

EVALUATING ANNUITIES (JOB AID)

Use this guide to determine if an annuity transaction is a potential transfer of asset. Do not use for IRA or annuities that were established by an employee or their employer relative to work.

STEP 1	<p>Was one or more of the following annuity transactions made on or after November 1, 2007, (within the look back period) by or on behalf of an <u>applicant/recipient</u>?</p> <p>(a) purchase of an annuity (b) addition of funds to an annuity (c) elective withdrawals (other than regular scheduled payments) from the annuity; (d) changes to the annuity distribution; or (e) annuitizing of an annuity purchased prior to November 1, 2007</p>	<p>YES NO</p>	<p>If YES, continue to Step 2. If NO, evaluate the annuity under pre-DRA policies, and Go to STEP 9 if there is a community spouse</p>
STEP 2	<p>Is the annuity irrevocable? If annuity language does not state "irrevocable", consider the annuity can be revoked, unless evidence to the contrary is provided.</p>	<p>YES NO</p>	<p>If YES continue to Step 3. If NO, count the amount the purchaser would receive from the annuity issuer if the account was cancelled.</p>
STEP 3	<p>Is the annuity non-assignable? If annuity language does not state "nonassignable," consider the annuity assignable, unless evidence to the contrary is provided.</p>	<p>YES NO</p>	<p>If YES continue to Step 4. If NO, count the amount the annuity can be sold for on the secondary market.</p>
STEP 4	<p>Is the annuity actuarially sound (pays back all principal and interest within the life expectancy of the annuitant)? <i>Refer to passage 1640.0609.02 in the manual for procedure to determine actuarially sound.</i></p>	<p>YES NO</p>	<p>If YES, continue If NO, apply transfer of assets policies</p>
STEP 5	<p>Does the individual have a spouse, minor child or a disabled adult child in the community?</p>	<p>YES NO</p>	<p>If YES, continue to STEP 6 If NO, go to STEP 7</p>
STEP 6	<p>If "YES" to STEP 5, does the annuity name the spouse, minor child, or disabled adult child in the first beneficiary position and the state in either the first position OR the second remainder beneficiary position?</p>	<p>YES NO</p>	<p>If YES, Go to STEP 8 If NO, apply transfer of asset policies.</p>
STEP 7	<p>If "NO" to STEP 5, does the annuity name the state (AHCA) in the first position as remainder beneficiary</p>	<p>YES NO</p>	<p>If YES, continue to Step 8 If NO, apply transfer of asset policies</p>
STEP 8	<p>Does the annuity pay the applicant/recipient interest and principal in equal monthly payments with no balloon payments?</p>	<p>YES NO</p>	<p>If YES, do not consider the annuity under transfer of asset provision; exclude the annuity as an asset; count payments (principal & interest) as unearned income in eligibility and patient responsibility AND continue to STEP 9 if there is a community spouse. If NO, apply transfer of assets policies. AND continue to STEP 9 if there is a community spouse.</p>
STEP 9	<p>At the point of application, was one or more of the following annuity transactions made on or after November 1, 2007 (within look back period) by or on behalf of a <u>community spouse</u>?</p> <p>(a) purchase of an annuity (b) addition of funds to an annuity (c) changes to the annuity distribution; or (d) Annuitizing of an annuity purchased prior to the November 1, 2007.</p>	<p>YES NO</p>	<p>If YES, go to STEP 10 If NO, evaluate the annuity under pre-Deficit Reduction Act policies.</p>
STEP 10	<p>Does the community spouse's annuity name the state (AHCA) in the first position (or in the second position after the institutionalized spouse's minor child or disabled adult child) as remainder beneficiary and is the community spouse's annuity actuarially sound? <i>Refer to passage 1640.0609.02 for procedure to determine actuarially sound.</i></p>	<p>YES NO</p>	<p>If YES apply no transfer of asset policies. If community spouse is asking for income allowance, count payments of principal & interest as community spouse's unearned income when determining the applicant/recipient's patient responsibility. If NO, apply DRA transfer of assets policies.</p>



LETTER TO ANNUITY ISSUER

Date _____

To: _____

_____Re: _____
Account No. _____

This letter is to notify your company that the person referenced above receives Medicaid (or is the spouse of a Medicaid recipient) in the State of Florida and informed our Department of his/her ownership interest in an annuity issued through your company. Receipt of Medicaid subjects the above named person to the provisions enacted under the Deficit Reduction Act of 2005 (Pub.L. 109-171) and codified as 1917(c)(3)(F); 1917(c)(3)(G) and 1917(e) of the Social Security Act.

The law requires, as a condition of receiving Medicaid funded long-term care services, that the owner and spouse:

- Disclose his/her ownership interest in any annuity, and
- Name the State in the first position as remainder beneficiary of the annuity, unless the individual has named their spouse, or minor or disabled child in the first position. In this event, the state has the right to be named as remainder beneficiary in the position following the spouse and/or the minor or disabled child.

As remainder beneficiary in the first position, the law requires that the state shall be paid (at the owner's death) all proceeds remaining in the annuity account up to the total amount of Medicaid dollars paid for the individual's care. Contact the following agency to settle accounts:

Health Management Systems, Inc.
2002 Old St. Augustine Road, Suite E-42
Tallahassee, FL 32301-4887

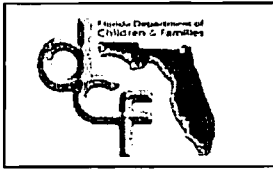
Attached, is a copy of the annuity at the point Medicaid was approved. We are requesting your cooperation in notifying the Department of Children and Families if any of the following changes in the annuity contract are made:

- A change in the owner or annuitant.
- A change in the beneficiary designation naming an entity other than the State in the first position.
- A change in the amount of income or principal disbursed from the annuity.
- Additions of funds to the annuity principle.
- A change in the disbursement period.

