

Chapter 182-513 WAC

CLIENT NOT IN OWN HOME—INSTITUTIONAL MEDICAL

<p>WAC</p> <p>182-513-1100</p> <p>182-513-1105</p> <p>182-513-1200</p> <p>182-513-1205</p> <p>182-513-1210</p> <p>182-513-1215</p> <p>182-513-1220</p> <p>182-513-1225</p> <p>182-513-1230</p> <p>182-513-1235</p> <p>182-513-1240</p> <p>182-513-1245</p> <p>182-513-1315</p> <p>182-513-1316</p> <p>182-513-1317</p> <p>182-513-1318</p> <p>182-513-1319</p> <p>182-513-1320</p> <p>182-513-1325</p> <p>182-513-1330</p> <p>182-513-1340</p> <p>182-513-1345</p> <p>182-513-1350</p> <p>182-513-1355</p> <p>182-513-1363</p> <p>182-513-1367</p> <p>182-513-1380</p> <p>182-513-1385</p> <p>182-513-1395</p> <p>182-513-1396</p> <p>182-513-1397</p> <p>182-513-1400</p> <p>182-513-1405</p> <p>182-513-1410</p> <p>182-513-1415</p> <p>182-513-1420</p> <p>182-513-1425</p>	<p>Definitions related to long-term services and supports (LTSS).</p> <p>Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF).</p> <p>Long-term services and supports (LTSS) 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(TSOA)—Spousal impoverishment.</p>
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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

<p>182-513-1300</p> <p>182-513-1301</p>	<p>Payment standard for persons in medical institutions. [WSR 13-01-017, recodified as § 182-513-1300, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-478-0040, filed 7/31/98, effective 9/1/98.] Repealed by WSR 17-03-116, filed 1/17/17, effective 2/1/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155.</p> <p>Definitions related to long-term care (LTC) services. [WSR 13-01-017, recodified as § 182-513-1301, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1301, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 71A.12.030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276. WSR 04-18-054, § 388-513-1301, filed 8/27/04, effective 9/27/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. WSR 02-09-052, § 388-513-1301, filed 4/12/02, effective 5/13/02. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.-057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1301, filed</p>
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- 12/8/99, effective 1/8/00.] Repealed by WSR 17-03-116, filed 1/17/17, effective 2/17/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155.
- 182-513-1305 Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF). [WSR 13-01-017, recodified as § 182-513-1305, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1305, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.08.090. WSR 06-07-077, § 388-513-1305, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1305, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 99-06-045, § 388-513-1305, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1305, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-83-036 and 388-99-036.] Repealed by WSR 17-03-116, filed 1/17/17, effective 2/17/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155.
- 182-513-1364 Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services. [WSR 13-01-017, recodified as § 182-513-1364, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1364, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-513-1364, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090. WSR 03-20-059, § 388-513-1364, filed 9/26/03, effective 10/27/03. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. WSR 03-06-048, § 388-513-1364, filed 2/28/03, effective 4/1/03.] Repealed by WSR 17-03-116, filed 1/17/17, effective 2/17/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155.
- 182-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services. [WSR 13-01-017, recodified as § 182-513-1365, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1365, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-513-1365, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.575. WSR 03-14-038, § 388-513-1365, filed 6/23/03, effective 8/1/03. Statutory Authority: RCW 74.08.090. WSR 01-02-076, § 388-513-1365, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1365, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 99-06-045, § 388-513-1365, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.585 and § 17 of the Social Security Act. WSR 97-05-040, § 388-513-1365, filed 2/14/97, effective 3/17/97. Statutory Authority: RCW 74.08.090. WSR 95-02-027 (Order 3818), § 388-513-1365, filed 12/28/94, effective 1/28/95; WSR 94-10-065 (Order 3732), § 388-513-1365, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-395.] Repealed by WSR 17-03-116, filed 1/17/17, effective 2/17/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155.
- 182-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services. [WSR 13-01-017, recodified as § 182-513-1366, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1366, filed 12/8/99, effective 1/8/00.] Repealed by WSR 17-03-116, filed 1/17/17, effective 2/17/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155.
- 182-513-1500 Payment standard for persons in certain group living facilities. [WSR 13-01-017, recodified as § 182-513-1500, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-478-0045, filed 7/31/98, effective 9/1/98.] Decodified by WSR 13-03-096, filed 1/15/13, effective 1/15/13. Recodified as § 182-515-1500.

WAC 182-513-1100 Definitions related to long-term services and supports (LTSS). This section defines the meaning of certain terms used in chapters 182-513 and 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, program of all-inclusive care for the elderly (PACE), and hospice in a medical institution are referred to collectively as long-term care (LTC). Long-term services and supports (LTSS) is a broader definition which includes institutional, HCB waiver, and other services such as medicaid personal care (MPC), community first choice (CFC), PACE, and hospice in the community. See chapter 182-500 WAC for additional definitions.

"Adequate consideration" means that the fair market value (FMV) of the property or services received, in exchange for transferred property, approximates the FMV of the property transferred.

"Administrative costs" or "costs" means necessary costs paid by the guardian including attorney fees.

"Aging and long-term support administration (AL TSA)" means the administration within the Washington state department of social and health services (DSHS).

"Alternate living facility (ALF)" is not an institution under WAC 182-500-0050; it is one of the following community residential facilities:

(a) An adult family home (AFH) licensed under chapter 70.128 RCW.

(b) An adult residential care facility (ARC) licensed under chapter 18.20 RCW.

(c) A mental health adult residential treatment facility under chapter 246-337 WAC.

(d) An assisted living facility (AL) licensed under chapter 18.20 RCW.

(e) A developmental disabilities administration (DDA) group home (GH) licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW.

(f) An enhanced adult residential care facility (EARC) licensed as an assisted living facility under chapter 18.20 RCW.

(g) An enhanced service facility (ESF) licensed under chapter 70.97 RCW.

"Assets" means all income and resources of a person and of the person's spouse, including any income or resources which that person or that person's spouse would otherwise currently be entitled to but does not receive because of action:

- (a) By that person or that person's spouse;
- (b) By another person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or
- (c) By any other person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

"Authorization date" means the date payment begins for long-term services and supports (LTSS) under WAC 388-106-0045.

"Clothing and personal incidentals (CPI)" means the cash payment (under WAC 388-478-0090, 388-478-0006, and 388-478-0033) issued by the department for clothing and personal items for people living in an ALF or medical institution.

"Community first choice (CFC)" means a medicaid state plan home and community based service developed under the authority of section 1915(k) of the Social Security Act under chapter 388-106 WAC.

"Community options program entry system (COPEs)" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-106 WAC.

"Community spouse (CS)" means the spouse of an institutionalized spouse.

"Community spouse resource allocation (CSRA)" means the resource amount that may be transferred without penalty from:

- (a) The institutionalized spouse (IS) to the community spouse (CS); or
- (b) The spousal impoverishment protections institutionalized (SIPI) spouse to the spousal impoverishment protections community (SIPC) spouse.

"Community spouse resource evaluation" means the calculation of the total value of the resources owned by a married couple on the first day of the first month of the institutionalized spouse's most recent continuous period of institutionalization.

"Comprehensive assessment reporting evaluation (CARE) assessment" means the evaluation process defined under chapter 388-106 WAC used by a department designated social services worker or a case manager to determine a person's need for long-term services and supports (LTSS).

"Continuing care contract" means a contract to provide a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services, which is conditioned upon the transfer of property, the payment of an entrance fee to the provider of such services, or the payment of periodic charges for the care and services involved.

"Continuing care retirement community" means an entity which provides shelter and services under continuing care contracts with its members and which sponsors or includes a health care facility or a health service.

"Dependent" means a minor child, or one of the following who meets the definition of a tax dependent under WAC 182-500-0105: Adult child, parent, or sibling.

"Developmental disabilities administration (DDA)" means an administration within the Washington state department of social and health services (DSHS).

"Developmental disabilities administration (DDA) home and community based (HCB) waiver" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-845 WAC authorized by DDA. There are five DDA HCB waivers:

- (a) Basic Plus;
- (b) Core;
- (c) Community protection;
- (d) Children's intensive in-home behavioral support (CIIBS); and
- (e) Individual and family services (IFS).

"Equity" means the fair market value of real or personal property less any encumbrances (mortgages, liens, or judgments) on the property.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market in an agreement, made by two parties freely and independently of each other, in pursuit of their own self-interest, without pressure or duress, and without some special relationship (arm's length transaction), at the time of transfer or assignment.

"Guardianship fees" or "fees" means necessary fees charged by a guardian for services rendered on behalf of a client.

"Home and community based (HCB) waiver programs authorized by home and community services (HCS)" means medicaid HCB waiver programs developed under the authority of Section 1915(c) of the Social Security Act under chapter 388-106 WAC authorized by HCS. There are three HCS HCB waivers: Community options program entry system (COPEs), new freedom consumer directed services (New Freedom), and residential support waiver (RSW).

"Home and community based services (HCBS)" means LTSS provided in the home or a residential setting to persons assessed by the department.

"Institutional services" means services paid for by Washington apple health, and provided:

- (a) In a medical institution;
- (b) Through an HCB waiver; or
- (c) Through programs based on HCB waiver rules for post-eligibility treatment of income under chapter 182-515 WAC.

"Institutionalized individual" means a person who has attained institutional status under WAC 182-513-1320.

"Institutionalized spouse" means a person who, regardless of legal or physical separation:

- (a) Has attained institutional status under WAC 182-513-1320; and
- (b) Is legally married to a person who is not in a medical institution.

"Life care community" see continuing care community.

"Likely to reside" means the agency or its designee reasonably expects a person will remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the person does not actually remain in the facility for that length of time.

"**Long-term care services**" see "Institutional services."

"**Long-term services and supports (LTSS)**" includes institutional and noninstitutional services authorized by the department.

"**Medicaid personal care (MPC)**" means a medicaid state plan home and community based service under chapter 388-106 WAC.

"**Most recent continuous period of institutionalization (MRCPI)**" means the current period an institutionalized spouse has maintained uninterrupted institutional status when the request for a community spouse resource evaluation is made. Institutional status is determined under WAC 182-513-1320.

"**Noninstitutional medicaid**" means any apple health program not based on HCB waiver rules under chapter 182-515 WAC, or rules based on a person residing in an institution for thirty days or more under chapter 182-513 WAC.

"**Nursing facility level of care (NFLOC)**" is under WAC 388-106-0355.

"**Participation**" means the amount a person must pay each month toward the cost of long-term care services received each month; it is the amount remaining after the post-eligibility process under WAC 182-513-1380, 182-515-1509, or 182-515-1514. Participation is not room and board.

"**Penalty period**" or "**period of ineligibility**" means the period of time during which a person is not eligible to receive services that are subject to transfer of asset penalties.

"**Personal needs allowance (PNA)**" means an amount set aside from a person's income that is intended for personal needs. The amount a person is allowed to keep as a PNA depends on whether the person lives in a medical institution, ALF, or at home.

"**Room and board**" means the amount a person must pay each month for food, shelter, and household maintenance requirements when that person resides in an ALF. Room and board is not participation.

"**Short stay**" means residing in a medical institution for a period of twenty-nine days or fewer.

"**Special income level (SIL)**" means the monthly income standard that is three hundred percent of the supplemental security income (SSI) federal benefit rate.

"**Spousal impoverishment protections**" means the financial provisions within Section 1924 of the Social Security Act that protect income and assets of the community spouse through income and resource allocation. The allocation process is used to discourage the impoverishment of a spouse due to the other spouse's need for LTSS. This includes services provided in a medical institution, HCB waivers authorized under 1915(c) of the Social Security Act, and through December 31, 2018, services authorized under 1115 and 1915(k) of the Social Security Act.

"**Spousal impoverishment protections community (SIPC) spouse**" means the spouse of a SIPI spouse.

"**Spousal impoverishment protections institutionalized (SIPI) spouse**" means a legally married person who qualifies for the noninstitutional categorically needy (CN) Washington apple health SSI-related program only because of the spousal impoverishment protections under WAC 182-513-1220.

"**State spousal resource standard**" means the minimum CSRA standard for a CS or SIPC spouse.

"**Third-party resource (TPR)**" means funds paid to or on behalf of a person by a third party, where the purpose of the funds is for payment of activities of daily living, medical services, or personal care. The agency does not pay for these services if there is a third-party resource available.

"**Transfer**" means, in the context of long-term care eligibility, the changing of ownership or title of an asset, such as income, real property, or personal property, by one of the following:

- (a) An intentional act that changes ownership or title; or
- (b) A failure to act that results in a change of ownership or title.

"**Uncompensated value**" means the fair market value (FMV) of an asset on the date of transfer, minus the FMV of the consideration the person receives in exchange for the asset.

"**Undue hardship**" means a person is not able to meet shelter, food, clothing, or health needs. A person may apply for an undue hardship waiver based on criteria under WAC 182-513-1367.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1100, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1105 Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF). (1) This section describes the personal needs allowance (PNA), which is an amount set aside from a client's income that is intended for personal needs, and the room and board standard.

(2) The PNA in a state veteran's nursing facility:

(a) Is \$70 for a veteran without a spouse or dependent children receiving a needs-based veteran's pension in excess of \$90;

(b) Is \$70 for a veteran's surviving spouse with no dependent children receiving a needs-based veteran's pension in excess of \$90; or

(c) Is \$160 for a client who does not receive a needs-based veteran's pension.

(3) The PNA in a medical institution for clients receiving aged, blind, or disabled (ABD) cash assistance or temporary assistance for needy families (TANF) cash assistance is the client's personal and incidental (CPI) cash payment based on residing in a medical institution, which is \$41.62.

(4) The PNA in an alternate living facility (ALF) for clients receiving ABD cash assistance or TANF cash assistance is the CPI based on residing in an ALF that is not an adult family home, which is \$38.84.

(5) The PNA for clients not described in subsections (2), (3), and (4) of this section:

(a) Is \$57.28 for clients who reside in a medical institution; or

(b) Is \$62.79 for clients who reside in an ALF.

(6) Effective January 1, 2018, and each year thereafter, the amount of the PNA in subsection (5) of this section may be adjusted by the percentage of the cost-of-living adjustment (COLA) for old-age, survivors, and disability social security benefits as published by the federal Social Security Administration. This adjustment is subject to state legislative funding.

(7) The room and board standard in an ALF used by home and community services (HCS) and the developmental

disabilities administration (DDA) is based on the federal benefit rate (FBR) minus the current PNA as described under subsection (5)(b) of this section.

(8) The current PNA and room and board standards used in long-term services and supports are published under the institutional standards on the Washington apple health (medicaid) income and resource standards chart located at www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1105, filed 11/8/17, effective 1/1/18.]

