h. Medicaid services. Persons eligible for Medicaid as medically needy will be eligible for all services covered by Medicaid except:

(1) Care in a nursing facility or an intermediate care facility for the mentally retarded.

(2) Care in an institution for mental disease.

(3) Care in a Medicare-certified skilled nursing facility.

(4) Rehabilitative treatment services pursuant to 441—Chapter 185.

i. Reviews. Reviews of eligibility shall be made for SSI-related medically needy recipients with a zero spenddown as often as circumstances indicate but in no instance shall the period of time between reviews exceed 12 months.

SSI-related medically needy persons shall complete Form 470-3118, Medically Needy Recertification/State Supplementary and Medicaid Review, as part of the review process when requested to do so by the county office.

j. Redetermination. When an SSI-related recipient who has had ongoing eligibility because of a zero spenddown has income that exceeds the MNIL, a redetermination of eligibility shall be completed to change the recipient's eligibility to a two-month certification with spenddown. This redetermination shall be effective the month the income exceeds the MNIL or the first month following timely notice.

(1) The Medically Needy Recertification/State Supplementary and Medicaid Review, Form 470-3118, shall be used to determine eligibility for SSI-related medically needy when an SSI recipient has been determined to be ineligible for SSI due to excess income or resources in one or more of the months after the effective date of the SSI eligibility decision.

(2) All eligibility factors shall be reviewed on recertifications. A face-to-face interview is not required for recertifications if the last face-to-face interview was less than 12 months ago and there has not been a break in assistance. When the length of time between face-to-face interviews would exceed 12 months, a face-to-face interview shall be required.

k. Recertifications. A new application shall be made when the certification period has expired and there has been a break in assistance as defined at rule 441—75.25(249A). When the certification period has expired and there has not been a break in assistance, the person shall use the Medically Needy Recertification/State Supplementary and Medicaid Review, Form 470-3118, to be recertified. This form shall be treated as an application. For cases on the X-PERT system, if an interview is required as specified at subparagraph 75.1(35)*"j"*(2), the applicant may complete Form 470-3112 or 470-3122 (Spanish). When the applicant completes Form 470-3112 or Form 470-3122 (Spanish), the Summary of Facts, Form 470-3114, shall be completed and attached to the Summary Signature Page, Form 470-3113 or Form 470-3123 (Spanish), which has been signed and returned to the local or area office.

If an interview is not required as specified at subparagraph 75.1(35)*"j"*(2), when the Application for Assistance, Part 1, Form 470-3112 or 470-3122 (Spanish), is completed, the applicant shall be requested to complete Form 470-3118.

l. Disability determinations. An applicant receiving social security disability benefits under Title II of the Social Security Act or railroad retirement benefits based on the Social Security Act definition of disability by the Railroad Retirement Board shall be deemed disabled without any further determination. In other cases under the medically needy program, the department shall conduct an independent determination of disability unless the applicant has been denied supplemental security income benefits based on lack of disability and does not allege either (1) a disabling condition different from or in addition to that considered by the Social Security Administration, or (2) that the applicant's condition has changed or deteriorated since the most recent Social Security Administration determination.

(1) In conducting an independent determination of disability, the department shall use the same criteria required by federal law to be used by the Social Security Administration of the United States Department of Health and Human Services in determining disability for purposes of Supplemental Security Income under Title XVI of the Social Security Act. The disability determination services bureau of the division of vocational rehabilitation shall make the initial disability determination on behalf of the department.

(2) For an independent determination of disability, a Disability Report, Form 470-2465, must be obtained from the applicant or recipient or the applicant's or recipient's authorized representative. A signed Authorization for Source to Release Information to the Department of Human Services, Form 470-2467, shall be completed for each medical source listed on the disability report.

(3) In connection with any independent determination of disability, the department shall determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility.

75.1(36) *Expanded specified low-income Medicare beneficiaries.* Medicaid benefits to cover the cost of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

a. The person's monthly income is at least 120 percent of the federal poverty level but is less than 135 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

b. The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

c. The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

d. The person is not otherwise eligible for Medicaid.

e. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

75.1(37) *Home health specified low-income Medicare beneficiaries.*

a. Medicaid benefits to cover the cost of the home health portion of the Medicare Part B premium shall be available to persons who are entitled to Medicare Part A provided the following conditions are met:

(1) The person's monthly income is at least 135 percent of the federal poverty level but is less than 175 percent of the federal poverty level (as defined by the United States Office of Management and Budget and revised annually in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

(2) The person's resources do not exceed twice the maximum amount of resources that a person may have and obtain benefits under the Supplemental Security Income (SSI) program.

(3) The amount of the income and resources shall be determined the same as under the SSI program unless the person lives and is expected to live at least 30 consecutive days in a medical institution and has a spouse at home. Then the resource determination shall be made according to subrules 75.5(3) and 75.5(4). Income shall not include any amount of social security income attributable to the cost-of-living increase through the month following the month in which the annual revision of the official poverty level is published.

(4) The person is not otherwise eligible for Medicaid.

b. The effective date of eligibility shall be as set forth in rule 441—76.5(249A).

c. Payment of the home health portion of Medicare Part B premium shall be made retroactively on an annual basis in April of each year for the prior calendar year.

75.1(38) *Continued Medicaid for disabled children from August 22, 1996.* Medical assistance shall be available to persons who were receiving SSI as of August 22, 1996, and who would continue to be eligible for SSI but for Section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.6.

441—75.2(249A) Medical resources. Medical resources include health and accident insurance, eligibility for care through Veterans' Administration, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources for meeting the cost of medical care which may be available to the recipient. These resources must be used when reasonably available.

When a medical resource may be obtained by filing a claim or an application, and cooperating in the processing of that claim or application, that resource shall be considered to be reasonably available, unless good cause for failure to obtain that resource is determined to exist.

Payment will be approved only for those services or that part of the cost of a given service for which no medical resources exist unless pay and chase provisions as defined in rule 441—75.25(249A) are applicable. Persons who have been approved by the Social Security Administration for supplemental security income shall complete Form MA-2124-0, Supplementary Information—Medicaid Application—Retroactive Medicaid Eligibility, and return it to the local office of the department of human services. Persons eligible for Part B of the Medicare program shall make assignment to the department on Form MA-2124-0, Supplementary Information—Medicaid Application—Retroactive Medicaid Eligibility.

75.2(1) The recipient, or one acting on the recipient's behalf, shall file a claim, or submit an application, for any reasonably available medical resource, and shall also cooperate in the processing of the claim or application. Failure to do so, without good cause, shall result in the termination of medical assistance benefits. The medical assistance benefits of a minor or a legally incompetent adult recipient shall not be terminated for failure to cooperate in reporting medical resources.

75.2(2) When a parent or payee, acting on behalf of a minor, or of a legally incompetent adult recipient, fails to file a claim or application for reasonably available medical resources, or fails to cooperate in the processing of a claim or application, without good cause, the medical assistance benefits of the parent or payee shall be terminated.

75.2(3) Good cause for failure to cooperate in the filing or processing of a claim or application shall be considered to exist when the recipient, or one acting on behalf of a minor, or of a legally incompetent adult recipient, is physically or mentally incapable of cooperation. Good cause shall be considered to exist when cooperation is reasonably anticipated to result in:

a. Physical or emotional harm to the recipient for whom medical resources are being sought.

b. Physical or emotional harm to the parent or payee, acting on the behalf of a minor, or of a legally incompetent adult recipient, for whom medical resources are being sought.

75.2(4) The determination of good cause shall be made by the Utilization Review Section of the Bureau of Medical Services. This determination shall be based on information and evidence provided by the recipient, or by one acting on the recipient's behalf.

75.2(5) When the department receives information through a cross-match with department of employment services and child support recovery files which indicates the absent parent of a Medicaid-eligible child is employed, the department shall send Form 470-0413, Absent Parent Insurance Questionnaire, to the absent parent in order to obtain health insurance coverage information. If the absent parent does not respond within 15 days from the date Form 470-0413 is sent, the department shall send Form 470-2240, Employer Insurance Questionnaire, to the employer in order to obtain the health insurance coverage information.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5 and 249A.6.

441—75.3(249A) Acceptance of other financial benefits. An applicant or recipient shall take all steps necessary to apply for and, if entitled, accept any income or resources for which the applicant or recipient may qualify, unless the applicant or recipient can show an incapacity to do so. Sources of benefits may be, but are not limited to, contributions, annuities, pensions, retirement or disability benefits, veterans' compensation and pensions, old-age, survivors, and disability insurance, railroad retirement benefits, black lung benefits, or unemployment compensation.

75.3(1) When it is determined that the supplemental security income (SSI)-related applicant or recipient may be entitled to other cash benefits, a Notice Regarding Acceptance of Other Cash Benefit, Form MA-3017-0, shall be sent to the applicant or recipient.

75.3(2) The SSI-related applicant or recipient must express an intent to apply or refuse to apply for other benefits within five working days from the date the notice is issued. A signed refusal to apply or failure to return the form shall result in denial of the application or cancellation of Medicaid unless the applicant or recipient is mentally or physically incapable of filing the claim for other cash benefits.

75.3(3) When the SSI-related applicant or recipient is physically or mentally incapable of filing the claim for other cash benefits, the local office shall request the person acting on behalf of the recipient to pursue the potential benefits.

75.3(4) The SSI-related applicant or recipient shall cooperate in applying for the other benefits. Failure to timely secure the other benefits shall result in cancellation of Medicaid.

EXCEPTION: An applicant or recipient shall not be required to apply for supplementary security income to receive Medicaid under subrule 75.1(17).

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.4(249A) Medical assistance lien.

75.4(1) The agency within the department of human services responsible for administration of the department's lien is the division of medical services. When payment is made by the department for medical care or expenses through the medical assistance program on behalf of a recipient, the department shall have a lien, to the extent of those payments, to all monetary claims which the recipient may have against third parties. A lien under this section is not effective unless the department files a notice of lien with the clerk of the district court in the county where the recipient resides and with the recipient's attorney when the recipient's eligibility for medical assistance is established. The notice of lien shall be filed before the third party has concluded a final settlement with the recipient, the recipient's attorney, or other representative. The third party shall obtain a written determination from the department concerning the amount of the lien before a settlement is deemed final for purposes of this section. A compromise, including, but not limited to, notification, settlement, waiver or release, of a claim under this section does not defeat the department's lien except pursuant to the written agreement of the director or the director's designee under which the department would receive less than full reimbursement of the amounts it expended. A settlement, award, or judgment structured in any manner not to include medical expenses or an action brought by a recipient or on behalf of a recipient which fails to state a claim for recovery of medical expenses does not defeat the department's lien if there is any recovery on the recipient's claim.

All notifications to the department required by law shall be directed to the Division of Medical Services—Third Party Liability, Fifth Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. Notification shall be considered made as of the time the notification is deposited so addressed, postage prepaid in the United States Postal Service system.

75.4(2) The department may pursue its rights to recover either directly from any third party or from any recovery obtained by or on behalf of any medical assistance recipient. If a recipient of the medical assistance program incurs the obligation to pay attorney fees and court costs for the purpose of enforcing a monetary claim to which the department has a lien under this section, upon the receipt of the judgment or settlement of the total claim, of which the lien for medical assistance payments is a part, the court costs and reasonable attorney fees shall first be deducted from this total judgment or settlement. One-third of the remaining balance shall then be deducted and paid to the recipient. From the remaining balance, the lien of the department shall be paid. Any amount remaining shall be paid to the recipient. An attorney acting on behalf of a recipient of medical assistance for the purpose of enforcing a claim to which the department has a lien shall not collect from the recipient any amount as attorney fees which is in excess of the amount which the attorney customarily would collect on claims not subject to this rule. The department will provide computer-generated documents or claim forms describing the services for which it has paid upon request of any affected recipient or the recipient's attorney. The documents may also be provided to a third party where necessary to establish the extent of the department's claim.

75.4(3) In those cases where appropriate notification is not given to the department or where the department's recovery rights are otherwise adversely affected by an action of the recipient or one acting on the recipient's behalf, medical assistance benefits shall be terminated. The medical assistance benefits of a minor child or a legally incompetent adult recipient shall not be terminated. Subsequent eligibility for medical assistance benefits shall be denied until an amount equal to the unrecovered claim has been reimbursed to the department or the individual produces documentation of incurred medical expense equal to the amount of the unrecovered claim. The incurred medical expense shall not be paid by the medical assistance program.

a. The client, or one acting on the client's behalf, shall provide information and verification as required to establish the availability of medical or third-party resources.

b. Rescinded IAB 9/4/91, effective 11/1/91.

c. The client or person acting on the client's behalf shall complete Form 470-2826, Supplemental Insurance Questionnaire, in a timely manner at the time of application, when any change in medical resources occurs during the application period, and when any changes in medical resources occur after the application is approved.

A report shall be considered timely when made within ten days from:

(1) The date that health insurance begins, changes, or ends.

(2) The date that eligibility begins for care through Veterans Administration, specialized child health services, Title XVIII of the Social Security Act (Medicare) and other resources.

(3) The date the client, or one acting on the client's behalf, files an insurance claim against an insured third party, for the payment of medical expenses that otherwise would be paid by Medicaid.

(4) The date the recipient, or one acting on the recipient's behalf, retains an attorney with the expectation of seeking restitution for injuries from a possibly liable third party, and the medical expenses resulting from those injuries would otherwise be paid by Medicaid.

(5) The date that the recipient, or one acting on the recipient's behalf, receives a partial or total settlement for the payment of medical expenses that would otherwise be paid by Medicaid.

The recipient may report the change in person, by telephone, by mail or by using the Ten Day Report of Change, Form PA-4106-0, which is mailed with the Aid to Dependent Children Assistance warrants.

d. The recipient, or one acting on the recipient's behalf, shall complete the Recipient Inquiry, Form MA-4047-0, when the department has reason to believe that the recipient has received an accident-related injury. Failure to cooperate in completing and returning this form, or in giving complete and accurate information, shall result in the termination of Medicaid benefits.

e. In those instances where the recovery rights of the department are adversely affected by the actions of a parent or payee, acting on the behalf of a minor, or legally incompetent adult recipient, the Medicaid benefits of the parent or payee shall be terminated. In those instances where a parent or payee fails to cooperate in completing or returning the Recipient Inquiry, Form MA-4047-0, or the Supplemental Insurance Questionnaire, Form 470-2826, or fails to give complete and accurate information concerning the accident-related injuries of a minor or legally incompetent adult recipient, the Medicaid benefits of the parent or payee shall be terminated.

f. The recipient, or one acting on the recipient's behalf, shall refund to the department from any settlement or payment received the amount of any medical expenses paid by Medicaid. Failure of the recipient to do so shall result in the termination of Medicaid benefits. In those instances where a parent or payee, acting on the behalf of a minor, or of a legally incompetent adult recipient, fails to refund a settlement overpayment to the department, the Medicaid benefits of the parent or payee shall be terminated.

75.4(4) Third party and provider responsibilities.

a. The health care services provider shall inform the department by appropriate notation on the Inpatient Hospital Claim, Form XIX HOSP-1, the Outpatient Hospital Claim, Form XIX HOSP-2, or on the Health Insurance Claim, Form HCFA 1500, that other coverage exists but did not cover the service being billed or that payment was denied.

b. The health care services provider shall notify the department in writing by mailing copies of any billing information sent to a recipient, an attorney, an insurer or other third party after a claim has been submitted to or paid by the department.

c. An attorney representing an applicant for or a past or present recipient of medical assistance on a claim to which the department has filed a lien under this rule shall notify the department of the claim of which the attorney has actual knowledge, prior to filing a claim, commencing an action or negotiating a settlement offer. Actual knowledge shall include the notice to the attorney pursuant to subrule 75.4(1). The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the department at its state or regional office location, is adequate legal notice of the claim.

75.4(5) Department's lien.

a. The department's liens are valid and binding on an attorney, insurer or other third party only upon notice by the department or unless the attorney, insurer or other third party has actual notice that the recipient is receiving medical assistance from the department and only to the extent that the attorney, insurer or third party has not made payment to the recipient or an assignee of the recipient prior to the notice.

Any information released to an attorney, insurer or other third party, by the health care services provider, that indicates that reimbursement from the state was contemplated or received, shall be construed as giving the attorney, insurer or other third party actual knowledge of the department's involvement. For example, information supplied by a health care services provider which indicates medical assistance involvement shall be construed as showing involvement by the department under Iowa Code section 249A.6. Payment of benefits by an insurer or third party pursuant to the rights of the lienholder in this rule discharges the attorney, insurer or other third party from liability to the recipient or the recipient's assignee to the extent of the payment to the department.

b. When the department has reason to believe that an attorney is representing an applicant for or recipient of medical assistance on a claim to which the department filed a lien under this rule, the department shall issue notice to that attorney of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the attorney.

c. When the department has reason to believe that an insurer is liable for the costs of a recipient's medical expenses, the department shall issue notice to the insurer of the department's lien rights by mailing the Notice of Medical Assistance Lien, Form 470-3030, to the insurer.

d. The mailing and deposit in a United States post office or public mailing box of the notice, addressed to the attorney or insurer is adequate legal notice of the department's subrogation rights.

75.4(6) For purposes of this rule the term "third party" includes an attorney, individual, institution, corporation, or public or private agency which is or may be liable to pay part or all of the medical costs incurred as a result of injury, disease or disability by or on behalf of an applicant for or a past or present recipient of assistance under the medical assistance program.

75.4(7) The department may enforce its lien by a civil action against any liable third party.

This rule is intended to implement Iowa Code sections 249A.4, 249A.5, and 249A.6.

441—75.5(249A) Determination of countable income and resources for persons in a medical institution. In determining eligibility for any coverage group under rule 441—75.1(249A), certain factors must be considered differently for persons who reside in a medical institution. They are:

75.5(1) Determining income from property.

a. Nontrust property. Where there is nontrust property, unless the document providing income specifies differently, income paid in the name of one person shall be available only to that person. If payment of income is in the name of two persons, one-half is attributed to each. If payment is in the name of several persons, including a Medicaid client, a client's spouse, or both, the income shall be considered in proportion to the Medicaid client's or spouse's interest. If payment is made jointly to both spouses and no interest is specified, one-half of the couple's joint interest shall be considered available for each spouse. If the client or the client's spouse can establish different ownership by a preponderance of evidence, the income shall be divided in proportion to the ownership.

b. Trust property. Where there is trust property, the payment of income shall be considered available as provided in the trust. In the absence of specific provisions in the trust, the income shall be considered as stated above for nontrust property.

