

EXPLANATION OF THE EFFECT OF TRANSFER OF ASSETS(S) ON MEDICAL ASSISTANCE ELIGIBILITY

This explains how a transfer of assets may affect your eligibility for Medical Assistance. Assets include all of your and your spouse's income and resources, including any income or resource which you or your spouse are entitled to receive but do not receive because of any action or inaction by you or your spouse. A transfer is when assets are given or sold from one person to another. For Medical Assistance purposes, a prohibited transfer is the voluntary giving or sale of your assets to another person without receiving something of equal or greater value in return, (uncompensated) in order to qualify for:

- Services provided in skilled nursing facilities or intermediate care facilities for the mentally retarded (ICF/MR),
- Services provided in swing bed or inappropriate level of care bed in a hospital,
- Services provided by the Community Alternative Programs or Program of All-Inclusive Care for the Elderly (PACE),
- In home health services and supplies after receiving any of the above services.

Medical Assistance will review all your and your spouse's income and resources for a period of 36 months up to 60 months to determine if a transfer(s) occurred.

To determine if an uncompensated transfer occurred we take the fair market value of the asset at the time it was transferred. We subtract any outstanding loans, mortgages or other legal encumbrances on the asset and the amount of compensation received in exchange for the asset. The result, if any, is the uncompensated transfer amount.

Some transfers do not affect Medical Assistance:

1. The asset(s) was transferred to your spouse, (or to another for the sole benefit of your spouse), or from your spouse to you; or
2. The asset(s) was transferred from your spouse to another person for the sole benefit of your spouse; or
3. The asset(s) was transferred to your child of any age who the Social Security Administration has determined is blind or disabled, or to a trust established solely for the benefit of that child; or
4. The asset transferred was your homesite and the homesite was transferred to:
 - a) Your spouse; or
 - b) Your minor child or children under age 21, or your child or children of any age who the Social Security Administration has determined is blind or disabled; or
 - c) Your sibling who also has an equity interest in the home and has been residing in the home for at least one year immediately before you entered a nursing facility or requested CAP or PACE.
 - d) Your child or children who were living in the home for at least two years immediately before you entered a nursing facility or requested CAP or PACE and provided care to you that permitted you to live at home rather than in a nursing facility throughout the 2 year period. Documentation must be provided that the adult child or children resided in the home during the two years that the adult child or children provided necessary care.

How coverage is determined if a transfer occurred:

When you or your spouse make a transfer of assets for less than they are worth, you cannot get Medicaid for the above listed services for a period of time, depending on the value of the transferred assets. We determine the number of months you are ineligible for these services by dividing the uncompensated value of the asset(s) transferred by the average monthly cost for private nursing home care. **For transfers prior to November 1, 2007**, the sanction period begins the first day of the month in which the asset was transferred. **For transfers on or after November 1, 2007**, the sanction period begins on the first day of the month in which you are institutionalized and would otherwise be eligible for Medicaid payment of the institutional services (those specified above), which ever is later, and does not occur during any other period of ineligibility.

What other transfers do not affect your Medicaid eligibility?

If you or your spouse transferred assets for less than fair market value, you can still get Medicaid coverage for the above listed services if you can prove that:

1. You or your spouse intended to dispose of the asset(s) at fair market value; or
2. The asset(s) was transferred exclusively for a purpose other than to qualify for Medicaid coverage; or
3. All of the transferred asset(s) have been returned.

In the absence of the evidence described in 1 or 2 above, we will not deny Medicaid coverage for institutional services if it is determined by the county department of social services that this denial of coverage for institutional services will result in an undue hardship for you. You must request a determination of undue hardship within 12 calendar days of notification of the right to a hardship review. We will consider your request for undue hardship if you can demonstrate with documentation:

1. You will be deprived of appropriate medical care without which your health or life would be endangered and your doctor certifies this in writing, or
2. You will be deprived of food, clothing, shelter, or other basic necessities of life and your doctor or other knowledgeable person certifies in writing that without these your health or life are in substantial danger, and
3. No other sources are available to provide for medical care, food, clothing, shelter, and other necessities of life, and
4. You demonstrate you have made a good faith effort to recover the resources and can demonstrate that they cannot be recovered.

What rights do you have?

You will receive a written notice regarding your Medicaid determination. You have the right to appeal our decision. Our written notice will provide you with the information on how to request an appeal.