Department of Social and Health Services
Olympia, Washington

ELIGIBILITY A-Z MANUAL REVISION

Revision #	**624**
Category / Section	**Long Term Care**
Issued	**06/17/2008**
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http://www.dshs.wa.gov/manuals/eaz/sections/LTCIndex.shtml
EAZ Long Term Care Section

http://www.dshs.wa.gov/pdf/ms/rpau/103P-08-11-047.pdf
Repeal of WAC 388-511-1105 and to view the changes in the WAC.

WAC 388-511-1105 has been repealed as this language is duplicated in chapter 388-475 WAC.

WAC 388-511-1105 indicated the disability criteria under SSI related that is now indicated in WAC 388-475-0050.

The following long-term care WACs have been updated with the current WAC references and links.

388-513-1363 Transfer of Assets
388-513-1364 Transfer of Assets
388-513-1365 Transfer of Assets
388-515-1540 MNRW
388-561-0100 Trusts
388-513-0300 Life Estates

The repeal of WAC 388-511-1105 and the update of current WACs was a joint effort with HRSA and ADSA as this repeal affected WACs owed by both HRSA and ADSA.

RULE-MAKING ORDER

CR-103 (June 2004)
(Implements RCW 34.05.360)

Agency: Department of Social and Health Services, Health and Recovery Services Administration

☒ **Permanent Rule**
☐ **Emergency Rule**

Effective date of rule:
Permanent Rules
☒ 31 days after filing.
☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Effective date of rule:
Emergency Rules
☐ Immediately upon filing.
☐ Later (specify) _____

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
☐ Yes ☒ No If Yes, explain:

Purpose: Chapter 388-475 WAC incorporates language published in Chapter 388-511 WAC for SSI-related eligibility requirements. The repeal of this WAC section is appropriate because the language is duplicated in chapter 388-475 WAC. The repeal of this WAC section provides the opportunity to consolidate and improve the usability of rules concerning the financial eligibility requirements for SSI within chapter 388-475 WAC.

Citation of existing rules affected by this order:
Repealed: WAC 388-511-1105
Amended: WAC 388-106-0225, 0310, 0410, 0510, 0705; 388-500-0005; 388-503-0510; 388-513-1363, 1364, 1365; 388-515-1540; 388-561-0100, 0300.
Suspended: None

Statutory authority for adoption: RCW 34.05.353(2)(d) and 74.08.090

Other authority : Chapter 74.09 RCW; Chapter 74.04 RCW

PERMANENT RULE ONLY (Including Expedited Rule Making)
Adopted under notice filed as WSR 08-05-106 on February 19, 2008.(date)
Describe any changes other than editing from proposed to adopted version: None.

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting: N/A
Name: phone ( )
Address: fax ( )
e-mail

EMERGENCY RULE ONLY
Under RCW 34.05.350 the agency for good cause finds:
☐ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
☐ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

Date adopted:
May 9, 2008

NAME (TYPE OR PRINT)
Stephanie Schiller

SIGNATURE
Stephanie E Schiller

TITLE
DSHS Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 15, 2008
TIME: 8:18 AM

WSR 08-11-047

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	___	Amended	___	Repealed	___
Federal rules or standards:	New	___	Amended	___	Repealed	___
Recently enacted state statutes:	New	___	Amended	___	Repealed	___

The number of sections adopted at the request of a nongovernmental entity:

	New	___	Amended	___	Repealed	___

The number of sections adopted in the agency's own initiative:

	New	___	Amended	___	Repealed	___

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	___	Amended	13	Repealed	1

The number of sections adopted using:

Negotiated rule making:	New	___	Amended	___	Repealed	___
Pilot rule making:	New	___	Amended	___	Repealed	___
Other alternative rule making:	New	___	Amended	13	Repealed	1

AMENDATORY SECTION (Amending WSR 07-21-020, filed 10/8/07, effective 11/8/07)

WAC 388-106-0225 How do I pay for MPC? (1) If you live in your own home, you do not participate toward the cost of your personal care services.

(2) If you live in a residential facility and are:

(a) An SSI beneficiary who receives only SSI income, you only pay for board and room. You are allowed to keep a personal needs allowance of forty dollars and twelve cents per month;

(b) An SSI beneficiary who receives SSI and SSA benefits, you only pay for board and room. You are allowed to keep a personal needs allowance of forty dollars and twelve cents. You keep an additional twenty dollar disregard from non-SSI income;

(c) An SSI-related person under WAC ((~~388-511-1105~~)) 388-475-0050, you may be required to participate towards the cost of your personal care services in addition to your board and room if your financial eligibility is based on the facility's state contracted rate described in WAC 388-513-1305. You are allowed to keep a personal needs allowance of forty dollars and twelve cents. You keep an additional twenty dollar disregard from non-SSI income; or

(d) A GA-X client in a residential care facility, you are allowed to keep a personal allowance of only thirty-eight dollars and eighty-four cents per month. The remainder of your grant must be paid to the facility.

(3) The department pays the residential care facility from the first day of service through the:

(a) Last day of service when the Medicaid resident dies in the facility; or

(b) Day of service before the day the Medicaid resident is discharged.

