



# Prepping the Canvas: Medicaid Eligibility Standards and Practices

**1 General CLE credit  
ID 86020 (part of 82312)**

**From the Oregon State Bar CLE seminar *The Art of Elder Law: A Broad Brushstroke Overview*, presented on October 1, 2021**



# Chapter 1

## Medicaid Eligibility for Long-Term Care; Basic Eligibility Requirements and Planning Strategies<sup>1</sup>

**EKUA HACKMAN**

The Commons Law Center  
Portland, Oregon

**JULIE NIMNIGHT**

Law Offices of Geoff Bernhardt & Julie Nimnicht PC  
Portland, Oregon

### Contents

Introduction . . . . .	1-1
Part 1. Medicaid Eligibility for Long-Term Care . . . . .	1-3
I. Analyzing Income . . . . .	1-3
A. Definition of Income . . . . .	1-3
B. Income Cap Trusts. . . . .	1-4
C. Reallocation of Income to Avoid Spousal Impoverishment . . . . .	1-6
II. Analyzing Resources . . . . .	1-6
A. Available vs. Not Available. . . . .	1-7
B. Excluded Resources. . . . .	1-7
C. Countable Resources . . . . .	1-11
III. Non-Financial Eligibility Requirements . . . . .	1-11
A. Disability Assessment . . . . .	1-11
Appendix A—Sample Income Cap Trust Agreement. . . . .	1-17
Appendix B—DHS Resource Assessment Form (SDS 3401) . . . . .	1-29
Part 2: Medicaid Issues and Planning Strategies . . . . .	1-37
I. Spousal Impoverishment Protections . . . . .	1-37
A. Community Spouse Resource Allowance . . . . .	1-37
B. Income of the Community Spouse. . . . .	1-38
C. The Monthly Maintenance Needs Allowance (MMNA). . . . .	1-38
D. Spend Down Considerations . . . . .	1-39
II. Impact of Gifts and Transfers . . . . .	1-40
A. Penalty Calculation . . . . .	1-40
B. Exempt Transfers . . . . .	1-41
C. Hardship Waiver . . . . .	1-43
III. Estate Recovery Developments . . . . .	1-43
A. Estate Recovery Overview. . . . .	1-43

<sup>1</sup>These materials have been updated from “Medicaid Eligibility for Long-Term Care; Medicaid Issues and Planning Strategies,” materials prepared by Jonas Hemenway and Julie Nimnicht for *Elder Law Elements 2015* (OSB CLE Seminars, October 2, 2015).

**Contents (continued)**

B.	Current Issues in Estate Recovery . . . . .	1–44
C.	Estate Recovery and the Oregon Health Plan on or after October 1, 2013 . . . . .	1–45
IV.	MAGI Medicaid . . . . .	1–45
A.	Coverage . . . . .	1–45
B.	Basic Eligibility Requirements . . . . .	1–46
C.	MAGI Programs in Oregon . . . . .	1–47
	Appendix C— Liability Worksheet for Long-Term Care or Home and Community-based Care . .	1–49
	Appendix D— Changes to Estate Recovery of Medical Assistance . . . . .	1–51

## INTRODUCTION

Medicaid is a jointly funded program provided and administered by the State of Oregon and the Federal Government. A basic understanding of Medicaid is invaluable to any estate planning and/or elder law practitioner. Whether or not you choose to include these services as part of your practice, being able to spot Medicaid related issues provides your clients with a great benefit. For example, deciding whether or not to advise your client to make gifts in a calendar year should include a Medicaid analysis.

Medicaid covers a large range of services, and is known across the state of Oregon by several names. These names are commonly shown as acronyms. The following are the most commonly used and seen:

- Oregon Health Plan – OHP, provides health insurance for low-income individuals and families, children, disabled adults, and pregnant women. This plan was recently expanded with the passage of the Affordable Care Act.
- Oregon Supplemental Income Program Medical – OSIPM, is designed to assist individuals with long-term care costs, such as monthly care costs incurred in assisted living facilities and/or nursing homes.

These materials will focus on OSIPM, as it is the version of Medicaid utilized by most individuals in need of long-term care. They are the vast majority of Medicaid related clients for any elder law practice dealing with long term care situations. Accordingly, throughout these materials, the term “Medicaid” will refer to OSIPM unless otherwise noted.

OSIPM is governed by the Oregon Administrative Rules (OARs). The majority of OARs that regulate how Medicaid is to be administered in the state of Oregon are found within OAR chapters 411 and 461. Throughout these materials we have endeavored to provide citations for the most pertinent OARs relating to each concept. However, these materials are not to be considered a substitute for becoming well versed with the OARs, particularly as OARs are subject to regular change, and do not go through the same legislative process as the Oregon Revised Statutes. It is vital to stay informed regarding these changes.

These materials will review the various eligibility requirements related to Medicaid in the state of Oregon, as well as provide an overview of some planning strategies which may be useful to an elder law practice. The scope of this presentation will not allow for an advanced strategy discussion, but the information provided will give a fairly comprehensive overview and should serve as a starting point to begin, or to expand, a Medicaid practice.

Medicaid eligibility is primarily governed by three criteria: Income, Resources, and Disability (or non-financial requirements). These materials will begin by exploring these three criteria.



## PART 1. MEDICAID ELIGIBILITY FOR LONG-TERM CARE

### I. Analyzing Income.

Careful evaluation of the Medicaid applicant's income is necessary in order to determine if the applicant satisfies that part of the eligibility test. Income can be broadly construed, and it is at times difficult to distinguish between an "income stream" and an "available resource."

OAR 461-155-0250(2) requires that a Medicaid applicant show gross monthly income of 300% or less of the SSI (Supplemental Security Income) standard. This is referred to as the "Income Cap." The current "Income Cap" is set at \$2,382 per month. If a Medicaid applicant has gross monthly income higher than this standard, he or she can still qualify for Medicaid benefits via the use of an Income Cap Trust (provided the applicant meets the resources and disability criteria). OAR 461-145-0540(10)(c).

The first step is to determine what income we have to count.

**A. Definition of Income.** The Oregon Administrative Rules do not provide a single OAR defining income for purposes of determining Medicaid eligibility. You are able, however, to view OAR 461 Division 145 to see a list of specific types of assets, and how they are classified (for example whether they are income or resources).

*Example : OAR 461-145-0030 describes the way(s) that a "Bank Account" is treated for Medicaid eligibility purposes.*

- 1. Gross vs. Net.** When determining Medicaid eligibility the Department of Human Services (DHS) will always count gross income from all income sources, whether earned income or unearned income. OAR 461-140-0040(4).
- 2. Earned vs. Unearned.** While the OARs do make a distinction in defining "earned income" (such as a salary) vs. "unearned income," this distinction is unimportant when determining Medicaid eligibility. DHS will count all income, whether earned or unearned, as equally countable.
- 3. Whose Income Counts?** When determining Medicaid eligibility only the gross income (earned or unearned) of the Medicaid applicant is counted – the income earned by the community spouse is not counted, nor is the income of any other member of the Medicaid applicant's household. OAR 461-110-0210(7).
- 4. Cannot Count an Asset as a Resource AND as Countable Income.** DHS must categorize an asset as either a resource OR as income. An asset may not be counted as a resource and as income in the same month. OAR 461-140-0010(7).  
Carefully examine how DHS has treated all available assets to ensure that no one asset is counted both as an income source and as an available resource.
- 5. Veterans Aid and Attendance Excluded.** Unlike other income sources Veterans Benefits that include Aid and Attendance payments are excluded from the income calculation when determining Medicaid eligibility. OAR 461-145-0580(2)(a)(A).
- 6. IRAs, and Other Retirement Accounts.** IRAs, even in repayment mode, are generally excluded as income sources. Rather, they are counted as available resources. Clients often mis-categorize this type of asset and list it as income rather than as a countable resource.

EXCEPTION: If the account cannot be withdrawn in one lump sum and the repayment schedule is actuarially sound then it is possible to have an IRA, or similar retirement account, counted as an income stream as opposed to a countable resource. OAR 461-145-0380.

Once we know what income we have to count, the next step is determining what we need to do with it.

## B. Income Cap Trusts

1. **Income Cap:** If the Medicaid applicant's countable monthly income is more than the current income cap (\$2,382/month gross) he or she will need an Income Cap Trust in order to qualify for Medicaid. OAR 461-145-0540(10)(c).
2. **Irrevocable:** The Income Cap Trust is an irrevocable living trust agreement. All of the Medicaid applicant's monthly income is deposited into an account held in the name of the Income Cap Trust. The trustee of the Income Cap Trust is then allowed to make certain distributions from the trust to or for the benefit of the Medicaid applicant. These distributions are outlined and described below. The balance of the monthly income must be used to pay for the Medicaid applicant's care costs. Medicaid then steps in to pay for the balance of what the Medicaid applicant's share couldn't cover.
3. **EIN:** Despite the fact that the Income Cap Trust is irrevocable, practitioners differ on whether or not to obtain a separate Taxpayer Identification Number (also called an Employer Identification Number, or EIN). Some choose to do so in order to ease the process of opening bank accounts in the name of the Income Cap Trust, as many banks require EINs whenever they see an irrevocable trust of any shape, size, or flavor. Alternatively, because the Income Cap Trust is, in fact, a grantor trust many practitioners choose to use the grantor's social security number. The choice does not seem to have any bearing on Medicaid eligibility.
4. **The Distribution Plan:** The Income Cap Trust allows for a distribution plan. This is, in essence, a budget for how the trustee of the Income Cap Trust is supposed to spend the Medicaid applicant's monthly income.

### *Personal Needs Allowance – OAR 461-145-0540(10)(c)(C)*

Nursing home residents are allowed \$64.94 per month as a personal needs allowance. OAR 461-160-0620(3)(c)(A). Note that a Medicaid applicant who receives VA benefits can be allowed up to \$90 per month as a personal needs allowance. OAR 461-160-0620(3)(c)(B).

For applicants living in community-based care settings, their monthly personal needs allowance is currently set at \$177.00, which is indexed to increase annually.

### *Room and Board – OAR 461-145-0540(10)(c)(C)*

If the applicant is receiving community-based care, he or she is expected to pay \$617 per month toward his or her room and board costs. This amount is indexed to increase annually.

*Reasonable Administrative Costs – OAR 461-145-0540(10)(c)(D)*

The trust allows for the use of trust funds to pay for costs incurred in the administration of the trust. “Reasonable administrative costs” include trustee fees, bank service charges, copy and postage expenses, tax preparation and accounting fees, future legal expenses, income taxes attributable to trust income, and conservatorship/ guardianship fees and costs. The trustee may only expend a total of \$50 from the trust per month on these expenses.

*Community Spouse and Family Monthly Maintenance Needs Allowance - OAR 461-145-0540(10)(c)(E)*

The trust can allocate some of the income each month to the community spouse (the spouse not receiving Medicaid benefits) in order to help ensure that he or she has enough to get by from month to month. If the community spouse’s monthly income is insufficient to pay his/her monthly living expenses, then a portion of the Medicaid recipient spouse’s income can be distributed each month to the community spouse. The minimum monthly maintenance needs allowance (MMMNA) the community spouse can receive is \$2,177.50 per month. If the community spouse has high enough costs of living then the amount can be increased to \$3,259.50 per month. In cases of great need this amount can be increased even higher by court order.

*Medicare and Other Private Medical Insurance Premiums – OAR 461-145-0540(10)(c)(F)*

The Medicaid recipient’s insurance premiums for Medicare and other supplemental health insurance policies may also be paid from the Income Cap Trust.

