acquired commercially, modified, or customized), that is used to increase, maintain, or improve functional capabilities or to address or eliminate architectural, communication, or other barriers confronted by people with disabilities.

“Assistive technology service” means any service that directly assists a person with a disability in the selection, acquisition, or use of an assistive technology device or other assistive technology. It includes, but is not limited to, services referred to or described in the Assistive Technology Act of 1998, 29 U.S.C. 3002(4).

Require the member to provide written verification from a physician, certified vocational rehabilitation counselor, licensed physical therapist, licensed speech therapist, or licensed occupational therapist that the technology being saved for is medically necessary and that the technology, device, or service can reasonably be expected to enhance the client's employment. Also require verification of an estimated cost for the technology.

- ◆ **Medical savings accounts.** These are accounts exempt from federal income taxation pursuant to Section 220 of the United States Internal Revenue Code (26 U.S.C. § 220). A person who has such an account will have documentation from the bank or other financial institution that set it up.
- ◆ **Retirement accounts.** This includes any retirement or pension fund or account listed in Iowa Code section 627.6(8)“f” as exemption from execution, regardless of the amount of contribution, the interest generated, or the total amount in the fund or account. The following are exempt under this provision:
 - Pension or retirement plans authorized under federal law, as follows:
 - Retirement plans qualified under the Employee Retirement Income Security Act of 1974 (“ERISA-qualified plans”).
 - Simplified employee pension plans.
 - Self-employed pension plans.
 - Keogh plans (also known as “H.R. 10 plans”).
 - Individual retirement accounts.
 - Roth individual retirement accounts.
 - Savings incentive matched plans for employees.
 - Salary reduction simplified employee pension plans (also known as “SARSEPs”).
 - Similar plans for retirement investments authorized under federal law after May 17, 1999.
 - Retirement plans established pursuant to a “qualified domestic relations order” as defined by federal law (26 U.S.C. section 414).

If the type of plan is unclear from the documentation provided, verify it with the plan administrator or send a clarification request to central office.

Specific SSI-Related Resources

This section lists specific types of resources that are countable or excluded, in total or in part, when determining initial or ongoing eligibility for SSI-related coverage groups. Some countable resources require calculations to determine the countable value to the applicant or member. Some resources are excluded only up to a certain limit, after which the remainder is countable.

And finally, some resources are exempt in the month of receipt and in some cases, the month following the month of receipt. Examples include:

- ◆ Death benefits
- ◆ Earned income credit
- ◆ Income tax refunds
- ◆ Retroactive cash payments
- ◆ Social services expenses
- ◆ Third party medical payments

See individual items for more information. (See [Exempt Resources For FMAP](#) for comparable information for FMAP-related coverage groups.)

AIDS/HIV Settlement Payments

Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

Payments from the original settlement or the Ricky Ray Hemophilia Relief Act of 1998 are exempt as a resource.

Annuities 20 CFR 416.1201

An annuity is a contract in which a person receives fixed payments for a specified time period. The person who receives the payments is referred to as the annuitant. The term of the annuity contract can be for either:

- ◆ The lifetime of the buyer;
- ◆ The lifetime of the buyer, with a minimum return of principal to a residual beneficiary if a specified portion of the principal is not returned before the buyer's death; or

- ◆ A certain number of years, with a guaranteed payment amount if the annuitant dies before the specified period has expired.

Review a copy of each annuity to determine the terms of the contract. Annuity contracts may be assigned, transferred, or cashed in for a lump sum. Or the contract may state that once payments are being made to the annuitant, the contract cannot be assigned, transferred, or cashed in for a lump sum.

- ◆ If the annuity can be assigned, transferred, or cashed in for a lump sum, the loan value or the amount the company will pay back to the annuitant is a countable resource.
- ◆ If the annuity may be assigned or transferred, but not cashed in, the annuitant must verify the amount that the annuity can be assigned or transferred for. The annuitant should obtain three estimates from knowledgeable sources. Use the average of these to determine the countable resource value of the annuity.
- ◆ If the annuity is counted as a resource and the annuitant is eligible for Medicaid, obtain verification of the portion of the payment that is interest and the portion of the payment that is principal.

Count the interest portion of the annuity payments as income to the annuitant when determining eligibility, spenddown, and client participation. Do not count the principal portion of the payment; this is already counted as a resource.

- ◆ If the annuity cannot be assigned, transferred, or cashed in and the annuitant verifies that the annuity has no cash value, the annuity is not a countable resource. Count the total annuity payment as income to the annuitant when determining eligibility, spenddown, and client participation.

Annuities must also be reviewed to determine if the purchase of the annuity constitutes a transfer of assets for less than fair market value. See [Transfers That Cause a Medicaid Penalty](#).

Request a copy of the contract and use the *Annuity Release of Information*, form 470-4699, to gather information on the annuity. If you need help interpreting the information provided on the form or the contract, send the form and contract to the DHS, SPIRS Help Desk.

Burial Contracts

20 CFR 416.1201,
20 CFR 416.1231, 441
IAC 75.56(249A)
(See also [Transfer of Assets](#).
20 CFR 416.1246,
42 USC 1396p(d))

Exclude a prepaid burial contract as a resource if it meets one of the following conditions:

The contract is irrevocable and the applicant or member can't access the funds.

Mutual consent of the applicant or member and the contract seller is required to revoke or access the contract, and the seller's consent can't be obtained.

Liquidation of the contract would create a significant hardship to the applicant or member. Usually, the only hardship considered significant is requiring the applicant or member to move out of Iowa to access the funds.

Unless the contract clearly indicates that the burial contract is irrevocable, obtain a written statement from the contract seller that the funds committed to the contract are unavailable to the applicant or member.

Investigate a contract drawn up in another state to determine whether the law in that state permits irrevocable burial contracts and whether the contract is irrevocable under that law.

If a certificate of deposit or another form of funds is tied to the irrevocable contract, only the amount specified in the irrevocable contract is excluded.

If the burial contract is set up by purchasing a life insurance policy, check if the funeral home either owns the policy or is the irrevocable beneficiary.

If the funeral home owns the policy, both the whole cash value and the dividends are unavailable. However, if the funeral home is the beneficiary, only the cash value is unavailable. Count dividends that are available to the applicant or member.

Since there is no limit on the amount of money in the burial contract, some applicants or members may use prepaid burial contracts to protect assets. If the amount of the burial contract exceeds \$11,566, which is the average cost of a funeral in Iowa, ask for an itemized list of funeral costs.

If the amount is less than or equal to the cost of the funeral, exclude the contract from resource consideration. If the amount in the burial contract exceeds the itemized listing, consider the excess deposits or payments as a transfer of assets for less than fair market value. See [Transfer of Assets](#).

The amount of money considered transferred is the amount designated for the contract minus the specified cost of the burial. Determine whether transferring has occurred rather than determining how much of the irrevocable burial contract is a countable resource.

If a relative changes the selection of services in the burial contract at the time of the funeral, this is not a transfer of resources.

The following charts provide a guide to understanding burial contracts and how to count as a resource or consider as a transfer of asset.

Burial Contracts		
If the client has...	Countable resource?	Transfer of asset?
Paid cash and burial contract is: ♦ Revocable ♦ Irrevocable	Yes. See below on how to count. No	No No
No burial contract and burial funds are: ♦ Revocable ♦ Irrevocable	Yes No	No Yes. See transfer of asset chart.
Revocable burial contract funded by: ♦ Revocable burial funds ♦ Irrevocable burial funds ♦ Life insurance policy with funeral home as the beneficiary ♦ Life insurance policy irrevocably assigned to funeral home	Yes. See below on how to count. No Yes, unless otherwise excluded. No	No Yes. See transfer of asset chart. No Yes. See transfer of asset chart.
Irrevocable burial contract funded by: ♦ Revocable burial funds ♦ Irrevocable burial funds ♦ Life insurance policy with funeral home as the beneficiary ♦ Life insurance policy irrevocably assigned to funeral home	Yes No Do not count cash value, but count any accessible dividends as a resource. No	No See transfer of asset chart. See transfer of asset chart. See transfer of asset chart.
Burial funds may include annuity proceeds, a certificate of deposit, a bank account, or a trust at a financial institution. If a countable resource: Exclude up to \$1,500 for the client and up to \$1,500 for the client's spouse when funds are held in a separate account designated for burial purposes.		

Burial Contracts – Transfer of Assets		
Transfer of Asset	Penalty	Amount
Irrevocable burial funds not in a burial contract	Yes	Penalty is the amount of the irrevocable burial funds. If the client sets up an irrevocable burial contract, the transfer of assets penalty can be expunged as of the first of the following month.
Revocable burial contract funded by irrevocable burial funds	Yes	Penalty is the amount of the irrevocable burial funds. If client changes the revocable burial contract to irrevocable, the transfer of assets penalty can be expunged as of the first of the following month.
Revocable burial contract funded by life insurance policy irrevocably assigned to funeral home (either ownership or beneficiary)	Yes	Penalty is the amount of cash value and dividends of the life insurance policy. If client changes the revocable burial contract to irrevocable, the transfer of assets penalty can be expunged as of the first of the following month.
Irrevocable burial contract funded with irrevocable burial funds OR assigned life insurance policy (either ownership or beneficiary) If the amount of contract is:		
<ul style="list-style-type: none"> ◆ Less than average cost of funeral in Iowa. ◆ More than the average Iowa funeral cost, ask for an itemized list of funeral costs. <ul style="list-style-type: none"> ● If burial contract amount is less than or equal to itemized list. ● If amount exceeds the itemized list. 	No	None
	No	None
	Yes	Penalty is the amount in excess of the burial contract.

Burial Funds

20 CFR 416.1231

(See also [Transfer of Assets](#).

20 CFR 416.1246,

42 USC 1396p(d))

Exclude up to \$1,500 for the client and up to \$1,500 for the client's spouse when funds held in a separate account designated for burial purposes. Examples of funds set aside for burial are:

- ◆ Revocable burial contracts.
- ◆ Trusts.
- ◆ Cash value of any life insurance policies.
- ◆ Any account or resource designated by the applicant or member for burial, cremation, or other funeral arrangements. An account or resource designated for burial could be bank accounts, CDs, real property, etc.

Burial funds must be in separately identifiable accounts. If funds are combined with other funds that are not for burial purposes, the client must separate the funds.

The client must sign a statement designating the funds for burial purposes. File a copy of the statement in the case record and give a copy to the applicant or member.

Exclude the fund as of the first of the month in which the fund is separated and designated as a burial fund.

Reduce the amount the client set aside for burial by any excluded whole life, term life, and irrevocable burial contracts. For policies on burial space, see [Burial Space](#). To determine the amount of burial funds that can be applied under this exclusion:

1. Obtain copies of irrevocable burial arrangements and life insurance policies to determine what burial funds the applicant or member owns.
2. If the irrevocable contract is over \$1,500, no other burial funds can be excluded. (The irrevocable burial contract is an excluded resource, but it does have an effect on whether any other funds can be set aside for burial.)
3. If the burial contract is less than \$1,500, determine the face value of any **excluded** whole life and term life insurance policies designated for burial funds. (Life insurance with a face value of \$1,500 or less is excluded. Life insurance with a face value of more than \$1,500 is not excluded.)

4. Add together the face value of excluded life insurance and the burial contract. Subtract this amount from the \$1,500 set-aside amount. If there is no remainder, no additional funds can be set aside for burial.

If the total amount set aside in the burial contract and excluded life insurance is under \$1,500, the client can designate additional funds for burial to make up the difference. The total cannot exceed \$1,500.

1. Mr. N has \$2,500 in a burial fund that is revocable. He has no other burial funds. The maximum excluded from resource consideration is \$1,500. \$1,000 is a countable resource.
2. Mrs. B has life insurance with a face value of \$3,000. The cash value is \$1,800. This policy is not exempt and she has no other funds set aside for burial. Mrs. B has no funds set aside for burial and provides a written statement designating this policy for burial. The worker excludes \$1,500 of the \$1,800 cash value for burial. \$300 is a countable resource.
3. Mrs. H has a \$2,000 burial fund that is revocable. She has life insurance with a face value of \$800. \$700 of the burial fund that can be excluded and the interest earned on this \$700 are exempt as income and a resource.

The remaining \$1,300 is countable as a resource. The on the \$1,300 is also counted, subject to policies on infrequent and irregular income.