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-106-0310 Am I eligible for COPES-funded services? You are eligible for COPES-funded services if you meet all of the following criteria. The department must assess your needs in CARE and determine that:

(1) You are age:

(a) Eighteen or older and blind or have a disability, as defined in WAC ((~~388-511-1105~~)) 388-475-0050; or

(b) Sixty-five or older.

(2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC

388-515-1505, community options program entry system (COPES).

(3) You:

(a) Are not eligible for Medicaid personal care services (MPC); or

(b) Are eligible for MPC services, but the department determines that the amount, duration, or scope of your needs is beyond what MPC can provide.

(4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless COPES services are provided) which is defined in WAC 388-106-0355(1).

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-106-0410 Am I eligible for MNRW-funded services? You are eligible for MNRW-funded services if you choose to receive services in a residential facility and you meet all of the following criteria. The department must assess your needs, using CARE, and determine that:

(1) You are age:

(a) Eighteen or older and blind or have a disability, as defined in WAC ((~~388-511-1105~~)) 388-475-0050; or

(b) Sixty-five or older.

(2) You meet financial eligibility requirements. This means the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1540.

(3) You are not eligible for Medicaid personal care services (MPC) or COPES.

(4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless MNRW services are provided) which is defined in WAC 388-106-0355(1).

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-106-0510 Am I eligible for MNIW-funded services? You are eligible for MNIW-funded services if you choose to receive services in your own home and you meet all of the following criteria. The department must assess your needs in CARE and determine that:

(1) You are age:

(a) Eighteen or older and blind or have a disability, as defined in WAC ((~~388-511-1105~~)) 388-475-0050; or

(b) Sixty-five or older.

(2) You meet financial eligibility requirements. This means

the department will assess your finances and determine if your income and resources fall within the limits set in WAC 388-515-1505;

(3) You are not eligible for Medicaid personal care services (MPC) or COPES;

(4) Your CARE assessment shows you need the level of care provided in a nursing facility (or will likely need the level of care within thirty days unless MNIW services are provided) which is defined in WAC 388-106-0355(1).

AMENDATORY SECTION (Amending WSR 06-05-022, filed 2/6/06, effective 3/9/06)

WAC 388-106-0705 Am I eligible for PACE services? To qualify for Medicaid-funded PACE services, you must apply for an assessment by contacting your local home and community services office. The department will assess and determine whether you:

(1) Are age:

(a) Fifty-five or older, and blind or have a disability, as defined in WAC ((~~388-511-1105~~)) 388-475-0050, SSI-related eligibility requirements; or

(b) Sixty-five or older.

(2) Need nursing facility level of care as defined in WAC 388-106-0355;

(3) Live within the designated service area of the PACE provider;

(4) Meet financial eligibility requirements. This means the department will assess your finances, determine if your income and resources fall within the limits, and determine the amount you may be required to contribute, if any, toward the cost of your care as described in WAC 388-515-1505;

(5) Not be enrolled in any other Medicare or Medicaid prepayment plan or optional benefit; and

(6) Agree to receive services exclusively through the PACE provider and the PACE provider's network of contracted providers.

AMENDATORY SECTION (Amending WSR Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.04.005, 74.08.331, 74.08A.010, [74.08A.]100, [74.08A.]210, [74.08A.]230, 74.09.510, 74.12.255, Public Law 104-193 (1997) and the Balanced Budget Act [of] 1997. 98-15-066, filed 7/13/98, effective 7/30/98)

WAC 388-500-0005 Medical definitions. Unless defined in this chapter or in other chapters of the *Washington Administrative Code*, use definitions found in the *Webster's New World Dictionary*. This section contains definitions of words and phrases the department uses in rules for medical programs. Definitions of words used for both medical and financial programs are defined under WAC

388-22-030.

"Assignment of rights" means the client gives the state the right to payment and support for medical care from a third party.

"Base period" means the time period used in the limited casualty program which corresponds with the months considered for eligibility.

"Beneficiary" means an eligible person who receives:

*A federal cash Title XVI benefit; and/or

*State supplement under Title XVI; or

*Benefits under Title XVIII of the Social Security Act.

"Benefit period" means the time period used in determining whether Medicare can pay for covered Part A services. A benefit period begins the first day a beneficiary is furnished inpatient hospital or extended care services by a qualified provider. The benefit period ends when the beneficiary has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for sixty consecutive days. There is no limit to the number of benefit periods a beneficiary may receive. Benefit period also means a "spell of illness" for Medicare payments.

"Cabulance" means a vehicle for hire designed and used to transport a physically restricted person.

"Carrier" means:

*An organization contracting with the federal government to process claims under Part B of Medicare; or

*A health insurance plan contracting with the department.

"Categorical assistance unit (CAU)" means one or more family members whose eligibility for medical care is determined separately or together based on categorical relatedness.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-503-0310, chapter 388-517 WAC and WAC 388-523-2305.

"Children's health program" means a state-funded medical program for children under age eighteen:

*Whose family income does not exceed one hundred percent of the federal poverty level; and

*Who are not otherwise eligible under Title XIX of the Social Security Act.

"Coinsurance-Medicare" means the portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is twenty percent of reasonable charges.

