# Chapter 182-515 WAC
# ALTERNATE LIVING—INSTITUTIONAL MEDICAL


**WAC**

182-515-1505 Long-term care home and community based services authorized by home and community services (HCS) and hospice.

182-515-1506 What are the general eligibility requirements for home and community based (HCB) services authorized by home and community services (HCS) and hospice?

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182-515-1514 How does the department determine how much of my income I must pay towards the cost of my DDD waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?

182-515-1540 Medically needy residential waiver (MNRW) effective March 17, 2003 through March 31, 2012.

182-515-1550 Medically needy in-home waiver (MNIW) effective May 1, 2004 through March 31, 2012.


**WAC 182-515-1505 Long-term care home and community based services authorized by home and community services (HCS) and hospice.** (1) This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) services administered by home and community services (HCS) and hospice services administered by the health care authority (HCA).

(2) The HCB service programs are:

(a) Community options program entry system (COPES);

(b) Program of all-inclusive care for the elderly (PACE);

(c) Washington medicaid integration partnership (WMIP); or

(d) New Freedom consumer directed services (New Freedom).

(3) Roads to community living (RCL) services. For RCL services this chapter is used only to determine your cost of care. Medicaid eligibility is guaranteed for three hundred sixty-five days upon discharge from a medical institution.

(4) Hospice services if you don't reside in a medical institution and:

(a) Have gross income at or below the special income level (SIL); and

(b) Aren't eligible for another CN or medically needy (MN) medicaid program.

(5) WAC 388-515-1506 describes the general eligibility requirements for HCS CN waivers.

(6) WAC 388-515-1507 describes eligibility for waiver services when you are eligible for medicaid using noninstitutional CN rules.

(7) WAC 388-515-1508 describes the initial financial eligibility requirements for waiver services when you are not eligible for noninstitutional CN medicaid described in WAC 388-515-1507(1).

(8) WAC 388-515-1509 describes the rules used to determine your responsibility in the cost of care for waiver services if you are not eligible for medicaid under a CN program listed in WAC 388-515-1507(1). This is also called client participation or post eligibility.

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**WAC 182-515-1506 What are the general eligibility requirements for home and community based (HCB) services authorized by home and community services (HCS) and hospice?** (1) To be eligible for home and community based (HCB) services and hospice you must:

(a) Meet the program and age requirements for the specific program:

(i) COPES, per WAC 388-106-0310;

(ii) PACE, per WAC 388-106-0705;

(iii) WMIP waiver services, per WAC 388-106-0750;

(iv) New Freedom, per WAC 388-106-1410;

(v) Hospice, per chapter 182-551 WAC; or

(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260.

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(c) Require the level of care provided in a nursing facility described in WAC 388-106-0355;

(d) Be residing in a medical institution as defined in WAC 182-500-0050, or likely to be placed in one within the next thirty days without HCB services provided under one of the programs listed in subsection (1)(a);

(e) Have attained institutional status as described in WAC 388-513-1320;

(f) Be determined in need of services and be approved for a plan of care as described in subsection (1)(a);

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:

(i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1365;

(i) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(2) Refer to WAC 388-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(3) Current income and resource standard charts are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html.

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**WAC 182-515-1507 What are the financial requirements for home and community based (HCB) services authorized by home and community services (HCS) when you are eligible for a noninstitutional categorically needy (CN) medicaid program?** (1) You are eligible for medicaid under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status;

(b) SSI-related CN medicaid described in WAC 182-512-0100 (2)(a) and (b);

(c) SSI-related health care for workers with disabilities program (HWD) described in WAC 182-511-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 182-511-1250;

(d) Aged, blind, or disabled (ABD) cash assistance described in WAC 388-400-0060 and are receiving CN medicaid.

(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1365. This does not apply to PACE or hospice services.

(3) You do not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).

(5) You do not pay (participate) toward the cost of your personal care services.

(6) If you live in a department contracted facility listed in WAC 388-515-1506 (1)(g), you pay room and board up to the ADSA room and board standard. The ADSA room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.

(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.

(b) If subsection (6)(a) applies and you are receiving HWD described in WAC 182-511-1000, you are responsible to pay your HWD premium as described in WAC 182-511-1250, in addition to the ADSA room and board standard.

(7) If you are eligible for aged, blind or disabled (ABD) cash assistance program described in WAC 388-400-0060 you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under WAC 388-478-0033;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard; or

(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive an ABD cash grant of thirty-eight dollars and eighty-four cents as described in WAC 388-478-0045, which you keep for your PNA.