We will review the individual's Medicaid eligibility annually and may request re-verification of their annuity during the review process.

If you have questions about this letter, please contact me.

Eligibility Specialist Name/Phone Number	Office Address
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THIRD PARTY RECOVERY TRANSMITTAL

DATE: _____

RE: _____
(Medicaid recipient)

TO: Health Management Systems, Inc.
202 Old St. Augustine Road, Suite E-42
Tallahassee, FL 32301-4887

RE: _____
(Spouse, if spouse's annuity)

PIN: _____

CASE NO. _____

This transmittal is to provide the following documents or information regarding the above named recipient:

- Approved income trust
- Approved trust for the disabled (including pooled trusts)
- Approved annuity naming the state of Florida as beneficiary.
- Medicaid recipient (or spouse) died on _____. Please contact the annuity issuer to settle the account.
- Disregarded assets based on benefits paid by Long-Term Care Insurance Partnership Policy (to be also disregarded for estate recovery purposes):
\$ _____

If you have questions about this matter, please contact the individual named below.

Eligibility Specialist Name/Phone Number	Office Address
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OFFICE OF INSURANCE REGULATION
Life & Health Product Review

APPROVED LONG TERM CARE PARTNERSHIP PROGRAM POLICY SUMMARY

- 1. Name of insured _____
- 2. Policy/certificate number _____
- 3. Effective date of coverage _____
- 4. The policy/certificate was issued in the state of _____
- 5. Issue age of the insured at the time the coverage was issued _____
- 6. The policy/certificate was issued With Without inflation coverage
- 7. The inflation coverage is Simple Inflation Compound Inflation None
- 8. The inflation coverage is currently in effect on the coverage Yes No
if no, the date inflation coverage ceased _____
- 9. The policy is intended to meet the standards of a tax qualified long-term care policy Yes No
- 10. The cumulative dollar amount of insurance benefits paid \$_____ (Note: The indicated amount does not include any payments for cash surrender, return of premium death benefits, or waiver of premium, and if joint coverage, the amount is for the indicated insured only)
- 11. The total dollar amount of insurance benefits remaining available under the policy \$_____
- 12. As of date for which this form was completed _____
- 13. The name, phone number and email address of the person completing this form

Name

Phone Number

Email Address

I hereby certify that the above information is true and accurate and that the coverage meets partnership status in Florida at the time of this certification.

Signature

Date: _____

Dear _____ :

We have determined that you gave away, reduced the value of, or sold the following asset(s) or income for less than fair market value.

XXXXXXXXX (*asset/income*);

The remaining uncompensated value is XXXXXXXXXXXX.

The uncompensated value amount is the difference between what the asset or income was worth (fair market value) and the value of what you received for the asset or income.

When you give an asset or income away, reduce the value of it, or sell it for less than it is worth, we must presume that you did this to receive Medicaid benefits. This action may result in your being ineligible for Medicaid Institutional Care program, Institutional Hospice, Home and Community Based Services programs, and Program of All-Inclusive Care for the Elderly, unless you present to us clear and convincing evidence that:

You gave away, reduced the value of, or sold the asset (or income) solely for a reason other than to receive Medicaid, OR

You would have a hardship situation because you cannot pay for food, clothing, a place to live, or medical care and your health or life would be endangered if a penalty period is imposed and you do not receive Medicaid under the above referenced programs. In order for the undue hardship waiver provision to apply, you must make all efforts to recover the transferred asset (or income), or to receive fair compensation.


You or your designated representative must contact the eligibility specialist whose name and telephone number appear above within 15 calendar days of the mailing date on this notice to discuss this matter.

With your consent or the consent of your designated representative, your facility may request a hardship exception on your behalf.

If we do not hear from you within 15 calendar days of the mailing date on this notice, we must presume that you made the transfer for the purpose of receiving Medicaid. We will send you a formal notice of your Medicaid eligibility status, including your rights to a fair hearing, when the final determination is complete.

The following individuals are members of this assistance group:

Joe Client

	REBUTTAL/UNDUE HARDSHIP QUESTIONNAIRE
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Print Name: _____ Case Number: _____

Instructions: Staff will ask the client or designated representative each of the following questions and accurately and completely record the individual's responses. Questions 1 – 7 apply to developing transfer rebuttal. Questions 8 – 12 apply to developing undue hardship claim.

(1) Explain why you (or someone acting on your behalf) transferred: _____ (asset/income determined transferred) and to whom: _____ (relationship)

(2) What is your reason for accepting less than fair market value for the asset/income.

(3) How was your health when the assets were transferred? *(If questionable, staff may contact CARES or other medical source for existing documentation of the client's health at time the asset was transferred, or request the client provide substantiation of their statement.)*

(4) How did you plan to pay for your healthcare expenses after your assets were transferred?

- (5) If you transferred your home, what arrangements did you make for a place to live?
(Ask this question only if the home or interest in the home was transferred.)
- (6) If someone disposed of your assets without your knowledge and agreement, was a report of exploitation made to the abuse registry or with the police? If not, why not? If so, explain. *(Staff may ask the client to provide documentation or contact Adult Services or the police department to confirm. Provide a copy of client's signed release of information form (CF-ES 2613) if information requested from source other than client.)*
- (7) Have the assets been returned to you or can the assets be returned to you? Explain.
(If assets have been returned, staff must ask the individual to provide proof.)
- (8) What efforts have you made to get the assets back or to receive fair compensation? *(If questionable, staff may ask the individual to provide documentation to support the statement.)*
- (9) Have you received a notice of discharge from the nursing facility or assisted living facility due to nonpayment of charges? *(If individual answers yes to this question, staff must verify notice of discharge by asking individual to provide a copy or by contacting the facility and requesting a copy.)*

(10) Is there a safe place where you can live if you are discharged from the facility?

