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TO: Income Maintenance Supervisors
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W-2 Agencies
Workforce Development Boards
Job Center Leads and Managers
Training Staff
Child Care Coordinators

FROM: Amy Mendel-Clemens
Technical Assistance and Training Section
Bureau of Enrollment Management
Division of Health Care Access and
Accountability

BEM/DFS OPERATIONS MEMO

No: 09-01

DATE: 1/7/2009

FS	<input type="checkbox"/>	MA	<input checked="" type="checkbox"/>	BC+	<input type="checkbox"/>
SC	<input type="checkbox"/>	CTS	<input type="checkbox"/>	FSET	<input type="checkbox"/>
CC	<input type="checkbox"/>	W-2	<input type="checkbox"/>	EA	<input type="checkbox"/>
CF	<input type="checkbox"/>	JAL	<input type="checkbox"/>	JC	<input type="checkbox"/>
RAP	<input type="checkbox"/>	WIA	<input type="checkbox"/>	Other	<input type="checkbox"/>
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PRIORITY: HIGH

SUBJECT: Divestment and Other Medicaid Asset Policy Changes Required Under the Deficit Reduction Act of 2005

CROSS REFERENCES: Wis. Statutes, sections 49.453 and 49.47
Deficit Reduction Act of 2005, P.L. 109-171 Sections 6011, et. seq.
Social Security Act Sec. 1917 (c), et. seq.
Chapter 17 of the Medicaid Eligibility Handbook

EFFECTIVE DATE: JANUARY 01, 2009

PURPOSE:

This memo provides instructions for implementing new rules pertaining to transfers of resources (a.k.a. divestments) and other specified assets, as required under the Deficit Reduction Act of 2005. Generally, the new divestment policies apply to any divestments that occur on or after January 01, 2009.

BACKGROUND

The Deficit Reduction Act of 2005 (DRA) made major changes to the Medicaid divestment laws. These changes included a new divestment penalty period begin date, a longer look back period, new treatment options for multiple divestments, a requirement that penalty periods include partial months, and the mandate that certain types of asset transfers be considered divestments. Under the DRA, these changes apply primarily to divestments that occur on or after February 8, 2006.

However, the Department's legal counsel determined that we could not implement the DRA provisions without changes to state law. The DRA provisions were included in 2007 Wisconsin Act 20, with an effective date of February 1, 2008. A workgroup consisting of representatives from the nursing home industry, the Bureau of Enrollment Management (BEM) and elder law attorneys and advocates was formed to explore policy and process options and to make recommendations to the Department of Health Services (DHS). This Operations Memo reflects DHS decisions about how to implement the law changes.

POLICY CHANGES

EFFECTIVE DATE

Most of the new policies described in this memo apply only to divestments that occurred on or after January 1, 2009. Generally, divestments that occurred prior to January 1, 2009 are subject to the previous asset transfer policies.

➤ **Reminders**

- Asset transfer policies apply to applicants and recipients of Long Term Care Medicaid including Institutional Medicaid, Home and Community Based Waivers (HCBW) including the Community Options Program (COP) and Managed Long Term Care (MLTC) Programs such as Family Care (FC), IRIS, Pace and Partnership. For purposes related to this and other divestment provisions, applicants for HCBW Programs and MLTC programs are considered to be institutionalized.
- If an individual is determined to be ineligible for Medicaid LTC coverage due to a divestment, s/he still qualifies for Medicaid card services if all other eligibility criteria are met.

LOOK-BACK PERIOD

Trusts

The look-back period for transfers involving trusts remains 60 months. This is true for all trust-related divestments, including those that occurred prior to or after January 1, 2009.

Non-Trust

Under the previous policy, transfers that didn't involve trusts were subject to a 36-month look-back period.

The DRA law requires a 60-month look-back period for any type of transfer, trust or otherwise. Beginning January 1, 2009 the look-back period for all transfers is 60 months prior to the date that an individual is both institutionalized and has applied for Long Term Care Medicaid. The look back period for applications from HCBW and MLTC programs is 60 months from the application filing date.

The 60-month look-back period for transfers not involving trusts is only applied to transfers that occurred on or after January 1, 2009. Because of this, the number of months workers will look back will remain 36 months until January 1, 2012. Between January 1, 2012 and January 1, 2014, the look back for transfers not involving trusts is back to January 1, 2009. After January 1, 2014, the look-back period is 60 months from the date the individual is both institutionalized and has applied for Long Term Care Medicaid.

Example 1: Marie moves to a nursing home and applies for Long Term Care Medicaid on October 10, 2009. She divested \$200,000 to her son on February 14, 2007. She also divested \$25,000 to her son on March 3, 2009. When processing the application, the eligibility worker must look back to October 2006 (36 months) to see if Marie has transferred any assets. The \$200,000 divestment was within the 36-month look-back period so a penalty period must be calculated using the previous divestment policies. The worker also needs to calculate the penalty period for the divestment that occurred in March 2009, using the new policies.

Example 2: John moves to a nursing home and applies for Long Term Care Medicaid on April 1, 2013. The look back period for transfers not involving trusts is back to January 1, 2009 (41 months). All transfers that occurred in the look-back period will have the penalty period calculated using the new policies.

Example 3: Ted moves to a nursing home and applies for Long Term Care Medicaid on November 1, 2016. The look back period for divestment is 60 months from the date of his application (November 2011).

PENALTY PERIOD BEGIN DATE

The penalty period begin date for divestments that occur on or after January 1, 2009, depends on whether or not the institutionalized individual is an applicant or recipient. To determine the penalty period begin date for divestments that occurred prior to January 1, 2009, see the MEH Chapter 17.5.

Medicaid applicants:

The penalty period begin date for divestments that occur on or after January 1, 2009, is the date on which the individual is institutionalized, has applied for Medicaid, and is otherwise eligible for Medicaid except for the imposition of the divestment penalty period.

Applications for Home and Community Based Waiver (HCBW) programs, including PACE and Partnership, are routinely made in counties that don't currently have any available waiver slots. For these individuals who are otherwise eligible for Medicaid, the lack of a waiver slot is irrelevant in the context of determining whether or not an individual is "otherwise eligible for Medicaid". The divestment penalty period for HCBW applicants begins on the date that they apply for a HCBW program, meet the appropriate level of care and functional screen criteria, and meet all other Medicaid non-financial and financial eligibility requirements, regardless of whether or not waiver funding is actually available.