(8) Current resource and income standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(9) Current PNA and ADSA room and board standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml.

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**WAC 182-515-1508 How does the department determine if you are financially eligible for home and community based (HCB) services authorized by home and community services (HCS) and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1)?** (1) If you are not eligible

for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1), the department must determine your eligibility using institutional medicaid rules. This section explains how you may qualify using institutional medicaid rules.

(2) You must meet the general eligibility requirements described in WAC 388-513-1315 and 388-515-1506.

(3) You must meet the following resource requirements:

(a) Resource limits described in WAC 388-513-1350.

(b) If you have resources over the standard allowed in WAC 388-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC 388-513-1350 if you verify these expenses.

(4) You must meet the following income requirements:

(a) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); or

(b) For home and community based (HCB) service programs authorized by HCS your gross nonexcluded income is:

(i) Above the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and

(ii) Net income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing gross nonexcluded income by:

(A) Medically needy (MN) disregards found in WAC 388-513-1345; and

(B) The average monthly nursing facility state rate is five thousand six hundred and twenty six dollars. This rate will be updated annually starting October 1, 2012 and each year thereafter on October 1. This standard will be updated annually in the long-term care standard section of the EAZ manual described at http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(5) The department follows the rules in WAC 388-515-1325, 388-513-1330, and 388-513-1340 to determine available income and income exclusions.

(6) Current resource and income standards (including the SIL, MNIL and FBR) for long-term care are found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

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**WAC 182-515-1509 How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC 388-515-1508?** If you are only eligible for medicaid under WAC 388-515-1508, the department determines how much you must pay based upon the following:

(1) If you are single and living at home as defined in WAC 388-106-0010, you keep all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA).

(2) If you are married living at home as defined in WAC 388-106-0010, you keep all your income up to the effective one-person medically needy income level (MNIL) for your PNA if your spouse lives at home with you. If you are married and living apart from your spouse, you're allowed to keep your income up to the FPL for your PNA.

(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:

(a) Keep a PNA from your gross nonexcluded income. The PNA is sixty-two dollars and seventy-nine cents effective July 1, 2008; and

(b) Pay for your room and board up to the ADSA room and board standard.

(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction is reduced by allowable deductions in the following order:

(a) If you are working, the department allows an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income.

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If the department allows this as deduction from your income, the department will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative, plus;

(V) The food assistance standard utility allowance (SUA) described in WAC 388-450-0195 provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www. dshs. wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) The amount allocated to the community spouse may be greater than the amount in subsection (d)(ii) only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent, or dependent sibling of your community or institutionalized spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowance in subsections (1), (2) and (3)(a) and (b); and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (4)(a); and

(iii) Guardianship fees and administrative costs in subsection (4)(b).

(5) You must pay your provider the combination of the room and board amount and the cost of personal care services after all allowable deductions.

(6) You may have to pay third party resources described in WAC 182-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.

(7) Current income and resource standards for long-term care (including SIL, MNIL, FPL, FBR) are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(8) If you are in multiple living arrangements in a month (an example is a move from an adult family home to a home setting on HCB services), the department allows you the highest PNA available based on all the living arrangements and services you have in a month.

(9) Current PNA and ADSA room and board standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml.

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**WAC 182-515-1510 Division of developmental disabilities (DDD) home and community based services waivers.** The four sections that follow describe the general and financial eligibility requirements for the division of developmental disabilities (DDD) home and community based services (HCBS) waivers.

(1) WAC 388-515-1511 describes the general eligibility requirements under the DDD HCBS waivers.

(2) WAC 388-515-1512 describes the financial requirements for the DDD waivers if you are eligible for medicaid under the noninstitutional categorically needy program (CN).

(3) WAC 388-515-1513 describes the initial financial requirements for the DDD waivers if you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1).

(4) WAC 388-515-1514 describes the post eligibility financial requirements for the DDD waivers if you are not eligible for medicaid under a categorically needy program CN listed in WAC 388-515-1512(1).

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**WAC 182-515-1511 What are the general eligibility requirements for waiver services under the division of developmental disabilities (DDD) home and community based services (HCBS) waivers?** (1) This section describes the general eligibility requirements for waiver services under the DDD home and community based services (HCBS) waivers.

