

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
 40 NORTH PEARL STREET, ALBANY, NEW YORK 12243 - 0001
 CESAR A. PERALES
Commissioner

4/2



ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 89-ADM-45

DIVISION: Medical Assistance

TO: Commissioners of Social Services

DATE: December 1, 1989

SUBJECT: Transfer of Resource Provisions Under the Medical Assistance Program

SUGGESTED DISTRIBUTION:

Medical Assistance Staff
 Public Assistance Staff
 Fair Hearing Staff
 Legal Staff
 Staff Development Coordinators

MICHAEL MCNAUGHTON CSS09
 DIRECTOR
 POLICY COMMUN UNIT
 1 COMMERCE PLZ RM 412
 ALBANY, NY

RP

CONTACT PERSON:

MA County Representative - 1-800-342-3715, extension 37581

MA New York City Representative - (212) 587-4853

ATTACHMENTS:

Attachments I-III available on-line. Attachment IV not available.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
89 ADM-7	80 ADM-68	311.4	104a	MARG p 305-	88 LCM-11
85 ADM-27	80 ADM-33	360-1.4	366.5	308, 351-	
83 ADM-17		360-4.4	367(c) (6)	354	
82 ADM-26		360-5	C. 558, L.	<u>Local Dis-</u>	
80 ADM-68		370.2(c) (6)	1989	<u>tric Mana-</u>	
80 ADM-33			S303(b) of	<u>gers Guide</u>	
			1988	Section 12	
			FSA of 1988		
			PHL, Section		
			2807-c		

DSS-296EL (REV. 9/89)

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

-
- Attachment I - County Listing by Region
- Attachment II - Letter of Explanation: "Effect of Transfers of Resources on Medical Assistance Eligibility"
- Attachment III - Examples 1 through 9
- Attachment IV - (a) DSS-4144: Notice Of Acceptance For Medical Assistance With Limited Coverage
- (b) DSS-4145: Notice Of Decision On Your Medical Assistance Application For Nursing Facility Services
- (c) DSS-4146: Notice Of Decision On Your Medical Assistance Application
- (d) DSS-4147: Notice Of Intent To Discontinue/Change Medical Assistance Coverage

TABLE OF CONTENTS

<u>SUBJECT</u>	<u>PAGE NUMBER</u>
I. PURPOSE	4
II. BACKGROUND	4
III. PROGRAM IMPLICATIONS	4
IV. REQUIRED ACTION	6
A. TRANSFERS BEFORE OCTOBER 1, 1989	6
B. TRANSFERS ON OR AFTER OCTOBER 1, 1989	7
1. Definition of Terms	7
2. Policy	8
a. Persons Affected	8
b. Excluded Care and Services	9
c. Penalty/Sanction Period	9
d. Exceptions to the Imposition of Transfer of Resource Penalties	13
3. Notice Requirements	17
V. SYSTEMS IMPLICATIONS	19
A. WMS/UPSTATE	19
B. WMS/NEW YORK CITY	20
C. EMEVS	20
D. MMIS (FISCAL AGENT)	20
VI. EFFECTIVE DATE	20
ATTACHMENTS I-IV	

I. PURPOSE

The purpose of this release is to advise local social services districts of the provisions of Chapter 558 of the Laws of 1989 which relate to transfer of resources under the Medical Assistance Program.

II. BACKGROUND

Section 303(b) of the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360) and the Family Support Act (FSA) of 1988 (P.L. 100-485), which amended Section 1917(c) of the Social Security Act (Act), require a period of Medical Assistance ineligibility for certain services for institutionalized persons who dispose of resources for less than fair market value (FMV) within or after the 30-month period immediately before institutionalization or before the date of application for Medical Assistance while institutionalized, whichever is later. The period of ineligibility is 30 months from the month of transfer, or for a number of months equal to the uncompensated value (UV) of the resources divided by the average cost for a private patient for nursing home care. The provisions apply to transfers occurring on or after October 1, 1989.

Prior to the passage of this legislation, any nonexempt resource transferred for less than FMV within a 24-month transfer period prior to application was considered in determining eligibility for Medical Assistance. The penalty period for transfers prior to October 1, 1989, is 24 months if the UV of the transferred resource is \$12,000 or less and an additional month for each \$2,000 by which the UV exceeds \$12,000, or until the individual incurs medical expenses equal to the amount of the excess resources, whichever period is shorter. Ineligibility for transfers made under these earlier rules resulted in a period of ineligibility for all medical care and services under the Medical Assistance Program. Under the new provisions, persons who transfer resources on or after October 1, 1989 will only be ineligible for up to 30 months for: nursing facility services, level of care equivalent to that of nursing facility services provided in a hospital, and for care, services and supplies for which a waiver has been obtained under Section 1915(c) of the Act.

Chapter 558 of the Laws of 1989 enacted the new federal transfer of resource provisions in the New York State Medicaid Program, by amending the previous transfer requirements contained in Section 366.5 of Social Services Law (SSL).

III. PROGRAM IMPLICATIONS

The new Section 366.5 of the SSL, as enacted by Chapter 558 of the Laws of 1989, provides that the UV of any countable resource transferred within or after the 30 months prior to the date of institutionalization, if the individual is in receipt of Medical Assistance on such date, or the date of application for Medical Assistance while institutionalized, if later, will be considered available to applicants/recipients (A/Rs) of Medical Assistance, barring certain exceptions.

NOTE: It is important to note that in the past, homesteads determined to be essential and appropriate to the needs of the household were automatically considered to be an exempt resource for purposes of an SSI-related or ADC-related A/R's eligibility. Such persons could, therefore, transfer their exempt homestead at any time and not jeopardize their eligibility or continued eligibility for Medical Assistance. This policy is no longer applicable, since the new prohibition on transfer of resources applies to homesteads, under certain circumstances.

Any transfer of a resource for less than FMV is presumed to have been made for the purpose of qualifying 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. However, if evidence is furnished that establishes that the transfer was made exclusively for some other purpose, the UV of the resource shall not be considered available in determining eligibility.

The new transfer provisions apply only to transfers occurring on or after October 1, 1989. Penalties may be imposed only for those persons who seek Medical Assistance to cover any portion of the costs for nursing facility services or for a level of care equivalent to that of nursing facility services provided in a hospital and for care, services and supplies pursuant to a waiver under section 1915(c) of the Act. In New York State such waived services are most frequently provided under the Long Term Home Health Care Program (LTHHCP).

The penalty period begins with the month in which the resources were transferred and the number of months of ineligibility for such services shall equal the lesser of: (1) 30 months or (2) a period equal to the total UV of the transferred resources divided by 120% of the average Medical Assistance rate for nursing facility services in the region in which the individual is institutionalized.

Under limited circumstances, institutionalized persons will not be penalized for transferring resources. If evidence is presented that confirms to the local social services district's satisfaction that: the A/R intended to dispose of the resource for FMV; or, that such resources were 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 Act; or, that a denial of eligibility would result in "undue hardship", no penalty period will be imposed. In addition, if resources are transferred to particular relatives, (i.e., spouse, children and siblings) and certain other criteria, as described in Section IV.B.2.d. of this Administrative Directive (ADM), are met, no penalty period will be imposed.

The new transfer of resource provisions apply to: all MA-only federally related A/Rs, FNP parents who live with their dependent children under age

21 and A/Rs of the Catastrophic Illness Program. The transfer provisions do not, however, apply to cash (ADC, HR or SSI) recipients or MA HR-related single individuals or childless couples. Both the DSS-2921 (application form) and DSS-3174 (recertification form) are being revised to include a question regarding the new transfer of resources provisions.