"Community services office (CSO)" means an office of the department which administers social and health services at the community level.

"Couple" means, for the purposes of an SSI-related client, an SSI-related client living with a person of the opposite sex and both presenting themselves to the community as husband and wife. The department shall consider the income and resources of such couple as if the couple were married except when determining institutional eligibility.

"Deductible-Medicare" means an initial specified amount that is the responsibility of the client.

***"Part A of Medicare-inpatient hospital deductible"** means an

initial amount of the medical care cost in each benefit period which Medicare does not pay.

***"Part B of Medicare-physician deductible"** means an initial amount of Medicare Part B covered expenses in each calendar year which Medicare does not pay.

"Delayed certification" means department approval of a person's eligibility for medicaid made after the established application processing time limits.

"Department" means the state department of social and health services.

"Early and periodic screening, diagnosis and treatment (EPSDT)" also known as the "healthy kids" program, means a program providing early and periodic screening, diagnosis and treatment to persons under twenty-one years of age who are eligible for Medicaid or the children's health program.

"Electronic fund transfers (EFT)" means automatic bank deposits to a client's or provider's account.

"Emergency medical condition" means the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

*Placing the patient's health in serious jeopardy;

*Serious impairment to bodily functions; or

*Serious dysfunction of any bodily organ or part.

"Emergency medical expense requirement" means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the medically indigent program.

"Essential spouse" see **"spouse."**

"Extended care patient" means a recently hospitalized Medicare patient needing relatively short-term skilled nursing and rehabilitative care in a skilled nursing facility.

"Garnishment" means withholding an amount from earned or unearned income to satisfy a debt or legal obligation.

"Grandfathered client" means:

*A noninstitutionalized person who meets all current requirements for Medicaid eligibility except the criteria for blindness or disability; and

*Was eligible for Medicaid in December 1973 as blind or disabled whether or not the person was receiving cash assistance in December 1973; and

*Continues to meet the criteria for blindness or disability and other conditions of eligibility used under the Medicaid plan in December 1973; and

*An institutionalized person who was eligible for Medicaid in December 1973 or any part of that month, as an inpatient of a medical institution or resident of an intermediate care facility that was participating in the Medicaid program and for each consecutive month after December 1973 who:

*Continues to meet the requirements for Medicaid eligibility that were in effect under the state's plan in December 1973 for institutionalized persons; and

*Remains institutionalized.

"Health maintenance organization (HMO)" means an entity

licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis.

"Healthy kids," see **"EPSDT."**

"Home health agency" means an agency or organization certified under Medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence.

"Hospital" means an institution licensed as a hospital by the department of health.

"Income for an SSI-related client," means the receipt by an individual of any property or service which the client can apply either directly, by sale, or conversion to meet the client's basic needs for food, clothing, and shelter.

***"Earned income"** means gross wages for services rendered and/or net earnings from self-employment.

***"Unearned income"** means all other income.

"Institution" means an establishment which furnishes food, shelter, medically-related services, and medical care to four or more persons unrelated to the proprietor. This includes medical facilities, nursing facilities, and institutions for the mentally retarded.

***"Institution-public"** means an institution, including a correctional institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

***"Institution for mental diseases"** means an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases including medical attention, nursing care, and related services.

***"Institution for the mentally retarded or a person with related conditions"** means an institution that:

*Is primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or a person with related conditions; and

*Provides, in a protected residential setting, on-going care, twenty-four hour supervision, evaluation, and planning to help each person function at the greatest ability.

***"Institution for tuberculosis"** means an institution for the diagnosis, treatment, and care of a person with tuberculosis.

***"Medical institution"** means an institution:

*Organized to provide medical care, including nursing and convalescent care;

*With the necessary professional personnel, equipment and facilities to manage the health needs of the patient on a continuing basis in accordance with acceptable standards;

*Authorized under state law to provide medical care; and

*Staffed by professional personnel. Services include adequate physician and nursing care.

"Intermediary" means an organization having an agreement with the federal government to process Medicare claims under Part A.

"Legal dependent" means a person for whom another person is required by law to provide support.

"Limited casualty program (LCP)" means a medical care program for medically needy, as defined under WAC 388-503-0320 and for medically indigent, as defined under WAC 388-503-0370.

"Medicaid" means the federal aid Title XIX program under which medical care is provided to persons eligible for:

*Categorically needy program as defined in WAC 388-503-0310 ((~~and 388-511-1105~~)); or

*Medically needy program as defined in WAC 388-503-0320.

"Medical assistance." See **"Medicaid."**

"Medical assistance administration (MAA)" means the unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs.

"Medical assistance unit (MAU)" means one or more family members whose eligibility for medical care is determined separately or together based on financial responsibility.

"Medical care services" means the limited scope of care financed by state funds and provided to general assistance (GAU) and ADATSA clients.

"Medical consultant" means a physician employed by the department.

"Medical facility" see **"Institution."**

"Medically indigent (MI)" means a state-funded medical program for a person who has an emergency medical condition requiring hospital-based services.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Medically needy (MN)" is the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"Medicare" means the federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

***"Part A"** covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

***"Part B"** is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

"Medicare assignment" means the method by which the provider receives payment for services under Part B of Medicare.

