TO: ALL OFFICES

SUBJECT: MANUAL MATERIAL

OAC 317:35-1-2; 35-5-4; 35-5-4.1; 35-5-41; 35-5-42; 35-5-49; 35-7-36; 35-7-61; and 35-7-61.1.

EXPLANATION: Policy revisions were approved by the Board and the Governor as required by the Administrative Procedures Act.

Rules are revised to establish a new Medicaid program for the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for Medicaid if residents of Nursing Facilities or Intermediate Care Facilities for the mentally retarded.
INSTRUCTIONS FOR FILING MANUAL MATERIAL

OAC is the acronym for Oklahoma Administrative Code. If OAC appears before a number on an Appendix or before a Section in text, it means the Appendix or text contains rules or administrative law. Lengthy internal policies and procedures have the same Chapter number as the OAC Chapter to which they pertain following a “DHS” number, such as personnel policy at DHS:2-1 and personnel rules at OAC 340:2-1. The “340” is the Title number that designates DHS as the rulemaking agency; the “2” specifies the Chapter number; and the “1” specifies the Subchapter number.

The chronological order for filing manual material is: (1) OAC 340 by designated Chapter and Subchapter number; (2) if applicable, DHS numbered text for the designated Chapter and Subchapter; and (3) all OAC Appendices with the designated Chapter number. For example, the order for filing personnel policy is OAC 340:2-1, DHS:2-1, and OAC 340:2 Appendices behind all Chapter 2 manual material. Any questions or assistance with filing manual material will be addressed by contacting Policy Management Unit staff at (405) 521-3611.

<table>
<thead>
<tr>
<th>REMOVE</th>
<th>INSERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>317:35-1-2</td>
<td>317:35-1-2, pages 1-6, revised 10-1-05</td>
</tr>
<tr>
<td>317:35-5-4</td>
<td>317:35-5-4, pages 1-8, revised 10-1-05</td>
</tr>
<tr>
<td>317:35-5-41</td>
<td>317:35-5-4.1, 1 page only, issued 10-1-05</td>
</tr>
<tr>
<td>317:35-5-42</td>
<td>317:35-5-41, pages 1-34, revised 10-1-05</td>
</tr>
<tr>
<td>317:35-5-42</td>
<td>317:35-5-42, pages 1-14, revised 10-1-05</td>
</tr>
<tr>
<td>317:35-5-49</td>
<td>317:35-5-49, 1 page only, issued 10-1-05</td>
</tr>
<tr>
<td>317:35-7-36</td>
<td>317:35-7-36, pages 1-2, revised 10-1-05</td>
</tr>
<tr>
<td>317:35-7-61</td>
<td>317:35-7-61, 1 page only, revised 10-1-05</td>
</tr>
<tr>
<td>317:35-7-61.1</td>
<td>317:35-7-61.1, 1 page only, issued 10-1-05</td>
</tr>
</tbody>
</table>
317:35-1-2. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Acute Care Hospital" means an institution that meets the requirements of 42CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

"Administrative agent" means the Long-Term Care Authority who is under contract with the Oklahoma Department of Human Services (OKDHS) to perform certain administrative functions related to the ADvantage Waiver.

"AFDC" means Aid to Families with Dependent Children.

"Aged" means an individual whose age is established as 65 years or older.

"Aid to Families with Dependent Children" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all Medicaid clients related to AFDC.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area
nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the Oklahoma Health Care Authority (OHCA).

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the Oklahoma Health Care Authority Board.

"Buy-in" means the procedure whereby the Authority pays the client's Medicare premium.

(A) "Part A Buy-in" means the procedure whereby the Authority pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) "Part B Buy-in" means the procedure whereby the Authority pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for client's to assist them in accessing services, advocacy and problem solving related to service delivery.
"Categorically needy" means that income and when applicable, resources are within the standards for the category to which the client is related.

"Categorically related" or "related" means the individual is:

(A) aged, blind, or disabled;

(B) pregnant;

(C) an adult individual who has a minor child under the age of 18 and who is deprived of parental support due to absence, death, incapacity, unemployment; or

(D) a child under 19 years of age.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"County" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for in-patient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Supplemental Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to
result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the recipient's estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the LTC nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, AĐvantage Waiver and Nursing Facility services.

"Local office" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"LTC nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The LTC nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of two separate programs. Part A is Hospital Insurance (HI) and Part B is Supplemental Medical Insurance (SMI).

(A) "Part A Medicare (HI)" means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.
(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for Medicaid benefits as categorically needy. They must however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) "Part B Medicare (SMI)" means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under Authority policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of 18.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for the mentally retarded or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.
"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Recipient lock-in" means when a recipient is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a Medicaid recipient has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for Medicaid if residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays expected to last not less than 60 days.

"Worker" means the OKDHS worker responsible for Medicaid eligibility determinations.
317:35-5-4. Determining categorical relationship to the disabled

An individual is related to disability if he/she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

(1) Determination of categorical relationship to the disabled by SSA. The procedures outlined in (A) through (G) of this paragraph are applicable when determining categorical relationship based on a SSA disability decision:

(A) Already determined eligible for Social Security disability benefits. If the applicant states he/she is already receiving Social Security benefits on the basis of disability, the information is verified by seeing the applicant's notice of award or the Social Security benefit check. If the applicant states an award letter approving Social Security disability benefits has been received but a check has not been received, this information is verified by seeing the award letter. Such award letter or check establishes categorical relationship. The details of the verification used are recorded in the case record.

(B) Already determined eligible for SSI on disability. If the applicant, under age 65, states he/she is already receiving SSI on the basis of his/her disability (or that a written notice of SSI eligibility on disability has been received but has not yet received a check) this information is verified by seeing the written notice or check. If neither are available, the county clears on the terminal system for the Supplemental Data Exchange (SDX) record. The SDX record shows, on the terminal, whether the individual has been approved or denied for SSI. If the individual has been approved for such benefits, the county uses this terminal clearance to establish disability for categorical relationship. The details of the verification used are recorded in the case record.

(C) Pending SSI/SSA application or has never applied for SSI. If the applicant says he/she has a pending SSI/SSA application, an SDX record may not appear on the terminal.
Therefore, it is requested that the applicant bring the notice regarding the action taken on his/her SSI/SSA application to the county office as soon as it is received. The other conditions of eligibility are established while awaiting the SSI/SSA decision. When the SSI/SSA notice is presented, the details of the verification are recorded in the case record and the indicated action is taken on the Title XIX application. If the applicant says he/she has never applied for SSI/SSA but appears potentially eligible from the standpoint of unearned income and has an alleged disability which would normally be expected to last for a period of 12 months, he/she is referred to the SSA office to make SSI/SSA application immediately following the filing of the Title XIX application.