75.5(2) Division of income between married people for SSI-related coverage groups.

a. Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining eligibility for the institutionalized spouse.

b. Spouses institutionalized and living together. Partners in a marriage who are residing in the same room in a medical institution shall be treated as a couple until the first day of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together. When spouses are treated as a couple, the combined income of the couple shall not exceed twice the amount of the income limit established in subrule 75.1(7). Persons treated together as a couple for income must be treated together for resources and persons treated individually for income must be treated individually for resources.

Spouses residing in the same room in a medical institution may be treated as individuals effective the first day of the seventh calendar month. The income of each spouse shall not exceed the income limit established in subrule 75.1(7).

c. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. Their income shall be treated separately for eligibility. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or receive reduced benefits by considering them separate individuals or if they choose to be considered together.

In the month of entry into a medical institution, income shall not exceed the amount of the income limit established in subrule 75.1(7).

75.5(3) Attribution of resources to institutionalized spouse and community spouse. The department shall determine the attribution of a couple's resources to the institutionalized spouse and to the community spouse when the institutionalized spouse is expected to remain in a medical institution at least 30 consecutive days on or after September 30, 1989, at the beginning of the first continuous period of institutionalization.

a. When initiated. The department shall initiate the attribution of resources when:

(1) Either spouse requests that the department determine the attribution of resources at the beginning of the person's continuous stay in a medical facility. This request must be accompanied by Form 470-2577, Resources Upon Entering a Medical Facility, and necessary documentation.

(2) The institutionalized spouse or someone acting on that person's behalf applies for Medicaid benefits. If the application is not made in the month of entry, the applicant shall also complete Form 470-2577 and provide necessary documentation.

b. Information required. The couple must provide the social security number of the community spouse. The attribution process shall include a match of the Internal Revenue Service data for both the institutionalized and community spouses.

c. Resources considered. The resources attributed shall include resources owned by both the community spouse and institutionalized spouse except for the following resources:

(1) The home in which the spouse or relatives as defined in 441—paragraph 41.22(3)*"a"* live (including the land that appertains to the home).

(2) Household goods, personal effects, and one automobile.

(3) The value of any burial spaces held for the purpose of providing a place for the burial of either spouse or any other member of the immediate family.

(4) Other property essential to the means of self-support of either spouse as to warrant its exclusion under the SSI program.

(5) Resources of a blind or disabled person who has a plan for achieving self-support as determined by division of vocational rehabilitation or the department of human services.

(6) For natives of Alaska, shares of stock held in a regional or a village corporation, during the period of 20 years in which the stock is inalienable, as provided in Section 7(h) and Section 8(c) of the Alaska Native Claims Settlement Act.

(7) Assistance under the Disaster Relief Act and Emergency Assistance Act or other assistance provided pursuant to federal statute on account of a presidentially declared major disaster and interest earned on these funds for the nine-month period beginning on the date these funds are received or for a longer period where good cause is shown.

(8) Any amount of underpayment of SSI or social security benefit due either spouse for one or more months prior to the month of receipt. This exclusion shall be limited to the first six months following receipt.

(9) A life insurance policy(ies) whose total face value is $1500 or less per spouse.

(10) An amount, not in excess of $1500 for each spouse that is separately identifiable and has been set aside to meet the burial and related expenses of that spouse. The amount of $1500 shall be reduced by an amount equal to the total face value of all insurance policies which are owned by the person or spouse and the total of any amounts in an irrevocable trust or other irrevocable arrangement available to meet the burial and related expenses of that spouse.

(11) Federal assistance paid for housing occupied by the spouse.

(12) Assistance from a fund established by a state to aid victims of crime for nine months from receipt when the client demonstrates that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime.

(13) Relocation assistance provided by a state or local government to a client comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 which is subject to the treatment required by Section 216 of the Act.

d. Method of attribution. The resources attributed to the institutionalized spouse shall be one-half of the documented resources of both the institutionalized and community spouse as of the first moment of the first day of the month of the spouse's first entry to a medical facility. However, if one-half of the resources is less than $24,000, then $24,000 shall be protected for the community spouse. Also, when one-half the resources attributed to the community spouse exceeds $80,760, the amount over $80,760 shall be attributed to the institutionalized spouse. (The maximum limit shall be indexed annually by the consumer price index.)

If the institutionalized spouse has transferred resources to the community spouse under a court order for the support of the community spouse, the amount transferred shall be the amount attributed to the community spouse if it exceeds the specified limits above.

e. Notice. The department shall provide each spouse a notice of the attribution results. The notice shall state that either spouse has a right to appeal the attribution if the spouse believes:

(1) That the attribution is incorrect.

(2) That the amount of income generated by the resources attributed to the community spouse is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance.

f. Appeals. Hearings on attribution decisions shall be governed by procedures in 441—Chapter 7. If the hearing establishes that the community spouse's resource allowance is inadequate to raise the community spouse's income to the minimum monthly maintenance allowance, there shall be substituted an amount adequate to provide the minimum monthly maintenance needs allowance.

(1) To establish that the resource allowance is inadequate and receive a substituted allowance, the applicant must provide verification of all the income of the community spouse.

(2) The amount of resources adequate to provide the community spouse minimum maintenance needs allowance shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the monthly maintenance needs allowance and other countable income not generated by either spouse's countable resources.

(3) The resources necessary to provide the minimum maintenance needs allowance shall be based on the maintenance needs allowance as provided by these rules at the time of the filing of the appeal.

(4) To receive the substituted allowance, the applicant shall be required to obtain three estimates of the cost of the annuity and these amounts shall be averaged to determine the cost of an annuity.

(5) The averaged estimates representing the cost of an annuity shall be substituted for the amount of resources attributed to the community spouse when the amount of resources previously determined is less than the averaged cost of an annuity. If the amount of resources previously attributed for the community spouse is greater than the averaged cost of an annuity, there shall be no substitution for the cost of the annuity and the attribution will remain as previously determined.

(6) The applicant shall not be required to purchase this annuity as a condition of Medicaid eligibility.

(7) If the appellant provides a statement from three insurance companies that they will not provide estimates due to the potential annuitant's age, the amount to be set aside shall be determined using the following calculation: The difference between the community spouse's gross monthly income not generated by countable resources (times 12) and the minimum monthly maintenance needs allowance (times 12) shall be multiplied by the annuity factor for the age of the community spouse in the Table for an Annuity for Life published at the end of Iowa Code chapter 450. This amount shall be substituted for the amount of resources attributed to the community spouse pursuant to subparagraph 75.5(3)*"f"*(5).

75.5(4) Consideration of resources of married people.

a. One spouse in a medical facility who entered the facility on or after September 30, 1989.

(1) Initial month. When the institutionalized spouse is expected to stay in a medical facility less than 30 consecutive days, the resources of both spouses shall be considered in determining initial Medicaid eligibility.

When the institutionalized spouse is expected to be in a medical facility 30 consecutive days or more, only the resources not attributed to the community spouse according to subrule 75.5(3) shall be considered in determining initial eligibility for the institutionalized spouse.

The amount of resources counted for eligibility for the institutionalized spouse shall be the difference between the couple's total resources at the time of application and the amount attributed to the community spouse under this rule.

(2) Ongoing eligibility. After the month in which the institutionalized spouse is determined eligible, no resources of the community spouse shall be deemed available to the institutionalized spouse during the continuous period in which the spouse is in an institution. Resources which are owned wholly or in part by the institutionalized spouse and which are not transferred to the community spouse shall be counted in determining ongoing eligibility. The resources of the institutionalized spouse shall not count for ongoing eligibility to the extent that the institutionalized spouse intends to transfer and does transfer the resources to the community spouse within 90 days unless unable to effect the transfer.

(3) Exception based on estrangement. When it is established by a disinterested third-party source that the institutionalized spouse is estranged from the community spouse, Medicaid eligibility will not be denied on the basis of resources when the applicant can demonstrate hardship.

The applicant can demonstrate hardship when the applicant is unable to obtain information about the community spouse's resources after exploring all legal means.

The applicant can also demonstrate hardship when resources attributed from the community spouse cause the applicant to be ineligible, but the applicant is unable to access these resources after exhausting legal means.

(4) Exception based on assignment of support rights. The institutionalized spouse shall not be ineligible by attribution of resources that are not actually available when:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse, or

2. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment, but the state has the right to bring a support proceeding against a community spouse without an assignment.

b. One spouse in a medical institution prior to September 30, 1989. When one spouse is in the medical institution prior to September 30, 1989, only the resources of the institutionalized spouse shall count for eligibility according to SSI policies the month after the month of entry. In the month of entry, the resources of both spouses are countable toward the couple resource limit.

c. Spouses institutionalized and living together. The combined resources of both partners in a marriage who are residing in the same room in a medical institution shall be subject to the resource limit for a married couple until the first of the seventh calendar month that they continuously reside in the facility. The couple may continue to be considered as a couple for medical assistance effective with the seventh month if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together. Persons treated together as a couple for resources must be treated together for income and persons treated individually for resources must be treated individually for income. Effective the first of the seventh calendar month of continuous residence, they may be treated as individuals, with the resource limit for each spouse the limit for a single person.

d. Spouses institutionalized and living apart. Partners in a marriage who are both institutionalized, although not residing in the same room of the institution, shall be treated as individuals effective the month after the month the partners cease living together. If they live in the same facility after six months of continuous residence, they may be considered as a couple for medical assistance effective the first day of the seventh calendar month of continuous residency if one partner would be ineligible for medical assistance or would receive reduced benefits by considering them separately or if they choose to be considered together.

In the month of entry into a medical institution, all resources of both spouses shall be combined and shall be subject to the resource limit for a married couple.

75.5(5) Consideration of resources for persons in a medical institution who have purchased and used a precertified or approved long-term care insurance policy pursuant to department of commerce, division of insurance, rules 191—Chapter 72. A person 65 years of age or older who is either the beneficiary of a certified long-term care policy or enrolled in a prepaid health care delivery plan that provides long-term care services pursuant to 191—Chapter 72 and who is eligible for medical assistance under 75.1(3), 75.1(4), 75.1(5), 75.1(6), 75.1(7), 75.1(9), 75.1(12), 75.1(13), 75.1(17), 75.1(18), 75.1(23) or 75.1(27) except for excess resources may be eligible for medical assistance under this subrule if the excess resources causing ineligibility under the listed coverage groups do not exceed the "asset adjustment" provided in this subrule. "Asset adjustment" shall mean a $1 disregard of resources for each $1 that has been paid out under the person's long-term care policy for qualified Medicaid long-term care services.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4 and chapter 249G.

441—75.6(249A) Disposal of resources for less than fair market value prior to July 1, 1989, or October 1, 1989, between spouses.

75.6(1) In determining eligibility for Medicaid for persons described in 75.1(3), 75.1(4), 75.1(6), 75.1(7), 75.1(9), 75.1(13), 75.1(17), 75.1(18), 75.1(23), 75.1(25), 75.1(27), 75.1(29), and 441—86.1(249A), resources transferred during or after the 24-month period prior to application which were not exempt at the time of transfer and which the person gave away or sold at less than fair market value prior to October 1, 1989, for transfers between spouses and prior to July 1, 1989, for transfers to others for the purpose of establishing eligibility for Medicaid shall be counted as resources still available to the person for the following period of time:

a. For uncompensated value of $12,000 or less: 24 months from the date of transfer.

b. For uncompensated value between $12,001 and $24,000: 36 months from the date of transfer.

c. For uncompensated value between $24,001 and $36,000: 48 months from the date of transfer.

d. For uncompensated value between $36,001 and $50,000: 60 months from the date of transfer.

e. For uncompensated value over $50,000: 72 months from the date of transfer.

75.6(2) Transfers of resources as described in 75.6(1) shall be presumed to be for the purpose of establishing eligibility for medical assistance unless the individual furnishes convincing evidence to establish that the transaction was exclusively for some other purpose. In addition to giving away or selling for less than fair market value, examples of transferring resources include but are not limited to establishing a trust, contributing to a charity or other organization, removing a name from a joint bank account, or decreasing the extent of ownership interest in a resource or any other transfer as defined in the supplemental security income program.

a. Convincing evidence to establish that the transaction was exclusively for a purpose other than establishing eligibility may include documents, letters, and contemporaneous writings, as well as other circumstantial evidence.

b. In rebutting the presumption that the resource was transferred to establish eligibility, the burden of proof is on the individual to establish:

(1) The fair market value of the compensation and

(2) That the compensation was provided pursuant to an agreement, contract, or expectation in exchange for the resource and

(3) That the agreement, contract, or expectation was established at the time of transfer.

75.6(3) Uncompensated value is defined as the fair market value of the resource minus the amount of compensation received by the individual in exchange for the resource. In no case will the amount of uncompensated value exceed the amount which would have been counted toward the resource limit (as of the date of transfer) if the resource had been retained.

a. Fair market value is defined as the price that the item can reasonably be expected to sell for on the open market in the particular geographic area involved and may be established by independent appraisal.

b. Compensation is defined as all money, real or personal property, food, shelter or services received by the individual in exchange for the resource if such money, property, food, shelter or services are provided in reliance on an agreement made at the time of transfer.

This rule is intended to implement Iowa Code section 249A.3.

441—75.7(249A) Furnishing of social security number. As a condition of eligibility applicants or recipients of Medicaid must furnish their social security account numbers or proof of application for the numbers if they have not been issued or are not known and provide their numbers upon receipt.

75.7(1) Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

75.7(2) The mother of a newborn child shall have until the second month following the mother's discharge from the hospital to apply for a social security account number for the child.

This rule is intended to implement Iowa Code section 249A.3.

441—75.8(249A) Medical assistance corrective payments. If a decision by the department or the Social Security Administration following an appeal on a denied application for any of the categories of medical assistance eligibility set forth in rule 441—75.1(249A) is favorable to the claimant, reimbursement will be made to the claimant for any medical bills paid by the claimant during the period between the date of the denial on the initial application and the date regular medical assistance coverage began when the bills were for medical services rendered in the period now determined to be an eligible period based on the following conditions:

75.8(1) These bills must be for services covered by the medical assistance program as set forth in 441—Chapter 78.

75.8(2) Reimbursement will be based on Medicaid rates for services in effect at the time the services were provided.

75.8(3) If a county relief agency has paid medical bills on the recipient's behalf and has not received reimbursement through assignment as set forth in 441—Chapter 80, the department will reimburse the county relief agency directly on the same basis as if the reimbursement was made to the recipient.

75.8(4) Recipients and county relief agencies shall file claims for payment under this subrule by submitting Form 470-2224, Verification of Paid Medical Bills, to the department. A supply of these forms is available from the county office. All requests for reimbursement shall be acted upon within 60 days of receipt of all Forms 470-2224 in the county office.

75.8(5) Any adverse action taken by the department with respect to an application for reimbursement is appealable under 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.4.

441—75.9(249A) Treatment of Medicaid qualifying trusts.

75.9(1) A Medicaid qualifying trust is a trust or similar legal device established, on or before August 10, 1993, other than by will by a person or that person's spouse under which the person may be the beneficiary of payments from the trust and the distribution of these payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the person. Trusts or initial trust decrees established prior to April 7, 1986, solely for the benefit of a mentally retarded person who resides in an intermediate care facility for the mentally retarded, are exempt.

75.9(2) The amount of income and principal from a Medicaid qualifying trust that shall be considered available shall be the maximum amount that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees for the distribution of the funds.

a. Trust income considered available shall be counted as income.

b. Trust principal (including accumulated income) considered available shall be counted as a resource, except where the trust explicitly limits the amount of principal that can be made available on an annual or less frequent basis. Where the trust limits the amount, the principal considered available over any particular period of time shall be counted as income for that period of time.

c. To the extent that the trust principal and income is available only for medical care, this principal or income shall not be used to determine eligibility. To the extent that the trust is restricted to medical expenses, it shall be used as a third party resource.

This rule is intended to implement Iowa Code section 249A.4.

441—75.10(249A) Residency requirements. Residency in Iowa is a condition of eligibility for medical assistance.

75.10(1) *Definitions.*

"Incapable of expressing intent" shall mean that the person meets one or more of the following conditions:

1. Has an IQ of 49 or less or has a mental age of seven or less.
2. Is judged legally incompetent.
3. Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other person licensed by the state in the field of mental retardation.

"Institution" shall mean an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Foster care facilities are included.

75.10(2) *Determining residency.* Residency is determined according to the following criteria:

a. Persons aged 21 and over.

(1) For any person not residing in an institution the state of residence is the state where the person is:

1. Living with the intention to remain there permanently or for an indefinite period (or, if incapable of expressing intent, where the person is living), or
2. Living and which the person entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized person who became incapable of indicating intent before age 21, the person's state of residence is:

1. That of the parent applying for Medicaid on the person's behalf, if the parents reside in separate states. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
2. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.
4. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized.

(3) For any institutionalized person who became incapable of expressing intent at or after age 21, the state of residence is the state in which the person is physically present, except where another state makes a placement.

(4) For any other institutionalized person the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

b. Persons under age 21.

(1) For any person who is emancipated from the person's parents or who is married and capable of expressing intent, the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

(2) For any person not residing in an institution or foster home whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the person is living.

(3) For any other person not in an institution or foster home and not subject to subparagraph (1) or (2) above, the state of residence is determined in accordance with rule 441—75.53(249A).

(4) For any person in an institution or foster home who is neither married nor emancipated, the state of residence is:

1. The parent's or legal guardian's state of residence at the time of placement. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

2. The current state of residence of the parent or legal guardian who files the application if the person is in institutionalized or in foster care in that state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent's.

3. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized or in foster care.

c. Persons placed by a state in an out-of-state foster home or institution. A state arranging or actually making the placement of a person in an institution or foster home in another state is considered the person's state of residence. However, a Title IV-E eligible child placed out of state by the department is eligible for Medicaid from the other state. Therefore, the Title IV-E eligible child shall only receive Iowa Medicaid until the receiving state provides coverage. A Title IV-E eligible child placed in Iowa by another state shall be considered eligible for Iowa Medicaid.

d. Medicaid-eligible persons receiving Medicaid from another state and gaining Iowa residency. These persons shall be granted Medicaid beginning with the month of residency in Iowa if the person is otherwise eligible and surrenders the other state's medical card. Good cause for not surrendering the other state's medical card shall exist when:

(1) The other state does not issue medical cards.

(2) The other state's medical card is a magnetic stripe or a computer chip card that contains more than Medicaid-related information.

(3) The other state's medical card: was left with Medicaid-eligible members of the person's household in the other state who did not move to Iowa with the person; was lost, mutilated, or destroyed; was not kept by the person upon the person's move to Iowa; or was previously surrendered to the other state.

In addition to surrendering the other state's medical card or establishing good cause, the cancellation of Medicaid in the other state shall be verified.

441—75.11(249A) Citizenship or alienage requirements.