WAC 182-513-1200 Long-term services and supports (LTSS) authorized under Washington apple health programs.

(1) Long-term services and supports (LTSS) programs available to people eligible for noninstitutional Washington apple health coverage who meet the functional requirements.

(a) Noninstitutional apple health coverage in an alternate living facility (ALF) under WAC 182-513-1205.

(b) Community first choice (CFC) under WAC 182-513-1210.

(c) Medicaid personal care (MPC) under WAC 182-513-1225.

(d) For people who do not meet institutional status under WAC 182-513-1320, skilled nursing or rehabilitation is available under the CN, medically needy (MN) or alternative benefits plan (ABP) scope of care if enrolled into a managed care plan.

(2) Non-HCB waiver LTSS programs that use institutional rules under WAC 182-513-1315 and 182-513-1380 or HCB waiver rules under chapter 182-515 WAC, depending on the person's living arrangement:

(a) Program of all-inclusive care for the elderly (PACE) under WAC 182-513-1230.

(b) Roads to community living (RCL) under WAC 182-513-1235.

(c) Hospice under WAC 182-513-1240.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1200, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1205 Determining eligibility for non-institutional coverage in an alternate living facility (ALF).

(1) This section describes the eligibility determination for noninstitutional coverage for a client who lives in a department-contracted alternate living facility (ALF) defined under WAC 182-513-1100.

(2) The eligibility criteria for noninstitutional Washington apple health (medicaid) coverage in an ALF follows SSI-related rules under WAC 182-512-0050 through 182-512-0960, with the exception of the higher income standard under subsection (3) of this section.

(3) A client is eligible for noninstitutional coverage under the categorically needy (CN) program if the client's monthly income after allowable exclusions under chapter 182-512 WAC:

(a) Does not exceed the special income level (SIL) defined under WAC 182-513-1100; and

(b) Is less than or equal to the client's assessed state rate at a department-contracted facility. To determine the CN

standard: $((y \times 31) + \$38.84)$, where "y" is the state daily rate. \$38.84 is based on the cash payment standard for a client living in an ALF setting under WAC 388-478-0006.

(4) A client is eligible for noninstitutional coverage under the medically needy (MN) program if the client's monthly income after allowable exclusions under chapter 182-512 WAC is less than or equal to the client's private rate at a department-contracted facility. To determine the MN standard: $((z \times 31) + \$38.84)$, where "z" is the facility's private daily rate. To determine MN spenddown liability, see chapter 182-519 WAC.

(5) For both CN and MN coverage, a client's countable resources cannot exceed the standard under WAC 182-512-0010.

(6) The agency or the agency's designee approves CN noninstitutional coverage for twelve months.

(7) The agency or the agency's designee approves MN noninstitutional coverage for a period of months described in WAC 182-504-0020 for an SSI-related client, provided the client satisfies any spenddown liability under chapter 182-519 WAC.

(8) Clients who receive medicaid personal care (MPC) or community first choice (CFC) pay all of their income to the ALF except a personal needs allowance under WAC 182-513-1105.

(9) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the payment under this subsection.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1205, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1205, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1210 Community first choice (CFC)

—**Overview.** (1) Community first choice (CFC) is a Washington apple health state plan benefit authorized under Section 1915(k) of the Social Security Act.

(2) CFC enables the agency and its contracted entities to deliver person-centered home and community based long-term services and supports (LTSS) to medicaid-eligible people who meet the institutional level of care under WAC 388-106-0355. See:

(a) WAC 388-106-0270 through 388-106-0295 for services included within the CFC benefit package.

(b) WAC 182-513-1215 for financial eligibility for CFC services.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1210, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1215 Community first choice (CFC)

—**Eligibility.** (1) A client who is determined functionally eligible for community first choice (CFC) services under WAC 388-106-0270 through 388-106-0295 is financially eligible to receive CFC services if the client is:

(a) Eligible for a noninstitutional Washington apple health (medicaid) program which provides categorically needy (CN) or alternative benefits plan (ABP) scope of care;

(b) A spousal impoverishment protections institutional (SIPI) spouse under WAC 182-513-1220; or

(c) Determined eligible for a home and community based (HCB) waiver program under chapter 182-515 WAC.

(2) A client whose only coverage is through one of the following programs is not eligible for CFC:

(a) Medically needy program under WAC 182-519-0100;

(b) Premium-based children's program under WAC 182-505-0215;

(c) Medicare savings programs under WAC 182-517-0300;

(d) Family planning program under WAC 182-505-0115;

(e) Take charge program under WAC 182-532-0720;

(f) Medical care services program under WAC 182-508-0005;

(g) Pregnant minor program under WAC 182-505-0117;

(h) Alien emergency medical program under WAC 182-507-0110 through 182-507-0120;

(i) State-funded long-term care (LTC) for noncitizens program under WAC 182-507-0125; or

(j) Kidney disease program under chapter 182-540 WAC.

(3) Transfer of asset penalties under WAC 182-513-1363 do not apply to CFC applicants, unless the client is applying for long-term services and supports (LTSS) that are available only through one of the HCB waivers under chapter 182-515 WAC.

(4) Home equity limits under WAC 182-513-1350 do apply.

(5) Post-eligibility treatment of income rules do not apply if the client is eligible under subsection (1)(a) or (b) of this section.

(6) Clients eligible under subsection (1)(a) or (b) of this section, who reside in an alternate living facility (ALF):

(a) Keep a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pay up to the room and board standard under WAC 182-513-1105 except when CN eligibility is based on the rules under WAC 182-513-1205.

(7) A client who receives CFC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board under WAC 182-513-1105, if residing in an ALF.

(8) Post-eligibility treatment of income rules do apply if a client is eligible under subsection (1)(c) of this section.

(9) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the room and board and participation.

(10) PNA, MNIL, and room and board standards are found at www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1215, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1215, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1220 Community first choice (CFC) —Spousal impoverishment protections for noninstitutional Washington apple health clients. (1) The agency or its designee determines eligibility for community first choice (CFC) using spousal impoverishment protections under this section, when an applicant:

(a) Is married to, or marries, a person not in a medical institution;

(b) Meets institutional level of care and eligibility for CFC services under WAC 388-106-0270 through 388-106-0295;

(c) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program:

(i) Due to spousal deeming rules under WAC 182-512-0920, or due to exceeding the resource limit in WAC 182-512-0010, or both; or

(ii) In an ALF due to combined spousal resources exceeding the resource limit in WAC 182-512-0010; and

(d) Meets the aged, blindness, or disability criteria under WAC 182-512-0050.

(2) The agency or its designee determines countable income using the SSI-related income rules under chapter 182-512 WAC but uses only the applicant's or recipient's separate income and not the income of the applicant's or recipient's spouse.

(3) The agency or its designee determines countable resources using the SSI-related resource rules under chapter 182-512 WAC, except pension funds owned by the spousal impoverishment protections community (SIPC) spouse are not excluded as described under WAC 182-512-0550:

(a) For the applicant or recipient, the resource standard is \$2000.

(b) Before determining countable resources used to establish eligibility for the applicant, the agency allocates the state spousal resource standard to the SIPC spouse.

(c) The resources of the SIPC spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for CFC services is established unless subsection (8) of this section applies.

(4) The SIPI spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of \$2000 to the SIPC spouse.

(5) A redetermination of the couple's resources under subsection (3) of this section is required if:

(a) The SIPI spouse has a break in CFC services of at least thirty consecutive days;

(b) The SIPI spouse's countable resources exceed the standard under subsection (3)(a) of this section; or

(c) The SIPI spouse does not transfer the amount under subsection (4) of this section to the SIPC spouse by the end of the month of the first regularly scheduled eligibility review.

(6) If the applicant lives at home and the applicant's separate countable income is at or below the SSI categorically needy income level (CNIL) and the applicant is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(7) If the applicant lives in an ALF, has separate countable income at or below the standard under WAC 182-513-1205(2), and is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(8) If the applicant is employed and has separate countable income at or below the standard under WAC 182-511-1060, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(9) Once a person no longer receives CFC services for thirty consecutive days, the agency redetermines eligibility without using spousal impoverishment protection, under WAC 182-504-0125.

(10) If the applicant's separate countable income is above the standards under subsections (6), (7), and (8) of this section, the applicant is not eligible for CFC services under this section.

(11) The spousal impoverishment protections under this section expire on December 31, 2018.

(12) Standards are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1220, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1225 Medicaid personal care (MPC).

(1) Medicaid personal care (MPC) is a state-plan benefit available to a client who is determined:

(a) Functionally eligible for MPC services under WAC 388-106-0200 through 388-106-0235; and

(b) Financially eligible for a noninstitutional categorically needy (CN) or alternative benefits plan (ABP) Washington apple health (medicaid) program.

(2) MPC services may be provided to a client residing at home, in a department-contracted adult family home (AFH), or in a licensed assisted living facility that is contracted with the department to provide adult residential care services.

(3) A client who resides in an alternate living facility (ALF) listed in subsection (2) of this section:

(a) Keeps a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pays room and board up to the room and board standard under WAC 182-513-1105, unless CN eligibility is determined using rules under WAC 182-513-1205.

(4) A client who receives MPC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board under WAC 182-513-1105, if residing in an ALF.

(5) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to room and board.

(6) Current PNA and room and board standards are found at www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1225, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1225, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1230 Program of all-inclusive care for the elderly (PACE). (1) The program of all-inclusive care for the elderly (PACE) provides long-term services and sup-

ports (LTSS), medical, mental health, and chemical dependency treatment through a department-contracted managed care plan using a personalized plan of care for each enrollee.

(2) Program rules governing functional eligibility for PACE are listed under WAC 388-106-0700, 388-106-0705, 388-106-0710, and 388-106-0715.

(3) A person is financially eligible for PACE if the person:

(a) Is age:

(i) Fifty-five or older and disabled under WAC 182-512-0050; or

(ii) Sixty-five or older;

(b) Meets nursing facility level of care under WAC 388-106-0355;

(c) Lives in a designated PACE service area;

(d) Meets financial eligibility requirements under this section; and

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

(4) Although PACE is not a home and community based (HCB) waiver program, financial eligibility is determined using the HCB waiver rules under WAC 182-515-1505 when a person is living at home or in an alternate living facility (ALF), with the following exceptions:

(a) PACE enrollees are not subject to the transfer of asset rules under WAC 182-513-1363; and

(b) PACE enrollees may reside in a medical institution thirty days or longer and still remain eligible for PACE services. The eligibility rules for institutional coverage are under WAC 182-513-1315 and 182-513-1380.

(5) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the room and board and participation.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1230, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1235 Roads to community living (RCL). (1) Roads to community living (RCL) is a demonstration project authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).

(2) Program rules governing functional eligibility for RCL are described in WAC 388-106-0250 through 388-106-0265. RCL services are authorized by the department.

(3) A person must have a stay of at least ninety consecutive days in a qualified institutional setting such as a hospital, nursing home, or residential habilitation center, to be eligible for RCL. The ninety-day count excludes days paid solely by medicare, must include at least one day of medicaid paid inpatient services immediately prior to discharge, and the person must be eligible to receive any categorically needy (CN), medically needy (MN), or alternate benefit plan (ABP) medicaid program on the day of discharge. In addition to meeting the ninety-day criteria, a person who is being discharged from a state psychiatric hospital must be under age twenty-two or over age sixty-four.

(4) Once a person is discharged to home or to a residential setting under RCL, the person remains continuously eli-

eligible for medical coverage for three hundred sixty-five days unless the person:

- (a) Returns to an institution for thirty days or longer;
 - (b) Is incarcerated in a public jail or prison;
 - (c) No longer wants RCL services;
 - (d) Moves out-of-state; or
 - (e) Dies.
- (5) Changes in income or resources during the continuous eligibility period do not affect eligibility for RCL services. Changes in income or deductions may affect the amount a person must pay toward the cost of care.
- (6) A person approved for RCL is not subject to transfer of asset provisions under WAC 182-513-1363 during the continuous eligibility period, but transfer penalties may apply if the person needs HCB waiver or institutional services once the continuous eligibility period has ended.

(7) A person who is not otherwise eligible for a noninstitutional medical program must have eligibility determined using the same rules used to determine eligibility for HCB waivers. If HCB rules are used to establish eligibility, the person must pay participation toward the cost of RCL services. HCB waiver eligibility and cost of care calculations are under:

- (a) WAC 182-515-1508 and 182-515-1509 for home and community services (HCS); and
- (b) WAC 182-515-1513 and 182-515-1514 for developmental disabilities administration (DDA) services.

(8) At the end of the continuous eligibility period, the agency or its designee redetermines a person's eligibility for other programs under WAC 182-504-0125.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1235, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1240 The hospice program. (1) General information.

(a) The hospice program provides palliative care to people who elect to receive hospice services and are certified as terminally ill by their physician.

(b) Program rules governing election of hospice services are under chapter 182-551 WAC.

(c) A person may revoke an election to receive hospice services at any time by signing a revocation statement.

(d) Transfer of asset rules under WAC 182-513-1363 do not apply to the hospice program in any setting, regardless of which apple health program the person is eligible to receive.

(2) When hospice is a covered service.

(a) A person who receives coverage under a categorically needy (CN), medically needy (MN), or alternative benefits plan (ABP) program is eligible for hospice services as part of the program specific benefit package.

(b) A person who receives coverage under the alien emergency medical (AEM) program under WAC 182-507-0110 may be eligible for payment for hospice services if pre-approved by the agency.

(c) A person who receives coverage under the medical care services (MCS) program is not eligible for coverage of hospice services.

(3) When HCB waiver rules are used to determine eligibility for hospice.

(a) A person who is not otherwise eligible for a CN, MN, or ABP noninstitutional program who does not reside in a medical institution, may be eligible for CN coverage under the hospice program by using home and community based (HCB) waiver rules under WAC 182-515-1505 to determine financial eligibility.

(b) When HCB waiver rules are used, the following exceptions apply:

(i) A person on the hospice program may reside in a medical institution, including a hospice care center, thirty days or longer and remain eligible for hospice services; and

(ii) A person residing at home on the hospice program who has available income over the special income limit (SIL), defined under WAC 182-513-1100, is not eligible for CN coverage. If available income is over the SIL, the agency or its designee determines eligibility for medically needy coverage under WAC 182-519-0100.

(c) When HCB waiver rules are used, a person may be required to pay income and third-party resources (TPR) as defined under WAC 182-513-1100 toward the cost of hospice services. The cost of care calculation is described under WAC 182-515-1509.

(d) When a person already receives HCB waiver services and elects hospice, the person must pay any required cost of care towards the HCB waiver service provider first.