*Other Incurred Medical Costs – OAR 461-145-0540(10)(c)(G)*

Those medical costs allowed under OAR 460-160-0030 and 461-150-0055 may be paid from the Income Cap Trust. These include medical and dental care, psychotherapy, rehabilitation services, hospitalization, outpatient treatment, prescription drugs and over-the-counter medications, medical supplies and equipment, dentures, hearing aids, prostheses, and prescribed eyeglasses. As you can see, most medical expenses can be covered by the Income Cap Trust. If there are too many medical expenses in a given month for the Income Cap Trust to cover, then an installment plan may be set up and paid from the Income Cap Trust for as many months as is necessary until the medical expense has been paid in full.

*Contributions to Reserves for Child Support, Alimony, and Income Taxes – OAR 461-145-0540(10)(c)(H)*

If the Medicaid applicant is responsible for child support and/or alimony obligations these costs can be paid from the Income Cap Trust. Income taxes can also be paid from the Income Cap Trust.

*Monthly Contributions to Reserves or Payments for the Purchase of Irrevocable Burial Plan – OAR 461-145-0540(10)(c)(I)*

The Income Cap Trust can pay for a pre-arranged, irrevocable burial plan, so long as the plan's value does not exceed \$5,000.

*Contributions for Home Maintenance – OAR 461-145-0540(10)(c)(J)*

If the Medicaid applicant plans to return to his or her residence, then the Income Cap Trust can make contributions to a reserve or payments for home maintenance. In order to make these payments the applicant must meet the criteria of either OAR 461-160-0630 or OAR 461-155-0660.

OAR 461-160-0630 allows the Income Cap Trust to make monthly payments for up to six months if the individual would not be able to afford to keep the home or rental property without the deduction and the applicant's physician documents that it is likely that the applicant will be medically able to return home within the next six months. Additionally, the department must determine that maintaining the home is consistent with the individual's care needs. The amount of the deduction is the total of the individual's housing cost, including taxes and homeowners insurance, plus the limited standard utility allowance for the SNAP program.

OAR 461-155-0660 allows for a temporary accommodation allowance in some limited circumstances if the Medicaid applicant has temporarily entered a qualifying long-term care situation, cannot afford to keep his or her residence without the additional allowance, will be able to return to the residence within six months of moving into the qualifying long-term care situation (this must be confirmed in writing by a medical professional), and the residence will accommodate the care needs of the Medicaid applicant. After six months the Medicaid applicant may request an extension so long as the above criteria continue to be met.

### **C. Reallocation of Income to Avoid Spousal Impoverishment**

1. Although the community spouse has no income cap, do not disregard his/her income in your planning. It is possible to re-allocate a portion of the Medicaid applicant's monthly income to the community spouse in order to prevent spousal impoverishment. This can be done with or without an Income Cap Trust.
2. The Minimum Monthly Maintenance Needs Allowance (MMMNA) currently set for the community spouse is \$2,177.50 per month. This amount can be increased to \$3,259.50 per month without court order if the community spouse has high "shelter costs." The amount may be increased even higher with court order if necessary.

## **II. Analyzing Resources.**

In order to determine whether a Medicaid applicant satisfies the resource criteria to qualify for assistance, careful evaluation of the applicant's resources is required. The first step is to

determine which of the financial group's<sup>1</sup> resources are considered “available.” The second step is to distinguish which of the available resources are specifically excluded under the Medicaid rules, and which are countable.

**A. Available vs. Not available.** A resource is generally considered available if the Medicaid applicant (and/or the applicant's spouse, if married) owns an interest in the resource. However, there are some exceptions set forth in OAR 461-140-0020(2). Specifically, a resource is not considered available if:

1. The applicant has a legal interest in the resource, but does not have possession of the resource and is unable to gain possession of it. OAR 461-140-0020(2)(a).
2. The applicant jointly owns the resource with one or more joint-owners not in the financial group who are unwilling to sell their interest and the applicant's interest is not reasonably saleable. OAR 461-140-0020(2)(b).
3. The applicant verifiably lacks the competence to gain access to or use the resource and has no legal representative available to act on the applicant's behalf. OAR 461-140-0020(2)(c).
4. The applicant is a victim of domestic violence and attempting to use the resource would subject the applicant to risk of domestic violence or the applicant is using the resource to avoid the abusive situation. OAR 461-140-0020(2)(d).
5. Except as provided in OAR 461-145-0540, the resource is included in an irrevocable or restricted trust and cannot be used to meet the basic monthly needs of the applicant or the applicant's spouse. OAR 461-140-0020(2)(e).
6. There is a legal bar to the sale of the resource. OAR 461-140-0020(2)(f).

If the resource does not fall under one of the above exceptions, it will generally be considered available. The next step is to determine which of the applicant's available resources are countable, and which are excluded.

*Jointly owned resources.* Jointly-owned resources are assumed to be available to the Medicaid applicant only to the extent they own the resource. OAR 461-140-0020(1)(b).

**B. Excluded Resources.** Excluded resources, which are set forth in chapter 461, division 145 of the Oregon Administrative Rules, will not be counted for purposes of determining a client's eligibility and benefits level as long as the resource is used in a manner consistent with the rule providing the exclusion. The following is a non-exhaustive list of some commonly encountered resources along with descriptions of the circumstances under which they might be excluded.

1. **Home.** The home owned by the applicant and/or the applicant's spouse may be excluded if certain conditions are satisfied.

*Applicant's spouse or child resides in the home.* A home is an excluded resource if the applicant's spouse or the applicant's biological or adoptive child (who is

---

<sup>1</sup> The “financial group” consists of all the people in the “filing group.” The “filing group” consists of the people whose resources are considered in the eligibility determination process. See OAR 461-110-0530 and OAR 461-110-0410.

under the age of 21 or, if over the age of 21, who meets the Social Security Administration criteria for blindness or disability) occupies the home (no matter the equity value). OAR 461-145-0220(2)(B)(i)-(ii).

*Applicant resides in the home alone.* If the applicant resides in the home alone (with no spouse or child), the home may be excluded as a resource as long as the applicant's equity value in the home is under \$603,000. OAR 461-145-0220(2)(a)(B)(iii)(I). (Note that, even if the equity value in the home is more than \$603,000, OAR 461-145-0220(2)(B)(iv) states that the home will be excluded as a resource if the applicant is unable legally to convert the equity value in the home to cash.)

*Temporary Absence.* Under OAR 461-145-0220(3)(c), the value of the home is excluded if the Medicaid applicant is absent to receive care in a medical institution if one of the following is true:

- i. The applicant has provided evidence that he or she will return to the home. The evidence must reflect the subjective intent of the applicant, regardless of the applicant's medical condition. A written statement from a competent individual is sufficient to prove intent. OAR 461-145-0220(3)(c)(A).
- ii. The home remains occupied by the applicant's spouse, child, or a relative dependent on the applicant for support. The child must be less than 21 years of age or, if over 21, must meet the Social Security Administration criteria for blindness or disability. OAR 461-145-0220(3)(c)(B).

*Unoccupied home.* If the equity value is under \$603,000, and neither the applicant, the applicant's spouse, nor the applicant's child is residing in the home, the property will be excluded if the financial group is making a good-faith effort to sell the property at a reasonable price. OAR 461-145-0420(3)(d).

*Proceeds from the sale of a home.* The proceeds from the sale of the home of the financial group are excluded for three months if the financial group intends to use the proceeds to buy another home. OAR 461-145-0460(3)(d)(A).

2. **Car.** The value of one vehicle selected by the financial group is excluded if it is used for transportation of the applicant or a member of the applicant's household. OAR 461-145-0360(4)(a). The equity value of any other vehicles owned by the financial group is counted as a resource. There is no limit on the value of the car that the applicant can exclude, and, if the applicant has more than one car, the applicant can exclude the value of the most expensive car.
3. **Personal belongings.** Personal belongings are excluded resources. OAR 461-145-0390. Personal belongings are "items needed for maintenance and occupancy of the home and personal items found in or near the home that are used on a regular basis, are ordinarily worn or carried by the individual, or otherwise have an intimate relation to the individual." There is no limit on the value of the personal belongings that can be excluded.

**4. Burial Arrangements.**

*Irrevocable burial plan.* The amount in an irrevocable burial trust or any other irrevocable arrangement to cover burial costs is excluded, regardless of the value. OAR 461-145-0040(2)(c). Note that, if the applicant has a preexisting burial plan that is revocable, he or she may elect to make the plan irrevocable at any time during the Medicaid application process in order to exclude the value of the plan from resource consideration.

*Burial fund.* If the applicant does not already have a burial plan and does not wish to establish one, he or she may instead set aside up for \$1,500 in a burial fund. The applicant may also set aside up to \$1,500 in a burial fund for his or her spouse. Each burial fund must be in a separate account in order to be excluded from resource consideration. The funds set aside for burial will be counted as a resource if commingled with assets unrelated to a burial. OAR 461-145-0040(3). There is no Medicaid penalty or overpayment in the event that the applicant later uses the money in an excluded burial fund for something other than burial costs. OAR 461-145-0040(4).

NB: The amount allowed for a burial fund is reduced by the face value of life insurance policies owned by the applicant that have already been excluded from resources (see Life Insurance Policies, below), and by the amount in an irrevocable burial trust or any other irrevocable arrangement designated to cover burial costs, including the face value of burial insurance considered to be an irrevocable arrangement. OAR 461-145-0040(3)(D)(ii).

- 5. Burial space and merchandise.** The equity value of a burial space and merchandise is excluded as a resource if owned by the applicant and designated for the applicant, the applicant's spouse, minor and adult children, siblings, parents, and the spouse of any of these individuals. OAR 461-145-0050. A "burial space" may refer to a conventional gravesite, crypt, mausoleum, urn, niche, burial vault, and other repository that is traditionally used for the remains of a deceased individual. A burial space also includes headstones and the opening and closing of the gravesite, and the reasonable and necessary improvements or additions to such space. Burial merchandise includes, but is not limited to, urns, caskets, liners, headstones, markers, plaques and foundations. Note that, if a burial space and merchandise serves the same purpose, only one item per individual is excluded.

**6. Life insurance policies.**

*Term Insurance.* All term insurance that has no cash surrender value is excluded. OAR 461-145-0320(5)(a).

*Whole Life Insurance.* The cash surrender value of life insurance policies owned by the financial group is excluded if the total face value of all policies for the insured individual is less than or equal to \$1,500. If the total face value of all policies for the insured individual is more than \$1,500, the entire cash surrender value is counted as a resource to the owner of the policy. OAR 461-145-0320(5)(c)(B).

**7. Pensions and retirement plans.**

*Pensions and Retirement Plans that only allow for periodic payments.* The equity value of a pension or retirement plan is excluded as a resource if the individual is eligible for monthly periodic payments under the terms of the plan and has applied for those payments. When an individual is permitted to choose or change a payment option, the individual must select the option that:

- i. Provides payments commencing on the earliest possible date; and
- ii. Completes payments within the actuarial life expectancy of the individual (per the Periodic Life Table of the Office of the Chief Actuary of the Social Security Administration). OAR 461-145-0380(4)(a)(A).

The equity value of all other pension and retirement plans that allow an individual to withdraw funds, minus any penalty for withdrawal, is counted as a resource. OAR 461-145-0380(4)(a)(B).

*Annuities Purchased with Funds from a Retirement Plan.* The equity value of an annuity purchased with funds from certain retirement plans (described in OAR 461-145-0380(1)(e)) is excluded if it meets the payout requirements of OAR 461-145-0022(10)(c). See OAR 461-145-0380(4)(b). The requirements of OAR 461-145-0022 are discussed in more detail in Part 2, section I.D., below.