4. Mrs. P has \$1,000 in a savings account that she has designated for burial. She also has a \$1,000 face value life insurance policy.

\$ 1,500	Maximum exclusion
- <u>1,000</u>	Life insurance
\$ 500	Can be excluded for burial
\$ 1,000	Designated burial account
- <u>500</u>	Remaining exclusion
\$ 500	Countable resource

5. Mr. Q has a \$1,600 life insurance policy and a \$1,000 irrevocable burial contract. The cash value of the life insurance policy is \$1,975. Mr. Q designated the cash surrender value of his life insurance as funds set aside for burial.

\$1,500	Maximum potential exemption
- <u>1,000</u>	Burial contract
\$ 500	Remaining potential exemption
\$1,975	Cash surrender value of life insurance
- <u>500</u>	Remaining exemption
\$1,475	Countable resource

Mr. Q's worker informs him that he could irrevocably assign the life insurance ownership to the irrevocable burial contract, at which point it would no longer count as a resource.

If the client spends any of the burial fund, count the amount spent as income during the period it was spent.

A client in a nursing home has \$1,400 in a burial fund, but spends \$1,000 in June. This \$1,000 is used for June eligibility, and client participation is adjusted for June.

**Burial Funds'
Increase in Value**
20 CFR 416.1124(9),
416.1231(7)

Burial funds may increase in value due to interest income or to appreciation in the value of the burial arrangement. Do not count interest on or increases in the value of burial funds that are **excluded** as a resource.

Count interest on and increases in value of the **countable** portion of burial funds. To do this, determine the percentage of the burial funds that is countable based on the value of the burial funds at the time they were gathered and apply that percentage to the increase in value.

When an SSI-related member has excluded funds set aside for burial at the time of cancellation of SSI:

- ◆ Exclude increased funds at the time of cancellation if the member becomes eligible for SSI-related Medicaid coverage within 12 months of cancellation.

However, if the member loses SSI because the member is no longer disabled, allow the increased funds to be excluded only if the member becomes eligible for an SSI-related program within three months.

- ◆ Allow only the same percentage increase in funds that was allowed before cancellation if the burial fund account is only partially excluded because the member has other burial funds. This is subject to the same 12-month period.

Contact the SSI representative at the district Social Security office to determine the amount of funds excluded at the time of cancellation when an SSI person becomes ineligible and then goes to another SSI-related coverage group.

Burial Space

20 CFR 416.1231(a)

Do not count the value of a burial space that is **owned** by the client and is intended for the client, the client's spouse, or any other member of the client's immediate family.

The "immediate family" includes a client's:

- ◆ Children, stepchildren, adopted children
- ◆ Brothers, sisters
- ◆ Parents, stepparents, adoptive parents

The "immediate family" does not include members of an ineligible spouse's family. If a space is not intended for the use of an immediate family member, count it as a resource.

Exclude only one space for each person. Document in the case record for whom each space is intended.

A "burial space" is:

- ◆ A conventional grave site, including opening and closing the grave.
- ◆ A crypt, vault, or mausoleum.
- ◆ The casket, urn, burial containers, and items traditionally used for the remains of a deceased person.
- ◆ Headstones, markers, or plaques.

A space can be all items that traditionally go with the burial space. For example, a space can include both a lot and a casket, but not an urn in addition to the lot and casket.

Child Tax Credit
20 CFR 416.1235

Exclude the child tax credit as a resource for nine months following the month of receipt.

Continuing Care Retirement and Life Care Community Entrance Fees
441 IAC 75.6(249A)

Entrance fees paid by persons residing in continuing care retirement communities or life care communities that collect an entrance fee on admission are considered a resource available to the person if:

- ◆ The person has the ability to use the entrance fee, or the contract between the person and the community provides that the entrance fee can be used to pay for care;
- ◆ The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the community contract; and
- ◆ The entrance fee does not confer an ownership interest in the community.

Dedicated Accounts
20 CFR 416.1247

Exclude the funds in a dedicated account as a resource for people receiving SSI. When past-due benefit payments are paid for an eligible person under age 18, the Social Security Administration requires the representative payee to establish a dedicated account.

The dedicated account may be used only for:

- ◆ Medical treatment, education, and job skills training.
- ◆ Personal needs assistance, special equipment, housing modification, and therapy or rehabilitation if related to the child's impairment.
- ◆ Other items and services related to the child's impairment approved by the Social Security Administration.

Stop excluding the funds in a dedicated account when the person loses SSI eligibility, even if the person later reapplies and is approved.

Disaster Assistance
20 CFR 416.1201,
416.1210, 416.1228,
416.1236; 416.1237; P.
L. 101-508

Exclude disaster assistance from a state, federal or local programs as a resource.

**Earned Income
Credit**

Exclude the earned income credit in the month it was received as well as in the following month. Funds remaining are countable resources after the end of the second month.

Tax Relief,
Unemployment
Insurance
Reauthorization, and
Job Creation Act of
2010 (P. L. 111-312)

NOTE: Exclude for 12 months from the date of receipt all EITC payments as part of a federal tax refund between January 1, 2010, and December 31, 2012.

**Educational
Assistance**
20 CFR 416.1236(7),
416.1236(15)

All student financial assistance received under Higher Education Act (HEA) or under Bureau of Indian Affairs (BIA) student assistance programs is excluded as a resource, regardless of use and regardless of how long the assistance is held. Examples of HEA (Title IV) programs are:

- ◆ PELL grants
- ◆ State Student Incentives
- ◆ Academic Achievement Incentive Scholarships
- ◆ Byrd Scholars
- ◆ Federal Supplemental Educational Opportunities Grants (FSEOG)
- ◆ Federal education loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)
- ◆ Upward Bound
- ◆ Gear Up (Gaining Early Awareness and Readiness for Undergraduate Programs)
- ◆ LEAP (Leveraging Educational Assistance Partnership)
- ◆ SLEAP (Special Leveraging Educational Assistance Partnership)
- ◆ Work-study programs

Other grants, scholarships, fellowships, or gifts used or intended to be used to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, are excluded from resources for nine months beginning the month after the month the assistance was received.

This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter.

“Necessary educational expenses” include the following:

- ◆ Laboratory fees
- ◆ Student activity fees
- ◆ Transportation
- ◆ Stationery supplies
- ◆ Books
- ◆ Technology fees
- ◆ Impairment-related expenses necessary to attend school or perform schoolwork (special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment, etc.)

Grants, scholarships, fellowships, and gifts that are retained after the nine-month exclusion are countable resources beginning the month after the exclusion period ends.

Excluded educational assistance becomes countable as income in the earliest of:

- ◆ The month any portion of the excluded assistance is used for something other than tuition, fees, or other necessary educational expenses, or
- ◆ The month the member no longer intends to use the funds to pay educational expenses.

Emergency Energy Conservation Assistance

20 CFR 416.1124(b)

Exclude any cash or in-kind assistance provided under the Emergency Energy Conservation Services Program or the Energy Crisis Assistance Program, including:

- ◆ Winterization of old or substandard dwellings. (Neither the cost of the materials nor the cost of labor is counted.)
- ◆ Insulation.
- ◆ Emergency loans and grants to install energy conservation devices.
- ◆ Alternative fuel supplies and special fuel vouchers or stamps.
- ◆ Alternative transportation activities designed to save fuel and guarantee continued access to training, education, and employment.
- ◆ Legal or technical training relating to the energy crisis.
- ◆ Fuel to operate food preparation appliances, or meals provided because utilities have been shut off.

Food Programs

20 CFR 416, Subpart L
Appendix

Exclude the value of:

- ◆ Allotment paid under the Food Stamp Act
- ◆ Food provided under WIC
- ◆ School lunches or breakfasts
- ◆ Congregate meals
- ◆ Federally donated food

Verification is not required.

Gifts Made Under Uniform Gift Act

20 CFR 416.1201

A gift given to a child under 21 is not considered an available resource under the Uniform Gift Act. When the child turns 21, the gift becomes a countable resource. Verify the amount of the gift before excluding it. See [8-E](#) for how to treat all other types of gifts.

**Household Goods
and Personal
Effects**

20 CFR 416.1216

Exclude household goods and personal effects if the equity value is less than \$2,000. Count any amount over \$2,000 toward the resource limit.

“Household goods” are items used to maintain the home as well as to accommodate, comfort and entertain the occupants.

“Personal effects” are belongings of family members, including clothing, books, and grooming aids. Do not count one set of a client’s wedding and engagement rings.

Exclude items required by any household member because of the person’s medical or physical condition, regardless of value. For example, exclude prosthetic devices, dialysis machines, wheel chairs, and hospital beds.

If the client reports household goods or personal effects equal to or more than \$500, investigate the total value of the household and personal effects against the \$2,000 exclusion. Accept the client’s estimated value of household goods and personal effects.

Exclude household goods and personal effects that were excluded in the attribution of resources. In spousal impoverishment cases, the household goods and personal effects retained by the community spouse are excluded as resources to the institutionalized spouse when determining Medicaid eligibility.

Housing Assistance Provided by HUD or FMHA

20 CFR 416.1124(b); U.S. Housing Act of 1937, Section 8; U.S. Housing Act of 1959, Section 202(h); National Housing Act; Housing Act of 1949, Title V; Housing and Urban Development Act of 1965, Section 101; (Section 1701 of 12 USC, section 1451 of 41 USC)

Do not count rent subsidies, cash toward utilities, or indirect assistance (guaranteed loans, mortgages, and mortgage insurance) provided to homebuyers by the Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture/World Development.

Do not count any rent reduction to a person in low-income housing when the assistance is under the U.S. Housing Act of 1937, as amended.

Verify the authority for the client's federal or federally assisted housing. If the client cannot get verification, contact the local public housing authority. If HUD and a private owner have entered into a contract directly, contact the owner or manager of the project to verify the nature and authority for the housing assistance payments. Record the findings in the client's case record.

Income Tax Refunds

Public Law 111-312
Public Law 112-240

Federal income tax refunds are excluded for 12 months from the date of receipt.

Exclude state income tax refunds as a resource for the month of receipt and the month following the month of receipt.

Individual Development Accounts

20 CFR 416.1201, 416.1210, 416.1236; P. L. 105-285, Section 415, P. L. 106-554

Contributions that are deposited in a Demonstration Project IDA are excluded from resources. Any matching funds that are deposited in a Demonstration Project IDA and interest earned are excluded from resources.

Indian Assistance

20 CFR 416.1201, 416.1210, 416.1228, 416.1232, 416.1236; P. L. 101-508, P. L. 92-254, P. L. 94-114, P. L. 103-66

Exclude judgment funds distributed to members of Indian tribes and payments that were received from certain lands and subsurface mineral rights, then distributed to tribal members.

Exclude up to \$2,000 in interest payments per year from Indian trusts or restricted lands. Exclude any land that the client or spouse cannot dispose without the consent of the tribe, a federal government agency, or other persons.

Insurance (Death Benefits)

20 CFR 416.1201,
416.1210, 416.1230;
P. L. 101-508

Exclude in the month of receipt and the following month life insurance or death benefits not spent on the insured's last illness or burial. If the money is reimbursement for expenses of the last illness or burial, exclude it only for the month of receipt.

Insurance (Life)

20 CFR 416.1230

Exclude the cash surrender value of life insurance policies with a combined face value totaling \$1,500 or less per owner. If the total face value of life insurance owned by the applicant or member is more than \$1,500, count the cash surrender value toward the resource limit.

Exclude the face value all life insurance that has no cash surrender value, such as term insurance.

For purposes of this comparison, the countable face value of a life insurance policy is the total face value minus any face value purchased with dividends from the policy. If the face value of the policy increases in other ways, use the adjusted face value. Do not include additional sums payable if the member dies in an accident.

The **cash surrender value** is the amount that the insurance company will pay if the policy is canceled before death (this value usually increases with the age of the policy). The cash surrender value may include dividends and may decrease with loans.

Funds paid as accelerated payments from the policy do not change the value of the resource. These payments, called **accelerated death benefits**, are counted as income.

1. Mr. X owns two life insurance policies, one with a face value of \$750 and the other with a face value of \$500. Since the total face value of life insurance is \$1,250, the policies are exempt from resource consideration.

2. Mr. Y owns three life insurance policies with face values of \$1,000, \$750, and \$500, totaling \$2,250. Mrs. Y owns one life insurance policy with a face value of \$1,000.