In summary, the new provisions change the treatment of individuals who have transferred resources in three main areas. First, it applies the prohibition on transfer of assets to certain resources which were previously considered to be exempt. Second, it restricts the Medical Assistance coverage an individual may receive, as opposed to making the individual totally ineligible. Third, it provides for a maximum of 30 months during which coverage is restricted, as opposed to the 24-month basic disqualification period.

IV. REQUIRED ACTION

Local social services districts must apply the following policies/procedures when it has been determined that MA-only A/Rs, who are subject to FP treatment of resources, have transferred resources. The date of transfer is the date that the resource was legally transferred by the A/R.

A. TRANSFERS BEFORE OCTOBER 1, 1989

Local social services districts must continue to apply the policies contained in 82 ADM-26 and 83 ADM-17 for MA-only A/Rs who have transferred resources prior to October 1, 1989. Thus, when the local social services district determines that an MA-only A/R is ineligible because s/he transferred a nonexempt resource or a homestead which is not essential and appropriate, without fair consideration or compensation within 24 months prior to application, s/he remains ineligible for the time period specified below:

1. If the UV of the transferred resource is \$12,000 or less, the A/R remains ineligible for a period of 24 months from the date of the transfer, or until such time as the individual can demonstrate that s/he has incurred medical expenses after the date of transfer in the amount of such transferred resources above applicable resource levels, whichever period is shorter.
2. If the UV of the transferred resource is more than \$12,000, the A/R remains ineligible for Medical Assistance for a period which exceeds 24 months in duration. This period of ineligibility is determined by adding an additional month of ineligibility for each \$2,000 in excess of \$12,000, or until such time as the individual can demonstrate that s/he has incurred medical expenses after the date of transfer in the amount of the UV above applicable resource levels, whichever period is shorter.

B. TRANSFERS ON OR AFTER OCTOBER 1, 1989

1. Definition of Terms

For purposes of implementing the new transfer of resource provisions the following definitions apply:

- a. Resources - Cash or other liquid assets or any real or personal property that an individual owns and could convert to cash to be used for his/her support and maintenance. This includes the individual's homestead, but does not include items of value owned by the A/R which are necessary for daily living or the production of his/her livelihood. A countable resource is a resource not subject to exclusion.
- b. Homestead - The home and land occupied by the A/R and members of his/her family including integral parts such as outbuildings and garages. It includes home trailers and mobile homes and the land on which they are located. The homestead may be a condominium, or cooperative apartment. It may include up to three apartments, or up to two apartments along with a business location. A homestead may be a countable resource, under certain circumstances.
- c. Compensation/Consideration - The compensation for a resource is a payment which can be in the form of money, real or personal property, food, shelter, or services received by the A/R at or after the time of transfer in exchange for the resource.
- d. Equity Interest - The term equity interest means that an individual has vested money in the property or has a right to the use of the property without necessarily having title to the property.
- e. Fair Market Value (FMV) - An estimate of the prevailing price of a resource if sold at the time it was actually transferred, based on criteria used in appraising the value of other comparable resources for the purpose of determining Medical Assistance eligibility.
- f. Uncompensated Value (UV) - The difference between the FMV at the time of transfer (less any outstanding loans, mortgages or other encumbrances on the resource) and the amount received for the resource. When a resource was jointly owned before the transfer, the UV is the difference between the value of the A/R's share and the amount of compensation received.
- g. Institutionalized Person - Any person who is an in-patient in a nursing facility or who is an in-patient in a medical facility and is receiving a level of care provided in a nursing facility, or who is receiving care, services or supplies, pursuant to a waiver under Section 1915(c) of the federal Social Security Act.

- h. Penalty/Sanction Period - The period of time of ineligibility for certain services under the Medical Assistance Program because of a prohibited transfer. This period of restricted coverage must never exceed 30 months.
- i. Provided Care - To make arrangements or actively participate in the arranging for care, either directly or indirectly, full time or part-time.
- j. Undue Hardship - Undue hardship exists when an institutionalized person is otherwise eligible for MA and despite his/her best efforts, is unable to have the transferred resource returned, or to receive FMV for the resource, and is unable to obtain appropriate medical care without the provision of Medical Assistance. Undue hardship cannot exist if the resource was transferred to a relative.
- k. Relative - For purposes of determining undue hardship, the term relative means any of the individual's relatives through blood, marriage or legal adoption.

2. Policy

a. Persons Affected

The following MA-only A/Rs must be evaluated at the time of initial application and each subsequent recertification to determine if the A/R has transferred resources for less than FMV within 30 months of the date of application, or, in the case of active recipients, since the previous recertification:

- o MA-only SSI-related A/Rs
- o MA-only ADC-related A/Rs
- o MA-only A/R's under age 21, and pregnant women
- o FNP parents who live with their dependent children under age 21
- o A/Rs of the Catastrophic Illness Program
- o A/Rs of the Medicare Buy-In Program (89 ADM-7)

It is especially important that local social services districts review active cases since a recipient may no longer transfer his/her homestead without penalty because of its exempt status. Under the new rules, transfers on or after October 1, 1989, may jeopardize continued Medical Assistance coverage for nursing facility services or for home and community-based waived services. (See Section IV.A.2.(d)(5) of this ADM.)

NOTE: For MA HR-related single individuals and childless couples, the provisions of 18 NYCRR 370.2(c)(6) continue to apply. Thus, for these FNP persons, a transfer of nonexempt resources within one year of application is presumed to have been made in order to qualify for assistance.

b. Excluded Care and Services

Persons determined to have made a prohibited transfer of resources are subject to restricted coverage for a specified period of time. The excluded care and services are as follows:

- (1) nursing facility services (i.e., skilled nursing facilities, health-related facilities, intermediate care facilities, residential treatment facilities)

NOTE: Ancillary services not included in the facility's per diem rate can be covered under the Medical Assistance Program (for example, eyeglasses, hearing aids, and dentures) for otherwise eligible individuals.

- (2) medical facility services equivalent to that of nursing facility services provided in a hospital (for example, alternate level of care (ALC) in acute care facilities)

- (3) home and community-based waived services provided under Section 1915(c) of the Act. The waived services currently available in New York State are:

- o Home Maintenance Tasks
- o Housing Improvement
- o Social Transportation
- o Congregate/Home Delivered Meals
- o Respite Care
- o Social Day Care
- o Personal Emergency Response System Services
- o Moving Assistance
- o Medical Social Services
- o Respiratory Therapy
- o Nutritional Counseling/Education Services

c. Penalty/Sanction Period

(1) Method of Calculation

The period of restricted coverage begins with the month in which the resource was transferred. In no instance can this period of restricted coverage exceed 30 months. This penalty/sanction period equals the lesser of:

- 30 months; or
- a period equal to the total UV of the transferred resource(s), divided by the following regional rates:

MA REGIONAL RATES*

<u>Region**</u>	<u>Monthly Rate</u>
Northeastern	\$3118
Rochester	\$3174
Central	\$3053
Western	\$2941
Northern Metropolitan	\$3671
Long Island	\$4149
New York City	\$4693

* These rates will be updated each January 1.

** See Attachment I for county listing by region.

When determining the UV of the transferred resource, the client is entitled to have an amount(s) deducted, if not already taken into account, for purposes of the applicable MA resource level. Likewise, amounts specified in Department Regulations must also be allowed for burial funds.