(4) Eligibility for hospice services in a medical institution:

(a) A person who elects to receive hospice services, resides in a medical institution for thirty days or longer, and has income:

(i) Equal to or less than the SIL is income eligible for CN coverage. Eligibility for institutional hospice is determined under WAC 182-513-1315; or

(ii) Over the SIL may be eligible for MN coverage under WAC 182-513-1245.

(b) A person eligible for hospice services in a medical institution may have to pay toward the cost of nursing facility or hospice care center services. The cost of care calculation is under WAC 182-513-1380.

(5) Changes in coverage. The agency or its designee redetermines a person's eligibility under WAC 182-504-0125 if the person:

(a) Revokes the election of hospice services and is eligible for coverage using HCB waiver rules only, described in subsection (3) of this section; or

(b) Loses CN, MN, or ABP eligibility.

(6) Personal needs allowance and income and resource standards for hospice and home and community based (HCB) waiver programs are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1240, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1245 Medically needy hospice program in a medical institution. (1) General information.

(a) When living in a medical institution, a person may be eligible for medically needy coverage under the hospice program. A person must:

(i) Meet program requirements under WAC 182-513-1315;

(ii) Have available income that exceeds the special income level (SIL), defined under WAC 182-513-1100, but is below the institution's monthly state-contracted rate;

(iii) Meet the financial requirements of subsection (4) or (5) of this section; and

(b) Elect hospice services under chapter 182-551 WAC.

(2) Financial eligibility.

(a) The agency or its designee determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.

(b) The agency or its designee determines a person's countable income by:

(i) Excluding income under WAC 182-513-1340;

(ii) Determining available income under WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income under WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources under WAC 182-513-1350.

(3) Determining the state-contracted daily rate in an institution, and the institutional medically needy income level (MNIL).

(a) The agency or its designee determines the state-contracted daily rate in an institution and the institutional MNIL based on the living arrangement, and whether the person is entitled to receive hospice services under medicare.

(b) When the person resides in a hospice care center:

(i) If entitled to medicare, the state-contracted daily rate is the state-contracted daily hospice care center rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(ii) If not entitled to medicare, the state-contracted daily rate is the state-contracted daily hospice care center rate, plus the state-contracted daily hospice rate. To calculate the institutional MNIL, multiply the state-contracted daily rate by 30.42.

(c) When the person resides in a nursing facility:

(i) If entitled to medicare, the state-contracted daily rate is ninety-five percent of the nursing facility's state-contracted daily rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(ii) If not entitled to medicare, the state-contracted daily rate is ninety-five percent of the nursing facility's state-contracted daily rate, plus the state-contracted daily hospice rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(4) Eligibility for agency payment to the facility for institutional hospice services and the MN program.

(a) If a person's countable income plus excess resources is less than or equal to the state-contracted daily rate under subsection (3) of this section times the number of days the person has resided in the medical institution, the person:

(i) Is eligible for agency payment to the facility for institutional hospice services;

(ii) Is approved for MN coverage for a twelve-month certification period;

(b) Pays excess resources under WAC 182-513-1350; and

(c) Pays income towards the cost of care under WAC 182-513-1380.

(5) Eligibility for institutional MN spenddown.

(a) If a person's countable income is more than the state-contracted daily rate times the number of days the person has resided in the medical institution, but less than the institution's private rate for the same period, the person:

(i) Is not eligible for agency payment to the facility for institutional hospice services; and

(ii) Is eligible for the MN spenddown program for a three-month or six-month base period when qualifying medical expenses meet a person's spenddown liability.

(b) Spenddown liability is calculated by subtracting the institutional MNIL from the person's countable income for each month in the base period. The values from each month are added together to determine the spenddown liability.

(c) Qualifying medical expenses used to meet the spenddown liability are described in WAC 182-519-0110, except that only costs for hospice services not included within the state-contracted daily rate are qualifying medical expenses.

(6) Eligibility for MN spenddown.

(a) If a person's countable income is more than the institution's private rate times the number of days the person has resided in the medical institution, the person is not eligible for agency payment to the facility for institutional hospice services and institutional MN spenddown; and

(b) The agency or its designee determines eligibility for MN spenddown under chapter 182-519 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1245, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1315 General eligibility requirements for long-term care (LTC) programs. This section lists the sections in this chapter that describe how the agency determines a person's eligibility for long-term care services. These sections are:

(1) WAC 182-513-1316 General eligibility requirements for long-term care (LTC) programs.

(2) WAC 182-513-1317 Income and resource criteria for an institutionalized person.

(3) WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice.

(4) WAC 182-513-1319 State-funded programs for non-citizens who are not eligible for a federally funded program.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1315, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1315, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1315, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. WSR 10-01-158, § 388-513-1315, filed 12/22/09, effective 1/22/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, and Deficit Reduction Act of 2005, 42 C.F.R. Section 435. WSR 09-07-036, § 388-513-1315, filed 3/10/09, effective 4/10/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.39.010. WSR 07-19-129, § 388-513-1315, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.08.090. WSR 06-07-077, § 388-513-1315, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 71A.12.030, 71A.10.020, chapters 71A.10 and 71A.12 RCW, 2004 c 276. WSR 04-18-054, § 388-513-1315, filed 8/27/04, effective 9/27/04. Statutory

Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1315, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 99-06-045, § 388-513-1315, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.08.090 and 42 C.F.R. 435.1005. WSR 98-04-003, § 388-513-1315, filed 1/22/98, effective 2/22/98. Statutory Authority: RCW 74.08.090. WSR 96-11-072 (Order 3980), § 388-513-1315, filed 5/10/96, effective 6/10/96. Statutory Authority: RCW 74.08.090 and 1995 c 312 § 48. WSR 95-19-007 (Order 3895), § 388-513-1315, filed 9/6/95, effective 10/7/95. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1315, filed 5/3/94, effective 6/3/94.]

WAC 182-513-1316 General eligibility requirements for long-term care (LTC) programs. (1) To be eligible for long-term care (LTC) services, a person must:

(a) Meet the general eligibility requirements for medical programs under WAC 182-503-0505, except:

(i) An adult age nineteen or older must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a) or (b);

(ii) A person under age nineteen must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a), (b), (c), or (d); and

(iii) If a person does not meet the requirements in (a)(i) or (ii) of this subsection, the person is not eligible for Medicaid and must have eligibility determined under WAC 182-513-1319.

(b) Attain institutional status under WAC 182-513-1320;

(c) Meet the functional eligibility under:

(i) Chapter 388-106 WAC for a home and community services (HCS) home and community based (HCB) waiver or nursing facility coverage; or

(ii) Chapter 388-828 WAC for developmental disabilities administration (DDA) HCB waiver or institutional services; and

(d) Meet either:

(i) SSI-related criteria under WAC 182-512-0050; or

(ii) MAGI-based criteria under WAC 182-503-0510(2), if residing in a medical institution. A person who is eligible for MAGI-based coverage is not subject to the provisions under subsection (2) of this section.

(2) A supplemental security income (SSI) recipient or a person meeting SSI-related criteria who needs LTC services must also:

(a) Not have a penalty period of ineligibility due to the transfer of assets under WAC 182-513-1363;

(b) Not have equity interest in a primary residence greater than the home equity standard under WAC 182-513-1350; and

(c) Disclose to the agency or its designee any interest the applicant or spouse has in an annuity, which must meet annuity requirements under chapter 182-516 WAC.

(3) A person who receives SSI must submit a signed health care coverage application form attesting to the provisions under subsection (2) of this section. A signed and completed eligibility review for LTC benefits can be accepted for people receiving SSI who are applying for long-term care services.

(4) To be eligible for HCB waiver services, a person must also meet the program requirements under:

(a) WAC 182-515-1505 through 182-515-1509 for HCS HCB waivers; or

(b) WAC 182-515-1510 through 182-515-1514 for DDA HCB waivers.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1316, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1317 Income and resource criteria for an institutionalized person. (1) This section provides an overview of the income and resource eligibility rules for a person who lives in an institutional setting.

(2) To determine income eligibility for an SSI-related long-term care (LTC) applicant under the categorically needy (CN) program, the agency or its designee:

(a) Determines available income under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340; and

(c) Compares remaining available income to the special income level (SIL) defined under WAC 182-513-1100. A person's available income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related LTC client under the medically needy (MN) program, the agency or its designee follows the income standards and eligibility rules under WAC 182-513-1395.

(4) To be resource eligible under the SSI-related LTC CN or MN program, the person must:

(a) Meet the resource eligibility requirements under WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of assets under WAC 182-513-1363;

(c) Disclose to the state any interest the person or the person's spouse has in an annuity, which must meet the annuity requirements under chapter 182-516 WAC.

(5) A resident of eastern or western state hospital is eligible for Medicaid if the person:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is under age twenty-one; or

(c) Applies for or receives inpatient psychiatric treatment in the month of the person's twenty-first birthday that will likely continue through the person's twenty-first birthday, and can receive coverage until:

(i) The facility discharges the person; or

(ii) The end of the month in which the person turns age twenty-two, whichever occurs first; or

(d) Is at least age sixty-five.

(6) To determine long-term care CN or MN income eligibility for a person eligible under a MAGI-based program, the agency or its designee follows the rules under chapter 182-514 WAC.

(7) There is no asset test for MAGI-based LTC programs under WAC 182-514-0245.

(8) The agency or its designee determines a person's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For an SSI-related person residing in a medical institution, see WAC 182-513-1380;

(b) For an SSI-related person on a home and community based waiver, see chapter 182-515 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1317, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice. (1) This section provides an overview of the income and resource eligibility rules for a person to be eligible for a categorically needy (CN) home and community based (HCB) waiver program under chapter 182-515 WAC or the hospice program under WAC 182-513-1240 and 182-513-1245.

(2) To determine income eligibility for an SSI-related long-term care (LTC) HCB waiver, the agency or its designee:

(a) Determines income available under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to:

(i) The special income level (SIL) defined under WAC 182-513-1100; or

(ii) For HCB service programs authorized by the aging and long-term supports administration (AL TSA), a higher standard is determined following the rules under WAC 182-515-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

(3) A person who receives MAGI-based coverage is not eligible for HCB waiver services unless found eligible based on program rules in chapter 182-515 WAC.

(4) To be resource eligible under the HCB waiver program, the person must:

(a) Meet the resource eligibility requirements and standards under WAC 182-513-1350;

(b) Not be in a period of ineligibility due to a transfer of asset penalty under WAC 182-513-1363;

(c) Disclose to the state any interest the person or that person's spouse has in an annuity and meet the annuity requirements under chapter 182-516 WAC.

(5) The agency or its designee determines a person's responsibility to pay toward the cost of care for LTC services as follows:

(a) For people receiving HCS HCB waiver services, see WAC 182-515-1509;

(b) For people receiving DDA HCB waiver services, see WAC 182-515-1514.

(6) To be eligible for the CN hospice program, see WAC 182-513-1240.

(7) To be eligible for the MN hospice program in a medical institution, see WAC 182-513-1245.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1318, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1319 State-funded programs for non-citizens who are not eligible for a federally funded program. (1) This section describes the state-funded programs available to a person who does not meet the citizenship and immigration status criteria under WAC 182-513-1316 for federally funded coverage.

(2) If a person meets the eligibility and incapacity criteria of the medical care services (MCS) program under WAC 182-508-0005, the person may receive nursing facility care or

state-funded residential services in an alternate living facility (ALF).

(3) Noncitizens age nineteen or older may be eligible for the state-funded long-term care services program under WAC 182-507-0125. A person must be preapproved by the aging and long-term support administration (AL TSA) for this program due to enrollment limits.

(4) Noncitizens under age nineteen who meet citizenship and immigration status under WAC 182-503-0535 (2)(e) are eligible for:

(a) Nursing facility services if the person meets nursing facility level of care; or

(b) State-funded personal care services if functionally eligible based on a department assessment under chapter 388-106 or 388-845 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1319, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1320 Determining institutional status for long-term care (LTC) services. (1) To attain institutional status outside a medical institution, a person must be approved for and receive:

(a) Home and community based (HCB) waiver services under chapter 182-515 WAC;

(b) Roads to community living (RCL) services under WAC 182-513-1235;

(c) Program of all-inclusive care for the elderly (PACE) under WAC 182-513-1230;

(d) Hospice services under WAC 182-513-1240(3); or

(e) State-funded long-term care service under WAC 182-507-0125.

(2) To attain institutional status in a medical institution, a person must reside in a medical institution thirty consecutive days or more, or based on a department assessment, be likely to reside in a medical institution thirty consecutive days or more.

(3) Once a person meets institutional status, the person's status is not affected if the person:

(a) Transfers between medical facilities; or

(b) Changes between any of the following programs: HCB waiver, RCL, PACE, hospice or services in a medical institution.

(4) A person loses institutional status if the person is absent from a medical institution, or does not receive HCB waiver, RCL, PACE, or hospice services, for more than twenty-nine consecutive days.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1320, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1320, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1320, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, and Deficit Reduction Act of 2005, 42 C.F.R. Section 435. WSR 09-07-036, § 388-513-1320, filed 3/10/09, effective 4/10/09. Statutory Authority: RCW 74.08.090. WSR 06-07-077, § 388-513-1320, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1320, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and

74.09.500, WSR 99-06-045, § 388-513-1320, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 42 C.F.R. 435.403 (j)(2). WSR 97-15-025, § 388-513-1320, filed 7/8/97, effective 8/8/97. Statutory Authority: RCW 74.08.090, WSR 96-11-072 (Order 3980), § 388-513-1320, filed 5/10/96, effective 6/10/96; WSR 94-10-065 (Order 3732), § 388-513-1320, filed 5/3/94, effective 6/3/94.]

WAC 182-513-1325 Determining available income for an SSI-related single client for long-term care (LTC) services. This section describes income the agency or its designee determines available when evaluating an SSI-related single client's eligibility for long-term care (LTC) services.

(1) See WAC 182-513-1330 for rules related to available income for legally married couples.

(2) The agency or its designee applies the following rules when determining income eligibility for SSI-related LTC services:

(a) WAC 182-512-0600 SSI-related medical—Definition of income;

(b) WAC 182-512-0650 SSI-related medical—Available income;

(c) WAC 182-512-0700 SSI-related medical—Income eligibility;

(d) WAC 182-512-0750 SSI-related medical—Countable unearned income;

(e) WAC 182-512-0840(3) self-employment income-allowable expenses; and

(f) WAC 182-512-0785, 182-512-0790, and 182-512-0795 for sponsored immigrants and how to determine if sponsors' income counts in determining benefits.