Example 4: Joan enters a nursing home on March 1, 2009 and applies for Medicaid on March 4, 2009. On her application, Joan reported that on February 2, 2009, she gave her adult daughter a \$100,000 cash gift, which is determined to be a divestment. Joan meets all other Medicaid eligibility requirements therefore Joan's divestment penalty period will begin on March 1, 2009. If Joan had been over the asset limit at the time of application she would not have been "otherwise eligible for Medicaid" so a divestment penalty would not have been imposed.

Example 5: John applies for a HCBW program on April 7, 2009. He indicates on his application that he gave his adult son a \$60,000 cash gift on February 15, 2009. John meets the community waiver functional screen criteria and all other Medicaid eligibility requirements. He resides in a county that doesn't have any available waiver slots and he is therefore put on a waiting list. The \$60,000 cash gift was determined to be a divestment. John is therefore ineligible for HCBW for the length of the penalty period. His penalty period would begin on April 7, 2009.

Example 6: Jeff enters a nursing home on March 1, 2009. He applies for Medicaid on April 15, 2009 and requests that his eligibility be backdated to March 1, 2009. John meets all other Medicaid eligibility requirements in March and April 2009, however he reports transferring \$100,000 in stocks and bonds to his brother on February 14, 2009. John's divestment penalty period begins on March 1, 2009, which is the date that he is institutionalized, has applied for Medicaid Long Term Care, and is otherwise eligible for Medicaid except for the imposition of the divestment penalty.

Medicaid recipients:

The penalty period begin date for divestments that occur on or after January 1, 2009 is the first day of the month in which the divestment occurred. Before the actual penalty can be imposed, the IM agency must provide adequate and timely notice to the recipient, advising him/her of the adverse action. Whether benefits are recoverable during the time between the penalty period start date and the date long term care benefits were terminated depends on whether the divestment was reported timely (within ten calendar days).

Example 7: *Divestment that was reported timely:*

On February 9, 2009, Alice, an institutionalized recipient, reports a divestment that occurred on January 31, 2009. The divestment results in a 165 day penalty period. The penalty period will begin on January 1, 2009 and end on June 14, 2009.

Because Adverse Action (AA) notice needs to be provided before coverage of long term care ends, the benefit will terminate effective March 1st if the worker processes the divestment prior to AA in February. If the worker processes the divestment after adverse action in February, the long term care benefit will terminate effective April 1, 2009. Because Alice reported the change timely, none of the Long Term Care benefits paid during the required adverse action notice period are subject to benefit recovery.

Example 8: *Divestment that was not reported timely:*

On March 1st, Edith, an institutionalized recipient, reports a divestment that occurred on January 2, 2009. The divestment results in a 165 day penalty period. The penalty period will begin on January 1, 2009 and end on June 14, 2009. If the worker processes the divestment prior to adverse action in March, Medicaid will discontinue paying for long term care on April 1, 2009.

If the divestment had been reported timely, the long term care benefits could have been terminated effective February 1, 2009. The long term care payments made in January are not considered an overpayment, however the payments made for the months of February and March are recoverable overpayments.

MULTIPLE TRANSFERS

For divestments that occur on or after January 1, 2009, all transfers made by the institutionalized individual or his/her spouse that occur during the look-back period must be added together, to arrive at a total divestment amount. That total will be used to calculate the appropriate divestment penalty period. For these divestments it doesn't matter if the divestments were made in sequential months, have penalty periods that overlap, or penalty periods that extend into a month immediately preceding a month in which there was another transfer.

Note about penalty period begin date for multiple transfers:

When an applicant or member has penalty periods from transfers that occurred prior to January 1, 2009, and transfers that occurred on or after January 1, 2009, the penalty period for the transfers in 2009 may not begin until the month after the earlier penalty period ends.

Example 9: Joan applies for HCBW on June 1, 2009 and is determined to be otherwise eligible for LTC Medicaid, except for the imposition of a penalty period. She transferred assets both prior to and after January 1, 2009. The penalty period for the transfers prior to January 1, 2009 ends on August 31, 2009. Even though the begin month for the later transfers would otherwise be the day she applied for Long Term Care Medicaid, she is already ineligible for that month due to the transfer. The new divestment penalty period begins September 1, 2009.

For additional policy information about how to process multiple divestments that occurred prior to January 1, 2009, see Chapter 17.6 in the Medicaid Eligibility Handbook emhandbooks.wi.gov/meh-ebd/.

INTENT

A transfer of income or assets is not a divestment if the individual can demonstrate that the transfer wasn't made with the intent of becoming eligible for Medicaid. The individual must present evidence that shows the specific purpose and reason for making the transfer, and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that s/he was not trying to become financially eligible for Medicaid are not sufficient.

The DRA did not change any aspect of the divestment policy regarding the matter of intent. However, the Department has expanded policy guidance related to intent as follows:

Any of the following circumstances are sufficient to establish that the applicant/member transferred resources without an intent to qualify for Medicaid.

1. The applicant/member had made arrangements to provide for his/her long term care needs by having sufficient financial resources and/or long term care insurance to pay for long term care services for at least a five-year period at the time of the transfer.

An exception to this requirement is allowed if the individual had a life expectancy of less than five years at the time of transfer. If the individual's life expectancy was less than five years at the time of the transfer, a divestment penalty is not applied if resources and/or insurance were sufficient to pay for his/ her long term care services for his/her remaining life expectancy.

To measure 'sufficient resources' use the average monthly nursing home cost of care in effect at the time of the divestment multiplied by 60. Compare that number to the income, assets and insurance held by the individual at the time of the divestment.

2. Taking into consideration the individual's health and age at the time of the transfer, there was no expectation of long-term care services being needed for the next five years. For example, someone who was gainfully employed and 50 years old at the time of the divestment is not expected to have set aside sufficient resources for five years of long-term care.
3. If an individual had a pattern of charitable gifting, or gifting to family members (i.e. birthdays, graduations, weddings, etc.) prior to the look-back period, similar transfers during the look-back period would not be considered to have been given with the intent to divest as long as the total yearly gifts did not exceed 15% of the individual's or couple's annual gross income. This exception is not limited to gifts made on traditional gift-giving occasions and does not preclude a pattern of giving to assist family members with educational or vocational goals.
4. Resources spent on the current support of dependent relatives living with the individual are not considered to be divestments. The individual must either claim the relative as a dependent for IRS tax purposes, or otherwise provide more than 50% of the cost of care and support for the dependent relative.