**8. Annuities.** The equity value of an irrevocable annuity issued by a business that is licensed and approved to issue commercial annuities by the state in which the annuity is purchased is excluded as a resource under OAR 461-145-0022(7) as long as the annuity is actuarially sound and it meets the following criteria:

- i. The applicant is living in a nonstandard living arrangement (i.e., an institutional or care facility setting), and the applicant or the applicant's spouse purchased the annuity between January 1, 2006 and June 30, 2006; or
- ii. The applicant is living in a standard living arrangement (i.e., not an institutional or care facility setting) and the applicant or the applicant's spouse purchased the annuity on or after January 1, 2006;

AND the annuity meets the following requirements:

- iii. If an unmarried applicant is the annuitant, the annuity must specify that upon the death of the client, the first remainder beneficiary is either of the following:
  - a. The Department, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the applicant; or
  - b. The child of the applicant (as long as the child is either under the age of 21 or any age and meets the Social Security Administration criteria for blindness or disability) if the Department is the next remainder beneficiary (after this child), up to the amount of medical benefits provided on behalf of the applicant, in the event that the child does not survive the applicant.

- iv. If a spouse of the applicant is the annuitant, the annuity must specify that, upon the death of the spouse of the applicant, the first remainder beneficiaries are either of the following:
  - a. The applicant, in the event that the applicant survives the spouse; and the Department, in the event that the applicant does not survive the spouse, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the applicant; or
  - b. A child of the applicant's spouse (as long as the child is either under the age of 21 or any age and meets the Social Security Administration criteria for blindness or disability); and the applicant in the event that this child does not survive the spouse.

An annuity may also be excluded under OAR 461-145-0022(6) if the applicant is living in a standard living arrangement and the applicant or the applicant's spouse purchased the annuity prior to January 1, 2006 from a business that is licensed and approved to issue commercial annuities by the state in which the annuity is purchased and the annuity makes regular payments for a lifetime or specified number of years.

(The Department has a flow chart titled "Treatment of Annuities for OSIPM" in its worker guide that illustrates under what circumstances annuities are excluded, and under what circumstances they are counted as resources. The flowchart is accessible here:

[http://www.dhs.state.or.us/spd/tools/additional/workergd/ann\\_flowchart.pdf](http://www.dhs.state.or.us/spd/tools/additional/workergd/ann_flowchart.pdf).)

9. **Real property other than the home.** The equity value of real property other than the home of the financial group is excluded if the financial group is making a good-faith effort to sell the real property at a reasonable price. The equity value is excluded for nine months unless the failure to sell is for reasons beyond the reasonable control of the financial group. OAR 461-145-0420(3)(d)(B).

10. **Income.** Income is not considered a resource in the calendar month of receipt.

- C. **Countable Resources.** An available resource that is not excluded is countable and its value is used to determine whether the applicant qualifies for assistance. The applicable resource limit for an applicant depends on whether the applicant is married or unmarried. An unmarried applicant is subject to a resource limit of \$2,000. OAR 461-160-0015(3)(a). See Part 2, Section I., below for information about the resource limits applicable to a married applicant.

### III. Non-Financial Eligibility Requirements

Beyond the financial eligibility requirements for Medicaid (Income and Resources) the Medicaid applicant must also meet certain non-financial eligibility requirements. These are generally medical in nature, and are often referred to as the applicant's disability.

- A. **Disability Assessment.** Following the application, the Department of Human Services (DHS) will perform an eligibility assessment. For this assessment DHS will assign a caseworker to evaluate the physical and mental needs of the Medicaid applicant. This assessment is sometimes referred to as the CAPS assessment (Client Assessment &

Planning System). This assessment is used to determine whether or not the Medicaid applicant is capable of handling any or all of his or her Activities of Daily Living (ADLs).

1. **Activities of Daily Living (ADL’s).** There are several different ADLs assessed by DHS when determining Medicaid eligibility. OAR 411-015-0006(1). DHS’s definition of each activity can be found at the corresponding Oregon Administrative Rule.

Within each category the Medicaid applicant will be rated as needing either “Assist,” or “Full Assist.” Within the Mobility category the ratings are expanded to include either “Minimal Assist,” “Substantial Assist,” or “Full Assist.”

- (a) Eating – OAR 411- 015- 0006(5)
- (b) Dressing/Grooming – OAR 411-015-0006(4)
- (c) Bathing/Personal Hygiene – OAR 411-015-0006(2)
- (d) Mobility (Ambulation & Transfer) – OAR 411-015-0006(7)
- (e) Elimination – OAR 411-015-0006(6)
- (f) Cognition/Behavior – OAR 411-015-0006(3)

It is important to remember that the assessment of the ADLs only evaluates the Medicaid applicant’s abilities and performance during the 30 days preceding the date of the assessment and how the Medicaid applicant is expected to perform for the 30 days following the date of the assessment. OAR 411-015-0006(1)(b).

When assessing the Medicaid applicant’s cognition the caseworker should consider, in addition to the 30 days preceding and succeeding the assessment date, how the Medicaid applicant has functioned without the assistance of another person. OAR 411-015-0006(3)(a).

It is also important to note that the assessment is based on the individual’s actual or predicted need for assistance, rather than possible or preventive needs. OAR 411-015-0006(2)(a).

ADL	Assist	Full Assist
Mobility - Ambulation	Minimal – Even with assistive devices, the individual requires hands-on assistance from another person to ambulate outside the home or care setting at least once each week, totaling four days per month. The individual requires hands-on assistance from another person to ambulate inside their home or care setting less than one day each week.	Even with assistive devices, the individual requires hands-on assistance from another person to ambulate every time the activity is attempted. Individuals who are confined to bed are a full assist in ambulation.

<b>ADL</b>	<b>Assist</b>	<b>Full Assist</b>
	Substantial -- Even with assistive devices the individual requires hands-on assistance from another person to ambulate inside their home or care setting at least one day each week totaling four days per month.	
Mobility - Transfers	Even with assistive devices, the individual requires hands-on assistance with a task of transferring inside the home or care setting at least one day each week totaling at least four days per month.	The individual requires hands-on assistance from another person every time the activity is attempted, even with assistive devices.
Eating	When eating, the individual requires another person to be within sight and immediately available to actively provide hands-on assistance with feeding, special utensils, or immediate hands-on assistance to address choking, or cueing during the act of eating at least one time each week totaling four days per month during the assessment timeframe.	When eating, the individual always requires one-on-one assistance through all tasks of the activity for direct feeding, constant cueing to prevent choking or aspiration every time the activity is attempted.
Elimination – Bladder & Bowel	Even with assistive devices, the individual requires hands-on assistance with a task of bladder at least one day each week totaling four days per month during the assessment timeframe.	The individual requires hands-on assistance of another person to complete all tasks of bladder and bowel care every time the task is attempted even with assistive devices.
Elimination - Toileting	Even with assistive devices, the individual requires hands-on assistance from another person with a task of toileting or cueing to prevent incontinence at least one day each week totaling four days per month during the assessment timeframe.	The individual is unable to accomplish all tasks of toileting without the assistance of another person. This means the individual needs assistance of another person through all tasks of the activity, every time the activity is attempted.

ADL	Assist	Full Assist
Bathing	Even with assistive devices, the individual requires assistance of another person for a task of bathing at least one day each week totaling four days per month. This means hands-on assistance, cueing, or stand-by presence during the activity.	Even with assistive devices, the individual is unable to accomplish any task of bathing without the assistance of another person. This means the individual needs hands-on assistance of another person through all tasks of the activity, every time the activity is attempted.
Personal Hygiene	Even with assistive devices, the individual requires assistance of another person for a task of personal hygiene at least one day each week totaling four days per month. This means hands-on assistance, cueing, or stand-by presence during the activity.	Even with assistive devices, the individual is unable to complete at least two personal hygiene tasks without the assistance of another person. This means the individual needs hands-on assistance of another person through all tasks, every time the activity is attempted.
Dressing	Even with assistive devices, the individual is unable to accomplish some tasks of dressing without the assistance of another person at least one time each week totaling four days per month. This means hands-on assistance, cueing, or stand-by presence during the activity.	Even with assistive devices, the individual is unable to accomplish any tasks of dressing without the assistance of another person. This means the individual needs hands-on assistance through all tasks of the activity, every time the activity is attempted.
Grooming	Even with assistive devices, the individual is unable to accomplish tasks of grooming, without the assistance of another person at least one time each week totaling four days per month. This means hands-on assistance, cueing, or stand-by presence during the activity.	Even with assistive devices, the individual is unable to perform any tasks of grooming without the assistance of another person. This means the individual needs hands-on assistance of another person through all tasks of the activity, every time the activity is attempted.

- 2. Service Priority Levels.** The ability (or inability) of the Medicaid applicant to handle their respective ADLs is computed as part of the CAPS assessment resulting in a score assigned to the applicant. This score is called the Medicaid applicant’s Service Priority Level. These scores range from 1-18 (1 being the

most disabled, and 18 being the most independent). A Medicaid applicant must score between 1 and 13 in order to be eligible for Medicaid benefits to assist with paying for long-term care.

The following are the current service priority levels and their respective scores. Note that only levels (1) through (13) are eligible for long-term care services. OAR 411-015- 0015(1)(a).

1	Requires Full Assistance in Mobility, Eating, Elimination, and Cognition
2	Requires Full Assistance in Mobility, Eating, and Cognition
3	Requires Full Assistance in Mobility, or Cognition, or Eating
4	Requires Full Assistance in Elimination
6	Requires Substantial Assistance with Mobility and Assistance with Eating
7	Requires Substantial Assistance with Mobility and Assistance with Elimination
8	Requires Minimal Assistance with Mobility and Assistance with Eating and Elimination
9	Requires Assistance with Eating and Elimination
10	Requires Substantial Assistance with Mobility
11	Requires Minimal Assistance with Mobility and Assistance with Elimination
12	Requires Minimal Assistance with Mobility and Assistance with Eating
13	Requires Assistance with Elimination
14	Requires Assistance with Eating
15	Requires Minimal Assistance with Mobility
16	Requires Full Assistance in Bathing or Dressing
17	Requires Assistance in Bathing or Dressing
18	Independent in the above levels but requires structured living for supervision for complex medical problems or a complex medication regimen

It is common for a Medicaid applicant to misinterpret or under-report their need for assistance. This is usually because of pride, confusion, mental incapacity, etc. On occasion coaching and guidance from the attorney can be very helpful. It is also advisable to have a friend, family member, and/or caregiver present at the assessment, in order to ensure that the information reported to the Medicaid caseworker is accurate. A very small reporting error can be the difference between full benefits and no benefits awarded.

DHS will re-evaluate the Medicaid recipient’s medical need on an annual basis. If a Medicaid recipient is denied as a result of one of these annual reviews, they should request a copy of the new CAPS assessment report to determine whether or not to appeal the decision. If the recipient decides to appeal, they have 10 days from the date of the Medicaid denial to request what’s called “Aid Paid Pending.” This provides a continuation of benefits while the appeal proceeds. If the recipient wins the appeal, they can continue to receive uninterrupted benefits. If, however, the recipient loses the appeal, they will be required to repay all of the benefits that were paid to or for the recipient’s benefit during the appeal process.



**SAMPLE**

**Irrevocable Living Trust Agreement, dated**

---

**Trustee, Trustee**

**For the Benefit of**

**Grantor, Beneficiary**

**Tax Identification Number of Trust: SSN  
(Grantor Trust)**

Prepared by

**SAMPLE**

**Irrevocable Living Trust Agreement**

dated \_\_\_\_\_  
effective \_\_\_\_\_

**RECITALS**

GRANTOR, by and through \*\*\*Gender of Client\*\*\* attorney-in-fact, POA, establishes a trust which is effective \_\_\_\_\_, for the benefit of GRANTOR, the lifetime Beneficiary (“Beneficiary”). The initial trustee is TRUSTEE.

**ARTICLE 1**

**Name of the Trust**

This irrevocable trust shall be known as SAMPLE.

**ARTICLE 2**

**Purpose of the Trust**

The purpose of this Trust is to provide for the administration and disposition of the trust estate during and after the lifetime of the Beneficiary, in accordance with the terms and conditions of the Trust. This Trust is created pursuant to Section 1917 (d)(4)(B) of the Social Security Act [42 USC 1396]. This trust document is created in order to enable the Beneficiary to qualify for Medicaid, any provisions of this trust which are deemed to be inconsistent or contrary to the intent of the above-referenced federal law shall be deemed to be void and of no further force or effect. All interpretations and actions taken by the Trustee pursuant to this trust shall be done for and with the purpose of creating, establishing and maintaining the Beneficiary’s eligibility for eligibility for Medicaid benefits.