(2) When To Determine Penalty Period

The penalty period must be established at the time the local social services district learns of the transfer. If the client is not receiving or in need of long term care at this time the estimated penalty period must be calculated based upon the presumption that the individual will receive nursing facility care and services in the region in which s/he currently resides. The purpose of this calculation is to inform both the client and any prospective provider(s) of the estimated period of restricted coverage. (See Attachment IV for mandated client notices.) The local social services district must (re)authorize an otherwise eligible A/R for all care and services except nursing facility services, level of care equivalent to nursing facility services provided in a hospital and home and community-based waived services. (See Section V. of this ADM for instructions regarding systems modifications which limit benefits.)

The MA Regional Rate used to determine the penalty period is the rate for the region in which the individual is institutionalized. The rate used must be the rate in effect for the year in which the individual first (re)applies as an institutionalized person. Therefore,

it may be necessary to recalculate the penalty period when a community-based A/R subsequently becomes institutionalized. For any given transfer, once a penalty period has been established for an institutionalized recipient, it is not necessary to recalculate this period.

If the penalty period has expired at the time the local social services district learns of the transfer, Medical Assistance must be (re)authorized to an otherwise fully eligible A/R for all care and services with no limitations. In situations in which a recipient may have erroneously received Medical Assistance coverage for restricted services, the local social services district should pursue legal action under the authority of SSL 369.

(3) Case Action

When the local social services district determines that an A/R has made a prohibited transfer, the following steps must be taken after the penalty period has been calculated.

(a) Community-based persons

The A/R's net available income is compared to the MA income standard for the appropriate size household in the community.

If the A/R's net income is at or below the allowable MA income standard and the individual is otherwise eligible, the individual must be authorized with Coverage Code 10. Such individual must be sent the appropriate client notice regarding eligibility limitations due to transfer of resources in accordance with Section IV.B.3 of this ADM.

If the A/R's income exceeds the allowable MA income standard and the person is otherwise eligible, the case should be denied/discontinued (if medical bills are not expected to equal or exceed the amount of excess income) or, if appropriate, opened under the Excess Income Program with Coverage Code 06 - Provisional Eligibility Excess Income. Once the incurred medical expenses in the amount of the excess are verified, MA coverage is limited to outpatient care (Coverage Code 02 for one month excess) or all care and services excluding LTC (Coverage Code 10 for six months excess). Such individuals must be sent the appropriate client notice(s) regarding eligibility limitations due to both transfer of resources and excess income, in accordance with Section IV.B.3 of this ADM and 89 ADM-7. (See Section V., SYSTEMS IMPLICATIONS.)

(b) Institutionalized persons

The A/R's net available income is compared to the MA income standard for a one person household residing in the community (\$459 effective January 1, 1989). Household size will always be one when it has been determined that spouses are separate and apart.

If an otherwise eligible A/R's net income is at or below the MA income standard, the individual must be authorized for Medical Assistance with restricted coverage and given MA Coverage Code 10. Such individuals must be sent the appropriate client notice regarding eligibility limitations due to transfer of resources in accordance with Section IV. B.3 of this ADM. These individuals are considered active recipients and are subject to recertification and any other procedures normally applied to undercare cases.

If an otherwise eligible A/R's income exceeds the allowable MA income standard, the case must be denied/discontinued, and the individual sent the appropriate client notice. Should the individual subsequently require Medical Assistance to cover the costs of acute care and/or any other ancillary services not prohibited due to a transfer of resources, a reapplication for Medical Assistance must be filed in accordance with existing application procedures. After medical expenses for ancillary services are verified, MA coverage should be authorized for outpatient care only (Coverage Code 02 for one month excess) or all care and services excluding LTC (Coverage Code 10 for six month excess). (See Section V., SYSTEMS IMPLICATIONS.)

NOTE: In instances in which an A/R fails or refuses to disclose information concerning the transfer of resources, it shall be presumed that a transfer was made exclusively 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 Act. Thus, an otherwise eligible community-based person who refuses to provide information regarding transfers must be given Coverage Code 10. An institutionalized A/R who refuses to provide information regarding transfers should be treated as outlined in (b) above, depending on whether or not his/her income exceeds the allowable MA income standard.

d. Exceptions to the Imposition of Transfer of Resource Penalties

If any one of the following situations exists, local social services districts must not restrict Medical Assistance to an otherwise eligible A/R.

- (1) The MA-only A/R presents evidence to the local social services district's satisfaction that the individual intended to dispose of the resources either for "fair market value" or in exchange for other valuable consideration, or that the resource 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 Act.

(a) Determination of Fair Consideration/Compensation

When the local social services district determines that fair consideration was received, no penalties or sanctions are imposed. Local social services districts must evaluate the availability of the resource received as fair consideration in determining Medical Assistance eligibility.

If the compensation given the client for the resource is not a fair equivalent of the value of the resource, the difference between the compensation and the FMV is counted as a resource to the A/R for purposes of determining the penalty period.

When determining whether fair consideration was made local social services districts should evaluate such factors as whether the person to whom the property was transferred had any interest in the property or whether s/he made any improvements to the property. Such claims, however, must be supported by receipts, cancelled checks or other documents.

Fair market value of real property or other resources may be established by means of an appraisal by a real estate broker or other qualified dealer or appraiser.

(b) Determination of Intent/Opportunity to Rebut Presumption

Intent is defined as what the client wanted to happen when the transfer took place. When the local

social services district learns of a transfer of a resource it can be presumed to have been done for the purpose of qualifying 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 Act. This presumption of client intent is rebuttable if the client provides evidence which proves that the transfer was exclusively for some other purpose.

Local social services districts must not take any adverse action on an MA-only A/R who has transferred resources without first advising the client in writing of his/her right to rebut this presumption. The client must be given the opportunity to prove to the local social services district's satisfaction that the transfer was not 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 Act. (See Section IV.B.3, Notice Requirements, of this ADM.) The A/R must be given a reasonable period of time in which to submit evidence concerning the rebuttal. For purposes of this requirement, a reasonable time period is a minimum of 20 days, unless the A/R requests additional time due to difficulties or delays in obtaining evidence.

When determining if a transfer was made for the purpose of qualifying 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 Act, all of the circumstances of the transaction must be considered. The facts and circumstances of each case will be different, and the local social services district must render a decision based on the client's statements and evidence, previous agency records and information gathered from collateral contacts (for example, physicians, county clerks).

Factors such as medical condition and income can be used to support or refute a client's stated intent. For example, if the A/R has had an unexpected onset

of a serious illness or disability after the transfer occurred, it is likely that the transfer was made for purposes 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 Act. In contrast, an A/R who transfers a homestead to adult children solely on the grounds that they have made payment of property taxes and/or other maintenance expenses is not in and of itself proof that the transfer was made for purposes 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 Act. Factors such as the A/R's age, health and financial situation must be considered.

(2) The local social services district determines that a restriction of Medical Assistance coverage would result in "undue hardship" for the A/R.

(a) Undue hardship is considered to exist if:

- i. the individual is otherwise eligible for Medical Assistance; and
- ii. despite his/her best efforts is unable to have the transferred resource returned, or to receive FMV for the resource; and
- iii. the individual is unable to obtain appropriate medical care without the provision of Medical Assistance. For example, an individual who is in AIC status in a hospital and who is unable to be placed in an appropriate nursing facility due to his/her ineligibility for Medical Assistance may meet the definition of undue hardship. In contrast, an individual in AIC status due to the unavailability of nursing facility beds does not in and of itself constitute undue hardship since s/he is receiving appropriate care.