(D) Already determined ineligible for SSI. If the applicant says he/she has been determined ineligible for SSI, the written notice of ineligibility from SSA is requested to determine if the denial was based on failure to meet the disability definition. If the SSI notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the SSI denial, the Title XIX application is denied for the same reason. If written notice is not available, the SDX record on the terminal system is used. This record shows whether the individual has been determined eligible or ineligible for SSI. If he/she has been determined ineligible, the payment status code for ineligibility is shown. The definition of this code is found on OKDHS Appendix Q in order to determine the reason for SSI ineligibility. If the reason for SSI ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for SSI ineligibility was based on some reason other than failure to meet the disability definition (and therefore, a determination of disability was not made), the Level of Care Evaluation Unit (LOCEU) must determine categorical relationship. In any instance in which an applicant who was denied SSI on "disability" states the medical condition has worsened since the SSI denial, he/she is referred to the SSA office to reapply for SSI immediately following the filing of the Title XIX application.

(E) Already determined ineligible for Social Security
disability benefits. If the applicant says he/she has been determined ineligible for Social Security disability benefits, he/she is requested to provide written notice of ineligibility to determine if the denial was based on failure to meet the disability definition. If the SSA notice shows ineligibility was due to not meeting the disability definition, and the applicant says the medical condition has not worsened since the denial, the Title XIX application is denied for the same reason. The details of the verification used are recorded in the case record. If the written notice is not available, TPQY procedure is used to verify the denial and the reason for ineligibility. If the reason for ineligibility was based on failure to meet the disability definition, the Title XIX application is denied for the same reason and the details of the verification are recorded in the case record. If the reason for ineligibility was based on some reason other than failure to meet the disability definition (and a determination of disability was, thus, not made), the LOCEU must determine categorical relationship. In any instance in which an applicant who was denied Social Security benefits on disability states the medical condition has worsened since the denial, he/she is referred to the SSA office to reapply immediately following the filing of the Title XIX application.

(F) Determined retroactively eligible for SSA/SSI due to appeal. If an individual becomes retroactively eligible for SSA/SSI due to a decision on an appeal, categorical relationship is established as of the effective date of the retroactive disability decision. Payment will be made for medical services only if the claim is received within 12 months from the date of medical services. If the effective date of the retroactive disability decision does not cover the period of the medical service because the SSA/SSI application was made subsequent to the service, a medical social summary with pertinent medical information is sent to the LOCEU for a categorical relationship decision for the time period of the medical service.

(G) SSA/SSI appeal with benefits continued. A Title XIX recipient who has filed an appeal due to SSA's determination that he/she is no longer disabled may continue to receive SSA benefits. The recipient has the option to have Title XIX benefits continued until the appeal decision has been
reached. After the decision has been reached, the appropriate case action is taken. If SSA's decision is upheld, an overpayment referral is submitted for any Title XIX benefits the recipient received beginning with the month that SSA/SSI determined the recipient did not meet disability requirements.

(H) Applicant deceased. Categorical relationship to the disabled is automatically established if an individual dies while receiving a medical service or dies as a result of an illness for which he/she was hospitalized if death occurs within two months after hospital release. The details of the verification used are recorded in the case record.

(2) Determination of categorical relationship to the disabled by the LOCEU.

(A) A disability decision from the LOCEU to determine categorical relationship to the disabled is required only when SSA makes a disability decision effective after medical services were received or when the SSA will not make a disability decision. The LOCEU is advised of the basis for the referral. SSA does not make disability decisions on individuals who:

(i) have been determined ineligible by SSA on some condition of eligibility other than disability,

(ii) have unearned income in excess of the SSI standard and, therefore, are not referred to SSA, or

(iii) do not have a disability which would normally be expected to last 12 months but the applicant disagrees.

(B) A disability decision from the LOCEU is not required if the disability obviously will not last 12 months and the individual agrees with the short term duration. The case record is documented to show the individual agrees with the short term duration.

(C) The local OKDHS office is responsible for submitting a medical social summary on OKDHS form ABCDM-80-B with pertinent medical information substantiating or explaining the individual's physical and mental condition. The medical social summary should include relevant social information.
such as the worker's personal observations, details of the individual's situation including date of onset of the disability, and the reason for the medical decision request. The worker indicates the beginning date for the categorical relationship to disability. Medical information submitted might include physical exam results, psychiatric, lab, and x-ray reports, hospital admission and discharge summaries, and/or doctors' notes and statements. Copies of medical and hospital bill and OKDHS Form MS-MA-5 are not normally considered pertinent medical information by themselves. Current (less than 90 days old) medical information is required for the LOCEU to make a decision on the client's current disability status. If existing medical information cannot be obtained without cost to the client, the county administrator authorizes either payment for existing medical information or one general physical examination by a medical or osteopathic physician of the client's choice. The physician cannot be in an intern, residency or fellowship program of a medical facility, or in the full-time employment of Veterans Administration, Public Health Service or other Agency. Such examination is authorized by use of OKDHS form ABCDM-16, Authorization for Examination and Billing. The OKDHS worker sends the ABCDM-16 and OKDHS form ABCDM-80, Report of Physician's Examination, to the physician who will be completing the exam.

(i) **Responsibility of Medical Review Team in the LOCEU.** The responsibilities of the Medical Review Team in the LOCEU include:

(I) The decision as to whether the applicant is related to Aid to the Disabled.

(II) The effective date (month and year) of eligibility from the standpoint of disability. (This date may be retroactive for any medical service provided on or after the first day of the third month prior to the month in which the application was made.)

(III) A request for additional medical and/or social information when additional information is necessary for a decision.

(IV) Authorizing specialists' examinations as needed.
(V) Setting a date for re-examination, if needed.

(ii) Specialist's examination. If, on receipt of the medical information from the county office, the LOCEU needs additional medical information, the LOCEU may, at their discretion, make an appointment for a specialist's examination by a physician selected by the medical member of the team and authorize it on Form M-S-32, Request to Physician for Examination and Authorization for Billing, routing the original of the form to the examining physician and a copy to the county office. As soon as the county receives a copy of Form M-S-32, the worker immediately notifies the individual of the appointment and explains that failure to keep the appointment with the specialist without good cause will result in denial of the application (or closure of the case in instances of determination of continuing disability). The worker assists the individual in keeping the appointment, if necessary.

(I) If the specialist requires additional laboratory work or X-rays, he/she should call the LOCEU for authorization. The LOCEU is responsible for making the decision regarding the request. If additional medical services are authorized, another Form M-S-32 will be completed.

(II) If the individual notifies the worker at least 24 hours prior to the date of the examination that he/she cannot keep the appointment, this constitutes good cause. In such an instance, the worker cancels the appointment, makes a new appointment, and submits information regarding the cancellation and the date of a new appointment to the LOCEU.

(III) When the individual fails to keep the appointment without advance notice, good cause must be determined. The worker determines the reasons and submits a memorandum to the LOCEU for a decision on good cause.

(IV) If the appointment was missed due to illness, the illness must be supported by a written statement from a physician. If missed for some reason other than illness, the reason must be supported by an affidavit signed by someone other than the individual or his/her
representative and sworn to before a notary public or other person authorized to administer oaths. If, in the opinion of the LOCEU, good cause is established, the LOCEU and the county follow the same procedures as outlined in (2)(C)(ii) of this Section for any other specialist's examination. If, in the opinion of the LOCEU, good cause is not established, the LOCEU notifies the local office. The local office is responsible for denying the application or closing the case with notification to individual in accordance with OHCA and Department policy.