(11) How will your health or life be affected if you are unable to qualify for Medicaid to help pay the cost of your care? *(Staff may contact CARES or other medical source for existing documentation of the client's current health status, or request the client provide documentation of their statement.)*

(12) Ask the individual if he/she will be deprived of any of the following if determined ineligible for Medicaid long-term care services. Ask the individual to explain why and record responses.

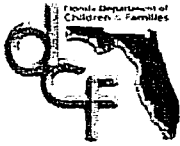
- Food
- Place to live
- Clothing
- Medical care
- Other necessities of life *(describe)* _____

Interview was completed by _____

Interview was completed with _____

(Relationship to applicant/recipient) _____

Date and time of interview: _____



NOTICE OF EXCESS HOME EQUITY INTEREST

Name: _____ Date Mailed: _____

Address _____ Case Number: _____

Dear _____:

We have determined that your equity interest in your home is greater than \$500,000. Due to your equity interest, you will be ineligible for Medicaid institutional care, institutional Hospice, Program of All-inclusive Care for the Elderly (PACE), or Home and Community Based Services waiver programs.

The home equity limit may be waived if:

- Your spouse, minor child, or blind or disabled child is living in your home; OR
- You provide clear and convincing evidence that you would have an undue hardship situation because you cannot pay for food, clothing, a place to live or medical care and your health or life would be endangered if you do not qualify for institutional care, institutional Hospice, PACE, or HCBS Medicaid assistance.

You or your designated representative must contact the eligibility specialist whose name and phone number appear below within 15 calendar days of the mailing date on this notice to discuss this matter.

With your consent, or the consent of your designated representative, your facility may request an undue hardship exception on your behalf.

If we do not hear from you within 15 calendar days of the mailing date on this notice, we will send you a formal notice of your Medicaid eligibility status, including your rights to a fair hearing, when the final determination is complete.

Eligibility Specialist:

Office Address/Phone Number



WAIVER of HOME EQUITY LIMIT QUESTIONNAIRE

Print Name: _____ Case No. _____

Instructions: Staff will ask the client or designated representative each of the following questions and accurately and completely record the individual's responses. If the answer to either question 1 or 2 is "yes", home equity interest exceeding \$500,000 is not a factor and development of undue hardship is not necessary.

- (1) Is your spouse residing in your home? If the answer is yes, what is his/her name.
- (2) Is your child (or children) under age 21 or your blind or disabled child of any age residing in your home? If the answer is yes, what are their name(s) and relationship(s) to you? *(If blind or disabled child over 21 is residing in the home, verification of a federal or state disability or blindness decision is required.)*
- (3) How will your health or life be affected if you are unable to qualify for Medicaid to help pay the cost of your care? *(Staff may contact CARES or other medical source for existing documentation of the client's current health status, or request the client provide documentation of their statement.)*
- (4) Ask the individual if he/she will be deprived of any of the following if determined ineligible for Medicaid long-term care services. Ask the individual to explain why and record responses.
- _____ Food
 - _____ Place to live
 - _____ Clothing
 - _____ Medical care
 - _____ Other necessities of life *(describe)* _____

Interview was completed by _____

Interview was completed with _____

(Relationship to applicant/recipient) _____

Date and time of interview: _____



REBUTTAL / UNDUE HARDSHIP EVALUATION

Date: _____	Client: _____
To: _____ (Region/Circuit Program Specialist)	Case Number: _____
From: _____ (ESS Name) (Unit)	Program Requested: _____
Telephone No.: _____	Living Arrangement: _____

Reason for rebuttal/undue hardship waiver request is due to the following: (Check all that apply)

- Potential transfer of asset (or income) penalty, or funds in revocable/irrevocable trust causes ineligibility.
(Complete #1 and 2 in Part I. Continue to Part II, if necessary.)
- Individual's equity interest in home exceeds \$500,000.
(Complete #3 in Part I. Continue to Part II, # 2, if necessary.)

Part I – Transfer Rebuttal /Home Equity Exception Evaluation	Processor
<p>1. Transfer of Asset(s) or Income (If not applicable, check N/A)</p> <p>a. Were the assets returned or further compensation received that fully compensates the value of the transferred asset?</p> <p>b. Did the individual present clear and convincing evidence the asset was transferred solely for a reason other than to become or remain Medicaid eligible?</p> <p>c. Was there a finding of exploitation by Adult Services or a court?</p> <p>[If answer to any of the above questions is "Yes", rebuttal is successful, Check <i>Rebuttal Approved</i> in #2 and approve ICP, institutional Hospice, HCBS, or PACE Medicaid. A hardship evaluation is not necessary. Region/Circuit office signoff is not required.]</p> <p>If answers to <u>all</u> above are "No", check <i>Rebuttal Unsuccessful</i> in #2 below and continue to Part II, #1.</p>	<p><input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Rebuttal Evaluation Results</p> <p><input type="checkbox"/> Rebuttal Successful.</p> <p><input type="checkbox"/> Rebuttal Unsuccessful. (If rebuttal unsuccessful, continue to Part II, for Hardship Evaluation.)</p>	
<p>3. Home Equity Interest Exceeds \$500,000 (If not applicable, check N/A)</p> <p>Is individual's spouse, minor child or blind or disabled child residing in the home?</p> <p>If "Yes", approve ICP, institutional Hospice, HCBS, or PACE Medicaid. A hardship waiver is not necessary and Region/Circuit office signoff is not required.</p> <p>If "No", Continue to Part II, # 2.</p>	<p><input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