**ARTICLE 3**

**Trust Funding**

**Initial Funding**

**Section 3.1** Grantor will cause to be transferred to trustee the monthly income of GRANTOR beginning in the month of \_\_\_\_\_. Grantor intends that the income described in Schedule “A”, together with all accretions and additions thereto shall be used, handled and disposed of by the Trustee and by any successor or substitute Trustee or Trustee as described in this instrument.

**No Other Assets In Trust**

**Section 3.2** No property other than the Beneficiary’s unearned income shall be placed in this trust. The Trustee shall place no other money in the trust bank account.

**ARTICLE 4**

**Distribution During Beneficiary’s Life**

**Section 4.1** During the lifetime of the Beneficiary, the Trustee shall use the Beneficiary’s income placed in the trust to pay:

- a. *Personal Needs Allowance.* The Beneficiary’s personal needs allowance or applicable OSIP standard;

- b. *Administrative Costs.* Reasonable administrative costs associated with maintenance of this trust of up to \$50 per month to cover trustee fees, bank service charges, copy charges, postage, accounting and tax preparation fees, income taxes attributable to trust income, and guardianship or conservatorship fees and costs.
- c. *Spouse, Family.* Monthly maintenance needs allowance for spouse and family.
- d. *Health Insurance Premium.* The Beneficiary's health insurance premiums.
- e. *Other Reserves.* Other incurred medical care costs that are not reimbursed by a third party. Contributions to reserves limited to child support, alimony, and income taxes. Contributions to reserves for the purchase of an irrevocable burial with a maximum value of \$5,000. Contributions to reserves for a home maintenance allowance may be made on a monthly basis if the client meets the criteria of OAR 461-155-0660 or OAR 461-160-0630.
- f. *Patient Liability.* Patient liability not to exceed the cost of waived services or nursing home care.
- g. *Excess.* The excess may be distributed to or on behalf of the Beneficiary to the extent allowed under the Oregon Administrative Rules governing Medicaid assistance. Excess income may be distributed to the state to repay it for any Medicaid assistance that it provided to Beneficiary, even if recovery for the past assistance is not required by federal or state law.

### **Distribution Plan**

**Section 4.2** The distribution plan of the Trustee is as set forth in Schedule B attached hereto and made a part hereof.

#### **Anticipated Distribution Plan Change**

The cost of care will vary with changes in the Beneficiary's income, the income cap amount, the community spouse income allowance, etc.

The representative of the state Medicaid program may from time to time notify the Trustee of changes in the rules (i.e., income cap changes, MMMNA changes) that affect the contribution to the cost of care. If the Trustee determines that a change in the distribution plan is warranted, the Trustee shall notify the Medicaid worker assigned to the Beneficiary's case.

### **ARTICLE 5**

#### **Distribution at Termination**

##### **Remainder Beneficiaries Named**

**Section 5.1** This trust shall cease and terminate when the Beneficiary dies, or earlier if the Trustee determines that the existence of the Trust is no longer necessary to establish or maintain Medicaid eligibility for the Beneficiary. Upon the termination of this trust, the remaining trust property shall be distributed as follows:

First, to any State that may have provided Beneficiary with medical assistance up to an amount equal to the total medical assistance paid on behalf of the Beneficiary by the state plan for Medicaid assistance or other approved waived programs; this provision is intended to meet the requirements of 42 USC 1396p as amended by OBRA '93; and

Second, any remainder after the state's claim has been paid shall pass outside of probate to those residuary beneficiaries named in the Beneficiary's will or trust, however, if the Beneficiary leaves no will or trust, then the remainder shall be distributed outside of probate to those heirs as determined by the Oregon law of intestate succession.

### **Winding Up Affairs of Trust**

**Section 5.2** When this trust terminates, the Trustee shall wind up the affairs of the trust before distribution, pay for all administrative costs and for preparation of the final tax return. The Trustee shall have the sole discretion to claim any tax deductions useful to reduce the tax paid by the living trust. After winding up the trust, the Trustee shall distribute the remainder, if any, as provided above.

### **ARTICLE 6**

#### **Authority to Initiate Proceedings for Eligibility**

The Trustee has full and complete discretion to initiate action to render the Beneficiary eligible for any such program or public benefit, and has full and complete discretion to initiate either administrative or judicial proceedings, or both, for the purpose of determining eligibility. All costs relating thereto, including reasonable attorney fees, shall be charged to the trust. The Trustee is directed to defend, at the expense of the trust, all contest or attacks of any nature against the trust.

### **ARTICLE 7**

#### **Tax Nature of the Trust**

It is the intent of the parties hereto that this Income Cap Trust be construed as a "grantor trust" under Internal Revenue Code Section 677(a). All income received, distributed, held, or accumulated by this trust shall be taxable to the Grantor. The Trustee may distribute directly to the taxing authority such amounts of income or principal of the trust as is necessary to satisfy the Beneficiary's tax obligations.

### **ARTICLE 8**

#### **Authority of Trustee**

The Trustee's discretion in choosing disbursements and establishing reserves is final as to all interested parties. The Trustee's sole and independent judgment, rather than any other person's determination, is intended to be final.

### **ARTICLE 9**

#### **Spendthrift/Nonassignment**

No interest in the principal or income of this trust shall be anticipated, assigned or encumbered, or be subject to any creditor's claim or to legal process prior to its actual receipt by Beneficiary. No Beneficiary shall have the power to sell, assign, transfer, encumber, or in any other manner anticipate or dispose of his interest in the trust or the income produced thereby, prior to its actual distribution by the Trustee for the benefit of the Beneficiary in the manner authorized by this agreement. No Beneficiary shall have any assignable interest in any trust created under this agreement or in the income therefrom. Neither the principal nor the income shall be liable for any debts of the Beneficiary. The limitations herein shall not restrict the exercise of any power of appointment or disclaimer.

**ARTICLE 10**  
**Irrevocable Nature of Trust**

Grantor retains no right to modify, change, alter or revoke this trust, as it is intended to be an irrevocable trust. The Beneficiary has no power to modify, change, alter or revoke the trust.

**ARTICLE 11**  
**Governing Law**

The validity and construction of this agreement shall be determined under Oregon law in effect on the date this agreement is signed.

**ARTICLE 12**  
**Powers of Trustee**

**Section 12.1** The Trustee shall have all powers granted by Oregon law as now existing or later amended, except to the extent limited by the other provisions by this trust. In addition, the Trustee shall have the power:

**Manage Assets**

**Section 12.2** To manage and distribute assets.

**Retain Assets**

**Section 12.3** To retain assets.

**Manner of making Distribution**

**Section 12.4** To make any distribution on behalf of the Beneficiary directly to the person or organization.

**Principal and Income**

**Section 12.5** The Trustee may allocate items of income or expenditure to either income or principal and create reserves out of income all as provided by law and to the extent not so provided to allocate to income or principal or create reserves on a reasonable basis and the fiduciary's decision made in good faith with respect thereto shall be binding and conclusive upon all persons.

**Undistributed Income**

**Section 12.6** Income accrued or undistributed at the termination of a Beneficiary's interest in a trust shall be added to and become part of the principal of that trust, and the rights of the Beneficiary to that income shall terminate.

**Employment of Agents**

**Section 12.7** The Trustee may engage persons, including attorneys, auditors, investment advisors, or agents to advise or assist the fiduciary at the cost of the trust estate.

**Do Other Acts**

**Section 12.8** Except as otherwise provided in this instrument, to do all acts that might legally be done by an individual in absolute ownership and control of property and which in the Trustee's judgment are necessary or desirable for the proper and advantageous management of the trust estate.

## **Trustee Liability**

### **Use of Funds to Research Programs**

**Section 12.9** It is recognized that the Trustee is not licensed nor skilled in the field of Social Services. The Trustee may seek the counsel and assistance of the Beneficiary's guardian or conservator, if any, and any State and local agencies that have been established to assist the handicapped or disabled in similar circumstances. The Trustee may use these resources to aid the Beneficiary, or the Beneficiary's guardian or conservator, as appropriate, in identifying programs which may be of social, financial, and/or developmental assistance to the Beneficiary. However, the trustee shall not in any event be liable to Beneficiary, the remainder shall not in any event be liable to Beneficiary, the remainder beneficiaries of the trust, or any other party for his acts as Trustee hereunder so long as the Trustee acts reasonably and in good faith. For example, the Trustee, the Beneficiary, and the Beneficiary's guardian or conservator, if any, shall not be liable for the failure to identify each program or resource that might be available to the Beneficiary because of disabilities.

### **Power to Amend**

**Section 12.10** The Trustee may amend the trust to conform with later changes in federal or state law, to better effect the purposes of the trust.

## **ARTICLE 13**

### **Trust Administration and Courts**

This trust shall be administered according to its terms expeditiously and without order, approval or other action by any court. However, the Trustee or any interested person may petition the court as allowed in this trust agreement, or by Oregon law. A court, however, shall have the continuing jurisdiction to modify any provision of this trust to the extent necessary to maintain the eligibility of the Beneficiary for medical assistance or other public benefits under applicable law.

## **ARTICLE 14**

### **Trustee Succession and General Administrative Provisions**

#### **Resignation of Trustee**

**Section 14.1** The Trustee may resign the trusteeship at any time. Any resignation shall be in writing, and shall become effective upon the earlier of a successor trustee accepting the office and responsibilities of trustee in writing, or thirty (30) days from the date of mailing of the written notice of resignation of trustee to the Beneficiary, the next successor trustee, and the first remainder Beneficiary named in this agreement. Notice shall be mailed to the most current addresses then known to the trustee. At this time, the addresses are:

**Name and Address:**

GRANTOR

State of Oregon

Estate Administration Unit

Department of Human Services

P.O. Box 14021

Salem, OR 97309-5024

**Reason Why Entitled to Notice:**

Beneficiary

First Remainder Beneficiary

SUCCTRUSTEE

Successor Trustee

**Designation of Successor Trustee**

**Section 14.2** The successor Trustee shall be SUCCTRUSTEE. Any named Trustee may nominate and appoint additional successor trustees to serve if the persons initially nominated as successors are unavailable or unwilling to serve.

**No Trustee**

**Section 14.3** If the trust at any time has no Trustee, and no successor has been nominated as described above, then a Court having jurisdiction may appoint, after notice to the Beneficiary and an opportunity to be heard, a successor Trustee at the request of any person interested in the trust, including the trust Beneficiary.

**Transfer to Successor Trustee**

**Section 14.4** Every successor Trustee shall have all the rights, title, powers, privileges and duties conferred on or imposed upon the original Trustee, without any conveyance or transfer. All right title and interest to the trust property shall immediately vest in the successor Trustee, upon the successor Trustee executing a document accepting the office. The prior Trustee shall, without warranty, transfer the existing trust property to the possession and control of the successor Trustee. The successor Trustee shall not have any duty to examine the records or actions of any former Trustee, and shall not be liable for the consequences of any act or failure to act of any former Trustee.

**Removal of Trustee**

**Section 14.5** Any interested person herein may petition any Oregon Circuit Court for removal of any Trustee. While any interested person may petition for removal of any trustee, the decision on whether to remove any Trustee shall be in the exclusive discretion and control of an Oregon Circuit Court.

**Replacement of Trustee**

**Section 14.6** Any Trustee may be replaced by a successor Trustee, upon the death, resignation, removal or incapacity of the prior Trustee. Also, should no successor Trustee have been nominated, any Oregon Circuit Court shall have the power to fill any vacancy in the trusteeship resulting from the death, resignation, removal or incapacity of a Trustee.