(D) When the LOCEU has made a determination of categorical relationship to disability and SSA later renders a different decision, the county uses the effective date of the SSA approval or denial as their date of disability approval or denial. No overpayment will occur based solely on the SSA denial superseding the LOCEU approval.

(E) Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, provides coverage to certain disabled children living in the home if they would qualify for Medicaid as residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays expected to last not less than 60 days. In addition to disability LOCEU determines the appropriate level of care and cost effectiveness.

(3) Determination of categorical relationship to the disabled based on TB infection. Categorical relationship to disability is established for individuals with a diagnosis of tuberculosis (TB). An individual is related to disability for TB related services if he/she has verification of an active TB infection established by a medical practitioner.

(4) Determination of categorical relationship to the disabled for TEFRA. Section 134 of TEFRA allows states, at their option, to make Medicaid benefits available to children, under 19 years of age, living at home who are disabled as defined by the Social Security Administration, even though these children would not ordinarily be eligible for SSI benefits because of the deeming of parental income or resources. Under TEFRA, a child living at home who requires the level of care provided in an acute care hospital (for a minimum of 60 days), nursing facility or
intermediate care facility for the mentally retarded, is determined eligible using only his/her income and resources as though he/she were institutionalized.
317:35-5-4.1. **Special level of care and cost effectiveness application procedures for TEFRA**

(a) In order for a child to be eligible for TEFRA he/she must require a level of care provided in an acute care hospital for a minimum of 60 days, or a nursing facility or intermediate care facility for the mentally retarded for a minimum of 30 days. It must also be appropriate to provide care to the child at home. The level of care determination is made by LOCEU. The level of care certification period may be for any number of months that the LOCEU determines appropriate. At the time of application, an assessment form is provided to the applicant for completion by the child's physician. Once completed by the physician and returned to the OKDHS worker, the Assessment form is forwarded to the LOCEU along with the request for a disability determination (if needed).

(b) The estimated cost of caring for the child at home must not exceed the estimated cost of treating the child within an institution at the appropriate level of care, i.e., hospital, NF, or ICF/MR. The initial cost analysis is established by LOCEU based on the information provided by the TEFRA-1 Assessment form, OKDHS worker, and medical information used in the relationship to disability determination.

(c) The level of care determination and cost effectiveness analysis are posted by LOCEU on MEDATS.
317:35-5-41. Determination of capital resources for individuals categorically related to aged, blind and disabled

(a) General. The term capital resources is a general term representing any form of real and/or personal property which has an available money value. All available capital resources, except those required to be disregarded by law or by policies of the OHCA or OKDHS are considered in determining need. Available resources are those resources which are in hand or under the control of the individual.

(1) In defining need, OHCA and OKDHS recognize the importance of a recipient retaining a small reserve for emergencies or special need and has established a maximum reserve a client or family may hold and be considered in need.

(2) Capital resources are evaluated on a monthly basis in determining eligibility for an applicant for medical services. An applicant is determined ineligible for any month resources exceed the resource standard at any time during that month. When a recipient has resources which exceed the resource standard, case closure action is taken for the next possible effective date. ■1

(3) State law is specific on the mutual responsibility of spouses for each other. Therefore, if husband and wife are living together, a capital resource and/or income available to one spouse constitutes a resource and/or income to the other. When there is a break in the family relationship and the husband and wife are separated, but not divorced or legally separated, they constitute a possible resource to each other and this possible resource is explored to determine what, if any, resource can be made available. ■1 When spouse is in a nursing facility, see Subchapter 9 and 19 of this Chapter.

(4) Only the resources of the child determined eligible for TEFRA are considered in determining eligibility.

(5) Household equipment used for daily living is not considered a resource.

(6) Each time that need is determined, gross income and the equity of each capital resource are established. Equity equals current market value minus indebtedness. The recipient may
change the form of capital resources from time to time without affecting eligibility so long as the equity is not decreased in doing so or increased in excess of the allowable maximum reserve. In the event the equity is decreased as the result of a sale or transfer, the reduction in the equity is evaluated in relation to policy applicable to resources disposed of while receiving assistance. ■ 2

(b) Eligibility. In determining eligibility based on resources, only those resources available for current use or those which the client can convert for current use (no legal impediment involved) are considered as countable resources. Examples of legal impediments include, but are not limited to, clearing an estate, probate, petition to sell or appointment of legal guardian.

(1) Generally, a resource is considered unavailable if there is a legal impediment to overcome. However, the client must agree to pursue all reasonable steps to initiate legal action within 30 days. While the legal action is in process, the resource is considered unavailable.

(2) If a determination is made and documented that the cost of making a resource available exceeds the gain, the client will not be required to pursue action to make it available.

(3) Determination of available and unavailable resources must be well documented in the case record.

(4) The major types of capital resources are listed in (c) and (d) of this Section. The list is not intended to be all inclusive and consideration must be given to all resources.

(c) Home/real property. Home property is excluded from resources regardless of value. For purposes of the home property resource exclusion, a home is defined as any shelter in which the individual has an ownership interest and which is used by the individual as his/her principal place of residence. The home may be either real or personal property, fixed or mobile. Home property includes all property which is adjacent to the home. ■ 3 Home property in a revocable trust under the direct control of the individual, spouse, or legal representative retains the exemption as outlines in OAC 317:35-5-41(c)(6). Property has a value regardless of whether there is an actual offer to purchase. Verification of home/real property value is established by collateral contacts with
specialized individuals knowledgeable in the type and location of property being considered.

(1) The home may be retained without affecting eligibility during periods when it is necessary to be absent for illness or other necessity. The OHCA has not set a definite time limit to the client's absence from the home. When it is determined that the client does not have a feasible plan for and cannot be expected to return to his/her home, the market value of the property is considered in relation to the reserve. The client is responsible for taking all steps necessary to convert the resource for use in meeting current needs. If the client is making an effort to make the resource available, a reasonable period of time is given (not to exceed 90 days) to convert the resource. He/she is advised in writing that the 90-day period begins with the determination that the property be considered in relation to the reserve. The 90-day period is given only if efforts are in progress to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the client, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the client. A written notification is also provided to the client at any time an extension is allowed. Detailed documentation in the case record is required.

(2) If the client fails or is unwilling to take steps necessary to convert the resource for use in meeting current needs, continuing eligibility cannot be established and the client is advised as to the effective date of closure and of the right to receive assistance when the resources are within the maximum reserve provided other conditions of eligibility continue to be met.

(3) When a recipient sells his/her home with the intention of purchasing another home or when an insurance payment for damage to the home is received, a reasonable period of time is given to reinvest the money in another home. A reasonable period of time is considered to be not in excess of a 90-day period. Extensions beyond the 90 days may be justified only after interviewing the client, determining that a good faith effort is still being made and that completion of the transaction is beyond his/her control. This must be documented in the case record.
(4) At the point a recipient decides not to reinvest the proceeds from the sale of his/her home in another home, the recipient's plan for use of the proceeds is evaluated in relation to rules on resources disposed of while receiving assistance.

(5) A home traded for another home of equal value does not affect the recipient's eligibility status. If the home is traded for a home of lesser value, the difference may be invested in improvement of the new home.