(b) Undue hardship is not considered to exist if the resource in question was transferred to a relative. (See Section IV.B.1 of this ADM for definition of a relative.)

In instances in which Medical Assistance is provided to an otherwise eligible individual on the basis of undue hardship, the local social services district may seek to take legal action against the person to whom the resource was transferred, pursuant to the provisions of Section 369 of the Social Services Law.

- (3) The resource was transferred to or for the sole benefit of a community spouse (the spouse of an institutionalized person).
- (4) The resource was transferred to or for the sole benefit of the spouse, other than a community spouse, as long as the spouse does not transfer such resource to another person other than the spouse, for less than FMV.
- (5) The resource was transferred to a certified blind, certified permanently and totally disabled child of any age. (This includes both Group I and Group II certifications.)

NOTE: MA-only clients claiming exemptions to the imposition of transfer of resource penalties based on the disability or blindness of children must satisfy the Federal definition of blindness/disability in accordance with 18 NYCRR 360-5. These cases should be processed for determinations in the same manner as the local social services districts currently process MA-only cases for review of disability/blindness.

- (6) The resource transferred was a homestead and the title to the homestead was transferred to one of the following individuals:
 - (a) the individual's spouse;
 - (b) the individual's minor child under age 21, or his/her certified blind, certified permanently and totally disabled child of any age;
 - (c) a sibling of the individual who has an equity interest in the home and has resided in such home for at least one year immediately before the date the individual became institutionalized;

NOTE: Equity interest must be documented by submission of: cancelled checks or money orders for mortgage payments; a deed reflecting ownership; or, other documents verifying expenses for capital improvements. Examples of expenses which would satisfy the requirement of equity interest, assuming there was no information to indicate otherwise, include: structural renovations (widening of doorways, installation of ramps, etc.) other than cosmetic (painting, landscaping, kitchen/bath remodeling, etc.); or

- (d) a son or daughter (other than a child who is under age 21 or who is certified blind/disabled) of the individual, who was residing in the A/R's home for at least two years immediately before the date the individual became institutionalized and who, as determined by the local social services district, provided care to the individual which permitted him/her to reside at home rather than in a nursing facility. (See Section IV.B.1 of this ADM for definition of "provided care".)

For purposes of this Section, an adult child who has resided with his/her parents for a period of two or more years shall be presumed to have met the requirement of "provided care" unless the local social services district has evidence to the contrary. For example, when the parent has developed a sudden and traumatic onset of disability (the A/R has a heart attack six weeks before institutionalization), the provided care requirement might not be satisfied.

NOTE: In instances of multiple periods of institutionalization, the sibling or adult child must have resided in the A/R's home for at least one or two years respectively, immediately before the last period of institutionalization.

3. Notice Requirements

At the time of the personal interview, the A/R must be given the opportunity to rebut the presumption that the transfer was made for the purpose of qualifying 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 Act.

The client must also be informed of:

- a. The criteria the local social services district uses to determine intent to dispose of resources at FMV or 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 Act; and
- b. The conditions under which a transfer would not result in restricted coverage; and
- c. The right to appeal the local social services district's decision.

Attachment II (EFFECT OF TRANSFERS OF RESOURCES ON MEDICAL ASSISTANCE ELIGIBILITY) must be used to meet these requirements. The content of this form is mandated and may not be modified unless the local social services district has received approval for a local equivalent.

Local social services districts must make Attachment II available to all individuals who request such information. In addition, this form must be given to all MA-only applicants at the time of the initial application interview or, if a recipient, at the next client contact or recertification interview, whichever occurs first. Local social services districts that have received a waiver for the personal recertification interview must mail Attachment II with the recert packet. An additional copy of Attachment II must also be sent when an A/R's (re)application is denied/discontinued due to a prohibited transfer. This form must be enclosed with the appropriate mandated client notice.

Attachment II is also required to be provided with the "Information Notice To Couples With An Institutionalized Spouse," and with the "Notice of Assessment," (Attachments A and E of the recently released ADM entitled "Treatment Of Income And Resources For Institutionalized Spouses/Individuals, And For Legally Responsible Relatives").

A/Rs whose Medical Assistance coverage is restricted based upon a finding that a transfer of resources was made for less than FMV for the purpose of qualifying 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 Act are entitled to adequate and timely notice and must be provided with one of the following:

- o DSS-4144: Notice Of Acceptance For Medical Assistance With Limited Coverage
[Use to accept institutionalized applicants with income under the MA income standard and community-based applicants, when these individuals have also transferred resources. Note: If the community-based individual is eligible only with excess income, the individual must also be sent the DSS-3973: Notice Of Decision On Your Medical Assistance Application (Excess Income).]
- o DSS-4145: Notice Of Decision On Your Medical Assistance Application For Nursing Facility Services
[Use when otherwise eligible institutionalized applicants have income in excess of the MA income standard and have transferred resources.]
- o DSS-4146: Notice Of Decision On Your Medical Assistance Application
[Use to deny institutionalized or community-based applicants who are not otherwise eligible and who have also transferred resources.]

- o DSS-4147: Notice Of Intent To Discontinue/Change Medical Assistance Coverage
[Use for undercare cases when coverage is being restricted or the case is being closed due to a transfer, or when the individual's period of restricted coverage has expired.]

These notices are mandated and must be reproduced by the local social services district until such time as they become available from this Department. Two copies of the appropriate notice must be sent to the A/R and the remaining copy filed in the case record.

Local social services districts must use the notices contained in Attachment IV, without modification, unless the Department has granted approval for local equivalents. Local district equivalent forms will be permitted only when a format change will ease local district administration or case processing. As with other notices, requests for local equivalents should be made in accordance with the Local District Manager's Guide, Section 12, pages 1 through 5.

NOTE: Public Assistance (PA) Notices: DSS-4013, 4014, 4015, 4016, 4003, and 4004, contain MA only messages concerning restricted Medical Assistance coverage due to a prohibited transfer. This MA message should be used in those instances in which a PA recipient's case is denied/ discontinued and a separate MA only determination results in a decision of restricted MA coverage. All ADC cash assistance A/R's who have made a transfer of resources on or after October 1, 1989, must also be given a copy of Attachment II.

V. SYSTEMS IMPLICATIONS

A. WMS/UPSTATE

System support is available on WMS for proper identification of these individuals. This can be achieved by entering Anticipated Future Action (AFA) Code 505 (End of Property Transfer Prohibition) on screen 1 for all affected cases and the End Date of the transfer penalty period. This will help to flag cases for reconsiderations of eligibility.

If the local social services district has determined that an otherwise eligible individual has made a prohibited transfer of resources, the individual should be given MA Coverage Code 10. This will ensure that no coverage will be provided for the restricted services described in Section IV.B.2.b of this ADM. For persons eligible only with an excess, enter the appropriate Coverage Code (Code 02 for one month excess, or Code 10 for six month excess) or deny/close the case, depending on whether the A/R is community-based or institutionalized, as instructed in Section IV.B.2.c.(3).

B. WMS/NEW YORK CITY

If an individual who is otherwise eligible for full coverage has transferred resources, Coverage Code 10 should be utilized. This will ensure that no coverage will be provided for restricted services.