_____ Processor's name	_____ Unit	_____ Date
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DATE: _____

TO: _____

(Region/Circuit Specialist)

Part II: Undue Hardship Evaluation	Processor		Region/Circuit Agree
1. Has the individual exercised all efforts to recover transferred assets or to receive fair compensation? (This item does not apply to Home Equity Exceeding \$500,000) (If answer is "no", go to Part III and deny undue hardship waiver. If answer is "yes" continue).	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does individual allege deprivation of any of the following? If Yes, check all that apply: <input type="checkbox"/> Medical care <input type="checkbox"/> Shelter <input type="checkbox"/> Food <input type="checkbox"/> Clothing or other necessities of life (If answer is "no", go to Part III and completely deny undue hardship waiver. If answer is "yes" continue.	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Medical care available to the individual (check all that apply). <input checked="" type="checkbox"/> Medicaid (except for long-term care services- MI T) <input type="checkbox"/> Medicare A <input type="checkbox"/> Medicare D <input type="checkbox"/> Other <input type="checkbox"/> Medicare B <input type="checkbox"/> Private ins <input type="checkbox"/> Inadequate medical care			
4. Evidence supports endangerment due to deprivation of medical care because medical coverage is inadequate.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Costs/allowance \$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Evidence supports deprivation of shelter	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Evidence supports deprivation of food	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Evidence supports deprivation of clothing or other necessities of life	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Transfer of Assets/Income - complete if transfer of assets/income case: a. Individual's gross monthly income \$ _____ b. Individual's total countable assets \$ _____ (does not include Community Spouse Resource Allowance (CSRA))			
9. Does the individual's income alone (8a), or income together with the countable assets (8a +8b) equal or exceed the total cost for items 4 -7 for one or more months? \$ _____ (see item instructions)		\$ _____ (total of 4-7)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 9 is less than the total of 4-7 above, the individual is eligible for the hardship waiver. If 9 is equal to or more than the total of 4-7 above, individual is ineligible for the hardship waiver for the period of month(s) in which the individual's resources, together with monthly income, can be used to pay for costs for which the individual otherwise would be deprived.			
10. Home Equity Interest - complete if home equity interest case a. Individual's gross monthly income \$ _____ b. Individual's total countable assets \$ _____ (does not include CSRA)			
11. Does the individual's income alone (10a), or income together with the countable assets (10a +10b) equal or exceed the total cost for items 4 -7 for one or more months? \$ _____ (see item instructions)		\$ _____ (total of 4-7)	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 11 is less than the total of 4-7 above, the individual is eligible for the hardship waiver. If 11 is equal to or more than the total of 4-7 above, individual is ineligible for the hardship waiver for the period of month(s) income, together with asset distribution, can be used to pay for costs for which the individual otherwise would be deprived.			
Part III: Undue Hardship Waiver Evaluation Results			
<input type="checkbox"/> Hardship Waiver is Granted beginning _____ (month/year) and ongoing. <input type="checkbox"/> Hardship Waiver is Denied for _____ (month(s)/year). <input type="checkbox"/> Hardship Waiver is Denied. Comments: _____			
Region/Circuit Specialist's Signature _____		Title _____	Date _____

FORM CF-ES 2357 REBUTTAL/HARDSHIP EVALUATION INSTRUCTIONS

General Instructions - The eligibility specialist completes the entry under "processor" column on page 1 and page 2. The second column of "yes"/"no" responses (hardship evaluation) is entered by the Region/Circuit office staff who reviews the work completed by the eligibility specialist and agrees or disagrees with the finding. The column titled "cost/allowances" is entered by the eligibility specialist.

Client, Case #.	Self-explanatory
Program Requested	Enter the program the individual is applying for or receiving.
Living Arrangement	Enter whether individual is residing at home, in an assisted living facility, or in a nursing facility.
Reason for Request	Check the reason(s) a rebuttal or undue hardship waiver is requested and follow the item instructions regarding how to proceed.

Part I

Item 1	Review the <i>Rebuttal/Hardship Request</i> (questionnaire). Determine if responses to questions and documentation satisfactorily support the rebuttal criteria and follow instructions for this section provided on the form.
Item 2	Indicate if rebuttal is successful or unsuccessful. If rebuttal is successful, the evaluation is complete. Proceed to signature, title and date. There is no need to send documents to the Region/Circuit program office. Scan all documents not already scanned. Follow FLORIDA instructions for completing the case and providing appropriate notice.
Item 3	Review the <i>Request for Waiver of Home Equity Limit</i> (if applicable). Follow the instructions provided on the form. Proceed to signature, title and date.

Part II

Item 1	Determine if individual's response to the questionnaire #3 and evidence submitted indicate that all efforts to recover the transferred asset(s) or to receive fair compensation have been exhausted? If the answer to this question is "No", hardship waiver <u>cannot</u> be granted. Go to Part III and deny hardship waiver. If the answer is "yes" continue.
Item 2	Check the client responses to #12 of the <i>Rebuttal/Undue Hardship Questionnaire</i> or #4 of the <i>Waiver of Home Equity Limit Questionnaire</i> . Follow item instructions on the <i>Evaluation</i> form.
Item 3	Review the case file and check all types of medical care coverage plans owned by the individual. Note: Medicaid, except for long-term care services is already marked. Regarding transfers, if the individual fails the rebuttal and hardship criteria, s/he still qualifies for MI T (basic Medicaid) coverage, presuming the individual meets all other factors of eligibility. Refer to FLORIDA instruction for processing "MI T-like" coverage for Home Equity Exceeding \$500,000. Definition of endangerment: Endangerment means the absence of medical care will cause acute symptoms in sufficient severity that will result in (a) serious jeopardy to the health of the individual or (b) serious impairment of bodily functions, or (c) serious dysfunction of a bodily organ or part.
Item 4	Does the individual's explanation and supporting documents prove endangerment to life and/or health due to deprivation of medical care? Check "yes" or "no". Note: Keep in mind that Medicaid (except for long-term care services), as well as individual's Medicare or other health insurance (if applicable) will provide medical care, including long-term care services in certain situations.