This list is not intended to be all inclusive when describing divestments which are permissible because the transfer was made without the intent to qualify for Medicaid. Other situations will arise and in those instances, the person's "intent" must be evaluated on a case-by-case basis to determine whether or not a divestment occurred. The fact that a person does not meet the criteria for a specific exception does not create a presumption that the person cannot show that the transfer was made for a purpose other than qualification for Medicaid. For example, a person may be able to show that a transfer to a dependent relative not living at home was made for a purpose other than qualifying for Medicaid.

- **Note:** The standards outlined above should also be used to guide the determination of 'intent' for transfers that occurred before January 1, 2009.

PURCHASE OF A LIFE ESTATE IN THE HOME OF ANOTHER PERSON

The purchase of a life estate interest in another individual's home on or after January 1, 2009, is a divestment unless the purchaser:

- Resides in the home for a period of at least 12 consecutive months after the date of purchase; and
- Received fair market value for the purchase.

Residency

Apply the following rules to determine whether a person has resided in the home for 12 consecutive months:

- The 12-month period may start immediately after the purchase or at any time after the purchase.
- Absences from the life estate home for less than 30 consecutive days will not affect the 12-month determination.

Example 10: Ralph purchases a life estate interest in his brother's home on January 5, 2009 and moves into that home on the same date. He goes to Florida on January 20, 2009 and returns to the home on February 10, 2009. January and February count as whole months of residence because Ralph's absence was less than 30 consecutive days.

- Absences from the life estate home for 30 days or more for vacations, trips or to stay elsewhere result in the 12-month period starting over.

Example 11: Vicki purchases a life estate interest in her sister's home on January 20, 2009 and moves into that home on the same date. On March 3, 2009 Vicki goes to Bermuda for a family vacation and returns on April 15, 2009. Since Vicki was absent from the home for 30 or more consecutive days, the consecutive month of residency string is broken. Vicki's 12-month residency clock is reset with April 2009 being her "new" first month of residency.

- Absences from the life estate home for 30 days or more because of hospitalization or a rehabilitation stay do not count towards the 12 consecutive months. However, such absences do not result in the 12-month period starting over.

Example 12: Jim purchases a life estate interest in his cousin's home on January 20, 2009 and moves into that home on the same date. Jim continues to reside in the home until April 10, 2009 at which time he is hospitalized as a result of an auto accident. Jim remains in the hospital until August 5, 2009 when he is discharged and returns home. Jim continues to reside in the home from August 5, 2009 until December 24, 2010.

Jim's residency in the home for the months of January, February, March, and part of April count as four consecutive months of residency. The months of May, June, and July are not included in the consecutive month count because he is absent from the home for those full calendar months. However the absence from the home for those months does not cause the 12-month clock to be restarted because Jim's absence was the result of his hospitalization. When Jim returns to the home on August 5, 2009, August counts as the fifth month of continuous residency. Jim will meet the 12 months of continuous residency requirement in March of 2010.

If the 12-month residency requirement has not been met at the time of the application for LTC Medicaid, the full purchase price of the life estate is used to determine the divested amount.

The divestment penalty remains in effect until the penalty period ends **or** the date the individual meets the 12 month residency requirement, whichever occurs first. There is no pro-ration of the divestment penalty period for living in the home for part of the 12 months.

Fair Market Value

If the 12-month residency requirement has been met at the time of the application for LTC, the local agency must also determine whether the applicant paid the fair market value (FMV) for the life estate. The FMV of the life estate is determined using the age of the life estate holder on the date that the life estate was created and the property's FMV on that date. Multiply the FMV by the life estate multiplier on the Life Estate and Remainder Interest Table ([MEH 39.1](#)). The result is the value of the property's life estate interest as of that date. If the applicant paid more than the life estate interest value, the difference is the divested amount.

- **NOTE:** Property tax assessments can be used to determine a property's FMV if both the local agency and applicant/member agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

Example 13: Joyce, age 75, has \$200,000 in her savings account. On February 3, 2009, she gives \$200,000 to her son in exchange for a life estate interest in her son's home. The FMV of the son's home as of February 3, 2009 was \$300,000. Joyce moved into her son's home on March 5, 2009 and has resided there continuously for more than 12 consecutive months. On April 9, 2010 Joyce applies for a Community Waiver program, meets the functional screen and all other Medicaid eligibility requirements. Joyce also establishes that as of her application date for Community Waivers, she has resided in her son's home for more than 12 consecutive months.

The divestment issue that now needs to be resolved is whether or not Joyce received FMV for the \$200,000 that was used to purchase the life estate. Using the Life Estate Table in [Chapter 39.1](#) of the Medicaid Eligibility Handbook, it is determined that Joyce's life estate interest was worth \$156,447 at the time of the purchase. Since Joyce paid \$200,000 for a life estate that was worth \$156,447, the divested amount is \$43,553. Joyce is ineligible for Community Waiver beginning on the date of her Community Waiver application.

When a couple jointly holds a life estate, the institutionalized spouse must reside in the home for 12 consecutive months or his/her portion of the life estate value will be considered a divestment. See [MEH 17.10.2](#) for instructions on calculating the spouse's portion of the life estate value.

PURCHASE OF PROMISSORY NOTES, LOANS, OR MORTGAGES

The purchase of a promissory note, loan or mortgage, on or after January 1, 2009 is a divestment unless such note, loan or mortgage meets all of the following criteria:

- Has a repayment term that is actuarially sound (paid out in the individual's life expectancy). The standards that must be used to decide whether or not a note, loan, or mortgage is actuarially sound are those determined by the Office of the Chief Actuary of the Social Security Administration (SSA). The standards are found in a table (called the Period Life Table), which can be found on the following SSA Web page: <http://www.ssa.gov/OACT/STATS/table4c6.html>. Use this table to calculate the individual's life expectancy as of the date the note, loan, or mortgage agreement was initiated. Determine if the lender was expected to live long enough so that s/he would receive payment in full during his/her lifetime; and
- Provides for payments to be made in equal amounts during the term of the loan, with no deferral or balloon payments made; and
- Does not allow cancellation of the note, loan or mortgage upon the death of the lender. Under Wisconsin law, the outstanding loan balance on these types of contracts is not automatically cancelled upon the death of the lender. Cancellation of the loan balance can only occur if the contract contains specific language to this effect. If a note, loan or mortgage contains language to cancel the balance upon the death of the lender, the note, loan or mortgage can be amended to remove this language and avoid a divestment penalty.

If all of the criteria above are not met, the purchase of the promissory note, loan, or mortgage is a divestment. The divested amount is the value of the outstanding balance due on the note, loan, or mortgage as of the date of application for Medicaid long term care services.