Mrs. Y's policy is ignored in the computation because its face value is less than \$1,500 per owner. Since Mr. Y's policies total \$2,250, the cash surrender value of each policy must be determined.

3. Mr. and Mrs. Q and their child have life insurance with a face value of \$4,000. Mr. Q owns the policy. The cash value is counted towards the resource limit.

Count accumulated dividends that are not used to purchase additional insurance as a resource in the same manner as money in a bank account. Count the accumulated dividends even if the countable face value of the policy is less than \$1,500 and the cash value of the life insurance is excluded.

Do not include the face value of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, include the cash surrender value of dividend additions in determining the resource value of the policy.

Mr. B has a \$1,000 whole life policy that he purchased in 1942. His dividends purchased an extra \$3,000 in face value in 1976. Now, the total face value of the policy is \$4,000, the cash value is \$2,800, and dividends are \$800.

Because the policy's face value, (not including the face value due to insurance purchased with dividends) is less than \$1,500, the cash value is excluded. However, the \$800 in dividends that were not used to buy additional insurance are countable resources.

Dividend accumulations may be considered as cash set aside for burial if all burial fund criteria are met. Do not automatically assume that the dividends are set aside for burial because the cash value of the life insurance is designated for burial.

If the life insurance policy is assigned to the funeral home in an irrevocable burial contract, do not count the cash value or the dividends as a resource.

If the funeral home is the beneficiary, the cash value of the policy may still be counted as a resource unless otherwise excluded. If the funeral home is the beneficiary and the client has an irrevocable burial contract, do not count the cash value of the policy, but count any accessible dividends as a resource to the client.

At the time of application, send form 470-0444, *Insurance Report*, to verify the:

- ◆ Total face value of the whole life insurance policy not including dividend additions.
- ◆ Amount of accumulated dividends not used to purchase additional insurance.
- ◆ Interest earned on accumulated dividends.

At annual reviews, send 470-0444 unless the total face value of all policies is \$1,500 or less and the last report indicated that the face values will not change. See [6-Appendix](#), for instructions on Insurance Report, Form 470-0444.

Insurance (VA Term Life)

People who are age 70 or older and have National Service Life Insurance (VA) term policies earn cash value when the term policy lapses or is canceled at their request.

When the policy lapses or is canceled, the cash value will be used to buy a limited amount of paid-up additional (PUA) insurance. With PUA insurance, the policyholder may:

- ◆ Receive insurance coverage without paying premiums.
- ◆ Borrow against the cash value.
- ◆ Surrender it for cash.
- ◆ Receive annual dividends that may be used to buy more PUA.

The VA term insurance policies will remain excluded as a resource after the policyholder reaches age 70, as long as the policyholder:

- ◆ Continues to pay the policy premiums and does not allow the policy to lapse; and
- ◆ Does not request cancellation of the policy.

If the policy lapses or if the policyholder requests cancellation, how the policy is subsequently treated depends on what the policyholder does with the PUA insurance. If the policyholder:

- ◆ Receives insurance coverage without a premium, the cash value of the insurance is countable as a resource the month after the change takes place.
- ◆ Surrenders the policy for cash, the cash is countable income in the month received.

**Life Estates or
Remainderman
Interest**

20 CFR 416.1201,
IAC 75.13(2)"e"

Policy:

Property can be divided into two parts, the life estate and the remainder interest. This applies whether the property is real estate or personal property or is liquid or nonliquid.

The value of a life estate or remainder interest depends on the value of the underlying property and the life expectancy of the person whose life controls it (the original holder of the life estate).

Comment:

Life estates and remainder interests generally count as resources for eligibility purposes. However, if the underlying property would be exempt, the life estate or remainder interest is also exempt.

For example, exclude real property in a life estate as a homestead if the owner of the life estate lives in the dwelling, or if the other exclusion policies for a homestead apply. See [Property in a Homestead](#).

People who receive or retain a **life estate** (“life tenants”) have the right to use the property during their lifetime, including the right to any income generated by the property during their life. Count income generated according to policy. See [8-E](#), [Lump-Sum Income](#).

This right has a value and can be sold to someone else. If the original owner of the life estate transfers or sells the life estate to someone else, the recipient of the life estate gets the right to use the property during the life of the original holder. The “life” that determines the life estate does not change with the transfer.

The owner of a **remainder interest**, the remainderman, has the right to receive the property when the life estate ends. Before the life estate ends, the owner of the remainder interest has no right to use the property or to receive any income from it.

The right to receive the property when the life estate ends also has value and can be sold. As with a transfer of the life estate, the transfer of the remainder interest does not change the life that controls the life estate. When the life estate ends, the remainderman then owns the entire property. It is no longer divided into a life estate and remainder interest.

Mrs. A, a nursing facility resident, has a life estate. She reports that the property held in the life estate was sold. Request documentation to determine if both the life estate and the remainder interest were sold, or if just the life estate or the remainder interest was sold.

If just the remainder interest was sold, Mrs. A continues to hold a life estate in the property. If both the life estate and the remainder interest were sold, Mrs. A is entitled to that portion of the sale proceeds that represent the value of the life estate. If only the life estate was sold, Mrs. A is entitled to all of the proceeds.

The owner of the entire, undivided property can divide the property into the two parts and can:

- ◆ Keep the life estate and transfer the remainder interest;
- ◆ Transfer the life estate and keep the remainder interest;
- ◆ Transfer both the remainder interest and the life estate to two different people.

If the life controlling the life estate is likely to be short, the value of the life estate is smaller and the value of the remainder interest greater. Conversely, if the life controlling the life estate is likely to be long, the value of the life estate is greater and the value of the remainder interest smaller.

Procedure:

Request verification of:

- ◆ What portion of the life estate the client owns,
- ◆ Which portion has been sold or transferred, and
- ◆ The date of the transaction.

To determine the value of a life estate or remainder interest, first determine the fair market value of the entire underlying property as if it was not divided into a life estate and remainder interest.

Obtain verification of the fair market value of the underlying property from a disinterested, knowledgeable source, in the same way as for any other undivided property. This could be an appraisal, a real estate fair market analysis, or an offer on the property from a disinterested knowledgeable source.

For **real estate**, the fair market value of the underlying property is the amount it could be sold for on the open market. A disinterested, knowledgeable source can be a real estate broker, Farmer's Home Administration, bank, mortgage company, or other lending institution.

For **farm land**, obtain the average value of an acre of land in the area from the Iowa State University Extension office.

For **liquid** resources such as a certificate of deposit or bank account, the fair market value is the amount that would be received if the resource were cashed in.

To determine the value of the **life estate** when the applicant or member is the life estate holder:

1. Determine the fair market value of the entire underlying property (as if it was not divided into a life estate and a remainder interest).
2. Find the line on the life estate column corresponding with the age of the person whose life controls the life estate (the original holder of the life estate) as of the date for which a value is being determined.
3. Multiply the fair market value by the figure in the life estate column.

To determine the value of the **remainder interest** when the client is the remainderman of a life estate:

1. Determine the fair market value the entire underlying property (as if it was not divided into a life estate and a remainder interest).
2. Find the line on the remainder column corresponding with age of the person whose life controls the life estate (the original holder of the life estate) as of the date for which a value is being determined.
3. Multiply the fair market value by the figure in the remainder column.

If the client maintains that the life estate or remainder interest cannot be sold for the amount determined using the table, the client must present other evidence to support this claim.

You may also use the table for mortality, life estates, and remainder published by the Iowa Department of Revenue at <http://www.iowa.gov/tax/forms/60059.pdf>. This table may be used as a second source in determining the fair market value of a life estate, along with the table in this chapter.

The client must obtain a statement from a disinterested, knowledgeable third party stating the value of the life estate or remainder interest.

A disinterested third party is someone who is free of bias and self-interest that can determine the value of the property. Use the “prudent person” concept in determining whether the party stating the value of the life estate has anything to gain by making the offer.

A disinterested, knowledgeable source may establish that a life estate or remainder interest has no value if it could not be sold at any price.

<u>Age</u>	<u>Life Estate</u>	<u>Remainder</u>	<u>Age</u>	<u>Life Estate</u>	<u>Remainder</u>
0	.97188	.02812	20	.97365	.02635
1	.98988	.01012	21	.97245	.02755
2	.99017	.00983	22	.97120	.02880
3	.99008	.00992	23	.96986	.03014
4	.98981	.01019	24	.96841	.03159
5	.98938	.01062	25	.96678	.03322
6	.98884	.01116	26	.96495	.03505
7	.98822	.01178	27	.96290	.03710
8	.98748	.01252	28	.96062	.03938
9	.98663	.01337	29	.95813	.04187
10	.98565	.01435	30	.95543	.04457
11	.98453	.01547	31	.95254	.04746
12	.98329	.01671	32	.94942	.05058
13	.98198	.01802	33	.94608	.05392
14	.98066	.01934	34	.94250	.05750
15	.97937	.02063	35	.93868	.06132
16	.97815	.02185	36	.93460	.06540
17	.97700	.02300	37	.93026	.06974
18	.97590	.02410	38	.92567	.07433
19	.97480	.02520	39	.92083	.07917

<u>Age</u>	<u>Life Estate</u>	<u>Remainder</u>	<u>Age</u>	<u>Life Estate</u>	<u>Remainder</u>
40	.91571	.08429	75	.52149	.47851
41	.91030	.08970	76	.51441	.49559
42	.90457	.09543	77	.48742	.51258
43	.89855	.10145	78	.47049	.52951
44	.89221	.10779	79	.45357	.54643
45	.88558	.11442	80	.43569	.56341
46	.87863	.12137	81	.41967	.58033
47	.87137	.12863	82	.40295	.59705
48	.86374	.13626	83	.38642	.61358
49	.85578	.14422	84	.36998	.63002
50	.84743	.15257	85	.35359	.64641
51	.83674	.16126	86	.33764	.66236
52	.82969	.17031	87	.32262	.67738
53	.82028	.17972	88	.30859	.69141
54	.81054	.18946	89	.29526	.70474
55	.80046	.19954	90	.28221	.71779
56	.79006	.20994	91	.26955	.73045
57	.77931	.22069	92	.25771	.74229
58	.76822	.23178	93	.24692	.75308
59	.75675	.24325	94	.23728	.76272
60	.74491	.25509	95	.22887	.77113
61	.73267	.26733	96	.22181	.77819
62	.72002	.27998	97	.21550	.78450
63	.70696	.29304	98	.21000	.79000
64	.69352	.30648	99	.20486	.79514
65	.67970	.32030	100	.19975	.80025
66	.66551	.33449	101	.19532	.80468
67	.65098	.34902	102	.19054	.80946
68	.63610	.36390	103	.18437	.81563
69	.62086	.37914	104	.17856	.82144
70	.60522	.39478	105	.16962	.83038
71	.58914	.41086	106	.15488	.84512
72	.57261	.42739	107	.13409	.86591
73	.55571	.44429	108	.10068	.89932
74	.53862	.46138	109	.04545	.95455

Source: 49 Federal Register/Vol. 49 No. 93/5-11-84
 Table -- Unisex Life Estate or Remainder Table.

**Loans and
Promissory Notes**
CFR 20 416.1207

Any amount that is borrowed through a loan is a resource if it is retained into the month following the month the loan is received.

When an applicant or member makes a loan to another person, determine the resource value of the loan or promissory note. The loan or promissory note can be sold or transferred from one person to another. The resource value is the amount a disinterested third party would pay to receive the balance of the payments on the loan or promissory note.

Loans and promissory notes must also be reviewed to determine if use of the funds to purchase or make the loan constitutes a transfer of assets for less than fair market value. See [Transfers That Cause a Medicaid Penalty](#).

**Mortgages and
Contracts**
20 CFR 416.1201

Count mortgages and contracts as resources. The countable value of a mortgage or contract is:

- ◆ The remaining balance on the contract; or
- ◆ The gross price for which it can be sold or discounted on the open market minus any legal debts, claims, or liens against the property.

Offer the applicant or member the opportunity to:

- ◆ Show that a contract is not legally transferable; or
- ◆ Establish the fair market value of the contract.

The fair market value of a mortgage or contract is the amount that the buyer would pay the seller for the mortgage or contract. To establish the fair market value of the contract, tell the applicant or member to obtain three written estimates of the mortgage or contract value.

Inform the applicant or member that obtaining outside estimates of the market value could increase or decrease the countable value of the resource. The institutions from which the estimates are obtained do not need to be in the area where the property is located.

The fair market value must be determined as the contract or mortgage stands, without any modification or conditions. However, the following conditions to a valuation are acceptable and do not prevent it from being a bona fide estimate of fair market value:

- ◆ Establishment of ownership.
- ◆ Production of abstract.
- ◆ Payment of filing fees. Deduct filing fees from the value of the contract.

Average the estimates provided by the applicant or member. If you receive only one unbiased estimate, use that value.

Make sure the financial institution is stating the actual worth of the contract and not an opinion on whether it wishes to buy the contract. Do not use the contract valuation to determine eligibility if it contains conditions such as:

- ◆ Credit approval of the buyer (unless there has been a recent credit approval of the buyer known to the client).
- ◆ Changes in the terms of the contract.
- ◆ Appraisal of the property at or above a particular value (unless there has been a recent appraisal at or above the stated value).

If a contract is jointly owned, the client's interest may be sold without the consent of the other owner. In Iowa, real property mortgages and contracts are usually legally transferable, even if the terms of the contract or mortgage prevent it. Although such terms are not legally enforceable, a nontransferable clause or an uncooperative co-owner may affect the fair market value.

If the contract is a countable resource, the portion of a mortgage or contract payment that represents interest, minus any interest used to purchase the property, is counted as unearned income. The principal portion of the payment is treated as a resource.

If the contract is not a resource and the principal is not treated as a resource, count the total payment on the contract as income.

Mr. H bought a property on contract that he is selling on contract. The value of the second contract is established at \$1,500. He has a checking account that had \$100 the first moment of the first day of the month, and no other resources. Mr. H is within resource limits.

Mr. H receives \$150 per month payment from the contract. Of this \$150 payment, \$40 a month is interest.

He pays \$12 a month interest in his payment for the property. The countable interest income for eligibility and client participation is \$28 per month. ($\$40 - \$12 = \28) The remaining \$110, if retained is counted as a resource.

Mortgages and contracts must be reviewed to determine if the purchase constitutes a transfer of assets for less than fair market value. See [Purchases Considered Transfers for Less Than Fair Market Value](#).

Other Excluded Federal Payments

20 CFR 416.1124,
P. L. 101-239,
P. L. 101-426,
P. L. 101-510
P. L. 106-398

Exclude the following federal payments:

- ◆ Income from any of the programs established under ACTION, Public Law 93-103, unless the director of the ACTION agency determines that the hourly rate is equal to or over the minimum wage. (So far, the director has never made this determination. Central Office will contact staff if that happens.) Programs under ACTION include:
 - University Year of Action (UYA).
 - Volunteers in Service to America (VISTA).
 - Foster Grandparents.
 - Retired Senior Volunteer Program (RSVP).
 - Senior Companion Program.
 - Special and Demonstration Volunteer Program.

- ◆ **Agent Orange Settlement Fund** payments or payments from any other fund established because of the settlement in the In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y).

NOTE: This settlement fund is now closed as all funds have been distributed.

- ◆ Dividend payments on shares of the **Alaska Native Fund**, and other revenue originated from the fund. The Alaska Native Fund was created by the Alaska Native Claims Settlement Act (Public Law 92-203), enacted on December 19, 1971.
- ◆ **Austrian Social Insurance** payments based partly or completely on wage credits granted under paragraphs 500-506 of the Austrian General Social Insurance Act. Use the award letter to determine how to count the payments.
- ◆ **Energy Employees' Occupational Illness Compensation Program** payments made to former employees or their families. Beneficiaries will receive one or two lump sum payments, which are excluded as income and as a resource. Award letters sent to the recipient from the Department of Labor should verify the amount and source of the payments.
- ◆ **German Reparations** payments made to survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution, whether they are paid periodically or in a lump sum.
- ◆ **Japanese-American (or their survivors) and Aleut restitution** payments made by the U.S. Government to people who were interned or relocated during World War II.
- ◆ **Japanese-Canadian** restitution payments from the Canadian Government to Japanese-Canadians who were interned or relocated during World War II. Use documents from the client to identify or verify the nature of the payments.

If the applicant or member has no documents, ask if they were imprisoned, relocated, deported, or deprived of other rights in Canada during the period of December 1941 to March 1949 because of Japanese ancestry. If yes, exclude the payment. If no, count the payment as a resource.

- ◆ **Radiation Exposure Compensation Act** payments that compensate persons for injuries or death resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person's death, payments are made to the surviving spouse, children, or grandchildren. Any interest on these funds is counted as income.
- ◆ **Relocation Assistance** payments provided to owners, tenants, or occupants who were displaced when property was acquired by a federal, state, or local government-assisted project.

Plan for Achieving Self-Support (PASS)

20 CFR 416.1180,
416.1181, 416.1226

Exclude resources of a blind or disabled member under the age of 65 if they are needed to fulfill a plan for achieving self-support (PASS). People 65 or over get this exclusion only if they were receiving SSI payments because of blindness or disability in the month before they turned 65. Check the SDX when an SSI recipient states that a plan for achieving self-support exists.

Property Necessary for Employment

20 CFR 416.1224

Exclude any tools, equipment, and uniforms necessary for a client's employment. The applicant or member must give you a signed statement listing the items required. If necessary, contact the employer for verification.

Property in a Homestead

20 CFR, 416.1212

Exclude a homestead as a resource regardless of value. A homestead is any shelter used as the principal place of residence by the member, spouse, or dependent (including a child under age 18 or the disabled adult child of the member or spouse). It includes surrounding contiguous land and any buildings on this land. It may be fixed or mobile and located on land or water.

Mr. K owns and operates the 80-acre farm on which he lives. The house, farm buildings, and farmland are exempt from consideration as a resource.

Mrs. Z owns 20 acres that is considered a homestead. Mrs. Z builds a second house and rents out the first house. Both houses are exempt as a resource because they sit on one contiguous homestead property.

Exclude the proceeds from the **sale** of the homestead (including homesteads sold on contract) for up to three months if the member intends to purchase another home. Ask the member to sign a statement such as the following:

"On ___(date)___ I received \$_____ net proceeds from the sale of my home. I plan to use that money to replace that home with another home within three months, by ___(date)___."

The member must report the date the new home is purchased and the purchase price. Count any excess proceeds from the sale of the old homestead that are not used to purchase the new homestead.

The homestead is sold for \$45,000 on December 2. A new home is purchased on February 16 for \$35,000. The \$10,000 difference is a countable resource on March 1.

If the proceeds are **not** used within three months to buy another homestead, count the proceeds as a resource at the end of the three-month period.

Also exclude a homestead as a resource if:

- ◆ It is not occupied by the member due to a **temporary absence**, such as a trip, visit, or stay in a residential care facility or medical institution. To be excluded, the member must intend to return to the home. If the member does not intend to return, the home becomes a nonhomestead property, and is countable as a resource.

Obtain a signed statement from the member or the member's representative that the member intends to return home. Place the statement in the case record.

If the statement contradicts previous statements by the member or the member's representative regarding intent to return home, obtain additional verification from a knowledgeable source.

- ◆ It is **occupied by the member's spouse or dependent relative** while the member is absent due to being institutionalized. "Dependent relative" includes:

- Child, grandchild, stepchild.
- Mother, stepmother, father, stepfather.
- Sister, stepsister, brother, stepbrother.
- Aunt, uncle, niece, nephew.
- Grandmother, grandfather.
- In-laws.

The dependency can be emotional, financial, or medical. If the dependent receives FIP assistance, the person can still be considered financially dependent on the member. Accept the member's statement that the relative is dependent unless you have reason to question it.

- ◆ It is not occupied by the member because the member is a victim of **domestic abuse** fleeing an abusive situation. Continue to exempt the home until the member establishes a new principal place of residence or otherwise takes action that makes the home no longer excludable.

Property in a Homestead for People Requesting Long-Term Care
441 IAC 75.15(249A)

A person is not eligible for payment of nursing facility services or other long-term care services, if the person has substantial equity interest in their homestead. This limit does not apply:

- ◆ If the spouse, or child who is under age 21, or the person's child who is blind or disabled, as defined by Social Security, resides in the home; or
- ◆ To people approved based on an application or request for payment of long-term care services filed before January 1, 2006.

Use the following chart to determine the correct maximum equity amount based on the date of application.

Application filed on or after:	Equity interest cannot exceed:
January 1, 2014	\$543,000
January 1, 2015	\$552,000

Property Earning Six Percent of Equity
20 CFR 416.1201

Exclude real property as a resource if its equity value does not exceed \$6,000 and the net annual return earned on the property is at least 6% of the equity value. **Equity** is the current market value of the property minus any legal debt on the property. **Market value** is the amount an item can be sold for on the open market.

To determine if the property is earning 6% of equity, multiply the net monthly income by 12 months. This amount is the net annual return earned on the property. Then multiply the equity value by 6%. Compare the net annual return amount to the 6% of equity amount.

If the net annual return is higher than 6% of the client's equity in the property, exclude the property if the equity value does not exceed \$6,000.

If the client's equity in the property exceeds \$6,000 and the property is earning at least 6% of equity, count only the amount of equity over \$6,000 as a resource.

Ms. T owns her home and rents it out for \$700 a month. The fair market value of the home is \$80,000 and she still owes \$50,000 on it. Ms. T's equity value is \$30,000. She files an application for medical assistance. Determine if the property is earning 6% of equity as follows:

$$\$700 \times 12 = \$8,400 \text{ net annual return}$$

$$\$30,000 \times 6\% = \$1,800$$

Since Ms. T's equity amount exceeds \$6,000 and the property is earning at least 6% of equity, count only the amount of equity over \$6,000 as a resource.

$$\$30,000 - \$6,000 = \$24,000 \text{ countable resource value}$$

If a property is not producing 6% of equity due to a client's illness, exclude the property as a resource for up to 24 months as long as the client plans to resume the business after the illness ends.

Property Used for Self-Support
20 CFR 416.1210

Exclude equity in non-income-producing real property that is valued under \$6,000 and produces goods and services necessary to the applicant's or member's daily living. Liquid resources used for self-support are **not** excluded.

Resource Replacement
20 CFR 416.1201,
416.1210, 416.1128,
416.1232, 416.1236;
P. L. 101-508

Exclude cash received for the replacement or repair of an excluded resource. Do not count the cash or the interest earned on the cash for nine months from the date it is received.

If the replacement or repair takes longer because of circumstances beyond the control of the member, exclude the cash for an additional nine-month period. Count it as a resource the first moment of the next month after the second nine-month period expires.

Retirement Funds
20 CFR 416.1201,
416.1210, 416.1232,
416.1236, 416.1244;
P. L. 101-508

Exclude retirement funds if the member has to quit a job to withdraw the funds.

If the retirement funds are not excluded:

- ◆ Count the verified net proceeds after penalties in the attribution and the eligibility process if the fund is owned by the member.
- ◆ Count the verified net proceeds after penalties in the attribution process if the fund is owned by the community spouse.
- ◆ Do not count retirement funds owned by the ineligible spouse in the deeming process when spouses live together.

NOTE: Taxes are not an allowable expense when determining net proceeds of retirement funds. The 10% early withdrawal penalty on an individual retirement account (IRA) is an additional tax.

A member who has a choice to withdraw retirement funds as a lump sum or as an annuity must choose the annuity.

Types of retirement plans include:

- ◆ **Defined benefit plan:** The employer promises the employee a specific monetary benefit at a specific age, based on factors such as salary and length of service. The employee cannot draw a pension until the employee meets certain requirements, such as being a certain age or being retired.

- ◆ **Defined contribution plan:** The employer and employee makes specific contributions to an employee's pension fund. The amount of the benefit depends on the amount saved and how well the employee's fund investments perform.

Most of these plans are 401(k) plans. Typically these plans can be accessed at age 59½ without a tax penalty or earlier with a tax penalty. Other withdrawal restrictions may apply depending on the plan.

- ◆ **Individual Retirement Account (IRA):** The employee establishes and funds these accounts. The employee can liquidate these funds at any time.

Retroactive Cash Payments

P. L. 101-508

Exclude any retroactive cash payments paid to ineligible spouses or parents for providing in-home supportive services to the applicant or member. Exclude the payments in the month of receipt and the following month.

Retroactive SSI and Social Security Lump-Sum Payments

20 CFR 416.1233

Exclude SSI and Social Security retroactive lump-sum income as a resource for nine months after receipt, as long as the funds are not combined with other funds and can be identified as the lump-sum funds. (See [8-E, Lump-Sum Income](#), for income guidelines.)

Verify that the funds are separate and represent a retroactive lump sum. Before the ninth month, the member must again verify resources. If resources exceed the limit, cancel the member, giving timely notice.

An unmarried member receives a social security lump sum of \$4,500 on October 12. The worker inputs a tickler for June 1. On June 19, the worker verifies the resources are \$2,600.

On July 30, the member is canceled and is ineligible for SSI-related coverage groups that have a \$2,000 resource limit. The worker completes a redetermination. Effective August 1, the member is eligible under Medically Needy.

**Self-Employment
Property and
Resources**

P.L. 101-239
SEC 8014

Exclude self-employment resources of the applicant or member, spouse, parent, or alien sponsor. Examples of self-employment resources are:

- ◆ Real property, buildings.
- ◆ Inventory, tools, equipment, machinery.
- ◆ Farm equipment and livestock.
- ◆ Motor vehicles.

If the homestead is used as the place of self-employment, exclude it as a home, if applicable; otherwise exclude it as a self-employment resource.

If you question whether a resource is used for self-employment or is the client's personal property, ask the client to sign a statement stating whether the resource is necessary for the self-employment. Allow the exclusion if client states the resource is necessary.

Exclude liquid resources that are essential for self-support and are used in the operation of self-employment. Obtain a signed statement that the liquid resources are used for self-employment.

Continue to allow the exclusion if:

- ◆ The business is operating at a loss.
- ◆ An illness or disability prevents the continuation of the self-employment business. This exclusion cannot exceed two years.
- ◆ The business is seasonal and the client is not currently working but is expected to return within one year after the last day of use.

1. Before Mrs. B entered a nursing facility, she and her husband farmed together. Mr. B continues to farm. Their animals, a truck, and farm machinery are necessary for farming and are not countable resources for attribution or eligibility determination. They are exempt as resources owned by the spouse necessary for self-employment.
2. Mr. and Mrs. W are farmers. They apply for Medically Needy and list livestock, a tractor, a combine, a car, two trucks, and a bank account as necessary for self-employment. All of the resources are determined to be necessary for self-employment, and are not counted.

Social Services

20 CFR 416.1201,
416.1210, 416.1228,
416.1232, 416.1236;
P. L. 101-508

Exclude payments for social service expenses for the month of receipt and the month after the month of receipt. If the funds are a reimbursement for bills previously paid by the applicant or member, count them as a resource in the month after receipt.

Third-Party Medical Payments

20 CFR 416.1201,
416.1210, 416.1228;
P. L. 101-508

Do not count funds received to pay for a medical service, such as Veterans unusual medical expense payments. These funds are exempt as a resource in the month of receipt and the month after the month of receipt. If the funds are repayment for bills the client already paid, count the funds as a resource the month after receipt.

Vehicles

20 CFR 416.1218

A vehicle is any device used to provide transportation, such as cars, trucks, motorcycles, boats, animals, animal-drawn devices, mopeds, etc. Vehicles can be unregistered or in need of repair, as long as the vehicle is used for transportation. Treat vehicles as follows:

1. Exclude one vehicle as a resource regardless of value if it is used for transportation of the individual or a member of the individual's household.
2. If the individual owns more than one automobile, apply the exclusion as follows:
 - a. Apply the exclusion in the manner most beneficial to the individual.

- b. Apply the total exclusion to the vehicle with the greatest equity value if the eligible individual owns more than one vehicle used for transportation of the individual or a member of the individual's household.
 - c. The equity value of any vehicle, other than the one wholly excluded, is a resource when it:
 - ◆ Is owned by the individual; **and**
 - ◆ Cannot be excluded under another reason (e.g., property essential to self-support, plan to achieve self-support).
3. Count the equity value of any other vehicles.
 4. Count the equity value of any vehicles used solely for purposes other than transportation, such as racing cars or antiques toward the resource limit. These vehicles are personal property, not household goods.

Do not count any vehicle that the applicant or member sold, even if the buyer has not recorded the title transfer with the appropriate authority.

To determine the value of vehicles, use a "blue book," such as the National Automobile Dealers Association (NADA) *Used Car Guide Book*.

Find the amount listed in the column for "average trade-in value." To find the specific value of the vehicle, use the value corresponding to the options that the vehicle has. If the vehicle is not listed in the "blue book," contact a motor vehicle dealer or knowledgeable source in the community.

Victim's Compensation Funds

20 CFR 416.1201,
416.1210, 416.1228

Exclude for nine months funds paid through the Crime Victim Reparation program. The Iowa Department of Justice administers this program, which compensates victims of crime for expenses incurred or losses suffered as a result of a crime. The funds should be separate and identifiable. Expenses paid by the Crime Victim Reparation Program include:

- ◆ Medical bills.
- ◆ Lost wages.
- ◆ Loss of support.
- ◆ Clothing held in evidence.
- ◆ Counseling.
- ◆ Burial.

**Worker's
Compensation
Medicare Set-Aside
Arrangements**

Treat a worker's compensation Medicare set-aside arrangement (WCMSA) as a trust created by a third party (the defendant in the worker's compensation claim).

Exclude it as a resource when determining eligibility if the member does not have a legal authority to revoke it or to direct the use of the assets for the member's basic needs.

The funds in the WCMSA are available only to pay medical providers for future medical costs related to the work injury that would otherwise be paid by Medicaid. Therefore, the funds set aside in the account and any income generated by those funds are not available or countable as resources or income in determining SSI-related Medicaid eligibility or benefits, unless they are actually used for basic needs.

If the trustee makes the trust principal or trust income available to the member for basic needs (in violation of the terms of the WCMSA), count the available funds as income in the month of receipt and as a resource the month after.

Refer the WCMSA to the Third Party Liability Unit.

FMAP-Related Resource Policies

Legal reference: 441 IAC 75.13(1), 75.9(249A), 75.15(249A), 75.56(249A)

Use FMAP-related policies regarding excluded resources, countable resources, and whose resources to consider when determining resource eligibility under FMAP-related programs.

Use FMAP-related policy to determine the value of the applicant's or member's property and consider the property for Medicaid eligibility. Exclude:

- ◆ Nonhomestead property that produces income that is consistent with its fair market value, and
- ◆ Nonhomestead property that is up for sale at a price that is consistent with its fair market value.

"Fair market value" is the gross price for which the property could be sold on the open market.

1. Ms. A and her children apply for FMAP. Ms. A owns nonhomestead real property valued at \$40,000. The worker explains to Ms. A that this property will be considered an accessible resource for her eligibility unless she either lists it for sale at a price that is consistent with the fair market value or it produces income which is consistent with the fair market value.

Ms. A chooses to list the property for sale at a fair market value and is approved for FMAP, as she meets all other eligibility factors.

2. Mr. L and his children receive FMAP. Mr. L inherits nonhomestead real property valued at \$25,000 and timely reports this to his worker. The property has been a rental property and currently has a tenant paying rent. The worker verifies that this property is producing income consistent with the fair market value. This property is exempt and Mr. L continues to receive FMAP.
3. Same as Example 2, except that this property is being rented to a relative and the income it is producing is not consistent with the fair market value. Mr. L chooses not to increase the rent.

Mr. L's FMAP assistance is canceled effective the first of the next month allowing a ten-day notice. However, Mr. L's children remain eligible since resources are not considered in determining FMAP-related eligibility for children. The children are now eligible under CMAP.

Use general Medicaid policy on trusts. Even though a trust may not be considered for the FIP determination, persons eligible for FIP who have a trust may not be eligible for Medicaid.

Ms. C and her son apply for FIP and Medicaid. Ms. C reports she is the beneficiary of a trust with a current principle of \$55,000. The trust principle is not countable as a resource for FIP and the trust is not paying out any income to Ms. C. However, the trust is a Medicaid qualifying trust and therefore, countable for Medicaid.

The application is approved for FIP, but, since Ms. C's countable resources exceed the resource limits of all Medicaid coverage groups, the application is denied for Medicaid for Ms. C. Ms. C's son would be eligible for CMAP. It does not matter that Ms. C is a FIP participant.

A transfer of assets between persons who are not spouses results in ineligibility for Medicaid payment for all long-term-care services. A claim may be established against the transferee. See [Transfer of Assets](#) for more information about eligibility.

Since transfers between spouses do not result in a penalty, a transfer of assets made by the stepparent to the spouse in order to qualify the group for FMAP does not disqualify the persons in the assistance unit from payment of nursing facility services.

A transfer of assets does not cause a period of ineligibility for specific Medicaid services for children when the children are eligible in a coverage group in which household resources are disregarded in determining children's eligibility.

Eligibility for Medicaid payment of nursing facility services for persons in the household is not affected by a transfer of assets made by self-supporting parents. The self-supporting parents' income is considered in determining Medicaid eligibility but their needs are not included in the eligibility determination. Remember, the resources of self-supporting parents are **not** included in the eligibility determination.

Parents who are not eligible for Medicaid, such as sanctioned parents, are included in the household size. Ineligible parent's assets are considered when determining FMAP eligibility for adults. Therefore, if assets of ineligible parents are transferred to persons other than their spouse, the transfer affects the eligibility for certain Medicaid services, for adults in the assistance unit.

Mrs. A transfers five acres of land to her brother in September. She applies for Medicaid for herself and her three children in October. The application is approved on October 26 but denied Medicaid payment for certain services for Mrs. A.

On December 14, Mrs. A enters a nursing facility after being injured in a car accident. She is expected to return home within one year. Mrs. A is ineligible for Medicaid payment of nursing facility care.

FMAP-Related Resource Limits

Legal reference: 441 IAC 75.9(249A), 75.56(249A)

For FMAP and FMAP-related Medicaid coverage groups, use FMAP resource limits:

- ◆ For an applicant's filing unit, the resource limit is \$2,000.
- ◆ For a member's filing unit, the resource limit is \$5,000.
- ◆ For transitional Medicaid, resources are not considered.
- ◆ \$10,000 in liquid resources is the resource limit for the Mothers and Children coverage group. See [8-F, Mothers and Children \(MAC\) Program](#).
- ◆ \$10,000 in liquid resources is the resource limit for FMAP-related Medically Needy. See 8-J, [MEDICALLY NEEDED](#).

When using the FMAP resource limits, apply the \$2,000 resource limit for each month of the retroactive period and for the month of application (even if retroactive Medicaid eligibility is established).

Apply the \$2,000 limit when a person enters a household receiving Medicaid but is not in the same filing unit. Once the applicant becomes a member, the resource limit increases to \$5,000.

Allow the \$5,000 resource limit when:

- ◆ A member leaves one coverage group to enter another coverage group.
- ◆ A person enters an existing Medicaid-eligible unit.

1. Mrs. K and her two children receive FMAP. The father of the children returns home. Because he is a mandatory household member and because he is entering an existing Medicaid-eligible group, he is subject to the \$5,000 resource limit.

2. Mr. P and his child apply for FMAP on January 2. Mr. P requests retroactive Medicaid for the three months before the month of application (October, November, and December). His resources are as follows:

\$1,700	October
\$1,800	November
\$1,900	December
\$2,100	January

If all other eligibility requirements are met, Mr. P is resource eligible in the retroactive period because his resources do not exceed \$2,000. A decision on his application is made in January and is denied for ongoing Medicaid, because he is over the \$2,000 resource limit for January.

Mr. P's child may be eligible for Medicaid under CMAP, MAC, or MN since resources are not counted when determining eligibility for children. Mr. P may be eligible for Medically Needy.

The resource limits apply only to adults in the eligible group.

The Automated Benefit Calculation (ABC) system determines whether to apply the \$2,000 applicant limit or the \$5,000 member limit according to your entries.

If **any** household member was active for Medicaid in the month before the month of application, the system applies the \$5,000 member resource limit.

If there is a break in assistance, the system applies the \$2,000 applicant resource limit.

Households are not members for any month that is subject to recoupment. To override the \$2,000 resource limit, enter an "A" for applicant on the RSCM screen in the ABC system.

1. Mr. D and his children are canceled from FMAP effective December 1. He reapplies on April 2. He has \$3,000 in countable resources. On April 22, the worker, in error, enters a "P" for participant on the resource screen that causes the system to apply the \$5,000 resource limit for members rather than the \$2,000 limit for applicants.

Since it is past timely notice to cancel for May, the worker cancels FMAP effective June 1. An automatic redetermination is completed for the children under CMAP and for Mr. D under Medically Needy.

2. Same as Example 1, except on April 1, Mr. D verifies that his resources are \$1,800. Mr. D is eligible for FMAP in December and ongoing. However, for April his children are eligible for CMAP and he is eligible for Medically Needy.
3. Family A is approved for FMAP effective October 12. The following March, the worker discovers that the family had these amounts in a savings account that the family had failed to report: October, \$2,500; November, \$2,500; December, \$1,800; January, \$2,400; February \$2,300; March, \$2,400.

The adults were ineligible for FMAP in October and November because their countable resources exceeded the \$2,000 applicant limit. The worker completes an automatic redetermination to CMAP and Medically Needy. However, in December, the family was eligible, because countable resources were below the \$2,000 applicant limit.

Once eligibility is established, the \$5,000 resource limit for members applies. Therefore, Family A continues to be eligible in January, February, and March.

An applicant becomes a member when the application is approved on the system, regardless of whether the date of decision is in the month of application or the following month. Therefore, apply the applicant limit through the month of decision. Apply the member limit beginning with the month after the month of decision.

1. Ms. A applies for Medicaid on October 15. The worker approves the application on November 12. The \$2,000 applicant limit under FMAP applies to October and November. The \$5,000 member limit applies beginning with the month of December.
2. Mr. B and his children apply for Medicaid on May 12. The worker makes the decision on June 8. In May, Mr. B's countable resources were \$1,800. On the date of decision, his resources are \$2,100. Mr. B's children are eligible for CMAP. Mr. B is eligible for FMAP for May but is ineligible for FMAP for June unless he can establish resources were below the limit any time in June before the date of decision. Eligibility under Medically Needy needs to be examined for Mr. B.

Countable Resources

Whose Resources to Count

Legal reference: 441 IAC 75.56(249A), (2)

Count the resources of all persons in the eligible group. Include the resources of a parent who is living in the home with the eligible children but who is not a member of the eligible group (e.g., excluded parent).

Do **not** consider the resources of:

- ◆ An ineligible stepparent living in the home.
- ◆ A Supplemental Security Income (SSI) recipient.
- ◆ A self-supporting parent when determining eligibility for the minor parent's child.
- ◆ An ineligible child living in the home. This means a child who is not included because the child receives subsidized adoption assistance.

NOTE: For more information on determining a child's eligibility, see [Resource Eligibility of Children](#).

What Resources to Count

Legal reference: 441 IAC 75.56(249A)

Unless specifically exempt, all resources are considered countable. The following table lists examples of countable and exempt resources:

Resource	FMAP	MAC/Medically Needy
Bank accounts used solely for a self-employment business	Countable	Exempt
Bonds (Use the redemptive value on date of decision or time of review.)	Countable	Countable
Cash on hand	Countable	Countable
Certificates of deposit	Countable	Countable
Checking or savings accounts	Countable	Countable

Resource	FMAP	MAC/Medically Needy
Employee's portion of a lump sum retirement fund payment when a client leaves employment, plus accumulated interest. (See 8-E, Nonexempt Lump Sums , regarding the employer's share of the retirement fund.)	Countable	Exempt
Life insurance cash value (the amount the insurance company pays upon borrowing against or canceling the policy before death). Use form 470-0444, <i>Insurance Report</i> , to get authorization to verify the amount of cash value and that the client has ownership of or access to this cash value.	Countable	Exempt
Medicaid qualifying trust whether trustee makes it available or not. If principal can be made available under discretion of trustee.	Countable	Countable
Motor vehicles (see Vehicles)	Countable Exempt one motor vehicle per household.	Exempt
Mutual funds	Countable	Countable
Net market value of available nonhomestead real property (see Determining Net Market Value of a Countable Resource)	Countable See Inaccessible Resources for exceptions.	Exempt
Promissory notes, mortgages and contracts	Countable	Exempt
Retirement accounts (IRAs, Keoghs, 401(k)s, IPERS)	Countable	Exempt
Stocks (Use the closing price on the date of decision or time of review.)	Countable	Countable

Count a resource only when:

- ◆ The applicant or member owns the property in part or in full and has control over it (meaning it can be occupied, rented, sold, etc. at their discretion).
- ◆ The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available.

Determine the availability of a resource regardless of the equity (net market) value.

An applicant or member need not gain title and control of an unavailable resource. Consider a resource unavailable when they own it in part or in full but have no control over it.

Joint Ownership

Legal reference: 441 IAC 75.56(249A), (6)

When a resource is owned by more than one person, assume everyone has equal shares unless you have verification to determine that the shares are different.

If an applicant or member owns a resource with another person but indicates that ownership is not equal, get a release signed so you can ask the co-owner to provide a written statement specifying the intent, degree, and terms of the joint ownership.

The intent of the co-owner is important. If the co-owner does not intend to provide the client access, the resource is unavailable. Examples include:

- ◆ An elderly parent of an FMAP member who has a joint account with the member in the event the parent becomes disabled.
- ◆ An adult child (an FMAP member) who is added to the title of a parent's home for ease of transfer in the event the parent should die.

In cases such as these, ask the other owner to write a statement indicating whether or not the Medicaid member has access to the account. If the statement indicates no access to the resource, consider it unavailable. Periodically check the availability of the resource.

If the applicant or member has joint ownership or tenancy-in-common ownership:

1. Determine the equity (net market) value of the total resource. If the total value plus other resources owned by the client are less than resource limits, take no further action.
2. Determine the client's share of the total equity (net market) value of the jointly owned resource. If the client's share plus other resources owned by them are less than the resource limit, take no further action.
3. If the client's share of the equity value would affect eligibility, contact the co-owner to determine if the co-owner would be willing to sell the resource. If so, count the client's share of the total equity value.
4. If the co-owner refuses to cooperate in the sale of the property, determine the equity (net market) value of only the client's share. The applicant or member must provide a written estimate of the value from a knowledgeable source.

The source must consider local market conditions as well as the condition and location of the resource. The source must also consider that the client has only a partial interest and that the co-owner refuses to sell.

If the estimate provided by the client appears reasonable, accept it. If the estimate is questionable, get a signed release of information so that you can independently verify the estimate.

5. Approve assistance, if otherwise eligible, when the equity value of the client's share in combination with other resources does not exceed resource limits. Deny or cancel assistance if that equity value, in combination with other resources, exceeds resource limits.

If the client disagrees with your decision, ask the client to supply additional information regarding the availability or value of the property.

If you are not able to determine availability, refer the case to central office staff on form 470-0116, *Clarification Request*.

Determining Net Market Value of a Countable Resource

Legal reference: 441 IAC 75.56(5)

Determine the net market (equity) value of countable resources only. The net market value is the gross price for which an item or property can be sold on the open market, less any legal debts, claims, or liens against it.

Consider each resource separately. The value of one resource does not affect another.

To determine the net market value:

1. Establish the gross sale price, called the "fair market value." Consider local market conditions and the condition and location of the property in determining the fair market value. For example:
 - ◆ A piece of real property may be worth less in one part of the state than a similar property is worth in another part of the state, due to a distressed local economy.
 - ◆ A piece of property may be worth less than it was previously because of depressed market conditions.
 - ◆ An item of real property may have a lower fair market value because of the location of that property (on a flood plain, remote location, etc.).

Contact a source knowledgeable about similar property, such as a car dealer, stockbroker, realtor, or banker.

If the client disagrees with the fair market value you determine, give the client an opportunity to provide written evidence of a different valuation.

2. Verify and subtract legal debts, claims, or liens, and document them in the case record. To be considered a lien or encumbrance against a resource, a loan or lien must give the creditor a legal right to satisfy the debt from the resource in question. In most cases, loans from family or friends do not meet this requirement.

When there is a legal debt against a combination of exempt and nonexempt property, look at the terms of the loan to see if any of the debt is deductible.

- ◆ When the terms of the loan require the proceeds from the sale of any part of the property to be applied to the balance of the loan, deduct the total legal debt from the fair market value of the nonexempt property.
- ◆ When the terms of the loan place a lien against the exempt property only, there is no legal debt to apply in determining the net market value of the nonexempt property.

1. Mr. A owns a home on 80 acres of land outside a city plat. There is a lien of \$20,000 on the **total** property. Proceeds from the sale of any part of the property must be used to reduce the balance of the loan. Deduct the entire \$20,000 from the gross value of the nonexempt property.
2. Ms. B owns a home on **one** acre of land inside a city. There is a lien of \$40,000 on the house and **one-half** acre. Do not deduct the \$40,000 from the gross value of the non-exempt property.

The balance after subtracting debts from fair market value is the net market (equity) value. Count as "zero" a resource that has a negative net value (that is, the debt against the property is more than the fair market value). Do not assign a negative number to any resource.

Subtract the expenses in selling the property only after it is sold.

Contracts

Legal reference: 441 IAC 75.56(249A), (4)

The resource value of a mortgage or contract is the gross price for which it can be sold or discounted on the open market, minus any legal debts, claims, or liens against it.

In Iowa, mortgages and contracts are always legally transferable, even if the terms of the contract or mortgage prohibit it. Although such terms are not legally enforceable in Iowa, they may affect the current market value of the contract or mortgage.

If the mortgages or contracts have terms that, as a practical matter, prevent sale, do not count them as resources.

Ms. B owns a contract with her two sisters, Ms. C and Ms. D. The terms of the contract prohibit any transfer or sale of the contract without approval of all of the siblings. Neither Ms. C nor Ms. D is willing to sell her shares or to buy Ms. B's share.

In reviewing the contract, a knowledgeable source determines that the terms of the contract prevent the sale. Even though these terms are not legally enforceable, they affect the market value of the contract or mortgage. Therefore, the contract is considered to have a value of zero.

Consider any **principal** payments received on a mortgage or contract as a resource upon receipt. Consider the monthly interest portion of the payment as a resource effective the first of the month after the month of receipt. If the interest is prorated, exempt it for the number of months in which the interest is prorated.

Determining Contract Value

Ask the applicant or member for a written estimate of the mortgage or contract value. The estimate must be based on local market conditions and the condition and location of the property. If the estimate provided appears reasonable, accept that value.

If you have more than one valuation, average the values.

Ms. A owns a contract. She obtained three written valuations: \$925, \$850, and \$800. The worker averages the three evaluations ($\$925 + \$850 + \$800 = \$2,575$ divided by 3 = \$858). The average value of \$858 is considered the fair market value of the contract.

If you doubt the value of the estimate, or if the client cannot get one, ask the client to sign a release of information so that you can independently verify or obtain the estimate. Obtain one or more estimates of value from sources knowledgeable in the business of buying and selling contracts.

These sources do not need to be in the area where the property is located, but the source must consider local market conditions and the condition and location of the property when determining the value. Valuations must be based on the most complete information possible.

If the applicant or member disagrees with your estimate, allow them to provide additional information.

Vehicles

Legal reference: 441 IAC 75.56(249A), (2) and (1)“e”

A vehicle is any motorized means of transportation that moves persons or articles from place to place. This includes automobiles, trucks, motorcycles, tractors, snowmobiles, recreational vehicles, campers, and motorized boats.

Vehicle Exemption

Legal reference: 441 IAC 75.56(1)

Exempt one motor vehicle without regard to its value. This exemption applies to each FMAP-related eligible group. Count the value of any additional vehicles owned by the eligible group, as described in [Equity Exclusion](#).

See [Determining Net Market Value of a Countable Resource](#) for instructions on how to calculate net market value of a vehicle. Use a current “blue book,” such as *National Automobile Dealers Association (NADA) Used Car Guide Book* (Blue Book) to determine value of a vehicle.

Find the amount listed in the left-hand column, entitled “Average Trade-In Value.” Do not increase the value because of low mileage or optional equipment. This is the value to use unless the applicant or member can establish a lower value.

If the vehicle is not listed in the Blue Book, contact a motor vehicle dealer in the community. Ask the dealer what the cash value would be of the same make, model, size, material, or condition as the client’s vehicle.

Special equipment that modifies a vehicle for a disabled person does not increase the value of the vehicle.

Equity Exclusion

Legal reference: 441 IAC 75.56(1)“d”

Exclude the equity value up to \$5,874 per vehicle of each adult (including a needy nonparental relative) and working teenaged child whose resources must be counted in determining eligibility. (The equity value limit changes each July 1 to reflect the latest increase in the consumer price index for used vehicles.)