75.11(1) *Definitions.*

"Care and services necessary for the treatment of an emergency medical condition" shall mean services provided in a hospital, clinic, office or other facility that is equipped to furnish the required care after the sudden onset of an emergency medical condition, provided the care and services are not related to an organ transplant procedure furnished on or after August 10, 1993. Payment for emergency medical services shall be limited to the day treatment is initiated for the emergency medical condition and the following two days.

"Emergency medical condition" shall mean a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

"Federal means-tested program" means all federal programs that are means-tested with the exception of:

1. Medical assistance for care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.
2. Short-term, non-cash, in-kind emergency disaster relief.
3. Assistance or benefits under the National School Lunch Act.
4. Assistance or benefits under the Child Nutrition Act of 1966.
5. Public health assistance (not including any assistance under Title XIX of the Social Security Act) for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not the symptoms are caused by a communicable disease.
6. Payments of foster care and adoption assistance under Parts B and E of Title IV of the Social Security Act for a parent or a child who would, in the absence of numbered paragraph "1," be eligible to have payments made on the child's behalf under such part, but only if the foster or adoptive parent (or parents) of the child is a qualified alien (as defined in Section 431).
7. Programs, services, or assistance (such as soup kitchens, crisis counseling and intervention, and short-term shelter) specified by the attorney general in the attorney general's sole and unreviewable discretion after consultation with appropriate federal agencies and departments, which:

- Deliver in-kind services at the community level, including through public or private nonprofit agencies.
- Do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and
- Are necessary for the protection of life or safety.

8. Programs of student assistance under Titles IV, V, IX, and X of the Higher Education Act of 1965, and Titles III, VII, and VIII of the Public Health Services Act.
9. Means-tested programs under the Elementary and Secondary Education Act of 1965.
10. Benefits under the Head Start Act.
11. Benefits under the Job Training Partnership Act.

"Qualified alien" means an alien who is:

1. Lawfully admitted for permanent residence under the Immigration and Nationality Act;
2. Granted asylum under Section 208 of the Immigration and Nationality Act;
3. A refugee and who is admitted to the United States under Section 207 of the Immigration and Nationality Act;
4. Paroled into the United States under Section 212(d)(5) of the Immigration and Nationality Act for a period of at least one year;
5. An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or
6. Granted conditional entry pursuant to Section 203(a)(7) of the Immigration and Nationality Act, as in effect prior to April 1, 1980.

"Qualifying quarters" includes all of the qualifying quarters of coverage as defined under Title II of the Social Security Act worked by a parent of an alien while the alien was under age 18 and all of the qualifying quarters worked by a spouse of the alien during their marriage if the alien remains married to the spouse or the spouse is deceased. No qualifying quarter of coverage that is creditable under Title II of the Social Security Act for any period beginning after December 31, 1996, may be credited to an alien if the parent or spouse of the alien received any federal means-tested public benefit during the period for which the qualifying quarter is so credited.

75.11(2) *Citizenship and alienage.*

a. To be eligible for Medicaid a person must be one of the following:

(1) A citizen or national of the United States.

(2) A qualified alien as defined in subrule 75.11(1) residing in the United States prior to August 22, 1996.

(3) A qualified alien who entered the United States on or after August 22, 1996, and who is:

- A refugee who is admitted to the United States under Section 207 of the Immigration and Nationality Act;
- Granted asylum under Section 208 of the Immigration and Nationality Act;
- An alien whose deportation is being withheld under Section 243(h) of the Immigration and Nationality Act; or
- A veteran with a discharge characterized as an honorable discharge and not on account of alienage, an alien who is on active duty in the Armed Forces of the United States other than active duty for training, or the veteran's spouse or unmarried dependent child.

(4) A qualified alien who entered the United States on or after August 22, 1996, and who has resided in the United States for a period of at least five years.

b. As a condition of eligibility, each recipient shall complete and sign Form 470-2549, Statement of Citizenship Status, attesting to the recipient's citizenship or alien status. The form shall be signed by the recipient, or when the recipient is incompetent or deceased, someone acting responsibly on the recipient's behalf. When both parents are in the home, both shall sign the form. An adult recipient shall sign the form for dependent children. As a condition of eligibility, all applicants for Medicaid shall attest to their citizenship status by signing the application form which contains the same declaration. As a condition of continued eligibility, recipients of SSI-related Medicaid not actually receiving SSI who have been continuous recipients since August 1, 1988, shall attest to their citizenship status by signing the application form which contains a similar declaration at time of review.

75.11(3) *Deeming of sponsor's income and resources.*

a. In determining the eligibility and amount of benefits of an alien, the income and resources of the alien shall be deemed to include the following:

(1) The income and resources of any person who executed an affidavit of support pursuant to Section 213A of the Immigration and Nationality Act (as implemented by the Personal Responsibility and Work Reconciliation Act of 1996) on behalf of the alien.

(2) The income and resources of the spouse of the person who executed the affidavit of support.

b. When an alien attains citizenship through naturalization pursuant to Chapter 2 of Title III of the Immigration and Nationality Act or has worked 40 qualifying quarters of coverage as defined in Title II of the Social Security Act or can be credited with qualifying quarters as defined at subrule 75.11(1) and, in the case of any qualifying quarter creditable for any period beginning after December 31, 1996, did not receive any federal means-tested public benefits, as defined in subrule 75.11(1), during any period, deeming of the sponsor's income and resources no longer applies.

75.11(4) *Eligibility for payment of emergency medical services.* Aliens who do not meet the provisions of subrule 75.11(2) and who would otherwise qualify except for their alienage status are eligible to receive Medicaid for emergency medical care as defined in subrule 75.11(1). To qualify under these provisions, the alien must meet all eligibility criteria, including state residence requirements provided at rules 441—75.10(249A) and 441—75.53(249A). However, the requirements of rule 441—75.7(249A) and subrules 75.11(2) and 75.11(3) do not apply to eligibility for aliens seeking the care and services necessary for the treatment of an emergency medical condition not related to an organ transplant procedure furnished on or after August 10, 1993.

441—75.12(249A) Persons who enter jails or penal institutions. A person who enters a jail or penal institution, including a work release center, shall not be eligible for Medicaid.

441—75.13(249A) Categorical relatedness.

75.13(1) *FMAP-related Medicaid eligibility.* Medicaid eligibility for persons who are under the age of 21, pregnant women, children, or specified relatives of dependent children who are not blind or disabled shall be determined using the income criteria in effect for the family medical assistance program (FMAP) as provided in subrule 75.1(14) unless otherwise specified. Income shall be considered prospectively.

75.13(2) *SSI-related Medicaid.* Medicaid eligibility for persons who are 65 years of age or older, blind, or disabled shall be determined using the eligibility requirements in effect governing the Supplemental Security Income (SSI) program in conjunction with the policies found in 441—Chapters 75 and 76. Income shall be considered prospectively.

Income that a person contributes to a trust as specified at 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for SSI-related Medicaid.

For purposes of determining eligibility for SSI-related Medicaid, the SSI conditional eligibility process at 20 CFR 416.1240 to 416.1245 as amended to March 21, 1990, by which a client may receive SSI benefits while attempting to sell excess resources, is not considered an eligibility methodology. Persons found eligible for Medicaid prior to October 1, 1993, based on the SSI conditional eligibility process as an eligibility methodology may continue to be eligible for Medicaid on that basis until no later than April 1, 1994.

441—75.14(249A) Establishing paternity and obtaining support.

75.14(1) As a condition of eligibility, applicants and recipients of Medicaid in households with an absent parent shall cooperate in obtaining medical support for the applicant or recipient as well as for any other person in the household for whom Medicaid is requested and for whom the person can legally assign rights for medical support, except when good cause as defined in subrule 75.14(8) for refusal to cooperate is established.

a. The applicant or recipient shall cooperate in the following:

(1) Identifying and locating the parent of the child for whom Medicaid is requested.

(2) Establishing the paternity of a child born out of wedlock for whom Medicaid is requested.

(3) Obtaining medical support and payments for medical care for the applicant or recipient and for a child for whom Medicaid is requested.

(4) Rescinded IAB 2/3/93, effective 4/1/93.

b. Cooperation is defined as including the following actions by the applicant or recipient:

(1) Appearing at the county office or the child support recovery unit to provide verbal or written information or documentary evidence known to, possessed by or reasonably obtainable by the applicant or recipient that is relevant to achieving the objectives of the child support recovery program.

(2) Appearing as a witness at judicial or other hearings or proceedings.

(3) Providing information, or attesting to the lack of information, under penalty of perjury.

c. The applicant or recipient shall cooperate with the county office in supplying information with respect to the absent parent, the receipt of medical support or payments for medical care, and the establishment of paternity, to the extent necessary to establish eligibility for assistance and permit an appropriate referral to the child support recovery unit.

d. The applicant or recipient shall cooperate with the child support recovery unit to the extent of supplying all known information and documents pertaining to the location of the absent parent and taking action as may be necessary to secure medical support and payments for medical care or to establish paternity. This includes completing and signing documents determined to be necessary by the state's attorney for any relevant judicial or administrative process.

e. The income maintenance unit in the county office shall make the determination of whether or not the client has cooperated.

75.14(2) Failure of the applicant or recipient to cooperate shall result in denial or cancellation of the person's Medicaid benefits. In family medical assistance program (FMAP)-related Medicaid cases, all deductions and disregards described at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be allowed when otherwise applicable but income shall not be diverted to meet the needs of the parent who refuses to cooperate without good cause when establishing eligibility for the children as described at paragraph 75.57(8)*"a."*

75.14(3) Each applicant for or recipient of Medicaid who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing medical support and payments for medical care. The provisions set forth in subrules 75.14(8) to 75.14(12) shall be used when making a determination of the existence of good cause.

75.14(4) Each applicant for or recipient of Medicaid shall assign to the department any rights to medical support and payments for medical care from any other person for which the person can legally make assignment. This shall include rights to medical support and payments for medical care on the applicant's or recipient's own behalf or on behalf of any other family member for whom the applicant or recipient is applying. An assignment is effective the same date the county office enters the eligibility information into the automated benefit calculation system or into the X-PERT system and is effective for the entire period for which eligibility is granted. Support payments not intended for medical support shall not be assigned to the department.

75.14(5) Referrals to the child support recovery unit for Medicaid applicants or recipients. The county office shall provide prompt notice to the child support recovery unit whenever assistance is furnished with respect to a child whose eligibility is based on the continued absence of a parent from the home or when any member of the eligible group is entitled to support payments.

"Prompt notice" means within two working days of the date assistance is approved.

75.14(6) Pregnant women establishing eligibility under the mothers and children (MAC) coverage group as provided at subrule 75.1(28) shall be exempt from the provisions in this rule for any born child for whom the pregnant woman applies for or receives Medicaid. Additionally, any previously pregnant woman eligible for postpartum coverage under the provision of subrule 75.1(24) shall not be subject to the provisions in this rule until after the end of the month in which the 60-day postpartum period expires. Pregnant women establishing eligibility under any other coverage groups except those set forth in subrule 75.1(24) or 75.1(28) shall be subject to the provisions in this rule when establishing eligibility for born children. A pregnant woman applying for or receiving Medicaid under any coverage group which requires her cooperation in establishing paternity and obtaining medical support for born children shall not be eligible under any other coverage group if she fails to cooperate without good cause.

75.14(7) Notwithstanding subrule 75.14(6), any pregnant woman or previously pregnant woman establishing eligibility under subrule 75.1(28) or 75.1(24) shall not be exempt from the provisions of 75.14(4) and 75.14(5) which require the applicant or recipient to assign any rights to medical support and payments for medical care and to be referred to the child support recovery unit.

75.14(8) Good cause for refusal to cooperate. Good cause shall exist when it is determined that cooperation in establishing paternity and securing support is against the best interests of the child.

a. The county office shall determine that cooperation is against the child's best interest when the applicant's or recipient's cooperation in establishing paternity or securing support is reasonably anticipated to result in:

(1) Physical or emotional harm to the child for whom support is to be sought; or

(2) Physical or emotional harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately.

(3) Physical harm to the parent or specified relative with whom the child is living which reduces the person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or specified relative with whom the child is living of a nature or degree that it reduces the person's capacity to care for the child adequately.

b. The county office shall determine that cooperation is against the child's best interest when at least one of the following circumstances exists, and the county office believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure support would be detrimental to the child for whom support would be sought.

(1) The child was conceived as the result of incest or forcible rape.

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction.

(3) The applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep the child or relinquish the child for adoption, and the discussions have not gone on for more than three months.

c. Physical harm and emotional harm shall be of a serious nature in order to justify a finding of good cause. A finding of good cause for emotional harm shall be based only upon a demonstration of an emotional impairment that substantially affects the individual's functioning.

d. When the good cause determination is based in whole or in part upon the anticipation of emotional harm to the child, the parent, or the specified relative, the following shall be considered:

(1) The present emotional state of the individual subject to emotional harm.

(2) The emotional health history of the individual subject to emotional harm.

(3) Intensity and probable duration of the emotional impairment.

(4) The degree of cooperation required.

(5) The extent of involvement of the child in the paternity establishment or support enforcement activity to be undertaken.

75.14(9) Claiming good cause. Each applicant for or recipient of Medicaid who is required to cooperate with the child support recovery unit shall have the opportunity to claim good cause for refusing to cooperate in establishing paternity or securing support payments.

a. Prior to requiring cooperation, the county office shall notify the applicant or recipient on Form CS-1105-5, Requirements of Support Enforcement, of the right to claim good cause as an exception to the cooperation requirement and of all the requirements applicable to a good cause determination. One copy of this form shall be given to the applicant or recipient and one copy shall be signed by the applicant or recipient and the worker and filed in the case record.

b. The initial notice advising of the right to refuse to cooperate for good cause shall:

(1) Advise the applicant or recipient of the potential benefits the child may derive from the establishment of paternity and securing support.

(2) Advise the applicant or recipient that by law cooperation in establishing paternity and securing support is a condition of eligibility for the Medicaid program.

(3) Advise the applicant or recipient of the sanctions provided for refusal to cooperate without good cause.

(4) Advise the applicant or recipient that good cause for refusal to cooperate may be claimed and that if the county office determines, in accordance with these rules, that there is good cause, the applicant or recipient will be excused from the cooperation requirement.

(5) Advise the applicant or recipient that upon request, or following a claim of good cause, the county office will provide further notice with additional details concerning good cause.

c. When the applicant or recipient makes a claim of good cause or requests additional information regarding the right to file a claim of good cause, the county office shall issue a second notice, Form CS-1106-5, Requirements of Claiming Good Cause. When the applicant or recipient chooses to claim good cause, Form CS-1106-5 shall be signed and dated by the client and returned to the county office. This form:

(1) Indicates that the applicant or recipient must provide corroborative evidence of good cause circumstance and must, when requested, furnish sufficient information to permit the county office to investigate the circumstances.

(2) Informs the applicant or recipient that, upon request, the county office will provide reasonable assistance in obtaining the corroborative evidence.

(3) Informs the applicant or recipient that on the basis of the corroborative evidence supplied and the agency's investigation when necessary, the county office shall determine whether cooperation would be against the best interests of the child for whom support would be sought.

(4) Lists the circumstances under which cooperation may be determined to be against the best interests of the child.

(5) Informs the applicant or recipient that the child support recovery unit may review the county office's findings and basis for a good cause determination and may participate in any hearings concerning the issue of good cause.

(6) Informs the applicant or recipient that the child support recovery unit may attempt to establish paternity and collect support in those cases where the county office determines that this can be done without risk to the applicant or recipient if done without the applicant's or recipient's participation.

d. The applicant or recipient who refuses to cooperate and who claims to have good cause for refusing to cooperate has the burden of establishing the existence of a good cause circumstance. Failure to meet these requirements shall constitute a sufficient basis for the county office to determine that good cause does not exist. The applicant or recipient shall:

(1) Specify the circumstances that the applicant or recipient believes provide sufficient good cause for not cooperating.

(2) Corroborate the good cause circumstances.

(3) When requested, provide sufficient information to permit an investigation.

75.14(10) Determination of good cause. The county office shall determine whether good cause exists for each applicant for or recipient of the Medicaid program who claims to have good cause.

a. The applicant or recipient shall be notified by the county office of its determination that good cause does or does not exist. The determination shall:

(1) Be in writing.

(2) Contain the county office's findings and basis for determination.

(3) Be entered in the case record.

b. The determination of whether or not good cause exists shall be made within 45 days from the day the good cause claim is made. The county office may exceed this time standard only when:

(1) The case record documents that the county office needs additional time because the information required to verify the claim cannot be obtained within the time standard, or

(2) The case record documents that the claimant did not provide corroborative evidence within the time period set forth in subrule 75.14(11).

c. When the county office determines that good cause does not exist:

(1) The applicant or recipient shall be so notified and afforded an opportunity to cooperate, withdraw the application for assistance, or have the case closed; and

(2) Continued refusal to cooperate will result in the imposition of sanctions.

d. The county office shall make a good cause determination based on the corroborative evidence supplied by the applicant or recipient only after it has examined the evidence and found that it actually verifies the good cause claim.

e. Prior to making a final determination of good cause for refusing to cooperate, the county office shall:

(1) Afford the child support recovery unit the opportunity to review and comment on the findings and basis for the proposed determination, and

(2) Consider any recommendation from the child support recovery unit.

f. The child support recovery unit may participate in any appeal hearing that results from an applicant's or recipient's appeal of an agency action with respect to a decision on a claim of good cause.

g. Assistance shall not be denied, delayed, or discontinued pending a determination of good cause for refusal to cooperate when the applicant or recipient has specified the circumstances under which good cause can be claimed and provided the corroborative evidence and any additional information needed to establish good cause.

h. The county office shall:

(1) Periodically, but not less frequently than every six months, review those cases in which the agency has determined that good cause exists based on a circumstance that is subject to change.

(2) When it determines that circumstances have changed so that good cause no longer exists, rescind its findings and proceed to enforce the requirements pertaining to cooperation in establishing paternity and securing support.

75.14(11) Proof of good cause. The applicant or recipient who claims good cause shall provide corroborative evidence within 20 days from the day the claim was made. In exceptional cases where the county office determines the applicant or recipient requires additional time because of the difficulty in obtaining the corroborative evidence, the county office shall allow a reasonable additional period of time upon approval by the worker's immediate supervisor.

a. A good cause claim may be corroborated with the following types of evidence.

(1) Birth certificates or medical or law enforcement records which indicate that the child was conceived as the result of incest or forcible rape.

(2) Court documents or other records which indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.

(3) Court, medical, criminal, child protective services, social services, psychological, or law enforcement records which indicate that the putative father or absent parent might inflict physical or emotional harm on the child or specified relative.