**Item 4
(continued)****Cost/Allowances Column**

If Yes, refer to page 1 of the form for the individual's program type.

- **Nursing facility:** Contact the nursing facility bookkeeper or administrator and ask for the current per diem rate for direct care. Multiply by 30 to obtain the monthly amount. If the facility is unable to provide the information, request the Region/Circuit specialist to contact central office. Central office staff will obtain the information from AHCA headquarters and relay to the Region/Circuit specialist.

- HCBS waiver: Enter the Medicaid HCBS services rate for the specific waiver program if HCBS applicant/recipient. (Contact the client's HCBS case manager to obtain the monthly charges for services based on the client's habilitation plan).
- Hospice: Enter the hospice services rate for ICP Hospice applicants/recipients (Contact the Hospice case manager to obtain the per diem or monthly charges for services). If per diem charges apply, multiply by 30 to get monthly amount.
- PACE: Enter the PACE services rate for PACE applicants/recipients (Contact the PACE case manager to obtain the per diem or monthly charges for services). If per diem charges apply, multiply by 30 to get monthly amount.

If No, enter zero.

Item 5

Does the individual's explanation and supporting documents prove deprivation of shelter due to eminent discharge from the placement facility, (i. e. nursing facility, assisted living facility) and there is no other safe place for the individual to reside. If the individual is residing at home, documentation must show that the individual will lose the ability to continue to live at home or another safe place. Check "Yes" or "No".

Cost/Allowances Column

If Yes and individual is residing in:

- Nursing Home: Contact the nursing facility bookkeeper or administrator and ask for the current Fair Rental Value System (FRVS) per diem amount. Multiply by 30 to obtain the monthly amount. If the facility is unable to provide the information, request the Region/Circuit specialist to contact central office. Central office staff will obtain the information from AHCA headquarters and relay to the program specialist.
- Assisted living facility, contact the facility to verify the charges for room only and enter the amount.
- Own home or home of other, use shelter costs, i. e. rent, mortgage (including principal and interest), taxes, home owner's insurance, mandatory condominium fees or mandatory homeowner associations fees and enter the amount.

If No, enter zero.

Item 6

Does the individual's explanation and supporting documents prove deprivation of food? Check "Yes" or "No".

Cost/Allowances Column

If Yes, enter the maximum Food Stamp rate for one.

If No, enter zero.

Item 7

Does the individual's explanation and supporting documents prove deprivation of clothing and other life necessities? Check "Yes" or "No".

Cost/Allowances Column

If Yes, enter \$35.

If No, enter zero.

Item 8 – 11

Enter individual's gross monthly income and total countable assets in 10a and 10b. Determine if the monthly income alone, or income combine with a portion of the total assets, is enough to cover the costs for which the individual has proven deprivation. For example, an MI I recipient has monthly income of \$1000 and \$1,500 in his bank account. Evidence submitted indicates he is endangered and would be deprived solely of medical care if a penalty period is assessed. The cost of his medical care is verified to be \$1500 per month. His income alone will not cover the cost; however, his assets can be used for 3 months to help cover the costs of his medical care. Therefore, the hardship waiver is denied for the first three months the individual is otherwise eligible (e.g. coverage is requested for November 2007 and ongoing, hardship waiver is denied for November, December, and January because his income of \$1000 per month, plus \$500 from assets each month covers the cost. The individual is placed in MI T coverage. An expected change is set for February 1 to return to the case and approve MI I for February and ongoing months.

Part III

The Region/Circuit Program Specialist shall review the items checked by the processor and determine if the processor's evaluation of the situation is appropriate. If the Region/Circuit specialist disagrees, contact should be made with the processor and/or their supervisor to discuss the discrepancy. The Region/Circuit specialist may override the processor's decision, since the Region/Circuit is responsible for making the final decision regarding hardship. The Region/Circuit specialist will fax the signed form to the unit no later than the 10th day after undue hardship waiver request was received by the department, followed by hard copy.

HOW TO PROCESS TRANSFERS FOR WAIVERS AND INSTITUTIONAL CARE

Currently the FLORIDA system computes the ineligibility period for Long Term Care Medicaid (ICP and Waivers, including PACE). NOTE: The system does not consider Transfers for Hospice, therefore, you must use a different process: HOW TO PROCESS TRANSFERS FOR HOSPICE ASSISTANCE GROUPS

Use this process if it is determined that an individual applying for ICP and Waivers, including PACE have transferred an asset, including Promissory Notes, Loans and Mortgages that have been determined to be a transfer or if the individual has purchased a Life Estate in another person's home on or after the implementation date and it is considered to be a transfer.

- transfers made prior to November 2007 –The system currently calculates the ineligibility period in months (not fractional months).
- transfers made on or after November 2007 – You must manually calculate the ineligibility period in fractional months. Divide the average nursing home cost (TMEP Table) into the uncompensated value of the transfer. If the amount results in a decimal, the decimal is multiplied by 30 and added to the months so that the ineligibility period is determined in months and days.