"Month of application" means the calendar month a person files the application for medical care. When the application is for the medically needy program, at the person's request and if the application is filed in the last ten days of that month, the month

of application may be the following month.

"Nursing facility" means any institution or facility the department [of health] licenses as a nursing facility, or a nursing facility unit of a licensed hospital, that the:

*Department certifies; and

*Facility and the department agree the facility may provide skilled nursing facility care.

"Outpatient" means a nonhospitalized patient receiving care in a hospital outpatient or hospital emergency department, or away from a hospital such as in a physician's office, the patient's own home, or a nursing facility.

"Patient transportation" means client transportation to and from covered medical services under the federal Medicaid and state medical care programs.

"Physician" means a doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed.

"Professional activity study (PAS)" means a compilation of inpatient hospital data, conducted by the commission of professional and hospital activities, to determine the average length of hospital stay for patients.

"Professional review organization for Washington (PRO-W)" means the state level organization responsible for determining whether health care activities:

*Are medically necessary;

*Meet professionally acceptable standards of health care; and

*Are appropriately provided in an outpatient or institutional setting for beneficiaries of Medicare and clients of Medicaid and maternal and child health.

"Prosthetic devices" means replacement, corrective, or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law to:

*Artificially replace a missing portion of the body;

*Prevent or correct physical deformity or malfunction; or

*Support a weak or deformed portion of the body.

"Provider" or **"provider of service"** means an institution, agency, or person:

*Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and

*Is eligible to receive payment from the department.

"Resources for an SSI-related client," means cash or other liquid assets or any real or personal property that an individual or spouse, if any, owns and could convert to cash to be used for support or maintenance.

*If an individual can reduce a liquid asset to cash, it is a resource.

*If an individual cannot reduce an asset to cash, it is not considered an available resource.

*Liquid means properties that are in cash or are financial instruments which are convertible to cash such as, but not limited to, cash, savings, checking accounts, stocks, mutual fund shares, mortgage, or a promissory note.

*Nonliquid means all other property both real and personal evaluated at the price the item can reasonably be expected to sell for on the open market.

"Retroactive period" means the three calendar months before the month of application.

"Spell of illness" see **"benefit period."**

"Spenddown" means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.

"Spouse" means:

***"Community spouse"** means a person living in the community and married to an institutionalized person or to a person receiving services from a home and community-based waivered program as described under chapter 388-515 WAC.

***"Eligible spouse"** means an aged, blind or disabled husband or wife of an SSI-eligible person, with whom such a person lives.

***"Essential spouse"** means, a husband or wife whose needs were taken into account in determining old age assistance (OAA), aid to the blind (AB), or disability assistance (DA) client for December 1973, who continues to live in the home and to be the spouse of such client.

***"Ineligible spouse"** means the husband or wife of an SSI-eligible person, who lives with the SSI-eligible person and who has not applied or is not eligible to receive SSI.

***"Institutionalized spouse"** means a married person in an institution or receiving services from a home or community-based waivered program.

***"Nonapplying spouse"** means an SSI-eligible person's husband or wife, who has not applied for assistance.

"SSI-related" means an aged, blind or disabled person not receiving an SSI cash grant.

"Supplemental security income (SSI) program, Title XVI" means the federal grant program for aged, blind, and disabled established by section 301 of the Social Security amendments of 1972, and subsequent amendments, and administered by the Social Security Administration (SSA).

"Supplementary payment (SSP)" means the state money payment to persons receiving benefits under Title XVI, or who would, but for the person's income, be eligible for such benefits, as assistance based on need in supplementation of SSI benefits. This payment includes:

***"Mandatory state supplement"** means the state money payment to a person who, for December 1973, was a client receiving cash assistance under the department's former programs of old age assistance, aid to the blind and disability assistance; and

***"Optional state supplement"** means the elective state money payment to a person eligible for SSI benefits or who, except for the level of the person's income, would be eligible for SSI benefits.

"Third party" means any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client.

"Title XIX" is the portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

"Transfer" means any act or omission to act when title to or any interest in property is assigned, set over, or otherwise vested or allowed to vest in another person; including delivery of personal property, bills of sale, deeds, mortgages, pledges, or any

other instrument conveying or relinquishing an interest in property. Transfer of title to a resource occurs by:

*An intentional act or transfer; or

*Failure to act to preserve title to the resource.

"Value-fair market for an SSI-related person" means the current value of a resource at the price for which the resource can reasonably be expected to sell on the open market.

"Value of compensation received" means, for SSI-related medical eligibility, the gross amount paid or agreed to be paid by the purchaser of a resource.

"Value-uncompensated" means, for SSI-related medical eligibility, the fair market value of a resource, minus the amount of compensation received in exchange for the resource.

AMENDATORY SECTION (Amending WSR 05-07-097, filed 3/17/05, effective 4/17/05)

WAC 388-503-0510 How a client is determined "related to" a categorical program. (1) A person is related to the Supplemental Security Income (SSI) program if they are:

(a) Aged, blind, or disabled as defined in ((~~WAC 388-511-1105(1) or~~)) chapter 388-475 WAC; or

(b) Considered as eligible for SSI under ((~~WAC 388-511-1105(5) or~~)) chapter 388-475 WAC; or

(c) Children meeting the requirements of WAC 388-505-0210(5).