(6) Absences from home for up to 90 days for trips or visits of six months for medical care (other than nursing facilities) do not affect receipt of assistance or the home exclusion as long as the individual intends to return home. Such absences, if they extend beyond those limits, may indicate the home no longer serves as the principal place of residence. Absence from home due to nursing facility care does not affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The Acknowledgment of Temporary Absence/Home Property Policy form is completed at the time of application for nursing facility care when the applicant has home property. After explanation of temporary absence, the client, guardian or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For recipients in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the recipient when it has been determined, after notice and opportunity for a hearing, that the recipient cannot reasonably be expected to be discharged and return home. However, a lien shall not be filed on the home property of the recipient while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

   (i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when
application is made for Medicaid benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the recipient will be discharged from the facility and return home and a lien may be filed against real property owned by the client for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the client to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A client who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse or relative lives there (regardless of whether the absence is temporary).

(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, halfsister, halfbrother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.

(H) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(7) Mineral rights associated with the home property are considered along with the surface rights and are excluded as a resource. However, mineral rights which are not associated with
the home property are considered as a resource. Since evaluation and salability of mineral rights fluctuate, the establishment of the value of mineral rights are established based on the opinion of collateral sources. Actual offers of purchase are used when established as a legitimate offer through a collateral source. Mineral rights not associated with home property which are income producing are considered in the same way as income producing property.

(8) The market value of real estate other than home property owned by the client or legal dependent and encumbrances against such property are ascertained in determining the equity (including the cost to the client of a merchantable title to be determined when the reserve approaches the maximum). The market value of real estate other than the home owned by the applicant is established on the basis of oral and/or written information which the applicant has on hand and counsel with persons who have specialized knowledge about this kind of resource. Refer to (12) of this subsection for exclusion of real estate that produces income.

(9) Land which is held by an enrolled member of an Indian tribe is excluded from resources as it cannot be sold or transferred without the permission of other individuals, the tribe, or a federal agency. If permission is needed, the land is excluded as a resource.

(10) A life estate conveys upon an individual or individuals for his/her lifetime, certain rights in property. Its duration is measured by the lifetime of the tenant or of another person; or by the occurrence of some specific event, such as remarriage of the tenant. The owner of a life estate has the right of possession, the right to use the property, the right to obtain profits from the property and the right to sell his/her life estate interest. However, the contract establishing the life estate may restrain one or more rights of the individual. The individual does not have title to all interest in the property and does not have the right to sell the property other than the interest owned during his/her lifetime. He/she may not usually pass it on to heirs in the form of an inheritance.

(A) When a life estate in property is not used as the client's home, it is necessary to establish the value. A computer procedure is available to compute the value of a life estate by input of the current market value of the
property and the age of the life estate owner. □ 5

(B) The value of a life estate on mortgaged property is based on equity rather than market value and the age of the individual.

(C) In the event the client does not accept as valid the value of the life estate as established through this method, the client will secure written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals, the worker and the client will jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current market values and who is acceptable to both the client and the worker.

(11) Homestead rights held by a client in real estate provide the client with shelter (or shelter and income) so long as he/she resides on the property. Payment for care in a nursing facility provided to the recipient through Medicaid constitutes a waiver of the homestead rights of the recipient. If the client moves from the property, a lien is filed, or the client otherwise abandons his/her homestead rights, the property becomes subject to administration. Since a homestead right cannot be sold, it does not have any value.

(12) Real and/or personal property which produces income is excluded if it meets the following conditions.

(A) Trade or business property. The existence of a trade or business may be established through business tax returns that would be used to compute self-employment earnings. If the current business tax return is unavailable, the existence of the business may be determined through other business forms, records, partnership, a detailed description of the business and its activities, etc. Once it is established that a trade or business exists, any property (real or personal) connected to it and in current use is excluded. This exclusion includes liquid assets, such as a bank account(s) necessary for the business operation. All property used by a trade or business and all property used by an employee in connection with employment is excluded as property essential to self support. The income from the trade or business is determined as any other self-employment income.
(B) **Non-trade or non-business property.** Property which produces income but is not used in a trade or business is excluded if the total equity value does not exceed $6000, and the net return equals at least 6% of the equity annually. An equity value in excess of $6000 is a countable resource. If the equity exceeds $6000 and 6% return is received on the total equity, only the amount in excess of $6000 is a countable resource. An annual return of less than 6% is acceptable if it is beyond the individual's control, and there is a reasonable expectation of a future 6% return. Liquid resources cannot be excluded as income producing property or meeting the $6000/6% rule (mortgages, including contract for deed, and notes which are income producing are considered as liquid resources). The $6000/6% rule applies to all resources in total, and not separately. Examples of non-business income producing property are rental property, timber rights, mineral rights, etc.

(d) **Personal property.**

(1) **Property used to produce goods and services.** Personal property necessary to perform daily activities or to produce goods for home consumption is excluded if the equity value does not exceed $6000. An equity value in excess of $6000 is a countable resource. The property does not have to produce a 6% annual return. The $6000 equity maximum includes all such resources in total and does not pertain to each item separately. Examples of property used to produce goods and services are tractors, woodcutting tools, mechanized equipment for gardening, livestock grown for home consumption, etc.

(2) **Cash savings and bank accounts.** Money on hand or in a savings account is considered as reserve. The client's statement that he/she does not have any money on hand or on deposit is sufficient unless there are indications to the contrary. When there is information to the contrary or when the client does not have records to verify the amount on deposit, verification is obtained from bank records. Title 56, O.S., Section 1671 provides that financial records obtained for the purpose of establishing eligibility for assistance or services must be furnished without cost to the client or the Agency.

(A) Checking accounts may or may not represent savings.
Current bank statements are evaluated with the client to establish what, if any, portion of the account represents savings. Any income which has been deposited during the current month is not considered unless it exceeds what is considered as ordinary maintenance expense for the month.

(B) Accounts which are owned jointly by the client and a non-recipient person are considered available to the client in their entirety unless it can be established what part of the account actually belongs to each of the owners and the money is actually separated and the joint account dissolved. When the recipient is in a nursing facility and the spouse is in the home or if both are institutionalized, a joint bank account may be maintained with one-half of the account considered available to each.

(3) **Life insurance policies.** If the total face value of all life insurance policies owned by an individual is $1,500 or less, the policies (both face value and cash surrender value) are excluded as resources.

(A) If the total face value of all policies owned by an individual exceeds $1,500, the net cash surrender value of such policies must be counted as resources. Life insurance policies which do not provide a cash surrender value (e.g., term insurance) are not used in determining whether the total face value of all policies is over $1,500.

(B) The face value of a life insurance policy which has been assigned to fund a prepaid burial contract must be evaluated and counted according to the policy on burial funds or, if applicable, the policy on the irrevocable burial contract.

(C) The net cash surrender value of insurance (i.e., cash surrender value less any loans or unpaid interest thereon) usually can be verified by inspection of the insurance policies and documents in the client's possession or by use of the Request to Insurance Company form.

(D) Dividends which accrue and which remain with the insurance company increase the amount of reserve. Dividends which are paid to the client are considered as income.