STEP	ACTION
1	Determine the individual's "Look Back Period" according to policy. Enter in CLRC: LOOK BACK DATE FOR TRANSFERS IS MM/DD/CCYY FOR FIRST/LAST NAME. example: LOOK BACK DATE FOR TRANSFERS IS 03/04/2007 FOR Su Smithee.
2	<p><i>On AAAT enter the earliest transfer in the "look back period". Note: The following fields are essential in computing the ineligibility period:</i></p> <ul style="list-style-type: none"> ✓ TYPE: Enter type of asset: VH (Vehicle); RP (Real Property); LI (Life Insurance); LA (Liquid Asset) ✓ VALUE: Enter the amount of the property value "prior to transfer". NOTE: If this is a Promissory Note, Loan or Mortgage that has been determined to be a transfer, enter the outstanding balance due as of the date of application for Long Term Care. ✓ AMOUNT: Enter the amount received for the transferred asset. NOTE: If this is a life estate, use the amount from the TLIF table of the value of the life estate based on age of the individual. ✓ VR: Enter "?". This will cause the MIT to PEND. ✓ DATE: If transfer is <ul style="list-style-type: none"> ○ PRE-DRA- enter the date of the transfer in accordance with policies prior to DRA. ○ POST DRA- enter the latter of the following dates: <ol style="list-style-type: none"> 1) The day the individual first applies for Long Term Care benefits, and meets all factors of eligibility (including appropriate placement) except for transfer of assets without fair compensation, or 2) The first day of the month in which the individual transfers the assets, or 3) The first day following the end of an existing penalty period. ✓ ADC/ICP/RAP PROPER: Enter N ✓ LIQUID ASSETS DATA: Enter the appropriate code from TLQA table. ✓ Transfer Notice AE08 Q1 will be generated.
3	Run AABC if you are not in the ASIA or ASRE driver, otherwise continue running driver. The system will FAIL the Long Term Care and build and PEND MIT.
4	Did the transfer occur prior to 11/01/2007, If YES , the system will calculate the ineligibility period in months and will show the correct ineligibility period on AAED. GO to STEP 6. If NO . Continue to STEP 5.

5	<p>If the transfer occurs on or after 11/01/2007,</p> <ul style="list-style-type: none"> ✓ the ineligibility period will have to be calculated manually in order to determine the correct fractional month of the ineligibility period. ✓ Follow policy to determine the penalty period begin date. ✓ Enter the Penalty Period Begin date on CLRC: Example: <ul style="list-style-type: none"> • PENALTY PERIOD FOR LONG TERM CARE BEGIN DATE: MM/DD/CCYY ✓ Enter the ineligibility period on CLRC. Example: <ul style="list-style-type: none"> • TRANSFER OCCURRED ON OR AFTER 11/01/2007, • INELIGIBILITY PERIOD: <ul style="list-style-type: none"> BEGIN DATE - MM/DD/CCYY END DATE: MM/DD/CCYY
6	<p>If multiple transfers, return to AAAT and PF9 for another blank screen. Return to STEP 2. Continue to STEP 7 if no more transfers.</p>
7	<p>AWEC – Set up Expected Change for the month prior to the ineligibility period end date to review and Ex Parte eligibility.</p>
8	<p>AWAA – Leave the MIT Pending until Rebuttal/Hardship evaluation is approved or denied NOTE: The Transfer notice with the Rebuttal/Hardship questionnaire will be sent from AAAT. <i>If the Rebuttal/Hardship evaluation is successful, Go to Step 10.</i> If the Rebuttal/Hardship evaluation is NOT successful, Continue to Step 9.</p>
9	<p>If the Rebuttal/Hardship is NOT successful,</p> <ul style="list-style-type: none"> ✓ Return to the same AAAT screen of the rebutted transfer and change the "?" in the VR field to a valid verification code. ✓ Run AABC – Long Term Care will FAIL and the MIT will PASS. <p>NOTE: If the Rebuttal/Hardship returned by the applicant indicates that the amount received is still less than the value of the transferred asset, there may still be an ineligibility period. You will need to suppress the MIT Transfer Notice (AE08 Q1) on CNIN</p> <ul style="list-style-type: none"> ✓ AWAA- Approve the MIT using reason code 149 in the first reason code field and reason code 155 in the second reason code field. <ul style="list-style-type: none"> • Suppress notice • Send Manual notice of approval
10	<p>If the Rebuttal/Hardship IS successful, Return to the same AAAT screen as the rebutted transfer and change</p> <ul style="list-style-type: none"> ✓ the AMOUNT received to equal the amount of the VALUE. ✓ "?" in the VR field to a valid verification code ✓ Run AABC – Long Term Care will PASS ✓ AWAA – Approve the Long Term Care using reason code 151 in the first reason code field.

05042007

HOW TO PROCESS TRANSFERS FOR INSTITUTIONAL HOSPICE

Currently the FLORIDA system does not consider Transfers for Institutional Hospice.

Use this process if it is determined that an individual applying for Institutional Hospice has transferred an asset, including Promissory Notes, Loans and Mortgages that have been determined to be a transfer or if the individual has purchased a Life Estate in another person's home on or after the implementation date and it is considered to be transfer.

Ineligibility Periods will have to be manually calculated. Divide the Average Monthly Nursing Rate into the uncompensated value of the transfer.

- transfers made prior to November 2007 –If the amount results in a decimal, the decimal is dropped and the ineligibility period is determined in months (not fractional months).
- transfers made on or after November 2007 - If the amount results in a decimal, the decimal is multiplied by 30 and added to the months so that the ineligibility period is determined in months and days.