(3) In initial categorically needy income eligibility for LTC, the agency does not allow any deductions listed in 1612(b) of the Social Security Act, for example:

(a) Twenty dollars per month income exclusion under WAC 182-512-0800;

(b) The first \$65 and the remaining one-half earned income work incentive under WAC 182-512-0840; and

(c) Impairment related work expense or blind work expense under WAC 182-512-0840.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1325, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1325, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1), WSR 12-21-091, § 388-513-1325, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. WSR 07-14-087, § 388-513-1325, filed 6/29/07, effective 7/30/07. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1325, filed 12/8/99, effective 1/8/00.]

WAC 182-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the agency or its designee determines available when evaluating a legally married person's eligibility for LTC services.

(1) The agency or its designee applies the following rules when determining income eligibility for LTC services:

(a) WAC 182-512-0600 SSI-related medical—Definition of income;

(b) WAC 182-512-0650 SSI-related medical—Available income;

(c) WAC 182-512-0700 SSI-related medical—Income eligibility;

(d) WAC 182-512-0750 SSI-related medical—Countable unearned income;

(e) WAC 182-512-0840(3), self-employment income-allowance expenses;

(f) WAC 182-512-0960 SSI-related medical—Allocating income—Determining eligibility for a spouse when the other spouse receives long-term services and supports (LTSS).

(2) In initial categorically needy income eligibility for LTC, the agency does not allow any deductions listed in 1612(b) of the Social Security Act, for example:

(a) Twenty dollars per month income exclusion under WAC 182-512-0800;

(b) The first \$65 and the remaining one-half earned income work incentive under WAC 182-512-0840; and

(c) Impairment related work expense or blind work expense under WAC 182-512-0840.

(3) The following income is available to an institutionalized spouse, unless subsections (5) and (6) apply:

(a) Income received in the institutionalized spouse's name;

(b) Income paid to a representative on the institutionalized spouse's behalf; and

(c) One-half of the income received in the names of both spouses.

(4) The following income is unavailable to an institutionalized spouse:

(a) Separate income received in the name of the community spouse; and

(b) Income established as unavailable through a court order.

(5) For the determination of eligibility only, if available income under subsection (3)(a) through (c) of this section, minus income exclusions under WAC 182-513-1340, exceeds the special income level (SIL), defined under WAC 182-513-1100, the agency or its designee:

(a) Follows Washington state community property law when determining ownership of income;

(b) Presumes all income received after the marriage by either spouse to be community income;

(c) Considers one-half of all community income available to the institutionalized spouse.

(6) If the total of subsection (5)(c) of this section plus the institutionalized spouse's separate income is over the SIL, determine available income using subsection (3) of this section.

(7) A stream of income, not generated by a transferred resource, is available to the institutionalized spouse, even if the institutionalized spouse transfers or assigns the rights to the stream of income to one of the following:

(a) The community spouse; or

(b) A trust for the benefit of the community spouse.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1330, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1330, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-

091, § 388-513-1330, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, and 2005 federal Deficit Reduction Act (DRA), Public Law 109-171. WSR 07-17-152, § 388-513-1330, filed 8/21/07, effective 10/1/07. Statutory Authority: RCW 74.08.090. WSR 06-07-077, § 388-513-1330, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1330, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 99-06-045, § 388-513-1330, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.05.040 and 20 C.F.R. 416.1110-1112, 1123 and 1160. WSR 97-10-022, § 388-513-1330, filed 4/28/97, effective 5/29/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. WSR 95-02-028 (Order 3819), § 388-513-1330, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1330, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-335 and 388-95-340.]

WAC 182-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the agency or its designee excludes when determining a person's eligibility and participation in the cost of care for long-term care (LTC) services.

(1) When determining a person's eligibility and participation in the cost of care for LTC services, the agency excludes:

- (a) Crime victim's compensation;
- (b) Earned income tax credit (EITC) for twelve months after the month of receipt;
- (c) American Indian/Alaskan native benefits excluded by federal statute (refer to WAC 182-512-0770);
- (d) Tax rebates or special payments excluded by other statutes;
- (e) Any public agency's refund of taxes paid on real property and/or on food;
- (f) Supplemental security income (SSI) and certain state public assistance based on financial need;
- (g) The amount a representative payee charges to provide services when the services are a requirement for the person to receive the income;
- (h) The amount of expenses necessary for a person to receive compensation, e.g., legal fees necessary to obtain settlement funds;
- (i) Education benefits under WAC 182-509-0335;
- (j) Child support payments received from a noncustodial parent for a child living in the home are the income of the child;
- (k) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);
- (l) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;
- (m) Assistance (other than wages or salary) received under the Older Americans Act;
- (n) Assistance (other than wages or salary) received under the foster grandparent program;
- (o) Certain cash payments a person receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;
- (p) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(q) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(r) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(s) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(t) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(u) Payments made under the Energy Employees Occupational Illness Compensation Program Act of 2000, (EEOICPA) Pub. L. 106-398;

(v) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(w) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(x) Payments made from *Susan Walker v. Bayer Corporation, et. al., 95-C-5024* (N.D. Ill.) (May 8, 1997) settlement funds;

(y) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(z) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(aa) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(bb) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(cc) Interest or dividends received by the institutionalized individual is excluded as income. Interest or dividends received by the community spouse of an institutional individual is counted as income of the community spouse. Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts. Institutional status is defined in WAC 182-513-1320;

(dd) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible person, e.g., chore services;

(2) The agency or its designee treats Department of Veterans Affairs (VA) benefits as follows:

(a) Any VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) UME, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance are third-party resources;

(c) Benefits in subsection (2)(b) of this section for a person who receives long-term care services are excluded when determining eligibility, but are available as a third-party resource (TPR) as defined under WAC 182-513-1100 when determining the amount the institutionalized individual contributes in the cost of care.

(3) Any other income excluded by federal law is excluded.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1340, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC

182-513-1340, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1340, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, Social Security Act § 1611, 1902, and C.F.R. 435.725. WSR 09-09-101, § 388-513-1340, filed 4/20/09, effective 5/21/09. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42 C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). WSR 00-01-087, § 388-513-1340, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. WSR 95-02-028 (Order 3819), § 388-513-1340, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1340, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 182-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the agency or its designee disregards when determining a person's eligibility for institutional or hospice services under the medically needy (MN) program. Disregarded income is available when determining a person's participation in the cost of care.

(1) The agency or its designee disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

- (i) Twenty dollars per month if unearned; or
- (ii) Ten dollars per month if earned.

(b) The first \$20 per month of earned or unearned income, unless the sole source of income paid to a person is:

- (i) Based on need; and
- (ii) Totally or partially funded by the federal government or a nongovernmental agency.

(2) For a person who is related to the supplemental security income (SSI) program under WAC 182-512-0050(1), the first \$65 per month of earned income not excluded under WAC 182-513-1340, plus one-half of the remainder.

(3) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception under subsection (4) of this section.

(4) Benefits under subsection (3)(b) of this section for a person who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) defined under WAC 182-513-1100 when determining the amount the person contributes in the cost of care.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1345, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1345, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1345, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.08.090. WSR 06-07-077, § 388-513-1345, filed 3/13/06, effective 4/13/06. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 42

C.F.R. 435.601, 42 C.F.R. 435.725-726, and Sections 4715 and 4735 of the Federal Balanced Budget Act of 1997 (P.L. 105-33) (H.R. 2015). WSR 00-01-087, § 388-513-1345, filed 12/14/99, effective 1/14/00. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter #94-33. WSR 95-02-028 (Order 3819), § 388-513-1345, filed 12/28/94, effective 1/28/95. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1345, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-340 (part).]

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services. (1) General information.

(a) This section describes how the agency or its designee defines the resource standard and countable or excluded resources when determining a person's eligibility for SSI-related long-term care (LTC) services.

(b) "Resource standard" means the maximum amount of resources a person can have and still be resource eligible for program benefits.

(c) For a person not SSI-related, the agency applies program specific resource rules to determine eligibility.

(2) Resource standards.

(a) The resource standard for the following people is \$2000:

- (i) A single person; or
- (ii) An institutionalized spouse.

(b) The resource standard for a legally married couple is \$3000, unless subsection (3)(b)(ii) of this section applies.

(c) The resource standard for a person with a qualified long-term care partnership policy under WAC 182-513-1400 may be higher based on the dollar amount paid out by a partnership policy.

(d) Determining the amount of resources that can be allocated to the community spouse when determining resource eligibility is under WAC 182-513-1355.

(3) Availability of resources.

(a) General. The agency or its designee applies the following rules when determining available resources for LTC services:

(i) WAC 182-512-0300 SSI-related medical—Resources eligibility;

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources; and

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(b) Married couples.

(i) When both spouses apply for LTC services, the resources of both spouses are available to each other through the month in which the spouses stopped living together.

(ii) When both spouses are institutionalized, the agency or its designee determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency or its designee has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, but after eligibility has been established and services authorized for the institutionalized spouse, then the agency applies the standard under subsection (2)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the agency applies subsection (2)(b) of this section for the couple.

(iv) The resources of the community spouse are unavailable to the institutionalized spouse the month after eligibility

for LTC services is established, unless (v) or (vi) of this subsection applies.

(v) When a single institutionalized individual marries, the agency or its designee redetermines eligibility applying the resource and income rules for a legally married couple.

(vi) A redetermination of the couple's resources under this section is required if:

(A) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(B) The institutionalized spouse's countable resources exceed the standard under subsection (2)(a) of this section, and WAC 182-513-1355 (2)(b) applies; or

(C) The institutionalized spouse does not transfer the amount, under WAC 182-513-1355 (3) or (5), to the community spouse by either:

(I) The end of the month of the first regularly scheduled eligibility review; or

(II) A reasonable amount of time necessary to obtain a court order for the support of the community spouse.

(4) Countable resources.

(a) The agency or its designee determines countable resources using the following sections:

(i) WAC 182-512-0200 SSI-related medical—Definition of resources.

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources.

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(iv) WAC 182-512-0300 SSI-related medical—Resources eligibility.

(v) WAC 182-512-0350 SSI-related medical—Property and contracts excluded as resources;

(vi) WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources;

(vii) WAC 182-512-0450 SSI-related medical—Life insurance excluded as a resource; and

(viii) WAC 182-512-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources.

(ix) Chapter 182-516 WAC, Trusts, annuities, life estates, and promissory notes—Effect on medical programs.

(b) The agency or its designee determines excluded resources based on federal law and WAC 182-512-0550, except:

(i) For institutional and HCB waiver programs, pension funds owned by a nonapplying spouse are counted toward the resource standard.

(ii) For long-term services and supports (LTSS), based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, one home is excluded only if it meets the home equity limits of subsection (8) of this section. See WAC 182-512-0350 (1)(b).

(c) The agency or its designee adds together the countable resources of both spouses if subsections (3)(b)(i) and (iv) apply, but not if subsection (3)(b)(ii) or (iii) apply. For a person with a community spouse, see WAC 182-513-1355.

(5) Excess resources.

(a) For LTC programs, a person may reduce excess resources by deducting incurred medical expenses under subsection (6) of this section;

(b) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) In a medical institution, excess resources and available income must be under the state medicaid rate based on the number of days the person spent in the medical institution in the month.

(B) For HCB waiver eligibility, incurred medical expenses must reduce resources within allowable resource standards. The cost of care for the HCB waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program, see:

(A) WAC 182-513-1395 for LTC programs; and

(B) WAC 182-513-1245 for hospice.

(c) Excess resources not otherwise applied to medical expenses will be applied to the projected cost of care for services in a medical institution under WAC 182-513-1380.

(6) Allowable medical expenses.

(a) The following incurred medical expenses may be used to reduce excess resources:

(i) Premiums, deductibles, coinsurance, or copayment charges for health insurance and medicare;

(ii) Medically necessary care defined under WAC 182-500-0070, but not covered under the state's medicaid plan. Information regarding covered services is under chapter 182-501 WAC;

(iii) Medically necessary care defined under WAC 182-500-0070 incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the specific facility that provided the services.

(b) To be allowed, the medical expense must:

(i) Have been incurred no more than three months before the month of the medicaid application;

(ii) Not be subject to third-party payment or reimbursement;

(iii) Not have been used to satisfy a previous spenddown liability;

(iv) Not have been previously used to reduce excess resources;

(v) Not have been used to reduce participation;

(vi) Not have been incurred during a transfer of asset penalty under WAC 182-513-1363; and

(vii) Be an amount for which the person remains liable.

(7) Nonallowable expenses. The following expenses are not allowed to reduce excess resources:

(a) Unpaid adult family home (AFH) or assisted living facility expenses incurred prior to medicaid eligibility;

(b) Personal care cost in excess of approved hours determined by the CARE assessment under chapter 388-106 WAC; and

(c) Expenses excluded by federal law.

(8) Excess home equity.

(a) A person with an equity interest in a primary residence in excess of the home equity limit is ineligible for long-term services and supports (LTSS) that are based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, unless one of the following persons lawfully resides in the home:

(i) That person's spouse; or

(ii) That person's dependent child under age twenty-one, blind child, or disabled child.

(b) The home equity provision applies to all applications for LTSS received on or after May 1, 2006.

(c) Effective January 1, 2016, the excess home equity limit is \$552,000. On January 1, 2017, and on January 1st of each year thereafter, this standard may change by the percentage in the consumer price index-urban.

(d) A person who is denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver under WAC 182-513-1367.

(9) Institutional resource standards are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-18-023, § 182-513-1350, filed 8/28/17, effective 9/28/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1350, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1350, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1350, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and 74.09.575. WSR 09-12-058, § 388-513-1350, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. WSR 08-13-072, § 388-513-1350, filed 6/16/08, effective 7/17/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, and 74.09.530. WSR 07-19-128, § 388-513-1350, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 2005 Federal Deficit Reduction Act (DRA) P.L. 109-171, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). WSR 07-01-073, § 388-513-1350, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). WSR 05-07-033, § 388-513-1350, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396r-5). WSR 04-04-072, § 388-513-1350, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396r-5). WSR 01-18-055, § 388-513-1350, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1350, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 99-06-045, § 388-513-1350, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 U.S.C. 1396r-5). WSR 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. WSR 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. WSR 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. WSR 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/1/95. Statutory Authority: RCW 74.08.090. WSR 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; WSR 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

WAC 182-513-1355 Allocating resources to a community spouse when determining resource eligibility for SSI-related long-term care services. (1) The agency or its designee uses this section to calculate the resource allocation from the institutionalized spouse to the community spouse for the determination of the institutionalized spouse's resource eligibility under WAC 182-513-1350 (2)(a)(ii).

(2) If the institutionalized spouse's most recent continuous period of institutionalization (MRCPI) began:

(a) Before October 1, 1989, the agency adds together one-half the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

- (i) The institutionalized spouse; and
- (ii) Both spouses.

(b) On or after October 1, 1989, the agency or its designee adds together the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

- (i) Either spouse; and
- (ii) Both spouses.