(2) A person or family is considered to be related to the temporary assistance for needy families (TANF) program if they:

(a) Meet the program requirements for the TANF cash assistance programs or the requirements of WAC 388-505-0220; or

(b) Would meet such requirements except that the assistance unit's countable income exceeds the TANF program standards in WAC 388-478-0065.

(3) Persons related to SSI or to TANF are eligible for categorically needy (CN) or medically needy (MN) medical coverage if they meet the other eligibility criteria for these medical programs. See chapters 388-475, 388-505 and 388-519 WAC for these eligibility criteria.

(4) Persons related to SSI or to TANF and who receive the related CN medical coverage have redetermination rights as described in WAC 388-503-0505(6).

AMENDATORY SECTION (Amending WSR 07-17-152, filed 8/21/07, effective 10/1/07)

WAC 388-513-1363 Evaluating the transfer of assets on or after May 1, 2006 for persons applying for or receiving long-term care (LTC) services. This section describes how the department evaluates asset transfers made on or after May 1, 2006 and their

affect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.

- Refer to WAC 388-513-1364 for rules used to evaluate asset transfers made on or after April 1, 2003 and before May 1, 2006.
- Refer to WAC 388-513-1365 for rules used to evaluate asset transfer made prior to April 1, 2003.

(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006 on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.

(2) The department does not apply a penalty period to transfers meeting the following conditions:

(a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;

(b) The transfer is an excluded resource described in WAC 388-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in subsection (2)(d);

(c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.

(ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing evidence must be presented regarding the specific purpose of the transfer.

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

(iv) The denial of eligibility would result in an undue hardship as described in WAC 388-513-1367.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 388-475-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the individual to remain in the home; or

(iii) Brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 388-475-0050 (1)(b) or (c);

(f) The transfer meets the conditions described in subsection (3), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the individual's child who meets the disability criteria described in WAC 388-475-0050 (1) (b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC ((~~388-511-1105~~)) 388-475-0050 (1)(b) or (c); or

(3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(f), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less; and

(d) The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b) and (7)(a) and (b).

(4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(5) The department considers the transfer of an asset in

exchange for care services given by a family member that does not meet the criteria as described under subsection (4) as the transfer of an asset without adequate consideration.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.

(7) If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:

(a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or

(b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and

(c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.

(8) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in subsection (8)(a) becomes an available resource as of the first day of the following month.

(9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in subsection (10)(a) is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsections (7)(a), (b), and (c).

(11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;

(a) We divide the penalty between the two spouses.

(b) If one spouse is no longer subject to a penalty (e.g. the

spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.

(12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

(13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW 74.08.331 Unlawful practices--Obtaining assistance--Disposal of realty;

(b) RCW 74.08.338 Real property transfers for inadequate consideration;

(c) RCW 74.08.335 Transfers of property to qualify for assistance; and

(d) RCW 74.39A.160 Transfer of assets--Penalties.

AMENDATORY SECTION (Amending WSR 03-20-059, filed 9/26/03, effective 10/27/03)

WAC 388-513-1364 Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1365 for rules used to evaluate the transfer of an asset made before April 1, 2003. Refer to WAC 388-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department does not apply a penalty period to the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1360~~)) 388-513-1350 with the exception of the client's home, unless the transfer of the client's home meets the conditions described in subsection (1)(d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC ((~~388-511-1105 (1)(b) or (c)~~)) 388-475-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the client to remain in the home; or

(iii) Brother or sister, who has:

(A) Equity in the home; and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the client's child who meets the disability criteria described in WAC ((~~388-511-1105 (1)(b) or (c)~~)) 388-475-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC ((~~388-511-1105 (1)(b) or (c)~~)) 388-475-0050 (1)(b) or (c); or

(f) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC ((~~388-511-1105 (1)(b) or (c)~~)) 388-475-0050 (1)(b) or (c).

(2) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of institutional status, if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the Medicaid state plan or the department's waivered services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(3) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (2) as the transfer of an asset without adequate consideration.

(4) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer

irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term or the trust, whichever is less; and

(d) The requirements in subsection (4)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b).

(5) If a client or the client's spouse transfers an asset within the look-back period described in WAC 388-513-1365 without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that begin on the latter of:

(i) The first day of the month in which the transfer is made; or

(ii) The first day after any previous penalty period has ended and end on the last day of the whole number of days as described in subsection (5)(a)(ii).

(6) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1360~~)) 388-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in subsection (6)(a) becomes an available resource as of the first day of the following month.

(7) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(8) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in subsection (8)(a) is divided by the statewide average daily private cost for nursing facilities at

the time of application; and

(c) A penalty period equal to the number of whole days found by following subsections (5)(a) and (b) and (8)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(9) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(10) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

AMENDATORY SECTION (Amending WSR 03-14-038, filed 6/23/03, effective 8/1/03)

WAC 388-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997 and before April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC 388-513-1366 for rules used to evaluate the transfer of an asset made before March 1, 1997. Refer to WAC 388-513-1364 for rules used to evaluate the transfer of an asset made on or after March 31, 2003. Refer to WAC 388-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1360~~)) 388-513-1350 with the exception of the client's home, unless the transfer meets the conditions described in subsection (1)(d);

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is

transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC ((~~388-511-1105 (1)(b) or (c)~~)) 388-475-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4), and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC ((~~388-511-1105 (1)(b) or (c)~~)) 388-475-0050 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-fours years old or younger and meets the disability criteria described in WAC ((~~388-511-1105 (1)(b) or (c)~~)) 388-475-0050 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e), if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC 388-561-0100.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997 and before April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in subsection (6)(a)(ii).

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1360~~)) 388-513-1350 does not affect the client's eligibility;

(b) That remains after an acquisition described in subsection (7)(a) becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (6) through (8).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in (9)(a) is divided by the statewide average monthly private cost for nursing facilities at the time of

application; and

(c) A penalty period equal to the number of whole months found by following subsections (9)(a) and (b) is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-515-1540 Medically needy residential waiver (MNRW) effective March 17, 2003. This section describes the financial eligibility requirements for waiver services under the medically needy residential waiver (MNRW) and the rules used to determine a client's responsibility in the total cost of care.

(1) To be eligible for MNRW, a client must meet the following conditions:

(a) Does not meet financial eligibility for Medicaid personal care or the COPES program;

(b) Is eighteen years of age or older;

(c) Meets the SSI related criteria described in WAC ((~~388-511-1105(1)~~)) 388-475-0050;

(d) Requires the level of care provided in a nursing facility as described in WAC 388-106-0355;

(e) In the absence of waiver services described in WAC 388-106-0400, would continue to reside in a medical facility as defined in WAC 388-513-1301, or will likely be placed in one within the next thirty days;

(f) Has attained institutional status as described in WAC 388-513-1320;

(g) Has been determined to be in need of waiver services as described in WAC 388-106-0410;

(h) Lives in one of the following department-contracted residential facilities:

(i) Licensed adult family home (AFH);

(ii) Assisted living (AL) facility; or

(iii) Enhanced adult residential care (EARC) facility.

(i) Is not subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366; and

(j) Meets the resource and income requirements described in subsections (2) through (6).

(2) The department determines a client's nonexcluded resources under MNRW as described in WAC 388-513-1350 ((~~(1) through (4)(a) and WAC 388-513-1360~~));

(3) Nonexcluded resources, after disregarding excess resources described in (4), must be at or below the resource standard described in WAC 388-513-1350 (1) and (2).

(4) In determining a client's resource eligibility, the department disregards excess resources above the standard described in subsection (3) of this section:

(a) In an amount equal to incurred medical expenses such as:

(i) Premiums, deductibles, and co-insurance/co-payment charges for health insurance and Medicare premiums;

(ii) Necessary medical care recognized under state law, but not covered under the state's Medicaid plan; or

(iii) Necessary medical care covered under the state's Medicaid plan.

(b) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Have not been used to satisfy a previous spend down liability;

(iii) Have not previously been used to reduce excess resources;

(iv) Have not been used to reduce client responsibility toward cost of care; and

(v) Are amounts for which the client remains liable.

(5) The department determines a client's countable income under MNRW in the following way:

(a) Considers income available described in WAC 388-513-1325 and 388-513-1330 (1), (2), and (3);

(b) Excludes income described in WAC 388-513-1340;

(c) Disregards income described in WAC 388-513-1345;

(d) Deducts monthly health insurance premiums, except Medicare premiums.

(6) If the client's countable income is:

(a) Less than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW subject to availability per WAC 388-106-0435;

(b) More than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW when they meet the requirements described in subsections (7) through (9), subject to availability per WAC 388-106-0435.

(7) The portion of a client's countable income over the department-contracted rate is called "excess income."

(8) A client who meets the requirements for MNRW chooses a three or six month base period. The months must be consecutive calendar months.

(9) A client who has or will have "excess income" is not eligible for MNRW until the client has medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown." The excess income from each of the months in the base period is added together to determine the total "spenddown" amount.

(10) Medical expenses described in subsection (4) of this WAC may be used to meet spenddown if not already used in subsection (4) of this WAC to disregard excess resources or to reduce countable

income as described in subsection (5)(d).

(11) In cases where spenddown has been met, medical coverage begins the day services are authorized.

(12) The client's income that remains after determining available income in WAC 388-513-1325 and 388-513-1330 (1), (2), (3) and excluded income in WAC 388-513-1340 is paid towards the cost of care after deducting the following amounts in the order listed:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Personal needs allowance (PNA) described in WAC 388-515-1505 ((~~(7)(b)~~)). (Long-term care standards can be found at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml);

(c) Medicare and health insurance premiums not used to meet spenddown or reduce excess resources described in WAC 388-513-1350;

(d) Incurred medical expenses described in (4) not used to meet spenddown or reduce excess resources described in WAC 388-513-1350.

AMENDATORY SECTION (Amending WSR 03-13-113, filed 6/17/03, effective 8/1/03)

WAC 388-561-0100 Trusts. (1) The department determines how trusts affect eligibility for medical programs.

(2) The department disregards trusts established, on or before April 6, 1986, for the sole benefit of a client who lives in an intermediate care facility for the mentally retarded (ICMR).

(3) For trusts established on or before August 10, 1993 the department counts the following:

(a) If the trust was established by the client, client's spouse, or the legal guardian, the maximum amount of money (payments) allowed to be distributed under the terms of the trust is considered available income to the client if all of the following conditions apply:

(i) The client could be the beneficiary of all or part of the payments from the trust;

(ii) The distribution of payments is determined by one or more of the trustees; and

(iii) The trustees are allowed discretion in distributing payments to the client.

(b) If an irrevocable trust doesn't meet the conditions under subsection (3)(a) then it is considered either:

(i) An **unavailable** resource, if the client established the trust for a beneficiary other than the client or the client's spouse; or

(ii) An **available** resource in the amount of the trust's assets that:

(A) The client could access; or

(B) The trustee distributes as actual payments to the client and the department applies the transfer of assets rules of WAC 388-513-1363, 388-513-1364 or 388-513-1365.

(c) If a revocable trust doesn't meet the description under

subsection (3)(a):

(i) The full amount of the trust is an available resource of the client if the trust was established by:

(A) The client;

(B) The client's spouse, and the client lived with the spouse; or

(C) A person other than the client or the client's spouse only to the extent the client had access to the assets of the trust.

(ii) Only the amount of money actually paid to the client from the trust is an available resource when the trust was established by:

(A) The client's spouse, and the client did not live with the spouse; or

(B) A person other than the client or the client's spouse; and

(C) Payments were distributed by a trustee of the trust.

(iii) The department considers the funds a resource, not income.

(4) For trusts established on or after August 11, 1993:

(a) The department considers a trust as if it were established by the client when:

(i) The assets of the trust, as defined under WAC 388-470-0005, are at least partially from the client;

(ii) The trust is not established by will; and

(iii) The trust was established by:

(A) The client or the client's spouse;

(B) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the client or the client's spouse; or

(C) A person, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(b) Only the assets contributed to the trust by the client are available to the client when part of the trust assets were contributed by any other person.

(c) The department does not consider:

(i) The purpose for establishing a trust;

(ii) Whether the trustees have, or exercise, any discretion under the terms of the trust;

(iii) Restrictions on when or whether distributions may be made from the trust; or

(iv) Restrictions on the use of distributions from the trust.

(d) For a revocable trust established as described under subsection (4)(a) of this section:

(i) The full amount of the trust is an available resource of the client;

(ii) Payments from the trust to or for the benefit of the client are income of the client; and

(iii) Any payments from the trust, other than payments described under subsection (4)(d)(ii), are considered a transfer of client assets.

(e) For an irrevocable trust established as described under subsection (4)(a) of this section:

(i) Any part of the trust from which payment can be made to or for the benefit of the client is an available resource. When payment is made from such irrevocable trusts, we will consider the payments as:

(A) Income to the client when payment is to or for the client's benefit; or

(B) The transfer of an asset when payment is made to any person for any purpose other than the client's benefit;

(ii) A trust from which a payment cannot be made to or for the client's benefit is a transfer of assets. For such a trust, the transfer of assets is effective the date:

(A) The trust is established; or

(B) The client is prevented from receiving benefit, if this is after the trust is established.

(iii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(5) For trusts established on or after August 1, 2003:

(a) The department considers a trust as if it were established by the client when:

(i) The assets of the trust, as defined under WAC 388-470-0005, are at least partially from the client or the client's spouse;

(ii) The trust is not established by will; and

(iii) The trust was established by:

(A) The client or the client's spouse;

(B) A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the client or the client's spouse; or

(C) A person, including a court or administrative body, acting at the direction of or upon the request of the client or the client's spouse.

(b) Only the assets contributed other than by will to the trust by either the client or the client's spouse are available to the client or the client's spouse when part of the trust assets were contributed by persons other than the client or the client's spouse.

(c) The department does not consider:

(i) The purpose for establishing a trust;

(ii) Whether the trustees have, or exercise, any discretion under the terms of the trust;

(iii) Restrictions on when or whether distributions may be made from the trust; or

(iv) Restrictions on the use of the distributions from the trust.

(d) For a revocable trust established as described under subsection (5)(a) of this section:

(i) The full amount of the trust is an available resource of the client;

(ii) Payments from the trust to or for the benefit of the client are income of the client; and

(iii) Any payments from the trust, other than payments described under subsection (5)(d)(ii), are considered a transfer of client assets.

(e) For an irrevocable trust established as described under subsection (5)(a) of this section:

(i) Any part of the trust from which payment can be made to or for the benefit of the client or the client's spouse is an available resource. When payment is made from such irrevocable trusts, the department will consider the payment as:

(A) Income to the client or the client's spouse when payment

is to or for the benefit of either the client or the client's spouse; or

(B) The transfer of an asset when payment is made to any person for any purpose other than the benefit of the client or the client's spouse;

(ii) A trust from which a payment cannot be made to or for the benefit of the client or client's spouse is a transfer of assets. For such a trust, the transfer of assets is effective the date:

(A) The trust is established; or

(B) The client or client's spouse is prevented from receiving benefit, if this is after the trust is established.