(E) If an individual has a life insurance policy which allows death benefits to be received while living, and the
individual meets the insurance company's requirements for receiving such proceeds, the individual is not required to file for such proceeds. However, if the individual does file for and receive the benefits, the payment will be considered as income in the month it is received and countable as a resource in the following months to the extent it is available. The payment of such benefits is not considered a conversion of a resource because the cash surrender value of the insurance policy is still available to the individual. The individual is in effect, receiving the death benefits and not the cash surrender value.

(4) **Burial spaces.** The value of burial spaces for an individual, the individual’s spouse or any member of the individual's immediate family will be excluded from resources. "Burial spaces" means conventional gravesites, crypts, mausoleums, urns, and other repositories which are customarily and traditionally used for the remains of deceased persons. "Immediate family" means individual's minor and adult children, including adopted children and step-children; and individual's brothers, sisters, parents, adoptive parents, and the spouse of these individuals. Neither dependency nor living in the same household will be a factor in determining whether a person is an immediate family member.

(5) **Burial funds.** Revocable burial funds not in excess of $1500 are excluded as a resource if the funds are specifically set aside for the burial arrangements of the individual or the individual's spouse. Any amount in excess of $1500 is considered as a resource. Burial policies which require premium payments and do not accumulate cash value are not considered to be prepaid burial policies.

(A) "Burial funds" means a prepaid funeral contract or burial trust with a funeral home or burial association which is for the individual's or spouse's burial expenses.

(B) The face value of a life insurance policy, when properly assigned by the owner to a funeral home or burial association, may be used for purchasing "burial funds" as described in (5)(A) of this subsection.

(C) The burial fund exclusion must be reduced by the face value of life insurance policies owned by the individual or spouse; and amounts in an irrevocable trust or other
irrevocable arrangement.

(D) Interest earned or appreciation on the value of any excluded burial funds are excluded if left to accumulate and become a part of the burial fund.

(E) If the client did not purchase his/her own prepaid burial, even if his/her money was used for the purchase, the client is not the "owner" and the prepaid burial funds cannot be considered a resource to him/her. However, if the client's money was used by another to purchase the prepaid burial, the rules on transfer of property must be applied since the purchaser (owner) could withdraw the funds any time.

(6) **Irrevocable burial contract.** Oklahoma law provides that a purchaser (buyer) of a prepaid funeral contract may elect to make the contract irrevocable. The irrevocability cannot become effective until 30 days after purchase.

(A) If the irrevocable election was made prior to July 1, 1986 and the client received assistance on July 1, 1986, the full amount of the irrevocable contract is not considered a countable resource. This exclusion applies only if the client does not add to the amount of the contract. Interest accrued on the contract is not considered as added by the client. Any break in assistance will require that the contract be evaluated at the time of reapplication according to rules in (B) of this paragraph.

(B) If the effective date for the irrevocable election or application for assistance is July 1, 1986 or later:

(i) the face value amount in an irrevocable contract cannot exceed $7,500, plus accrued interest.

(ii) a client may exclude the face value, up to $7,500, plus accrued interest in any combination of irrevocable contract, revocable prepaid account, designated account or cash value in life insurance policies not used to fund the burial policy, regardless of the face value, provided the cash value in policies and designated accounts does not exceed $1500. When the amount exceeds $7,500, the client is ineligible for assistance. Accrued interest is not counted as a part of the $7,500 limit regardless of when
it is accrued. ■ 6

(iii) the face value of life insurance policies used to fund burial contracts is counted towards the $7,500 limit. ■ 7

(C) For an irrevocable contract to be valid, the election to make it irrevocable must be made by the purchaser (owner) or the purchaser's guardian or an individual with power of attorney for the purchaser (owner).

(D) In instances where Management of Recipient's Funds form is on file in the nursing facility, the form serves as a power of attorney for the administrator to purchase and/or elect to make irrevocable the burial funds for the client.

(7) **Medical insurance.** When a client has medical insurance, the available benefits are applied toward the medical expense for which the benefits are paid. The type of insurance is clarified in the record. If an assignment of the insurance is not made to the provider and payment is made directly to the client, the client is expected to apply the payment to the cost of medical services. Any amount remaining after payment for medical services is considered in relation to the reserve.

(8) **Stocks, bonds, mortgages and notes.** The client's equity in stocks and bonds (including U.S. Savings Bonds series A thru EE) is considered in relation to the reserve. The current market value less encumbrances is the equity. In general, determination of current market value can be obtained from daily newspaper quotations, brokerage houses, banks, etc.

(A) The current value of U.S. Savings bonds which have been held beyond the maturity date is the redemption value listed in the table on the back of the bond for the anniversary date most recently reached. If the bond has been held beyond maturity date, it has continued to draw interest. An acceptable determination of the value may be made by checking against a chart at the bank.

(B) The amount which can be realized from notes and mortgages and similar instruments, if offered for immediate sale, constitutes a reserve. Notes and mortgages and similar instruments have value regardless of whether there is an
actual offer. Appraisals obtained from bankers, realtors, loan companies and others qualified to make such estimates are obtained in determining current market value. When a total reserve approaches the maximum, it is desirable to get two or more estimates.

(C) Mortgages (including contracts for deed) and notes which are income producing are liquid countable resources.

(9) Trust accounts. Monies held in trust for an individual applying for or receiving Medicaid must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, etc., or the Bureau of Indian Affairs (BIA).

(A) Availability determinations. The social worker should be able to determine the availability of a trust using the definitions and explanations listed in (B) of this subsection. However, in some cases, the worker may wish to submit a trust to the OKDHS State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(B) Definition of terms. The following words and terms, when used in this paragraph, shall have the following meaning, unless the context clearly indicates otherwise:

(i) Beneficiary. Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(ii) Corpus/principal. Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(iii) Discretionary powers. Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income
and add it to the principal of the trust.

(iv) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(v) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(vi) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(vii) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(viii) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(ix) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(x) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.
(xi) Testamentary trust. Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(xii) Trustee. Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(C) Documents needed. To determine the availability of a trust for an individual applying for or receiving Medicaid, copies of the following documents are obtained:

(i) Trust document;

(ii) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(iii) Documentation reflecting prior disbursements (date, amount, purpose).

(D) Trust accounts established on or before August 10, 1993. The rules found in (i) - (iii) of this subparagraph apply to trust accounts established on or before August 10, 1993.

(i) Support trust. The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (I)-(III) of this unit, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available
by:

(I) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(II) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(III) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available.

If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that Medicaid benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(ii) Medicaid Qualifying Trust (MQT). A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to Title 12 Oklahoma Statute '83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the
maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for Medicaid; and, whether or not discretion is actually exercised.

(I) **Similar legal device.** MQT rules listed in of this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the client petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(II) **MQT resource treatment.** For revocable MQTs, the entire principal is an available resource to the client. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the client can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the client, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the client (or to use it for the client's benefit), the entire principal is an available resource to the client. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the client (or to be used for his/her benefit), but those distributions are not made, the client's countable resources increase cumulatively by the undistributed amount.
(III) **Income treatment.** Amounts of MQT income distributed to the client are countable income when distributed. Amounts of income distributed to third parties for the client's benefit are countable income when distributed.