**Trustee's Reporting Responsibility**

**Section 14.7** The Trustee shall report, at least every twelve months, to the Beneficiary and his legal representative, if any, and also to the next successor Trustee's report shall advise of any change if the Beneficiary's eligibility for public benefit programs and shall list all of the receipts, disbursements, and distributions occurring during the reporting period, along with a complete list of the assets held by the trust. The account shall be deemed to have been delivered when it has been placed in the United States Mail addressed to that person at the person's last known address. A copy of the most recent bank account statement and a copy of the most recently filed trust tax return shall be attached to the accounting.

### Availability of Records

**Section 14.8** The records of the Trustee, along with all trust documentation, shall be available and open at all reasonable times for the inspection by the trust Beneficiary, and/or his legal representative, and by trust remaindermen, during regular business hours upon five calendar days notice to the Trustee.

### Trustee Compensation

**Section 14.9** The Trustee may receive reasonable compensation and reimbursement for expenses such as travel costs (if automobile, then-current IRS mileage expense allowance), postage, copy and fax charges, and long distance telephone charges required to administer the trust estate.

### Trustee Indemnification

**Section 14.10** Trustee is entitled to be indemnified, to his or her reasonable satisfaction, against liabilities lawfully incurred in the administration of this trust, at the cost of the trust.

### Bond

**Section 14.11** No bond shall be required of any Trustee.

DATED \_\_\_\_\_, 2021.

\_\_\_\_\_  
GRANTOR, Grantor

\_\_\_\_\_  
TRUSTEE, Trustee

STATE OF OREGON                    )  
                                                  ) ss.  
COUNTY OF CLACKAMAS        )

POA, attorney-in-fact for GRANTOR, Grantor, acknowledged this instrument to be his voluntary act and deed on \_\_\_\_\_, 2021.

\_\_\_\_\_  
Notary Public

STATE OF OREGON                    )  
                                                  ) ss.  
COUNTY OF CLACKAMAS        )

TRUSTEE, Trustee, acknowledged this instrument to be \*\*\*Trustee Gender\*\*\* voluntary act and deed on \_\_\_\_\_, 2021.

\_\_\_\_\_  
Notary Public

**ACCEPTANCE OF OFFICE BY TRUSTEE**

TRUSTEE, the named Trustee in this instrument, accepts the office and responsibilities of Trustee.

DATED on \_\_\_\_\_, 2021.

\_\_\_\_\_  
TRUSTEE, Trustee

STATE OF OREGON                    )  
                                                  ) ss.  
COUNTY OF CLACKAMAS        )

TRUSTEE, Trustee, acknowledged this instrument before me on \_\_\_\_\_, 2021.

\_\_\_\_\_  
Notary Public

**SCHEDULE A**

**SAMPLE**

TRUSTEE, Trustee

Tax Identification Number: SSN

Asset transferred to trust at time of creation:

Account Location: \_\_\_\_\_

Account Number: \_\_\_\_\_

**Sources and Amounts of GROSS Monthly Income:**

Pension through

Civil Service Pension \$ \_\_\_\_\_

Social Security Administration \$ \_\_\_\_\_

National Guard Retirement \$ \_\_\_\_\_

Total Gross Monthly Income: \$ \_\_\_\_\_

Monthly Deposit Amount (after automatic deductions): \$ \_\_\_\_\_

These funds will be kept in a bank account opened in the name of “TRUSTEE, Trustee, or \*\*\*Trustee Gender\*\*\* successor in trust under SAMPLE, dated \*\*\*Closing Date\*\*\*” under the tax identification number of the trust.

**COMMITMENT TO TRANSFER**

I hereby promise to cause the income of the Beneficiary, at present \$ \_\_\_\_\_ from Social Security, Civil Service Pension, and Pension through the National Guard to be transferred to the Trustee of the SAMPLE.

DATED \_\_\_\_\_, 2021.

\_\_\_\_\_  
TRUSTEE, Trustee

**SCHEDULE B  
SAMPLE CLIENT  
Income Cap Trust**

The distribution plan of the Trustee, beginning with the month of October 2021, is as set forth here:

**October 2021**

**Total Monthly Income: \$2,470.24**

**Deductions:**

1.	Personal Needs Allowance/Maintenance Standard	\$	177.00
2.	Administrative Costs		
	Federal Taxes (if automatically withheld)	\$	0.00
	State Taxes (if automatically withheld)	\$	0.00
	Other Taxes (if automatically withheld)	\$	0.00
	Trustee Fees	\$	50.00
3.	Community Spouse Monthly Maintenance	\$	0.00
	Family Dependent Allowance	\$	0.00
4.	Health Insurance Premiums	\$	185.00
	Medicare B Premium	\$	148.50
5.	Other Reserves	\$	0.00
	Medical Bills, Burial Plan, Other	\$	0.00
6.	Other Incurred Medical costs (OIM)	\$	0.00
7.	Room & Board	\$	617.00
8.	Patient Liability	\$	1,292.74
<b>9.</b>	<b>Total amount paid to facility each month (includes Room &amp; Board and Patient Liability)</b>	<b>\$</b>	<b>1,909.74</b>





## Resource Assessment

Program:	Branch:	Case number:	Worker ID:
Case name:			
Date assessment requested:			
Date assessment completed:			

Name of person getting care:	Date of birth:	Social Security number:		
Spouse's name:	Date of birth:	Social Security number:		
Home address:				
Type of care ( <i>nursing facility care, in-home care, adult foster care, etc.</i> ):				
Name and address of place of care:	Date care started:			
		month	day	year
Enter the date the person getting care started getting care in their home, in the community or in a nursing facility. If there was a break in care that lasted <b>30 days or more</b> , enter the date care began again after the break.				

1. Complete all items below. Enter amounts owned by you, your spouse or both of you.  
(If none, write "none.")

	On the date care started			Now		
	Amount or value:	Who does it belong to?	Location and account number:	Amount or value:	Who does it belong to?	Location and account number:
Time certificate of deposit:	\$			\$		
PI funds:	\$			\$		
Money in safe deposit box:	\$			\$		
Bonds:	\$			\$		
Stocks:	\$			\$		
Trust fund:	\$			\$		
Money held for you by others:	\$			\$		

1. Complete all items below. Enter amounts owned by you, your spouse or both of you. *(Continued)*  
*(If none, write "none")*

	On the date care started			Now		
	Amount or value:	Who does it belong to?	Location and account number:	Amount or value:	Who does it belong to?	Location and account number:
Sales contract:	\$			\$		
Estate fund:	\$			\$		
Annuity:	\$			\$		
Cash on hand:	\$			\$		
Checking account:	\$			\$		
Savings account:	\$			\$		
Securities:	\$			\$		
Retirement fund:	\$			\$		
Other:	\$			\$		
<b>Agency use only</b> #1 countable resources:	\$			\$		

2. Complete all items below. Enter amounts owned by you, your spouse or both of you.  
*(If none, write "none")*.

	On the date care started			Now		
	Make, model and year:	Approximate value:	Amount owed:	Make, model and year:	Approximate value:	Amount owed:
Automobiles:		\$	\$		\$	\$
Motorcycle:		\$	\$		\$	\$
Boat:		\$	\$		\$	\$
Business equipment:		\$	\$		\$	\$
Camper:		\$	\$		\$	\$
Crops:		\$	\$		\$	\$
Farm equipment:		\$	\$		\$	\$
Livestock:		\$	\$		\$	\$

2. Complete all items below. Enter amounts owned by you, your spouse or both of you. (Continued)  
(If none, write "none").

	On the date care started			Now		
	Make, model and year:	Approximate value:	Amount owed:	Make, model and year:	Approximate value:	Amount owed:
Mining equipment:		\$	\$		\$	\$
Motor home:		\$	\$		\$	\$
Snowmobile:		\$	\$		\$	\$
Timber:		\$	\$		\$	\$
Tools of trade:		\$	\$		\$	\$
Trailer:		\$	\$		\$	\$
Other property:		\$	\$		\$	\$
<b>Agency use only</b> #2 countable resources:	\$			\$		

3. Do you or your spouse, own or are you buying: a house, mobile home, houseboat, other land or buildings? On the date care started?  Yes  No Now?  Yes  No

If yes complete the following:	On the date care started		Now	
	Property:		Property:	
Address:			1.	
Do you or your spouse live there? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, how do you use the property? (rent, lease, vacant, for sale)				
Type of property:				
Owner (name on title):				
Fair market value:	\$	\$	\$	\$
Amount owed:	\$	\$	\$	\$
<b>Agency use only</b> #3 countable resources:	\$		\$	

4. Do you or your spouse have burial or life insurance?  
 On the date care started?  Yes  No Now?  Yes  No

If yes complete the following:	On the date care started	Now
Type of insurance:		
Name of insured:		
Name of insurance company:		
Policy number:		
Face value:	\$                      \$	\$                      \$
Cash value:	\$                      \$	\$                      \$
<b>Agency use only</b> #4 countable resources:	\$	\$

5. Do you or your spouse have prepaid funeral plan?  
 On the date care started?  Yes  No Now?  Yes  No

Do you or your spouse have money left with others for funeral expenses?  
 On the date care started?  Yes  No Now?  Yes  No

If yes complete the following:	On the date care started	Now
Person covered:		
Who holds plan or money?		
Address of holder:		
Amount of plan or money:	\$	\$
<b>Agency use only</b> #5 countable resources:	\$	\$

6. Within the last 60 months, have you or your spouse sold, traded or given away any personal property (*cars or cash*) or real property (*land or buildings*)?  Yes  No  
 If yes, describe the situation:

\_\_\_\_\_

This form is not an application for Medicaid. You may apply for Medicaid at any time. Where would you like your copy of this form sent?

Name: \_\_\_\_\_ Phone number: \_\_\_\_\_

Mailing address: \_\_\_\_\_

\_\_\_\_\_  
 Signature of person requesting assessment Date

\_\_\_\_\_  
 Signature of agency eligibility worker Date

**Agency calculation**

**Step 1 Determine total countable resources**

Add together the countable resources from each question on this form.

Question number	On the date care started	Now
1.	\$ _____	\$ _____
2.	\$ _____	\$ _____
3.	\$ _____	\$ _____
4.	\$ _____	\$ _____
5.	\$ _____	\$ _____
<b>Total:</b>	<b>Box A</b> \$ _____	<b>Box B</b> \$ _____

**Step 2 Determine the community spouse's share of resources.**

Enter one-half of total countable resources on the date care started  
(from Step 1, Box A)..... \$ \_\_\_\_\_

**Step 3 Determine the community spouse's resource allowance.**

Check the largest amount:

- Spouse's share of countable resources (from Step 2)  
**(Effective January 1, 2018 limited to \$123,600.)** ..... \$ \_\_\_\_\_
- State community spouse resource allowance **(Effective January 1, 2018 the minimum community spouse resource allowance.)** ..... \$ 24,720.00
- Court ordered community spouse resource allowance..... \$ \_\_\_\_\_
- Spouse's resource allowance based on the amount necessary to generate income **(the amount required to purchase a single premium immediate annuity: OAR 461-160-0580[2][c][D]and [2][f][D]).** ..... \$ \_\_\_\_\_

**Step 4 Determine client's resources.**

Enter total countable resources now  
(from Step 1, Box B) ..... \$ \_\_\_\_\_

Subtract spousal allowance  
(Largest amount from Step 3.) ..... \$ \_\_\_\_\_

Resources available to client. .... \$ \_\_\_\_\_

**Step 5 Compare resources available to client to OSIP resource standard.**

Resources available to client (from Step 4) . . . . .	\$	_____
OSIP resource standard for one person . . . . .	\$	<u>2000.00</u>

<b>Decision</b>
-----------------

Please review the information below regarding your resource assessment.