Example 14: On February 1, 2009, Mary gave her adult daughter \$50,000 in exchange for a promissory note, which was expected to be paid back in full during her life expectancy. The terms of the note required Mary's daughter to repay the loan within a 48-month period by making payments of \$100 per month for the first 47 months and a \$45,300 payment in the 48th month. Twelve months later, on February 1, 2010, Mary enters a nursing home and applies for Medicaid. She is otherwise eligible for Medicaid but acknowledges the promissory note transaction that occurred during her look-back period.

Since the terms of the promissory note contained a provision for a balloon payment, the purchase of the promissory note is a divestment. As of the date of Mary's application for Medicaid long term care services (February 1, 2010), Mary's daughter has repaid her mother only \$1,200, and the outstanding balance on the note is \$48,800. Mary's divested amount is \$48,800 which will be used to calculate a penalty period beginning February 1, 2010.

Example 15: John purchased a \$60,000 promissory note from his brother Al on April 1, 2009. At that time, John was 80 years old, with a life expectancy of 7.62 years. The terms of the note required equal monthly payments over a 10-year period. Since John's life expectancy was less than the repayment term, the note is not actuarially sound. Several years later, John enters a nursing home and applies for Medicaid. The outstanding balance on the promissory note on the date of John's application for Medicaid long term care services is \$40,000. The divested amount that will be used in calculating John's divestment penalty period is \$40,000.

DISCLOSURE AND TREATMENT OF ANNUITIES

Disclosure

Beginning January 1, 2009, all applicants for Medicaid long term care services and all recipients of Medicaid long term care services undergoing an eligibility review are required to disclose information about any annuities purchased on or after January 1, 2009, in which they or their community spouses have an interest.

This requirement also applies to annuities purchased before January 1, 2009, if any action is taken by the individual that changes either the course of payment from the annuity or the treatment of the income or principal of the annuity. These transactions include:

- additions of principal,
- elective withdrawals,
- requests to change the distribution of the annuity,
- elections to annuitize the contract,
- a change in ownership, or
- any other non-routine action not listed below

The following types of changes and events would not subject an annuity purchased prior to January 1, 2009 to treatment under the new policy rules:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances;
- Changes that occur based on terms of the annuities which existed prior to January 1, 2009 and which do not require a decision, election or action to take effect; or
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status.

A separate annuity disclosure form (Annuity Information – Disclosure [F-10192](#)) must be completed by applicants for each annuity owned by the applicant or the applicant's community spouse in order to meet the disclosure requirement. This form must also be sent to SSI recipients who are applying for HCBW and MLTC programs. The Disclosure form must be sent to all applicants and recipients who indicate that they have an annuity. A copy of the completed form and any documents verifying the status of the annuity must be scanned into the electronic case file (ECF).

The Wisconsin Medicaid for the Elderly, Blind, and Disabled Application ([F-10101](#)) has been updated to collect additional information about annuities and provide information about the requirement to designate the State as a remainder beneficiary of the annuities owned by applicants for LTC Medicaid or their spouses. The new version of the application will be available with the next printing. Forms Coordinators will be notified when the updated version is available.

If the applicant/member or his/her spouse (or representative) refuses to disclose the required information related to the annuity, the applicant/member is ineligible for Medicaid for the failure to cooperate in providing requested information.

Remainder Beneficiary Designation

Annuities purchased on or after January 1, 2009 by an individual who is applying for Medicaid Long Term Care Services (or his/her spouse) must name the "Wisconsin Department of Health Services Estate Recovery Program" (hereafter referred to as "the State") as a remainder beneficiary. The requirement to name the State as a remainder beneficiary also applies to annuities purchased prior to January 1, 2009 if certain transactions (those described above) involving the annuity were made by the individual or spouse on or after January 1, 2009. This requirement applies to all annuities, regardless of whether they are considered revocable or not. An annuity must name the State as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual, unless there is a community spouse and/or a minor or disabled child. A child is considered disabled if he or she has been determined disabled by the DHS Disability Determination Bureau, or receives Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) benefits. [See the definition of disability found at [Chapter 5.2](#) of the Medicaid Eligibility Handbook (MEH).] If there is a community spouse and/or any minor or disabled child, the State must be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the State has been named as a remainder beneficiary after a community spouse and/or a minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the State must then be named in the first position. For example, this might apply if the community spouse or child changes the annuity beneficiary during the recipient's lifetime.

The IM agency must determine if the annuity transaction or purchase occurred prior to January 1, 2009. If so, it is subject to pre-DRA divestment policy. If the annuity transaction or purchase occurs on or after January 1, 2009, the State must be designated as a remainder beneficiary. To do this, a separate annuity beneficiary designation form (Annuity Beneficiary Designation, [F-10191](#)) must be completed and signed by all applicants (or spouses), for each annuity that must have the state designated as the remainder beneficiary. This form must also be sent to SSI recipients who are applying for HCBW and MLTC programs. The local agency must then send a copy of the completed and signed beneficiary designation form(s) to the annuity issuer with the cover form (Issuer of Annuity - Notice of Obligation, [F-10190](#)) that instructs the issuer to make the state a remainder beneficiary. Allow the issuer up to 30 days to confirm the designation has been made.

When the issuer responds and indicates that the State has been designated the remainder beneficiary, or that there is no death benefit available under this annuity, treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination.

If the issuer does not respond within 30 days, the IM agency must contact the issuer by phone and request that the issuer respond within 10 days. If the issuer does not respond 40 days after the Notice of Obligation form was sent, contact the CARES Call Center for further guidance.

If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this annuity as meeting the designation requirement and proceed with the LTC eligibility determination. If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed. If the issuer has not responded 10 days after the request was made, contact the CARES Call Center for further guidance.

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Issuer of Annuity - Notice of Obligation ([F-10190](#)).

Copies of all of these completed forms must be scanned into the ECF.

Pend the Medicaid LTC application until:

- The applicant provides the required disclosure or beneficiary designation forms by the verification due date,
- Verification has been received that the State of Wisconsin has been legally named as the appropriate remainder beneficiary of the annuity, or that no death benefit is available under the annuity,
- Verification has been received that the beneficiary designation change is in process,
- The issuer indicates that the applicant, member or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary, or
- You receive direction from the CARES Call Center to certify the applicant/member for LTC coverage.

A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process. The divestment date is the date the annuity was purchased, or the date of the latest annuity transaction. The amount of the divestment is the full purchase price of the annuity.