(IV) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the client or using it for the client's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the client, the principal is not an available resource and has, therefore, been transferred).

(iii) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including Medicaid benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including Medicaid benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(E) **Trust accounts established on or after August 11, 1993.** The rules found in (i) - (iii) of this subparagraph apply to trust accounts established on or after August 11, 1993.

(i) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(I) the individual;

(II) the individual's spouse;
(III) 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

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

(ii) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(iii) There are two types of trusts, revocable trusts and irrevocable trusts.

(I) In the case of a revocable trust, the principal is considered an available resource to the individual. Home property in a revocable trust under the direct control of the individual, spouse or legal representative retains the exemption as outlined in OAC 317:35-5-41(c)(6). Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(II) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made shall be considered available resources. Payments from the principal or income of the trust shall be considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to
the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(F) **Exempt trusts.** Subparagraph (E) of this paragraph shall not apply to the following trusts:

(i) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(I) The trust may only contain the assets of the disabled individual.

(II) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(III) Trust records shall be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(IV) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(V) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled
(VI) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing, and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

(VII) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.

(VIII) The OKDHS Supplemental Needs Trust form is an example of the trust. Social workers may give the sample form to the client or his/her representative to use or for their attorney's use.

(IX) To terminate or dissolve a Supplemental Needs Trust, the social worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: HR&MS explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(ii) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(I) The individual is in need of long-term care and has
countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1) but less than $2500 per month.

(II) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(III) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(IV) The trust must retain an amount equal to the client's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee shall distribute the remainder.

(V) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(VI) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records shall be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(VII) The State will receive all amounts remaining in the trust up to an amount equal to the total Medicaid benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(VIII) Accumulated funds in the trust may only be used for medically necessary items not covered by Medicaid, or other health programs or health insurance and a reasonable cost of administering the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.
(IX) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(X) An example trust is included on OKDHS form M-11. Social Workers may give this to the client or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(XI) To terminate or dissolve a Medicaid Income Pension Trust, the social worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(iii) A trust containing the assets of a disabled individual when all of the following are met:

(I) The trust is established and managed by a non-profit association;

(II) The trust must be made irrevocable;

(III) The trust must be approved by the Department of Human Services and may not be amended without the permission of the Department of Human Services;

(IV) The disabled person has no ability to control the spending in the trust;

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

(VI) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the recipients;

(VII) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual,
the individual, or by a court;

(VIII) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary’s account at the time of the beneficiary’s death may be retained by the trust.

(G) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands shall not be considered a resource in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(H) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

(10) **Retirement funds.** The rules regarding the countable value, if any, of retirement funds are found in subparagraph (A) - (B) of this paragraph:

(A) **Annuities.**

(i) Annuities purchased prior to February 1, 2005. An annuity gives the right to receive fixed, periodic payments either for life or a term of years. The annuity instrument itself must be examined to determine the provisions and requirements of the annuity. For example, it is determined whether the individual can access the principal of the annuity; e.g., can it be cashed in. If so, the annuity is treated as a revocable trust (OAC 317:35-5-41(d)(9)(E)(iii)(I). If the individual cannot access the principal, the annuity is treated as an irrevocable trust. In this instance, it must also be determined what part of the annuity can, under any circumstances, be paid to, or for the benefit of the individual. When making such a determination, the date of
application is used or, if later, the date of institutionalization (for an institutionalized individual) or the date of creation of the annuity (for a non-institutionalized individual). Also, these dates are used in determining whether the transfer of asset provisions apply to a particular annuity. If the annuity provides for payments to be made to the individual, those payments would be considered income to the individual. Any portion of the principal of the annuity that could be paid to or on behalf of the individual would be treated as a resource to the individual and portions of the annuity that cannot be paid to or for the benefit of the individual are treated as transfers of assets. Annuities may also be a transfer of assets for less than fair market value. The worker determines, in accordance with the OKDHS life expectancy tables, \[8\] whether the client will receive fair market value from the annuity during his/her projected lifetime. Any funds used to purchase the annuity that will not be repaid to the client during his/her projected lifetime, are a transfer of assets and the appropriate penalty period is imposed. \[8\]


(I) An annuity is presumed to be an available resource to the individual who will receive the payments because the annuity can be sold. The value of the annuity is the total of all remaining payments, discounted by the Applicable Federal Rate set by the IRS for the valuation of annuities for the month of application or review.

(II) The applicant or recipient may rebut the presumption that the annuity can be sold by showing compelling evidence to the contrary, in which case the annuity is not considered available. The applicant or recipient may also rebut the presumed annuity value by showing compelling evidence that the actual value of the annuity is less than the presumed value.

(B) Other retirement investment instruments. This subparagraph relates to individual retirement accounts (IRA), Keogh plans, profit sharing plans, and work related plans in which the employee and/or employer contribute to a retirement
account.

(i) **Countability of asset.** In each case, the document governing the retirement instrument must be examined to determine the availability of the retirement benefit at the time of application. Retirement benefits are considered countable resources if the benefits are available to the applicant and/or spouse. Availability means that the applicant and/or spouse has an option to receive retirement benefits or is actually receiving benefits. For example, a retirement instrument may make a fund available at the time of termination of employment, at age 65, or at some other time. A retirement fund is not a countable resource if the applicant is currently working and must terminate employment in order to receive benefits. An individual may have the choice of withdrawing the monies from the retirement fund in a single payment or periodic payments (i.e., monthly, quarterly, etc.). If the individual elects to receive a periodic payment, the payments are considered as income as provided in OAC 317:35-5-42(c)(3). If the monies are received as a lump sum, the rules at OAC 317:35-5-42(c)(3)(C)(i) apply.

(ii) **Asset valuation.** Valuation of retirement benefits is the amount of money that an individual can currently withdraw from the fund or is actually receiving. Valuation does not include the amount of any penalty for early withdrawal. Taxes due on the monies received by the applicant are not deducted from the valuation.

(iii) **Timing of valuation.** Retirement funds are a countable resource in the month that the funds are available to the applicant. For purposes of this subsection, the month that the funds are available means the month following the month of application for the funds. For example, the retirement instrument makes retirement funds available at age 65. The applicant turns 65 on January 1st. The applicant makes a request for the funds on February 1st and the monies are received on June 1st. The retirement fund would be considered as a countable resource in the month of March. The resource would not be counted in the month in which it is later received.
(11) **Automobiles, pickups, and trucks.** Automobiles, pickups, and trucks are considered in the eligibility determination for Medicaid benefits.

(A) **Exempt automobiles.** One automobile is excluded from counting as a resource to the extent its current market value (CMV) does not exceed $4,500. The CMV in excess of $4,500 is counted against the resource limit; or exempt one automobile, pickup or truck per family regardless of the value if it is verified that the car is used:

(i) for medical services 4 times a year to obtain either medical treatment or prescription drugs; or

(ii) for employment purposes; or

(iii) especially equipped for operation by or transportation of a handicapped person.

(B) **Other automobiles.** The equity in other automobiles, pickups, and trucks is considered in relation to the reserve. The current market value, less encumbrances on the vehicle, is the equity. Only encumbrances that can be verified are considered in computing equity.