- Resources are less or equal to the Medicaid standard
- Resources are over the Medicaid standard

**Oregon Administrative Rule - OAR 461-160-0580**

Countable resources at time of application. . . . .	\$	_____
Resources allowed for applicant . . . . .	\$	<u>2000.00</u>
Resources allowed for your spouse. . . . .	\$	_____

**Amount of excess resources.** . . . . . \$ \_\_\_\_\_

You may spend some of your resources on the cost of care and reapply at a later date. As of today, if you spent the **amount of excess resources** above, your resources would meet the Medicaid limit.

To be eligible, your resources cannot exceed: \$ \_\_\_\_\_  
 (total resources allowed for applicant and spouse above)

If you get more resources, this calculation will change. Please contact your worker.  
 The money you spend must be spent on items worth fair market value.  
 Otherwise, there could be a disqualification from Medicaid.

*If you disagree with this action, you have the right to a hearing.  
 Read your hearing rights below. Please call if you have a question.*

## Your Hearing Rights

What you can do when you do not agree with this decision:

- You have the right to challenge this decision by requesting a hearing. Hearings are held by the Office of Administrative Hearings, which is independent from the Department of Human Services (DHS) or Oregon Health Authority (OHA).  
If you want a hearing, you must request it on time.
- You can also talk with a manager. You can call a local office phone number listed at <http://www.oregon.gov/dhs/localoffices/localoffices.pdf>. Your deadline date to request a hearing (*part 1 below*) does not change even if you are in contact with a manager or are trying to reach one. If you still need further assistance, you may contact the Governor’s Advocacy Office at 1-800-442-5238.

---

### Part 1 — Ask for a hearing.

**What must I do to get a hearing?** For food benefits and medical eligibility, you can ask for a hearing on form MSC 0443, by phone, in writing, or by asking a DHS employee in person. For other benefits, you must fill out an Administrative Hearing Request form (MSC 0443) and return it to a DHS or OHA office. You can get this form at a DHS or OHA office or on the web at <https://apps.state.or.us/Forms/Served/me0443.pdf>. Your local office can help you with a hearing request. You may request a hearing at any time if you disagree with the current amount of your food benefits. You have 90 days to request a hearing for food benefits, medical eligibility, and for TANF reductions for not cooperating with your case plan. In other situations, DHS must receive your request within 45 days from the date on the notice.

**Note to military personnel:** Active duty service members have a right to stay (delay) these proceedings under the federal Servicemembers Civil Relief Act (SCRA). For more information, you may contact the Oregon State Bar (1-800-452-8260), the Oregon Military Department (1-800-452-7500) or the nearest legal assistance office, [legalassistance.law.af.mil](mailto:legalassistance.law.af.mil).

**Who can help with my hearing?** For food benefits and for medical programs, anyone may represent you. In all other programs, you must represent yourself or have a lawyer or a legal assistant (*supervised by a Legal Aid attorney*) represent you. You may call the Public Benefits Hotline (*a program of Legal Aid Services of Oregon and the Oregon Law Center*) at 1-800-520-5292 for advice and possible representation.

**What are my other hearing rights?** At the hearing, you can tell why you do not agree with the decision. You can have people testify for you. The laws about your hearing rights and the hearing process are at OAR 137-003-0501 to 0700, 410-120-1860, 410-141-0264, 461-025-0300 to 0375, ORS 183.411 to 183.470 and ORS 411.095.

**What happens if there is no hearing?** If you do not ask for a hearing on time, or if you withdraw the hearing request or miss your hearing, you may lose your right to a hearing. This notice will be the final DHS or OHA decision (*called a “final order by default”*). You will not get a separate final order by default. The case file, along with any materials you submitted in this matter, is the record. The record is used to support the DHS decision upon default. You may appeal the final order by default by filing a petition in the Oregon Court of Appeals (ORS 183.482). If you do not ask for a hearing, this appeal must be filed within 60 days of the date this notice becomes a final order, by default. If you withdraw a hearing request or miss your hearing, the appeal deadline is set out in the dismissal order.

---

### Part 2 — How can I keep getting benefits until my hearing?

- You can ask for your benefits to stay the same until the hearing decision (*“continuing benefits”*). For food and medical benefits, use form MSC 0443, phone, write or ask a DHS employee in person. In other programs, you must ask on the Administrative Hearing Request form (MSC 0443).
- You must ask your branch for continuing benefits by either the “effective date” on the notice, 10 days after the date of the notice, or (for medical only) 10 days after receipt of the notice. You must ask by whichever date is later.
- If you keep getting benefits but lose the hearing, you must pay back the benefits you should not have received.
- If you don’t keep getting benefits and win the hearing, DHS or OHA will give you the benefits you should have received.

---

### Part 3 — Can I have an expedited hearing?

You may have the right to an “expedited hearing” for any of the following types of benefits or situations:

- **Expedited or emergency food benefits**
- **JOBS and Pre-TANF payments**
- **Temporary Assistance for Domestic Violence Survivors (TA-DVS) eligibility and payments**
- **In a medical case, you have an immediate need for health services and standard timeline for the appeal process could jeopardize your life or health or ability to attain, maintain, or regain maximum function**
- **DHS or OHA denied your request to keep getting benefits until your hearing.**

---

**DHS and OHA do not discriminate against anyone. This means that DHS/OHA will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs, disability or sexual orientation. You may file a complaint if you believe DHS or OHA treated you differently for any of these reasons.**

MSC 0447 (01/14)

Reprinted with permission of the Oregon Department of Human Services. The Resource Assessment form (SDS 3401) is available here: <http://apps.state.or.us/Forms/Served/se3401.doc>.

## PART 2: MEDICAID ISSUES AND PLANNING STRATEGIES

### I. Spousal Impoverishment Protections

In 1988, Congress passed the Medicare Catastrophic Coverage Act (MCCA) which included specific provisions designed to avoid impoverishing the spouse of a Medicaid applicant. MCCA provides for the pooling and division of a married couple's total resources and allows the community spouse to retain a portion of the couple's resources in his or her name. These resources represent the Community Spouse Resource Allowance (CSRA). As a result of MCCA, the income of the community spouse is no longer deemed available to the ill spouse for the cost of his or her care. In addition, the community spouse is entitled to a Monthly Maintenance Needs Allowance (MMNA), which may include income diverted from the ill spouse.

**A. Community Spouse Resource Allowance.** The CSRA is composed only of countable resources. Medicaid uses a formula set forth at OAR 461-160-0580 to calculate the total amount of resources the community spouse is entitled to keep in his or her name while enabling the ill spouse to qualify for assistance. OAR 461-160-0580(2) sets forth a six-step process to use to determine how much the community spouse may retain in his or her name, and how much the couple will have to spend down in order to qualify the ill spouse for assistance:

1. The first step is the determination of what the couple's combined countable resources were *at the beginning of the most recent continuous period of care*<sup>2</sup> (also called the "snapshot date"). At this point in the computation, the couple's combined countable resources are considered available equally to both spouses.
2. The second step is the calculation of one half of what the couple's combined countable resources were at the beginning of the continuous period of care. The community spouse's half of the couple's combined resources is treated as a constant amount when determining eligibility.
3. The third step is the determination of the community spouse's resource allowance. The community spouse's resource allowance is the *largest of the following four amounts*:
  - a. The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care, but not more than \$130,380. (This number represents the maximum community spouse resource allowance and is indexed up annually.)
  - b. \$26,076 (This number represents the minimum community spouse resource allowance and is indexed up annually.)
  - c. A court-ordered community spouse resource allowance that, in relation to the income generated, would raise the community spouse's income to a

---

<sup>2</sup> Continuous period of care is defined as "Reside for a period of at least 30 consecutive days or until death in a long-term care facility, home and community-based care setting, or an acute care hospital. There must be sufficient evidence to show there is a reasonable expectation that the client will remain in care for at least 30 consecutive days. For the purposes of this policy, an interruption in care (for example, leaving and then returning to a nursing home, or switching from one type of care to another) that lasts less than 30 days is not considered a break in the 30 consecutive days of care. A new period of care begins if care is interrupted for 30 or more days." OAR 461-001-0030(2).

court- approved monthly maintenance needs allowance. (The rule specifies that the couple must use all of the ill spouse’s and the community spouse’s available income to meet the community spouse’s monthly maintenance needs allowance before any resources are used to generate interest income to meet the allowance, unless the Department determines that the resulting community spouse resource allowance would create an undue hardship on the spouse.) OAR 461-160- 0580(4).

- c. An enhanced resource allowance which, if invested, would raise the community spouse’s income to the monthly maintenance needs allowance. After considering the income of the community spouse and the income available from the institutionalized spouse, if the community spouse’s income falls short of his or her monthly maintenance needs allowance, the amount allowed under this provision is the amount required to purchase a single premium immediate annuity to make up the shortfall.
4. The fourth step is the determination of what the couple’s *current* combined countable resources are at the time the application for OSIPM is made.
5. The fifth step is the subtraction of the community spouse’s resource allowance from the couple’s current combined countable resources. The resources remaining are considered available to the ill spouse.
6. The sixth step is a comparison of the resources considered available to the ill spouse and the ill spouse’s resource allowance of \$2,000. Any remaining resources in excess of \$2,000 must be “spent down” in order for the applicant to qualify for assistance.

**B. Income of the Community Spouse.** After MCCA, the income of the community spouse is no longer counted when determining whether the ill spouse is eligible for assistance. However, the community spouse’s income is relevant when calculating the community spouse resource allowance, as discussed in more detail below.

**C. The Monthly Maintenance Needs Allowance (MMNA).** The community spouse’s income is not subject to any cap when determining eligibility for the ill spouse. However, the State has determined that the community spouse is entitled to a minimum amount in order to ensure that he or she has sufficient income for his or her support. The current Minimum Monthly Maintenance Needs Allowance (MMMNA) is \$2,177.50. This means that, if the community spouse’s monthly income is less than \$2,177.50, the ill spouse may be able to divert a portion of the ill spouse’s income to the community spouse so ensure that the community spouse has at least \$2,177.50 per month in income. If the community spouse has high shelter costs, however, he or she may qualify for an increased MMNA of up to \$3,259.50 under OAR 461-160-0620(3)(d)(A). A MMNA in excess of \$3,259.50 may be allowed under exceptional circumstances or if the community spouse would otherwise suffer significant financial distress. OAR 461-160- 0620(3)(d)(C). A court order for spousal support is generally required to increase the MMNA over \$3,259.50.

1. **Calculation of MMNA.** In order to calculate the monthly maintenance needs allowance, the community spouse’s shelter costs must be calculated. For the purpose of this calculation, shelter expenses are the rent or home mortgage

payment (principal and interest), taxes, insurance, required maintenance charges for a condominium or cooperative, and the full standard utility allowance for the SNAP program (currently, \$442). If the community spouse is residing a facility of some kind and pays an all-inclusive rate that covers items that are not allowable shelter expenses, including meals or housekeeping in an assisted living facility, or the rate includes utilities, to the extent they can be distinguished, these items must be deducted from the all-inclusive rate to determine allowable shelter expenses.

Next, \$653.25 is deducted from the community spouse's monthly shelter expenses. The result is added to the \$2,177.50. This sum or \$3,259.50 whichever is less, is the monthly maintenance needs allowance. OAR 461-160-0620(3)(d)(A).

2. **Calculation of Income Allowance.** The countable income of the community spouse is subtracted from the monthly maintenance needs allowance determined using the calculation set forth above. The difference is equal to the income allowance or the amount that the ill spouse (after deducting the personal needs allowance and room and board rate) is allowed to divert to the community spouse to help the community spouse reach his or her monthly maintenance needs allowance. OAR 461-160-0620(3)(d)(B).
3. **Enhanced Resource Allowance under OAR 461-160-0580(2)(c)(D).** If the community spouse's income is less than his or her monthly maintenance needs allowance, and if the ill spouse has insufficient available income to make up the shortfall, the community spouse may be entitled to an increased resource allowance for his or her support. To calculate the increased resource allowance, both the community spouse's income and the income that the ill spouse is able to divert to the community spouse are subtracted from the MMNA. The difference is the amount of additional income that the community spouse needs for his or her support. This monthly deficit or shortfall is multiplied by the community spouse's remaining life expectancy (in months). The result, to the extent that it exceeds the standard resource allowance the community spouse would otherwise be entitled to keep, is the CSRA.