We have attached a flow chart to guide eligibility workers on the entire process of getting the disclosures, the designation of the state as a beneficiary and informing the annuity issuers of the state's interest and their reporting obligation.

Additional Divestment Criteria for unavailable annuities owned by the institutionalized applicant/member

The following policy changes do not apply to annuities that are considered to be available resources.

Annuities that are considered "unavailable" and purchased on or after January 1, 2009, by or on behalf of an annuitant who has applied for Medicaid coverage of Long Term Care Services, as well as annuities purchased prior to January 1, 2009 and for which certain transactions (see above) were made on or after January 1, 2009 are subject to the following divestment rules.

The annuities described in this section only refer to annuities purchased by or on behalf of an annuitant who is an applicant for or recipient of Medicaid Long Term Care Services. These divestment rules do not apply to annuities for which the community spouse is the annuitant. The annuity will not be treated as a divestment if the annuity meets any of the following conditions:

1. The annuity is considered either:
 - An individual retirement annuity (according to Sec. 408(b)) of the Internal Revenue Code of 1986 (IRC), or
 - A deemed Individual Retirement Account (IRA) under a qualified employer plan (according to Sec. 408(q) of the IRC),

or

2. The annuity is purchased with proceeds from one of the following:
 - A traditional IRA (IRC Sec. 408a);
 - Certain accounts or trusts which are treated as traditional IRAs (IRC Sec. 408 §(c));
 - A simplified retirement account (IRC Sec. 408 §(p));
 - A simplified employee pension (IRC Sec. 408 §(k)); or
 - A Roth IRA (IRC Sec. 408A).

or

3. The annuity meets all of the following requirements:

- The annuity is irrevocable and non-assignable;
- The annuity is actuarially sound; and
- The annuity provides payments in approximately equal amounts, with no deferred or balloon payments.

To determine that an annuity is established under any of the various provisions of the Internal Revenue Code that are referenced in items 1 and 2 above, rely on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the institutionalized individual (or his/her representative) to produce this documentation.

To determine if an annuity is actuarially sound, use the life expectancy tables, from Social Security at <http://www.ssa.gov/OACT/STATS/table4c6.html> which is compiled from information published by the Office of the Actuary of the Social Security Administration. The guarantee payout period of the annuity cannot be longer than the annuitant's life expectancy. If the individual is not expected to live longer than the guarantee payout period of the annuity, the individual will not receive fair market value for the annuity based on the projected return. In this case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place.

For any annuity which does not meet the above conditions, the amount of the transfer is the amount spent to purchase the annuity and the date of transfer is the date of the purchase or the date of the most recent transaction for this annuity.

An annuity that meets the requirements above is not considered a divestment, but it must still be disclosed and the state designated as the remainder beneficiary. Failure to disclose results in ineligibility and failure to designate the state as a remainder beneficiary on the annuity results in a divestment penalty period.

PARTIAL MONTH PENALTIES

The DRA requires the imposition of partial months of ineligibility for divestments. For all divestments that occur on or after January 1, 2009, the penalty periods are to be calculated as the number of days for which Medicaid will not pay for long term care services. Penalty periods are no longer rounded down to whole months. In order to impose partial months of ineligibility, as required by the DRA, all divestment penalties will be calculated in days, using the average daily nursing home cost to a private pay patient. The average daily rate is computed by multiplying the average monthly rate by 12 and dividing by 365 ($\$6,259 \times 12 = 75,108$ divided by $365 = \$205.77$).

Example 16: Jane divested \$20,000 on January 15, 2009. She was admitted to a nursing home, applied for Institutional Medicaid on January 20, 2009 and was determined to be otherwise eligible for Medicaid. The average daily cost of nursing home care is \$205.77 so the calculated penalty period for the divestment is 97 days ($\$20,000$ divided by $\$205.77 = 97.19$). Partial days of ineligibility will be rounded down (97.19 days is rounded down to 97 days). The penalty period runs from January 20, 2009 through April 26, 2009 (12 days in January, 28 days in February, 31 days in March, and 26 days in April). On April 27, Medicaid will begin to pay for the cost of Jane's institutional care.

Example 17: Bob divested \$4,500 on January 4, 2009. He was admitted to a nursing home, applied for Institutional Medicaid on January 10, 2009 and was determined to be otherwise eligible. Bob's penalty period is calculated at 21 days ($\$4,500$ divided by $\$205.77 = 21.86$). The penalty period is from January 10, 2009 through January 30, 2009. On January 31, 2009, Medicaid will begin to pay for the cost of Bob's institutional care.

Once you have determined the number of days that will constitute the individual's divestment penalty period, use the following website to establish when the penalty period will end and the exact date on which eligibility for Long Term Care Services can begin: <http://cgi.cs.duke.edu/%7EEdes/datecalc/datecalc.cgi>.

This website contains two date calculators. Use the one that "calculates the date some number of days from an initial date". Using example 16 above, enter 01/20/2009 as your start date and enter 97 as the number of days. Hit the submit button and you will receive the date on which the divestment penalty no longer exists (04/27/2009). Therefore the divestment notice to the member must indicate that the divestment penalty runs from January 20, 2009 through April 26, 2009.

RECALCULATION OF PENALTY PERIODS

Divestment related penalty periods that have been established for individuals receiving or requesting Medicaid LTC services must be adjusted when the divested resource or its equivalent fair market value is returned to the individual.

Full Refund

When the entire divested resource or equivalent value is returned to the individual, the entire penalty period is nullified. You must then re-evaluate the individual's Medicaid eligibility for LTC services retroactively, back to the beginning date of the previously imposed penalty period. The individual can then be certified for Medicaid LTC services if s/he met all other eligibility requirements during this retroactive adjustment period. The refunded resources will be counted as available assets beginning with the month in which they were returned.

Example 18: Scott gave a \$10,000 certificate of deposit to his adult son on March 10, 2009. On October 1, 2009, Scott entered a nursing home and applied for Medicaid. Due to his prior divestment, Scott was ineligible for Medicaid coverage for the cost of his institutional care. The divestment penalty period started on October 1, 2009 and ended on November 20, 2009. Scott was certified for Medicaid LTC on November 21, 2009.

Scott's son had already cashed in the CD but on December 5, 2009, he returned \$10,000 in cash to Scott as a refund of the prior gift from his father. Since the equivalent value of Scott's previously transferred asset has been returned, Scott is now potentially eligible for Medicaid LTC services for the period of October 1, 2009 through November 20, 2009. Scott met all other eligibility requirements during that retroactive period and he is certified for Medicaid LTC services for that same period. The \$10,000 that Scott received and reported on December 5, 2009 is counted as an asset beginning in December and would make him ineligible for Medicaid, effective January 1, 2010, unless his assets are reduced to program limits prior to January 1, 2010.