STEP	ACTION
1	Determine the individual's "Look Back Period" according to policy and record on CLRC. Enter in CLRC: LOOK BACK DATE FOR TRANSFERS IS MM/DD/CCYY FOR FIRST/LAST NAME. Example: LOOK BACK DATE FOR TRANSFERS IS 09/04/2007 FOR Su Smithee. ✓ Enter Pre-DRA transfers first.
2	On AAAT enter the earliest transfer in the "look back period". Note: The following fields are essential in computing the ineligibility period: <ul style="list-style-type: none"> ✓ TYPE: Enter type of asset: VH (Vehicle); RP (Real Property); LI (Life Insurance); LA (Liquid Asset) ✓ VALUE: Enter the amount of the property value "prior to transfer". NOTE: If this is a Promissory Note, Loan or Mortgage that has been determined to be a transfer, enter the outstanding balance due as of the date of application for Long Term Care. ✓ AMOUNT: Enter the amount received for the transferred asset. NOTE: If this is a life estate, use the amount from the TLIF table of the value of the life estate based on age of the individual. ✓ VR: Enter "?". This will <u>not</u> cause the MIT to build or PEND for Hospice AGs. ✓ DATE: Enter the date of the transfer. NOTE: If multiple transfers, this date will be the date used on each AAAT screen in order to make all of the transfers contiguous, or to calculate the maximum ineligibility period. ✓ ADC/ICP/RAP PROPER: Enter N ✓ LIQUID ASSETS DATA: Enter appropriate code from TLQA Table ✓ NOTE: Transfer Notice AE08 Q1 will NOT be generated.
3	AARP - Enter the information using the codes appropriately in the following fields: TYPE – code 27 (TROP Table) RES - "N" AVAIL – "?" JOINT – "N" unless jointly owned, then enter "Y" % OWNED - per cent owned with another if "Y" in JOINT field. OWNED WITH –short list number if jointly owned with someone in the case. Enter 99 if jointly owned with someone outside of the case. MARKET VALUE – amount for which expected to sell in geographic region AMOUNT OWED – total amount owed EQUITY – system entered NAME AND ADDRESS OF PERSON TO WHOM OWED – Press <Enter>

4	Run AABC if you are not in the ASIA or ASRE driver, otherwise continue running driver. The system will PEND for MHH/MHM.
5	Did the transfer occur prior to 11/01/2007, If YES, manually calculate the ineligibility period using the whole month calculation. Continue to STEP 6. If NO. Continue to STEP 6
6	If the transfer occurs on or after 11/01/2007, ✓ manually calculate the ineligibility period using the fractional month calculation. ✓ Follow policy to determine the penalty period begin date.
7	✓ Enter the Penalty Period Begin date on CLRC: Example: • PENALTY PERIOD FOR LONG TERM CARE BEGIN DATE: MM/DD/CCYY ✓ Enter the ineligibility period on CLRC. Example: • TRANSFER OCCURRED ON OR AFTER 11/01/2007, • INELIGIBILITY PERIOD: BEGIN DATE - MM/DD/CCYY END DATE: MM/DD/CCYY
8	If multiple transfers, return to AAAT and PF9 for another Blank screen. Return to STEP 2. Continue to STEP 9 if no more transfers.
9	AWEC – Set up Expected Change for the month prior to the ineligibility period end date to review eligibility.
10	AWAA – Leave the MHH/MHM Pending until Rebuttal/Hardship evaluation is approved or denied NOTE: The Transfer notice with the Rebuttal/Hardship questionnaire will be NOT be sent from AAAT. Send Manual Rebuttal/Hardship Notice. If the Rebuttal/Hardship evaluation is successful, Go to Step 11. If the Rebuttal/Hardship evaluation is NOT successful, Go to Step 12.
11	If the Rebuttal/Hardship is successful, ✓ Return to the same AARP screen of the rebutted transfer • AVAIL - change the "?" in the field to N and • VR – enter the appropriate verification code. ✓ Run AABC – NOTE: If the Rebuttal/Hardship returned by the applicant indicates that the amount received is still less than the value of the transferred asset, there may still be an ineligibility period. ✓ AWAA - Approve the MHH/MHM using Reason code 151 in the first reason code slot and Enter 040 in the second reason code slot.
12	If the Rebuttal/Hardship is NOT successful, ✓ Return to the same AARP screen of the rebutted transfer • AVAIL - change the "?" in the field to Y and • VR – enter the appropriate verification code. Run AABC – The assets will cause the MHH/MHM to FAIL and NS will be built and FAIL
13	AEFT/AEIF – FIAT the NS to PASS and the SOC to 0.
14	AEFT/AEIF - The supervisor must approve the FIAT. AWAA – The supervisor must approve the NS by ✓ changing Reason Code 300 to 149 in the first reason code slot and ✓ entering Reason Code 155 in the second reason code slot

HOW TO RECONVEY AN ASSET TRANSFER WHEN SUCCESSFULLY REBUTTED

When an asset transfer is successfully rebutted or the individual meets the hardship criteria, the transfer can be reconveyed on the same AAAT screen of the original transfer.

STEP	ACTION
1	AAAT – Return to the screen which has the transfer which has been successfully rebutted or meets the Hardship criteria.
2	DATE RECONVEY Field – Enter the date of that the Rebuttal or Hardship was approved.
3	Run AABC.
4	Long Term Medicaid will be built. Verify on AAED that the ineligibility period has been removed.
5	Authorize as appropriate.

04182007

HOW TO PROCESS ANNUITIES IN THE FLORIDA SYSTEM

Use this process when an individual applying for Long Term Care or their community spouse has an annuity.

