

ARTICLE 2. MEDICAID RECIPIENTS; ELIGIBILITY

Rule 1. General Requirements; Medicaid Recipient Eligibility

405 IAC 2-1-1 Definitions

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 1. (a) As used in this article, “applicant” means the person for whom medical assistance is requested.

(b) As used in this article, “dependent child” means a nonrecipient child under eighteen (18) years of age or between eighteen (18) and twenty-one (21) years of age and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him or her for gainful employment. A dependent child must be the biological or adoptive child of the applicant or recipient or the biological or adoptive child of the applicant’s or recipient’s parent.

(c) As used in this article, “essential person” means a person who is not the applicant’s or recipient’s spouse or parent, who lives in the place of residence of the applicant or recipient, and who is considered by the applicant or recipient to be essential to his or her well-being because he or she provides services to the applicant or recipient which would have to be paid for otherwise.

(d) As used in this article, “nonrecipient” means a person who is not receiving medical assistance.

(e) As used in this article, “parent(s)” means the biological or adoptive parent(s) living with an unmarried applicant or recipient who is either:

(1) under eighteen (18) years of age; or

(2) between eighteen (18) and twenty-one (21) years of age and a student regularly attending a school, college, or university, or a course of vocational or technical training designed to prepare him or her for gainful employment.

(f) As used in this article, “recipient” means a person who is receiving medical assistance.

(g) As used in this article, “spouse” means the legal husband or wife of an applicant or recipient who is either living with the applicant or recipient or physically separated from him or her only for medical reasons. (*Office of the Secretary of Family and Social Services; 405 IAC 2-1-1; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1012, eff Apr 1, 1984; filed Jun 19, 1984, 10:25 a.m.: 7 IR 1820, eff Jul 1, 1984 [IC 4-22-2-5 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #84-29 was filed Jun 19, 1984.]; filed Apr 10, 1985, 2:20 p.m.: 8 IR 989; filed Apr 4, 1986, 11:07 a.m.: 9 IR 1854; filed Aug 15, 1986, 3:00 p.m.: 10 IR 6; filed May 11, 1987, 9:30 a.m.: 10 IR 1864; filed Apr 26, 1988, 12:55 p.m.: 11 IR 3028; filed Oct 6, 1989, 4:50 p.m.: 13 IR 282; filed May 2, 1990, 4:55 p.m.: 13 IR 1704; filed Aug 9, 1991, 11:00 a.m.: 14 IR 2224; filed May 14, 1992, 5:00 p.m.: 15 IR 2189; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1780; filed Nov 26, 1996, 4:30 p.m.: 20 IR 955; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-1) by P.L. 9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-1-2 Interview of applicants and recipients

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 2. (a) In addition to the requirements of 470 IAC 2.1-1-2, each applicant for and recipient of medical assistance or the individual authorized to act in the individual’s behalf must be interviewed by the county office at the time of the initial investigation and at each annual reinvestigation of eligibility.

(b) An application for medical assistance shall be filed on the form prescribed by the division of family and children.

(c) The applicant or recipient may use an authorized representative to apply for medical assistance, to represent the applicant or recipient in all interviews, and to notify the county office of any changes. The authorization must be in writing except as provided in subsections (e) and (f).

(d) Notwithstanding the availability of an authorized representative, the county office may require personal contact with the applicant or recipient in order to obtain information necessary for the determination of eligibility.

(e) The parents of an applicant or recipient under twenty-one (21) years of age may apply for medical assistance on behalf of the applicant or recipient without the written authorization specified in subsection (c).

(f) The written authorization specified in subsection (c) shall not be required if medical documentation shows that the applicant or recipient is medically unable to provide such authorization.

(g) An applicant or recipient who does not meet the requirements of this section shall be ineligible for medical assistance. (*Office of the Secretary of Family and Social Services; 405 IAC 2-1-2; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1013, eff Apr 1, 1984; filed*

Jun 19, 1984, 10:25 a.m.: 7 IR 1821, eff Jul 1, 1984 [IC 4-22-2-5 suspends the effectiveness of a rule document for thirty (30) days after filing with the secretary of state. LSA Document #84-29 was filed with the secretary of state June 19, 1984.]; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1781; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-2) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-1-3 Date of application for assistance

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 3. For the purpose of determining when notice of the decision to approve or deny assistance must be mailed to an applicant for medical assistance under 42 CFR 435.911, the date of application is the date on which the application for assistance, Part I, is received by the county office. (*Office of the Secretary of Family and Social Services; 405 IAC 2-1-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1013, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1781; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-1-3) to the Office of the Secretary of Family and Social Services (405 IAC 2-1-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

Rule 2. Eligibility Requirements Other than Need

405 IAC 2-2-1 Age requirement; medical assistance for the aged

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 1. In order to be eligible for assistance under the medical assistance for the aged program as an aged person, the applicant must be at least sixty-five (65) years of age. (*Office of the Secretary of Family and Social Services; 405 IAC 2-2-1; filed Mar 1, 1984, 2:31 pm: 7 IR 1014, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-2-2 Visual eligibility; medical assistance for the blind

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) An individual is visually eligible for the medical assistance for the blind program if he has central visual acuity of 20/200 or less in the better eye with correction or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20 degrees.

(b) Each applicant for medical assistance for the blind is required to undergo an eye examination by a qualified examiner as defined in IC 12-1-1-1(o) [*IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.*] unless:

(1) verification is obtained that the individual is currently receiving supplemental security income (SSI) benefits based on blindness; or

(2) reexaminations have been waived by the supervising ophthalmologist of the state department.

(c) The determination of visual eligibility of an applicant or recipient shall be made by the supervising ophthalmologist of the state department upon receipt of a written report on the form prescribed by the state department or in any other format that contains the same information as requested on this form. This report must be completed by the eye examiner and must be based on an examination given not more than six (6) months prior to the date of the eye examiner's report.

(d) The supervising ophthalmologist of the state department may require additional examinations in order to determine visual eligibility. (*Office of the Secretary of Family and Social Services; 405 IAC 2-2-2; filed Mar 1, 1984, 2:31 pm: 7 IR 1014, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-2) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-2-3 Disability determination

Authority: IC 12-8-6-5; IC 12-15-1-10

Affected: IC 12-13-7-3; IC 12-14-15-1; IC 12-15

Sec. 3. (a) The determination of whether an applicant or recipient is disabled according to the definition of disability prescribed in IC 12-14-15-1(2) is made by the Medicaid medical review team (MMRT) based upon the following principles:

(1) The determination of whether a condition appears reasonably certain to result in death or that appears reasonably certain to last for a continuous period of at least twelve (12) months without significant improvement is made on the basis of the expected duration of the condition. A condition that is temporary (less than twelve (12) months) or transient does not fulfill this requirement. The expected duration of the condition does not preclude the possibility of future medical advances, changed diagnosis or prognosis, unforeseen recovery, or successful treatment subsequent to the initial prognosis.

(2) The determination of whether a condition substantially impairs the applicant's ability to perform labor or services or to engage in a useful occupation will be made based upon a consideration of the following:

(A) The applicant's functional limitations, as follows:

(i) Consideration is given to the applicant's significant physical functions and capacity that affect vocational capacity, such as standing, walking, lifting, range of motion, strength, agility, and stamina.

(ii) Consideration is given to the individual's intellectual and sensory functions that affect vocational capacity, such as sight, speech, hearing, reasoning, and following directions.

(iii) Consideration is given to the applicant's capacity for sustained activity on a regular basis.

(B) The applicant's age, as follows:

(i) An individual who is not engaged in a useful occupation solely because of age cannot be found disabled if the individual's impairment, education, and work experience would enable the individual to function in a useful capacity.

(ii) If the applicant is over fifty-five (55) years of age, the applicant's age may be considered a significant factor in the applicant's ability to engage in or adapt to a useful occupation.

(iii) If the applicant is under eighteen (18) years of age, the applicant's condition is evaluated in terms of how it affects the applicant's activities and restricts the applicant's physical, mental, emotional, and social growth, learning, and development.

(iv) A condition that is likely to substantially impair a child's ability to become an independent and self-supporting adult is a basis for a finding of disability.

(C) The applicant's education and training, as follows:

(i) Consideration is given to the applicant's formal schooling and other training that contributes to the applicant's ability to meet vocational requirements.

(ii) Past work experience, daily activities, and hobbies are considered in determining and evaluating skills not acquired in a formal setting.

(iii) In determining whether these factors are vocationally significant, consideration is given to the time elapsed since the completion of education, training, or the exercise of acquired skills.

(iv) Lack of education and training is not of itself a basis for a finding of disability.

(D) The applicant's work experience, as follows:

(i) The applicant's inability to engage in the applicant's former occupation is not, in itself, a basis for a finding of disability.

(ii) Work performed fifteen (15) or more years before an application is not considered vocationally relevant. Similarly, an individual who has no work experience or only sporadic work experience in the previous fifteen (15) years is considered to have no work experience relevant to the determination of disability.

(iii) The absence of work experience is not in itself a basis for a finding of disability.

(iv) If an applicant is physically or mentally unable to engage in any previous occupation but the applicant's remaining functional capacity and vocational capabilities are sufficient to meet the demands and adjustments required by a different occupation, the applicant is not considered disabled.

(b) Except as provided below, a redetermination of disability is required annually of each recipient at the time the county office does its complete redetermination of all factors of eligibility. Redeterminations of disability may be required more frequently or may be waived at the discretion of the MMRT based upon the condition of the recipient. (*Office of the Secretary of Family and Social*

Services; 405 IAC 2-2-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1015, eff Apr 1, 1984; errata, 7 IR 1254; filed Dec 21, 2000, 2:06 p.m.: 24 IR 1342; errata filed Apr 30, 2001, 3:27 p.m.: 24 IR 2709; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 21, 2005, 3:00 p.m.: 29 IR 9) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-2-3) to the Office of the Secretary of Family and Social Services (405 IAC 2-2-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-2-4 Payment for examinations and tests

Authority: IC 12-8-6-5; IC 12-15-1-10

Affected: IC 12-13-5-1

Sec. 4. The office of Medicaid policy and planning (office) shall pay for the costs of necessary medical examinations and diagnostic tests required to determine whether the applicable visual or disability requirement is met to qualify for Medicaid to the blind or disabled, subject to the following limitations:

- (1) Payment will be made only to the medical practitioner upon submission of a completed claim form prescribed by the office.
- (2) Payment for the cost of submitting a report of a previously completed medical examination or other record shall not exceed ten dollars (\$10).
- (3) Payment for an eye examination and completion of a report thereon shall not exceed twenty-nine dollars (\$29).
- (4) Payment for a physical examination or evaluation and completion of a report thereon shall not exceed sixty-five dollars (\$65). Examination fees include expenses for basic blood testing and urinalysis. Fees relating to these tests will not be reimbursed separately.
- (5) Payment for a psychiatric evaluation or testing and completion of a report thereon shall not exceed eighty dollars (\$80) per hour.
- (6) Diagnostic procedures, such as laboratory tests, x-rays, and special testing, may be reimbursed only if authorized in advance of the procedure by the Medicaid medical review team (MMRT) physician. Authorization will only be granted if additional testing is necessary in order to:
 - (A) confirm the diagnosis or to measure the severity of the impairment; or
 - (B) assist in completing the examination.

Payment will not be made for any treatment given to the applicant.

- (7) All prior-authorized additional testing, as referenced in subdivision (6), will be reimbursed according to the Medicaid fee-for-service schedule applicable on the date of service.

(Office of the Secretary of Family and Social Services; 405 IAC 2-2-4; filed Nov 1, 1995, 8:30 a.m.: 19 IR 351; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)

Rule 3. Eligibility Requirements Based on Need; Aged, Blind, and Disabled Program

NOTE: 405 IAC 2-3 was transferred from 470 IAC 9.1-3. Wherever in any promulgated text there appears a reference to 470 IAC 9.1-3, substitute 405 IAC 2-3.

405 IAC 2-3-1 Transfer of property to meet eligibility requirements (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Mar 13, 2002, 10:09 a.m.: 25 IR 2475)*

405 IAC 2-3-1.1 Transfer of property; penalty

Authority: IC 12-8-1-9; IC 12-8-6-5; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5; IC 12-15-39.6

Sec. 1.1. (a) The following definitions apply throughout this section:

- (1) "Assets" includes all income and resources of the applicant or recipient, and of the applicant's or recipient's spouse, including any income or resources that the applicant or recipient or the applicant's or recipient's spouse is entitled to receive but does not receive because of action by:

- (A) the applicant or recipient or the applicant's or recipient's spouse;
- (B) a person, including, but not limited to, a court or administrative body with legal authority to act in place of or on behalf of the applicant or recipient or the applicant's or recipient's spouse; or

(C) a person, including, but not limited to, a court or administrative body acting at the direction or upon the request of the applicant or recipient or the applicant's or recipient's spouse.

The term includes assets that an individual is entitled to receive but does not receive because of failure to take action subject to subsection (j).

(2) "Individual" means an applicant or recipient of Medicaid.

(3) "Institutionalized individual" means an applicant or recipient who is:

(A) an inpatient in a nursing facility;

(B) an inpatient in a medical institution for whom payment is made based on a level of care provided in a nursing facility; or

(C) receiving home and community-based waiver services.

(4) "Net income" means the income produced by real property after deducting allowable expenses of ownership. Allowable and nonallowable expenses are as follows:

(A) The following are allowable expenses of ownership if the owner is responsible for the expenses:

(i) Property taxes.

(ii) Interest payments.

(iii) Repairs and maintenance.

(iv) Advertising expenses.

(v) Lawn care.

(vi) Property insurance.

(vii) Trash removal expenses.

(viii) Snow removal expenses.

(ix) Utilities.

(x) Any other expenses of ownership allowed by the Supplemental Security Income program.

(B) The following are not allowable expenses of ownership:

(i) Depreciation.

(ii) Payments on mortgage principal.

(iii) Personal expenses of the owner.

(iv) Mortgage insurance.

(v) Capital expenditures.

(5) "Noninstitutionalized individual" means an applicant or recipient receiving any of the services described in subsection (e).

(6) "Qualified long term care insurance policy" has the meaning set forth in 760 IAC 2-20-30.

(7) "Uncompensated value" means the difference between the fair market value of the asset and the value of the consideration received by the applicant or recipient in return for transferring the asset.

(b) A transfer of assets includes any cash, liquid asset, or property that is transferred, sold, given away, or otherwise disposed of as follows:

(1) Transfer includes any total or partial divestiture of control or access, including, but not limited to, any of the following:

(A) Converting an asset from individual to joint ownership.

(B) Relinquishing or limiting the applicant's or recipient's right to liquidate or sell the asset.

(C) Disposing of a portion or a partial interest in the asset while retaining an interest.

(D) Transferring the right to receive income or a stream of income, including, but not limited to, income produced by real property.

(E) Renting or leasing real property.

(F) Waiving the right to receive a distribution from a decedent's estate, or failing to take action to receive a distribution that the individual is entitled to receive by law subject to subsection (j).

(2) If an applicant or recipient relinquishes ownership or control over a portion of an asset, but retains ownership, control, or an interest in the remaining portion, the portion relinquished is considered transferred.

(3) A transfer of the applicant's or recipient's assets completed by the applicant's or recipient's power of attorney or legal guardian is considered a transfer by the applicant or recipient.

(4) For purposes of this section, 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

transferred by the applicant or recipient when any action is taken, either by the applicant or recipient or by any other person, that reduces or eliminates the applicant's or recipient's ownership or control of the asset.

(5) This section applies without regard to the exclusion of the home described in 42 U.S.C. 1382b(a)(1).

(6) This section applies without regard to the exclusion of income-producing real property described in section 15 of this rule, except for property used in a trade or business. The transfer of income-producing real property other than property used in a trade or business is subject to penalty under subsections (h) and (l). "Trade or business" means a trade or business that is actively managed or operated by the applicant or recipient.

(c) If an applicant or recipient of Medicaid, or the spouse of an applicant or recipient, disposes of assets for less than fair market value on or after the look-back date specified in this subsection, the applicant or recipient is ineligible for medical assistance for services described in subsections (d) through (e), for a period beginning on the first day of the first month 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 section. If the transfer took place prior to July 1, 2003, the penalty period begins in the month of the transfer. The ineligibility period is equal to the number of months specified in subsection (g). The look-back date is determined as follows:

(1) In the case of transfers that do not involve a trust, the look-back date is determined as follows:

(A) For an institutionalized individual, the look-back date is thirty-six (36) months before the first date as of which the individual both:

- (i) is an institutionalized individual; and
- (ii) has applied for medical assistance.

(B) For a noninstitutionalized individual, the look-back date is thirty-six (36) months before the later of the date on which the individual:

- (i) applies for medical assistance; or
- (ii) disposes of assets for less than fair market value.

(2) In the case of transfers that involve payments from a trust or portions of a trust that are treated as assets disposed of by an applicant or recipient under section 22(b)(3) or 22(c)(2) of this rule, the look-back date is determined as follows:

(A) For an institutionalized individual, the look-back date is sixty (60) months before the first date as of which the individual both:

- (i) is an institutionalized individual; and
- (ii) has applied for medical assistance.

(B) For a noninstitutionalized individual, the look-back date is sixty (60) months before the later of the date on which the individual:

- (i) applies for medical assistance; or
- (ii) disposes of assets for less than fair market value.

(d) During the penalty period, an institutionalized individual is ineligible for medical assistance for the following services:

- (1) Nursing facility services.
- (2) A level of care in any institution equivalent to that of nursing facility services.
- (3) Home or community-based waiver services.

(e) During the penalty period, a noninstitutionalized individual is ineligible for the following services:

- (1) Home health care services.
- (2) Home and community care services for functionally disabled elderly individuals.
- (3) Personal care services as defined in 42 U.S.C. 1396a(a)(24).
- (4) Any other long term care services, including, but not limited to, the services listed in subsection (d).

(f) If an individual is ineligible for medical assistance for services under this section, expenses for those services are not allowable medical expenses in calculating an individual's nursing home liability for any month of Medicaid eligibility.

(g) 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 subsection (c), divided by the average monthly cost to a private patient of nursing facility services in the geographic area that includes the county where the individual resides at the time of application. As used in this subsection, "geographic area" means the region identified in Section 2640.10.35.20 of the Family and Social Services Administration Program Policy Manual for Cash Assistance, Food Stamps, and Health Coverage. For transfers taking place on or after July 1, 2003, in determining the total, cumulative uncompensated value of assets transferred, transfers made in consecutive months are added together. The penalty period begins with the month following the first month in which assets were transferred, and that does not occur in any other penalty period.

(h) This subsection applies to the transfer of a stream of income, including, but not limited to, the transfer of the income generated by income-producing real property. The uncompensated value of income transferred is determined by calculating the greater of:

- (1) the fair market value; or
- (2) the actual amount;

of total net income that the property or other source of income is capable of producing during the lifetime of the transferor, based on life expectancy tables published by the office, and subtracting the income, if any, that the transferor will receive from the property or other source of income after the transfer.

(i) When an individual accepts a rental payment that is less than the fair market rental value for income-producing property, the uncompensated value of the transfer is determined by:

- (1) calculating the difference between the fair market rental value and the amount of rent accepted; and
- (2) multiplying the difference by the person's life expectancy based on life expectancy tables published by the office.

(j) This subsection applies to a transfer of assets that results from failure to take action to receive assets to which one is entitled to receive by law. No penalty will be imposed if any of the following circumstances applies:

(1) The applicant or recipient, or the individual with legal authority to act on behalf of the applicant or recipient, is unaware of his or her right to receive assets or becomes aware of the right to receive assets after the deadline for taking action has passed. If the office notifies the applicant or recipient of his or her right to receive assets prior to the deadline for taking action, the individual will be presumed to be aware of his or her right to receive assets unless subdivision (2) applies.

(2) A physician states that the applicant or recipient is not capable of taking action to receive the assets, and there is no guardian or other individual with the authority to act on the applicant's or recipient's behalf.

(3) The expenses of collecting the assets would exceed the value of the assets.

(4) In the case of a surviving spouse who fails to take a statutory share of a deceased spouse's estate, no penalty will be imposed if the deceased spouse has made other equivalent arrangements to provide for a spouse's needs. "Other equivalent arrangements" includes, but is not limited to, a trust established for the benefit of the surviving spouse.

(k) An applicant or recipient shall not be ineligible for medical assistance under this section if any of the following apply:

(1) The assets transferred were a home, and title to the home was transferred to any of the following persons:

(A) The spouse of the applicant or recipient.

(B) A child of the applicant or recipient who is:

- (i) under twenty-one (21) years of age; or
- (ii) blind or disabled as defined in 42 U.S.C. 1382c.

(C) A sibling of the applicant or recipient who has an equity interest in the home and who was residing in the applicant's or recipient's home for a period of at least one (1) year immediately before the date the applicant or recipient becomes an institutionalized individual.

(D) A son or daughter of the applicant or recipient, other than a child described in clause (B), who was residing in the applicant's or recipient's home for a period of at least two (2) years immediately before the date the applicant or recipient becomes an institutionalized individual and who the office determines has provided care to the applicant or recipient that permitted the applicant or recipient to reside at home rather than in an institution or facility.

(2) The assets were transferred to the applicant's or recipient's spouse or to another for the sole benefit of the applicant's or recipient's spouse.

(3) The assets were transferred from the applicant's or recipient's spouse to another for the sole benefit of the applicant's or recipient's spouse.

(4) The assets were transferred to:

(A) the applicant's or recipient's child who is disabled or blind as defined in 42 U.S.C. 1382c; or

(B) to a trust, including a trust described in section 22(i) of this rule, established solely for the benefit of the applicant's or recipient's child who is disabled or blind as defined in 42 U.S.C. 1382c.

(5) The assets were transferred to a trust, including a trust described in section 22(i) of this rule, established solely for the benefit of an individual under sixty-five (65) years of age who is disabled as defined in 42 U.S.C. 1382c.

(6) The assets transferred are disregarded for eligibility purposes through the use of a qualified long term care insurance policy under IC 12-15-39.6. If an asset is disregarded through the use of a qualified long term care insurance policy, that asset and any income generated by that asset may be transferred without penalty.

(7) A satisfactory showing is made to the office, in accordance with standards specified under 42 U.S.C. 1396p(c)(2)(C) by

the Secretary of Health and Human Services, that:

- (A) the applicant or recipient intended to dispose of the assets at fair market value or for other valuable consideration;
- (B) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or
- (C) all assets transferred for less than fair market value have been returned to the applicant or recipient.

In order to establish that a transfer was made exclusively for purposes other than qualifying for medical assistance, the applicant or recipient must submit sufficient evidence to show that the transfer was made exclusively for reasons not related to Medicaid eligibility, estate recovery, or lien.

(8) The office may waive the application of this section in cases of undue hardship, but only to the extent required by standards specified under 42 U.S.C. 1396p(c)(2)(D) by the Secretary of Health and Human Services.

(l) For transfers of income-producing real property not used in a trade or business on and after July 1, 2003, six thousand dollars (\$6,000) of the equity value can be transferred without penalty if the transferred property produces an annual income of at least three hundred sixty dollars (\$360). If the equity value of the property is less than six thousand dollars (\$6,000), the property can be transferred without penalty if the property produces an annual income of at least six percent (6%) of the equity. This six thousand dollars (\$6,000) exemption is a single, one (1) time exemption that applies to the total value of all income-producing real property transferred by the applicant during the applicant's lifetime. If the property does not produce an annual income of at least six percent (6%) of the lesser of six thousand dollars (\$6,000) or the equity value, the entire equity is the uncompensated value.

(m) In the case of a transfer by the spouse of an applicant or recipient that results in a period of ineligibility for medical assistance, the office shall apportion the period of ineligibility, or any portion of that period, between the applicant or recipient and the applicant's or recipient's spouse, if the spouse otherwise becomes eligible for medical assistance, as specified in regulations promulgated under 42 U.S.C. 1396p(c)(4) by the Secretary of Health and Human Services. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-1.1; filed May 1, 1995, 10:45 a.m.: 18 IR 2223; errata filed Jun 9, 1995, 2:30 p.m.: 18 IR 2796; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 13, 2002, 10:09 a.m.: 25 IR 2472; filed Apr 8, 2004, 3:16 p.m.: 27 IR 2479*)

405 IAC 2-3-1.2 Transfers involving annuities

Authority: IC 12-8-1-9; IC 12-8-6-5; IC 12-15-1-10

Affected: IC 12-15-4

Sec. 1.2. (a) For purposes of this section, "annuity" means a policy, certificate, contract, or other arrangement between two (2) or more parties whereby one (1) party pays a lump sum of money or other valuable consideration to the other party in return for the right to receive payments in the future.

(b) The purchase of an annuity, any instrument purporting to be an annuity, or any other arrangement that meets the definition of an annuity in subsection (a) shall be considered an uncompensated transfer of assets resulting in a penalty under section 1.1 of this rule unless the following criteria are met:

(1) The annuity is purchased from one (1) of the following:

- (A) An insurance company or another commercial company that sells annuities as part of the normal course of business.
- (B) A nonprofit organization qualified under Section 501(c) of the Internal Revenue Code as amended.

(2) The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent (5%) or less from the payment in the previous year.

(3) The annuity will return the full purchase price within the purchaser's life expectancy as determined by life expectancy tables published by the office.

(c) If an annuity complies with the criteria in subsection (b)(1) and (b)(2), but does not comply with subsection (b)(3), the uncompensated value of the transfer is the difference between the purchase price and the amount that the annuity will return within the purchaser's life expectancy. If an annuity does not comply with one (1) or more of the criteria in subsection (b)(1) or (b)(2), the uncompensated value is the entire purchase price.

(d) If an annuity is revocable or can be assigned to another person, it is considered an available resource for Medicaid eligibility purposes.

(e) This section applies to any annuity regardless of purchase date, except that the requirements in subsection (b)(1) and (b)(2) apply only to the following:

(1) Any annuity purchased on or after the later of:

- (A) June 1, 2002; or
- (B) the effective date of this rule.
- (2) Any annuity regardless of purchase date, if the annuity is annuitized on or after the later of:
 - (A) June 1, 2002; or
 - (B) the effective date of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-1.2; filed May 1, 2002, 10:38 a.m.: 25 IR 2726; errata filed Aug 22, 2002, 3:12 p.m.: 26 IR 35)

405 IAC 2-3-2 Life care contracts

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. An applicant who has entered into a life care contract with an institution whereby he has transferred his available assets to the institution in exchange for full maintenance and medical care during his lifetime in that institution is ineligible for medical assistance for the aged, blind, or disabled unless the contracting institution can prove to the county department by a complete and accurate accounting of all funds involved that it is unable to fulfill its contract obligations to the applicant. *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-2; filed Mar 1, 1984, 2:31 pm: 7 IR 1018, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-4) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-2) by P.L. 9-1991, SECTION 131, effective January 1, 1992.*

405 IAC 2-3-3 Income of applicant or recipient (calculation)

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-4; IC 12-15-5

Sec. 3. Countable income is gross monthly income less the deductions and exclusions required to be excluded by federal and state statute or regulation and the deductions and exclusions as follows:

- (1) Determination of net earned income as follows:
 - (A) All of the earned income of a child under fourteen (14) years of age is excluded.
 - (B) Up to ten dollars (\$10) of earned income is disregarded if the income is received only once during the calendar quarter from a single source (infrequent) or could not be reasonably to expected (irregular). If the total amount of infrequent or irregular earned income received in a month exceeds ten dollars (\$10), this disregard cannot be applied.
 - (C) Expenses allowed by the Internal Revenue Service shall be deducted from gross income from self-employment to determined net self-employment earnings.
 - (D) Sixty-five dollars (\$65) of earned income per month, plus impairment-related work expenses described in 405 IAC 2-9-2(b) for individuals in the disabled category, plus one-half (½) of remaining earned income is excluded.
- (2) Funds from a grant, scholarship, or fellowship, other than that excluded by federal regulations, which are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes shall be deducted from the total of such funds.
- (3) Tax refunds are excluded from income.
- (4) Home energy assistance is disregarded.
- (5) Up to twenty dollars (\$20) of unearned income is disregarded if the income is received only once during the calendar quarter from a single source (infrequent) or could not reasonably be expected (irregular). If the total amount of infrequent or irregular unearned income received in a month exceeds twenty dollars (\$20), this disregard cannot be applied.
- (6) A general income disregard of fifteen dollars and fifty cents (\$15.50) is deducted per month.
- (7) Payments made to foster parents or licensed child caring institutions from county funds or reimbursed under Title IV-B of the Social Security Act on behalf of an applicant or recipient who is a ward of the county department shall be excluded.
- (8) For an applicant or recipient of medical assistance under the blind category, an amount of his or her income, as specified in an approved plan for achieving self-support, is disregarded for a period of time not to exceed twelve (12) months. Such a plan will be approved by the family and social services administration, if the plan is in writing and fully documents that the income to be disregarded will be used by the applicant or recipient in pursuing a bona fide activity aimed at achieving self-support.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-3; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1018, eff Apr 1, 1984; filed Jul 16, 1987, 2:00 p.m.: 10 IR 2669; errata, 11 IR 799; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1783; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3114; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-5) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-3) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-4 Income of legally responsible relatives; inclusion

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 4. The countable income of an applicant for or recipient includes income of certain legally responsible relatives in the following situations:

(1) Except as provided in subdivision (3), if the applicant or recipient is under eighteen (18) years of age and is living with his or her parent(s), his or her income includes the income of his or her parent(s).

(2) If the applicant or recipient is living with his or her spouse, his or her income includes the income of his or her spouse.

(3) Income of the parent(s) is not included if the applicant or recipient is under eighteen (18) years of age and has been approved from home and community based services under an approved waiver, in accordance with 42 U.S.C.A. 1396n, which specifies the exclusion of parental income.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-4; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1019, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1784; filed May 10, 2001, 9:20 a.m.: 24 IR 3022; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-6) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-4) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-5 Income of parents; calculation (Repealed)

Sec. 5. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-6 Income levels for immediate family of institutionalized applicant or recipient (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-7 Available income of immediate family of institutionalized applicant or recipient (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-8 Income eligibility of noninstitutionalized applicant or recipient (Repealed)

Sec. 8. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-9 Income eligibility of institutionalized applicant or recipient (Repealed)

Sec. 9. *(Repealed by Office of the Secretary of Family and Social Services; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788)*

405 IAC 2-3-10 Spend-down eligibility

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 10. (a) The following definitions apply throughout this section:

(1) "County office" means the county office of the division of family resources of the family and social services administration.

(2) "Incurred medical expenses" has the meaning set forth in 42 CFR 435.121(f) and subsection (e). The term includes expenses incurred by the applicant's or recipient's spouse or parent whose income is counted in determining the applicant's

or recipient's eligibility for Medicaid. The term does not include expenses that are subject to payment or have been paid by a third party, except expenses paid by the following:

- (A) A state program.
- (B) A local program.
- (C) Discounts or assistance received under the Medicare drug discount card and transitional assistance program authorized under 42 U.S.C. 1395w-141.

(3) "Spend-down obligation" means the amount of any excess monthly income remaining in the eligibility determination in section 20(a)(14) of this rule.

(b) In order to be enrolled in Medicaid under the spend-down provision, an otherwise eligible applicant must provide documentation to the county office of incurred medical expenses in excess of the spend-down obligation. If the applicant's ongoing incurred medical expenses do not exceed his or her excess income, his or her application will be denied. Medicaid coverage will be approved for any month prior to the denial date in which incurred medical expenses equaled or exceeded the spend-down obligation, if all other eligibility requirements are met for the month. The Medicaid program will reimburse covered services in accordance with 405 IAC 5 for incurred medical expenses in excess of the spend-down obligation.

(c) Incurred medical expenses will credit the spend-down obligation in the following order and manner:

- (1) Incurred medical expenses submitted to the county office as described in subsections (e) and (f).
- (2) Medicaid copayments beginning with the month the service requiring the copayment was incurred and continuing in subsequent months until the full copayment has credited the spend-down obligation.
- (3) Medicaid claims filed by Medicaid providers in accordance with 405 IAC 1-1-3.1.

(d) Claims submitted by Medicaid participating providers for services rendered to enrolled Medicaid recipients will credit the recipient's spend-down obligation in the month of the service and in the order of submission. A service that is not payable by the Medicaid program under 405 IAC 5 will not credit the spend-down obligation, except for a service that is not covered for the following reasons:

- (1) The service is subject to a benefit limit; and
- (2) There is no provision for obtaining prior authorization for coverage for services that exceed the benefit limit.

Any amount paid or payable by a third party will not credit the spend-down obligation. The amount owed by the recipient after the third party has adjudicated the claim will credit the spend-down.

(e) Incurred medical expenses for services for which claims cannot be submitted directly by Medicaid providers must be submitted to the county office for the purpose of crediting the spend-down obligation. The documentation of an expense submitted to the county office must be a bill, a receipt, or other documentation of the individual's liability for the expense. The following are examples of expenses that must be submitted to the county office:

- (1) Expenses incurred before the individual was eligible for Medicaid.
- (2) Expenses incurred by the recipient's spouse or other person whose income is considered in determining the recipient's eligibility.
- (3) Expenses incurred for services provided by a non-Medicaid provider.

(f) For expenses submitted to the county office under subsection (e), the spend-down obligation will be credited for the month following the month of submission to the county office or, at the request of the recipient, in the month of service or in the month of submission of the expense to the county office. The incurred medical expense shall credit spend-down in subsequent months until the entire balance of the expense has been applied. The following incurred medical expenses will be credited toward spend-down under this subsection:

- (1) Medical care provided by physicians, psychiatrists, and other licensed medical practitioners.
- (2) Laboratory testing, x-rays, and other diagnostic procedures.
- (3) Dental services provided by a licensed dentist, including dentures.
- (4) Hospitalization and outpatient treatment.
- (5) Nursing facility services and rehabilitative services.
- (6) Respiratory, occupational, speech, physical, and audiology therapy services.
- (7) Prescription drugs and over-the-counter medication, including insulin, when prescribed by a licensed medical practitioner who is authorized to prescribe legend drugs under Indiana law.
- (8) The cost of postage incurred by the individual for mail order prescriptions.
- (9) Medical supplies, if ordered in writing by a licensed physician or dentist for treatment of a medical condition, except those items identified as noncovered medical supplies under 405 IAC 5.

- (10) Durable medical equipment if ordered in writing by a licensed physician except those items listed as noncovered equipment under 405 IAC 5-19-18.
- (11) Home health care provided by a licensed home health agency.
- (12) Nursing services provided by a registered nurse or licensed practical nurse.
- (13) Audiology services and hearing aids if ordered in writing by a physician.
- (14) Prosthetic devices other than those dispensed for purely cosmetic purposes, if ordered in writing by a physician, optometrist, or dentist.
- (15) Vision care services including eyeglasses, examinations, and diagnostic procedures.
- (16) Cost of transportation to obtain medical services that are allowable medical expenses. If transportation is provided by a business transportation carrier, the verified carrier's charge will be allowed. If the individual or a friend or family member drives the individual to medical services, mileage cost is allowed at the rate per mile established by the Indiana legislature for state employees.
- (17) The premium of the recipient's spouse who receives Medicaid for Employees with Disabilities (MED Works).
- (18) Medicaid copayments and any copayments required by other health coverage programs or health insurance carriers.
- (19) Premiums for health and hospitalization insurance policies that limit benefits to the reimbursement of medical expenses.
- (20) Medicare premiums.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-10; filed Mar 1, 1984, 2:31 p.m.: 7 IR 1021, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; filed Jul 25, 1995, 5:00 p.m.: 18 IR 3382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Sep 7, 2004, 5:00 p.m.: 28 IR 178; filed Jul 18, 2005, 1:00 p.m.: 28 IR 3579) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-12) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-10) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-11 Loans; inclusion as income

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 11. (a) A loan shall not be considered as income in the month of receipt if the written or verbal loan agreement is legally binding under state law and includes the following:

- (1) the borrower's acknowledgement of an obligation to repay; and
- (2) a timetable and plan for repayment; and
- (3) the borrower's express intent to repay either by pledging real or personal property or anticipated income.

(b) An amount remaining in the month following the month of receipt shall be considered in determining whether the applicant or recipient is within the resource limit set forth in 470 IAC 9.1-3-1 [*Repealed filed Dec 16, 1986, 11:00 am: 10 IR 1081, eff Feb 1, 1987*]. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-11; filed Mar 1, 1984, 2:33 pm: 7 IR 1043, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-13) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-11) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-12 Contract sale of real property; calculation as income

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 12. In the determination of countable income received as a result of a contract sale of real property, the county department shall determine the amount of the monthly contractual payment, subtract all ownership expenses, and the remainder shall be counted as unearned income.

The down payment portion shall be considered a resource. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-12; filed Mar 1, 1984, 2:33 pm: 7 IR 1043, eff Apr 1, 1984; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-14) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-12) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-13 In-kind support and maintenance; inclusion as income

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 13. (a) The following definitions apply throughout this section:

(1) "In-kind support and maintenance" means any food, clothing, or shelter which is received by the applicant or recipient and his or her spouse, or by the child applicant or recipient and his or her parent(s) because someone else pays for it.

(2) "Shelter" means room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewerage, and garbage collection services.

(3) "Pro rata share of shelter" means the average value of monthly shelter costs divided by the number of people in the household, regardless of age.

(4) "Pro rata share of food" means the average monthly expenses for food divided by the number of people in the household, regardless of age.

(b) In-kind support and maintenance shall be considered as unearned income and shall be the actual value of food, clothing, or shelter received not to exceed one-third (1/3) of the applicable income standard in section 18 of this rule.

(c) In-kind support and maintenance for shelter or food shall not be considered if the applicant or recipient and his or her spouse, or his or her parent(s) if he or she is a child, live in someone else's household, and pay at least a pro rata share of shelter or food. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-13; filed Mar 1, 1984, 2:33 p.m.: 7 IR 1043, eff Apr 1, 1984; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-15) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-13) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-14 Resources; general

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 14. (a) Definitions. (1) Resources are all of the real and personal property owned by the applicant or recipient and his spouse or parent(s). Resources must be available in order to be considered in the eligibility determination. If the individual has the right, authority or ability to liquidate the property, or his share of the property, it is considered an available resource.

(2) Liquid assets are those assets that are in cash or are financial instruments which are convertible to cash.

(3) Current market value is the average price that the property can reasonably be expected to sell for on the open market in the particular geographic area involved.

(4) Equity value is the current market value minus the total amount of liens against the property. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-14; filed Dec 16, 1986, 11:00 am: 10 IR 1079, eff Feb 1, 1987; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-16) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-14) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-15 Resources; limitations and exclusions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 15. (a) An applicant or recipient is ineligible for medical assistance for any month in which the total equity value of all nonexempt personal property exceeds the applicable limitation, set forth as follows, on the first day of the month:

(1) One thousand five hundred dollars (\$1,500) for the applicant or recipient, including the amount determined in subsection (b), or in addition to the amount determined in subdivision (3), if applicable.

(2) Two thousand two hundred fifty dollars (\$2,250) for the applicant or recipient and his or her spouse if the couple is living together, or if the most recent continuous period of institutionalization of one (1) member of the couple began prior to September 30, 1989.

(3) Twelve thousand dollars (\$12,000), subject to adjustment under Section 1924(g) of the Social Security Act, as the spousal resource standard provided for in Section 1924(f)(2)(A)(i) of the Social Security Act, or a higher amount as determined under:

(A) Section 1924(f)(2)(A)(ii);

(B) Section 1924(f)(2)(A)(iii); or

(C) Section 1924(f)(2)(A)(iv);

of the Social Security Act for a community spouse as defined in Section 1924(h) of the Social Security Act.

(b) Except as provided in subdivision (3), if the applicant or recipient is under eighteen (18) years of age, his or her personal property includes the value of his or her parents' personal property in excess of the following limitations and in the following situations:

(1) If the child lives with one (1) parent, one thousand five hundred dollars (\$1,500) of the parent's personal property is excluded. If the child lives with two (2) parents, two thousand two hundred fifty dollars (\$2,250) of the parents' personal property is excluded.

(2) If the child is institutionalized, one thousand five hundred dollars (\$1,500) of the personal property of his or her custodial parent or two thousand two hundred fifty dollars (\$2,250) of the personal property of both parents is excluded.

(3) If the child is approved for home and community based services under the waiver for persons with autism, in accordance with 42 U.S.C. 1396n, parental resources are excluded regardless of parental income.

(c) In addition to that property required to be excluded by federal statute or regulation, the following property is exempt from consideration:

(1) All household goods and personal effects.

(2) Personal property required by an individual's employer while the individual is employed.

(3) The equity value of personal property used to produce food for home consumption or used in the production of income.

(4) The value of life insurance with a total face value of one thousand four hundred dollars (\$1,400) or less if provision has been made for payment of the applicant's or recipient's funeral expenses from the proceeds of such insurance. However, the one thousand four hundred dollars (\$1,400) limitation shall be reduced by any amount in an irrevocable burial trust or irrevocable prepaid funeral agreement.

(5) For a period of no more than nine (9) months from the date of receipt, the proceeds or any interest earned on the proceeds of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property if the applicant or recipient demonstrates that the proceeds are being used to repair or replace the damaged, destroyed, lost, or stolen exempt property.

(6) One (1) motor vehicle according to the following provisions:

(A) One (1) motor vehicle is excluded, regardless of value, if, for the applicant or recipient or other member of his or her household, the motor vehicle is:

(i) necessary for employment;

(ii) necessary for the medical treatment of a specific or regular medical problem; or

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

(B) If no motor vehicle is excluded under clause (A), four thousand five hundred dollars (\$4,500) of the current market value of one (1) motor vehicle is excluded.

(7) Burial spaces.

(8) Subject to the requirements in subsection (d), the home which is the principal place of residence of:

(A) the applicant or recipient;

(B) the spouse of the applicant or recipient;

(C) the parent(s) of the applicant or recipient;

(D) the applicant's or recipient's biological or adoptive child(ren) under eighteen (18) years of age; or

(E) the applicant's or recipient's blind or disabled biological or adoptive child(ren) eighteen (18) years of age or older.

(9) For an applicant or recipient of medical assistance under the blind category, an amount of his or her resources, as specified in an approved plan for achieving self-support, is disregarded for a period of time not to exceed twelve (12) months. Such a plan will be approved by the division of family and children in conjunction with the Indiana division of services for the blind if the plan is in writing and fully documents that the resources to be disregarded will be used by the applicant or recipient in pursuing a bona fide activity aimed at achieving self-support.

(10) Income producing real property if the income is greater than the expenses of ownership.

(d) The home exempted by subsection (c)(8) is exempt until such time as it is verified that none of the persons listed in subsection (c)(8) intends to reside there. The home is the shelter in which the person resides, the land on which the shelter is located, and related outbuildings.

(e) As a condition of eligibility for medical assistance for the aged, blind, and disabled, each applicant and recipient and his

or her legally responsible relatives must sign an agreement to offer for sale or for rent all nonexempt real property that he or she or his or her legally responsible relatives own, except in those situations involving a community spouse and an institutionalized spouse, as defined in Section 1924(h) of the Social Security Act, wherein the total equity value of all resources of the couple does not exceed the sum of the institutionalized spouse's resource limitation specified in subsection (a)(1) and the community spouse resource standard, as determined under Section 1924(f)(2)(A) of the Social Security Act.

(f) If nonexempt real property is not offered for sale or for rent at current market value within thirty (30) days of written notification of medical assistance or within thirty (30) days after the agreement referenced in subsection (e) is signed, whichever is later, the recipient shall be ineligible for medical assistance. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-15; filed Dec 16, 1986, 11:00 a.m.: 10 IR 1080, eff Feb 1, 1987; filed Jul 16, 1987, 2:00 p.m.: 10 IR 2670; errata, 11 IR 96; filed Jun 30, 1989, 5:00 p.m.: 12 IR 2048; filed Dec 15, 1989, 11:50 a.m.: 13 IR 878; filed Aug 21, 1996, 2:00 p.m.: 20 IR 13; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-17) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-15) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-16 Funeral trusts; consideration

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15; IC 30-2-10

Sec. 16. A funeral trust established under IC 30-2-10 et seq. which contains a technical defect in the documents required by IC 30-2-10-5 shall be deemed for the purposes of Medicaid eligibility to be valid as of the original date of establishment of the trust if the defect is corrected within twenty (20) days after receipt of notice from the county department of the defect. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-16; filed Dec 16, 1986, 11:00 am: 10 IR 1081; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-18) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-16) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-17 Income eligibility of institutionalized applicant or recipient with community spouse; posteligibility

Authority: IC 12-8-6-5; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5; IC 12-15-7-2

Sec. 17. (a) As used in this section, "institutionalized spouse" and "community spouse" have the meanings set forth in 42 U.S.C.A. 1396r-5(h)(1).

(b) The income eligibility of an institutionalized applicant or recipient with a community spouse shall be determined as follows:

- (1) Determine the applicant's or recipient's countable income under section 3 of this rule and in accordance with income ownership provisions set forth in 42 U.S.C.A. 1396r-5(d).
- (2) Subtract from the amount determined in subdivision (1) the individual income standard specified in section 18 of this rule.
- (3) If the remainder calculated in subdivision (2) is zero dollars (\$0) or less, the applicant or recipient is eligible for medical assistance.
- (4) If the remainder calculated in subdivision (2) is greater than zero dollars (\$0), the applicant or recipient is eligible if his or her estimated medical expenses exceed this remainder.

(c) If an applicant or recipient is determined eligible for medical assistance under subsection (b), posteligibility treatment of income to calculate the amount of income to be paid to the institution is determined as follows:

- (1) Subtract from the applicant's or recipient's gross income determined according to ownership provisions set forth in 42 U.S.C.A. 1396r-5(b) those exclusions required by federal law.
- (2) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.
- (3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant or recipient's legal guardian, not to exceed thirty-five dollars (\$35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.
- (4) Subtract a spousal allocation equal to the community spouse's total income, in accordance with ownership provisions set forth in 42 U.S.C.A. 1396r-5(b), subtracted from the sum of nine hundred eighty-four dollars (\$984), plus an excess shelter allowance determined under 42 U.S.C.A. 1396r-5(d)(4), subject to all provisions of 42 U.S.C.A. 1396r-5(d), 42 U.S.C.A.

1396r-5(e), and 42 U.S.C.A. 1396r-5(g).

(5) Subtract an allocation for each dependent family member, as defined in subsection (e), equal to one-third ($\frac{1}{3}$) of the amount by which nine hundred eighty-four dollars (\$984) exceeds the family member's total income, subject to the provisions of 42 U.S.C.A. 1396r-5(d), 42 U.S.C.A. 1396r-5(e), and 42 U.S.C.A. 1396r-5(g).

(d) The spousal allocation calculated in subsection (c)(4) is deducted from the institutionalized applicant's or recipient's income only to the extent that it is actually made available to, or for the benefit of, the community spouse.

(e) "Dependent family member", for the purpose of determining the allocation in subsection (c)(5), is a person listed, as follows, who resides with the community spouse:

(1) Biological or adoptive children of either spouse under twenty-one (21) years of age.

(2) Biological or adoptive children of the community or institutionalized spouse who are twenty-one (21) years of age or over and who are claimed for tax purposes by either spouse under the Internal Revenue Service Code.

(3) The parent(s) of the community or institutionalized spouse who are claimed as dependents by either spouse for tax purposes under the Internal Revenue Service Code.

(4) Biological and adoptive siblings of the community or institutionalized spouse who are claimed by either spouse for tax purposes under the Internal Revenue Service Code.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-17; filed Dec 1, 1989, 5:00 p.m.: 13 IR 628; filed May 2, 1990, 4:55 p.m.: 13 IR 1707; filed Aug 9, 1991, 11:00 a.m.: 14 IR 2227; filed May 14, 1992, 5:00 p.m.: 15 IR 2191; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1785; filed Feb 23, 1998, 11:30 a.m.: 21 IR 2383; filed Feb 7, 2000, 3:26 p.m.: 23 IR 1377; errata filed Mar 20, 2000, 3:19 p.m.: 23 IR 2003; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:55 a.m.: 26 IR 2867) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-3-19) to the Office of the Secretary of Family and Social Services (405 IAC 2-3-17) by P.L.9-1991, SECTION 131, effective January 1, 1992.

405 IAC 2-3-18 Income standards

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 18. (a) The standards used in determining the income eligibility of an applicant or recipient under sections 17 and 20 of this rule are as follows:

(1) Individual standard, four hundred seventy dollars (\$470).

(2) Couple standard, seven hundred five dollars (\$705).

(3) Nonapplicant or nonrecipient dependent child standard, two hundred thirty-five dollars (\$235).

(4) Applicant or recipient dependent child standard, four hundred seventy dollars (\$470).

(5) Essential person standard, two hundred thirty-five dollars (\$235).

(6) One (1) parent standard, four hundred seventy dollars (\$470).

(7) Two (2) parent standard, seven hundred five dollars (\$705).

(8) Stepparent standard, two hundred thirty-five dollars (\$235).

(b) Beginning in calendar year 1997, the income standards specified in subsection (a) shall increase annually in the same percentage amount that is applied to Supplemental Security Income (SSI) benefits under 42 U.S.C. 1382(f). The increase in the income standards shall be effective on the first day of the same month in which the division of family and children processes the Title II costs of living adjustments received by public assistance recipients under 42 U.S.C. 415(i). *(Office of the Secretary of Family and Social Services; 405 IAC 2-3-18; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1786; filed Jul 18, 1994, 11:00 a.m.: 17 IR 2853; filed Jun 15, 1995, 10:00 a.m.: 18 IR 2760; filed Aug 21, 1996, 2:00 p.m.: 20 IR 15; filed Feb 12, 1997, 4:00 p.m.: 20 IR 1734; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

405 IAC 2-3-19 Income deemed from parents

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 19. (a) Except as provided in section 4 of this rule, the amount of income of a parent(s) to be included as income to an applicant or recipient in section 20 of this rule is determined according to the following procedures:

(1) Determine the unearned income of the parent(s) which is not excluded by state or federal statute or regulation.

- (2) If the stepparent of the applicant or recipient is living in the home of the applicant or recipient and his or her parent, subtract an allocation from the income of the parent as determined under subsection (b).
- (3) Subtract an allocation to dependent children as determined under subsection (b).
- (4) Subtract the general income disregard specified in section 3 of this rule. The resulting amount is countable unearned income.
- (5) Determine the earned income of the parent(s).
- (6) Subtract any remaining allocation to dependent children as determined under subsection (b).
- (7) Subtract any remaining amount of the general income disregard.
- (8) Subtract the earned income disregard specified in section 3 of this rule. The resulting amount is countable earned income.
- (9) Combine countable unearned and countable earned income.
- (10) Subtract the appropriate parental income standard specified in section 18 of this rule.
- (11) The resulting amount is deemed as income to the applicant or recipient.
- (b) An allocation equal to the individual's income subtracted from the applicable income standard in section 18 of this rule shall be subtracted first from unearned income and then from earned income for the following individuals:
 - (1) The applicant's or recipient's stepparent and the stepparent's dependent children who are not receiving assistance to families with dependent children. The allocation shall not exceed the stepparent standard specified in section 18 of this rule.
 - (2) A nonapplicant or nonrecipient dependent child of the parent(s), if the child is not receiving adoption assistance or assistance to families with dependent children. The allocation shall be subtracted from the income of the child's biological or adoptive parent(s).
 - (c) An allocation is not subtracted if the individual's income equals or exceeds the applicable income standard. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-19; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1787; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*)

405 IAC 2-3-20 Income eligibility of applicant or recipient

Authority: IC 12-13-5-3; IC 12-13-7-3; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5

Sec. 20. (a) Except as provided in section 17 of this rule, an applicant's or recipient's income eligibility shall be determined by the following procedures:

- (1) Determine the applicant's or recipient's unearned income which is not excluded by state or federal statute or regulation.
- (2) Add to the amount determined in subdivision (1) the amount of the spouse's unearned income after subtracting any allocation to a dependent child of the spouse as provided in subsection (b).
- (3) Add to the amount determined in subdivision (1) any deemed income from a parent as determined under section 19 of this rule.
- (4) Subtract the general income disregard specified in section 3 of this rule.
- (5) Subtract any allocation as determined under subsection (b). The resulting amount is countable unearned income.
- (6) Determine the earned income of the applicant or recipient.
- (7) Add the spouse's earned income after subtracting any remaining allocation to a dependent child from subdivision (2).
- (8) Subtract any remaining general income disregard.
- (9) Subtract the remaining allocations as determined under subsection (b).
- (10) Subtract the earned income disregard specified in section 3 of this rule. The resulting amount is countable earned income.
- (11) Combine countable unearned and countable earned income.
- (12) Subtract the individual income standard specified in section 18 of this rule if the applicant or recipient is not living with a spouse or is living with a spouse who is receiving assistance to families with dependent children.
- (13) Subtract the couple income standard specified in section 18 of this rule if the applicant or recipient is living with a spouse who is not receiving assistance to families with dependent children.
- (14) If the resulting amount in subdivision (12) or (13) is zero dollars (\$0) or less than zero dollars (\$0), the applicant or recipient is eligible for medical assistance. If the resulting amount is greater than zero dollars (\$0), the applicant or recipient is eligible if he or she meets the requirements of section 10 of this rule.
- (b) An allocation equal to the individual's income subtracted from the applicable income standard in section 18 of this rule shall be subtracted first from unearned income and then from earned income for the following individuals:

- (1) A dependent child of the spouse of an applicant or recipient if the child is not receiving adoption assistance or assistance to families with dependent children.
- (2) A nonapplicant or nonrecipient dependent child of the applicant or recipient if the child is not receiving adoption assistance or assistance to families with dependent children.
- (3) An applicant or recipient child of the applicant or recipient.
- (4) One (1) essential person of the applicant or recipient if the essential person is not receiving assistance to families with dependent children.

(c) An allocation is not subtracted if the individual's income equals or exceeds the applicable income standard. (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-20; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1787; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*)

405 IAC 2-3-21 Posteligibility income calculation

Authority: IC 12-8-6-5; IC 12-15-1-10

Affected: IC 12-15-4; IC 12-15-5; IC 12-15-7-2

Sec. 21. Except as provided in section 17 of this rule, the following procedures are used to determine the amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under section 20 of this rule and who is residing in a Title XIX certified hospital, nursing facility, intermediate care facility for the mentally retarded, or public institution:

- (1) Determine the applicant's or recipient's total income which is not excluded by federal statute. Total income includes amounts deducted in the eligibility determination under section 20 of this rule.
- (2) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.
- (3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant or recipient's legal guardian, not to exceed thirty-five dollars (\$35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.
- (4) Subtract the amount of health insurance premiums.
- (5) Subtract an amount for expenses incurred for necessary medical or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.
- (6) The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

(*Office of the Secretary of Family and Social Services; 405 IAC 2-3-21; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1788; filed Feb 23, 1998, 11:30 a.m.: 21 IR 2384; filed Feb 7, 2000, 3:26 p.m.: 23 IR 1378; errata filed Mar 20, 2000, 3:19 p.m.: 23 IR 2003; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:55 a.m.: 26 IR 2868*)

405 IAC 2-3-22 Trusts

Authority: IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-2-17; IC 12-15-3

Sec. 22. (a) This section governs the treatment of trusts when determining eligibility of an applicant or recipient of Medicaid. This section applies to trusts established by an applicant or recipient of Medicaid as defined in subsection (e). As used in this section, "individual" means an applicant or recipient of Medicaid.

(b) A revocable trust established by an applicant or recipient shall be considered as follows:

- (1) The corpus of the trust shall be considered resources available to the individual.
- (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 for purposes of section 1.1 of this rule.

(c) An irrevocable trust established by an applicant or recipient shall be considered as follows:

(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 corpus or income from which payment to the individual could be made shall be considered resources available to the individual. Payments from that portion of the corpus or income shall be counted as follows:

- (A) Payments to or for the benefit of the individual shall be considered income of the individual.
- (B) Payments for any other purpose shall be considered assets disposed of by the individual subject to section 1.1 of

this rule.

(2) If there are no circumstances under which payment from a portion of the trust could be made to or for the benefit of the individual, the portion of the corpus or income from which no payment to the individual could be made shall be considered to be assets disposed of by the individual for purposes of section 1.1 of this rule. For purposes of section 1.1 of this rule, the following shall apply:

(A) The assets shall be considered disposed of as of the date of establishment of the trust or the date on which payment to the individual was foreclosed, whichever is later.

(B) The value of the trust shall be determined by including the amount of any payments made from that portion of the trust after the date in clause (A).

(d) As used in this section, "trust" includes, but is not limited to, any legal instrument or device that is similar to a trust. The term includes an annuity only to such extent and in such manner as allowed by regulations of the Secretary of Health and Human Services.

(e) For purposes of this section, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust other than by will:

(1) The individual.

(2) The individual's spouse.

(3) A person with legal authority to act in place of or on behalf of the individual or the individual's spouse, including, but not limited to, a court or administrative body.

(4) A person acting at the direction or upon the request of the individual or the individual's spouse, including, but not limited to, a court or administrative body.

(f) As used in this section, "assets" 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:

(1) by the individual or the individual's spouse;

(2) by a person with legal authority to act in place of or on behalf of the individual or the individual's spouse, including, but not limited to, a court or administrative body; or

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

(g) In the case of a trust, the corpus of which includes assets of an individual and assets of any other person or persons, this subsection shall apply to that portion of the trust attributable to the assets of the individual.

(h) Subject to subsection (i), this subsection shall apply without regard to any of the following:

(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 distributions may be made from the trust.

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

(i) This section shall not apply to any of the following trusts:

(1) A trust containing the assets of an individual under sixty-five (65) years of age who is disabled as defined in 42 U.S.C. 1382c(a)(3), 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.

(2) A trust composed only of:

(A) pension;

(B) Social Security;

(C) other income of the individual; and

(D) accumulated income in the trust;

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.

(3) A trust containing the assets of an individual who is disabled as defined in 42 U.S.C. 1382c(a)(3) that meets the following conditions:

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

(B) 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.

(C) Accounts in the trust are established solely for the benefit of individuals who are disabled by:

- (i) the parent, grandparent, or legal guardian of the individuals;
- (ii) the individuals; or
- (iii) a court.

(D) To the extent that amounts remaining in the beneficiary's account upon the 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.

(j) The office may waive the application of this section in cases of undue hardship, but only to the extent required by standards specified under 42 U.S.C. 1396p(d)(5) by the Secretary of Health and Human Services.

(k) This section applies to trusts established on or after August 11, 1993. Trusts established before August 11, 1993, are governed by 42 U.S.C. 1396a(k). (*Office of the Secretary of Family and Social Services; 405 IAC 2-3-22; filed May 1, 1995, 10:45 a.m.: 18 IR 2225; errata filed Jun 9, 1995, 2:30 p.m.: 18 IR 2796; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*)

405 IAC 2-3-23 Savings bonds

Authority: IC 12-8-1-9; IC 12-8-6-5; IC 12-15-1-10

Affected: IC 12-15-3

Sec. 23. United States Savings Bonds are considered available for Medicaid eligibility purposes beginning on the date of purchase. During the six (6) month period following the date of issue, bonds are valued for eligibility purposes as follows:

(1) Bonds issued at face value, including, but not limited to, Series I and HH bonds, are valued at face value.

(2) Bonds issued for less than face value, including, but not limited to, Series EE bonds, are valued at the purchase price.

(*Office of the Secretary of Family and Social Services; 405 IAC 2-3-23; filed Oct 10, 2002, 10:50 a.m.: 26 IR 730*)

Rule 3.1. Eligibility Requirements Based on Need; Pregnancy-Related Coverage; Coverage for Children 18 Years of Age and Under (Voided)

NOTE: Voided by P.L.119-1997, SECTION 6, effective April 9, 1997.

Rule 4. Burial Expenses

405 IAC 2-4-1 Payment of burial expenses

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) For the purpose of implementing the provisions of IC 12-1-5-11 [*IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.*], IC 12-1-6-11 [*IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.*], and IC 12-1-7.1-13 [*IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.*], a recipient of medical assistance for the aged, blind, and disabled is that person who is receiving medical assistance as of the date of his death, or who applied for medical assistance prior to the date of his death and was subsequently determined eligible.

(b) The state department shall pay for the cost of the deceased recipient's burial expenses subject to the following limitations:

(1) Payment will be made only to the funeral director or cemetery representative upon submission of a completed claim form prescribed by the state department.

(2) Payment shall not be made to a funeral director who submits a claim for cemetery expenses unless he attaches proof to the claim that he is the cemetery representative or has been designated the cemetery representative.

(3) In determining the amount to be paid by the state department to the funeral director, contributions paid and payments made or available from the estate of the deceased recipient in excess of the exclusion provided by IC 12-1-5-11 [*IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.*], IC 12-1-6-11 [*IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.*], and IC 12-1-7.1-13 [*IC 12-1 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.*] shall be subtracted from the statutory maximum. The balance of the unpaid expenses, up to the statutory maximum, shall be paid by the state department.

(4) In determining the amount to be paid by the state department to the cemetery representative, contributions paid and payments made or available from the estate of the deceased recipient in excess of the statutory exclusion shall be subtracted

from the statutory maximum. The balance of the unpaid expenses, up to the statutory maximum, shall be paid by the state department.

(Office of the Secretary of Family and Social Services; 405 IAC 2-4-1; filed Mar 1, 1984, 2:31 pm: 7 IR 1021, eff Apr 1, 1984; errata, 7 IR 1254; filed Aug 2, 1985, 2:39 pm: 8 IR 2023, eff Sep 1, 1985; filed Jul 16, 1987, 2:00 pm: 10 IR 2671; errata, 11 IR 799; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822) NOTE: Transferred from the Division of Family and Children (470 IAC 9.1-4-1) to the Office of the Secretary of Family and Social Services (405 IAC 2-4-1) by P.L.9-1991, SECTION 131, effective January 1, 1992.

Rule 5. Determination of Monthly Income

405 IAC 2-5-1 Conversion of income

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4

Affected: IC 12-14; IC 12-15

Sec. 1. (a) When determining eligibility and the amount of assistance payment for the months beginning with the month of application, the following computations shall be made to establish income for the payment month:

(1) Income received on a less than monthly basis shall be converted to a monthly amount as follows:

(A) Income received weekly shall be multiplied by four and three-tenths (4.3) to determine the monthly income.

(B) Income received every two (2) weeks shall be multiplied by two and fifteen-hundredths (2.15) to determine the monthly income.

(C) Income received twice per month shall be multiplied by two (2) to determine the monthly income.

(2) Income which is not expected to continue throughout the payment month shall be considered in the actual amount anticipated to be received in that month.

(3) Income received on a contractual basis shall be prorated over the number of months covered under the contract, and the resultant amount shall be considered available monthly income.

(4) Income received on a quarterly, semiannual, or annual basis shall be divided by the appropriate number of months to establish a monthly amount.

(5) Income received to defray the cost of education shall be prorated over the period intended to be covered by the income.

(6) Fluctuating income may be averaged to determine a monthly amount.

(b) In determining eligibility for months prior to the month of application, the actual amount of income received shall be considered income. *(Office of the Secretary of Family and Social Services; 405 IAC 2-5-1; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1778; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 6. Medical Assistance for Individuals 18, 19, and 20 Years of Age

405 IAC 2-6-1 Medical assistance for individuals 18, 19, and 20 years of age

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4

Affected: IC 12-14; IC 12-15

Sec. 1. (a) An individual eighteen (18), nineteen (19), or twenty (20) years of age who meets the criteria established in 42 CFR 435.220, as revised and effective on October 1, 1991, is eligible for medical assistance.

(b) The income eligibility determination for such person shall be based upon those income standards established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-3 [470 IAC 10.1-3-3 was repealed filed Aug 26, 1987, 11:00 a.m.: 11 IR 90. See 470 IAC 10.1-3-3.1].

(c) The budgeting methodologies established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-4 shall apply to this rule.

(d) The income and resources of the applicant or recipient and that of his or her parents living in the home with the applicant or recipient are considered in determining the individual's eligibility. *(Office of the Secretary of Family and Social Services; 405 IAC 2-6-1; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1779; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822)*

Rule 7. Medical Assistance for Individuals Receiving Supplemental Security Income Benefits

405 IAC 2-7-1 Definitions

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4

Affected: IC 12-14; IC 12-15

Sec. 1. (a) As used in this rule, “dependent child” means a child under eighteen (18) years of age, who meets the conditions of 45 CFR 233.90, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom) or 45 CFR 233.100, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom).

(b) As used in this rule, “caretaker” means a relative as defined in 45 CFR 233.90, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom) who has a specified degree of relationship to and assumes the primary responsibility for a dependent child. (*Office of the Secretary of Family and Social Services; 405 IAC 2-7-1; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1779; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*)

405 IAC 2-7-2 Medical assistance for supplemental security income recipients

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-13-7-3; IC 12-14-2-4

Affected: IC 12-14; IC 12-15

Sec. 2. (a) Supplemental security income recipients who meet the criteria established in 42 CFR 435.210, as revised and effective on October 1, 1991, (not including tertiary Code of Federal Regulations citations resulting therefrom) are eligible for medical assistance.

(b) The income and resources of the following individuals are considered in the eligibility determination:

(1) The supplemental security income recipient.

(2) His or her spouse, if the supplemental security income recipient is a caretaker.

(3) His or her parent, if the supplemental security income recipient is a dependent child.

(c) The income eligibility determination for such person shall be based upon those income standards established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-3 [470 IAC 10.1-3-3 was repealed filed Aug 26, 1987, 11:00 a.m.: 11 IR 90. See 470 IAC 10.1-3-3.1].

(d) The budgeting methodology established for the assistance to families with dependent children program in accordance with 470 IAC 10.1-3-4 shall apply to this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 2-7-2; filed Feb 16, 1993, 5:00 p.m.: 16 IR 1779; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*)

Rule 8. Claims Against Estate of Medicaid Recipients

405 IAC 2-8-1 Claims against estate for benefits paid

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-9; IC 12-15-39.6-10

Sec. 1. (a) Upon the death of a Medicaid recipient fifty-five (55) years of age or older, the office of Medicaid policy and planning (office) shall seek recovery from the recipient’s estate for medical assistance paid on behalf of the recipient after the recipient became fifty-five (55) years of age or older. Recovery shall be made for benefits provided prior to October 1, 1993, only if the recipient was sixty-five (65) years of age or older at the time the benefits were provided.

(b) As used in this section, “estate”, with respect to a deceased recipient, shall include all of the following:

(1) All real and personal property and other assets included within the recipient’s estate as defined for purposes of state probate law.

(2) Any interest in real property owned by the individual at the time of death that was conveyed to the individual’s survivor through joint tenancy with right of survivorship, if the joint tenancy was created after June 30, 2002.

(3) Any real or personal property conveyed through a nonprobate transfer. As used in this section, “nonprobate transfer” means a valid transfer, effective at death, by a transferor who immediately before death had the power, acting alone, to prevent transfer of the property by revocation or withdrawal and:

(A) use the property for the benefit of the transferor; or

(B) apply the property to discharge claims against the transferor’s probate estate.

The term does not include a transfer of a survivorship interest in a tenancy by the entireties real estate or payment of the death proceeds of a life insurance policy.

(c) If the recipient is survived by a spouse, recovery shall be made after the death of the surviving spouse. Only those assets that are included in the recipient's estate as defined in subsection (b) are subject to recovery.

(d) If the recipient is survived by a child, no recovery shall be made while the child is either:

- (1) under twenty-one (21) years of age; or
- (2) blind or disabled as defined in 42 U.S.C. 1382c.

(e) A claim may not be enforced against the following assets:

- (1) Personal effects, ornaments, or keepsakes of the deceased.
- (2) Assets of an individual who purchases a long term care insurance policy that are disregarded pursuant to IC 12-15-39.6-10.
- (3) Nonprobate assets that were determined exempt or unavailable for purposes of the decedent's Medicaid eligibility prior to May 1, 2002.
- (4) Assets that the decedent transferred through a nonprobate transfer prior to May 1, 2002.

(f) The office may waive the application of this section in cases of undue hardship pursuant to section 2 of this rule. (*Office of the Secretary of Family and Social Services; 405 IAC 2-8-1; filed May 1, 1995, 10:45 a.m.: 18 IR 2226; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1563; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 10, 2002, 10:55 a.m.: 26 IR 731; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984*)

405 IAC 2-8-1.1 Claims against estate; exemption

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-15-1-10

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 1.1. (a) This section applies only to real property owned by the individual at the time of death that was conveyed to the individual's survivor through joint tenancy with right of survivorship.

(b) The office may enforce its claim against property described in subsection (a) only to the extent that the value of the recipient's combined total interest in all real property described in subsection (a) subject to the claim exceeds seventy-five thousand dollars (\$75,000).

(c) This section expires January 1, 2008. (*Office of the Secretary of Family and Social Services; 405 IAC 2-8-1.1; filed Oct 10, 2002, 10:55 a.m.: 26 IR 732; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984*)

405 IAC 2-8-2 Undue hardship

Authority: IC 12-8-6-5; IC 12-13-5-3; IC 12-15-1-10; IC 12-15-9-6

Affected: IC 12-15-9; IC 29-1-14-9

Sec. 2. (a) The office may waive the enforcement of the state's claim, in whole or in part, if enforcement of the state's claim will result in substantial and undue hardship for the surviving beneficiaries of the decedent's estate. The state's claim is suspended as long as the undue hardship condition continues to exist.

(b) For the purposes of this section, undue hardship exists only if enforcement of the state's claim would result in one (1) or more of the following conditions:

- (1) Causing a beneficiary of the decedent's estate to become eligible for public assistance. As used in this section, "public assistance" means Aid to Families with Dependent Children, Medicaid, food stamps, or Supplemental Security Income.
- (2) Causing a beneficiary of the decedent's estate who is currently eligible for public assistance to remain dependent on that public assistance.
- (3) The complete loss of an income-producing asset or assets when the beneficiary of the decedent's estate has no other source of income and the beneficiary's income does not exceed one hundred percent (100%) of the poverty level as determined annually by the U. S. Department of Health and Human Services.
- (4) Other compelling circumstances as determined on a case-by-case basis by the office. Undue hardship does not exist in circumstances where the state's recovery simply results in a loss of a preexisting standard of living.

(c) To be eligible for consideration for an undue hardship waiver, the beneficiary of the decedent's estate must, with the exception noted in this subsection, be a member of the immediate family of either the deceased recipient or the deceased recipient's spouse. For purposes of this section, "immediate family" is defined as a spouse, child, grandchild, great-grandchild, parent,

grandparent, brother, or sister. In exceptional circumstances, if good cause is shown, a person other than an immediate family member may be eligible for consideration for an undue hardship waiver.

(d) The office shall notify the executor or personal representative of the deceased Medicaid recipient's estate of the state's claim against the estate and the affected beneficiary's right to apply for an undue hardship waiver. Application for an undue hardship waiver shall be submitted to the office on such forms as may be designated by the secretary and shall include all of the following information:

- (1) The name of the deceased recipient.
- (2) The name of the person filing the application.
- (3) The relationship of the applicant to the deceased.
- (4) An explanation of the basis for requesting an undue hardship waiver.
- (5) Documentation of the existence of one (1) or more of the conditions described in subsection (b).
- (6) Other information as may be deemed necessary by the secretary.

Such application shall include a statement attesting to the accuracy of the information contained in the application and be signed by the applicant. Applications for an undue hardship waiver shall be filed with the office within ninety (90) calendar days of the date that the executor or personal representative of the deceased's estate receives notification of the state's claim.

(e) The office shall review and rule on an application for a waiver of the state's claim within forty-five (45) calendar days of the receipt of a properly completed waiver application.

(f) If the office determines that an undue hardship does not exist, the office shall notify the applicant of its decision in writing and shall inform the applicant of his or her right to request an administrative hearing and the procedures for filing an appeal. An appeal and request for hearing must be filed within thirty (30) days of receipt of the office's decision that an undue hardship waiver has been denied.

(g) The office may not grant an undue hardship waiver if the granting of such waiver will result in the payment of claims to other creditors with a lower priority standing in accordance with IC 29-1-14-9.

(h) The office may deny an undue hardship waiver if the granting of such waiver will not result in the abatement of the undue hardship. (*Office of the Secretary of Family and Social Services; 405 IAC 2-8-2; filed Feb 15, 1996, 11:20 a.m.: 19 IR 1564; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822*)

Rule 9. Medicaid for Employees with Disabilities

405 IAC 2-9-1 Purpose and general eligibility requirements

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-15-2-6.5; IC 12-15-3-1; IC 12-15-3-2; IC 12-15-41

Sec. 1. (a) This rule establishes the eligibility requirements for the two (2) optional Medicaid categories for Employees with Disabilities identified in 42 U.S.C. 1396a(a)(10)(A)(ii)(XV) and 42 U.S.C. 1396a(a)(10)(A)(ii)(XVI), and in accordance with the provisions of IC 12-15-41.

(b) As used in this rule, "applicant or recipient" means an individual whose Medicaid eligibility is being determined under one (1) of the Medicaid categories referenced in subsection (a) and in accordance with the requirements of this rule.

(c) A person who is less than sixteen (16) years of age, or sixty-five (65) years of age or older is not eligible for Medicaid for employees with disabilities.

(d) A recipient must report any change in income, resources, employment status, or marital status within ten (10) days of the date of the change. An additional ten (10) days is allowed to provide any necessary verification.

(e) A disabled individual will be considered for eligibility under this rule if the individual is ineligible for Medicaid under the disability category for any of the following reasons:

- (1) The individual's income exceeds the applicable standard specified in 405 IAC 2-3-18.
- (2) The individual's resources exceed the limit in IC 12-15-3-1 or IC 12-15-3-2.
- (3) The individual's gross earnings exceed the substantial gainful activity amount established by the Social Security Administration in 20 CFR 416.974.

(f) In addition to the requirements in this rule, the requirements in the following rules apply to applicants and recipients of Medicaid for employees with disabilities:

- (1) 405 IAC 2-1-2.

- (2) 405 IAC 2-1-3.
- (3) 405 IAC 2-2-4.
- (4) 405 IAC 2-3-1.1.
- (5) 405 IAC 2-3-2.
- (6) 405 IAC 2-3-11.
- (7) 405 IAC 2-3-12.
- (8) 405 IAC 2-3-13.
- (9) 405 IAC 2-3-14.
- (10) 405 IAC 2-3-22.
- (11) 405 IAC 2-4-1.
- (12) 405 IAC 2-5-1.
- (13) 405 IAC 2-8-1.
- (14) 405 IAC 2-8-2.

(Office of the Secretary of Family and Social Services; 405 IAC 2-9-1; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3115; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35)

405 IAC 2-9-2 Income of applicant or recipient

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-15-2-6.5; IC 12-15-41

Sec. 2. (a) Countable income is gross monthly income less the deductions and exclusions required by federal or state statute or regulation and the deductions and exclusions in this section.

(b) The following are disregarded or deducted in determining net earned income:

(1) Up to ten dollars (\$10) of earned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total amount of infrequent or irregular earned income received in a month exceeds ten dollars (\$10), this disregard cannot be applied.

(2) Expenses allowed by the Internal Revenue Service shall be deducted from gross income from self-employment to determine net self-employment earnings.

(3) Sixty-five dollars (\$65) of earned income per month, plus impairment-related work expenses described in subdivision (4) below, plus one-half (½) of remaining earned income is excluded.

(4) Impairment-related work expenses are expenses that are paid by the applicant or recipient for the purchase or rental of certain items and services that are necessary, due to the severity of his or her impairment, in order for the applicant or recipient to work. No deduction is allowed if the expense has been, could be, or will be paid by another source or if the applicant or recipient will be reimbursed by another source, including, but not limited to, Medicaid, Medicare, private health insurance, or another agency. Allowable impairment-related expenses are as follows:

(A) Payments for attendant care services in the following circumstances:

(i) Because of the applicant's or recipient's impairment, he or she needs assistance in traveling to and from work, or while at work needs assistance with personal functions (e.g., eating, toileting) or with work-related functions (e.g., reading, communicating).

(ii) Because of the applicant's or recipient's impairment, assistance is needed at home with personal functions (e.g., dressing, administering medications) in preparation for going to and returning from work.

(iii) Payments made to a family member for attendant care services will be allowed only if the family member suffers an economic loss by terminating his or her employment or by reducing the number of hours he or she worked in order to perform the services.

(iv) A family member is anyone who is related to the applicant or recipient by blood, marriage, or adoption, whether or not that person lives with the applicant or recipient.

(v) If only part of the payment to a person is for services that come under the provisions of items (i) and (ii), only the portion attributable to those services will be allowed.

(B) Payments for medical devices. If the impairment requires the applicant or recipient to utilize medical devices in order to work, the payments made for those devices may be deducted. As used in this clause, medical devices include

durable medical equipment that can withstand repeated use, is customarily used for medical purposes, and is generally not useful to a person in the absence of an illness or injury. Examples of durable medical equipment are wheelchairs, hemodialysis equipment, canes, crutches, inhalators, and pacemakers.

(C) Payments for prosthetic devices. If the impairment requires the applicant or recipient to utilize a prosthetic device in order to work, the payments made for that device may be deducted. A prosthetic device is that which replaces an internal body organ or external body part. Examples of prosthetic devices are artificial replacements of arms, legs, and other parts of the body.

(D) Payments for work-related equipment. If the impairment requires the applicant or recipient to utilize special equipment in order to do his or her job, the payments made for that equipment may be deducted.

(E) Payments for residential modifications. If the impairment requires the applicant or recipient to make modifications to his or her place of residence, the location of the workplace will determine if the cost of these modifications will be deducted. If the applicant or recipient is employed away from home, only the cost of changes made outside of the home to permit the applicant or recipient to get to his or her means of transportation (e.g., the installation of an exterior ramp for a wheelchair confined person or special exterior railings or pathways for someone who requires crutches) will be deducted. Costs relating to modifications of the inside of the home will not be deducted if the person works away from home. If the applicant or recipient works at home, the costs of modifying the inside of the home in order to create a working space to accommodate his or her impairment will be deducted to the extent that the changes pertain specifically to the space in which he or she works. Examples of such changes are the enlargement of a doorway leading into the work space or modification of the work space to accommodate problems in dexterity. However, if the applicant or recipient is self-employed at home, any cost deducted as a business expense cannot be deducted as an impairment-related work expense.

(F) Payments for transportation costs in the following circumstances are allowed:

(i) The impairment requires that in order for the applicant or recipient to get to work, a vehicle that has structural or operational modifications is required. The modifications must be critical to the applicant's or recipient's operation or use of the vehicle and directly related to his or her impairment. The costs of the modifications will be deducted, but not the cost of the vehicle. A mileage allowance for the trip to and from work will be allowed in the same amount as allowed by the Supplemental Security Income program for this purpose.

(ii) The impairment requires the applicant or recipient to use driver assistance, taxicabs or other hired vehicles in order to work. Amounts paid to the driver and, if the applicant's or recipient's own vehicle is used, a mileage allowance will be deducted for the trip to and from work.

(iii) The impairment prevents the applicant or recipient from taking available public transportation to and from work and he or she must drive his or her (unmodified) vehicle to work. A mileage allowance for the trip to and from work will be deducted if verification is obtained through the applicant's or recipient's physician or other sources that the need to drive is caused by the impairment, and not due to the unavailability of public transportation.

(G) All other impairment-related expenses allowed by the Supplemental Security Income program.

(c) Funds from a grant, scholarship, or fellowship that are designated for tuition and mandatory books and fees at an educational institution or for vocational rehabilitation or technical training purposes shall be deducted from the total of such funds except as prohibited by federal regulations.

(d) Tax refunds are excluded from income.

(e) Home energy assistance is disregarded.

(f) Up to twenty dollars (\$20) of unearned income is disregarded if the income is either infrequent or irregular. Infrequent income is income received only once during the calendar quarter from a single source. Irregular income is income that could not reasonably be expected. If the total amount of infrequent or irregular unearned income received in a month exceeds twenty dollars (\$20), this disregard cannot be applied.

(g) A general income disregard of fifteen dollars and fifty cents (\$15.50) is deducted per month.

(h) Payments made to foster parents or licensed child caring institutions from county funds or reimbursed under Title IV-B of the Social Security Act on behalf of an applicant or recipient who is a ward of the county department are excluded.

(i) Income of the spouse of the applicant or recipient is excluded.

(j) Income of the parents of the applicant or recipient is excluded. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-2; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3116; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35*)

405 IAC 2-9-3 Income eligibility and posteligibility determinations of applicant or recipient

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-15-2-6.5; IC 12-15-7-2; IC 12-15-41

Sec. 3. (a) An applicant's or recipient's income eligibility shall be determined by the following procedures:

- (1) Determine the applicant's or recipient's unearned income which is not excluded by state or federal statute or regulation.
- (2) Subtract the general income disregard specified in section 2 of this rule. The resulting amount is countable unearned income.
- (3) Determine the earned income of the applicant or recipient.
- (4) Subtract any remaining general income disregard.
- (5) Subtract the earned income disregard(s) specified in section 2 of this rule. The resulting amount is countable earned income.
- (6) Combine countable unearned and countable earned income.
- (7) Subtract the monthly income standard that is equal to three hundred fifty percent (350%) of the federal poverty guideline for a family size of one (1), divided by twelve (12) and rounded up to the next whole dollar.
- (8) If the resulting amount in subdivision (7) is zero dollars (\$0) or less than zero dollars (\$0), the applicant or recipient is eligible for Medicaid for employees with disabilities. If the resulting amount is greater than zero dollars (\$0), the applicant or recipient is not eligible.

(b) The income standard referenced in subsection (a)(7) shall be increased annually beginning the second month following the month in which the federal poverty guidelines are published in the Federal Register.

(c) The following procedures are used to determine the amount of income to be paid to an institution for an applicant or recipient who has been determined eligible under subsection (a) and who is residing in a Title XIX certified health care facility:

- (1) Determine the applicant's or recipient's total income which is not excluded by federal statute. Total income includes amounts deducted in the eligibility determination under subsection (a).
- (2) Subtract the minimum personal needs allowance specified in IC 12-15-7-2.
- (3) Subtract an amount for increased personal needs as allowed under Indiana's approved Medicaid state plan. The increased personal needs allowance includes, but is not limited to, court ordered guardianship fees paid to an institutionalized applicant's or recipient's legal guardian, not to exceed thirty-five dollars (\$35) per month. Guardianship fees include all services and expenses required to perform the duties of a guardian, as well as any attorney fees for which the guardian is liable.
- (4) Subtract the amount of health insurance premiums.
- (5) Subtract an amount for expenses incurred for necessary medical or remedial care recognized by state law but not covered under the state plan, subject to any reasonable limits set forth in Indiana's approved Medicaid state plan.
- (6) The resulting amount is the amount by which the Medicaid payment to the facility shall be reduced.

(Office of the Secretary of Family and Social Services; 405 IAC 2-9-3; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3117; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35)

405 IAC 2-9-4 Resource eligibility of applicant or recipient

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-15-2-6.5; IC 12-15-41-2

Sec. 4. (a) An applicant or recipient is ineligible for Medicaid for employees with disabilities for any month in which the total equity value of all nonexempt personal property owned by the applicant and his or her spouse exceeds the applicable limitation for a single individual or married couple as prescribed by the Supplemental Security Income program.

(b) The resources of the applicant's or recipient's parents are excluded.

(c) In addition to that property required to be excluded by federal statute or regulation, the following property is exempt from consideration:

- (1) All household goods and personal effects.
- (2) Personal property required by an individual's employer while the individual is employed.
- (3) The equity value of personal property used to produce food for home consumption or used in the production of income.
- (4) The value of life insurance with a total face value of ten thousand dollars (\$10,000) or less if provision has been made for payment of the applicant's or recipient's funeral expenses from the proceeds of such insurance. However, the ten thousand dollar (\$10,000) limitation shall be reduced by any amount in an irrevocable burial trust or irrevocable prepaid funeral

agreement.

(5) For a period of no more than nine (9) months from the date of receipt, the proceeds or any interest earned on the proceeds of casualty insurance received as a result of damage, destruction, loss, or theft of exempt real or personal property if the applicant or recipient demonstrates that the proceeds are being used to repair or replace the damaged, destroyed, lost, or stolen exempt property.

(6) One (1) motor vehicle according to the following provisions:

(A) One (1) motor vehicle is excluded, regardless of value, if, for the applicant or recipient or other member of his or her household, the motor vehicle is:

- (i) necessary for employment;
- (ii) necessary for the medical treatment of a specific or regular medical problem; or
- (iii) modified for operation by or transportation of a handicapped person.

(B) If no motor vehicle is excluded under clause (A), four thousand five hundred dollars (\$4,500) of the current market value of one (1) motor vehicle is excluded.

(7) Burial spaces.

(8) Subject to the requirements in subsection (d), the home which is the principal place of residence of:

- (A) the applicant or recipient;
- (B) the spouse of the applicant or recipient;
- (C) the parent of the applicant or recipient who is under eighteen (18) years of age;
- (D) the applicant's or recipient's biological or adoptive child under eighteen (18) years of age; or
- (E) the applicant's or recipient's blind or disabled biological or adoptive child eighteen (18) years of age or older.

(9) Income producing real property if the income is greater than the expenses of ownership.

(10) Up to twenty thousand dollars (\$20,000), as approved by the central office of the family and social services administration, for an independence and self-sufficiency account defined in IC 12-15-41-2(3). A resource disregard for this purpose will be approved if the applicant or recipient submits a plan in writing to the local office of family and children caseworker that describes specifically the goods and or services that he or she intends to purchase that will increase, maintain, or retain his or her employability or independence. The items must be reasonable in terms of the applicant's or recipient's ability to achieve a stated goal which is focused on the individual's employability by removing barriers. Items for personal recreational use will not be approved. A request to save money without specifying goods or services to be purchased within an achievable period of time will not be approved. An approved account will be reviewed by the local office of family and children caseworker at each annual redetermination. If the terms of the original approved account have not been met, the recipient will be required to submit an updated request to the caseworker within thirty (30) days of receiving written notification from the caseworker that such an update is required. If the recipient fails to submit the update, the disregard will be disapproved and resource eligibility will be redetermined without it. The caseworker will forward updates to the central office for approval. At any time during the period of eligibility under the Medicaid for employees with disabilities program, the recipient may submit an update requesting an adjustment in the approved amount. Approval will not be given for any services that are available to the recipient under Medicaid or any other publicly funded program.

(11) Retirement accounts held by the applicant or recipient or his or her spouse are exempt. This includes Individual Retirement Accounts, Keogh Plans, 401(k), 403(b), and 457 plans, and any employer-related retirement account.

(d) The home exempted by subsection (c)(8) is exempt until such time as it is verified that none of the persons listed in subsection (c)(8) intends to reside there. The home is the shelter in which the person resides, the land on which the shelter is located, and related outbuildings.

(e) As a condition of eligibility for Medicaid for employees with disabilities, an applicant or recipient and his or her spouse must sign an agreement to offer for sale or for rent all nonexempt real property that he or she or his or her spouse own.

(f) If nonexempt real property is not offered for sale or for rent at current market value within thirty (30) days of written notification of medical assistance or within thirty (30) days after the agreement referenced in subsection (e) is signed, whichever is later, the recipient shall be ineligible. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-4; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3118; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35*)

405 IAC 2-9-5 Employment requirements; continuing eligibility when employment ends

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-41-15

Affected: IC 12-15-2-6.5; IC 12-15-41

Sec. 5. (a) In order for an individual to be eligible for Medicaid for employees with disabilities, the individual must be engaged in a substantial and reasonable work effort. This means that the person must be either employed or self-employed, with the intent of such work activity being ongoing. The individual's monthly earned income must exceed the sixty-five dollar (\$65) earned income disregard described in section 2 of this rule. Employment must be verifiable by pay stubs or other verification from an employer documenting that the income is subject to income tax and FICA withholding. Self-employment must be verified by the individual's income tax return or, in the case of a new business for which a tax return has not yet been filed, the personal business records of the individual.

(b) In order for a recipient of Medicaid for employees with disabilities to remain eligible when the definition of medically improved disability in section 7 of this rule is met, the recipient must be employed as defined in subsection (a) and must have monthly earnings as calculated under 405 IAC 2-5-1 that are equal to or greater than the federal minimum wage times forty (40), unless the provisions in subsection (c) are met.

(c) A recipient who is involuntarily not working can remain eligible for the Medicaid for employees with disabilities program for up to twelve (12) months if he or she meets all other program requirements and either:

- (1) is on temporary medical leave from his or her employment as defined in subsection (d); or
- (2) maintains a connection to the workforce by participating in at least one (1) of the following activities:

- (A) Enrollment in a vocational rehabilitation program.
- (B) Enrollment or registration with the department of workforce development.
- (C) Participation in a transition from school to work program.
- (D) Participation with an approved provider of employment services.

(d) As used in this section, "temporary medical leave" means a leave from the place of employment due to health reasons when the employer is keeping a position open for the individual to return. If the employer is no longer holding a position open, the recipient must maintain a connection to the workforce as defined in subsection (c)(2) in order for coverage to continue under Medicaid for employees with disabilities.

(e) In order to remain eligible upon becoming unemployed, the recipient or his or her authorized representative must submit a written request for continued coverage to the local office of family and children no later than sixty (60) days after termination of employment. Attached to this written request must be verification that the recipient meets the requirements in subsection (c). On a quarterly basis thereafter, as long as the recipient continues to be unemployed and wishes coverage to continue, verification of his or her medical leave or workforce connection status must be provided to the local office of family and children. The quarterly verification must consist of a statement from the agency or service provider that documents the recipient's continued participation in an activity that constitutes connection to the workforce, or from the recipient's employer stating he or she remains on a temporary involuntary medical leave.

(f) A recipient who voluntarily terminates his or her employment for any reason is not eligible for Medicaid for employees with disabilities. Eligibility for the other Medicaid categories will be pursued.

(g) A recipient who fails to submit the initial request for coverage continuation within the required sixty (60) day period or who fails to submit the quarterly verification report is no longer eligible for Medicaid for employees with disabilities. Eligibility for other Medicaid categories will be pursued. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-5; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3119; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769; errata filed Aug 22, 2002, 3:14 p.m.: 26 IR 35; filed Jun 21, 2005, 3:00 p.m.: 29 IR 10*)

405 IAC 2-9-6 Medical disability determination

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 6. (a) In order to qualify for Medicaid for employees with disabilities, an applicant must meet the definition of disability in IC 12-14-15-1(2). If not for earned income, the applicant or recipient would medically qualify for Medicaid under the traditional disability category according to statute.

(b) The determination of disability is made by the Medicaid medical review team (MMRT) based upon the principles found in 405 IAC 2-2-3, except that the determination of whether an impairment is substantial enough to meet the definition of disability is made without considering work activity, earnings, and substantial gainful activity (SGA). If not for the fact that the applicant or recipient is working, the condition would otherwise be substantial enough to prevent the person from participating in gainful activity.

(c) A redetermination of disability is required annually of each recipient at the time the county office does its complete

redetermination of all factors of eligibility. A redetermination of disability may be required more frequently or may be waived at the discretion of the MMRT based upon the condition of the recipient. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-6; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120*)

405 IAC 2-9-7 Medically improved disability

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 7. (a) In order to qualify for the Medicaid for employees with disabilities program after improvement of a medical condition, a recipient must meet the requirements in this section.

(b) The person must be a recipient of Medicaid under the Medicaid for employees with disabilities group described in section 6 of this rule who no longer qualifies for coverage under that category due to a medical improvement in his or her condition. The improvement of the condition must be verifiable by acceptable clinical standards; however, the disease, illness, or process must be of a type that, due to the nature and course of the illness, will continue to be a disabling impairment. A condition that has been resolved or a person who is completely recovered does not medically qualify for this program.

(c) The determination of whether a recipient meets the medical eligibility requirements for this category will be made at the time of the regularly scheduled annual redetermination for Medicaid by the county office. Determination of medical eligibility under this section is made by the Medicaid medical review team (MMRT). (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-7; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120*)

405 IAC 2-9-8 Premiums

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-41-15

Affected: IC 12-14-15-1; IC 12-15-2-6.5; IC 12-15-41

Sec. 8. (a) To be eligible for Medicaid for employees with disabilities, an individual must pay monthly premiums in accordance with the requirements specified in this section, unless the gross income of the individual and the individual's spouse is less than one hundred fifty percent (150%) of the federal poverty level. The amount of the premium is based on the gross income of the recipient and the recipient's spouse as a percentage of the federal poverty level for the applicable family size as determined in subsection (b) or (c). The amount of the premium will be adjusted by the premium amount of other creditable private health insurance as defined in 42 U.S.C. §300gg-91 that covers the applicant or recipient and is paid by the applicant or recipient or his or her spouse or parent. The amount of the premium is calculated as described in the following Table:

Income as a Percent of the Federal Poverty Level	Amount of Premium	
	Individual	Married Couple
Less than 150% – No Premium is Required		
150% to 175%	\$ 48	\$ 65
More than 175% to 200%	\$ 69	\$ 93
More than 200% to 250%	\$ 107	\$ 145
More than 250% to 300%	\$ 134	\$ 182
More than 300% to 350%	\$ 161	\$ 218
More than 350%	\$ 187	\$ 254

(b) The individual premium amount is used when the individual, regardless of age, is not married or not living with his or her spouse. When the individual premium amount is used, only the individual's income is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of one (1).

(c) The married couple premium amount is used when the individual is legally married and living with his or her spouse. When the couple premium amount is used, the income of both spouses is considered in calculating the premium, and the income is compared to the federal poverty level for a family size of two (2).

(d) When an applicant is determined eligible, the applicant will be conditionally approved pending payment of the premium. The first month for which a premium is required is the month following the month in which an applicant is approved as conditional. After the premium is received, coverage will be retroactive to the first day of the third month prior to the month of application if all

eligibility requirements were met in the prior months.

(e) The individual must pay the first premium in order to receive coverage. If payment is not received by the due date specified in the second premium notice, the Medicaid application will be denied. A payment of less than the full amount due will be considered nonpayment.

(f) If any premium after the first premium is not paid by the due date, coverage will continue for a maximum of sixty (60) days before being discontinued. When an individual or couple have been discontinued from the program due to nonpayment of premiums, an application must be filed in order to be considered for eligibility. To be reenrolled based on an application filed after such a discontinuance, the individual must pay all past due premiums in addition to premiums owed for the current application. Past due premiums remain the obligation of the individual as a condition of eligibility for two (2) years after the date of discontinuance.

(g) When both spouses are recipients of Medicaid for employees with disabilities, the enrollment and continued eligibility of the couple is based on the payment of the married couple premium amount. Failure to pay the required premium amount in accordance with this section will result in the discontinuance of Medicaid coverage for both spouses.

(h) When a recipient reports a change in income or marital status as required by section 1(d) of this rule, and the change results in a lower premium, the new premium amount will be effective the first month following the date in which verification of the change is received.

(i) When a recipient who is eligible for Medicaid in the blind or disabled categories obtains employment, the change must be reported within ten (10) days as required by 470 IAC 2.1-1-2. An additional ten (10) days is allowed to provide verification of the employment. If the recipient is eligible for Medicaid for employees with disabilities, eligibility begins the first month following the date on which verification is received, subject to the timely notice requirements in 42 CFR 431.211. (*Office of the Secretary of Family and Social Services; 405 IAC 2-9-8; filed Jun 10, 2002, 2:21 p.m.: 25 IR 3120; errata filed Jun 28, 2002, 10:17 a.m.: 25 IR 3769*)

Rule 10. Lien Attachment and Enforcement

405 IAC 2-10-1 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 1. The following definitions apply throughout this rule:

(1) "Disabled" is defined according to the criteria established under 42 U.S.C. 1382c.

(2) "Interest" means any equitable right, title, or interest in real property.

(3) "Lawfully residing in the home" means residing in the recipient's place of residence with the permission of the owners or, if under guardianship, the owner's legal guardian.

(4) "Medical institution" means a long term care facility, an intermediate care facility for the mentally retarded (ICF/MR), or other residential medical facility.

(5) "Permanently institutionalized" means an individual of any age who:

(A) is an inpatient in a nursing facility, ICF/MR facility, or other medical institution;

(B) is required, as a condition of receiving services in such institution under the state plan, to spend for costs of medical care all but a minimum amount of his income required for personal needs; and

(C) after notice and opportunity for a hearing, has been determined to have a medical condition of such severity that he or she cannot reasonably be expected to be discharged from the medical institution and returned to the noninstitutional home environment prior to death.

(6) "Real property" means land, including houses or immovable structures or objects attached permanently to the land in which a recipient has ownership rights and interests, including, but not limited to, the recipient's home.

(7) "Recipient's home" means the recipient's place of residence prior to institutionalization.

(8) "Residing in recipient's home on a continuous basis" means using the home as the principal place of residence.

(9) "TEFRA" means Tax Equity Fiscal Responsibility Act.

(*Office of the Secretary of Family and Social Services; 405 IAC 2-10-1; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1547*)

405 IAC 2-10-2 Recovery

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 2. The office shall seek reimbursement for Medicaid benefits paid on behalf of a recipient by either or both of the following methods:

- (1) Filing and enforcing a lien in accordance with this rule.
- (2) Filing and enforcing a claim against the estate of a deceased recipient in accordance with 405 IAC 2-8.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-2; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1547)

405 IAC 2-10-3 Criteria for instituting a TEFRA lien

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 3. (a) When the office in accordance with 42 U.S.C. 1396p determines that a Medicaid recipient who resides in a medical institution cannot reasonably be expected to be discharged and return home, the office may attach a lien on the Medicaid recipient's real property subject to the provisions of this rule and IC 12-15-8.5.

(b) The office may not obtain a lien on the recipient's home if any of the following people lawfully reside in the home of the institutionalized recipient:

- (1) The recipient's spouse.
- (2) The recipient's child who is less than twenty-one (21) years of age, blind, or disabled as defined in 42 U.S.C. 1382c.
- (3) The recipient's sibling who:
 - (A) was residing in the recipient's home for a period of at least one (1) year immediately before the recipient's institutionalization; and
 - (B) has an ownership interest in the home.
- (4) The recipient's parent.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-3; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1547; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3984)

405 IAC 2-10-4 Notice and opportunity for hearing

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 4. (a) The office shall notify the recipient and the recipient's authorized representative, if applicable, of its determination that the recipient is permanently institutionalized and not reasonably expected to return home and its intent to file a lien on recipient's real property. Notice must include an explanation of liens and their effect on an individual's ownership of real property.

(b) The office may file a lien not less than thirty-one (31) days following notice to recipient and after any hearing process has been completed, if a hearing is requested. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-4; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548)*

405 IAC 2-10-5 Appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 5. (a) A recipient or his or her designee may, within thirty (30) days after receipt of notice described in this rule, request an administrative hearing under this rule.

(b) Administrative hearings and appeals by Medicaid recipients are governed by the procedures and time limits set out in 405 IAC 1.1.

(c) Only one (1) appeal shall be afforded to a recipient, for each notice received in accordance with section 4 of this rule, notwithstanding the number of parcels owned by the recipient and identified in the notice. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-5; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548)*

405 IAC 2-10-6 Lien attachment

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 6. (a) The office or its designee shall file a notice of lien with the recorder of the county in which the real property subject to the lien is located. The notice shall be filed prior to the recipient's death and shall include the following:

- (1) Name and place of residence of the recipient against whom the lien is asserted.
- (2) Legal description of the real property subject to the lien.

(b) The office shall file one (1) copy of the notice of lien with the county office of family and children in the county in which the real property is located. The county office shall retain a copy of the notice with the county office's records.

(c) The office shall provide one (1) copy of the notice of lien to the recipient or the recipient's authorized representative, if applicable, whose real property is affected. (*Office of the Secretary of Family and Social Services; 405 IAC 2-10-6; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548*)

405 IAC 2-10-7 Effect of filing; duration

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 7. (a) From the date on which the notice of lien is recorded in the office of the county recorder, the notice of lien:

- (1) constitutes due notice of a lien against the recipient or recipient's estate for any amount then recoverable and any amounts that become recoverable under this article; and
 - (2) gives a specific lien in favor of the office on the Medicaid recipient's interest in the real property.
- (b) The lien continues from the date of filing until the lien:
- (1) is satisfied;
 - (2) is released; or
 - (3) expires.

The lien automatically expires unless the office commences a foreclosure action not later than two (2) years after the Medicaid recipient's death. (*Office of the Secretary of Family and Social Services; 405 IAC 2-10-7; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3985*)

405 IAC 2-10-7.1 Notice to office to file an action to foreclose the lien

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 7.1. (a) This section applies after the death of the Medicaid recipient whose property is subject to a lien under this rule or after the sale or other transfer of property that is subject to the lien.

(b) A lien under this rule is void if both of the following occur:

- (1) The owner of property subject to a lien under this rule or any person or corporation having an interest in the property, including a mortgagee or a lienholder, provides written notice to the office to file an action to foreclose the lien.
- (2) The office fails to file an action to foreclose the lien in the county where the property is located not later than thirty (30) days after receiving the notice. However, this section does not prevent the claim from being collected as other claims are collected by law.

(c) A person who gives notice under subsection (a)(1) by registered or certified mail to the office at the address given in the recorded statement and notice of intention to hold a lien may file an affidavit of service of the notice to file an action to foreclose the lien with the recorder of the county in which the property is located. The affidavit must state the following:

- (1) The facts of the notice.
- (2) That more than thirty (30) days have passed since the notice was received by the office.
- (3) That no action for foreclosure of the lien is pending.
- (4) That no unsatisfied judgment has been rendered on the lien.
- (d) The recorder shall:
 - (1) record the affidavit of service in the miscellaneous record book of the recorder's office; and
 - (2) certify on the face of the record any lien that is fully released.

When the recorder records the affidavit and certifies the record under this subsection, the real estate described in the lien is released from the lien. (*Office of the Secretary of Family and Social Services; 405 IAC 2-10-7.1; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3985*)

405 IAC 2-10-8 Enforcement; foreclosure

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 8. (a) The office may not enforce a lien on the recipient's home under this rule if the following individuals are lawfully residing in the recipient's home and have resided there on a continuous basis since the recipient's date of admission to the medical institution:

(1) The recipient's child of any age who:

(A) resided in the recipient's home for at least twenty-four (24) months before the recipient was institutionalized; and

(B) establishes to the satisfaction of the office that he or she provided care to the recipient that enabled the recipient to reside in his or her home delaying institutionalization.

(2) The recipient's sibling who has resided in the recipient's home for a period of at least one (1) year immediately before the date of the recipient's admission to the medical institution.

(b) The office may not enforce a lien on the real property of the recipient under this rule as long as the recipient is survived by any of the following:

(1) The recipient's spouse.

(2) The recipient's child who is less than twenty-one (21) years of age, blind, or disabled as defined in this rule.

(c) If there is no condition present in subsection (a) or (b), the office, or its designee, may bring a proceeding in foreclosure on the lien or to make arbitration of the amount due on the lien as follows:

(1) If the real property or recipient's interest is sold or otherwise transferred during the lifetime of the recipient.

(2) Upon the death of the recipient.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-8; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3985)

405 IAC 2-10-9 Release; subordination

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-9

Sec. 9. (a) The office shall release a lien obtained under this rule within ten (10) business days after the county office of family and children receives notice that the recipient is no longer institutionalized and is living in his or her home.

(b) A lien obtained under this rule is subordinate to the security interest of a financial institution as defined in IC 12-15-8.5 that loans money to the recipient provided that the recipient is able to establish to the satisfaction of the office that the funds were used for operating capital for the operation of the recipient's farm, the recipient's business, or the recipient's real property that is income-producing.

(c) If the real property subject to the lien is sold, the office shall release its lien at the closing, and the lien shall attach to the net proceeds of the sale. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-9; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1549; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3986)*

405 IAC 2-10-10 Exemption (Repealed)

Sec. 10. *(Repealed by Office of the Secretary of Family and Social Services; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3986)*

405 IAC 2-10-11 Exemption

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5

Affected: IC 12-15-3-6; IC 12-15-39.6-10

Sec. 11. Real property that is disregarded for eligibility purposes in connection with the purchase and use of a qualified long term care insurance policy pursuant to IC 12-15-39.6-10 is exempt from lien placement and enforcement. *(Office of the Secretary of Family and Social Services; 405 IAC 2-10-11; filed Jul 21, 2004, 5:15 p.m.: 27 IR 3986)*

MEDICAID RECIPIENTS; ELIGIBILITY

*