(4) Medical records which indicate emotional health history and present emotional health status of the specified relative or the children for whom support would be sought; or written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the specified relative or the child for whom support would be sought.

(5) A written statement from a public or licensed private social agency that the applicant or recipient is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.

(6) Sworn statements from individuals other than the applicant or recipient with knowledge of the circumstances which provide the basis for the good cause claim.

b. When, after examining the corroborative evidence submitted by the applicant or recipient, the county office wishes to request additional corroborative evidence which is needed to permit a good cause determination, the county office shall:

(1) Promptly notify the applicant or recipient that additional corroborative evidence is needed, and

(2) Specify the type of document which is needed.

c. When the applicant or recipient requests assistance in securing evidence, the county office shall:

(1) Advise the applicant or recipient how to obtain the necessary documents, and

(2) Make a reasonable effort to obtain any specific documents which the applicant or recipient is not reasonably able to obtain without assistance.

d. When a claim is based on the applicant's or recipient's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

(1) The county office shall investigate the good cause claim when the office believes that the claim is credible without corroborative evidence and corroborative evidence is not available.

(2) Good cause shall be found when the claimant's statement and investigation which is conducted satisfies the county office that the applicant or recipient has good cause for refusing to cooperate.

(3) A determination that good cause exists shall be reviewed and approved or disapproved by the worker's immediate supervisor and the findings shall be recorded in the case record.

e. The county office may further verify the good cause claim when the applicant's or recipient's statement of the claim together with the corroborative evidence do not provide sufficient basis for making a determination. When the county office determines that it is necessary, it may conduct an investigation of good cause claims to determine that good cause does or does not exist.

f. When it conducts an investigation of a good cause claim, the county office shall:

(1) Contact the absent parent or putative father from whom support would be sought when the contact is determined to be necessary to establish the good cause claim.

(2) Prior to making the necessary contact, notify the applicant or recipient so the applicant or recipient may present additional corroborative evidence or information so that contact with the parent or putative father becomes unnecessary, withdraw the application for assistance or have the case closed, or have the good cause claim denied.

75.14(12) Enforcement without specified relative's cooperation. When the county office makes a determination that good cause exists, it shall also make a determination of whether or not child support enforcement can proceed without risk of harm to the child or specified relative when the enforcement or collection activities do not involve their participation.

a. Prior to making the determination, the child support recovery unit shall have an opportunity to review and comment on the findings and basis for the proposed determination and the county office shall consider any recommendations from the unit.

b. The determination shall be in writing, contain the county office's findings and basis or the determination, and be entered into the case record.

c. When the county office excuses cooperation but determines that the child support recovery unit may proceed to establish paternity or enforce support, it shall notify the applicant or recipient to enable the individual to withdraw the application for assistance or have the case closed.

This rule is intended to implement Iowa Code sections 239.5 and 249A.4.

441—75.15(249A) Disposal of resources for less than fair market value on or after July 1, 1989, or on or after October 1, 1989, between spouses, and on or before August 10, 1993.

75.15(1) In determining Medicaid eligibility for persons described in 441—Chapters 75, 83, and 86, transfers of resources occurring on or after October 1, 1989, between spouses or on or after July 1, 1989, between others, and on or before August 10, 1993, will affect Medicaid payment for medical services as provided in this rule. Resources transferred by an institutionalized person or an institutionalized person's spouse during or after the 30-month period before the date the person entered the medical institution (for persons eligible for Medicaid on that date), or (for persons not eligible on that date), the date application is made while a person is residing in a medical institution, shall disqualify the institutionalized person for Medicaid payment of nursing facility services and for a level of care in a medical institution equivalent to that of nursing facility services and for home- and community-based waiver services with these exceptions:

a. The transfer of resources was between spouses or to another for the sole benefit of the institutionalized person's spouse on or after October 1, 1989.

b. Rescinded IAB 3/7/90, effective 5/1/90.

c. The transfer of resources was pursuant to a court order against the institutionalized spouse for the support of a community spouse and the resources were transferred for the support of the community spouse, or for the support of a minor or dependent child, dependent parent, or dependent sibling of the institutionalized or community spouse residing with the community spouse.

d. The resource transferred was a home and the home was transferred to any of the following:

(1) The spouse of the institutionalized person.

(2) A child of the institutionalized person who is under age 21, or who is blind or disabled as defined under Section 1614 of the Social Security Act.

(3) A sibling of the institutionalized person who has an equity interest in the home and who was residing in the home for a period of at least one year immediately before the date the person became an "institutionalized person" or eligible for home- and community-based waiver.

(4) A son or daughter of the institutionalized person who was residing in the person's home for a period of at least two years immediately before the date the person became an institutionalized person and who provided care to the person which permitted the person to reside at home rather than in a medical institution.

e. The transfer of resources was to the institutionalized person's blind or disabled child as defined under Section 1614 of the Social Security Act.

f. The transferor makes a satisfactory showing that the transferor intended to dispose of the resource either at fair market value or for other valuable consideration, or that the resource was transferred exclusively for another purpose other than to establish eligibility for Medicaid.

g. It is determined that denial of eligibility would work an undue hardship under 75.15(3).

75.15(2) Unless exempt, the transfer of resources will result in 30 months of ineligibility beginning with the month of transfer, or a lesser period determined by dividing the total uncompensated value of resources transferred by the average statewide cost of nursing facility services to a private pay resident at the time of application.

a. When there is more than one transfer of resources within the 30 months before application for nursing facility care or home- and community-based waiver services or after assistance is granted for nursing facility care or HCBW services, and the penalty periods for the multiple transfers overlap, the uncompensated value of the transferred resources shall be added together to determine the period of ineligibility. The penalty period shall begin with the month of the first transfer, and the period shall not exceed 30 months from the last transfer.

b. The average statewide cost to a private pay resident shall be determined by the department and updated annually for nursing facilities.

For the period from July 1, 1998, through June 30, 1999, this average statewide cost shall be $2,567.77 per month or $84.42 per day.

75.15(3) Undue hardship in denying eligibility will exist only where both of the following conditions are met:

a. The person who transferred the resource or the person's spouse has exhausted all means including legal remedies and consultation with an attorney to recover the resource.

b. The person's remaining available resources (after the attribution for the community spouse) are less than the monthly statewide average cost of nursing facility services to a private pay resident. The value of all resources is counted except for:

(1) The home if occupied by a dependent relative, or a doctor verifies that the person is expected to return home.

(2) Household goods.

(3) A vehicle required by the client for transportation.

(4) Funds for burial of $4,000 or less.

Hardship will not be found if the resource was transferred to a person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless the client demonstrates the payments cannot be obtained from the funds of the person who handled the financial affairs to pay for nursing facility services.

This rule is intended to implement Iowa Code section 249A.4.

441—75.16(249A) Client participation in payment for medical institution care. Medicaid clients are required to participate in the cost of medical institution care. However, no client participation is charged when the combination of Medicare payments and the Medicaid benefits available to qualified Medicare beneficiaries covers the cost of institutional care.

75.16(1) *Income considered in determining client participation.* The department determines the amount of client participation based on the client's total monthly income, with the following exceptions:

a. FMAP-related clients. The income of a client and family whose eligibility is FMAP-related is not available for client participation when both of the following conditions exist:

(1) The client has a parent or child at home.

(2) The family's income is considered together in determining eligibility.

b. SSI-related clients who are employed. If a client receives SSI and is substantially gainfully employed, as determined by the Social Security Administration, the client shall have the SSI and any mandatory state supplementary assistance payment exempt from client participation for the two full months after entry to a medical institution.

c. SSI-related clients returning home within three months. If the Social Security Administration continues a client's SSI or federally administered state supplementary assistance payments for three months because it is expected that the client will return home within three months, these payments shall be exempt from client participation.

d. Married couples.

(1) Institutionalized spouse and community spouse. If there is a community spouse, only the institutionalized person's income shall be considered in determining client participation.

(2) Both spouses institutionalized. Client participation for each partner in a marriage shall be based on one-half of the couple's combined income when the partners are considered together for eligibility. Client participation for each partner who is considered individually for eligibility shall be determined individually from each person's income.

(3) Rescinded, IAB 7/11/90, effective 7/1/90.

e. State supplementary assistance recipients. The amount of client participation that a client paid under the state supplementary assistance program is not available for Medicaid client participation in the month of the client's entry to a medical institution.

f. Foster care recipients. The amount of income paid for foster care for the days that a child is in foster care in the same month as entry to a medical institution is not available for client participation.

75.16(2) *Allowable deductions from income.* In determining the amount of client participation, the department allows the following deductions from the client's income, taken in the order they appear:

a. Ongoing personal needs allowance. All clients shall retain $30 of their monthly income for a personal needs allowance with the following exception. If the client is a veteran or surviving spouse of a veteran who receives a Veterans' Administration pension subject to limitation of $90 after the month of entry pursuant to 38 U.S.C. Section 3203(f)(2), the veteran or surviving spouse of a veteran shall retain $90 from the veteran's pension for their personal needs allowance beginning the month after entry to a medical institution. The $90 allowance from a veteran's pension is in lieu of the $30 allowance from any income, not in addition thereto.

If the client has earned income, an additional $65 is added to the ongoing personal needs allowance from the earned income only.

b. Personal needs in the month of entry.

(1) Single person. A single person shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a single person.

(2) Spouses entering institutions together and living together. Partners in a marriage who enter a medical institution in the same month and live in the same room shall be given an allowance for stated home living expenses during the month of entry, up to the amount of the SSI benefit for a couple.

(3) Spouses entering an institution together but living apart. Partners in a marriage who enter a medical institution during the same month and who are considered separately for eligibility shall each be given an allowance for stated home living expenses during the month of entry, up to one-half of the amount of the SSI benefit for a married couple. However, if the income of one spouse is less than one-half of the SSI benefit for a couple, the remainder of the allowance shall be given to the other spouse. If the couple's eligibility is determined together, an allowance for stated home living expenses shall be given to them during the month of entry up to the SSI benefit for a married couple.

(4) Community spouse enters a medical institution. When the second member of a married couple enters a medical institution in a later month, that spouse shall be given an allowance for stated expenses during the month of entry, up to the amount of the SSI benefit for one person.

c. Personal needs in the month of discharge. The client shall be allowed a deduction for home living expenses in the month of discharge. The amount of the deduction shall be the SSI benefit for one person (or for a couple, if both members are discharged in the same month). This deduction does not apply when a spouse is at home.

d. Maintenance needs of spouse and other dependents.

(1) Persons covered. An ongoing allowance shall be given for the maintenance needs of a community spouse. The allowance is limited to the extent that income of the institutionalized spouse is made available to or for the benefit of the community spouse. If there are minor or dependent children, dependent parents, or dependent siblings of either spouse who live with the community spouse, an ongoing allowance shall also be given to meet their needs.

(2) Income considered. The verified gross income of the spouse and dependents shall be considered in determining maintenance needs. The gross income of the spouse and dependent shall include all monthly earned and unearned income and assistance from the family investment program (FIP), supplemental security income (SSI), and state supplementary assistance (SSA). It shall also include the proceeds of any annuity or contract for sale of real property. Otherwise, the income shall be considered as the SSI program considers income. In addition, the spouse and dependents shall be required to apply for every income benefit for which they are eligible except that they shall not be required to accept SSI, FIP or SSA in lieu of the maintenance needs allowance. Failure to apply for all benefits shall mean reduction of the maintenance needs allowance by the amount of the anticipated income from the source not applied for.

(3) Needs of spouse. The maintenance needs of the spouse shall be determined by subtracting the spouse's gross income from $2,019. (This amount shall be indexed for inflation annually according to the consumer price index.)

However, if either spouse established through the appeal process that the community spouse needs income above $2,019, due to exceptional circumstances resulting in significant financial duress, an amount adequate to provide additional income as is necessary shall be substituted.

Also, if a court has entered an order against an institutionalized spouse for monthly income to support the community spouse, then the community spouse income allowance shall not be less than this amount.

(4) Needs of other dependents. The maintenance needs of the other dependents shall be established by subtracting each person's gross income from 133 percent of the monthly federal poverty level for a family of two and dividing the result by three. (Effective July 1, 1992, the percent shall be 150 percent.)

e. Maintenance needs of children (without spouse). When the client has children under 21 at home, an ongoing allowance shall be given to meet the children's maintenance needs.

The income of the children is considered in determining maintenance needs. The children's countable income shall be their gross income less the disregards allowed in the FIP program.

The children's maintenance needs shall be determined by subtracting the children's countable income from the FIP payment standard for that number of children. (However, if the children receive FIP, no deduction is allowed for their maintenance needs.)

f. Client's medical expenses. A deduction shall be allowed for the client's incurred expenses for medical or remedial care that are not subject to payment by a third party. This includes Medicare premiums and other health insurance premiums, deductibles or coinsurance, and necessary medical or remedial care recognized under state law but not covered under the state Medicaid plan.

This rule is intended to implement Iowa Code sections 239.5 and 249A.4.

441—75.17(249A) Verification of pregnancy. For the purpose of establishing Medicaid eligibility for pregnant women under this chapter, a signed statement from a maternal health center, family planning agency, physician's office, physician-directed qualifying provider, or advanced registered nurse practitioner who is a certified nurse midwife, as specified under the federal Social Security Act, Subsection 1902, shall serve as verification of pregnancy. Additionally, the number of fetuses shall be verified if more than one exists, and the probable date of conception shall be established when necessary to determine eligibility. When an examination is required and other medical resources are not available to meet the expense of the examination, the provider shall be authorized to make the examination and submit the claim for payment.

441—75.18(249A) Continuous eligibility for pregnant women. A pregnant woman who applies for Medicaid prior to the end of her pregnancy and subsequently establishes initial Medicaid eligibility under the provisions of this chapter shall remain continuously eligible throughout the pregnancy and the 60-day postpartum period, as provided in subrule 75.1(24), regardless of any changes in family income.

441—75.19(249A) Persons who may be excluded from the eligible group in determining FIP-related Medicaid eligibility. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.20(249A) Disability requirements for SSI-related Medicaid.

75.20(1) *Applicants receiving federal benefits.* An applicant receiving supplemental security income on the basis of disability, social security disability benefits under Title II of the Social Security Act, or railroad retirement benefits based on the Social Security law definition of disability by the Railroad Retirement Board, shall be deemed disabled without further determination of disability.

75.20(2) *Applicants not receiving federal benefits.* When disability has not been established based on the receipt of social security disability or railroad retirement benefits based on the same disability criteria as used by the Social Security Administration, the department shall determine eligibility for SSI-related Medicaid based on disability as follows:

a. A Social Security Administration (SSA) disability determination under either a social security disability (Title II) application or a supplemental security income application is binding on the department until changed by SSA unless the applicant meets one of the following criteria:

(1) The applicant alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination.

(2) The applicant alleges more than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements, and has not applied to SSA for a determination with respect to these allegations.

(3) The applicant alleges less than 12 months after the most recent SSA determination denying disability that the applicant's condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements, and:

1. The applicant has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations, or

2. The applicant no longer meets the nondisability requirements for SSI but may meet the department's nondisability requirements for Medicaid eligibility.

b. When there is no binding SSA decision and the department is required to establish eligibility for SSI-related Medicaid based on disability, initial determinations shall be made by disability determination services, a bureau of the Iowa department of education under the division of vocational rehabilitation services.

A disability report shall be completed by the client on Form 470-2465, Disability Report. A signed release, Form 470-2467, Authorization for Source to Release Information to the Department of Human Services, shall be completed for each medical source listed on the Disability Report.

c. When an SSA decision on disability is pending when the person applies for Medicaid or when the person applies for either Title II benefits or SSI within ten working days of the Medicaid application, the department shall stay a decision on disability pending the SSA decision on disability.

75.20(3) *Time frames for decisions.* Determination of eligibility based on disability shall be completed within 90 days unless the applicant or an examining physician delays or fails to take a required action, or there is an administrative or other emergency beyond the department's or applicant's control.

75.20(4) *Redeterminations of disability.* In connection with any independent determination of disability, the department will determine whether reexamination of the person's medical condition will be necessary for periodic redeterminations of eligibility.

75.20(5) *Recipients whose disability was determined by the department.* When a Medicaid recipient has been approved for Medicaid based on disability determined by the department and later is determined by SSA not to be disabled for SSI, the recipient shall continue to be considered disabled for Medicaid eligibility purposes for 65 days from the date of the SSA denial. If at the end of the 65 days there is no appeal to the SSA, Medicaid shall be canceled with timely notice. If there is an appeal within 65 days, the recipient shall continue to be considered disabled for Medicaid eligibility purposes until a final SSA decision.

This rule is intended to implement Iowa Code section 249A.4.

441—75.21(249A) Health insurance premium payment program. The department shall pay for the cost of enrolling an eligible Medicaid recipient in a health insurance plan when the department determines it is cost-effective to do so.

75.21(1) *Condition of eligibility.* The recipient, or a person acting on the recipient's behalf, shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of group health insurance. Persons who are eligible to enroll in a group health insurance plan which the department has determined is cost-effective, and who are otherwise eligible for Medicaid, shall apply for enrollment in the plan as a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid-eligible persons through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

When a parent fails to provide information necessary to determine availability and cost-effectiveness of group health insurance, fails to enroll in a group health insurance plan that has been determined cost-effective, or disenrolls from a group health insurance plan the department has determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

a. There was a serious illness or death of the parent or a member of the parent's family.

b. There was a family emergency or household disaster, such as a fire, flood, or tornado.

c. The parent offers a good cause beyond the parent's control.

d. There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of the spouse of the employed person shall not be terminated due to the employed person's failure to cooperate when the spouse cannot enroll in the plan independently of the employed person.

The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) *Non-employer related health insurance plans.* Participation in a health insurance plan that is not group health insurance as defined in rule 441—75.25(249A) is not a condition of Medicaid eligibility.

75.21(3) *Cost-effectiveness.* Cost-effectiveness shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under an insurance plan for those services. When determining the cost-effectiveness of the insurance plan, the following data shall be considered:

a. The cost of the insurance premium, coinsurance and deductibles. An employer-related group health insurance plan that provides major medical coverage and costs $50 or less per month shall be determined cost-effective when establishing eligibility for one-person Medicaid-eligible households. An employer-related group health insurance plan that provides major medical coverage and costs $100 or less per month shall be determined cost-effective when establishing eligibility for households of two or more Medicaid-eligible persons.

b. The scope of services covered under the insurance plan, including exclusions for preexisting conditions, etc.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for persons covered under the insurance plan.

d. The specific health-related circumstances of the persons covered under the insurance plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. Employer-related group health insurance plans that provide major medical coverage shall be determined cost-effective when there is a Medicaid-eligible pregnant woman who can be covered under the plan.

e. Annual administrative expenditures of $50 per Medicaid recipient covered under the health insurance policy.

f. Whether the estimated savings to Medicaid for persons covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.* When it is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However, the needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness and payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in 441—Chapter 86, when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made.

g. The person is eligible only for limited Medicaid services under the specified low-income Medicare beneficiary (SLMB) coverage group, in accordance with subrule 75.1(34).

h. Insurance coverage is being provided through the Iowa Comprehensive Health Insurance Association, in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

75.21(6) *Duplicate policies.* When more than one cost-effective health insurance plan or policy is available, the department shall pay the premium for only one plan. The recipient may choose in which cost-effective plan to enroll. However, in situations where the department is buying in to the cost of Medicare Part A or Part B for eligible Medicare beneficiaries, the cost of premiums for a Medicare supplemental insurance policy may also be paid if the department determines it is likely to be cost-effective to do so.