STEP	ACTION
1	<p>Does the annuity for the individual or community spouse meet the policy requirements to be excluded as an asset transfer?</p> <ul style="list-style-type: none"> ✓ If No, Enter the Annuity as a Transfer on AAAT screen as a Liquid Asset (LA). NOTE: Follow the instructions on <ul style="list-style-type: none"> • HOW TO PROCESS TRANSFERS FOR WAIVERS AND INSTITUTIONAL CARE, OR • HOW TO PROCESS TRANSFERS FOR INSTITUTIONAL HOSPICE ✓ If Yes, Continue to Step 2.
2	<p>AAAQ – Enter Y for OT. This will drive to the AALA screen.</p>
3	<p>AALA - Enter the information about the annuity as a liquid asset. Enter the account # with 'AN' either before or after it. If no account # enter the word 'annuity' Is the Annuity irrevocable and non-assignable? <ul style="list-style-type: none"> • If YES, enter N in the AV field to indicate that the asset is not available. It will <u>not</u> be counted in the total assets. • If NO, enter Y in the AV field to indicate that the asset is available. It <u>will</u> be counted in the total assets. Note: If the annuity is revocable and/or assignable, Enter Y in the AV field to indicate that the asset is available. It <u>will</u> be counted in the total assets.</p>
4	<p>AFIQ - Enter Y to OTHER SOURCES. This will drive to the AFMI screen.</p>
5	<p>AFMI - Enter OT in the unearned income TYPE field. Enter AN in the unearned income SUB TYPE field. NOTE: OTAN is on the TVIN reference table with the description as ANNUITIES.</p>
6	<p>Run AABC if you are not in the ASIA or ASRE driver, otherwise continue running driver.</p>
7	<p>AWES – Check asset eligibility and verify that the annuity is not counted or counted as indicated on AALA. Check income eligibility and verify that the annuity income is included in the budget.</p>
8	<p>AWAA – Authorize as appropriate.</p>

09282007

HOW TO PROCESS HOME EQUITIES EXCEEDING \$500,000

Enter Excess Home Interest on the AARP screen when the individual applying for long term care has

- ✓ equity in the home exceeding \$500,000, and
- ✓ no spouse, child under 21, or blind or disabled child of any age residing in the home.

STEP	ACTION
1	<p>Does the individual's equity in the home exceed 500,000 (Market value minus debt)? If NO, enter the homestead information on AARP as exempt homestead property:</p> <ul style="list-style-type: none"> ✓ TYPE – code 01 ✓ EXEMPT – code HP ✓ Continue running driver to AWAA <p>If YES, continue to Step 2.</p>
2	<p>Does the individual's spouse, child under 21, or blind or disabled child of any age live in the home? If NO, continue to Step 3.</p> <p>If YES, enter the homestead information on AARP as homestead property:</p> <ul style="list-style-type: none"> ✓ TYPE – code 01 ✓ EXEMPT- code HP ✓ NAME OF PERSON LIVING IN THE HOUSE – name of individual living in the house ✓ REL – Enter relationship to individual ✓ Continue running driver to AWAA
3	<p>AARP - Enter the information using the codes appropriately in the following fields: TYPE – code 27 (TROP Table) RES - "N" AVAIL – "Y" JOINT – "N" unless jointly owned, then enter "Y" % OWNED - per cent owned with another if "Y" in JOINT field. OWNED WITH –short list number if jointly owned with someone in the case. Enter 99 if jointly owned with someone outside of the case. MARKET VALUE – amount for which expected to sell in geographic region AMOUNT OWED – total amount owed EQUITY – system entered NAME AND ADDRESS OF PERSON TO WHOM OWED – Press <Enter></p>
4	<p>AARC- Enter the information appropriately.</p>
5	<p>Continue running the Driver to AWAA. NOTE: The assets will cause the MII/MIM to FAIL and NS will build and FAIL.</p>
6	<p>AWAA –</p> <ul style="list-style-type: none"> ✓ Do not DENY the NS. ✓ Send Manual Notices: Notice of Excess Home Equity Interest Greater than \$500,000
7	<p>If the Undue Hardship waiver is approved:</p> <ul style="list-style-type: none"> ✓ AARP – Change AVAIL from Y to N ✓ Run AABC. Long Term Care will build and PASS ✓ AWAA – OPEN the Long Term Care with reason codes 152 and 040. You are finished!
8	<p>1) If the individual or their representative does NOT respond to the Notice of Excess Home Equity Interest Greater than \$500,000 OR 2) the Undue Hardship waiver is <u>not</u> approved 3) Run AABC</p>

9	AEFT/AEIF – case#/category/sequence <ul style="list-style-type: none">✓ FIAT the NS to PASS and the SOC to 0.✓ Use Reason code 108 (TFRC).✓ The supervisor must approve the FIAT.
10	AWAA- <ul style="list-style-type: none">▪ If the individual or their representative <u>did not respond</u> to the Notice of Excess Home Equity Interest Greater than \$500,000, the supervisor must approve the NS by<ul style="list-style-type: none">✓ changing the reason code 300 to 612 and✓ entering reason code 155 in the second reason code field.✓ entering reason code 154 in the third reason code field.▪ If the Undue Hardship Waiver is <u>NOT approved</u>, the supervisor must approve the NS by<ul style="list-style-type: none">✓ changing the reason code 300 to Reason code 612 and✓ entering reason code 150 in the second reason code field and✓ entering reason code 155 in the third reason code field.

HOW TO PROCESS CONTINUING CARE RETIREMENT COMMUNITY ENTRANCE FEES

Use this process when it is determined that the individual has a contract with a Continuing Care Retirement Community (CCRC).

STEP:	ACTION:
1	AAAQ - Enter the Continuing Care Retirement Community Entrance Fee as OT- Other. This will drive to AALA
2	AALA – Enter the information in the following fields: <ul style="list-style-type: none"> ✓ ACCOUNT NUMBER: CCRC Contract ✓ TOTAL AMOUNT: Remaining Amount of entrance fee ✓ AV: Y if the fee meets the requirements to be considered a countable asset; or N if the fee does NOT meet the requirements to be considered a countable asset ✓ BEG MMCCYY: month and year of the first month of eligibility requested.
3	Continue running driver (ASIA or ASRE), or run AABC if not in a driver.
4	AWAA – Approve or Deny as appropriate.

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