- D. Spend down Considerations.** When a couple has excess resources that must be spent down in order for the ill spouse to qualify for assistance, they have several options. Depending on the couple's needs and the community spouse's circumstances, it may be advantageous for the couple to purchase irrevocable funeral plans for both spouses. (Irrevocable burial plans are excluded under OAR 461-145-0040(2)(c).) It may behoove the community spouse to pay down any debt that the couple may have, including a home mortgage or car loan. Since the couple can exclude the value of one vehicle (OAR 461-145-0360(4)(a)), the community spouse might want to trade in an old car and buy a more reliable one, or make improvements to his or her home, or buy some items for the home (personal property is also excluded under OAR 461-145-0390).

**PRACTICE TIP:** In cases where the ill spouse has not yet entered continuous care, and the couple is planning to spend down marital resources in order for the ill spouse to qualify for assistance, it is important to advise the client to delay beginning the spend-down until after the snapshot date.

*Single Premium Immediate Annuity.* In some cases, if the applicant is living in a nonstandard living arrangement (i.e., an institutional or care facility setting), and if the community spouse is in good health and would benefit from receiving additional monthly income, it may be appropriate to discuss the option of purchasing a single premium immediate annuity or Medicaid compliant annuity as a way to spend down some of the couple's excess resources.

*General requirements under OAR 461-145-0022(10):* In order for the annuity to be Medicaid compliant, the annuity must be:

1. Irrevocable and non-assignable;
2. Actuarially sound (i.e., it must pay principal and interest out in equal monthly installments over the actuarial life expectancy of the annuitant); and
3. Issued by a business that is licensed and approved to issue a commercial annuity by the state in which the annuity is purchased.

*Payout requirements:* The annuity may name the ill spouse or the community spouse as the annuitant, and must comply with one of the following paragraphs:

4. The first remainder beneficiary is the community spouse and, in the event that the spouse transfers any of the remainder of the annuity for less than fair market value, the Department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the ill spouse;
5. The first remainder beneficiary is the annuitant's child (who is under the age of 21, or any age and meets the Social Security Administration criteria for blindness or disability), and in the event that the child or a representative on behalf of the child transfers any of the remainder of the annuity for less than fair market value, the Department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the ill spouse; or
6. The first remainder beneficiary is the Department for up to the total amount of medical benefits paid on behalf of the ill spouse.

Payments from an annuity that meets all of the requirements set forth above are counted as unearned income to the payee.

## II. Impact of Gifts and Transfers.

As part of the Medicaid application the applicant is asked whether the applicant, and/or the applicant's spouse, have made any uncompensated gifts or transfers within the past 5 years (60 months). OAR 461-140-0210(5)(b). An uncompensated transfer made by either the Medicaid applicant, or by the applicant's spouse, may result in a penalty period during which the Medicaid applicant will not be eligible to receive Medicaid benefits.

**A. Penalty Calculation.** If an uncompensated transfer is made, and if the Medicaid applicant is otherwise eligible to receive benefits (i.e., he or she meets the income, resources, and disability eligibility criteria), then benefits will be denied and DHS will assess a penalty.

1. DHS calculates the penalty by dividing the total amount of the uncompensated transfer by \$9,551. OAR 461-140-0296(2)(k).

2. The result is the total number of months of long-term care that the amount transferred “could have” paid for and represents the length of the penalty period (during which time the applicant is ineligible to receive Medicaid benefits, even if he or she is otherwise eligible).

*Example: An uncompensated transfer of \$100,000 will result in a penalty calculation of 10.5 months.  $\$100,000 / \$9,551 = 10.5$ . Note that an applicant must apply for Medicaid benefits and disclose any uncompensated gifts or transfers in order to start serving the applicable penalty period.*

**B. Exempt Transfers.** If the Medicaid applicant has made any gifts or transfers within the 5 years prior to making an application for Medicaid, then DHS determines whether the transfer is considered to be disqualifying (meaning that the value of the asset is used to calculate a penalty period – see above for details), or if the gift/transfer can be considered exempt from any penalty calculation. The following gifts/transfers are considered exempt:

1. *Transfers of personal belongings.* OAR 461-140-0220(1). Personal belongings are defined as “...items needed for maintenance and occupancy of the home and personal items found in or near the home that are used on a regular basis, are ordinarily worn or carried by the individual, or otherwise have an intimate relation to the individual.” OAR 461-145-0390.
2. *Any assets sold or traded.* The sale or trade must be for compensation equal to or greater than fair market value. OAR 461-140-0220(2).
3. *Legal Claims.* The transfer was made in order to settle a legally enforceable claim against the asset or the Medicaid applicant. OAR 461-140-0220(4).
4. *Fraud, Etc.* The Medicaid applicant was the victim of fraud, misrepresentation, or coercion, and legal steps have been taken to recover the asset. OAR 461-140-0220(8).
5. *Single Premium Immediate Annuities (SPIAs).* Under OAR 461-145-0022 DHS allows for the purchase of certain commercial annuities if those annuities meet the criteria set forth in Part 2, Section I.D., above (Spousal Impoverishment Protections – Spend Down Considerations). If the annuity meets these requirements, then it is counted as unearned income, rather than as a resource, and the transfer of resources to purchase the annuity is considered an exempt transfer.
6. *Transfer Not for Medicaid Eligibility.* If the transfer was made exclusively for purposes other than establishing eligibility or maintaining benefits then the transfer is considered exempt. OAR 461-140-0242(2)(a). The rules further clarify that any transfer made for less than fair market value is presumed to be for the purpose of establishing or maintaining eligibility. This presumption is rebuttable with convincing evidence, other than the Medicaid applicant’s own statement(s). OAR 461-140-0242(5) – (6).

The burden of proof is on the Medicaid applicant. The applicant can meet the burden by showing any of the following [set forth at OAR 461-140-0242(6)(a) – (d) respectively]:

- (a) The decision to make the transfer was not within the applicant’s control;
- (b) At the time of the transfer, the applicant could not reasonably have anticipated applying for medical assistance;
- (c) Unexpected loss of resources or income occurred between the time of transfer and the application for medical assistance.
- (d) Because of other, similarly convincing circumstances, it appears more likely than not that the transfer was not made, in whole or in part, for the purpose of establishing or maintaining eligibility for benefits.

7. *Transfers to Community Spouse and/or to Blind or Disabled Child(ren)*. OAR 461-140-0242(2)(b) provides that resources transferred to the community spouse are considered exempt from the calculation of a penalty. Note, however, that the community spouse does have a limit on the amount of resources he/she can have while maintaining eligibility for the Medicaid applicant spouse (see section on Community Spouse Resource Allowance, or CSRA, under “Spousal Impoverishment Protections” in Part 2, Section I.A., above).

This rule also allows for the transfer of resources to or for the benefit of a blind and/or disabled child of the Medicaid applicant. This transfer must be arranged in such a way that no individual or entity, except the child, can benefit from the asset transferred in any way, whether at the time of transfer or at any time in the future.

For both of the above transfers (to a community spouse and/or to a blind or disabled child) any direct transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse or child who is blind or has a disability is not considered to be established for the benefit of either of those individuals.

Further, in order for a transfer to a trust to be considered exempt under this exception the trust instrument/document must provide for the spending of the funds involved for the benefit of the individual (spouse/disabled child) based on the life expectancy of the individual.

8. *Certain Trusts*. Transfers to certain types of trusts, as defined in OAR 461-145-0540(10) are exempt.
9. *Transfer of Home to Caregiver Child*. OAR 461-140-0242(3)(c) provides that the residence of the Medicaid applicant may be transferred to a natural or adoptive son or daughter who meets the following requirements:

The son or daughter resided with the applicant in the applicant’s home continuously for at least two years prior to the applicant’s admission to long-term care.

The son or daughter provides convincing evidence that he or she provided services that permitted the applicant to stay in the applicant’s residence for at least two years rather than in an institution or long-term care facility. The type of care required is detailed further in OAR 461-140-0242(3)(c)(C).

- C. **Hardship Waiver.** DHS has the discretion to waive disqualifications based on transfers if such disqualification would create an undue hardship on the applicant. Hardship is defined in greater detail in OAR 461-140-0300(3).

### III. Estate Recovery Developments

- A. **Estate Recovery Overview.** Under federal law, as a condition of participating in the Medicaid program, the State of Oregon must comply with federal estate recovery provisions set forth at 42 USC § 1396p. Accordingly, the Oregon Department of Human Services has procedures in place to recoup funds expended for medical assistance and long-term care from the estates of deceased Medicaid recipients.

1. *Timing of Medicaid Estate Recovery Claim.* There is generally no obligation to repay correctly provided benefits during the Medicaid recipient's lifetime, even if the individual receives assets that results in the termination of his or her benefits. The state must defer any claim to recover benefits to a Medicaid recipient until after the recipient's death. Additionally, if the Medicaid recipient is survived by a spouse, the State must also defer its claim until after the spouse has passed away. OAR 461-135-0835(3)(b).
2. *Notice to the Estate Administration Unit.* Any appointed personal representative, claiming successor of a small estate, or trustee petitioning the probate court to determine the claims of creditors of a settlor of a trust must send or deliver notice of the proceeding to the Estate Administration Unit, Office of Payment Accuracy and Recovery, Department of Human Services in accordance with OAR 461-135-0834(1). In addition, if the Department of Human Services has presented a claim in a probate proceeding, and the claim has not been settled or paid in full, the personal representative must provide the Department with notice upon filing the final account and general judgment of distribution, along with a copy of the final account, under ORS 116.093(5).
3. *Burial Expenses.* If the Department of Human Services has a claim against an estate for recovery of Medicaid assistance provided and where there would be insufficient assets remaining after any funeral costs to satisfy the Department's claim in full, the State will allow up to \$3,500 in estate assets, less any prearranged funeral trust, funds set aside for burial, life insurance policies specifically identified to pay for funeral expenses, or burial insurance, to be expended for funeral expenses and disposition of the remains of the decedent before the State's claim is paid. In cases where estate assets are insufficient to pay all claims in full, Oregon law prioritizes certain creditor claims over others. ORS 115.125. Specifically, "expenses of a plain and decent funeral and disposition of the remains of the decedent" have priority over an estate recovery claim by the Department. ORS 115.125(c). See also ORS 114.305(1). The probate code does not, however, provide any guidelines regarding the cost of a plain and decent funeral. Accordingly, the Department of Human Services has determined that a plain and decent funeral and disposition of the remains of a decedent (including all professional services and merchandise) can be arranged for an average cost of \$3,500. OAR 461-135-0833.

4. *Limit on Estate Recovery.* The state may not enforce its claim if the deceased recipient is survived by a child under age 21, a child with a disability, or a child with a visual impairment; and the child survives to the closing of the probate estate. OAR 461-135-0835(3)(d).
5. *Undue Hardship Waiver.* The Department may waive enforcement of any estate recovery claim if it finds that enforcing the claim would result in an undue hardship to the beneficiaries, heirs, or family members of the deceased client claiming entitlement to receive the assets of the deceased client. OAR 461-135-0841.

In determining whether an undue hardship exists, the Department considers the circumstances of the individual or individuals applying for the waiver to determine whether enforcement of the estate recovery claim would cause the waiver applicant to become eligible for assistance, and whether enforcement of the claim would cause the waiver applicant, who would otherwise be eligible for assistance, to become homeless. OAR 461-135-0841(2).

If the Department determines a waiver is warranted, the State may forgive all or part of the claim as the Department deems fit, or may accept a mortgage or trust deed in lieu of enforcement. OAR 461-135-0841(3).