75.21(7) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, a review shall be completed in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If it is determined the policy is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, premium payment shall be discontinued pending timely and adequate notice.

d. If the policyholder leaves the household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance coverage is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) *Effective date of premium payment.* The effective date of premium payments for cost-effective health insurance plans shall be determined as follows:

a. Premium payments shall begin no earlier than the first day of the month in which the Employer's Statement of Earnings, Form 470-2844, or the Health Insurance Premium Payment Application, Form 470-2875, is received by the division of medical services or the first day of the first month in which the plan is determined to be cost-effective, whichever is later.

b. If the person is not enrolled in the plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the policy is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time prior to the current effective date of coverage.

d. In no case shall payments be made for premiums which were used as a deduction to income when determining client participation, the amount of the spenddown obligation, or for premiums due for periods of time covered prior to July 1, 1991.

The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and premiums for persons enrolled in group health insurance plans.

75.21(9) *Method of premium payment.* Payments of health insurance premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to the employer in order to circumvent a payroll deduction.

b. When the employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the policyholder directly for payroll deductions or for payments made directly to the employer for the payment of health insurance premiums.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for said withdrawals.

d. When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall reimburse the policyholder for premium payments made to the entity.

75.21(10) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) *Reviews of cost-effectiveness.* Reviews of cost-effectiveness shall be completed annually or at the time of the next health insurance contract renewal date for employer-related group health plans. Reviews may be conducted more frequently at the discretion of the department. The Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, shall be used for this purpose.

Reviews of cost-effectiveness shall be completed annually for non-employer-related group health plans. The recipient shall sign the Insurance Carrier Authorization to Release Information, Form 470-3015, as part of the review of non-employer-related plans so that the department may obtain pertinent information necessary to establish continued eligibility.

Failure of the policyholder to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

Redeterminations shall also be completed whenever a predetermined premium rate, deductible, or coinsurance increases, some of the persons covered under the policy lose full Medicaid eligibility, employment terminates or hours are reduced which affects the availability of health insurance, the insurance carrier changes, the policyholder leaves the home, or there is a decrease in the services covered under the policy. The policyholder shall report changes that may affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person. A HIPP Change Report, Form 470-3007, shall accompany all premium payments.

When employment terminates, hours of employment are reduced, or some other qualifying event affecting the availability of health insurance coverage occurs, the department shall verify whether insurance may be continued under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, the Family Leave Act, or other insurance continuation provisions. The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose. If cost-effective, the department shall pay premiums to maintain insurance coverage for eligible Medicaid recipients after the occurrence of the qualifying event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the insurance plan and notify the recipient of the decision regarding payment of the premiums within 65 days from the date an Employer's Statement of Earnings, Form 470-2844, indicating the availability of group insurance or a Health Insurance Premium Payment Application, Form 470-2875, is received. Additional time may be granted when, for reasons beyond the control of the department or the recipient, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.* An adequate notice shall be provided to the household under the following circumstances:

a. To inform the household of the initial decision on cost-effectiveness and premium payment.

b. To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy.

c. The policy is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

A timely and adequate notice shall be provided to the household informing them of a decision to discontinue payment of the health insurance premium because the department has determined the policy is no longer cost-effective or because the recipient has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the policy lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the recipient's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs.

441—75.22(249A) AIDS/HIV health insurance premium payment program. For the purposes of this rule, "AIDS" and "HIV" are defined in accordance with Iowa Code section 141.21.

75.22(1) *Conditions of eligibility.* The department shall pay for the cost of continuing health insurance coverage to persons with AIDS or HIV-related illnesses when the following criteria are met:

a. The person with AIDS or HIV-related illness shall be the policyholder, or the spouse of the policyholder, of an individual or group health plan.

b. The person shall be a resident of Iowa in accordance with the provisions of rule 441—75.10(249A).

c. The person shall not be eligible for Medicaid. The person shall be required to apply for Medicaid benefits when it appears Medicaid eligibility may exist. Persons who are required to meet a spend-down obligation under the medically needy program, as provided in 441—Chapter 86, are not considered Medicaid-eligible for the purpose of establishing eligibility under these provisions.

When Medicaid eligibility is attained, premium payments shall be made under the provisions of rule 441—75.21(249A) if all criteria of that rule are met.

d. A physician's statement shall be provided verifying the policyholder or the spouse of the policyholder suffers from AIDS or an HIV-related illness. The physician's statement shall also verify that the policyholder or the spouse of the policyholder is or will be unable to continue employment in the person's current position or that hours of employment will be significantly reduced due to AIDS or HIV-related illness. The Physician's Verification of Diagnosis, Form 470-2958, shall be used to obtain this information from the physician.

e. Gross income shall not exceed 300 percent of the federal poverty level for a family of the same size. The gross income of all family members shall be counted using the definition of gross income under the supplemental security income (SSI) program.

f. Liquid resources shall not exceed $10,000 per household. The following are examples of countable resources:

(1) Unobligated cash.

(2) Bank accounts.

(3) Stocks, bonds, certificates of deposit, excluding Internal Revenue Service defined retirement plans.

g. The health insurance plan must be cost-effective based on the amount of the premium and the services covered.

75.22(2) *Application process.*

a. Application. Persons applying for participation in this program shall complete the AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953. The applicant shall be required to provide documentation of income and assets. The application shall be available from and may be filed at any county departmental office or at the Division of Medical Services, Department of Human Services, Hoover State Office Building, Des Moines, Iowa 50319-0114.

An application shall be considered as filed on the date an AIDS/HIV Health Insurance Premium Payment Application, Form 470-2953, containing the applicant's name, address and signature is received and date-stamped in any county departmental office or the division of medical services.

b. Time limit for decision. Every reasonable effort will be made to render a decision within 30 days. Additional time for rendering a decision may be taken when, due to circumstances beyond the control of the applicant or the department, a decision regarding the applicant's eligibility cannot be reached within 30 days (e.g., verification from a third party has not been received).

c. Eligible on the day of decision. No payments will be made for current or retroactive premiums if the person with AIDS or an HIV-related illness is deceased prior to a final eligibility determination being made on the application, if the insurance plan has lapsed, or if the person has otherwise lost coverage under the insurance plan.

d. Waiting list. After funds appropriated for this purpose are obligated, pending applications shall be denied by the division of medical services. A denial shall require a notice of decision to be mailed within ten calendar days following the determination that funds have been obligated. The notice shall state that the applicant meets eligibility requirements but no funds are available and that the applicant will be placed on the waiting list, or that the applicant does not meet eligibility requirements. Applicants not awarded funding who meet the eligibility requirements will be placed on a statewide waiting list according to the order in which the completed applications were filed. In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the day of the month of the applicant's birthday, lowest number being first on the waiting list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

75.22(3) *Presumed eligibility.* The applicant may be presumed eligible to participate in the program for a period of two calendar months or until a decision regarding eligibility can be made, whichever is earlier. Presumed eligibility shall be granted when:

a. The application is accompanied by a completed Physician's Verification of Diagnosis, Form 470-2958.

b. The application is accompanied by a premium statement from the insurance carrier indicating the policy will lapse before an eligibility determination can be made.

c. It can be reasonably anticipated that the applicant will be determined eligible from income and resource statements on the application.

75.22(4) *Family coverage.* When the person is enrolled in a policy that provides health insurance coverage to other members of the family, only that portion of the premium required to maintain coverage for the policyholder or the policyholder's spouse with AIDS or an HIV-related illness shall be paid under this rule unless modification of the policy would result in a loss of coverage for the person with AIDS or an HIV-related illness.

75.22(5) *Method of premium payment.* Premiums shall be paid in accordance with the provisions of subrule 75.21(9).

75.22(6) *Effective date of premium payment.* Premium payments shall be effective with the month of application or the effective date of eligibility, whichever is later.

75.22(7) *Reviews.* The circumstances of persons participating in the program shall be reviewed quarterly to ensure eligibility criteria continues to be met. The AIDS/HIV Health Insurance Premium Payment Program Review, Form 470-2877, shall be completed by the recipient or someone acting on the recipient's behalf for this purpose.

75.22(8) *Termination of assistance.* Premium payments for otherwise eligible persons shall be paid under this rule until one of the following conditions is met:

a. The person becomes eligible for Medicaid. In which case, premium payments shall be paid in accordance with the provisions of rule 441—75.21(249A).

b. The insurance coverage is no longer available.

c. Maintaining the insurance plan is no longer considered the most cost-effective way to pay for medical services.

d. Funding appropriated for the program is exhausted.

e. The person with AIDS or an HIV-related illness dies.

f. The person fails to provide requested information necessary to establish continued eligibility for the program.

75.22(9) *Notices.*

a. An adequate notice as defined in 441—subrule 7.7(1) shall be provided under the following circumstances:

(1) To inform the applicant of the initial decision regarding eligibility to participate in the program.

(2) To inform the recipient that premium payments are being discontinued under these provisions because Medicaid eligibility has been attained and premium payments will be made under the provisions of rule 441—75.21(249A).

(3) To inform the recipient that premium payments are being discontinued because the policy is no longer available.

(4) To inform the recipient that premium payments are being discontinued because funding for the program is exhausted.

(5) The person with AIDS or an HIV-related illness dies.

b. A timely and adequate notice as defined in 441—subrule 7.7(1) shall be provided to the recipient informing the recipient of a decision to discontinue payment of the health insurance premium when the recipient no longer meets the eligibility requirements of the program or fails to cooperate in providing information to establish eligibility.

75.22(10) *Confidentiality.* The department shall protect the confidentiality of persons participating in the program in accordance with Iowa Code chapter 141. When it is necessary for the department to contact a third party to obtain information in order to determine initial or ongoing eligibility, a Consent to Release or Obtain Information, Form 470-0429, shall be signed by the recipient authorizing the department to make the contact.

This rule is intended to implement Iowa Code section 249A.4.

441—75.23(249A) Disposal of assets for less than fair market value after August 10, 1993. In determining Medicaid eligibility for persons described in 441—Chapters 75, 83, and 86, a transfer of assets occurring after August 10, 1993, will affect Medicaid payment for medical services as provided in this rule.

75.23(1) *Ineligibility for services.*

a. If an institutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date specified in 75.23(2), the institutionalized individual is ineligible for medical assistance for nursing facility services, a level of care in any institution equivalent to that of nursing facility services, and home- and community-based waiver services during the period beginning on the first day of the first month during or after which assets were transferred for less than fair market value and which does not occur in any other periods of ineligibility under this rule and equal to the number of months specified in 75.23(3).

b. If a noninstitutionalized individual or the spouse of the individual disposed of assets for less than fair market value on or after the look-back date specified in 75.23(2), the individual is ineligible for medical assistance for home health care services, home and community care for functionally disabled elderly individuals, personal care services, and other long-term care services during the period beginning on the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this rule and equal to the number of months specified in 75.23(3).

75.23(2) *Look-back date.* The look-back date is the date that is 36 months (or, in the case of payments from a trust or portion of a trust that are treated as assets disposed of by the individual, 60 months) before the date an institutionalized individual is both an institutionalized individual and has applied for medical assistance or the date the noninstitutionalized individual applies for medical assistance.

75.23(3) *Period of ineligibility.* The number of months of ineligibility shall be equal to the total cumulative uncompensated value of all assets transferred by the individual (or the individual's spouse) on or after the look-back date specified in 75.23(2), divided by the statewide average private pay rate for nursing facility services at the time of application. The statewide average private pay rate for nursing facility services is set forth at 75.15(2)*"b."*

75.23(4) *Reduction of period of ineligibility.* The number of months of ineligibility otherwise determined with respect to the disposal of an asset shall be reduced by the months of ineligibility applicable to the individual prior to a change in institutional status.

75.23(5) *Exceptions.* An individual shall not be ineligible for medical assistance, under this rule, to the extent that:

a. The assets transferred were a home and title to the home was transferred to either:

(1) A spouse of the individual.

(2) A child who is under the age of 21 or is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(3) A sibling of the individual who has an equity interest in the home and who was residing in the individual's home for a period of at least one year immediately before the individual became institutionalized.

(4) A son or daughter of the individual who was residing in the individual's home for a period of at least two years immediately before the date of institutionalization and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility.

b. The assets were transferred:

(1) To the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) From the individual's spouse to another for the sole benefit of the individual's spouse.

(3) To a trust established solely for the benefit of a child who is blind or permanently and totally disabled as defined in 42 U.S.C. Section 1382c.

(4) To a trust established solely for the benefit of an individual under 65 years of age who is disabled as defined in 42 U.S.C. Section 1382c.

c. A satisfactory showing is made that:

(1) The individual intended to dispose of the assets either at fair market value, or for other valuable consideration.

(2) The assets were transferred exclusively for a purpose other than to qualify for medical assistance.

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

d. The denial of eligibility would work an undue hardship as set forth in 75.15(3).

75.23(6) *Assets held in common.* In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by the individual when any action is taken, either by the individual or by any other person, that reduces or eliminates the individual's ownership or control of the asset.

75.23(7) *Transfer by spouse.* In the case of a transfer by a spouse of an individual which results in a period of ineligibility for medical assistance under the state plan for the individual, the period of ineligibility shall be apportioned between the individual and the individual's spouse if the spouse otherwise becomes eligible for medical assistance under the state plan. The remaining penalty period shall be evenly divided on a monthly basis, with any remaining month of penalty (prorated as a half month to each spouse) applied to the spouse who initiated the transfer action.

If a spouse subsequently dies prior to the end of the penalty period, the remaining penalty period shall be applied to the surviving spouse's period of ineligibility.

75.23(8) *Definitions.* In this rule the following definitions apply:

"Assets" shall include all income and resources of the individual and the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by:

1. The individual or the individual's spouse.

2. 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.

3. Any person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

"Income" shall be defined by 42 U.S.C. Section 1382a.

"Institutionalized individual" shall mean an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility or who is eligible for home- and community-based waiver services.

"Resources" shall be defined by 42 U.S.C. Section 1382b without regard (in the case of an institutionalized individual) to the exclusion of the home and land appertaining thereto.

This rule is intended to implement Iowa Code section 249A.4.

441—75.24(249A) Treatment of trusts established after August 10, 1993. For purposes of determining an individual's eligibility for, or the amount of, medical assistance benefits, trusts established after August 10, 1993, (except for trusts specified in 75.24(3)) shall be treated in accordance with 75.24(2).

75.24(1) *Establishment of trust.*

a. For the purposes of this rule, an individual shall be 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 any of the following individuals established the trust other than by will: the individual, the individual's spouse, 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 a person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

b. The term "assets," with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action by the individual or the individual's spouse, by a person (including a court or administrative body, with legal authority to act in place of or on behalf of the individual's spouse), or by any person (including a court or administrative body) acting at the direction or upon the request of the individual or the individual's spouse.

c. In the case of a trust, the principal of which includes assets of an individual and assets of any other person or persons, the provisions of this rule shall apply to the portion of the trust attributable to the individual.

d. This rule shall apply without regard to:

(1) The purposes for which a trust is established.

(2) Whether the trustees have or exercise any discretion under the trust.

(3) Any restrictions on when or whether distribution may be made for the trust.

(4) Any restriction on the use of distributions from the trust.

e. The term "trust" includes any legal instrument or device that is similar to a trust, including a conservatorship.

75.24(2) *Treatment of revocable and irrevocable trusts.*

a. In the case of a revocable trust:

(1) The principal of the trust shall be considered an available resource.

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

(3) Any other payments from the trust shall be considered assets disposed of by the individual, subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

b. In the case of an irrevocable trust:

(1) If there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the principal from which, or the income on the principal from which, payment to the individual could be made shall be considered an available resource to the individual and payments from that principal or income to or for the benefit of the individual shall be considered income to the individual. Payments for any other purpose shall be considered a transfer of assets by the individual subject to the penalties described at rule 441—75.23(249A) and 441—Chapter 89.

(2) 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 shall be 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 of by the individual subject to the penalties specified at 75.23(3) and 441—Chapter 89. The value of the trust shall be determined for this purpose by including the amount of any payments made from this portion of the trust after this date.

75.24(3) *Exceptions.* This rule shall not apply to any of the following trusts:

a. A trust containing the assets of an individual under the age of 65 who is disabled (as defined in Section 1614(a)(3) of the Social Security Act) and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court if the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual.

b. A trust established for the benefit of an individual if the trust is composed only of pension, social security, and other income to the individual (and accumulated income of the trust), and the state will receive all amounts remaining in the trust upon the death of the individual up to the amount equal to the total medical assistance paid on behalf of the individual.

For disposition of trust amounts pursuant to Iowa Code sections 633.707 to 633.711, the average statewide charges and Medicaid rates for the period from July 1, 1998, to June 30, 1999, shall be as follows:

(1) The average statewide charge to a private pay resident of a nursing facility is $2,397 per month.

(2) The average statewide charge to a private pay resident of a hospital-based skilled nursing facility is $7,471 per month.

(3) The average statewide charge to a private pay resident of a non-hospital-based skilled nursing facility is $3,671 per month.

(4) The average statewide Medicaid rate for a resident of an intermediate care facility for the mentally retarded is $8,319 per month.

(5) The average statewide charge to a resident of a mental health institute is $9,975 per month.

(6) The average statewide charge to a private pay resident of a psychiatric medical institution for children is $4,135 per month.

(7) The average statewide charge to a home- and community-based waiver applicant or recipient shall be consistent with the level of care determination and correspond with the average charges and rates set forth in this paragraph.

c. A trust containing the assets of an individual who is disabled (as defined in 1614(a)(3) of the Social Security Act) that meets the following conditions:

(1) The trust is established and managed by a nonprofit association.

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

(3) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in 1614(a)(3) of the Social Security Act) by the parent, grandparent, or legal guardian of the individuals, by the individuals or by a court.

(4) To the extent that amounts remaining in the beneficiary's account upon death of the beneficiary are not retained by the trust, the trust pays to the state from the remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary.

This rule is intended to implement Iowa Code section 249A.4.

441—75.25(249A) Definitions.

"Aged" shall mean a person 65 years of age or older.

"Applicant" shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Blind" shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

"Break in assistance" for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

"Central office" shall mean the state administrative office of the department of human services.

"Certification period" for medically needy shall mean the period of time not to exceed six consecutive months in which a person is eligible without a spenddown obligation, or not to exceed two consecutive months in which a person is conditionally eligible for Medicaid as medically needy.

"Client" shall mean an applicant for or a recipient of Medicaid.

"CMAP-related medically needy" shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

"Community spouse" shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.15(249A), 441—75.16(249A), and 441—76.10(249A).

"Conditionally eligible recipient" shall mean a medically needy person who has completed the application process and has been assigned a certification period and spenddown amount but who has not spent down for the certification period.

"Coverage group" shall mean a group of persons who meet certain common eligibility requirements.

"Department" shall mean the Iowa department of human services.

"Disabled" shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

"Eligible recipient" under the provisions of the medically needy program shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced excess income through spenddown to the MNIL during the certification period.

"FMAP-related medically needy" shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

"Group health insurance" shall mean any plan of, or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Health insurance" shall mean protection which provides payment of benefits for covered sickness or injury.

"Incurred medical expenses" for medically needy shall mean (1) medical bills paid by a recipient, responsible relative or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the recipient or responsible relative remains obligated.

"Institutionalized person" shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rules 441—75.5(249A) and 441—75.15(249A).

"Institutionalized spouse" shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.15(249A), 441—75.16(249A), and 441—76.10(249A).

"Local office" shall mean the county office of the department of human services or the mental health institute or hospital school.

"Medically needy income level (MNIL)" shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

"Necessary medical and remedial services" for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

"Noncovered Medicaid services" for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

"Nursing facility services" shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.15(249A).

"Obligated medical expense" for medically needy shall mean a medical expense for which the recipient or responsible relative continues to be legally liable.

"Ongoing eligibility" for medically needy shall mean that eligibility continues for an SSI-related medically needy person with a zero spenddown.

"Pay and chase" shall mean that the state pays the total amount allowed under the agency's payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

"Payee" refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

"Recertification" in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Recipient" shall mean a person who is receiving assistance including receiving assistance for another person.

"Responsible relative" for medically needy shall mean a spouse, parent, or stepparent living in the household of the eligible recipient.

"Retroactive certification period" for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

"Retroactive period" shall mean the three calendar months immediately preceding the month in which an application is filed.

"Spenddown" shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

"SSI-related" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

"SSI-related medically needy" shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

"Supply" shall mean the requested information is received by the department by the specified due date.

"Transfer of resources" shall mean transfer of resources for less than fair market value for the purposes of rule 441—75.15(249A). For example, a transfer of resources could include establishing a trust, contributing to a charity, removing a name from a resource, or reducing ownership interest in a resource.

"Unborn child" shall include an unborn child during the entire term of pregnancy.

"X-PERT" means an automated knowledge-based computer system that determines eligibility for Medicaid and other assistance programs.

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) *Class settlement payments.* Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) *Other settlement payments.* Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

441—75.28 to **75.49** Reserved.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

441—75.50(249A) Definitions.

"Applicant" shall mean a person who is requesting assistance on the person's own behalf or on behalf of another person, including recertification under the medically needy program. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

"Assistance unit" includes any person whose income is considered when determining eligibility.

"Bona fide offer" means an actual or genuine offer which includes a specific wage or a training opportunity at a specified place when used to determine whether the parent has refused an offer of training or employment.

"Budget month" means the calendar month from which the county office uses income or circumstances of the eligible group to calculate eligibility.

"Central office" shall mean the state administrative office of the department of human services.

"Change in income" means a permanent change in hours worked, rate of pay, or beginning or ending income.

"Change in work expenses" means a permanent change in the cost of dependent care or the beginning or ending of dependent care.

"Client" shall mean an applicant or recipient of Medicaid.

"Department" shall mean the Iowa department of human services.

"Income in-kind" is any gain or benefit which is not in the form of money payable directly to the eligible group including nonmonetary benefits, such as meals, clothing, and vendor payments. Vendor payments are money payments which are paid to a third party and not to the eligible group.

"Initial two months" means the first two consecutive months for which eligibility is granted.

"Medical institution," when used in this division, shall mean a facility which is organized to provide medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility's license. A medical institution may be public or private. Medical institutions include the following:

1. Hospitals.
2. Extended care facilities (skilled nursing).
3. Intermediate care facilities.
4. Mental health institutions.
5. Hospital schools.

"Nonrecurring lump sum unearned income" means a payment in the nature of a windfall, for example, an inheritance, an insurance settlement for pain and suffering, an insurance death benefit, a gift, lottery winnings, or a retroactive payment of benefits such as social security, job insurance or workers' compensation.

"Parent" means the natural or adoptive parent.

"Prospective budgeting" means the determination of eligibility and the amount of assistance for a calendar month based on the best estimate of income and circumstances which will exist in that calendar month.

"Recipient" means a person for whom Medicaid is received as well as parents living in the home with the eligible children and other specified relatives as defined in subrule 75.55(1) who are receiving Medicaid for the children. Unless otherwise specified, a person is not a recipient for any month in which the assistance issued for that person is subject to recoupment because the person was ineligible.

"Report month" for retrospective budgeting means the calendar month following the budget month. "Report month" for prospective budgeting means the calendar month in which a change occurs.

"Retrospective budgeting" means the calculation of eligibility for a month based on actual income and circumstances which existed in the budget month.

"Schedule of needs" means the total needs of a group as determined by the schedule of living costs, described at subrule 75.58(2).

"Stepparent" means a person who is the legal spouse of the child's natural or adoptive parent by ceremonial or common-law marriage.

"Suspension" means a month in which an otherwise ineligible household continues to remain eligible for one month when eligibility is expected to exist the following month.

"Unborn child" shall include an unborn child during the entire term of the pregnancy.

"Uniformed service" means the Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service of the United States.

441—75.51(249A) Reinstatement of eligibility. Eligibility for the family medical assistance program (FMAP) and FMAP-related programs shall be reinstated without a new application when all necessary information is provided at least three working days before the effective date of cancellation and eligibility can be reestablished, except as provided in the transitional Medicaid program in accordance with subparagraph 75.1(31)*"j"*(2).

Assistance may be reinstated without a new application when all necessary information is provided after the third working day but before the effective date of cancellation and eligibility can be reestablished before the effective date of cancellation.

When all eligibility factors are met, assistance shall be reinstated when a completed Public Assistance Eligibility Report, Form PA-2140-0, or a Review/Recertification Eligibility Document, Form 470-2881, is received by the county office within ten days of the date a cancellation notice is sent to the recipient because the form was incomplete or not returned.

441—75.52(249A) Continuing eligibility.

75.52(1) *Reviews.* Eligibility factors shall be reviewed at least every six months for the family medical assistance program and family medical assistance-related programs. A semiannual review shall be conducted using information contained in and verification supplied with Form PA-2140-0, Public Assistance Eligibility Report. A face-to-face interview shall be conducted at least annually at the time of a review using information contained in and verification supplied with Form 470-2881, Review/Recertification Eligibility Document.

a. Any assistance unit with one or more of the following characteristics shall report monthly:

(1) The assistance unit contains any member with earned income unless the income is exempt under paragraph 75.57(7)*"u,"* or the only earned income is from exempt work study, annualized self-employment, or Job Corps unless the participant is aged 20 or older.

(2) The assistance unit contains any member with a recent work history. A recent work history means the person received earned income during either one of the two calendar months immediately preceding the budget month, unless the income was exempt under paragraph 75.57(7)*"u,"* or the only earned income was from exempt work study, annualized self-employment, or Job Corps unless the participant is aged 20 or older.

(3) The assistance unit contains any member receiving nonexempt unearned income, the source or amount of which is expected to change more often than once annually, unless the income is from job insurance benefits or interest; or unless the assistance unit's adult members are 60 years old or older, or are receiving disability or blindness payments under Titles I, II, X, XIV, or XVI of the Social Security Act; or unless all adults, who would otherwise be members of the assistance unit, are receiving Supplemental Security Income (SSI) including state supplementary assistance (SSA).

(4) The assistance unit contains any member residing out of state on a temporary basis.

b. The assistance unit subject to monthly reporting shall complete a Public Assistance Eligibility Report (PAER), Form PA-2140-0, for each budget month, unless the assistance unit is required to complete Form 470-2881, Review/Recertification Eligibility Document (RRED) for that month. The PAER shall be signed by the recipient, the recipient's authorized representative or, when the recipient is incompetent or incapacitated, someone acting responsibly on the recipient's behalf. When both parents or a parent and a stepparent are in the home, both shall sign the form.

75.52(2) *Additional reviews.* A redetermination of specific eligibility factors shall be made when:

a. The recipient reports a change in circumstances, or

b. A change in the recipient's circumstances comes to the attention of a staff member.

75.52(3) *Forms.* Information for semiannual reviews shall be submitted on Form PA-2140-0, Public Assistance Eligibility Report (PAER). Information for the annual face-to-face determination interview shall be submitted on Form 470-2881, Review/Recertification Eligibility Document (RRED). When the client has completed Form PA-2207-0, Public Assistance Application, for another purpose, this form may be used as the review document for the semiannual or annual review.

75.52(4) *Recipient responsibilities.* Responsibilities of recipients (including individuals in suspension status). For the purposes of this subrule, recipients shall include persons who received assistance subject to recoupment because the persons were ineligible.

a. The recipient shall cooperate by giving complete and accurate information needed to establish eligibility.

b. The recipient shall complete Form PA-2140-0, Public Assistance Eligibility Report (PAER), or Form 470-2881, Review/Recertification Eligibility Document (RRED), when requested by the county office in accordance with these rules. Either form will be supplied as needed to the recipient by the department. The department shall pay the cost of postage to return the form. When the form is issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the county office by the fifth calendar day of the report month. When the form is not issued in the department's regular end-of-month mailing, the recipient shall return the completed form to the county office by the seventh day after the date it is mailed by the department. The county office shall supply the recipient with a PAER or a RRED upon request. Failure to return a completed form shall result in cancellation of assistance. A completed form is a form with all items answered, signed, dated no earlier than the first day of the budget month and accompanied by verification as required in paragraphs 75.57(1)*"f"* and 75.57(2)*"l."*

c. The recipient, or an individual being added to the existing eligible group, shall timely report any change in the following circumstances:

(1) Income from all sources, including any change in care expenses and any change in full-time or part-time employment status as defined in subparagraph 75.57(2)*"b"*(2).

(2) Resources.

(3) Members of the household.

(4) School attendance.

(5) Becoming incapacitated or recovery from incapacity.

(6) Change of mailing or living address.

(7) Payment of child support.

(8) Receipt of a social security number.

(9) Payment for child support, alimony, or dependents as defined in paragraph 75.57(8)*"b."*

d. A report shall be considered timely when made within ten days from:

(1) The receipt of resources, income, or increased or decreased income.

(2) The date care expenses increase or decrease or the date full-time or part-time employment status, as defined in subparagraph 75.57(2)*"b"*(2), changes.

(3) The date the address changes.

(4) The date the child is officially dropped from the school rolls.

(5) The date the person enters or leaves the household.

(6) The date medical or psychological evidence indicates a person becomes incapacitated or recovers from incapacity.

(7) The date the client increases or decreases child support payments.

(8) The receipt of a social security number.

(9) The date a stepparent described in paragraph 75.57(8)*"b"* or an underage parent described in paragraph 75.57(8)*"c"* increases or decreases payments for child support, alimony or dependents.

e. When a change is not timely reported, any excess Medicaid paid shall be subject to recovery.

75.52(5) *Effective date.* After assistance has been approved, eligibility for continuing assistance shall be effective as of the first of each month. Any change affecting eligibility reported during a month shall be effective the first day of the next calendar month, subject to timely notice requirements at rule 441—7.6(217) for any adverse actions.

a. Any change not reported prospectively in the budget month and reported on the Public Assistance Eligibility Report (PAER), Form PA-2140-0, or the Review/Recertification Eligibility Document (RRED), Form 470-2881, shall be effective for the corresponding benefit month. When the change creates ineligibility for more than one month, eligibility under the current coverage group shall be canceled and an automatic redetermination of eligibility shall be completed in accordance with rule 441—76.11(249A).

b. When the recipient timely reports, as defined in 441—subrule 76.2(5) or paragraph 75.52(4)*"d,"* a change in income or circumstances during the first initial month of eligibility, prospective eligibility for the second initial month shall be determined based on the change.

c. When an individual included in the eligible group becomes ineligible, that individual's needs shall be removed prospectively effective the first of the next month unless the action must be delayed due to timely notice requirements at rule 441—7.6(217).

441—75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups. Notwithstanding the provisions of rule 441—75.10(249A), the following rules shall apply when determining eligibility for persons under FMAP or FMAP-related coverage groups.

75.53(1) *Definition of resident.* A resident of Iowa is one:

a. Who is living in Iowa voluntarily with the intention of making that person's home there and not for a temporary purpose. A child is a resident of Iowa when living there on other than a temporary basis. Residence may not depend upon the reason for which the individual entered the state, except insofar as it may bear upon whether the individual is there voluntarily or for a temporary purpose; or

b. Who, at the time of application, is living in Iowa, is not receiving assistance from another state, and entered Iowa with a job commitment or seeking employment in Iowa, whether or not currently employed. Under this definition the child is a resident of the state in which the specified relative is a resident.

75.53(2) *Retention of residence.* Residence is retained until abandoned. Temporary absence from Iowa, with subsequent returns to Iowa, or intent to return when the purposes of the absence have been accomplished does not interrupt continuity of residence.

75.53(3) *Suitability of home.* The home shall be deemed suitable until the court has ruled it unsuitable and, as a result of such action, the child has been removed from the home.

75.53(4) *Temporary absence from the home.* The needs of an individual who is temporarily out of the home are included in the eligible group unless the person is in a jail or penal institution, including a work release center, in accordance with the provisions of rule 441—75.12(249A) or is excluded from the eligible group in accordance with the provisions of rule 441—75.59(249A). A temporary absence exists in the following circumstances.

a. An individual is anticipated to be in the medical institution for less than a year, as verified by a physician's statement. Failure to return within one year from the date of entry into the medical institution will result in the individual's needs being removed from the eligible group.

b. When an individual is out of the home to secure education or training, as defined for children in paragraph 75.54(1)*"b"* and for adults in 441—subrule 93.114(1), first sentence, as long as the specified relative retains supervision of the child.

c. An individual is out of the home for reasons other than reasons in paragraphs *"a"* and *"b"* and intends to return to the home within three months. Failure to return within three months from the date the individual left the home will result in the individual's needs being removed from the eligible group.

441—75.54(249A) Eligibility factors specific to child.

75.54(1) *Age.* Unless otherwise specified at rule 441—75.1(249A), Medicaid shall be available to a needy child under the age of 18 years without regard to school attendance.

a. A child is eligible for the entire month in which the child's eighteenth birthday occurs, unless the birthday falls on the first day of the month.

b. Medicaid shall also be available to a needy child aged 18 years who is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and who is reasonably expected to complete the program before reaching the age of 19 if the following criteria are met.

(1) A child shall be considered attending school full-time when enrolled or accepted in a full-time (as certified by the school or institute attended) elementary, secondary or the equivalent level of vocational or technical school or training leading to a certificate or diploma. Correspondence school is not an allowable program of study.

(2) A child shall also be considered to be in regular attendance in months when the child is not attending because of an official school or training program vacation, illness, convalescence, or family emergency. A child meets the definition of regular school attendance until the child has been officially dropped from the school rolls.

(3) When a child's education is temporarily interrupted pending adjustment of an education or training program, exemption shall be continued for a reasonable period of time to complete the adjustment.

75.54(2) *Residing with a relative.* The child shall be living in the home of one of the relatives specified in subrule 75.55(1). When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until the time custody is actually relinquished.

a. Living with relatives implies primarily the existence of a relationship involving an accepted responsibility on the part of the relative for the child's welfare, including the sharing of a common household.

b. Home is the family setting maintained or in the process of being established as evidenced by the assumption and continuation of responsibility for the child by the relative.

75.54(3) *Deprivation of parental care and support.* Medicaid is available to a child of unmarried parents or married parents when all eligibility factors are met. For coverage groups which require that a child be deprived as a condition of eligibility, a child shall be considered as deprived of parental support or care when:

a. A parent is out of the home in which the child lives under the following conditions. When these conditions exist, the parent may be absent for any reason, and may have left only recently or some time previously; except that a parent whose absence is occasioned solely by reason of the performance of active duty in the uniformed services of the United States is not considered absent from the home. A parent who is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday is considered absent from the home.

(1) The nature of the absence either interrupts or terminates the parent's functioning as a provider of maintenance, physical care, or guidance for the child; and

(2) The known or indefinite duration of the absence precludes relying on the parent to plan for the present support or care of the child.

b. A parent is incapacitated. A parent is considered incapacitated when a clearly identifiable physical or mental defect has a demonstrable effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the child. The incapacity shall be expected to last for a period of at least 30 days from the date of application.

(1) The determination of incapacity shall be supported by medical or psychological evidence. The evidence may be submitted either by letter from the physician or on a Report on Incapacity, Form PA-2126-5.

(2) When an examination is required and other resources are not available to meet the expense of the examination, the physician shall be authorized to make the examination and submit the claim for payment on an Authorization for Examination and Claim for Payment, Form PA-5113-0.

(3) A finding of eligibility for social security benefits or supplemental security income benefits based on disability or blindness is acceptable proof of incapacity for family medical assistance program (FMAP) and FMAP-related program purposes.

(4) A parent who is considered incapacitated shall be referred to the department of education, division of vocational rehabilitation services, for evaluation and services. Acceptance of these services is optional.

c. The parents are considered unemployed. A child shall be eligible for assistance on the basis of being deprived of parental care or support by reason of both parents' being considered unemployed as described in subparagraphs (1) and (2) below.

When deprivation exists because of parental absence or incapacity, that deprivation factor supersedes and the case shall not be processed on the basis of the parents' unemployment.

(1) When both parents of a common child are in the home and neither parent is incapacitated as defined at paragraph 75.54(3)"*b,*" eligibility for assistance shall be determined based on the unemployment of the parents, without regard to either parent's hours of employment. Unless the person is excluded in accordance with the provisions of rule 441—75.59(249A), for the purpose of determining eligibility, the eligible group shall include the common child, any parent, and any deprived sibling of the common child living in the home with the common child as described at subrule 75.58(1). Each parent in an unemployed parent case shall meet the following requirements:

1. Both parents shall be unemployed. Parents who are employed but whose earnings are insufficient to meet the needs of the family according to the schedule of needs as provided in subrule 75.58(2) shall be considered unemployed for the purpose of establishing eligibility under this subrule.

2. The parent who is an applicant and who is out of work due to refusal, without good cause, of a bona fide offer of employment or training for employment shall not be considered unemployed.

(2) After assistance is approved, when either parent is no longer considered unemployed because of failure to apply for or draw job insurance benefits in accordance with the provisions of rule 441—75.3(249A), ineligibility shall result for those persons whose eligibility is dependent on the unemployment of both parents.

d. When a child is deprived of support or care of a natural parent, the presence of an able-bodied stepparent in the home shall not disqualify a child from assistance, provided that other eligibility factors are met.

75.54(4) *Assistance continued.* For coverage groups which require that a child be deprived as a condition of eligibility, an adjustment period following the incapacitated parent's recovery or the absent parent's return home shall continue for only as long as is necessary to determine whether there is eligibility on the basis of parental unemployment. When deprivation on the basis of unemployment cannot be established, assistance shall be continued for a maximum of three months. When the three-month adjustment period expires, eligibility shall be reexamined in accordance with the automatic redetermination provisions of rule 441—76.11(249A).

441—75.55(249A) Eligibility factors specific to specified relatives.

75.55(1) *Specified relationship.*

a. A child may be considered as meeting the requirement of living with a specified relative if the child's home is with one of the following or with a spouse of the relative even though the marriage is terminated by death or divorce:

Father or adoptive father.

Mother or adoptive mother.

Grandfather or grandfather-in-law, meaning the subsequent husband of the child's natural grandmother, i.e., stepgrandfather or adoptive grandfather.

Grandmother or grandmother-in-law, meaning the subsequent wife of the child's natural grandfather, i.e., stepgrandmother or adoptive grandmother.

Great-grandfather or great-great-grandfather.

Great-grandmother or great-great-grandmother.

Stepfather, but not his parents.

Stepmother, but not her parents.

Brother, brother-of-half-blood, stepbrother, brother-in-law or adoptive brother.

Sister, sister-of-half-blood, stepsister, sister-in-law or adoptive sister.

Uncle or aunt, of whole or half blood.

Uncle-in-law or aunt-in-law.

Great uncle or great-great-uncle.

Great aunt or great-great-aunt.

First cousins, nephews, or nieces.

b. A relative of the putative father can qualify as a specified relative if the putative father has acknowledged paternity by the type of written evidence on which a prudent person would rely.

75.55(2) *Liability of relatives.* All appropriate steps shall be taken to secure support from legally liable persons on behalf of all persons in the eligible group, including the establishment of paternity as provided in rule 441—75.14(249A).

a. When necessary to establish eligibility, the county office shall make the initial contact with the absent parent at the time of application. Subsequent contacts shall be made by the child support recovery unit.

b. When contact with the family or other sources of information indicates that relatives other than parents and spouses of the eligible children are contributing toward the support of members of the eligible group, have contributed in the past, or are of such financial standing they might reasonably be expected to contribute, the county office shall contact these persons to verify current contributions or arrange for contributions on a voluntary basis.

441—75.56(249A) Resources.

75.56(1) *Limitation.* Unless otherwise specified, an applicant or recipient may have the following resources and be eligible for the family medical assistance program (FMAP) or FMAP-related programs. Any resource not specifically exempted shall be counted toward the applicable resource limit.

a. A homestead without regard to its value. A mobile home or similar shelter shall be considered as a homestead when it is occupied by the recipient. Temporary absence from the homestead with a defined purpose for the absence and with intent to return when the purpose of the absence has been accomplished shall not be considered to have altered the exempt status of the homestead. The net market value of any other real property shall be considered with personal property.

b. Household goods and personal effects without regard to their value. Personal effects are personal or intimate tangible belongings of an individual, especially those that are worn or carried on the person, which are maintained in one's home, and include clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

c. Life insurance which has no cash surrender value. The owner of the life insurance policy is the individual paying the premium on the policy with the right to change the policy as the individual sees fit.

d. An equity not to exceed a value of $3,000 in one motor vehicle for each adult and working teenage child whose resources must be considered as described in subrule 75.56(2). The disregard shall be allowed when the working teenager is temporarily absent from work. The equity value in excess of $3,000 of any vehicle shall be counted toward the resource limit in paragraph 75.56(1)"*e.*" When a motor vehicle(s) is modified with special equipment for the handicapped, the special equipment shall not increase the value of the motor vehicle(s).

Beginning July 1, 1994, and continuing in succeeding state fiscal years, the motor vehicle equity value to be disregarded shall be increased by the latest increase in the consumer price index for used vehicles during the previous state fiscal year.

e. A reserve of other property, real or personal, not to exceed $2,000 for applicant assistance units and $5,000 for recipient assistance units.

EXCEPTION: Applicant assistance units with at least one member who was a recipient in Iowa in the month prior to the month of application are subject to the $5,000 limit.

Resources of the applicant or the recipient shall be determined in accordance with persons considered, as described at subrule 75.56(2).

f. Money which is counted as income in a month, during that same month; and that part of lump sum income defined at subparagraph 75.57(9)"*c*"(2) reserved for the current or future month's income.

g. Payments which are exempted for consideration as income and resources under subrule 75.57(6).

h. An equity not to exceed $1,500 in one funeral contract or burial trust for each member of the eligible group. Any amount in excess of $1,500 shall be counted toward resource limits unless it is established that the funeral contract or burial trust is irrevocable.

i. One burial plot for each member of the eligible group. A burial plot is defined as a conventional gravesite, crypt, mausoleum, urn, or other repository which is customarily and traditionally used for the remains of a deceased person.

j. Settlements for payment of medical expenses.

k. Life estates.

l. Earned income credit payments in the month of receipt and the following month, regardless of whether these payments are received with the regular paychecks or as a lump sum with the federal income tax refund.

m. The balance in an individual development account (IDA), including interest earned on the IDA.

n. An equity not to exceed $10,000 for tools of the trade or capital assets of self-employed households.

When the value of any resource is exempted in part, that portion of the value which exceeds the exemption shall be considered in calculating whether the eligible group's property is within the reserve defined in paragraph *"e."*

75.56(2) *Persons considered.*

a. Resources of persons in the eligible group shall be considered in establishing property limits.

b. Resources of the parent who is living in the home with the eligible children but whose needs are excluded from the eligible group shall be considered in the same manner as if the parent were included in the eligible group.

c. Resources of the stepparent living in the home shall not be considered when determining eligibility of the eligible group, with one exception: The resources of a stepparent included in the eligible group shall be considered in the same manner as a parent.

d. The resources of supplemental security income (SSI) recipients shall not be counted in establishing property limitations. When property is owned by both the SSI beneficiary and a Medicaid recipient in another eligible group, each shall be considered as having a half interest in order to determine the value of the resource, unless the terms of the deed or purchase contract clearly establish ownership on a different proportional basis.

e. The resources of a nonparental specified relative who elects to be included in the eligible group shall be considered in the same manner as a parent.

75.56(3) *Homestead defined.* The homestead consists of the house, used as a home, and may contain one or more contiguous lots or tracts of land, including buildings and appurtenances. When within a city plat, it shall not exceed ½ acre in area. When outside a city plat it shall not contain, in the aggregate, more than 40 acres. When property used as a home exceeds these limitations, the equity value of the excess property shall be determined in accordance with subrule 75.56(5).

75.56(4) *Liquidation.* When proceeds from the sale of resources or conversion of a resource to cash, together with other nonexempted resources, exceed the property limitations, the recipient is ineligible to receive assistance until the amount in excess of the resource limitation has been expended unless immediately used to purchase a homestead, or reduce the mortgage on a homestead.

a. Property settlements. Property settlements which are part of a legal action in a dissolution of marriage or palimony suit are considered as resources upon receipt.

b. Mortgages and contracts for the sale of property. The resource value of a mortgage or contract is the gross price for which it can be sold or discounted on the open market, less any legal debts, claims, or liens against the mortgage or contract.

Mortgage or contract payments are exempt as income. The portion of any payment received representing principal is considered a resource upon receipt. The interest portion of the payment is considered a resource the month following the month of receipt.

75.56(5) *Net market value defined.* Net market value is the gross price for which property or an item can currently be sold on the open market, less any legal debts, claims, or liens against the property or item.

75.56(6) *Availability.*

a. A resource must be available in order for it to be counted toward resource limitations. A resource is considered available under the following circumstances:

(1) The applicant or recipient owns the property in part or in full and has control over it. That is, it can be occupied, rented, leased, sold, or otherwise used or disposed of at the individual's discretion.

(2) The applicant or recipient has a legal interest in a liquidated sum and has the legal ability to make the sum available for support and maintenance.

b. An applicant or recipient shall take all appropriate action to gain title and control of any resource the value of which would affect eligibility.

c. When property is owned by more than one person, unless otherwise established, it is assumed that all persons hold equal shares in the property.

75.56(7) *Damage judgments and insurance settlements.*

a. Payment resulting from damage to or destruction of an exempt resource shall be considered a resource to the applicant or recipient the month following the month the payment was received. When the applicant or recipient signs a legal binding commitment no later than the month after the month the payment was received, the funds shall be considered exempt for the duration of the commitment providing the terms of the commitment are met within eight months from the date of commitment.

b. Payment resulting from damage to or destruction of a nonexempt resource shall be considered a resource in the month following the month in which payment was received.

75.56(8) *Conservatorships.*

a. Conservatorships established prior to February 9, 1994. The department shall determine whether assets from a conservatorship, except one established solely for the payment of medical expenses, are available by examining the language of the order establishing the conservatorship.

Funds clearly conserved and available for care, support, or maintenance shall be considered toward resource or income limitations.

When the county office questions whether the funds in a conservatorship are available, the county office shall refer the conservatorship to central office. When assets in the conservatorship are not clearly available, central office staff may contact the conservator and request that the funds in the conservatorship be made available for current support and maintenance. When the conservator chooses not to make the funds available, the department may petition the court to have the funds released either partially or in their entirety or as periodic income payments. Funds in a conservatorship that are not clearly available shall be considered unavailable until the conservator or court actually makes the funds available. Payments received from the conservatorship for basic or special needs are considered income.

b. Conservatorships established on or after February 9, 1994. Conservatorships established on or after February 9, 1994, shall be treated according to the provisions of paragraphs 75.24(1)*"e"* and 75.24(2)*"b."*

75.56(9) *Not considered a resource.* Inventories and supplies, exclusive of capital assets, that are required for self-employment shall not be considered a resource. Inventory is defined as all unsold items, whether raised or purchased, that are held for sale or use and shall include, but not be limited to, merchandise, grain held in storage and livestock raised for sale. Supplies are items necessary for the operation of the enterprise, such as lumber, paint, and seed. Capital assets are those assets which, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. When self-employment is temporarily interrupted due to circumstances beyond the control of the household, such as illness, inventory or supplies retained by the household shall not be considered a resource.

441—75.57(249A) Income. When determining initial and ongoing eligibility for the family medical assistance program (FMAP) and FMAP-related Medicaid coverage groups, all unearned and earned income, unless specifically exempted, disregarded, deducted for work expenses, or diverted as defined in these rules, shall be considered in determining initial and continuing eligibility. Unless otherwise specified at rule 441—75.1(249A), the determination of initial eligibility is a three-step process. Initial eligibility shall be granted only when (1) the countable gross nonexempt unearned and earned income received by the eligible group and available to meet the current month's needs is no more than 185 percent of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); (2) the countable net earned and unearned income is less than the schedule of living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2); and (3) the countable net unearned and earned income, after applying allowable disregards, is less than the schedule of basic needs as identified at subrule 75.58(2) for the eligible group (Test 3). The determination of continuing eligibility is a two-step process. Continuing eligibility shall be granted only when (1) countable gross nonexempt income, as described for initial eligibility, does not exceed 185 percent of the living costs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 1); and (2) countable net unearned and earned income is less than the schedule of basic needs as identified in the schedule of needs at subrule 75.58(2) for the eligible group (Test 2). Child support assigned to the department in accordance with 441—subrule 41.22(7) shall be considered unearned income for the purpose of determining continuing eligibility, except as specified at paragraphs 75.57(1)*"e,"* 75.57(6)*"u,"* and 75.57(7)*"o."* Expenses for care of children or disabled adults, deductions, and diversions shall be allowed when verification is provided. The county office shall return all verification to the applicant or recipient.

75.57(1) *Unearned income.* Unearned income is any income in cash that is not gained by labor or service. When taxes are withheld from unearned income, the amount considered will be the net income after the withholding of taxes (Federal Insurance Contribution Act, state and federal income taxes). Net unearned income, from investment and nonrecurring lump sum payments, shall be determined by deducting reasonable income-producing costs from the gross unearned income. Money left after this deduction shall be considered gross income available to meet the needs of the eligible group.

a. Social security income is the amount of the entitlement before withholding of a Medicare premium.

b. Financial assistance received for education or training. Rescinded IAB 2/11/98, effective 2/1/98.

c. Rescinded IAB 2/11/98, effective 2/1/98.

d. When the applicant or recipient sells property on contract, proceeds from the sale shall be considered exempt as income. The portion of any payment that represents principal is considered a resource upon receipt as defined in subrule 75.56(4). The interest portion of the payment is considered a resource the month following the month of receipt.

e. Support payments in cash shall be considered as unearned income in determining initial and continuing eligibility.

(1) Any nonexempt cash support payment, for a member of the eligible group, made while the application is pending shall be treated as unearned income.

(2) Support payments shall be considered as unearned income in the month in which the IV-A agency (income maintenance) is notified of the payment by the IV-D agency (child support recovery unit).

The amount of income to consider shall be the actual amount paid or the monthly entitlement, whichever is less.

(3) Support payment reported by child support recovery during the budget month shall be used to determine prospective and retrospective eligibility for the corresponding eligibility month.

(4) When the reported support payment, combined with other income, creates ineligibility under the current coverage group, an automatic redetermination of eligibility shall be conducted in accordance with the provisions of rule 441—76.11(249A). Persons receiving Medicaid under the family medical assistance program in accordance with subrule 75.1(14) may be entitled to continued coverage under the provisions of subrule 75.1(21). Eligibility may be reestablished for any month in which the countable support payment combined with other income meets the eligibility test.

f. The applicant or recipient shall cooperate in supplying verification of all unearned income. When the information is available, the county office shall verify job insurance benefits by using information supplied to the department by Iowa workforce development. When the county office uses this information as verification, job insurance benefits shall be considered received the second day after the date the check was mailed by Iowa workforce development. When the second day falls on a Sunday or federal legal holiday, the time shall be extended to the next mail delivery day. When the client notifies the county office that the amount of job insurance benefits used is incorrect, the client shall be allowed to verify the discrepancy. The client must report the discrepancy prior to the eligibility month or within ten days of the date on the Notice of Decision, Form PA-3102-0, applicable to the eligibility month, whichever is later.

75.57(2) *Earned income.* Earned income is defined as income in the form of a salary, wages, tips, bonuses, commission earned as an employee, income from Job Corps, or profit from self-employment. Earned income from commissions, wages, tips, bonuses, Job Corps, or salary means the total gross amount irrespective of the expenses of employment. With respect to self-employment, earned income means the profit determined by comparing gross income with the allowable costs of producing the income. Income shall be considered earned income when it is produced as a result of the performance of services by an individual.

a. Each person in the assistance unit whose gross nonexempt earned income, earned as an employee or net profit from self-employment, considered in determining eligibility is entitled to one 20 percent earned income deduction of nonexempt monthly gross earnings. The deduction is intended to include work-related expenses other than child care. These expenses shall include, but are not limited to, all of the following: taxes, transportation, meals, uniforms, and other work-related expenses.

b. Each person in the assistance unit is entitled to a deduction for care expenses subject to the following limitations.

Persons in the eligible group and excluded parents shall be allowed care expenses for a child or incapacitated adult in the eligible group.

Stepparents as described at paragraph 75.57(8)*"b"* and self-supporting parents on underage parent cases as described at paragraph 75.57(8)*"c"* shall be allowed child care expenses for the ineligible dependents of the stepparent or self-supporting parent.

(1) Child care or care for an incapacitated adult shall be considered a work expense in the amount paid for care of an individual, not to exceed $175, or $200 in the case of a child under the age of two, per month for a full-time employee and $174, or $199 in the case of a child under the age of two, for a part-time employee or the going rate in the community, whichever is less.

(2) Full-time employment shall be defined as employment of 129 or more hours per month. Part-time employment shall be defined as employment of fewer than 129 hours per month. The determination as to whether self-employment income is full-time or part-time shall be made on the basis of whether the average net monthly income from self-employment is at least equal to the state or federal minimum wage, whichever is higher, multiplied by 129 hours a month. "Net monthly income" means income in a month remaining after deduction of allowable business expenses as described at paragraphs 75.57(2)*"f"* through *"j."*

(3) The deduction is allowable only when the care covers the actual hours of the individual's employment plus a reasonable period of time for commuting; or the period of time when the individual who would normally care for the child or incapacitated adult is employed at such hours that the individual is required to sleep during the waking hours of the child or incapacitated adult, excluding any hours a child is in school.

(4) Any special needs of a physically or mentally handicapped child or adult shall be taken into consideration in determining the deduction allowed.

(5) The expense shall be verified by receipt or a statement from the provider of care and shall be allowed when paid to any person except a parent or legal guardian of the child or another member of the eligible group, or to any person whose needs are met by diversion of income from any person in the eligible group.

c. After deducting the allowable work expenses as defined at paragraphs 75.57(2)*"a"* and *"b"* and income diversions as defined at subrules 75.57(4) and 75.57(8), 50 percent of the total of the remaining monthly nonexempt earned income, earned as an employee or the net profit from self-employment, of each individual whose income must be considered is deducted in determining eligibility for the family medical assistance program (FMAP) and those FMAP-related coverage groups subject to the three-step process for determining initial eligibility as described at rule 441—75.57(249A). The 50 percent work incentive deduction is not time-limited. Initial eligibility under the first two steps of the three-step process is determined without the application of the 50 percent work incentive deduction as described at subparagraphs 75.57(9)*"a"*(2) and (3).

Individuals whose needs have been removed from the eligible group for refusing to cooperate in applying for or accepting benefits from other sources, in accordance with the provisions of rule 441—75.2(249A), 441—75.3(249A), or 441—75.21(249A), are eligible for the 50 percent work incentive deduction but the individual is not eligible for Medicaid.

d. Ineligibility for expenses and disregards.