Instructions concerning the processing of persons whose income exceeds the allowable MA income standard will be provided via a WMS transmittal.

C. EMEVS

The Medicaid Eligibility Terminal (MET) and Point of Service Terminal (POST) telephone responses for Coverage Code 10 will be "ELIG EXCEPT LTC" and "Eligible Except Long Term Care", respectively.


D. MMIS (FISCAL AGENT)

Systems changes have been put in place to deny long term care claims for persons given an MA Coverage Code of 10 while allowing the payment of all other claim types. No further action is required by the local social services district to ensure appropriate payment or denial when this coverage is used.

VI. EFFECTIVE DATE

The new transfer of resource provisions are effective October 1, 1989, and are limited to those transfers occurring on or after October 1, 1989.

All transfers of resources which have occurred prior to October 1, 1989, but within 24 months of the Medical Assistance application are to be treated in accordance with prior State policies regarding the transfer of resources.



Jo-Ann A. Costantino
Deputy Commissioner

Division of Medical Assistance

ATTACHMENT I

COUNTY LISTING BY REGION

NORTHEASTERN

Albany
Clinton
Columbia
Delaware
Essex
Franklin
Fulton
Greene
Hamilton
Montgomery
Otsego
Rensselaer
Saratoga
Schenectady
Schoharie
Warren
Washington

WESTERN (Buffalo)

Allegany
Cattaraugus
Chautauqua
Erie
Genesee
Niagara
Orleans
Wyoming

ROCHESTER

Chemung
Livingston
Monroe
Ontario
Schuyler
Seneca
Steuben
Yates
Wayne

LONG ISLAND

Nassau
Suffolk

NORTHERN METROPOLITAN
(New Rochelle)

Dutchess
Orange
Putnam
Rockland
Sullivan
Ulster
Westchester

NEW YORK CITY

Bronx
Kings (Brooklyn)
NY (Manhattan)
Queens
Richmond (Staten Island)

CENTRAL (Syracuse)

Broome
Cayuga
Chenango
Cortland
Herkimer
Jefferson
Lewis
Madison
Oneida
Onondaga
Oswego
St. Lawrence
Tioga
Tompkins

1. Use the region in which the facility is located, or if the A/R is not institutionalized, use the region in which the individual resides.
2. For out of state facilities, use the region closest to the location of the facility.

ATTACHMENT II

EFFECT OF TRANSFERS OF RESOURCES ON MEDICAL ASSISTANCE ELIGIBILITY

The following is an explanation of how a transfer of certain resources or assets may affect your eligibility for Medical Assistance. A transfer is when the title or right to property or assets is conveyed or transferred from one person to another. For Medical Assistance purposes, a prohibited transfer is the voluntary assignment or the giving of your property or assets to another person without receiving something of equal value in return, in order 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. The following information applies only to transfers made on or after October 1, 1989.

The Medical Assistance Program does not allow the 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 within or after the 30 months immediately before the date you become in need of the services listed in 1, 2, or 3 below, if you are receiving Medical Assistance on that date, or within or after 30 months of the date you apply for Medical Assistance for these services. If it is determined 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. Limited coverage means that during this period of time you will not be able to receive coverage for the following types of care and services:

1. services provided in skilled nursing facilities, health-related facilities, intermediate care facilities, or residential treatment facilities;
2. alternate level of care provided to persons whose acute care needs have already been met but who are awaiting placement in a lower level of care (for example, a nursing home or home care program);
3. the non-medical home and community-based services listed below, which are provided primarily through the Long Term Home Health Care Program or the Nursing Home Without Walls Program:
 - o Home Maintenance Tasks
 - o Housing Improvement
 - o Social Transportation
 - o Congregate/Home Delivered Meals
 - o Respite Care
 - o Social Day Care
 - o Personal Emergency Response System Services
 - o Moving Assistance
 - o Medical Social Services
 - o Respiratory Therapy
 - o Nutritional Counseling/Educational Services

ATTACHMENT II (Continued)

You will, however, be able to receive coverage for all other eligible services provided under the Medical Assistance Program, provided you are otherwise eligible.

How is the limited coverage period determined?

The period of time during which your Medical Assistance coverage will be limited begins with the month in which you made the prohibited transfer, even if you were not receiving Medical Assistance or were not in need of nursing facility services at that time. It will be equal to the lesser of:

1. 30 months; or
2. a period equal to the total uncompensated value of the transferred resource(s), divided by the average monthly rate* for nursing facility services in the region in which you reside. In computing this period of time, we use the regional rate in effect at the time you first apply or reapply for Medical Assistance coverage for any of the services listed previously.

We determine the total uncompensated value of a transferred resource by obtaining an estimate of the fair market value of the resource at the time it was transferred, and deducting any outstanding loans, mortgages or other encumbrances on the resource and the amount of compensation received in exchange for the resource. We will also deduct the amount you are allowed to keep up to the Medical Assistance resource standard, if not already taken into account through other resources owned by you. (If you are married and either you or your spouse is institutionalized, refer to "Information Notice To Couples With An Institutionalized Spouse", for information regarding the Medical Assistance eligibility resource requirements which are effective October 1, 1989.)

How do we determine if you have made a prohibited transfer?

There are exceptions to the transfer of resource prohibitions. Under the following circumstances, we are not required to limit your Medical Assistance coverage when a transfer has been made if:

1. you transferred the resource to or for the sole benefit of your community spouse. (A community spouse is the spouse of an institutionalized person.); or
2. you transferred the resource(s) to or for the sole benefit of your spouse, other than your community spouse, as long as your spouse does not transfer the resource(s) to another person, for less than fair market value; or
3. you transferred the resource(s) to your child who is certified blind, certified permanently and totally disabled; or

*Information on average rates is available upon request from your local social services district.

ATTACHMENT II (Continued)

4. the resource transferred was your homestead, and title to the homestead was transferred to:
- your spouse;
 - your minor child under age 21, or your child of any age who is certified blind, 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 we determine provided care to you which permitted you to reside at home rather than in a nursing facility.

The transfer of resources for less than fair market value under any other circumstances is not allowed and will result in limitation of your Medical Assistance coverage unless:

1. you present evidence that proves you intended to sell the resource(s) at fair market value or to receive other valuable consideration in exchange for the resource(s); or
2. you present evidence that proves 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. you present evidence which proves that limitation of your Medical Assistance coverage will result in undue hardship for you. We will consider undue hardship to exist if you meet all other eligibility requirements, and despite your best efforts you are unable to have the transferred resource returned or to receive fair market value for the resource, and you are unable to obtain appropriate medical care without Medical Assistance. We will not consider undue hardship to exist if the prohibited transfer was made to any of your relatives through blood, marriage or legal adoption.

NOTE: If we provide you with coverage for any of the excluded services previously noted based on your documented claim of undue hardship, we may pursue a recovery in accordance with Section 369 of the Social Services Law.

How can you prove you did not transfer to qualify for these certain medical services?

ATTACHMENT II (Continued)

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 for the purpose of qualifying 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 your transfer of resources for less than fair market value. If you are in a nursing facility or require the previously listed services at the time we make our decision, the notice will tell you how long you will have limited coverage. If you are not in a nursing facility or receiving nursing facility services, the notice will only tell you the projected period of 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.