(3) If subsection (2)(b) of this section applies, the agency or its designee determines the amount of resources allocated to the community spouse, before determining the amount of countable resources used to establish eligibility for the institutionalized spouse under WAC 182-513-1350:

(a) If the institutionalized spouse's MRCPI began on or after October 1, 1989, and before August 1, 2003, the agency or its designee allocates the federal spousal resource maximum;

(b) If the institutionalized spouse's MRCPI began on or after August 1, 2003, the agency or its designee allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources, up to the federal spousal resource maximum; or

(ii) The state spousal resource standard.

(4) Countable resources under subsection (3)(b) of this section determined as of the first day of the month in which MRCPI began.

(5) The agency or its designee uses a community spouse evaluation to determine the amount of the spousal share under subsection (3)(b)(i) of this section.

(6) The agency or its designee completes a community spouse resource evaluation:

(a) Upon request by the institutionalized spouse, or the institutionalized spouse's community spouse;

(b) At any time between the date that the MRCPI began and the date that eligibility for long-term care (LTC) is determined; and

(c) Upon receipt of any verification required to establish the amount of the couple's resources in the month of MRCPI.

(7) The community spouse resource evaluation can be completed prior to an application for LTC or as part of the LTC application if:

(a) The beginning of the MRCPI was prior to the month of application; and

(b) The spousal share exceeds the state spousal resource standard.

(8) The amount of allocated resources under subsection (3) of this section can be increased, but only if:

(a) A court has entered an order against the institutionalized spouse for the support of the community spouse or a dependent of either spouse; or

(b) A final order is entered under chapter 182-526 WAC, ruling that the institutionalized spouse or community spouse established that the income generated by the resources allocated under subsection (3) of this section is insufficient to raise the community spouse's income to the monthly mainte-

nance needs allowance (MMNA) determined under WAC 182-513-1385, but only after the application of the income-first rule under 42 U.S.C. 1396r-5 (d)(6).

(9) If a final order establishes that the conditions identified in subsection (8)(b) of this section have been met, then an amount of allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(10) The institutionalized spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of \$2000 to the community spouse.

(11) Standards in this section are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1355, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1363 Evaluating an asset transfer for people applying for or receiving long-term care (LTC) services. (1) When determining a person's eligibility for long-term care (LTC) services, the agency or its designee evaluates the effect of an asset transfer made within the sixty-month period before the month that the person:

(a) Attained institutional status, or would have attained institutional status but for a period of ineligibility; and

(b) Applied for LTC services.

(2) The agency or its designee evaluates all transfers for recipients of LTC services made on or after the month the recipient attained institutional status.

(3) The agency or its designee establishes a period of ineligibility during which the person is not eligible for LTC services if the person, the person's spouse, or someone acting on behalf of either:

(a) Transfers an asset within the time period under subsection (1) or (2) of this section; and

(b) Does not receive adequate consideration for the asset, unless the transfer meets one of the conditions in subsection (4)(a) through (g) of this section.

(4) The agency or its designee does not apply a period of ineligibility for uncompensated value if:

(a) The total of all transfers in a month does not exceed the average daily private nursing facility rate in that month;

(b) The transferred resource was an excluded resource under WAC 182-513-1350 except a home, unless the transfer of the home meets the conditions under (d) of this subsection;

(c) The asset was transferred for less than fair market value (FMV), and the person can establish one of the following:

(i) An intent to transfer the asset at FMV. To establish such an intent, the agency or its designee must be provided with convincing evidence of the attempt to dispose the asset for FMV;

(ii) The transfer was not made to qualify for medicaid, continue to qualify for medicaid, or avoid estate recovery. Convincing evidence must be presented regarding the specific purpose of the transfer;

(iii) All assets transferred for less than FMV have been returned to the person or the person's spouse; or

(iv) The denial of eligibility would result in an undue hardship under WAC 182-513-1367;

(d) The transferred asset was a home, if the home was transferred to the person's:

(i) Spouse;

(ii) Child who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(iii) Child who was under age twenty-one; or

(iv) Child who lived in the home and provided care, but only if:

(A) The child lived in the person's home for at least two years;

(B) The child provided verifiable care during the time period in (d)(iv)(A) of this subsection for at least two years;

(C) The period of care under (d)(iv)(B) of this subsection was immediately before the person's current period of institutional status;

(D) The care was not paid for by medicaid;

(E) The care enabled the person to remain at home; and

(F) The person provided physician's documentation that the in-home care was necessary to prevent the person's current period of institutional status; or

(v) Sibling, who has lived in and has had an equity interest in the home for at least one year immediately before the date the person attained institutional status;

(e) The asset was transferred to the person's spouse; or to the person's child, if the child meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(f) The transfer was to a family member before the current period of institutional status, and all the following conditions are met. If all the following conditions are not met, the transfer is an uncompensated transfer, regardless of consideration received:

(i) The transfer is in exchange for care services the family member provided to the person;

(ii) The person had a documented need for the care services provided by the family member;

(iii) The care services provided by the family member are allowed under the medicaid state plan or the department's home and community based waiver services;

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

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

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

(vii) The assets were transferred as the care services were performed, or with no more time delay than one calendar month between the provision of the service and the transfer.

(g) The transfer meets the conditions under subsection (5) of this section, and the asset is transferred; or

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

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

(iii) To a trust established for the sole benefit of the person's child who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c); or

(iv) To a trust established for the sole benefit of a person who is under age sixty-five who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c).

(5) An asset transfer or establishment of a trust is for the sole benefit of a person under subsection (4)(g) of this section if the document transferring the asset:

(a) Was made in writing;

(b) Is irrevocable;

(c) States that the person's spouse, blind or disabled child, or another disabled person can benefit from the transferred assets; and

(d) States that all assets involved must be spent for the sole benefit of the person over an actuarially sound period, based on the life expectancy of that person or the term of the document, whichever is less, unless the document is a trust that meets the conditions of a trust established under Section 42 U.S.C. 1396p (d)(4)(A) or Section 42 U.S.C. 1396 (d)(4)(C) as described under chapter 182-516 WAC.

(6) To calculate the period of ineligibility under subsection (3) of this section:

(a) Add together the total uncompensated value of all transfers under subsection (3) of this section; and

(b) Divide the total in (a) of this subsection by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility;

(7) The period of ineligibility under subsection (6) of this section begins:

(a) For an LTC services applicant: The date the person would be otherwise eligible for LTC services, but for the transfer, based on an approved application for LTC services or the first day after any previous period of ineligibility has ended; or

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

(8) The period of ineligibility ends after the number of whole days, calculated in subsection (6) of this section, pass from the date the period of ineligibility began in subsection (7) of this section.

(9) If the transfer was to the person's spouse, and it includes the right to receive an income stream, the agency or its designee determines availability of the income stream under WAC 182-513-1330.

(10) If the transferred asset for which adequate consideration was not received was made to someone other than the person's spouse and included the right to receive a stream of income not generated by the transferred asset, the length of the period of ineligibility is calculated and applied in the following way:

(a) The amount of reasonably anticipated future monthly income, after the transfer, is multiplied by the actuarial life expectancy in months of the person who owned the income. The actuarial life expectancy is based on age of the person in the month the transfer occurs;

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

the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility; and

(c) The period of ineligibility begins under subsection (7) of this section and ends under subsection (8) of this section.

(11) A period of ineligibility for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses have attained institutional status. When both spouses are institutionalized, the agency or its designee divides the penalty equally between the two spouses. If one spouse is no longer subject to a period of ineligibility, the remaining period of ineligibility that applied to both spouses will be applied to the other spouse.

(12) Throughout this section, the date of an asset transfer is:

(a) For real property:

(i) The day the deed is signed by the grantor if the deed is recorded; or

(ii) The day the signed deed is delivered to the grantee;

(b) For all other assets, the day the intentional act or the failure to act resulted in the change of ownership or title.

(13) If a person or the person's spouse disagrees with the determination or application of a period of ineligibility, a hearing may be requested under chapter 182-526 WAC.

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

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

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1363, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1363, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.-050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp. s. c 37 § 209(1). WSR 12-21-091, § 388-513-1363, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-513-1363, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, and 2005 federal Deficit Reduction Act (DRA), Public Law 109-171. WSR 07-17-152, § 388-513-1363, filed 8/21/07, effective 10/1/07.]

WAC 182-513-1367 Hardship waivers. (1) People who are denied or terminated from long-term services and supports (LTSS) due to a transfer of asset penalty under WAC 182-513-1363, or having excess home equity under WAC 182-513-1350 may apply for an undue hardship waiver. The agency or its designee gives notice of the right to apply for an undue hardship waiver whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

(a) Defines undue hardship;

(b) Specifies the approval criteria for an undue hardship request;

(c) Establishes the process the agency or its designee follows for determining undue hardship; and

(d) Establishes the appeal process for a client whose request for an undue hardship is denied.

(2) Undue hardship exists:

(a) When a person who transferred the assets or income, or on whose behalf the assets or income were transferred, either personally or through a spouse, guardian, or another person authorized to act on behalf of the person through a power of attorney document (attorney-in-fact), has exhausted all reasonable means including legal remedies to recover the assets or income or the value of the transferred assets or income that have caused a penalty period the person provides sufficient documentation to support the efforts to recover the assets or income; or

(b) The person is unable to access home equity in excess of the standard under WAC 182-513-1350; and

(c) When, without LTSS benefits, the person is unable to obtain:

(i) Medical care to the extent that health or life is endangered; or

(ii) Food, clothing, shelter or other basic necessities of life.

(3) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.

(4) Undue hardship does not exist:

(a) When the transfer of asset penalty period or excess home equity provision inconveniences a person or restricts the person's lifestyle but does not seriously deprive the person as defined in subsection (2)(c)(i) and (ii) of this section;

(b) When the resource is transferred to a person who is handling the financial affairs of the person; or

(c) When the resource is transferred to another person by the individual that handles the financial affairs of the person.

(5) Undue hardship may exist under subsection (4)(b) and (c) of this section if the department has found evidence of financial exploitation.

(6) An undue hardship waiver may be requested by:

(a) The person;

(b) The person's spouse;

(c) The person's authorized representative; or

(d) With the consent of the person, the person's guardian, or a medical institution, as defined in WAC 182-500-0050, in which an institutionalized person resides.

(7) The hardship waiver request must:

(a) Be in writing;

(b) State the reason for requesting the hardship waiver;

(c) Be signed by the requestor and include the requestor's name, address and telephone number. If the request is being made on behalf of a person, then the person's name, address and telephone number must be included;

(d) Be made within thirty days of the date of denial or termination of LTSS; and

(e) Returned to the originating address on the denial/termination letter.

(8) If additional information is needed to determine a hardship waiver, the agency or its designee sends a written notice to the person requesting additional information within fifteen days of the request for an undue hardship waiver. The person may request additional time to provide the information.

(9) If the hardship is approved:

(a) The agency sends a notice within fifteen days of receiving all information needed to determine a hardship waiver. The approval notice specifies a time period the undue hardship waiver is approved.

(b) Any changes in a person's situation that led to the approval of a hardship must be reported to the agency or its designee within thirty days of the change per WAC 182-504-0110.

(10) If the hardship waiver is denied:

(a) The agency or its designee sends a denial notice within fifteen days of receiving the requested information. The letter will state the reason it was not approved.

(b) The denial notice has instructions on how to request an administrative hearing. The agency or its designee must receive an administrative hearing request within ninety days of the date of the adverse action or denial.

(11) If there is a conflict between this section and chapter 182-526 WAC, this section prevails.

(12) The agency or its designee may revoke approval of an undue hardship waiver if any of the following occur:

(a) A person, or the person's authorized representative, fails to provide timely information or resource verifications as it applies to the hardship waiver when requested by the agency or its designee per WAC 182-503-0050 and 182-504-0105;

(b) The lien or legal impediment that restricted access to home equity in excess of the home equity limit is removed; or

(c) Circumstances for which the undue hardship was approved have changed.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1367, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1367, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1367, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, Section 1917 (c)(2)(D) of the Social Security Act (42 U.S.C. 1396p (c)(2)(D), and Section 6011(d) of the federal Deficit Reduction Act of 2005. WSR 07-17-005, § 388-513-1367, filed 8/2/07, effective 9/2/07.]

WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care in a medical institution. This rule describes how the agency or the agency's designee allocates income and excess resources when determining participation in the cost of care in a medical institution.

(1) The agency or the agency's designee defines which income and resources must be used in this process under WAC 182-513-1315.

(2) The agency or the agency's designee allocates nonexcluded income in the following order, and the combined total of (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) under WAC 182-513-1105.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program under WAC 182-512-0050(1); and

(ii) Receives the wages as part of an agency-approved or department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction, employment expenses are not deducted.

(d) Guardianship fees and administrative costs, including any attorney fees paid by the guardian, as allowed under WAC 182-513-1505 through 182-513-1525.

(3) The agency or the agency's designee allocates nonexcluded income after deducting amounts under subsection (2) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is:

(i) For the current month;

(ii) For the time period covered by the PNA; and

(iii) Not counted as the dependent member's income when determining the dependent allocation amount under WAC 182-513-1385.

(b) A monthly maintenance needs allowance for the community spouse as determined using the calculation under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income up to the PNA.

(c) A dependent allowance for each dependent of the institutionalized client or the client's spouse, as determined using the calculation under WAC 182-513-1385.

(d) Medical expenses incurred by the institutionalized individual and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 182-513-1350.

(e) Maintenance of the home of a single institutionalized client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client or couple is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income deduction.

(4) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the participation.

(5) A client is responsible to pay only up to the state rate for the cost of care. If long-term care insurance pays a portion of the state rate cost of care, a client pays only the difference up to the state rate cost of care.

(6) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has in a month.