The rules state that no waiver will be granted if the Department finds that the undue hardship was created by resort to estate planning methods by which the waiver applicant or deceased Medicaid benefits recipient divested, transferred or otherwise encumbered assets, in whole or in part, to avoid estate recovery, nor will a waiver be granted if the Department finds that the undue hardship will not be remedied by the grant of the waiver. OAR 461-135-0841(4)-(5).

6. *Assets Subject to Recovery.* The Medicaid rules define “estate” very broadly to include all real property, personal property, or other assets, wherever located, in which the recipient had any legal title or ownership or beneficial interest at the time of death of the recipient. This includes assets that the Medicaid recipient owned an interest in at the time of their death that pass through the recipient’s probate estate, as well as those assets that pass outside of probate through tenancy by the entirety, joint tenancy, tenancy in common, survivorship, life estate, transfer on death deeds, living trusts, or certain annuities. OAR 461-135-0832(12).

## **B. Current Issues in Estate Recovery**

1. *Definition of “Estate” Under Federal and Oregon Law.* 42 USC §1396p(a)(4) defines the term “estate” for purposes of Medicaid estate recovery: (A) shall include all real and personal property and other assets included within the individual’s estate, as defined for purposes of State probate law; and (B) may include, at the option of the State . . . any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in

common, survivorship, life estate, living trust, or other arrangement.” (Emphasis added.)

2. *Status of Nay v. Dep’t of Human Services*. As a refresher, Attorney Tim Nay asserted that DHS improperly amended OAR 461–135–0832(10)(b)(B)(viii) and OAR 461–135–0835(1)(e)(B)(iii) to expand Oregon’s Medicaid “estate recovery” provisions to include assets owned by a Medicaid recipient at the time of the recipient’s death, in addition to assets that the recipient conveyed to the recipient’s spouse or others within five years of the date of the Medicaid application or anytime thereafter. *Nay v. Dep’t of Human Servs.*, 267 Or. App. 240, 340 P.3d 720 (Or. App. 2014). The Oregon Court of Appeals agreed, and upon review, the Oregon Supreme Court affirmed. *Nay v. Dep’t of Human Servs.*, 360 Or 668, 385 P.3d 1001 (Or. 2016). For more information, see *Developments in Estate Recovery* by Julie Meyer-Rowett, *OSB Elder Law Newsletter*, Volume 23, Number 4, October 2020.

Note that *Nay v. Department of Human Services*, 267 Or App 240 (2014) and, *Nay v. Department of Human Services*, 360 Or 688 (2016) currently control estate recovery in Oregon.

- C. **Estate Recovery and the Oregon Health Plan on or after October 1, 2013.** The State cannot recover the cost of basic medical, dental and mental health care provided through the Oregon Health Plan (OHP) to recipients on or after October 1, 2013 who were under the age of 55 when the benefits were provided. The State can recover the cost of benefits provided through OHP for recipients over the age of 55 under limited circumstances.

1. *Benefits Subject to Estate Recovery for Recipients Over the Age of 55.* If a recipient receives OHP benefits on or after October 1, 2013 and is over the age of 55 at the time, the State will limit its Medicaid estate recovery claim to the amount of any benefits paid (including OHP and long-term care benefits) “during the time the Department was paying any of the cost of care of the individual in a nursing facility, home and community-based care (see OAR 461-001-0030), or in home services through the State Plan Personal Care Services (see OAR 411-034-0010) ....” OAR 461-135-0835(4)(f)(D).

#### IV. MAGI Medicaid

Prior to the expansion under the ACA, Medicaid provided health care coverage for low-income families with children, as well as the aged, blind, or disabled. MAGI Medicaid expands that coverage to include a larger number of low-income families and individuals.

MAGI stands for Modified Adjusted Gross Income. The name comes from one of the key eligibility tests for the expanded Medicaid coverage. Eligibility is determined by taking the Adjusted Gross Income (AGI) from the Medicaid applicant’s tax return and modifying it by adding tax-exempt incomes, such as Social Security, interest, and foreign investment income previously excluded from federal income tax. Thus, we have a modified AGI, or MAGI.

- A. **Coverage.** MAGI Medicaid is not intended to cover those individuals needing long-term care, or who are seeking Medicaid coverage due to a permanent disability. The coverage is designed to include nearly all non-pregnant adults under the age of 65 who have

household incomes of up to 133% of the Federal Poverty Level (FPL). 42 USC 1396(a)(10)(A)(i)(VIII), ACA Section 2001(a)(1).

MAGI Medicaid provides the same coverage as Oregon Health Plan Plus (OHP Plus), including:

1. Chemical Dependency
2. Dental
3. Hearing Aids and Hearing Exams
4. Home Health; private duty nursing
5. Hospice Care
6. Hospital Care (emergency, inpatient, and outpatient)
7. Immunizations
8. Labor, Delivery, and Post-Partum care
9. Laboratory and X-Rays
10. Medical care from a physician, nurse practitioner, or physician assistant
11. Medical equipment and supplies
12. Medical transportation
13. Mental health
14. Physical, occupational, and speech therapy
15. Prescription drugs
16. Vision

Below are the basic eligibility requirements for the various MAGI programs in the state of Oregon:

**B. Basic Eligibility Requirements**

1. *Income.* MAGI Medicaid is available for individuals with a modified household adjusted gross income (as described above) of 133% of the FPL, plus a 5% income disregard (effectively making the income limit for an individual 138% of FPL).
2. *Age.* MAGI Medicaid is only intended to cover persons who are between the ages of 19 and 65.
3. *No Medicare or Long-term Care Services.* MAGI Medicaid is not available to individuals who are eligible for Medicare, and/or who are either applying for or receiving long-term care services.
4. *No Resource Limits.* MAGI Medicaid does not set any asset or resource limits when determining eligibility.

5. *No Long-Term Care.* Persons needing long-term care for 30 days or more are not eligible for MAGI Medicaid. These persons will be assessed under the standard OSIPM Medicaid eligibility criteria discussed above.
6. *Enrollment.* MAGI recipients must enroll in a Coordinated Care Organization (CCO), a Prepaid Health Plan (PHP), or Physician Care Organization (PCO). Their OHP covered services must come through that plan or organization. OAR 410-120-0250.
7. *Copay – No Premium.* MAGI Medicaid recipients will not be charged a monthly premium. However, most MAGI recipients will be responsible for a co-payment of \$4 or less per medical service or prescription.

**C. MAGI Programs in Oregon.** OAR 410-200-0410 through OAR 410-200-0435 lists the various MAGI programs in the state of Oregon and their eligibility requirements. The programs and their respective OARs are as follows.

1. MAGI CHIP (Child Health Insurance Program) – OAR 410-200-0410
2. MAGI Child – OAR 410-200-0415
3. MAGI Parent or Other Caretaker Relative – OAR 410-200-0420
4. MAGI Pregnant Women – OAR 410-200-0425
5. MAGI Adult – OAR 410-200-0435





## Liability Worksheet for Long-term Care or Home and Community-based Care

### Step 1. List recipient income

a. Earned income amount.....	_____	
b. Unearned income amount.....	+	_____
c. Other income amount.....	+	_____
d. Standard earned income deduction of \$65.....	-	\$ 0.00
e. Deductions under self-support plan.....	-	_____
f. Deduct approved special needs <u>AND</u> OSIP maintenance		
\$64.94 for someone receiving long-term care services.....	-	_____
\$90 for eligible individual with VA benefits reduced to \$90.....	-	_____
\$1,294 for someone in in-home services.....	-	_____
\$794 for someone in other home and community-based care.....	-	_____
g. Deduct trust costs amount.....	-	_____
h. <b>Recipient adjusted income</b> .....	=	\$ 0.00 → <u>\$ 0.00</u>

### Step 2. Community spouse income allowance computation

a. Community spousal allowance standard is \$2,177.50	_____
b. Shelter expense:	
Rent or mortgage.....	_____
Taxes/insurance.....	+ _____
Food — SNAP ( <i>Supplemental Nutrition Assistance Program</i> )	
Federal Utility Allowance (FUA) \$442.00	+ \$ 0.00
Total shelter.....	= \$ 0.00
Shelter allowance is \$653.25.....	- \$ 653.25
Total allowance.....	= \$ 0.00 → + \$ 0.00
<b>Subtotal</b> ( <i>not to exceed CAP</i> ) \$3,259.50.....	= \$ 0.00
c. Spouse's gross income.....	- _____
<b>Total community spouse income allowance...</b> ( <i>Enter on line 4a.</i> )	= <u>\$ 0.00</u>

### Step 3. Dependent income allowance

From page 2 of this form (*3a or 3b*).....(*Enter on line 4b.*) = \$ 0.00

### Step 4. List deductions allowed from recipient income

a. Community spouse income allowance. ( <i>Step 2 computation above</i> ).....	\$ 0.00
b. Dependent income allowance. ( <i>Step 3 computation above</i> ).....	+ \$ 0.00
c. Possible Income Diversion to Spouse (LDS).....	= \$ 0.00
d. LDS amount ( <i>calculated</i> ). ( <i>Compare possible diversion with recipient's adjusted income. Whichever is less, is the LDS amount.</i> ).....	_____
e. Cost to maintain home. ( <i>Long term care only 461-160-0630</i> ).....	+ _____
f. Cost of uncovered medical expenses. ( <i>Including health insurance premiums of the client</i> ).....	+ _____
g. <b>Total recipient deductions</b> .....	= \$ 0.00 → - \$ 0.00

**Step 5. Recipient liability amount** (*subtract line 4g from line 1h.*) = \$ 0.00



## Changes to estate recovery of medical assistance

*This brochure includes changes made on Oct. 1, 2013, to the estate recovery program for medical assistance (sometimes called Medicaid).*

<b>Medical assistance paid to you BEFORE October 1, 2013</b>	
The following applies to medical assistance you received before Oct.1, 2013.	
The benefits were paid before October 1, 2013, and:	Estate recovery will seek reimbursement from your estate (as defined in ORS 416.350) of:
<ul style="list-style-type: none"> <li>You were 55 years or older.</li> </ul>	All medical assistance benefits, after you turned 55 years of age, including OHP. OHP benefits may include monthly fees paid to a coordinated care organization or managed care organization. Excluding, on or after January 1, 2010, Medicare cost sharing, such as Medicare co-pays, coinsurance, premiums and deductibles. QMB only benefits on or after January 1, 2010 are not included.

<b>Medical assistance for benefits paid to you ON or AFTER October 1, 2013</b>	
The following applies to medical assistance you received on or after Oct. 1, 2013.	
The benefits were paid on or after October 1, 2013, and:	Estate recovery will seek reimbursement from your estate (as defined in ORS 416.350) of:
<ul style="list-style-type: none"> <li>You were 55 years or older; and</li> <li>You received medical assistance to pay some or all of the cost of long-term care in:                             <ul style="list-style-type: none"> <li>An assisted living facility;</li> <li>A residential care facility;</li> <li>An adult foster home;</li> <li>In-home care, including the State Plan Personal Care program;</li> <li>A nursing facility;</li> <li>An intermediate care facility for individuals with intellectual or developmental disabilities; or</li> <li>Other similar long-term care.</li> </ul> </li> </ul>	All medical assistance benefits, including OHP you received since age 55 while getting long-term care benefits. OHP benefits may include monthly fees paid to a coordinated care organization. Excluding, on or after January 1, 2010, Medicare cost sharing, such as Medicare co-pays, coinsurance, premiums and deductibles. QMB only benefits on or after January 1, 2010 are not included.

This table was published by the Oregon Department of Human Services in its Estate Recovery Program brochure (MSC 9093) and is reprinted with permission of the department. This table is informational only and does not supersede statutes or rules and is subject to change without notice. The Estate Recovery Program brochure (MSC 9093) is available here: <https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/me9093.pdf>.