(i) The market value of each year's make and model is established on the basis of the "av'g. Trade In" value as shown in the current publication of the National Automobile Dealers Association (NADA) on "Cars, Trucks, and Imports" which is provided monthly to each county office by the OKDHS State Office.

(ii) If a vehicle's listing has been discontinued in the NADA book, the household's estimate of the value of the vehicle is accepted unless the worker has reason to believe the estimate is incorrect.

(iii) The market value of a vehicle no longer operable is the verified salvage value.

(iv) In the event the client and worker cannot agree on the value of the vehicle, the client secures written appraisal by two persons who are familiar with current values. If there is substantial unexplained divergence between these appraisals or between the book value and one
or more of these appraisals, the worker and the client jointly arrange for the market value to be established by an appraisal made by a third person who is familiar with current values and who is acceptable to both the client and the worker.

(12) **Resource disregards.** In determining need, the following are not considered as resources:

(A) The coupon allotment under the Food Stamp Act of 1977;

(B) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(C) Education grants (excluding Work Study) scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(D) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

   (i) an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, OKDHS Form ADM-103, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or Form ADM-103 are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

   (ii) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

   (iii) Proceeds of a loan secured by an exempt asset are not an asset.
(E) Indian payments or items purchased from Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;

(F) Special allowance for school expenses made available upon petitions (in writing) from funds held in trust for the student;

(G) Benefits from State and Community Programs on Aging (Title III) are disregarded. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as earned income. Both Title III and Title V are under the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;

(H) Payments for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Services Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(I) Payment to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(J) The value of supplemental food assistance received under the Child Nutrition Act or the special food services program for children under the National School Lunch Act;
(K) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(L) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(M) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(N) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(O) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

(P) Interests of individual Indians in trust or restricted lands. However, any disbursements from the trust or the restricted lands are considered as income;

(Q) Resources set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of resources excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(R) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(S) A migratory farm worker's out-of-state homestead is disregarded if the farm worker's intent is to return to the homestead after the temporary absence;

(T) Payments received under the Civil Liberties Act of 1988.
These payments are to be made to individuals of Japanese ancestry who were detained in interment camps during World War II;

(U) Dedicated bank accounts established by representative payees to receive and maintain retroactive SSI benefits for disabled/blind children up to the legal age of 18. The dedicated bank account must be in a financial institution, the sole purpose of which is to receive and maintain SSI underpayments which are required or allowed to be deposited into such an account. The account must be set up and verification provided to SSA before the underpayment can be released; and

(V) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. Payments are not considered as income or resources. A penalty cannot be assessed against the individual if he/she disposes of part or all of the payment. The rules at OAC:35-5-41(d)(9) regarding the availability of a trust do not apply if an individual establishes a trust using the settlement payment.

(e) Changes in capital resources. Rules on transfer or disposal of capital resources are not applicable. See OAC 317:35-9, OAC 317:35-17, and OAC 317:35-19 if the individual enters a nursing home or receives Home and Community Based Waiver Services, HCBWS/MR or ADvantage waiver services.

(1) Resources of an applicant. If the resource(s) of an applicant is in a form which is not available for immediate use, such as real estate, mineral rights, or one of many other forms, and the applicant is trying to make the resource available, the applicant may be certified and given a reasonable amount of time to make this available. A reasonable amount of time would normally not exceed 90 days. The client is notified in writing that a period of time not to exceed 90 days will be given to make the resource available. Any extension beyond the initial 90-day period is justified only after interviewing the client, determining that a good faith effort to sell is still being made and failure to sell is due to circumstances beyond the control of the client.

(2) Capital resources acquired while receiving assistance. If
the recipient acquires resources which increase his/her available reserve above the maximum, he/she is ineligible for assistance unless there are specific plans for using the resources in compliance with rules on "resources disposed of while receiving assistance". The term "using the resource" is construed to mean that the resource has been encumbered or actually transferred. If the facts show a reasonable delay in executing the plan to use the required resource or if the resource is in a form which is not available for immediate use (such as real estate, mineral rights, or one of many other forms), and if efforts are in progress to make the resource available, the recipient is given a reasonable amount of time to make this available. The client is notified in writing that a period of time not to exceed 90 days will be given to make the resources available.  ■ 9

(A) Any extension beyond the initial 90 day period is justified only after interviewing the client, determining that a good faith effort is still being made and that failure to make the resource available is due to circumstances beyond the control of the client.

(B) Money borrowed on any of the client's resources, except the home, merely changes his/her resource from one form to another. Money borrowed on the home is evaluated in relation to the reserve.

(f) Maximum reserve. Maximum reserve is a term used to designate the largest amount which a recipient can have in one or more nonexempt resources, and still be considered to be in need. A recipient's reserve may be held in any form or combination of forms. If the resources of the applicant or recipient exceed the maximums listed on OKDHS Appendix C-1, he/she is not eligible.

(1) For each minor blind or disabled child up to the age of 18 living with parent(s) whose needs are not included in a TANF grant, or receiving SSI and/or SSP, the resource limit is the same as the individual limit as shown on OKDHS Appendix C-1. If the parent's resources exceed the maximum amount, the excess is deemed available to the child (resources of an ineligible child are not deemed to an eligible child). If there is more than one eligible child, the amount is prorated.

(2) If the minor blind or disabled child:
(A) is residing in a nursing facility, or a medical facility if the confinement lasts or is expected to last for 30 days, the parent(s)' resources are not deemed to the child; or

(B) under age 19 is eligible for TEFRA, the parent's(s') resources are not deemed to the child.

(3) Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents resources are not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.

(4) when both parents are in the home and one parent is included in an aged, blind or disabled case and the spouse is included in an TANF case with the children, the resources of both parents are evaluated in relation to eligibility for SSI and therefore not considered on the AFDC case. All resources of the parents would be shown on the aged, blind or disabled case.

INSTRUCTIONS TO STAFF

1. When the applicant is in a NF, see OAC 317:35-19-21. If the individual is receiving ADvantage Services, see OAC 317:35-17-11.

2. See OAC 317:35-5-41(e).

3. Property that is separated from the home by a street, highway, stream or other body of water, etc., is considered part of the home property.

4. Example: Client is admitted to the facility 10-28-92 and the 12-month exclusion ends 10-29-93. Appropriate case action to end the exemption of home property is taken effective 11-1-93.

5. For life estate computations, use online transaction LEC. Instructions for this transaction may be viewed by entering M(sp)LEC.
6. The information in 35-5-41(d)(3) is not applicable when determining the amount of irrevocable burial.

7. According to the Oklahoma State Insurance Commission, a funeral home cannot be the beneficiary of a life insurance policy used to fund a burial contract. Therefore, when life insurance is used to fund a burial contract, there must be an irrevocable assignment of proceeds to the funeral home.

8. Refer to DHS Appendix M-13, Medicaid Life Expectancy Table.

9. Detailed documentation in the case record is required.
317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

(a) General. The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income.

(1) If it appears the applicant or recipient is eligible for any type of income (excluding SSI or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, consider only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together.