Partial Refund

Individuals who are currently serving a divestment penalty may receive a partial refund of a previously transferred resource. When part of a resource or its equivalent value is returned through a cash payment, the divested amount and the penalty period is recalculated only if the returned resource is used to pay for medical and remedial expenses incurred during the divestment penalty period or for the cost of care previously provided to the individual during the divestment penalty period. The costs must be for care that was provided to an individual by a nursing home or other medical institution, a community based residential facility (CBRF), or other assisted living facility. The individual must verify that s/he used the refund to pay for previously provided care s/he was obligated to pay or other medical and remedial expenses. Payments for care or remedial expenses provided by family members, (i.e. supportive home care), will not be allowed under this partial refund policy unless there was a written and notarized contract in existence at the time the service was provided, which specified the services that were being provided and the cost of those services. The cost for services cannot exceed reasonable compensation for the services provided. "Reasonable compensation" is the prevailing local market rate for the service at the time the service is provided.

Example 19: Dale resides in a nursing home and is currently serving a 97-day penalty period due to a \$20,000 divestment that he made to his brother last month. Dale receives a partial refund of \$6,000 from his brother which he promptly uses to purchase \$6,000 worth of lottery tickets. When Dale reports the receipt of the refund and describes what he did with it, there is no adjustment to the original 97-day penalty period because Dale didn't use the partial refund to pay for care that was previously provided to him by the nursing home. If Dale had verified that he paid the \$6,000 to the nursing home for past care provided, which he was legally obligated to pay, his penalty period would have been modified. The original divested amount of \$20,000 would have been reduced to \$14,000, which would have ultimately resulted in the 97-day penalty period being reduced to a 68-day penalty period.

In situations where the partial refund is made with a non-cash item such as land, stocks, bonds, etc, the refund will result in a reduced penalty period even though no payment is made for previously incurred medical, remedial, or care expenses.

UNDUE HARDSHIP WAIVERS

A divestment penalty period must be waived when the imposition of the penalty period deprives the individual of:

- Medical care such that the individual's health or life would be endangered; or
- Food, clothing, shelter, or other necessities of life.

The ability to establish an undue hardship and ultimately waive the divestment penalty period is not a new concept. Undue hardship provisions have existed prior to the DRA. However, the DRA expands the definition of undue hardship to include not only threats to the individual's health or life, but also the deprivation of food, shelter, clothing, and other necessities of life.

Hardship Waiver Request Process

To insure that the new undue hardship waiver process is understood by those persons having a divestment penalty period imposed on them and have an adequate opportunity to request a waiver, we are instituting the following process.

At the same time that the worker issues the manual Negative Notice of Decision (F-16001) to the applicant or recipient informing the person of the divestment penalty period, the worker is to complete the Divestment Penalty and Undue Hardship Notice ([F-10187](#)). In addition, the worker is to attach the Undue Hardship Waiver Request form ([F-10193](#)) to the Hardship Notice, filling in the Case Name and Number. The two forms must either be mailed with the Negative Notice of Decision, or mailed the same day as the negative notice.

Valid Request

In order to be considered, the completed Undue Hardship Waiver Request form ([F-10193](#)) must be submitted to the Income Maintenance (IM) agency. A written and signed request that fulfills the minimum request requirements is also acceptable.

The DRA allows the Long Term Care (LTC) facility in which the individual is residing to file an undue hardship request on behalf of the institutionalized individual. However, the LTC facility must have the client or their authorized representative's written permission, using the Undue Hardship Waiver Request form ([F-10193](#)) to file the undue hardship request.

The LTC facility can also represent the institutionalized individual in any subsequent fair hearing activity involving an undue hardship request/denial, as long as the facility has the member (or his/her representative's) written permission to do so. This can also include the actual request for a fair hearing.

Effective Date of Approved Waivers

Timely request- received within 20 days after notification is mailed

If the valid request for an undue hardship waiver is received by the local agency within 20 days after the local agency mails out the Divestment Penalty and Undue Hardship Notice ([F-10187](#)), and the request is approved, the effective date of the waiver will be the initial date of the penalty period.

Example 20: Amy receives a notice dated February 10, 2009 that her January 20, 2009 application for Community Waivers is being denied and that she will have a 100-day divestment penalty period beginning January 20, 2009. Amy submits an undue hardship request to the IM agency, which is received on February 15, 2009. The undue hardship request is ultimately approved by the IM agency and Amy's penalty period is waived. Amy is subsequently certified for Community Waiver Medicaid beginning January 20, 2009.

Untimely request- received later than 20 days after notification is mailed

A request may be submitted later than 20 days after the local agency mails out the Divestment Penalty and Undue Hardship Notice ([F-10187](#)), (for example, when there is a change in circumstances), but if approved, the waiver effective date will not be earlier than the date of the request.

Example: Alice receives a notice dated February 10, 2009 that her January 20, 2009 application for Community Waivers is being denied and that she will have a 350-day divestment penalty period beginning January 20, 2009. In June 2009, Alice's health deteriorates and her monthly income decreases by 60%. Alice submits an undue hardship request to the IM agency, which is received on June 25, 2009. The undue hardship request is ultimately approved by the IM agency and Alice's remaining penalty period is waived. Alice is subsequently certified for Community Waiver Medicaid beginning June 25, 2009.

Required Documentation

The applicant (or his/her representative) must submit the following verification of hardship:

1. A statement signed by the individual (or his/her representative) which describes whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets,

AND

2. Proof that an undue hardship would exist if the penalty period is applied (as follows).
 - If the ***member is currently institutionalized***, s/he must submit a copy of the notification sent from the LTC facility which states both the date of involuntary discharge and alternative placement location or other proof that if the hardship waiver is not granted, the individual will be deprived of medical care such that the individual's health or life would be endangered; or deprived of food, clothing, shelter, or other necessities of life.
 - If the ***member is applying for Community Waivers COP, FamilyCare,, IRIS, PACE or Partnership***, s/he must submit an estimate of the cost of the LTC services needed to meet his/her medical and remedial needs (as determined by the waivers case manager) and an estimate of costs for food, shelter, clothing and other necessities of life.