(2) The requirements for services for DDD HCBS waivers are described in chapter 388-845 WAC. The department establishes eligibility for DDD HCBS waivers. To be eligible, you must:

(a) Be an eligible client of the division of developmental disabilities (DDD);

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(c) Require the level of care provided in an intermediate care facility for the intellectually disabled (ICF/ID);

(d) Have attained institutional status as described in WAC 388-513-1320;

(e) Be able to reside in the community and choose to do so as an alternative to living in an ICF/ID;

(f) Need waiver services as determined by your plan of care or individual support plan, and:

(i) Be able to live at home with waiver services; or

(ii) Live in a department contracted facility, which includes:

(A) A group home;

(B) Group training home;

(C) Child foster home, group home or staffed residential facility;

(D) Adult family home (AFH); or

(E) Adult residential care (ARC) facility.

(iii) Live in your own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider; and

(g) Be both medicaid eligible under the categorically needy program (CN) and be approved for services by the division of developmental disabilities.

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**WAC 182-515-1512 What are the financial requirements for the DDD waiver services if I am eligible for medicaid under the noninstitutional categorically needy program (CN)?** (1) You automatically meet income and resource eligibility for DDD waiver services if you are eligible for medicaid under a categorically needy program (CN) under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status. These clients have medicaid eligibility determined and maintained by the Social Security Administration;

(b) Health care for workers with disabilities (HWD) described in WAC 182-511-1000 through 182-511-1250;

(c) SSI-related (CN) medicaid described in WAC 182-512-0100 (2)(a) and (b) or meets the requirements in WAC 182-512-0880 and is (CN) eligible after the income disregards have been applied;

(d) CN medicaid for a child as described in WAC 182-505-0210 (1), (2), (7) or (8); or

(e) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060.

(2) If you are eligible for a CN medicaid program listed in subsection (1) above, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services.

(3) If you are eligible for a CN medicaid program listed in subsection (1) above, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).

(4) If you are eligible for a CN medicaid program listed in subsection (1), you pay up to the ADSA room and board standard described in WAC 388-515-1507. Room and board and long-term care standards are located at http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(a) If you live in an ARC, AFH or DDD group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ADSA room and board standard. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents.

(5) If you are eligible for a premium based medicaid program such as health care for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that CN-P program.

[13-01-017, recodified as WAC 182-515-1512, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). 12-21-091, § 388-515-1512, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, 74.09.530. 08-24-069, § 388-515-1512, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). 08-11-083, § 388-515-1512, filed 5/20/08, effective 6/20/08.]

**WAC 182-515-1513 How does the department determine if I am financially eligible for DDD waiver service medical coverage if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?** If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC 388-515-1514. To qualify, you must meet both the resource and income requirements.

(1) Resource limits are described in WAC 388-513-1350. If you have resources which are higher than the standard allowed, we may be able to reduce resources by your unpaid medical expenses described in WAC 388-513-1350.

(2) You are not subject to a transfer of asset penalty described in WAC 388-513-1363 through 388-513-1365.

(d) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.

(3) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC 388-515-1325, 388-513-1330 and 388-513-1340 to determine available income and income exclusions.

(4) Refer to WAC 388-513-1315 for rules used to determine countable resources, income and eligibility standards for long-term care services.

(5) Current income and resources standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

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**WAC 182-515-1514 How does the department determine how much of my income I must pay towards the cost**

**of my DDD waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?** If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1), the department determines how much you must pay based upon the following:

(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).

(2) If you are an SSI-related client and you live in an ARC, AFH or DDD group home, you:

(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents; and

(b) Pay for your room and board up to the ADSA room and board rate described in http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(3) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction described in (2) above, is reduced by allowable deductions in the following order:

(a) If you are working, we allow an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative plus;

(V) The food assistance standard utility allowance (SUA) provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) May be greater than the amount in subsection (d)(ii) only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowances in subsection (1) for in home or subsection (2)(a) in a residential setting; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (3)(a); and

(iii) Guardianship fees and administrative costs in subsection (3)(b).

(4) If you are eligible for aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060 you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the ABD cash program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard described in http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; or

(c) When you live in an ARC or DDD group home, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents which you keep for your PNA.

(5) You may have to pay third party resources (TPR) described in WAC 182-501-0200 in addition to room and board and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been

considered is called your total responsibility. You pay this amount to the ARC, AFH or DDD group home provider.

[13-01-017, recodified as WAC 182-515-1514, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). 12-21-091, § 388-515-1514, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, 74.09.530. 08-24-069, § 388-515-1514, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). 08-11-083, § 388-515-1514, filed 5/20/08, effective 6/20/08.]

**WAC 182-515-1540 Medically needy residential waiver (MNRW) effective March 17, 2003 through March 31, 2012.** