

**EXPLANATION OF THE EFFECT OF TRANSFER OF RESOURCES
ON MEDICAL ASSISTANCE ELIGIBILITY**

This explains how a transfer of certain resources or assets may affect your eligibility for Medical Assistance. A transfer is when property or assets are given or sold from one person to another. For Medical Assistance purposes, a prohibited transfer is the voluntary giving or sale of your property or assets to another person without receiving something of equal value in return, in order to qualify for:

- o nursing care and related services in a nursing facility;
- o a level of care provided in a hospital which is the same as the level of care provided in a nursing facility; or
- o care, services, or supplies furnished pursuant to a waiver under Section 1915(c) of the federal Social Security Act.

The following information applies only to transfers made by you on or after October 1, 1989, and to transfers made by your spouse on or after September 1, 1991.

The Medical Assistance Program will not pay for any of the services listed below if a prohibited transfer of countable resources (the value of property and assets that are in excess of the allowable Medical Assistance resource standard) for less than fair market value is made within 30 months before, or at any time after, the date you apply for Medical Assistance to pay for the services listed in the "limited coverage" section below. (In most cases, once you are found to be eligible for these services, a transfer by your spouse does not affect your Medical Assistance coverage.) If we decide that a prohibited transfer has been made within this time period, and you meet all other eligibility requirements, your Medical Assistance coverage will be limited for a period of time.

What does limited coverage mean?

Limited coverage means that for a period of time you will not be able to receive Medical Assistance coverage for the following types of care and services:

- o nursing facility services (residential health care facilities, residential treatment facilities or Intermediate Care Facilities for the Developmentally Disabled);
- o nursing facility services provided in a hospital;
- o home and community-based waived services which are provided primarily through the Long Term Home Health Care Program or the Nursing Home Without Walls Program:

- Congregate/home delivered meals
- Home maintenance tasks
- Housing improvement
- Social transportation
- Respite care
- Social day care
- Personal emergency response system services
- Moving assistance
- Medical social services
- Respiratory therapy
- Nutritional counseling/education services

How is the limited coverage period determined?

When you or your spouse make certain transfers of resources for less than they are worth, you cannot get Medical Assistance for the services listed above for up to 30 months from the date the resource was transferred. We determine the number of months you are ineligible for these services by dividing the uncompensated value of the resource transferred by the average monthly rate for nursing facility services in the region where you live. Information on average monthly rates is available upon request from your social services district.

How do we determine the uncompensated value of the transferred resources?

We estimate the fair market value of the resource at the time it was transferred. We deduct any outstanding loans, mortgages or other encumbrances on the resource and the amount of compensation received in exchange for the resource. If you have no other countable resources, we deduct the Medical Assistance resource standard for one person. We also deduct a burial reserve for you and your spouse, if applicable.

What transfers do not affect your eligibility for Medical Assistance?

There are exceptions to the transfer of resource rules. Your Medical Assistance coverage is not limited when a transfer has been made if:

1. the resource(s) was transferred to (or for the sole benefit of) your spouse, or from your spouse to you; or
2. the resource(s) was transferred to your child who is certified blind, or certified permanently and totally disabled; or
3. the resource transferred was your homestead (for example a house or apartment you live in), and the homestead was transferred to:
 - your spouse;
 - your minor child under age 21, or your child of any age who is certified blind or certified permanently and totally disabled;
 - your brother or sister who also has an equity interest in the home and who lived in the home for at least one year immediately before you entered a nursing facility;
 - your child (other than a child who is under 21 or who is certified blind/disabled) who was living in your home for at least two years immediately before you entered a nursing facility and who provided care which permitted you to reside at home rather than in a nursing facility.

What other transfers for less than fair market value do not affect your eligibility for Medical Assistance?

If you or your spouse transferred a resource for less than fair market value you can still get full Medical Assistance coverage if you can prove that:

1. you or your spouse intended to sell the resource(s) at fair market value or to receive other valuable consideration in exchange for the resource(s); or
2. the resource(s) was transferred exclusively for a purpose other than to qualify for nursing care and related services in a nursing facility; a level of care provided in a hospital which is equivalent to the level of care provided in a nursing facility; or care, services, or supplies furnished pursuant to a waiver under Section 1915(c) of the federal Social Security Act; or
3. in the absence of the evidence described in 1. or 2. above, we will not limit your Medical Assistance coverage if we determine that such limitation will result in undue hardship for you. We will consider undue hardship to exist if you: (a) meet all other eligibility requirements; and (b) are unable to obtain appropriate medical care without the provision of Medical Assistance; and (c) despite your best efforts you or your spouse are unable to have the transferred resource returned or to receive fair market value for the resource. Best efforts must include cooperation with the Department of Social Services in pursuing the return of the resource. Best efforts may include pursuing the return of the resource in a court of law, if determined appropriate by the social services district.

How can you prove the transfer was not made to qualify for these certain medical services?

We will presume that any prohibited transfer of a resource made within or after 30 months immediately before the date you become in need of the previously listed services, if you are receiving Medical Assistance on that date, or within or after 30 months of your application for Medical Assistance for these services, was made to qualify for: nursing care and related services in a nursing facility; a level of care provided in a hospital which is equivalent to the level of care provided in a nursing facility; or care, services, or supplies furnished pursuant to a waiver under Section 1915(c) of the federal Social Security Act. If you disagree with this presumption, you should present evidence to your Medical Assistance eligibility examiner which proves that the transfer was made exclusively for some other purpose. Some factors which may establish that a transfer was made for a purpose other than to obtain Medical Assistance eligibility are:

1. sudden, unexpected onset of serious illness or disability after the transfer occurred;
2. unexpected loss of other resources or income which would have made you ineligible for Medical Assistance, after the transfer occurred;
3. court-ordered transfers.

These are examples only. All of the circumstances of the transfer will be considered as well as factors such as your age, health and financial situation at the time the transfer was made. It is important to note that you have the burden of providing this agency with complete information regarding all assets and any other relevant factors which may affect your eligibility.

What appeal rights do you have?

You will receive a written notice if we determine that your Medical Assistance coverage is to be limited based on a transfer of resources for less than fair market value. If you are in a nursing facility or require the services listed under the "limited coverage" section at the time we make our decision, the notice will tell you how long you will have limited coverage. This period will never be more than 30 months and may be shorter, based on the average rate for nursing facility services in the region in which you reside.

You have the right to appeal our decision to limit your coverage. Our written notice will provide you with information on how to request a conference with us to review our actions. Our notice will also provide you with information on your right to a State Fair Hearing if you believe our action is wrong.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT YOUR
MEDICAL ASSISTANCE ELIGIBILITY EXAMINER.