Compare the two estimates to the individual or couple's income and assets. If the IM agency determines that the individual does not have enough income and/or assets to pay for his or her LTC and other needs (i.e. food, shelter, etc.), consider the individual's health to be endangered.

If the required documentation is not submitted with the request for an undue hardship waiver, send a written request for verification. If the applicant/member fails to submit the required verification within 10 days after the request is mailed, deny the undue hardship waiver request and notify the individual with the Undue Hardship Decision Notice ([F-10188](#)). Extend the deadline to submit the required documentation for up to ten days when the individual communicates a need for additional time or assistance in obtaining it.

Determination Process Timeframe

A decision about whether to grant an undue hardship waiver shall be made by the local IM agency within 30 days after receipt of the request. Send the member/applicant the appropriate manual Positive or Negative Notice of Decision based on the IM agency's decision.

Bed Hold Payments and Notification

When a hardship waiver request is received by an IM agency from an institutionalized individual, the agency will send the institution the Undue Hardship Bed Hold Notice ([F-10189](#)) to inform them that the request was received. The Notice will inform the institution that a "bed hold" payment will be made on the client's behalf for the period of time while the IM agency is making a decision about the hardship waiver request. The period covered begins on the date a written hardship waiver request is received at the IM agency until the date the agency issues its decision on the waiver request, up to a maximum of 30 days.

Use the Undue Hardship Waiver Decision ([F-10188](#)) form to notify the institution of the agency's decision about the undue hardship waiver and the availability of the bed hold payment (when applicable). If the request for an undue hardship waiver is approved, the penalty period will be waived and the need for a bed hold payment is therefore unnecessary. If the undue hardship waiver request is denied, indicate on the Waiver Decision form the dates for which the State will make the bed hold payments. Attach a copy of the Waiver Decision form to the manual Negative Notice of Decision that you send the member/applicant. The Negative Notice must include the agency's reason for the denial, "You have not proven that the divestment penalty will create an undue hardship for you." The Notice must also inform the member/applicant that Medicaid/Forward Health will pay for LTC services received during the bed hold period. Manually certify the bed hold period by completing a manual Medicaid certification form ([F-10110](#) -formerly DES 3070) and sending it to the fiscal agent for processing.

Only one bed hold payment will be made for each divestment penalty period. Bed hold payments can only be made on behalf of individuals residing in medical institutions (i.e. nursing homes, etc.) who are requesting an undue hardship determination. They will not be made for Community Waivers or Family Care applicants.

Fair Hearing Rights

If the request for an undue hardship waiver is denied, the individual has the right to appeal the decision through a written request to the Division of Hearings & Appeals. The individual has 45 days from the date of the notice issuance to file the appeal. These same hearing rights are also applicable to the facility in which the individual resides, as long as the facility has the institutionalized individual's written permission to represent him/her in the appeal process.

Referral

If a Power of Attorney (POA) or other authorized representative transferred the asset, the IM agency must consider making a referral to the local Adult-at-Risk agency for investigation of possible financial exploitation of an elderly, blind, or disabled individual.

TREATMENT OF CONTINUING CARE RETIREMENT COMMUNITY ENTRANCE FEES

A Continuing Care Retirement Community (CCRC) or Life Care Community (LCC) typically provides a variety of living arrangements, from independent living through skilled nursing care. In many cases, potential residents must provide extensive information about their finances, including their assets and income, before being accepted for admission. In addition, they frequently must pay substantial entrance fees and sign detailed contracts before moving to the community.

Effective January 1, 2009, entrance fees paid by an individual to a CCRC or LCC will be counted as an available non-exempt asset of the individual for Medicaid eligibility determinations when all of the following conditions apply:

- The person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, even in part, to pay for care if the person's other resources or income are insufficient to pay for their care,
- The person is eligible for a refund of any remaining entrance fee when the person dies or terminates the contract and leaves the community, and
- The entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

With regard to the first condition described above, it is not necessary for the CCRC or LCC to provide a full, lump sum refund of the entrance fee to the resident. If even a portion of the fee can be refunded or applied to pay for care as required, this condition would be met.

Also, in order to meet the second condition described above, it is not necessary for the resident to actually receive a refund of the entrance fee or deposit. This second condition is met as long as the resident could receive a refund were the contract to be terminated or if the resident dies.

The ownership interest that is referenced in the third condition described above is not specifically defined under either state or federal law. An ownership interest generally means the right to possess and convey property, but recognize that it might not be an all-inclusive definition. Therefore, the resident will be required to verify whether or not they have an ownership interest in the CCRC or LCC by presenting documentation from the facility to that effect. If the CCRC or LCC confirms that the entrance fee does not confer an ownership interest to the resident, then the third condition described above is met.

For Medicaid eligibility determinations, all normal spousal impoverishment rules regarding income and asset allocations for a community spouse are applicable to married couples who reside in a CCRC or LCC, when one spouse resides in the skilled nursing care section of the facility, and the other spouse (the community spouse) resides in a more independent living setting. CCRC and LCC contracts are required by federal law to account for spousal impoverishment income and asset allocations to a community spouse, before determining the amount of resources that a resident must spend on his or her own care.

Entrance fees which meet all three conditions described above will be counted as an available non-exempt asset for all Medicaid eligibility determinations for the elderly, blind, and disabled, regardless of whether or not the individual is requesting long term care services. An entrance fee which does not meet all three conditions described above is an unavailable asset.

This provision must be applied to all Medicaid applications and eligibility reviews that occur on or after January 1, 2009, regardless of when the entrance fee was actually paid.

HOME EQUITY

Effective January 1, 2009, persons who apply for Medicaid coverage of long term care (LTC) services (i.e. Institutional, Community Waivers, Family Care, etc.) are not eligible for LTC services if the equity interest in their home is greater than \$750,000. S/he is still eligible for card services if all other eligibility requirements are met.

This restriction does not apply if a spouse, minor or disabled child resides in the home. In addition, this restriction does not apply to non-institutionalized Medicaid eligibility determinations (i.e. a Medicaid application by someone who does not reside in a medical institution for 30 days or more, someone who is not applying for Community Waivers, Family Care, PACE, or Partnership).

The \$750,000 LTC home equity limit can be waived in situations whereby the imposition of this eligibility requirement results in an "undue hardship" for the individual. When determining whether or not an undue hardship exists, follow the same undue hardship guidelines that are discussed earlier in the Undue Hardship Waiver section of this Operations Memo.

The equity value of a home is the current fair market value (FMV) minus any encumbrance on it. An encumbrance is a legally binding debt against the home. This can be a mortgage, reverse mortgage, home equity loan, or other debt secured by the home.