(7) Standards under this section for long-term care are found at www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1380, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1380, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1380, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057,

74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1380, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Deficit Reduction Act of 2005, 42 C.F.R. Section 435. WSR 09-07-037, § 388-513-1380, filed 3/10/09, effective 4/10/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. WSR 08-13-072, § 388-513-1380, filed 6/16/08, effective 7/17/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and 2006 c 372. WSR 07-19-126, § 388-513-1380, filed 9/19/07, effective 10/20/07; WSR 07-01-072, § 388-513-1380, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530 and 2005 c 518 § 207 and Sec. 1924 Social Security Act (42 U.S.C. 1396r-5). WSR 06-07-144, § 388-513-1380, filed 3/21/06, effective 4/21/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). WSR 05-07-033, § 388-513-1380, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396r-5). WSR 04-04-072, § 388-513-1380, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396r-5). WSR 01-18-055, § 388-513-1380, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924(g) of the Social Security Act. WSR 00-17-058, § 388-513-1380, filed 8/9/00, effective 9/9/00. Statutory Authority: RCW 72.36.160, 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924(g) of the Social Security Act, Section 4715 of the BBA of 1997 (Public Law 105-33, HR 2015). WSR 99-11-017, § 388-513-1380, filed 5/10/99, effective 6/10/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 43.20B.460, 11.92.180, and Section 1924 (42 U.S.C. 396r-5). WSR 98-08-077, § 388-513-1380, filed 3/31/98, effective 4/1/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(1)(m). WSR 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. WSR 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. WSR 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. WSR 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

WAC 182-513-1385 Determining the community spouse monthly maintenance needs allowance and dependent allowance in post-eligibility treatment of income for long-term care (LTC) programs. (1) This section describes how to calculate the monthly maintenance needs allowance (MMNA) in post-eligibility treatment of income for long-term care (LTC) programs for a community spouse or dependent of the institutionalized individual.

(2) The community spouse MMNA standards are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc>, unless a greater amount is calculated under subsection (5) of this section. The MMNA standards may change each January and July based on the consumer price index.

(3) The community spouse MMNA is allowed only to the extent that the institutionalized spouse's income is made available to the community spouse, and is calculated as follows:

(a) The minimum MMNA as calculated in subsection (4)(a) of this section plus excess shelter expenses as calculated in subsection (4)(b) of this section;

(i) The total under (a) of this subsection cannot be less than the minimum MMNA; and

(ii) If the total under subsection (4)(a) of this section exceeds the maximum MMNA, the maximum MMNA is the result under subsection (4)(a) of this section; and

(b) The total under subsection (4)(a) of this section is reduced by the community spouse's gross income. The result is the MMNA.

(4) The minimum MMNA and excess shelter expense values are calculated as follows:

(a) The minimum MMNA is one hundred fifty percent of the two-person federal poverty level (FPL); and

(b) If excess shelter expenses are less than zero, the result is zero. Excess shelter expenses are calculated as follows:

(i) Add:

(A) Mortgage or rent, which includes space rent for mobile homes;

(B) Real property taxes;

(C) Homeowner's insurance;

(D) Required maintenance fees for a condominium, cooperative, or homeowner's association that are recorded in a covenant; and

(E) The food assistance standard utility allowance (SUA) under WAC 388-450-0195 minus the cost of any utilities that are included in (b)(i)(D) of this subsection.

(ii) Subtract the standard shelter allocation from the total in (b)(i) of this subsection. The standard shelter allocation is thirty percent of one hundred fifty percent of the two-person FPL. The result is the value of excess shelter expenses.

(5) The amount allocated to the community spouse may be greater than the amount determined in subsection (3) of this section, but only if:

(a) A court order has been entered against the institutionalized spouse approving a higher MMNA for the support of the community spouse; or

(b) A final order has been entered after an administrative hearing has been held under chapter 182-526 WAC ruling the institutionalized spouse or the community spouse established the community spouse needs income, above the level otherwise provided by the MMNA, due to exceptional circumstances causing significant financial duress.

(6) If a final order establishes that the conditions identified in subsection (5)(b) of this section have been met, then an amount of allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(7) The agency or its designee determines the dependent allowance for dependents of the institutionalized individual or the institutionalized individual's spouse. The amount the agency allows depends on whether the dependent resides with the community spouse.

(a) For each dependent who resides with the community spouse:

(i) Subtract the dependent's income from one hundred fifty percent of the two-person FPL;

(ii) Divide the amount determined in (a)(i) of this subsection by three;

(iii) The result is the dependent allowance for that dependent.

(b) For each dependent who does not reside with the community spouse:

(i) The agency determines the effective MNIL standard based on the number of dependent family members in the home;

(ii) Subtracts each dependent's separate income;

(iii) The result is the dependent allowance for the dependents.

(c) Child support received from a noncustodial parent is the child's income.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1385, filed 1/17/17, effective 2/17/17.]

WAC 182-513-1395 Determining eligibility for institutional services for people living in a medical institution under the SSI-related medically needy program. (1) For the purposes of this section only, "remaining income" means all gross nonexcluded income remaining after the post-eligibility calculation under WAC 182-513-1380.

(2) General information. To be eligible for institutional services when living in a medical institution under the SSI-related medically needy (MN) program, a person must:

(a) Meet program requirements under WAC 182-513-1315;

(b) Have gross nonexcluded income in excess of the special income level (SIL) defined under WAC 182-513-1100; and

(c) Meet the financial requirements of subsection (3) or (4) of this section.

(3) Financial eligibility.

(a) The agency or its designee determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.

(b) The agency or its designee determines a person's countable income by:

(i) Excluding income under WAC 182-513-1340;

(ii) Determining available income under WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income under WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources under WAC 182-513-1350.

(4) Eligibility for agency payment to the facility for institutional services and the MN program.

(a) If a person's remaining income plus excess resources is less than, or equal to, the state-contracted daily rate times the number of days the person has resided in the facility, the person:

(i) Is eligible for agency payment to the facility for institutional services and the MN program; and

(ii) Is approved for a twelve-month certification period.

(b) The person must pay income and excess resources towards the cost of care under WAC 182-513-1380.

(5) Eligibility for agency payment to the facility for institutional services and MN spenddown. If a person's remaining income is more than the state-contracted daily rate times the number of days the person has resided in the facility, but less than the private nursing facility rate for the same period, the person:

(a) Is eligible to receive institutional services at the state-contracted rate; and

(i) Is approved for a three-month or six-month base period;

(ii) Pays income and excess resources towards the state-contracted cost of care under WAC 182-513-1380; and

(b) Is eligible for the MN program for the same three-month or six-month base period when the total of additional medical expenses incurred during the base period exceeds:

(i) The total remaining income for all months of the base period;

(ii) Minus the total state-contracted rate for all months of the base period.

(6) If a person has excess resources and the person's remaining income is more than the state-contracted daily rate times the number of days the person has resided in the facility, the person is not eligible to receive institutional services and the MN program.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1395, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1395, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1395, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.39.010. WSR 07-19-129, § 388-513-1395, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1395, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 99-06-045, § 388-513-1395, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090 and Budget Note 17. WSR 96-16-092, § 388-513-1395, filed 8/7/96, effective 8/29/96. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18 §§ 2095a and 5b. WSR 95-24-017 (Order 3921, #100267), § 388-513-1395, filed 11/22/95, effective 1/1/96. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1395, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-400.]

WAC 182-513-1396 People living in a fraternal, religious, or benevolent nursing facility. (1) The agency or its designee determines apple health coverage under noninstitutional rules for a person who meets all other eligibility requirements and lives in a licensed, but nonmedicaid-contracted facility operated by a fraternal, religious, or benevolent organization.

(2) Nothing in subsection (1) of this section prevents the agency or its designee from evaluating contracts with facilities not described in subsection (1) of this section.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1396, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1396, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1396, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1396, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-310.]

WAC 182-513-1397 Treatment of entrance fees for people residing in a continuing care retirement community or a life care community. (1) A person's entrance fee in a continuing care retirement community or life care community is an available resource to the person, to the extent that:

(a) The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the person be insufficient to pay for care;

(b) The person is eligible for a refund of any remaining entrance fee when the person dies or when the person terminates the continuing care retirement community or life care community contract and leaves the community; and

(c) The entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(2) Nothing in subsection (1) of this section prevents the agency or its designee from evaluating contracts with facilities not described in subsection (1) of this section.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1397, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1397, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1397, filed 10/22/12, effective 11/22/12.]

WAC 182-513-1400 Long-term care (LTC) partnership program (index). Under the long-term care (LTC) partnership program, people who purchase qualified long-term care partnership insurance policies can apply for long-term care medicaid under special rules for determining financial eligibility. These special rules generally allow the person to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care medicaid and will not subsequently be subject to estate recovery for medicaid and long-term care services paid. The Washington long-term care partnership program is effective on December 1, 2011.

The following rules govern long-term care eligibility under the long-term care partnership program:

(1) WAC 182-513-1405 Definitions.

(2) WAC 182-513-1410 LTC partnership policy qualifications.

(3) WAC 182-513-1415 Assets that can't be protected under the LTC partnership provisions.

(4) WAC 182-513-1420 Eligibility for asset protection under a partnership policy.

(5) WAC 182-513-1425 Not qualifying for LTC medicaid if an LTC partnership policy is in pay status.

(6) WAC 182-513-1430 Change of circumstances that must be reported when there is an LTC partnership policy paying a portion of care.

(7) WAC 182-513-1435 When Washington recognizes an LTC partnership policy purchased in another state.

(8) WAC 182-513-1440 Determining how many assets can be protected.

(9) WAC 182-513-1445 Designating a protected asset and required proof.

(10) WAC 182-513-1450 How the transfer of assets affects LTC partnership and medicaid eligibility.

(11) WAC 182-513-1455 Protected assets under an LTC partnership policy after death.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1400, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1400, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1400, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1405 Definitions. For purposes of WAC 182-513-1400 through 182-513-1455, the following terms have the meanings stated. See chapter 182-500 WAC and WAC 182-513-1100 for additional definitions.

"Issuer" means any entity that delivers, issues for delivery, or provides coverage to, a resident of Washington, any policy that claims to provide asset protection under the Washington long-term care partnership act, chapter 48.85 RCW. As used in this chapter, issuer specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

"Long-term care (LTC) insurance" means a policy under chapter 284-83 WAC.

"Protected assets" means assets that are designated as excluded or not taken into account upon determination of long-term care medicaid eligibility under WAC 182-513-1315. The protected or excluded amount is up to the dollar amount of benefits that have been paid for long-term care services by the qualifying long-term care partnership policy on the medicaid applicant's or client's behalf. The assets are also protected or excluded for the purposes of estate recovery under chapter 182-527 WAC, up to the amount of benefits paid by the qualifying policy for medical and long-term care services.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid Services (CMS), and the health care authority (HCA) which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of a person who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(c)(iii) of the act. These policies are described in chapter 284-83 WAC.

"Reciprocity agreement" means an agreement between states approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA) under which the states agree to provide the same asset protections for qualified partnership policies purchased by a person while residing in another state and that state has a reciprocity agreement with the state of Washington.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1405, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1405, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1405, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1410 LTC partnership policy qualifications. A LTC partnership policy is a LTC policy that has been approved by the office of insurance commissioner as a LTC partnership policy described in chapter 284-83 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1410, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1410, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1410, filed 11/18/11, effective 12/19/11.]

(11/8/17)

WAC 182-513-1415 Assets that can't be protected under the LTC partnership provisions. The following assets cannot be protected under a LTC partnership policy.

(1) Resources in a trust under WAC 182-516-0100 (6) and (7).

(2) Annuity interests in which Washington must be named as a preferred remainder beneficiary as under WAC 182-516-0201.

(3) Home equity in excess of the standard under WAC 182-513-1350. Individuals who have excess home equity interest are not eligible for long-term care medicaid services.

(4) Any portion of the value of an asset that exceeds the dollar amount paid out by the LTC partnership policy.

(5) The unprotected value of any partially protected asset is subject to estate recovery described in chapter 182-527 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1415, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1415, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1415, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1420 Eligibility for asset protection under a partnership policy. (1) The LTC partnership policy must meet all the requirements in chapter 284-83 WAC. For existing LTC policies which are converted to a LTC partnership policy via an exchange or through the addition of a policy rider or endorsement, the conversion must take place on or after December 1, 2011 unless the policy is paying out benefits at the time the policy is exchanged.

(2) You meet all applicable eligible requirements for LTC medicaid and:

(a) Your LTC partnership policy benefits have been exhausted and you are in need of LTC services.

(b) Your LTC partnership policy is not exhausted and is:

(i) Covering all costs in a medical institution and you are still in need for medicaid; or

(ii) Covering a portion of the LTC costs under your LTC partnership policy but does not meet all of your LTC needs.

(c) At the time of your LTC partnership policy has paid out more benefits than you have designated as protected. In this situation your estate can designate additional assets to be excluded from the estate recovery process up to the dollar amount the LTC partnership policy has paid out.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1420, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1420, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1420, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1425 Not qualifying for LTC medicaid if an LTC partnership policy is in pay status. You are not eligible for long-term care (LTC) medicaid when the following applies:

(1) The income you have available to pay toward your cost of care under WAC 182-513-1380, combined with the

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amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate at the institution.

(2) The income you have available to pay toward your cost of care on a home and community based (HCB) waiver under chapter 182-515 WAC, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate in a home or residential setting.

(3) You fail to meet another applicable eligibility requirement for LTC medicaid.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1425, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1425, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1425, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1430 Change of circumstances that must be reported when there is an LTC partnership policy paying a portion of care. You must report changes described in WAC 182-504-0105 plus the following:

(1) You must report and verify the value of the benefits that your issuer has paid on your behalf under the long-term care (LTC) partnership policy upon request by the agency, and at each annual eligibility review.

(2) You must provide proof when you have exhausted the benefits under your LTC partnership policy.

(3) You must provide proof if you have given away or transferred assets that you have previously designated as protected. Although, there is no penalty for the transfer of protected assets once you have been approved for LTC medicaid, the value of transferred assets reduces the total dollar amount that is designated as protected and must be verified.

(4) You must provide proof if you have sold an asset or converted a protected asset into cash or another type of asset. You will need to make changes in the asset designation and verify the type of transaction and new value of the asset.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1430, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1430, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1430, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1435 When Washington recognizes an LTC partnership policy purchased in another state. The Washington long-term care partnership program provides reciprocity with respect to qualifying long-term care insurance policies covered under other state long-term care insurance partnerships. This allows you to purchase a partnership policy in one state and move to Washington without losing your asset protection. If your LTC policy is in pay status at the time you move to Washington and you are otherwise eligible for LTC medicaid, Washington will recognize the amount of protection you accumulated in the other state.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1435, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1435, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405,

284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1435, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1440 Determining how many of my assets can be protected. You can protect assets based on the amount paid by your LTC partnership policy. Assets are protected in both LTC eligibility and estate recovery. If the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the long-term care (LTC) medicaid program.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1440, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1440, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1440, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1445 Designating a protected asset and required proof. (1) Complete a department of social and health services (DSHS) 10-438 long-term care partnership (LTCP) asset designation form listing assets and the full fair market value that are earmarked as protected at the time of initial application for long-term services and supports under medicaid.

(a) The full fair market value (FMV) of real property or interests in real property will be based on the current assessed value for property tax purposes for real property. A professional appraisal by a licensed appraiser can establish the current value if the assessed value is disputed.

(b) The value of a life estate in real property is determined using the life estate tables found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/determining-value-life-estates>.

(c) If you own an asset with others, you can designate the value of your pro rata equity share.

(d) If the dollar amount of the benefits paid under a LTCP policy is greater than the fair market value of all assets protected at the time of the application for long-term care medicaid, you may designate additional assets for protection under this section. The DSHS LTCP asset designation form must be submitted with the updated assets indicated along with proof of the current value of designated assets.

(e) The value of your assets protected for you under your LTC partnership policy do not carry over to your spouse should the spouse need medicaid LTC services during or after your lifetime. If your surviving spouse has an LTC partnership policy the spouse may designate assets based on the dollar amount paid under the spouse's own policy.

(f) Assets designated as protected under this subsection will not be subject to transfer penalties under WAC 182-513-1363.

(2) Proof of the current fair market value of all protected assets is required at the initial application and each annual review.

(3) Submit current verification from the issuer of the LTCP policy of the current dollar value paid toward LTC benefits. This verification is required at application and each annual eligibility review.

(4) Any person or the personal representative of the person's estate who asserts that an asset is protected has the initial burden of:

(a) Documenting and proving by convincing evidence that the asset or source of funds for the asset in question was designated as protected;

(b) Demonstrating the value of the asset and the proceeds of the asset beginning from the time period the LTC partnership has paid out benefits to the present; and

(c) Documenting that the asset or proceeds of the asset remained protected at all times.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1445, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1445, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1445, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1450 How the transfer of assets affects LTC partnership and medicaid eligibility. (1) If you transfer an asset within the sixty months prior to the medicaid application or after medicaid eligibility has been established, the agency will evaluate the transfer based on WAC 182-513-1363 and determine if a penalty period applies unless:

(a) You have already been receiving institutional services;

(b) Your LTC partnership policy has paid toward institutional services for you; and

(c) The value of the transferred assets has been protected under the LTC partnership policy.

(2) The value of the transferred assets that exceed your LTC partnership protection will be evaluated for a transfer penalty.

(3) If you transfer assets with values that are protected, you lose that value as future protection unless all the transferred assets are returned.

(4) The value of your protected assets less the value of transferred assets equals the adjusted value of the assets you are able to protect.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1450, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1450, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1450, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1455 What happens to protected assets under a LTC partnership policy after death. Assets designated as protected prior to death are not subject to estate recovery for medical or long-term care (LTC) services paid on your behalf under chapter 182-527 WAC as long as the following requirements are met:

(1) A personal representative who asserts an asset is protected under this section has the initial burden of providing proof under chapter 182-527 WAC.

(2) A personal representative must provide verification from the LTC insurance company of the dollar amount paid out by the LTC partnership policy.

(11/8/17)

(3) If the LTC partnership policy paid out more than was previously designated, the personal representative has the right to assert that additional assets should be protected based on the increased protection. The personal representative must use the DSHS LTCP asset designation form and send it to the office of financial recovery.

(4) The amount of protection available to you at death through the estate recovery process is decreased by the FMV of any protected assets that were transferred prior to death.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1455, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1455, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1455, filed 11/18/11, effective 12/19/11.]

WAC 182-513-1505 Purpose. These rules implement RCW 11.92.180 and 43.20B.460 to the extent that those statutes require the department to establish by rule the maximum amount of guardianship fees and additional compensation for administrative costs that may be allowed by the court for a guardian or limited guardian of an incapacitated person who is a Medicaid client of the department and is thus required by federal law to contribute to the cost of the client's long-term care.

[WSR 16-15-042, recodified as § 182-513-1505, filed 7/14/16, effective 7/14/16. Statutory Authority: RCW 11.92.180, 43.20B.460. WSR 03-16-022, § 388-79-010, filed 7/28/03, effective 8/28/03; WSR 98-10-055, § 388-79-010, filed 4/30/98, effective 5/31/98.]

WAC 182-513-1510 Definitions. "Administrative costs" or "costs" means necessary costs paid by the guardian including attorney fees.

"Client" means a person who is eligible for and is receiving Medicaid-funded long-term care.

"Guardianship fees" or "fees" means necessary fees charged by a guardian for services rendered on behalf of a client.

"Participation" means the amount the client pays from current monthly income toward the cost of the client's long-term care.

[WSR 16-15-042, recodified as § 182-513-1510, filed 7/14/16, effective 7/14/16. Statutory Authority: RCW 11.92.180, 43.20B.460. WSR 03-16-022, § 388-79-020, filed 7/28/03, effective 8/28/03; WSR 98-10-055, § 388-79-020, filed 4/30/98, effective 5/31/98.]

WAC 182-513-1515 Maximum fees and costs. The superior court may allow guardianship fees and administrative costs in an amount set out in an order. For orders entered after June 15, 1998, where the order establishes or continues a legal guardianship for a department client, and requires a future review or accounting; then unless otherwise modified by the process described in WAC 388-79-040:

(1) The amount of guardianship fees shall not exceed one hundred seventy-five dollars per month;

(2) The amount of administrative costs directly related to establishing a guardianship for a department client shall not exceed seven hundred dollars; and

(3) The amount of administrative costs shall not exceed a total of six hundred dollars during any three-year period.

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[WSR 16-15-042, recodified as § 182-513-1515, filed 7/14/16, effective 7/14/16. Statutory Authority: RCW 11.92.180, 43.20B.460. WSR 03-16-022, § 388-79-030, filed 7/28/03, effective 8/28/03; WSR 98-10-055, § 388-79-030, filed 4/30/98, effective 5/31/98.]

WAC 182-513-1520 Procedure to revise award letter after June 15, 1998, but before September 1, 2003. After June 15, 1998, but before September 1, 2003, where a department client is subject to a guardianship then the department shall be entitled to notice of proceedings as described in RCW 11.92.150.

(1) The notice shall be given to the appropriate regional administrator of the program serving the department client. A list of the regional administrators will be available upon request.

(2) If the fees and costs requested and established by the order are equal to or lower than the maximum amount set by this rule then the award letter or document setting the department's client's participation shall be adjusted to reflect that amount upon receipt by the department of the court order setting a monthly amount.

(3) Should fees and costs above those requested in WAC 388-79-030 be requested:

(a) The appropriate regional administrator will be given notice of the hearing as described in RCW 11.92.150, and provided with copies of all supporting documents filed with the court.

(b) Should the court determine after consideration of the facts, law and evidence of the case, that fees and costs higher than normally allowed in WAC 388-79-030 are just and reasonable and should be allowed then the award letter or document setting the department client's participation shall be adjusted to reflect that amount upon receipt by the department of the court order setting a monthly amount.

[WSR 16-15-042, recodified as § 182-513-1520, filed 7/14/16, effective 7/14/16. Statutory Authority: RCW 11.92.180, 43.20B.460. WSR 03-16-022, § 388-79-040, filed 7/28/03, effective 8/28/03; WSR 98-10-055, § 388-79-040, filed 4/30/98, effective 5/31/98.]

WAC 182-513-1525 Procedure for allowing fees and costs from client participation after September 1, 2003.

(1) After September 1, 2003, where a client is subject to a guardianship the department shall be entitled to notice of proceedings as described in RCW 11.92.150.

(2) The notice must be served to the department's regional administrator of the program that is providing services to the client. A list of the regional administrators will be furnished upon request.

(3) If the fees and costs requested and established by the order are equal to or less than the maximum amounts allowed under WAC 388-79-030, then the department will adjust the client's current participation to reflect the amounts allowed upon receipt by the department of the court order setting the monthly amounts.

(4) Should fees and costs in excess of the amounts allowed in WAC 388-79-030 be requested:

(a) At least ten days before filing the request with the court, the guardian must present the request in writing to the appropriate regional administrator to allow the department an opportunity to consider whether the request should be granted on an exceptional basis.

(b) In considering a request for extraordinary fees or costs, the department must consider the following factors:

(i) The department's obligation under federal and state law to ensure that federal medicaid funding is not jeopardized by noncompliance with federal regulations limiting deductions from the client's participation amount;

(ii) The usual and customary guardianship services for which the maximum fees and costs under WAC 388-79-030 must be deemed adequate for a medicaid client, including but not limited to:

(A) Acting as a representative payee;

(B) Managing the client's financial affairs;

(C) Preserving and/or disposing of property;

(D) Making health care decisions;

(E) Visiting and/or maintaining contact with the client;

(F) Accessing public assistance programs on behalf of the client;

(G) Communicating with the client's service providers; and

(H) Preparing any reports or accountings required by the court.

(iii) Extraordinary services provided by the guardian, such as:

(A) Unusually complicated property transactions;

(B) Substantial interactions with adult protective services or criminal justice agencies;

(C) Extensive medical services setup needs and/or emergency hospitalizations; and

(D) Litigation other than litigating an award of guardianship fees or costs.

(c) Should the court determine after consideration of the facts and law that fees and costs in excess of the amounts allowed in WAC 388-79-030 are just and reasonable and should be allowed, then the department will adjust the client's current participation to reflect the amounts allowed upon receipt by the department of the court order setting the monthly amounts.

(5) In no event may a client's participation be prospectively or retrospectively reduced to pay fees and costs incurred before the effective date of the client's medicaid eligibility; or during any subsequent time period when the client was not eligible for, or did not receive long-term care services; or after the client has died. There is no client participation towards DDD certified and contracted supported living services under chapter 388-820 WAC, so the department has no responsibility to reimburse the client for guardianship fees when those fees result in the client having insufficient income to pay their living expenses.

(6) If the court at a prior accounting has allowed the guardian to receive fees and costs from the client's monthly income in advance of services rendered by the guardian, and the client dies before the next accounting, the fees and costs allowed by the court at the final accounting may be less than, but may not exceed, the amounts advanced and paid to the guardian from the client's income.

(7) Guardians must furnish the regional administrator with complete packets to include all documents filed with the court and with formal notice clearly identifying the amount requested.

[WSR 16-15-042, recodified as § 182-513-1525, filed 7/14/16, effective 7/14/16. Statutory Authority: RCW 11.92.180, 43.20B.460. WSR 03-16-022, § 388-79-050, filed 7/28/03, effective 8/28/03.]

WAC 182-513-1600 Medicaid alternative care (MAC)—Overview. Medicaid alternative care (MAC) is a Washington apple health benefit authorized under section 1115 of the Social Security Act. It enables the medicaid agency and the agency's designees to deliver an array of person-centered long-term services and supports (LTSS) to unpaid caregivers caring for a medicaid-eligible person who meets nursing facility level of care under WAC 388-106-0355.

(1) For services included with the MAC benefit package, see WAC 388-106-1900 through 388-106-1990.

(2) For financial eligibility for MAC services, see WAC 182-513-1605.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1600, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1605 Medicaid alternative care (MAC)—Eligibility. (1) The person receiving care must meet the financial eligibility criteria for medicaid alternative care (MAC).

(2) To be eligible for MAC services, the person receiving care must:

- (a) Be age fifty-five or older;
- (b) Be assessed as meeting nursing facility level of care under WAC 388-106-0355, and choose to receive services under the MAC program instead of other long-term services and supports;
- (c) Meet residency requirements under WAC 182-503-0520;
- (d) Live at home and not in a residential or institutional setting;
- (e) Have an eligible unpaid caregiver under WAC 388-106-1905;
- (f) Meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a) or (b); and
- (g) Be eligible for either:
 - (i) A noninstitutional medicaid program, which provides categorically needy (CN) or alternative benefit plan (ABP) scope of care under WAC 182-501-0060; or
 - (ii) An SSI-related CN program by using spousal impoverishment protections institutionalized (SIPI) spouse rules under WAC 182-513-1660.
- (3) An applicant whose eligibility is limited to one or more of the following programs is not eligible for MAC:
 - (a) The medically needy program under WAC 182-519-0100;
 - (b) The medicare savings programs under WAC 182-517-0300;
 - (c) The family planning program under WAC 182-505-0115;
 - (d) The TAKE CHARGE program under WAC 182-532-720;
 - (e) The medical care services (MCS) program under WAC 182-508-0005;
 - (f) The alien emergency medical (AEM) program under WAC 182-507-0110 through 182-507-0120;

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(g) The state funded long-term care for noncitizens program under WAC 182-507-0125;

(h) The kidney disease program under chapter 182-540 WAC; or

(i) The tailored supports for older adults (TSOA) program under WAC 182-513-1610.

(4) The following rules do not apply to services provided under the MAC benefit:

- (a) Transfer of asset penalties under WAC 182-513-1363;
- (b) Excess home equity under WAC 182-513-1350; and
- (c) Estate recovery under chapter 182-527 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1605, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1610 Tailored supports for older adults (TSOA)—Overview. (1) The tailored supports for older adults (TSOA) program is a federally funded program approved under section 1115 of the Social Security Act. It enables the medicaid agency and the agency's designees to deliver person-centered long-term services and supports (LTSS) to a person who:

(a) Meets nursing facility level of care described in WAC 388-106-0355; and

(b) Meets the functional requirements under WAC 388-106-1900 through 388-106-1990.

(2) For the purposes of TSOA, the applicant is the person receiving care even though services may be authorized to the person providing care.

(3) TSOA does not provide Washington apple health coverage.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1610, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1615 Tailored supports for older adults (TSOA)—General eligibility. (1) The person receiving care must meet the financial eligibility criteria for tailored supports for older adults (TSOA).

(2) To be eligible for the TSOA program, the person receiving care must:

- (a) Be age fifty-five or older;
- (b) Be assessed as meeting nursing facility level of care under WAC 388-106-0355;
- (c) Meet residency requirements under WAC 182-503-0520;
- (d) Live at home and not in a residential or institutional setting;
- (e) Have an eligible unpaid caregiver under WAC 388-106-1905, or meet the criteria under WAC 388-106-1910 if the person does not have an eligible unpaid caregiver;
- (f) Meet citizenship or immigration status requirements under WAC 182-503-0535. To be eligible for TSOA, a person must be a:
 - (i) U.S. citizen under WAC 182-503-0535 (1)(c);
 - (ii) U.S. national under WAC 182-503-0535 (1)(d);
 - (iii) Qualifying American Indian born abroad under WAC 182-503-0535 (1)(f); or

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(iv) Qualified alien under WAC 182-503-0535 (1)(b) and have either met or is exempt from the five-year bar requirement for medicaid.

(g) Provide a valid Social Security number under WAC 182-503-0515;

(h) Have countable resources within specific program limits under WAC 182-513-1640; and

(i) Meet income requirements under WAC 182-513-1635.

(3) TSOA applicants who receive coverage under Washington apple health programs are not eligible for TSOA, unless their enrollment is limited to the:

(a) Medically needy program under WAC 182-519-0100;

(b) Medicare savings programs under WAC 182-517-0300;

(c) Family planning program under WAC 182-505-0115;

(d) TAKE CHARGE program under WAC 182-532-720; or

(e) Kidney disease program under chapter 182-540 WAC.