**THIS INFORMATION APPLIES ONLY TO TRANSFERS MADE
ON OR AFTER OCTOBER 1, 1989**

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

ATTACHMENT III

EXAMPLE 1

Situation: Mr. Smith transferred his home for less than fair market value on October 16, 1989. He is institutionalized on January 1, 1990 in Albany County and is not entitled to Medical Assistance at that time. On February 7, 1990, while institutionalized, he applies for Medical Assistance. None of the conditions apply under which the local district would be required to waive the applicability of the transfer of resources penalty. Since Mr. Smith is institutionalized and transferred resources for less than fair market value during the 30-month period prior to February 7, 1990 and none of the exceptions apply, he is subject to a period of restricted coverage. The uncompensated value of the home is \$109,130 and the MA regional rate in Albany County at the time of application is \$3118. The \$109,130 uncompensated value divided by the MA regional rate ($\$109,130/\3118) equals 35, the number of months that the coverage restriction would apply. However, the period of restricted coverage is limited to not more than 30 months.

Disposition: Mr. Smith remains ineligible for nursing facility services, equivalent services in a medical institution, and home and community-based waived services from October 1, 1989 through March 30, 1992 (30 months from the month of the transfer and 26 months from the month of application).

Point to consider

- o Although the transfer did not occur until October 16, the period of restricted coverage begins on the first day of the month in which the transfer occurred.

ATTACHMENT III (Continued)

EXAMPLE 2

Situation: Mr. Jones transferred his home for less than fair market value on October 12, 1989. He is institutionalized on November 1, 1990 in Buffalo and is not entitled to Medical Assistance. While institutionalized, he applies for Medicaid on December 3, 1990, 14 months after the home was transferred. None of the conditions apply under which the local district would be required to waive the applicability of the transfer of resources penalty. Since Mr. Jones is institutionalized and transferred resources for less than fair market value during the 30-month period prior to his application for Medical Assistance and none of the exceptions apply, he is subject to a period of restricted coverage. The uncompensated value of the home is \$35,292 and the MA regional rate in Erie County at the time of application is \$2941. The \$35,292 uncompensated value divided by the MA regional rate ($\$35,292/\2941) equals 12, the number of months that the coverage restriction would apply.

Disposition: Because Mr. Jones' penalty period expired prior to the date of his Medical Assistance application, he may receive coverage for all Medical Assistance approved care and services, providing he is otherwise eligible.

ATTACHMENT III (Continued)

EXAMPLE 3

Situation: Mr. White is institutionalized on January 1, 1990 in New York City and he is entitled to Medical Assistance. He transferred his home on March 1, 1990. In March the local district learns of the transfer and reevaluates eligibility. It is determined that none of the conditions apply under which the local district would be required to waive the applicability of the transfer of resources penalty. Since Mr. White is institutionalized and transferred resources for less than fair market value [after the 30-month period which occurred immediately before the date he became institutionalized], and none of the exceptions apply, he is subject to a period of restricted coverage. The uncompensated value of the home is \$42,237 and the MA regional rate in NYC is \$4693. The \$42,237 uncompensated value divided by the MA regional rate ($\$42,237/\4693) equals 9 months, the number of months that the coverage restriction would apply.

Disposition: Mr. White remains ineligible for nursing facility services, equivalent services in a medical institution, and home and community-based waived services from March 1, 1990 through November 30, 1990 (9 months from the date of transfer and 9 months from the month of his Medicaid redetermination).

ATTACHMENT III (Continued)

EXAMPLE 4

Situation: Miss Jones applies for community MA in Washington County in November, 1989 and is found fully eligible. In December, 1989 she transfers ownership of her home worth \$40,000 to a nephew in Kalamazoo. She has other resources equal to the MA level. In March, 1990, she is institutionalized. Due to eligibility for Veterans benefits, her net income has changed from \$430 to \$510. During the conversion to chronic care budgeting, the uncompensated transfer is discovered. The U.V. is \$40,000 and the MA regional rate in the Northeastern Region is \$3,118.

Disposition: Miss Jones would be ineligible for payment of the nursing home bill for 12.8 months (\$40,000/\$3118 beginning in December, 1989). Because her net income is greater than \$459 the case would be discontinued due to a prohibited transfer. She would have to reapply if she needs ancillary services or in-patient care.

In December 1990, the 13th month of the penalty period, her NAMI is computed as follows:

12 x \$3,118	=	\$37,416
\$40,000 - \$37,416	=	\$ 2,584
\$510 (income) - \$50 (PIA)	=	\$ 460
\$2,584 + \$460	=	\$ 3,044 (NAMI for 12/90)

Points to consider

- o None of the exceptions apply; undue hardship is not a consideration because the transfer was to a relative.
- o She is already at the MA resource level.
- o The period of restriction begins in December, 1989 because this is the month of transfer.

Note: This figure is based on 1989 data; MA income levels subject to change in January, 1990.

ATTACHMENT III (Continued)

EXAMPLE 5

Situation: Mr. Avery, who lives in Broome County, transfers his home for less than fair market value to his sister in Toledo in October, 1989. In January, 1990, he applies for MA in the community. The amount of the uncompensated transfer is \$100,000. His net income is \$400 per month.

Disposition: Because his net income is less than the MA level (\$459), he is accepted with coverage code 10: $\$100,000/\$3,053$ (MA regional rate in the Central Region) = 30 months (really 32.75 months, but the maximum restriction is 30 months). Counting from October, 1989, the restriction would end on March 31, 1992.

ATTACHMENT III (Continued)

EXAMPLE 5a: In June, 1990, Mr. Avery is institutionalized. How does this affect the period of restricted coverage?

Answer: Not at all. Even though the calculated period is 32.75 months, the 30 month period still applies.

EXAMPLE 5b: Mr. Avery transfers his home to his 19 year old son instead of to his sister in Toledo. Does this make a difference?

Answer: Yes, since there is no prohibition against transferring a home to a minor child, it would not result in restricted coverage.

EXAMPLE 5c: Mr. Avery transfers his home to his 30 year old son who has lived at home for five years due to his father's poor health. Should this transfer result in a period of restricted coverage? If so, for how long?

Answer: No, because the son had resided with Mr. Avery for at least two years immediately before his institutionalization.

Points to consider

- o This is a non-penalty transfer because it is a homestead transferred to an adult child who resided with the parent for at least two years.
- o The presumption exists that Mr. Avery's son met the requirement of "provided care" unless the local district has evidence to the contrary.

ATTACHMENT III (Continued)

EXAMPLE 6

Situation: Mr. Cooper transfers \$20,000 to his grandchild on September 15, 1989. He applies for MA in the community in June, 1990. The transfer is discovered during the eligibility determination. What is the effect on his eligibility?

Disposition: He is ineligible for all care and services under MA until January, 1992 (from September, 1989 through August, 1991 for the first \$12,000 and one additional month for each \$2,000, or four additional months), or until his medical bills equal \$20,000, whichever period is shorter.

Point to consider

- o Mr. Cooper transferred the resource prior to October 1, 1989, therefore, the previous rules apply.

ATTACHMENT III (Continued)

EXAMPLE 7

Situation: Mr. Green, who lives in New York City, transferred \$50,000 to his business partner in November, 1989. In January, 1990 he enters an HRF and applies for Medicaid. He has \$3,000 in resources and is otherwise eligible. Mr. Green made several attempts to contact his business partner in an attempt to recover the money, but the partner was uncooperative. The HRF is threatening to discharge him for nonpayment. What is the effect of this transfer on his eligibility? Does he have any recourse?