- **NOTE:** Property tax assessments can be used to determine a property's FMV if both the local agency and applicant/member agree that it accurately represents the price it would sell for on the open market in that geographic area. If both parties do not agree, statements from one or more realtors could be sufficient. If the local agency requests a comparative analysis, they are required to pay for it. Regardless of what process is used, the member always has the right to appeal the agency decision if they think it is incorrect.

Example 21: Bob is a 66 year old bachelor, living in his own home who applies for Medicaid on February 1, 2009. His home has a FMV of \$760,000 with no encumbrances. Bob meets all other Medicaid eligibility requirements and is certified for Medicaid effective February 1, 2009. In October 2009, Bob's health deteriorates and he applies for a Community Waiver program. That application is denied because Bob's equity interest in his home exceeds the LTC eligibility limit by \$10,000.

On December 15, 2009 Bob reapplies for a Community Waiver program and reports that on December 1, 2009, he took out a \$12,000 home equity loan and used the entire loan proceeds to purchase exempt burial assets and furniture for his home. Bob's December 15, 2009 application for Community Waivers is approved because Bob's equity interest in his home is now \$748,000, which is below the LTC eligibility limit, and he meets all other Medicaid eligibility requirements.

Example 22: Dave is 75 years old, married and living with his wife Ruth in their home which sits on a 75 acre parcel of property. The entire property qualifies as homestead property. It has a FMV of \$1,000,000 with no encumbrances. On March 5, 2009, Dave applies for Family Care. The Family Care application is approved because even though Dave's home equity value exceeds the \$750,000 LTC eligibility limit, his wife resides in the home, which negates the \$750,000 LTC home equity restriction.

This home equity provision applies only to individuals who apply for LTC Medicaid (i.e. nursing home, Family Care, etc.), on or after January 1, 2009. It does not apply to individuals who are current recipients of Medicaid LTC programs as of January 1, 2009, as long as they remain continuously eligible for LTC Medicaid after that date. A Medicaid LTC recipient who becomes ineligible for Medicaid LTC after January 1, 2009, for a calendar month or more, would be subject to the \$750,000 home equity limit during any subsequent reapplication for Medicaid LTC programs.

CARES PROCESSING

Penalty Period Begin Date

Until CARES can be updated to accommodate these policy changes, local agency workers need to total all divestments that occurred on or after January 1, 2009 and enter the total on the Transfer/ Divestment Page in CWW with a divestment date equal to the begin date of the penalty period. Because CARES will incorrectly round the penalty period down, the worker must enter the correct penalty period begin and end dates in case comments. DHS staff will manually adjust the penalty period end date in interChange to match the date in case comments.

To properly notify the applicant/member about a divestment penalty period and the potential availability of an undue hardship waiver, suppress the CARES-generated notice and issue the manual “Negative Notice” ([F-16001](#)). You must also issue the “Divestment Penalty and Undue Hardship Notice” ([F-10187](#)) and “Undue Hardship Waiver Request” ([F-10193](#)) forms. (See the Hardship Waiver Request Process above.) The Negative Notice should include the following legal citation for all divestments: § 49.453, Wis. Stats.

Home Equity

CARES is not currently programmed to deny eligibility for an individual living in a home with equity greater than \$750,000. To deny or terminate for this reason, use the AIOE/AGOE override with the 024 failure code. Once the override has been completed and notice is provided, change the ‘residence’ question on the Real Property Page to “No”. This will prevent the case from ‘popping open’ if eligibility is rerun.

In order to provide notification of the denial due to excess assets, suppress the CARES-generated notice and issue manually the “Negative Notice” (F-16001) with the following denial reason and legal citation:

“Your home equity exceeds \$750,000.” §49.47(4)(bc), Stats.

Annuity Disclosure

If the applicant/recipient or his/her community spouse refuses to complete and sign the annuity disclosure form, enter an NV in the verification field for the annuity asset on the liquid asset page. Suppress the CARES-generated notice and manually issue a “Negative Notice” ([F-16001](#)) with the following denial reason and legal citation.

“You have failed to disclose information about an annuity owned by you or your spouse.”
§49.47(4)(cr), Stats.

Annuity Beneficiary Designation

If the applicant/recipient refuses to take action to designate the state as a remainder beneficiary on an annuity, calculate a divestment penalty period.

To properly notify the applicant/member about a divestment penalty period and the potential availability of an undue hardship waiver, suppress the CARES-generated notice and manually issue the “Negative Notice” ([F-16001](#)) with the following denial reason and legal citation:

“You have failed to designate the Wisconsin Department of Health Services Estate Recovery Program as a remainder beneficiary on an annuity owned by you or your spouse.” § 49.47(4)(cr), Stats.

You must also issue the “Divestment Penalty and Undue Hardship Notice” ([F-10187](#)) and “Undue Hardship Waiver Request” ([F-10193](#)) forms.

TRAINING

We will be offering a follow up conference call for this Operations Memo. Please read this memo and bring your follow up questions to this conference call. The name of the Conference Call is DRA Changes and it will be held on February 5, 2009 from 9 a.m. until 11 a.m. There is a limited number of lines so please have interested staff from your agency attend as one group.

To attend, dial 1(877)873-8017 or 1(636)651-3181 to access the DRA Changes Conference call, then enter the following 7 digit access code 1701464 followed by the # sign.

ATTACHMENTS

[Flow Chart- Process for Naming DHS a Preferred Remainder Beneficiary](#)

[F-10187 Divestment Penalty and Undue Hardship Notice](#)

[F-10188 Undue Hardship Waiver Decision](#)

[F-10189 Undue Hardship Bed Hold Notice](#)

[F-10190 Issuer of Annuity- Notice of Obligation](#)

[F-10191 Annuity Beneficiary Designation](#)

[F-10192 Annuity Information Disclosure](#)

[F-10193 Undue Hardship Waiver Request](#)

CONTACTS

BEM CARES Information & Problem Resolution Center

*Program Categories – FS – FoodShare, MA – Medicaid, BC+ – BadgerCare Plus, SC – Senior Care, CTS – Caretaker Supplement, CC – Child Care, W-2 – Wisconsin Works, FSET – FoodShare Employment and Training, CF – Children First, EA – Emergency Assistance, JAL – Job Access Loan, JC - Job Center Programs, RAP – Refugee Assistance Program, WIA – Workforce Investment Act, Other EP – Other Employment Programs.

DHFS/DHCAA/BEM/JU