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (14 - 494 is rounded down, and 504 - 994 is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) Income disregards. In determining need, the following are not considered as income:
(1) The coupon allotment under the Food Stamp Act of 1977;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide. If the loan agreement is not written, Form Adm-103, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or Form Adm-103 are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;

(5) One-third of child support payments received on behalf of the disabled minor child;

(6) Indian payments (including judgement funds or funds held in trust) distributed per capita by the Secretary of the Interior (BIA) or distributed per capita by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are made per capita. For purposes of this Subchapter, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;
(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;

(8) Title III benefits from State and Community Programs on Aging;

(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the national School Lunch Act;

(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;

(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;

(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(17) Governmental rental or housing subsidies by governmental
agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;

(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;

(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

(22) Income of a sponsor to the sponsored eligible alien;

(23) The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the social worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual client, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered in determining eligibility. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as unearned income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual client, guardian or conservator, these
disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual client, guardian or conservator. 

When the county office is unable to resolve the situation with the BIA, the county submits a referral to the appropriate section in OKDHS Family Support Services Division (FSSD). The referral must include specific details of the situation, including the county's efforts to resolve the situation with the BIA. If FSSD cannot make a determination, a legal decision regarding availability will be obtained by FSSD, and then forwarded to the county office by FSSD. When a referral is sent to FSSD, the funds are considered as unavailable with a legal impediment until the county is notified otherwise.

(C) At each reapplication or redetermination, the social worker is to contact BIA to obtain information regarding any changes as to the availability of the funds and any information regarding modifications to the IIM account. Information regarding prior disbursements is also obtained at this time. All of this information is reviewed for the previous six or twelve-month period, or since the last contact if the contact was within the last certification or redetermination period.

(D) When disbursements have been made, the worker determines whether such disbursements were made to the client or to a third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the client. Workers should obtain documentation to verify services rendered and payment made by BIA.

(E) Amounts disbursed directly to the clients are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received;

(24) Income up to $2,000 per year received by individual Indians, which are derived from leases or other uses of individually-owned trust or restricted lands;

(25) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The
Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(26) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(27) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in interment camps during World War II; and

(28) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual.

(c) Determination of income. The client is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a client is determined to be categorically needy and is also an SSI recipient, any change in countable income, (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of medical assistance and amount of SSP as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the case with computer update at the time that SSI makes the change (in order not to penalize the client twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the
medical assistance and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the client's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Appendix C-2-A.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by Medicaid. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or
Champus payment whether paid directly to the client or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the client.

(II) Own home care. The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is Medicaid eligible, and is residing in a nursing facility that is approved under Medicaid. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. The $90 payment becomes the monthly maintenance standard for the veteran. Any vendor payment or spenddown will be computed by using other income minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a Medicaid approved nursing facility.

(B) SSI benefits. SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a Medicaid approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) Lump sum payments.

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the
exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) Income from capital resources and rental property. Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two month's royalty income is averaged to compute countable monthly income.

(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will
verify whether or not the income is from self-employment. Otherwise, income received from rent property is treated as unearned income.

(iii) When property rental is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the client is considered as income.

(E) Earned income/self-employment. The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services; e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with Medicaid benefits.

(i) Advance payments of EITC or refunds of EITC received as a result of filing a federal income tax return are considered as earned income in the month they are received.

(ii) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

(iii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expense and appropriate earned income disregards.
(iv) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount as well as the allowable deductions are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).

(v) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are
then applied to establish countable earned income.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

   (i) **Daily.** Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

   (ii) **Weekly.** Income received weekly is multiplied by 4.3.

   (iii) **Twice a month.** Income received twice a month is multiplied by 2.

   (iv) **Biweekly.** Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are
available for current living expenses must be considered.

(d) **Computation of income.**

(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.

(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) if there are ineligible minor children.

(3) **Countable income.** The countable income is the sum of the earned income after exclusions and the total gross unearned income.

(4) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) A mentally retarded child living in the home who is ineligible for SSP due to the deeming process may be approved for Medical Assistance under the Home and Community Based Waiver (HCBW) Program as outlined in OAC 317:35-9-5.

(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents income are not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.
(6) Procedures for deducting ineligible minor child allocation. When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Appendix C-1, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.

(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.

(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(7) Special exclusions for blind individuals. Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;

(B) job performance; and

(C) job improvement.

INSTRUCTIONS TO STAFF

1. Individuals related to ABD must apply for SSI benefits to be eligible for the SSP case assistance.
317:35-5-49. Determination of income and resources for categorical relationship to TEFRA

Countable income and resources for a child categorically related to disability for TEFRA are determined in accordance with rules for individuals determined aged, blind, or disabled (see OAC 317:35-5-41, 317:35-5-42, and 317:35-7-36). Income and resources may not exceed the maximum standards as shown on OKDHS Appendix C-1, Schedules VIII. B. and D.
317:35-7-36. Financial eligibility of individuals categorically related to ABD

In determining financial eligibility for Medical Services for an individual related to ABD, the income and resources of the individual and spouse (if any) are considered. However, consideration is not given to the income and resources of a spouse included in a TANF case. Income of an ineligible spouse may be deemed to the minor dependent child as explained in OAC 317:35-7-38(1)(D). The income and resources of a minor dependent child are not considered in determining financial eligibility for the individual related to ABD. The minor dependent child is defined as any biological or adopted child under 18 years of age and residing in the home.

(1) If an individual and spouse cease to live together because of institutionalization or any other reason, income and resources are considered available to each other through the month in which they are separated. Mutual consideration ceases with the month after the month in which the separation occurs. Any amounts which are actually contributed to the eligible individual after the mutual consideration has ended are considered.

(2) If the individual related to Aid to the Blind or Aid to the Disabled is a minor child living in the home of parent(s) or spouse of a parent, the parent'(s) or spouses' income and resources are deemed to the child.

(A) Income is not deemed if the parent or spouse is included in a TANF case or determined categorically needy for Medicaid benefits only. A minor is defined as a child under 18 years and residing in the home. At the point that the minor child no longer resides in the home of the parent(s) or spouse of the parent, the deeming of income and resources ceases with the month after the month of separation. No longer residing in the home includes not only residing in the home of another, but also confinement in a medical facility if the confinement lasts, or is expected to last, 30 days. Any amounts which are actually contributed to the minor child after deeming ends are considered.

(B) For TEFRA children, the income and resources of the parent(s) are not considered.
(3) Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parent's income and resources are not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents. While an infant born below this birth weight is considered disabled under SSI disability provisions, SSI cash payments are only effective the month the parent or legal guardian files an SSI application. If the SSI effective date does not go back to the month of birth, it will not be necessary to request a decision from the Level of Care Evaluation Unit at OHCA in order to consider the infant disabled effective the date of birth.
317:35-7-61. Redetermination of eligibility for persons receiving ABD or TANF

A periodic redetermination of eligibility for Medical Services is required every twelve months on all categorically needy cases which also receive a money payment, QMBP, SLMB, QI-1, QDWI, or TEFRA.
317:35-7-61.1. Special redetermination procedures for TEFRA

The OHCA conducts an annual cost effectiveness review for all active TEFRA children. The local county office is notified of the results of the review for any necessary case action. If OHCA determines the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.