Disposition: Initially it appears that this is a prohibited transfer but the district determines that restricted coverage would result in undue hardship and Mr. Green is given full coverage.

Point to consider

- o The district should evaluate the cost effectiveness of pursuing a recovery of the transferred resource for MA incorrectly paid. The eligibility examiner should refer the case to Legal for its determination as to the feasibility of taking action against the person who received the transferred resource.

ATTACHMENT III (Continued)

EXAMPLE 8

Situation: Mr. Morris who lives in Orleans County transfers \$10,000 to his sister in June, 1989, and \$10,000 to his grandson in December, 1989. He keeps \$3,000. He enters a nursing home and applies for Medicaid in June, 1990.

Disposition: He is ineligible for 24 months, from June, 1989 through May, 1991, for the first transfer. However, as soon as his medical bills equal \$10,000, his eligibility would have to be re-evaluated. We would then impose a period of restricted coverage based upon the second transfer as follows: $\$10,000/\2941 (MA regional rate in the Western Region) = 3.4 months, beginning December, 1989. Since he is not applying until June, 1990, this period has already passed, and therefore the second transfer has no effect on his eligibility.

ATTACHMENT III (Continued)

EXAMPLE 9

Situation: Anna and Elaine are 72 and 74 year old sisters who have live together for nine years in Anna's house. Anna enters a nursing home in January, 1990. She transferred her home to Elaine in December, 1989. Although Elaine did not own the house until 12/89, she produces cancelled checks to show that she occasionally made the mortgage payments and paid the real estate taxes.

Disposition: If Anna is otherwise eligible, she would be accepted with full coverage.

Point to Consider

- o The resource transferred was a homestead and was transferred to a sibling who has an equity interest in the home and who has resided with the applicant for at least one year.

NOTICE OF INTENT TO DISCONTINUE/CHANGE MEDICAL ASSISTANCE COVERAGE

NOTICE DATE:	EFFECTIVE DATE:	NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN / RID NUMBER			
CASE NAME (And C/O Name if Present) AND ADDRESS		GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ ----- OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____		
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

This is to advise you that this Department intends to change your Medical Assistance coverage as indicated below.

We have determined that on (date) _____ you transferred (item(s)) _____ valued at \$ _____. The difference between this value and the amount you actually received (\$ _____) is \$ _____. This amount is considered to be the uncompensated value.

Because you transferred this resource(s) for less than it was worth, you are not eligible for the following types of care and services:

- services provided in skilled nursing facilities, health-related facilities, intermediate care facilities, or residential treatment facilities
- nursing facility services provided in a hospital
- home and community-based services provided pursuant to S1915(c) of the Social Security Act.

Based on your current circumstances we are taking the following action:

REDUCE your Medical Assistance coverage from coverage for all care and services under the Medical Assistance Program to limited coverage effective (date) _____. You are not eligible to receive the services listed above. However, you are eligible to receive all other care and services provided under the Medical Assistance Program effective (date) _____. You will have to meet an excess income requirement for these services if there is an in the box below.

DISCONTINUE your Medical Assistance coverage effective (date) _____

Based on your current circumstances you are not eligible for the above noted care and services for a period of _____ month(s) or until (date) _____. This is based on the following calculations:

Uncompensated value of transferred resources \$ _____
(Less MA exemption if applicable)

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.
 If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. *It is not the way you request a fair hearing.* If you ask for a conference you are still entitled to a fair hearing. If you want to have your benefits continue unchanged (aid continuing) until you get a fair hearing decision, you must request a fair hearing in the way described below. A request for a conference alone will not result in continuation of benefits. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) **Telephoning:** (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550**

If you live in: **Cattaraugus, Chautauqus, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 847-3877**

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 238-8282**

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 428-4117**

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schoenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781**

OR

(2) **Writing:** By sending a copy of this notice completed, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, hearing bills, medical verification, letters, etc. that may be helpful in presenting your case.

CONTINUING YOUR BENEFITS: If you request a fair hearing before the effective date stated in this notice, you will continue to receive your benefits unchanged until the fair hearing decision is issued. However, if you lose the fair hearing, we may recover the cost of any Medical Assistance benefits that you should not have received. If you want to avoid this possibility, check the box below to indicate that you do not want your aid continued, and send this page along with your hearing request. If you do check the box, the action described above will be taken on the effective date listed above.

I agree to have the action taken on my Medical Assistance benefits, as described in this notice, prior to the issuance of the fair hearing decision.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by

YOU HAVE THE RIGHT TO APPEAL THIS DECISION
BE SURE TO READ THE BACK OF THIS NOTICE ON HOW TO APPEAL THIS DECISION

READ THE ENCLOSED NOTICE (Effect of Transfer of Resources on Medical Assistance Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANSFERS OF RESOURCES.
The LAW AND/OR REGULATIONS which allow us to do this are Section 366.5 of the Social Services Law and 18 NYCRR 360-4.4 and 360-4.7.

NOTE: If there are other factors which affect your Medical Assistance coverage, a separate notice is enclosed.
See the enclosed DSS-3973: Notice of Decision on Your Medical Assistance Application (Excess Income).

EXCESS INCOME

If you are not currently in need of the services listed above, this period of limited coverage is subject to change based on the average annual rate in the region where you reside when you become in need of these services. Therefore, if you require these services, you should notify this Department immediately.

Uncompensated value of transferred resources (less MA exemption, if applicable) \$ _____
+ Monthly regional rate \$ _____
Period of limited coverage: _____ (month(s))

We have determined that the period of limited coverage will continue for _____ month(s) based on the following calculations:

services if there is an in the box below.
You will have to meet an excess income requirement for these effective _____.

You are eligible to receive all other care and services provided under the Medical Assistance Program home and community-based services provided pursuant to §1915(c) of the Social Security Act.

- services provided in skilled nursing facilities, health-related facilities, intermediate care facilities, or residential treatment facilities
- nursing facility services provided in a hospital
- home and community-based services provided pursuant to §1915(c) of the Social Security Act.

Because you transferred this resource(s) for less than it was worth, you are not eligible to receive coverage for the following care and services:

We have determined that on (date) _____ you transferred (item(s)) _____ valued at \$ _____. The difference between this value and the amount you actually received (\$ _____) is \$ _____. This amount is considered to be the uncompensated value.

This is to advise you that this Department has ACCEPTED your Medical Assistance application dated _____.

OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.
QUESTIONS OR HELP				
OR Agency Conference				
Fair Hearing information and assistance				
Record Access				
Legal Assistance information				

RIGHT TO A CONFERENCE: You may have a conference to review these actions. If you want a conference, you should ask for one as soon as possible. At the conference, if we discover that we made the wrong decision or if, because of information you provide, we determine to change our decision, we will take corrective action and give you a new notice. You may ask for a conference by calling us at the number on the first page of this notice or by sending a written request to us at the address listed at the top of the first page of this notice. This number is used only for asking for a conference. *It is not the way you request a fair hearing.* If you ask for a conference you are still entitled to a fair hearing. Read below for fair hearing information.

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550

If you live in: Cattaraugus, Chautauque, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 847-3877

If you live in: Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 238-8282

If you live in: Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 428-4117

If you live in: Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schoenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781

OR

(2) Writing: By sending a copy of this notice completed, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, hearing bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION FOR NURSING FACILITY SERVICES

NOTICE DATE:		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE		
CASE NUMBER	CIN / RID NUMBER	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP ----- OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____		
CASE NAME (And C/O Name if Present) AND ADDRESS				
OFFICE NO.	UNIT NO.	WORKER NO.	UNIT OR WORKER NAME	TELEPHONE NO.