(4) A person who receives apple health coverage under a categorically needy (CN) or alternative benefit plan (ABP) program is not eligible for TSOA but may qualify for:

(a) Caregiver supports under medicaid alternative care (MAC) under WAC 182-513-1605; or

(b) Other long-term services and supports under chapter 182-513 or 182-515 WAC.

(5) The following rules do not apply to services provided under the TSOA benefit:

(a) Transfer of asset penalties under WAC 182-513-1363;

(b) Excess home equity under WAC 182-513-1350;

(c) Client financial responsibility under WAC 182-515-1509;

(d) Estate recovery under chapter 182-527 WAC;

(e) Disability requirements under WAC 182-512-0050;

(f) Requirement to do anything necessary to obtain income under WAC 182-512-0700(1); and

(g) Assignment of rights and cooperation under WAC 182-503-0540.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1615, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1620 Tailored supports for older adults (TSOA)—Presumptive eligibility (PE). (1) A person may be determined presumptively eligible for tailored supports for older adults (TSOA) services upon completion of a prescreening interview.

(2) The prescreening interview may be conducted by either:

(a) The area agency on aging (AAA); or

(b) A home and community services intake case manager or social worker.

(3) To receive services under presumptive eligibility (PE), the person must meet:

(a) Nursing facility level of care under WAC 388-106-0355;

(b) TSOA income limits under WAC 182-513-1635; and

(c) TSOA resource limits under WAC 182-513-1640.

(4) The PE period begins on the date the determination is made and:

(a) Ends on the last day of the month following the month of the PE determination if a full TSOA application is not completed and submitted by that date; or

(b) Continues through the date the final TSOA eligibility determination is made if a full TSOA application is submitted before the last day of the month following the month of the PE determination.

(5) If the person applies and is not determined financially eligible for TSOA, there is no overpayment or liability on the part of the applicant for services received during the PE period.

(6) The medicaid agency or the agency's designee sends written notice as described in WAC 182-518-0010 when PE for TSOA is approved or denied.

(7) A person may receive only one PE period within a twelve-consecutive-month period.

(8) If the agency establishes a waitlist for TSOA services under WAC 388-106-1975, then PE does not apply.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1620, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1625 Tailored supports for older adults (TSOA)—Applications. (1) Applications for tailored supports for older adults (TSOA) are submitted:

(a) Online at Washington Connection at www.washingtonconnection.org;

(b) By sending a completed HCA 18-008 application for TSOA form to P.O. Box 45826, Olympia, WA 98605;

(c) By faxing a completed HCA 18-008 application for TSOA form to 1-855-635-8305;

(d) By contacting the local area agency on aging (AAA) office at 1-855-567-0252; or

(e) By contacting the local home and community services (HCS) office. To find the local HCS office, see www.altsa.dshs.wa.gov/Resources/clickmap.htm.

(2) Help filing an application:

(a) The medicaid agency or the agency's designee provides help with the application or renewal process in a manner that is accessible to people with disabilities, limitations, or other impairments as described in WAC 182-503-0120 and to those who are limited-English proficient as described in WAC 182-503-0110;

(b) For help filing an application, a person may:

(i) Contact a local AAA office;

(ii) Contact a local HCS office; or

(iii) Have an authorized representative apply on the person's behalf.

(3) The following people can apply for the TSOA program:

(a) The applicant (the person receiving care);

(b) The applicant's spouse;

(c) The applicant's caregiver (person providing in-home caregiver services);

(d) A legal guardian; or

(e) An authorized representative, as defined in WAC 182-500-0010.

(4) A phone interview is required to establish TSOA financial eligibility, but may be waived if the applicant is unable to comply:

- (a) Due to the applicant's medical condition; and
- (b) Because the applicant does not have another person that is able to conduct the interview on the applicant's behalf.

(5) The agency or the agency's designee processes TSOA applications using the same timelines under WAC 182-503-0060.

(6) TSOA begins on the date the person is determined presumptively eligible for TSOA under WAC 182-513-1620, or on the date all eligibility requirements are established if the person is not found presumptively eligible.

(7) When the person withdraws an application for TSOA, or is determined ineligible for TSOA services, the agency or the agency's designee denies the application under WAC 182-503-0080.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1625, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1630 Tailored supports for older adults (TSOA)—Rights and responsibilities. (1) A person applying for or receiving tailored supports for older adults (TSOA) has the right to:

(a) Have TSOA rights and responsibilities explained and provided in writing;

(b) Be treated politely and fairly without regard to race, color, political beliefs, national origin, religion, age, gender (including gender identity and sex stereotyping), sexual orientation, disability, honorably discharged veteran or military status, or birthplace;

(c) Get help with the TSOA application if requested;

(d) Have an application processed promptly and no later than the timelines described in WAC 182-503-0060;

(e) Have at least ten calendar days to give the medicaid agency or the agency's designee information needed to determine eligibility and be given more time if asked for;

(f) Have personal information kept confidential. The agency or the agency's designee may share information with other state and federal agencies for purposes of eligibility and enrollment in other Washington apple health programs;

(g) Get written notice, in most cases, at least ten calendar days before the agency or the agency's designee denies, terminates, or changes eligibility for TSOA;

(h) Ask for an appeal if the person disagrees with the agency or the agency's designee's decision. A person can also ask a department supervisor or administrator to review the decision or action without affecting the right to a fair hearing;

(i) Ask for and get interpreter or translator services at no cost and without delay;

(j) Ask for voter registration assistance;

(k) Refuse to speak to an investigator if the person's case is audited. If the person does not want to let the investigator enter their home, there is no requirement to do so and the person may ask the investigator to come back at another time. Such a request will not affect a person's eligibility for TSOA; and

(l) Get equal access services under WAC 182-503-0120 if eligible.

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(2) An applicant or recipient of TSOA is responsible to:

(a) Report changes in household or family circumstances as required under WAC 182-513-1650;

(b) Provide the agency or the agency's designee with any information or proof needed to determine eligibility. If the person has trouble getting proof, the agency or the agency's designee helps get the proof needed or contacts other persons or agencies for it;

(c) Provide a valid Social Security number or immigration document number in order to verify identity, citizenship, immigration status, date of birth, and whether the person has other health care coverage. This information is not shared with the department of homeland security;

(d) Complete renewals when requested; and

(e) Cooperate with quality assurance when requested.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1630, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1635 Tailored supports for older adults (TSOA)—Income eligibility. (1) To determine income eligibility for the tailored supports for older adults (TSOA) program, the medicaid agency or the agency's designee uses the following rules depending on whether the person is single or married.

(2) If the TSOA applicant is single, the agency or the agency's designee:

(a) Determines available income under WAC 182-513-1325;

(b) Excludes income under WAC 182-513-1340; and

(c) Compares remaining gross nonexcluded income to the special income level (SIL). To be eligible, a person's gross income must be equal to or less than the SIL (three hundred percent of the federal benefit rate (FBR)).

(3) If the TSOA applicant is married, the agency or the agency's designee:

(a) Determines available income under WAC 182-513-1330 with the exception of subsections (5) and (6) of that section;

(b) Excludes income under WAC 182-513-1340; and

(c) Compares the applicant's remaining gross nonexcluded income to the SIL. To be eligible, a person's gross income must be equal to or less than the SIL (three hundred percent of the FBR).

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1635, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1640 Tailored supports for older adults (TSOA)—Resource eligibility. (1) The resource standard for a single applicant for tailored supports for older adults (TSOA) is \$53,100.

(2) The resource standard for a married couple is \$53,100 for the TSOA applicant plus the state spousal resource standard for the spousal impoverishment protections community (SIPC) spouse. The state spousal resource standard may change annually on July 1st. The resource standards are found at www.hca.wa.gov/free-or-low-cost-health

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care/program-administration/program-standard-income-and-resources.

(3) The medicaid agency or the agency's designee uses rules in WAC 182-513-1350 (1), (3) and (4) to determine general eligibility relating to resources, availability of resources, and which resources count.

(4) The TSOA recipient has one year from the date of initial eligibility of TSOA to transfer resources in excess of the TSOA standard to the SIPC spouse.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1640, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1645 Tailored supports for older adults (TSOA)—Certification periods. (1) A certification period is the period of time a person is determined eligible for the tailored supports for older adults (TSOA) program. It begins on the first day of the month that the medicaid agency or the agency's designee determines the person is eligible for TSOA services, and continues through the last day of the month of the certification period.

(2) TSOA is certified for twelve months of continuous coverage regardless of a change in circumstances, unless the person:

- (a) Moves out-of-state;
- (b) Meets institutional status under WAC 182-513-1320;
- (c) Becomes eligible for a categorically needy or alternate benefit plan Washington apple health program; or
- (d) Dies.

(3) Financial eligibility for the TSOA program may not be approved prior to the date of a presumptive or full eligibility determination.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1645, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1650 Tailored supports for older adults (TSOA)—Changes of circumstances requirements.

(1) Changes in tailored supports for older adults (TSOA) household and family circumstances described in subsection (2) of this section must be reported to the medicaid agency or the agency's designee within thirty days of the date of the change.

(2) The following changes must be reported:

- (a) A change in residential or mailing address, including if the TSOA recipient moves out-of-state;
 - (b) When the TSOA recipient admits to an institution, as defined in WAC 182-500-0050, and is likely to reside there for thirty days or longer; or
 - (c) When the TSOA recipient dies.
- (3) Effective date of changes.

(a) When TSOA terminates because the recipient dies, the effective date is the date of death.

(b) When TSOA terminates because of one of the following reasons, the effective date is the first day of the month following the advance notice period described in subsection (4) of this section. The TSOA recipient:

(i) Is admitted to an institution as defined in WAC 182-503-0050, and is expected to reside there for thirty days or longer;

(ii) Is approved for coverage under a home and community-based waiver program;

(iii) No longer meets nursing facility level of care under WAC 388-106-0355; or

(iv) Becomes eligible for categorically needy (CN) or alternative benefits plan (ABP) apple health coverage. The recipient may continue to receive authorized services through the medical alternative care (MAC) program under WAC 182-513-1600. The person may also apply for other long-term services and supports available under chapters 182-513 and 182-515 WAC.

(4) The advance notice period:

(a) Begins on the day the letter about the change is mailed; and

(b) Is determined according to the rules in WAC 182-518-0025.

(5) When a law or regulation requires a change in TSOA, the date specified by the law or regulation is the effective date of the change.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1650, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1655 Tailored supports for older adults (TSOA)—Renewals. (1) A person who receives tailored supports for older adults (TSOA) services must complete a renewal of all eligibility factors for the program at least every twelve months.

(2) Forty-five days prior to the end of the certification period, notice is sent to the recipient with the HCA 18-008 application for TSOA form. The TSOA recipient may complete the TSOA renewal in any of the following ways:

(a) Complete the TSOA application form, sign it, and mail it to P.O. Box 45826, Olympia, WA 98605 by the due date on the letter;

(b) Complete the TSOA application form, sign it, and fax it to 1-855-635-8305 by the due date on the letter;

(c) Renew online at Washington connection at www.washingtonconnection.org by the due date on the letter; or

(d) Call the local home and community services office at the telephone number on the letter by the due date on the letter.

(3) During the renewal process, the medicaid agency or the agency's designee reviews all eligibility factors to determine ongoing eligibility for TSOA, and may request additional verification of eligibility factors under WAC 182-503-0050 if unable to verify information through existing data sources. If additional information is needed, the agency or the agency's designee sends written notice under WAC 182-518-0015.

(4) If the agency or the agency's designee is unable to complete the renewal or determine eligibility for TSOA beyond the certification period, prior to ending eligibility for TSOA, the agency or the agency's designee sends a written termination notice as described in WAC 182-518-0025.

(5) A person who is terminated from TSOA for failure to renew has thirty days from the termination date to submit a

completed renewal. If still the person is eligible, TSOA is reopened without a break in eligibility.

(6) Equal access services as described in WAC 182-503-0120 are provided for anyone who needs help meeting the requirements of this section.

(7) A person who disagrees with an action regarding TSOA eligibility may ask for a hearing under chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1655, filed 5/30/17, effective 7/1/17.]

WAC 182-513-1660 Medicaid alternative care (MAC) and tailored supports for older adults (TSOA)—Spousal impoverishment.

(1) The medicaid agency or the agency's designee determines financial eligibility for medicaid alternative care (MAC) or tailored supports for older adults (TSOA) using spousal impoverishment protections under this section, when an applicant or recipient:

(a) Is married to, or marries, a person who is not in a medical institution; and

(b) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program or the TSOA program due to:

(i) Spousal deeming rules under WAC 182-512-0920 for MAC;

(ii) Exceeding the resource limit in WAC 182-512-0010 for MAC, or the limit under WAC 182-513-1640 for TSOA; or

(iii) Both (b)(i) and (ii) of this subsection.

(2) When a resource test applies, the agency or the agency's designee determines countable resources using the SSI-related resource rules under chapter 182-512 WAC, except pension funds owned by the spousal impoverishment protections community (SIPC) spouse are not excluded as described under WAC 182-512-0550:

(a) Resource standards:

(i) For MAC, the resource standard is \$2,000; or

(ii) For TSOA, the resource standard is \$53,100.

(b) Before determining countable resources used to establish eligibility for the applicant, the agency or the agency's designee allocates the state spousal resource standard to the SIPC spouse.

(c) The resources of the SIPC spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for MAC or TSOA services is established.

(3) The SIPI spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of \$2,000 (for MAC) or \$53,100 (for TSOA) to the SIPC spouse.

(4) Income eligibility:

(a) For MAC:

(i) The agency or the agency's designee determines countable income using the SSI-related income rules under chapter 182-512 WAC, but uses only the applicant or recipient's income;

(ii) If the applicant's or recipient's countable income is at or below the SSI categorically needy income level (CNIL), the applicant or recipient is considered a SIPI spouse and is

income eligible for noninstitutional CN coverage and MAC services;

(iii) If the applicant is employed and the applicant's countable income is at or below the standard under WAC 182-511-1060, the applicant is considered a SIPI spouse and is income eligible for noninstitutional CN coverage under the health care for workers with disabilities (HWD) program and MAC services.

(b) For TSOA, see WAC 182-513-1635.

(5) Once a person no longer receives MAC services, eligibility is redetermined without using spousal impoverishment protections under WAC 182-504-0125.

(6) If the applicant's separate countable income is above the standards described in subsection (4) of this section, the applicant is not income eligible for MAC or TSOA services.

(7) The spousal impoverishment protections described in this section are time-limited and expire on December 31, 2018.

(8) Standards described in this chapter are located at www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1660, filed 5/30/17, effective 7/1/17.]