(iii) The value of the trust includes any payments made from the trust after the effective date of the transfer.

(6) Trusts established on or after August 11, 1993 are not considered available resources if they contain the assets of either:

(a) A person sixty-four years of age or younger who is disabled as defined by SSI criteria (as described in WAC ((~~388-503-0510~~)) 388-475-0050) and the trust:

(i) Is established for the sole benefit of this person by their parent, grandparent, legal guardian, or a court; and

(ii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client, up to the amount of Medicaid spent on the client's behalf; or

(b) A person regardless of age, who is disabled as defined by SSI criteria (as described in WAC ((~~388-503-0510~~)) 388-475-0050), and the trust meets the following criteria:

(i) It is irrevocable;

(ii) It is established and managed by a nonprofit association;

(iii) A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

(iv) Accounts in the trust are established solely for the benefit of the disabled individual as defined by the SSI program;

(v) Accounts in the trust are established by:

(A) The individual;

(B) The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

(C) The individual's parent, grandparent, legal guardian;

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

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

(vi) It stipulates that either:

(A) The state will receive all amounts remaining in the client's separate account upon the death of the client, up to the amount of Medicaid spent on the client's behalf; or

(B) The funds will remain in the trust to benefit other disabled beneficiaries of the trust.

(7) Trusts established on or after August 1, 2003 are not considered available resources if they contain the assets of either:

(a) A person sixty-four years of age or younger who is disabled as defined by SSI criteria (as described in WAC

((~~388-503-0510~~)) 388-475-0050) and the trust:

(i) Is irrevocable;

(ii) Is established for the sole benefit of this person by their parent, grandparent, legal guardian, or a court; and

(iii) Stipulates that the state will receive all amounts remaining in the trust upon the death of the client, the end of the disability, or the termination of the trust, whichever comes first, up to the amount of Medicaid spent on the client's behalf; or

(b) A person regardless of age, who is disabled as defined by SSI criteria (as described in WAC ((~~388-503-0510~~)) 388-475-0050), and the trust meets the following criteria:

(i) It is irrevocable;

(ii) It is established and managed by a nonprofit association;

(iii) A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

(iv) Accounts in the trust are established solely for the benefit of the disabled individual as defined by the SSI program;

(v) Accounts in the trust are established by:

(A) The individual;

(B) The individual's spouse, where the spouse is acting in the place of or on behalf of the individual;

(C) The individual's parent, grandparent, legal guardian;

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

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

(vi) It stipulates that either:

(A) The state will receive all amounts remaining in the client's separate account upon the death of the client, the end of the disability, or the termination of the trust, whichever comes first, up to the amount of Medicaid spent on the client's behalf; or

(B) The funds will remain in the trust to benefit other disabled beneficiaries of the trust.

(8) Trusts described in subsection (6)(a) and (7)(a) continue to be considered an unavailable resource even after the individual becomes age sixty-five. However, additional transfers made to the trust after the individual reaches age sixty-five would be considered an available resource and would be subject to a transfer penalty.

(9) The department does not apply a penalty period to transfers into a trust described in subsections (6)(b) and (7)(b) if the trust is established for the benefit of a disabled individual under age sixty-five as described in WAC 388-513-1363 and 388-513-1364 and the transfer is made to the trust before the individual reaches age sixty-five.

(10) The department considers any payment from a trust to the client to be unearned income. Except for trusts described in subsection (6), the department considers any payment to or for the benefit of either the client or client's spouse as described in subsections (4)(e) and (5)(e) to be unearned income.

(11) The department will only count income received by the client from trusts and not the principal, if:

(a) The beneficiary has no control over the trust; and

(b) It was established with funds of someone other than the client, spouse or legally responsible person.

(12) This section does not apply when a client establishes that undue hardship exists.

(13) WAC 388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366 apply under this section when the department determines that a trust or a portion of a trust is a transfer of assets.

AMENDATORY SECTION (Amending WSR 01-06-043, filed 3/5/01, effective 5/1/01)

WAC 388-561-0300 Life estates. (1) The department determines how life estates affect eligibility for medical programs.

(2) A life estate is an excluded resource when either of the following conditions apply:

(a) It is property other than the home, which is essential to self-support or part of an approved plan for self-support; or

(b) It cannot be sold due to the refusal of joint life estate owner(s) to sell.

(3) Remaining interests of excluded resources in subsection (2) may be subject to transfer of asset penalties under WAC 388-513-1363, 388-513-1364 and 388-513-1365.

(4) Only the client's proportionate interest in the life estate is considered when there is more than one owner of the life estate.

(5) A client or a client's spouse, who transfers legal ownership of a property to create a life estate, may be subject to transfer-of-resource penalties under WAC 388-513-1363, 388-513-1364 and 388-513-1365.

(6) When the property of a life estate is transferred for less than fair market value (FMV), the department treats the transfer in one of two ways:

(a) For noninstitutional medical, the value of the uncompensated portion of the resource is combined with other nonexcluded resources; or

(b) For institutional medical, a period of ineligibility will be established according to WAC 388-513-1363, 388-513-1364 and 388-513-1365.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-511-1105	SSI-related eligibility requirements.