The exclusion applies regardless of who owns the vehicle, as long as the owner is a person whose resources must be counted. Do not allow an exclusion for additional vehicles over and above the number of exclusions to which the eligible group is entitled.

When a person whose resources must be counted has multiple vehicles, apply the exclusion to the vehicle with the highest equity value. Allow the exclusion for a working teenager regardless of the teen’s age, whether the teen has a driver’s license or whether the car is needed for the teen to drive to work.

The exclusion for the teen continues when the teen is temporarily absent from the job for illness, vacation, between jobs or due to the nature of employment (for example, if the teenager works only during summer vacation). The exclusion does not apply to a teenager who is looking for work but has not been employed in the past.

Ms. A receives FMAP benefits for herself and three children. One teenaged daughter is employed. The family owns four vehicles; the equity values are \$10,000, \$8,000, \$5,000, and \$500. The family has no other resources.

	<u>Vehicle 1</u>	<u>Vehicle 2</u>	<u>Vehicle 3</u>	<u>Vehicle 4</u>
Equity value	\$ 10,000	\$ 8,000	\$ 5,000	\$ 500
Exemption/exclusion	- <u>10,000</u>	<u>5,874</u>	- <u>5,874</u>	- <u>0</u>
Excess resources	\$ 0	\$ 2,126	\$ 0	\$ 500

- ◆ The motor vehicle with the highest equity value is exempt.
- ◆ The vehicle exclusion for Ms. A and the employed teen is deducted from the two vehicles with the next highest equity values.
- ◆ Count the equity value of the lowest valued vehicle since there is no exclusion.

Ms. A's countable resources are within the \$5,000 limit for members.

If Ms. A were an applicant for FMAP, her resources would exceed the \$2,000 limit. The children may be eligible under CMAP and Ms. A may be eligible under Medically Needy.

When the household has a vehicle that is used for a self-employment enterprise and also used for personal use, apply the one motor vehicle exemption policy, the \$10,000 exemption for capital assets, and the vehicle exclusion. See [Self-Employment Assets](#).

Ms. A receives Medicaid under FMAP. She has the following resources: One camper valued at \$12,000, one car valued at \$6,000, \$1,000 in savings, \$200 cash value in a life insurance policy, and \$5,000 equity in tools needed for her self-employment.

<u>Countable Resources</u>		<u>Exempt Resources</u>	
\$ 1,000	Savings	\$12,000	Camper (exempt one motor vehicle)
200	Cash value of insurance	\$5,000	Equity in tools
+ 196	Excess equity in car	\$5,874	Car equity exclusion
\$ 1,396	Countable resources		

Ms. A is resource-eligible for Medicaid under FMAP.

Exempt Resources For FMAP

Legal reference: 441 IAC 75.56(1), 75.56(2), 75.56(6), 75.56(8), 75.56(9) and 75.57(6)

Some resources are always exempt under FMAP. However, for other resources, the exemption lasts only for the month of receipt and the month following the month of receipt. Any resources remaining are then counted towards the maximum resource limit.

The following resources are exempt in the month of receipt and perhaps in the following month of receipt. See individual sections for more information.

- ◆ [Corrective payments](#)
- ◆ [Earned income credit \(EIC\) payments](#)
- ◆ [Property settlements](#)
- ◆ [Insurance settlements and damage judgments](#)

A listing of exempt resources follows. These resources are **totally exempt** for FMAP. Count any resources not on the exempt list as well as the value of any resources exceeding the excluded amounts toward the resource limit.

**AIDS/HIV
Settlement
Payments**

441 IAC 75.56(249A)

Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

AmeriCorps

Public Law 103-82,
441 IAC 75.57(6)"i"

Exempt as a resource the living allowance (stipend) payments made to participants in the AmeriCorps*VISTA program as long as the Director of ACTION determines that the value of all such payments is less than either the federal or state minimum wage when divided by the number of hours the volunteer is serving. To date, no AmeriCorps*VISTA payments have exceeded this standard.

Exempt the educational award as a resource, because the award is issued directly to the educational institution or the holder of the loan and is not considered available to the recipient.

Also exempt as a resource the health insurance, reasonable accommodations, supplies, and services made available for AmeriCorps participants who have disabilities.

Burial Plot

441 IAC 75.56(1)"i"

Exempt one burial plot for each member of the eligible group. A burial plot is a gravesite, crypt, mausoleum, urn, or other repository customarily used for the deceased's remains.

When the client owns more than one plot for each member of the eligible group, count the net market value of the excess plots toward the resource limit. Also count the net market value of a burial plot for an ineligible person whose resources must be considered (e.g., an excluded parent).

**Burial Trusts or
Funeral Contracts**

441 IAC 75.56(1)“h”

Exempt equity not to exceed \$1,500 in one burial trust or funeral contract for each member of the eligible group. Count any amount over \$1,500 towards the resource limit, unless the contract or trust is irrevocable. (“Irrevocable” means that the contract or trust cannot be terminated or amended unless both parties to the contract or trust agree.)

Count burial trusts and funeral contracts held by an ineligible person whose resources must be considered (e.g., an excluded parent).

**Child Support \$50
Exemption**

441 IAC 75.57(6)“u”

Exempt the first \$50 of a current monthly support obligation or a voluntary support payment from a parent of a child in the eligible group or from a person who is under court order to pay support for a member of the eligible group. (A parent of a child is considered legally responsible, whether or not that parent is ordered to pay support.)

The maximum exempt amount is the lowest of the following:

- ◆ \$50.
- ◆ The amount paid.
- ◆ The monthly obligation.

**Corrective
Payments**

441 IAC 75.56(1)“f”

Exempt retroactive FIP payments in the month received and in the following month.

**Current Month’s
Income**

441 IAC 75.56(1)“f”

Do not add current month’s income to the total countable resource amount for that month. This includes situations when you prorate lump-sum or self-employment income and project it as future months’ income. Exclude the prorated income from consideration as a resource during the period of months over which you prorate it and count it as income.

When you verify that a liquid resource amount includes current month’s income, subtract the income from the resource amount you count for the month. Count any income remaining after the month of receipt as a resource.

**Disaster and
Emergency
Assistance
Payments**

441 IAC 75.57(6)"y"

Exempt disaster and emergency assistance payments as provided under the Disaster Relief Act of 1974, as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

This policy covers:

- ◆ Payments provided by the Federal Emergency Management Agency (FEMA), including payments from the Individual and Family Grant Program.
- ◆ Disaster unemployment benefits provided under the 1988 amendments to the Disaster Relief Act of 1974. Under this Act, unemployment benefits are provided to persons who are out of work due to a major disaster, including self-employed persons and others who are not covered under regular unemployment insurance benefits.
- ◆ Disaster and emergency assistance provided under the 1988 Amendments to the Disaster Relief and Emergency Assistance Act of 1974 and comparable assistance provided by states, local governments, and disaster assistance organizations.

Exempt vendor payments made under Iowa's Emergency Assistance program.

Before exempting the payments verify the source.

**Domestic
Volunteer Services
Act**

441 IAC 75.57(6)"j"

Exempt payments from programs under Titles II and III of the Domestic Volunteer Services Act made to volunteers for support services or reimbursement of out-of-pocket expenses.

Programs under this act include:

- ◆ University Year for Action (UYA)
- ◆ Service Corps of Retired Executives (SCORE)
- ◆ Active Corps of Retired Executives (ACE)
- ◆ Foster Grandparents

**Earned Income
Credit (EIC)
Payments**

441 IAC 75.56(1)"l";
Tax Relief,
Unemployment
Insurance
Reauthorization, and
Job Creation Act of
2010, P. L. 111-31

Exempt Earned Income Credit (EIC) payments in the month received as well as in the following month. Exempt payments in these two months whether they are received with a regular paycheck or in a lump sum as part of a federal income tax refund. Funds remaining are countable resources after the end of the second month.

NOTE: Exclude for 12 months from the date of receipt all EITC payments received as part of federal tax refund between January 1, 2010, and December 31, 2012.

**Education
Assistance**

441 IAC 75.57(6)"r"

Exempt all earned and unearned financial assistance for education or training.

**Energy Assistance
Payments**

441 IAC 75.57(6)"f"

Exempt energy assistance payments made to eligible households through the Division of Community Action Agencies of the Department of Human Rights under the Low-Income Home Energy Assistance Act of 1981 (LIHEAP). LIHEAP covers costs such as:

- ◆ Insulation.
- ◆ Home energy assistance.
- ◆ Emergency lodging because utilities have been shut off.
- ◆ Winterizing old or substandard dwellings. (Neither the cost of the materials nor the cost of labor is counted as a resource.)

Exempt other support and maintenance energy assistance when the assistance is based on need and is furnished by a:

- ◆ Supplier of home heating gas or oil, whether in cash or in kind.
- ◆ Municipal utility providing home energy, whether in cash or in kind.
- ◆ Private nonprofit organization, but only if the assistance is in-kind.

- ◆ Rate-of-return entity providing home energy, whether in cash or in kind. "Rate-of-return" means that revenues are primarily received from charges to the public for goods or services, and the charges are based on rates regulated by a state or federal agency.

"Support and maintenance" assistance is any assistance designed to meet day-to-day living expenses. This includes assistance to pay for heating or cooling a home.

"Based on need" means that assistance is issued to or on behalf of a person according to income limits at or below 150 percent of the federal poverty level.

There may be other assistance for home energy costs provided to FMAP households. When other assistance meets the criteria above, that assistance is also exempt.

**Family Support
Subsidy Program**
441 IAC 75.57(6)"p"

Exempt Iowa Family Support Subsidy payments made to families with children who have special educational needs due to physical or mental disabilities. The purpose of the program is to reduce the need for out-of-home placements or to facilitate the return of the child from an out-of-home placement.

**Federal Tax
Refunds**

Tax Relief,
Unemployment
Insurance
Reauthorization, and
Job Creation Act of
2010, P.L. 111-312.
P.L. 112-240

Federal tax refunds are excluded for 12 months from the date of receipt.

Food Programs
441 IAC 75.57(6)"b"
through "e"

Exempt the value of:

- ◆ Benefits received under the Food Assistance program.
- ◆ Commodities donated by the U.S. Department of Agriculture.

- ◆ Supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended, (Public Laws 92-433 and 93-150).
- ◆ Congregate meals or other benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act of 1965.

Grants

441 IAC 75.57(6)"q"

Exempt grants obtained and used under conditions that preclude their use for current living costs.

Home Produce for Personal Consumption

441 IAC 75.57(6)"a"

Exempt the value of home-produced garden products, orchards, animals, etc., that are eaten by the household. When home produce is raised for sale or exchange, consider it a business operation and treat it as self-employment income.

Homestead

441 IAC 75.56(1)"a"
& (3)

Exclude the applicant's or member's homestead without regard to its value. A homestead is any house, mobile home, or similar shelter used as the applicant's or member's home. It may contain one or more adjacent lots or tracts of land, including buildings and equipment.

A homestead may contain any type or number of buildings within the land limits described including:

- ◆ A duplex. (Exempt the entire duplex.)
- ◆ An apartment. (If the client lives in the building and does not sell any of the apartments, exempt the entire apartment house. Apartments include both standard buildings and single-family houses converted to apartments.)
- ◆ A family home containing a room or apartment. (If the client lives in one of the units, exempt the home.)
- ◆ A condominium or row house occupied by the client. (Exempt only the unit occupied by the client.)

There is a limit on the amount of land that may be exempted as part of the homestead:

- ◆ When outside a city plat, exclude no more than a total of 40 acres of land.
- ◆ Within the city plat, exclude no more than one-half acre of land.

To determine if the homestead within a city plat is within size limits, multiply the length of the property by the width to calculate the square footage. Compare this figure to 21,780 (the number of square feet in one-half acre). If necessary, obtain courthouse or tax records to find the legal descriptions of the property.

Property that exceeds the allowable limit is counted as a resource.

Exempt a homestead when an applicant or member temporarily leaves if they:

- ◆ Are absent for a defined purpose, **and**
- ◆ Lived in the home immediately before the absence, **and**
- ◆ Intend to return when the purpose of the absence has been accomplished.

Regularly document the client's intentions to return home. If the client does not intend to return home, the homestead becomes a countable resource.

Do not apply the homestead exemption to nonhomestead property which the household acquires intending to make the property its homestead in the future.