(1) Except for persons described at paragraphs 75.57(8)*"b"* and *"c,"* a person whose earned income must be considered is not eligible for the 20 percent earned income deduction or the child or adult care expense described at paragraphs 75.57(2)*"a"* and *"b"* for one month if within 30 days preceding the month of application or the report month the individual terminated employment, reduced earned income, or refused to accept a bona fide offer of employment, as defined at rule 441—42.21(239), in which the individual was able to engage, unless the individual has identified problems with participation of a temporary or incidental nature as described at rule 441—93.133(249C) or barriers to participation as described at rule 441—93.134(249C). However, the individual is eligible for the 50 percent work incentive deduction as described at paragraph 75.57(2)*"c,"* if there are earnings to be considered.

(2) Except for persons described at paragraphs 75.57(8)*"b"* and *"c,"* a person whose earned income must be considered is not eligible for the 20 percent earned income deduction or the care expense described at paragraphs 75.57(2)*"a"* and *"b"* for any month in which the individual failed, without good cause, to timely report a change in earned income or to timely report earned income on Form PA-2140-0, Public Assistance Eligibility Report (PAER), or Form 470-2881, Review/Recertification Eligibility Document (RRED). However, the individual is eligible for the 50 percent work incentive deduction described at paragraph 75.57(2)*"c."* Good cause for not timely returning a PAER or a RRED or timely reporting a change in earned income shall be limited to circumstances beyond the control of the individual, such as, but not limited to, a failure by the department to provide needed assistance when requested, to give needed information, to follow procedure resulting in a delay in the return of the PAER or the RRED, or when conditions require the forms to be mailed other than with the regular end-of-the-month mailing. Good cause shall also include, but not be limited to, circumstances when the individual was prevented from reporting by a physical or mental disability, death or serious illness of an immediate family member, or other unanticipated emergencies, or mail was not delivered due to a disruption of regular mail delivery. The applicant or recipient who returns the PAER or the RRED listing earned income by the sixteenth day of the report month shall be considered to have good cause for not timely returning the PAER or the RRED.

e. A person is considered self-employed when the person:

(1) Is not required to report to the office regularly except for specific purposes such as sales training meetings, administrative meetings, or evaluation sessions.

(2) Establishes the person's own working hours, territory, and methods of work.

(3) Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

f. The net profit from self-employment income in a non-home-based operation shall be determined by deducting only the following expenses that are directly related to the production of the income:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees of the self-employed.

(3) The cost of shelter in the form of rent, the interest on mortgage or contract payments; taxes; and utilities.

(4) The cost of machinery and equipment in the form of rent or the interest on mortgage or contract payments.

(5) Insurance on the real or personal property involved.

(6) The cost of any repairs needed.

(7) The cost of any travel required.

(8) Any other expense directly related to the production of income, except the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

g. When the client is renting out apartments in the client's home, the following shall be deducted from the gross rentals received to determine the profit:

(1) Shelter expense in excess of that set forth on the chart of basic needs components at subrule 75.58(2) for the eligible group.

(2) That portion of expense for utilities furnished to tenants which exceeds the amount set forth on the chart of basic needs components at subrule 75.58(2).

(3) Ten percent of gross rentals to cover the cost of upkeep.

h. In determining profit from furnishing board, room, operating a family life home, or providing nursing care, the following amounts shall be deducted from the payments received:

(1) $41 plus an amount equivalent to the monthly maximum food stamp allotment in the food stamp program for a one-member household for a boarder and roomer or an individual in the home to receive nursing care, or $41 for a roomer, or an amount equivalent to the monthly maximum food stamp allotment in the food stamp program for a one-member household for a boarder.

(2) Ten percent of the total payment to cover the cost of upkeep for individuals receiving a room or nursing care.

i. Gross income from providing child care in the applicant's or recipient's own home shall include the total payments received for the service and any payment received due to the Child Nutrition Amendments of 1978 for the cost of providing meals to children. In determining profit from providing child care services in the applicant's or recipient's own home, 40 percent of the total gross income received shall be deducted to cover the costs of producing the income, unless the individual requests to have actual expenses in excess of the 40 percent considered. When the applicant or recipient requests to have expenses in excess of the 40 percent considered, profit shall be determined in the same manner as specified at paragraph 75.57(2)*"j."*

j. In determining profit for a self-employed enterprise in the home other than providing room and board, renting apartments or providing child care services, the following expenses shall be deducted from the income received:

(1) The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.

(2) Wages, commissions, and mandated costs relating to the wages for employees.

(3) The cost of machinery and equipment in the form of rent; or the interest on mortgage or contract payment; and any insurance on such machinery equipment.

(4) Ten percent of the total gross income to cover the costs of upkeep when the work is performed in the home.

(5) Any other direct cost involved in the production of the income, except the purchase of capital equipment and payment on the principal of loans for capital equipment and payment on the principal of loans for capital assets and durable goods or any cost of depreciation.

k. Income in-kind received in payment for work shall be given the same consideration as cash. Except in unusual circumstances, the cash value of the income in-kind is the amount the client would pay in cash for the service or product if the work were not performed. Unusual circumstances include situations which are very unfair to the client or the department.

l. The applicant or recipient shall cooperate in supplying verification of all earned income. A self-employed individual shall keep any records necessary to establish eligibility.

75.57(3) *Shared living arrangements.* When an applicant or recipient shares living arrangements with another family or person, funds combined to meet mutual obligations for shelter and other basic needs are not income. Funds made available to the applicant or recipient, exclusively for the applicant's or recipient's needs, are considered income.

75.57(4) *Diversion of income.*

a. Nonexempt earned and unearned income of the parent shall be diverted to meet the unmet needs of the dependent, but ineligible children of the parent living in the family group. Income of the parent shall be diverted to meet the unmet needs of the ineligible children of the parent and a companion in the home only when the income and resources of the companion and the children are within family medical assistance program standards. The maximum income that shall be diverted to meet the needs of the dependent but ineligible children shall be the difference between the needs of the eligible group if the ineligible children were included and the needs of the eligible group with the ineligible children excluded, except as specified at paragraph 75.57(8)*"b."*

b. Nonexempt earned and unearned income of the parent shall be diverted to permit payment of court-ordered support to children not living with the parent when the payment is actually being made.

75.57(5) *Income of unmarried specified relatives under the age of 19.*

a. Income of the unmarried specified relative under the age of 19 when that specified relative lives with a parent who receives coverage under family medical assistance-related programs or lives with a nonparental relative or in an independent living arrangement.

(1) The income of the unmarried, underage specified relative who is also an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as that of any other child. The income for the unmarried, underage specified relative who is not an eligible child in the eligible group of the specified relative's parent shall be treated in the same manner as though the specified relative had attained majority.

(2) The income of the unmarried, underage specified relative living with a nonparental relative or in an independent living arrangement shall be treated in the same manner as though the specified relative had attained majority.

b. Income of the unmarried specified relative under the age of 19 who lives in the same home as a self-supporting parent. The income of the unmarried specified relative under the age of 19 living in the same home as a self-supporting parent shall be treated in accordance with subparagraphs (1), (2), and (3) below.

(1) When the unmarried specified relative is under the age of 18 and not a parent of the dependent child, the income of the specified relative shall be exempt.

(2) When the unmarried specified relative is under the age of 18 and a parent of the dependent child, the income of the specified relative shall be treated in the same manner as though the specified relative had attained majority. The income of the specified relative's self-supporting parents shall be treated in accordance with paragraph 75.57(8)*"c."*

(3) When the unmarried specified relative is 18 years of age, the specified relative's income shall be treated in the same manner as though the specified relative had attained majority.

75.57(6) *Exempt as income and resources.* The following shall be exempt as income and resources:

a. Food reserves from home-produced garden products, orchards, domestic animals, and the like, when used by the household for its own consumption.

b. The value of the coupon allotment in the food stamp program.

c. The value of the United States Department of Agriculture donated foods (surplus commodities).

d. The value of supplemental food assistance received under the Child Nutrition Act and the special food service program for children under the National School Lunch Act.

e. Any benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act.

f. Benefits paid to eligible households under the Low Income Home Energy Assistance Act of 1981.

g. Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.

h. Any judgment funds that have been or will be distributed per capita or held in trust for members of any Indian tribe. When the payment, in all or part, is converted to another type of resource, that resource is also exempt.

i. Payments to volunteers participating in the Volunteers in Service to America (VISTA) program, except that this exemption will not be applied when the director of ACTION determines that the value of all VISTA payments, adjusted to reflect the number of hours the volunteers are serving, is equivalent to or greater than the minimum wage then in effect under the Fair Labor Standards Act of 1938, or the minimum wage under the laws of the state where the volunteers are serving, whichever is greater.

j. Payments for supporting services or reimbursement of out-of-pocket expenses received by volunteers in any of the programs established under Titles II and III of the Domestic Volunteer Services Act.

k. Tax-exempt portions of payments made pursuant to the Alaskan Native Claims Settlement Act.

l. Experimental housing allowance program payments made under annual contribution contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1936 as amended.

m. The income of a supplemental security income recipient.

n. Income of an ineligible child.

o. Unearned income in-kind.

p. Family support subsidy program payments.

q. Grants obtained and used under conditions that preclude their use for current living costs.

r. All earned and unearned educational funds of an undergraduate or graduate student or a person in training. Any extended social security or veterans benefits received by a parent or nonparental relative as defined at subrule 75.55(1), conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

s. Rescinded IAB 2/11/98, effective 2/1/98.

t. Any income restricted by law or regulation which is paid to a representative payee, living outside the home, other than a parent who is the applicant or recipient, unless the income is actually made available to the applicant or recipient by the representative payee.

u. The first $50 received by the eligible group which represents a current monthly support obligation or a voluntary support payment, paid by a legally responsible individual, but in no case shall the total amount exempted exceed $50 per month per eligible group.

v. Bona fide loans. Evidence of a bona fide loan may include any of the following:

(1) The loan is obtained from an institution or person engaged in the business of making loans.

(2) There is a written agreement to repay the money within a specified time.

(3) If the loan is obtained from a person not normally engaged in the business of making a loan, there is borrower's acknowledgment of obligation to repay (with or without interest), or the borrower expresses intent to repay the loan when funds become available in the future, or there is a timetable and plan for repayment.

w. 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.).

x. The income of a person ineligible due to receipt of state-funded foster care, IV-E foster care, or subsidized adoption assistance.

y. Payments for major disaster and emergency assistance provided under the Disaster Relief Act of 1974 as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

z. Payments made to certain United States citizens of Japanese ancestry and resident Japanese aliens under Section 105 of Public Law 100-383, and payments made to certain eligible Aleuts under Section 206 of Public Law 100-383, entitled "Wartime Relocation of Civilians."

aa. Payments received from the Radiation Exposure Compensation Act.

ab. Deposits into an individual development account (IDA) when determining eligibility. The amount of the deposit is exempt as income and shall not be used in the 185 percent eligibility test. The deposit shall be deducted from nonexempt earned and unearned income that the client receives in the same budget month in which the deposit is made. To allow a deduction, verification of the deposit shall be provided by the end of the report month or the extended filing date, whichever is later. The client shall be allowed a deduction only when the deposit is made from the client's money. The earned income deductions at paragraphs 75.57(2)*"a," "b,"* and *"c"* shall be applied to nonexempt earnings from employment or net profit from self-employment that remains after deducting the amount deposited into the account. Allowable deductions shall be applied to any nonexempt unearned income that remains after deducting the amount of the deposit. If the client has both nonexempt earned and unearned income, the amount deposited into the IDA account shall first be deducted from the client's nonexempt unearned income. Deposits shall not be deducted from earned or unearned income that is exempt.

75.57(7) *Exempt as income.* The following are exempt as income.

a. Reimbursements from a third party.

b. Reimbursement from the employer for a job-related expense.

c. The following nonrecurring lump sum payments:

(1) Income tax refund.

(2) Retroactive supplemental security income benefits.

(3) Settlements for the payment of medical expenses.

(4) Refunds of security deposits on rental property or utilities.

(5) That part of a lump sum received and expended for funeral and burial expenses.

(6) That part of a lump sum both received and expended for the repair or replacement of resources.

d. Payments received by the family for providing foster care when the family is operating a licensed foster home.

e. A small monetary nonrecurring gift, such as a Christmas, birthday or graduation gift, not to exceed $30 per person per calendar quarter.

When a monetary gift from any one source is in excess of $30, the total gift is countable as unearned income. When monetary gifts from several sources are each $30 or less, and the total of all gifts exceeds $30, only the amount in excess of $30 is countable as unearned income.

f. Earned income credit.

g. Supplementation from county funds, providing:

(1) The assistance does not duplicate any of the basic needs as recognized by the chart of basic needs components in accordance with subrule 75.58(2), or

(2) The assistance, if a duplication of any of the basic needs, is made on an emergency basis, not as ongoing supplementation.

h. Any payment received as a result of an urban renewal or low-cost housing project from any governmental agency.

i. A retroactive corrective payment.

j. The training allowance issued by the division of vocational rehabilitation, department of education.

k. Payments from the PROMISE JOBS program.

l. The training allowance issued by the department for the blind.

m. Payments from passengers in a car pool.

n. Support refunded by the child support recovery unit for the first month of termination of eligibility and the family does not receive the family investment program.

o. Support refunded by the child support recovery unit or otherwise paid to or for the recipient for a month of suspension. The maximum exempt payment shall be the amount of the monthly support entitlement. The payment shall never exceed the amount of support collected for the month of suspension.

p. Retrospective income received by an individual, whose needs are prospectively removed from the eligible group or who is no longer a member of the household, except nonrecurring lump sum income that causes a period of ineligibility and the income of a parent or stepparent who remains in the home.

q. Income of a nonparental relative as defined at subrule 75.55(1) except when the relative is included in the eligible group.

r. The retrospective income of individuals who are prospectively added to an eligible group for the initial two months of eligibility unless retrospective budgeting is required by subparagraph 75.57(9)*"a"*(5).

s. Compensation in lieu of wages received by a child under the Job Training Partnership Act of 1982.

t. Any amount for training expenses included in a payment issued under the Job Training Partnership Act of 1982.

u. Earnings of an applicant or recipient aged 19 or younger who is a full-time student as defined at subparagraphs 75.54(1)*"b"*(1) and (2). The exemption applies through the entire month of the person's twentieth birthday.

EXCEPTION: When the twentieth birthday falls on the first day of the month, the exemption stops on the first day of that month.

v. Retrospective income attributed to an unmarried, underage parent in accordance with paragraph 75.57(8)*"c"* effective the first day of the month following the month in which the unmarried, underage parent turns age 18 or reaches majority through marriage. When the unmarried, underage parent turns 18 on the first day of a month, the retrospective income of the self-supporting parents becomes exempt as of the first day of that month.

w. Incentive payments received from participation in the adolescent pregnancy prevention programs.

x. Payments received from the comprehensive child development program, funded by the Administration for Children, Youth, and Families, provided the payments are considered complimentary assistance by federal regulation.

y. Incentive allowance payments received from the work force investment project, provided the payments are considered complimentary assistance by federal regulation.

z. Interest and dividend income.

aa. Terminated income of recipient households who are subject to retrospective budgeting beginning with the calendar month the source of the income is absent, provided the absence of the income is timely reported as described at 441—subrule 76.2(5) and subparagraph 75.52(4)*"d"*(1).

EXCEPTION: Income that terminated in one of the two initial months occurring at time of an initial application that was not used prospectively shall be considered retrospectively as required by subparagraph 75.57(9)*"b"*(1). This subrule shall not apply to nonrecurring lump sum income defined at subparagraph 75.57(9)*"c"*(2).

ab. Honorarium income. All moneys paid to an eligible household in connection with the welfare reform demonstration longitudinal study or focus groups shall be exempted.

ac. Income that an individual contributes to a trust as specified at paragraph 75.24(3)*"b"* shall not be considered for purposes of determining eligibility for the family medical assistance program (FMAP) or FMAP-related Medicaid coverage groups.

ad. Benefits paid to the eligible household under the family investment program (FIP).

ae. Moneys received through the pilot self-sufficiency grants program or through the pilot diversion program.

af. Earnings from new employment of any person whose income is considered when determining eligibility during the first four calendar months of the new employment. The date the new employment or self-employment begins shall be verified before approval of the exemption. This four-month period shall be referred to as the work transition period (WTP).

(1) The exempt period starts the first day of the month in which the client receives the first pay from the new employment and continues through the next three benefit months, regardless if the job ends during the four-month period.

(2) To qualify for this disregard, the person shall not have earned more than $1,200 in the 12 calendar months prior to the month in which the new job begins, the income must be reported timely in accordance with rule 441—76.10(249A), and the new job must have started after the date the application is filed. For purposes of this policy, the $1,200 earnings limit applies to the gross amount of income without any allowance for exemptions, disregards, work deductions, diversions, or the costs of doing business used in determining net profit from any income test in rule 441—75.57(249A).

(3) If another new job or self-employment enterprise starts while a WTP is in progress, the exemption shall also be applied to earnings from the new source that are received during the original 4-month period, provided that the earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

(4) An individual is allowed the 4-month exemption period only once in a 12-month period. An additional 4-month exemption shall not be granted until the month after the previous 12-month period has expired.

(5) If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

(6) When a person living in the home whose income is not considered subsequently becomes an assistance unit member whose income is considered, the new job must start after the date of the change that causes the person's income to be considered in order for that person to qualify for the exemption.

(7) A person who begins new employment or self-employment that is intermittent in nature may qualify for the WTP. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families. However, a person is not considered as starting new employment or self-employment each time intermittent employment restarts or changes such as when the same temporary agency places the person in a new assignment or a child care provider acquires another child care client.

75.57(8) *Treatment of income in excluded parent cases, stepparent cases, and underage parent cases.*

a. Treatment of income in excluded parent cases. A parent who is living in the home with the eligible children but whose needs are excluded from the eligible group is eligible for the 20 percent earned income deduction, child care expenses for children in the eligible group, the 50 percent work incentive deduction described at paragraphs 75.57(2)*"a," "b,"* and *"c,"* and diversions described at subrule 75.57(4), and shall be permitted to retain that part of the parent's income to meet the parent's needs as determined by the difference between the needs of the eligible group with the parent included and the needs of the eligible group with the parent excluded except as described at subrule 75.57(10). All remaining nonexempt income of the parent shall be applied against the needs of the eligible group. Excluded parents are subject to the earned income sanctions at subparagraphs 75.57(2)*"d"*(1) and (2). The 20 percent earned income deduction and child care expenses described at paragraphs 75.57(2)*"a"* and *"b"* shall not be allowed for sanctioned earnings. However, the 50 percent work incentive deduction as at paragraph 75.57(2)*"c"* and diversions at subrule 75.57(4) shall be allowed.