We have determined that on (date) _____ you transferred (item(s)) _____ valued at \$ _____. The difference between this value and the amount you actually received (\$ _____) is \$ _____. This amount is considered to be the uncompensated value.

Because you transferred this resource(s) for less than it was worth, you are not eligible for the following types of care and services:

- services provided in skilled nursing facilities, health-related facilities, intermediate care facilities, or residential treatment facilities
- nursing facility services provided in a hospital
- home and community-based services provided pursuant to S1915(c) of the Social Security Act.

Based on your current circumstances you are not eligible for the above noted care and services for a period of _____ month(s) or until (date) _____. This is based on the following calculations:

Uncompensated value of transferred resources (less MA exemption, if applicable)	\$	
	÷	
Monthly regional rate	\$	
Period of limited coverage:		
		(month(s))

Although you are not eligible for certain types of care and services because of the above-referenced transfer, you may be eligible for coverage of other care and services not included in the facility's rate, (e.g., eyeglasses, hearing aids, dentures and acute hospital care). In order for you to be eligible for this coverage, either: (1) your income must be less than the allowable MA income standards; or (2) if your income exceeds the allowable MA income standards, you must meet certain excess income requirements. We have determined that your income exceeds the allowable MA income standards based on the following:

Your total gross monthly income is \$ _____. Your total monthly deductions are \$ _____. The difference between these is your net monthly income. This is \$ _____. The allowable income standard for a family household your size is \$ _____. The difference between your net monthly income amount and this standard (\$ _____) is your monthly spenddown or excess income amount. Your excess income for six months is \$ _____. Please see the enclosed Form DSS-4038, which explains how you can meet the excess income requirements and become eligible for coverage under the EXCESS INCOME PROGRAM.

NOTE: If there are other factors which affect your Medical Assistance coverage, a separate notice is enclosed.

READ THE ENCLOSED NOTICE (Effect of Transfer of Resources on Medical Assistance Eligibility) FOR IMPORTANT INFORMATION CONCERNING TRANSFERS OF RESOURCES.

The LAW AND/OR REGULATIONS which allow us to do this are Section 366.5 of the Social Services Law and 18 NYCRR 360-4 and 360-4.7.

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550**

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 847-3877**

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 238-8282**

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 428-4117**

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781**

OR

(2) Writing: By sending a copy of this notice completed, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.

NOTICE OF DECISION ON YOUR MEDICAL ASSISTANCE APPLICATION

NOTICE DATE: _____		NAME AND ADDRESS OF AGENCY/CENTER OR DISTRICT OFFICE _____ _____		
CASE NUMBER _____	CIN / RID NUMBER _____	GENERAL TELEPHONE NO. FOR QUESTIONS OR HELP _____ ----- OR Agency Conference _____ Fair Hearing information and assistance _____ Record Access _____ Legal Assistance information _____		
CASE NAME (And C/O Name if Present) AND ADDRESS _____ _____ _____				
OFFICE NO. _____	UNIT NO. _____	WORKER NO. _____	UNIT OR WORKER NAME _____	TELEPHONE NO. _____

This Department has made a decision concerning eligibility under the Medical Assistance Program. We are sending this notice to tell you that this Department will:

DENY the Medical Assistance application dated _____ for (name(s)) _____ because:

- You have **RESOURCES** totaling \$ _____. The allowable Medical Assistance resource standard is \$ _____. The difference between these (\$ _____) is the **EXCESS RESOURCE** amount.
- In addition to excess resources, you have **EXCESS INCOME** in the amount of \$ _____/month. Please see the enclosed Form DSS-4038, which explains how you can meet the excess income requirements and become eligible for coverage under the **EXCESS INCOME PROGRAM**.
- Other: _____

Accordingly, you are presently ineligible for Medical Assistance. Should you become eligible for Medical Assistance because the above-noted reasons are no longer valid, we have determined that your eligibility for Medical Assistance will be limited and that you will not be eligible for the following types of care and services:

- services provided in skilled nursing facilities, health-related facilities, intermediate care facilities, or residential treatment facilities
- nursing facility services provided in a hospital
- home and community-based services provided pursuant to S1915(c) of the Social Security Act.

This determination is based upon your transfer of (item(s)) _____ on (date) _____ valued at \$ _____. The difference between this value and the amount you actually received (\$ _____) is \$ _____. This amount is considered to be the **uncompensated value**.

Because you transferred this resource(s) for less than it was worth, should you subsequently become eligible for Medical Assistance, your eligibility for Medical Assistance will be limited as noted above for a period of _____ month(s) or until (date) _____. This is based on the following calculations:

Uncompensated value of transferred resources \$ _____
 (less MA exemption, if applicable) ÷

RIGHT TO A FAIR HEARING: If you believe that the above action is wrong, you may request a State fair hearing by:

(1) Telephoning: (PLEASE HAVE THIS NOTICE WITH YOU WHEN YOU CALL)

If you live in: **New York City (Manhattan, Bronx, Brooklyn, Queens, Staten Island): (212) 488-6550**

If you live in: **Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans or Wyoming County: (716) 847-3877**

If you live in: **Allegany, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne or Yates County: (716) 238-8282**

If you live in: **Broome, Cayuga, Chenango, Cortland, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tompkins or Tioga County: (315) 428-4117**

If you live in: **Albany, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Montgomery, Nassau, Orange, Otsego, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Suffolk, Sullivan, Ulster, Warren, Washington or Westchester County: (518) 474-8781**

OR

(2) Writing: By sending a copy of this notice *completed*, to the Fair Hearing Section, New York State Department of Social Services, P.O. Box 1930, Albany, New York 12201. Please keep a copy for yourself.

I want a fair hearing. The Agency's action is wrong because:

Signature of Client _____ Date _____

YOU HAVE 60 DAYS FROM THE DATE OF THIS NOTICE TO REQUEST A FAIR HEARING

If you request a fair hearing, the State will send you a notice informing you of the time and place of the hearing. You have the right to be represented by legal counsel, a relative, a friend or other person, or to represent yourself. At the hearing you, your attorney or other representative will have the opportunity to present written and oral evidence to demonstrate why the action should not be taken, as well as an opportunity to question any persons who appear at the hearing. Also, you have a right to bring witnesses to speak in your favor. You should bring to the hearing any documents such as this notice, paystubs, receipts, medical bills, heating bills, medical verification, letters, etc. that may be helpful in presenting your case.

LEGAL ASSISTANCE: If you need free legal assistance, you may be able to obtain such assistance by contacting your local Legal Aid Society or other legal advocate group. You may locate the nearest Legal Aid Society or advocate group by checking your Yellow Pages under "Lawyers" or by calling the number indicated on the first page of this notice.

ACCESS TO RECORDS / INFORMATION: You have the right to review your case record. Upon your request, you have the right to free copies of documents which we will present into evidence at the fair hearing. Also, upon request, you have the right to free copies of other documents from your case record which you need for your fair hearing. To request such documents or to find out how you may review your case record, call the number indicated on the first page of this notice, or send a written request to us at the address listed at the top of the first page of this notice.

If you want additional information about your case, how to request a fair hearing, how to gain access to your case file and/or additional copies of documents, you may call the number indicated on the first page of this notice or write us at the address listed at the top of the first page of this notice.