**Homestead for
People Requesting
Long-Term Care
Payments**

441 IAC 75.26

Effective January 1, 2006, a person is not eligible for payment of nursing facility services or other long-term care services if the person's equity interest in the person's home exceeds \$500,000. For more information, see [Property in a Homestead for People Requesting Long-Term Care](#).

**Household Goods
and Personal
Effects**

441 IAC 75.56(1)"b"

Exempt household goods and personal effects without regard to their value. Household goods are items used in and about the house in connection with home occupancy. They are items used to maintain the home as well as to accommodate, comfort, and entertain the occupants.

"Personal effects" are the belongings of family members, including clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

Animals, pets, and collections are **not** excluded and must be counted.

**Inaccessible
Resources**

441 IAC 75.56(6)"a,"
"c," "d"

Exempt resources that are not available to the applicant or member. Examples of instances in which a resource is **not** available include:

- ◆ Property jointly owned by spouses involved in a divorce proceeding. The property is not available until a decision on property distribution has been made.
- ◆ Real or personal property in which the terms of the joint tenancy or tenancy in common make the property unavailable. See [Joint Ownership](#).
- ◆ Nonhomestead property jointly owned by a FMAP parent and a separated or divorced spouse or a deceased spouse's estate, when the parent is not able to have control of it. This may occur because the other owner has possession of the property or because it is in litigation.
- ◆ Nonhomestead property for so long as the property is publicly advertised for sale at an asking price consistent with its fair market value. To verify that the property is up for sale at fair market value, use collateral contacts and documentation, such as newspaper ads or real estate broker listings.

Income in Kind

441 IAC 75.57(6)"o"

Exempt as a resource unearned income-in-kind such as money paid on an applicant's or member's behalf to a third party (vendor payments). Also exempt earned income in-kind, such as meals, reduced rent received in exchange for performing work or a service.

**Indian Tribe
Judgment Funds**
441 IAC 75.57(6)“h”

Exempt as a resource Indian tribe judgment funds that have been or will be distributed to each member or held in trust for members of any Indian tribe.

When all or part of the payment is converted to another type of resource, also exempt that resource. If this resource decreases in value, the exemption applies to the remaining value of the resource. If the resource appreciates in value, only the original amount is exempted.

**Individual
Development
Accounts**
441 IAC 75.56(1)“m”
& 75.57(6)“ab”

Individual Development Accounts (IDAs) are optional, interest-bearing accounts much like IRAs. IDAs encourage families to save and plan for the future, without the savings affecting eligibility for assistance. The accounts allow withdrawal without penalty for items such as educational expenses, business start-up, home ownership, and emergencies.

Exempt the balance in an IDA and any interest applied to the account.

**Insurance
Settlements and
Damage
Judgments**
441 IAC 75.56(7)

Consider insurance settlements and damage judgments received for damage or destruction of an **exempt or nonexempt** resource as liquidating a resource and not as income.

When the applicant or member intends to repair or replace the resource, and signs a legal, binding commitment no later than the month after the payment is received, exempt the payments for the duration of the commitment (up to eight months following the commitment date).

For example, if a homestead is damaged by fire, the applicant or member must commit any settlement funds in excess of resource limits in a binding contract to rebuild or repair the home to avoid being over the resource limit.

Document the settlement and the legal commitment in the case record.

If the applicant or member does not intend to repair or replace the home, or the payments are for a **nonexempt** resource, count the amount of the settlement as a resource in the month following the month payment was received.

Life Estates
441 IAC 75.56(1)“k”

Exclude a life estate of the life estate holder. A life estate is defined as the ownership of the right to live on, use, or receive income from a property in which the person does not have full rights of disposition. The life estate holder may use the property but may not alter or transfer it.

Exclude any interest in a property held by an applicant or member when another person holds the life estate until the holder dies or surrenders the life estate to the applicant or member.

**Life Insurance
With No Cash
Surrender Value**
441 IAC 75.56(1)“c”

Exclude any types of life insurance that have no cash value, such as term insurance or group insurance. The owner of the life insurance policy is the person paying the premium who has the right to change the policy.

The cash surrender value of insurance is generally available to the premium payor, unless it is assigned or in some other manner actually transferred on the records of the insurance company to the insured or other named person. Do not automatically assume that the applicant or member does not own the policy simply because another person is paying the premium.

Loans
441 IAC 75.57(6)“v”

Exempt bona fide loans. A bona fide loan is one that includes an agreement between the lender and the borrower that the money is a loan. This agreement may be oral or in writing, as long as it indicates an intent to repay the money.

**Lump Sum
(Nonrecurring)**
441 IAC 75.56(1) “f”
& “l”

Exempt the amount of a nonrecurring lump sum that is reserved for current or future month's income. See [8-E](#) for more information about how to treat lump sums.

**Medical Expense
Settlement**
441 IAC 75.56(1)“j”

Exempt settlements for payment of medical expenses.

**Other Excluded
Federal Payments**

441 IAC 75.57(6) "w"

Exclude the following federal payments:

- ◆ Payments received through the Agent Orange Settlement Fund or any other fund established because of the settlement in the "In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)." NOTE: This settlement fund is now closed as all funds have been distributed.

441 IAC 75.57(6) "k"

- ◆ Payments made by the U.S. government under Public Law 92-203, the Alaskan Native Claims Settlement Act. Exempt the tax-exempt portions.

441 IAC 75.57(6) "z"

- ◆ Payments made by the U.S. government to individual Japanese-Americans (or their survivors) who were interned or relocated during World War II.

441 IAC 75.57(6) "z"

- ◆ Payments made to eligible civilian Aleuts under section 206 of Public Law 100-383. This payment is available only to those Aleuts who were living on August 10, 1988, the date Public Law 100-383 was enacted.

441 IAC 75.57(6) "aa"

- ◆ Payments made under the Radiation Exposure Compensation Act, Public Law 101-426 which compensates persons for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person's death, payments are made to the surviving spouse, children, or grandchildren.

P. L. 106-398

- ◆ Payments received under the Energy Employees' Occupational Illness Compensation Program. Payments are made to former employees or their families. Members may receive one or two lump sum payments. Award letters are sent to the recipient from the Department of Labor.

441 IAC 75.57(6) "l"

- ◆ Payments from the Experimental Housing Allowance Program under annual contribution contracts entered into before January 1, 1975, under section 23 of the U.S. Housing Act of 1936, as amended.

441 IAC 75.57(6) "g"

- ◆ Payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968. The federal government makes these payments to persons displaced when the government acquires their property for a federal or federally assisted project. Local poverty agencies administer these programs.

**Property
Producing Income
Consistent with
Fair Market Value**
441 IAC 75.56(1)"o"

Exempt the resource value of nonhomestead property producing income consistent with the property's fair market value, such as when income from rental property is consistent with rental income for similar rental properties in the area. Allow the exemption even when the property produces the income on a seasonal basis.

If the property does not produce income consistent with its fair market value, count the net market (equity) value of the property toward the resource limit.

NOTE: If the household uses the real property for self-employment purposes, consider the exemptions as described under [Tools of the Trade](#).

See [Determining Net Market Value of a Countable Resource](#) for information determining net as well as fair market (gross) value. Also see [Inaccessible Resources](#) to determine availability of the nonhomestead property.

**Property
Settlements**
441 IAC 75.56(4)"a"

Exempt property settlements that are part of a legal action in the dissolution of marriage or palimony suits, regardless if received as a lump sum or in periodic payments. Exempt settlements for the month of receipt and the following month.

**Property Sold
Under Installment
Contract**
441 IAC 75.56(4)"b"

Exempt property sold under an installment contract or held as security in exchange for a price consistent with its fair market value. Also exempt the value of the installment contract.

If the price is not consistent with the fair market value, count the net market (equity) value of the installment contract (rather than the equity value of the property) toward the resource limit. See [Determining Net Market Value of a Countable Resource](#) for information on determining contract value.

Prorated Income
441 IAC 75.56(1)"f"

Exempt prorated income during the period of months over which you prorate it. See [Current Month's Income](#).

Self-Employment Assets

441 IAC 75.56(9)

See [8-E](#) for information on how to determine if an enterprise is considered self-employment.

See [Current Month's Income](#) for more information.

Exempt **inventory** and **supplies** that are needed for self-employment.

“Inventory” is defined as all unsold items, whether raised or purchased, that are held for sale or use. Examples are:

- ◆ Merchandise
- ◆ Grain held in storage by a farmer
- ◆ Livestock raised for sale
- ◆ Antiques held by a dealer
- ◆ Cosmetics held by a beautician

Mr. A is a self-employed toy maker. His unsold toys (his inventory), as well as his lumber, glue, varnish, and other supplies are exempt as inventory.

“Supplies” are items that are necessary for the operation of the business like lumber, paint, seed, and fertilizer.

Capital assets are not considered to be inventory or supplies. These are assets that, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. (See below.)

Capital gains result from sale of a resource and are a resource upon receipt.

Continue to exempt self-employment inventory or supplies if the self-employment is temporarily interrupted due to circumstances beyond the control of the household (such as illness). There must be a defined purpose for the interruption and an intent to return to the self-employment. Apply prudent-person guidelines to determine if this is a situation where you can expect the person to return.

**Subsidized
Guardianship
Payments**

441 IAC 75.57(6)"s"

Payment made under a subsidized guardianship program are exempt as a resource.

Tools of the Trade

441 IAC 75.56(1)"n"

Exempt up to a total of \$10,000 in equity (net market) value for **tools of the trade or capital assets** for self-employed households. First deduct what the applicant or member owes on the tools. Then count any equity value over \$10,000.

The \$10,000 limit applies to the entire household, regardless of how many members are self-employed.

Tools of the trade and capital assets are those items that, if sold, could be used to claim gains or losses for federal income tax purposes. A capital asset usually has a life span of more than one year. It can include real as well as personal property.

Examples include:

- ◆ Farm equipment of a farmer
- ◆ Farm land
- ◆ Hair dryers of a beautician
- ◆ Tools of a mechanic
- ◆ Electric saw and sander of a toy maker
- ◆ Computer and other equipment of a word processor
- ◆ Stoves and ovens of a baker
- ◆ Photocopy machines in a copy center

Livestock used for breeding, show, or dairy purposes are capital assets if depreciated for federal income tax purposes. If not, the livestock is considered inventory and is entirely exempt.

When the household has a vehicle that is used for the self-employment enterprise and also for personal use, apply the motor vehicle exemption policy, the \$10,000 exemption for capital assets, and the vehicle exclusion. See [Vehicles](#).

The tools of the trade exemption also applies when:

- ◆ The household is in the process of setting up a business, and provides verification, or
- ◆ A member's self-employment is temporarily interrupted because of circumstances beyond the control of the household (for example, because of illness or training directly related to self-employment).

The \$10,000 exemption no longer applies when the self-employment ends or when the applicant or member files Chapter 7 bankruptcy. The household loses this exemption beginning the month after the self-employment ends.

Transfers to Minors

Iowa Code 565B
441 IAC 75.56(6)

When a child has assets in an account set up under the Uniform Transfers to Minors Act (Iowa Code Chapter 565B), an adult is named as custodian of the account. The adult has discretion in withdrawing money from the account to give to the child (or spend for the child).

When the custodian of the account lives with the FMAP household, consider the money in the account as a countable resource, regardless whether the custodian receives Medicaid with the other household members. If the custodian is a parent in the eligible group, count the money as available even if the parent is temporarily absent.

When the custodian is someone who does **not** live with the FMAP household (other than a parent who is temporarily absent), count as an available resource only the amount the custodian is willing to make available to the household.

Obtain a signed statement from the custodian to determine the amount the custodian is willing to make available to the FMAP household. Consider the remainder in the account as an unavailable resource.

The Act specifies that the custodianship terminates and the property is distributed when the minor turns 21.

VISTA Payments
441 IAC 75.57(6)“i”

Exempt as a resource Title I VISTA volunteer payments, as long as the value of all payments is less than either the federal or state minimum wage when dividing the payments by the hours of service.

To date, no VISTA payments have been determined by the Director of ACTION to equal or exceed the minimum wage.

**Women, Infants
and Children
(WIC) Nutrition
Program**
441 IAC 75.57(6)“d”

Exempt the value of food assistance received through the Women, Infants, and Children Nutrition Program administered by the Department of Public Health through local health agencies.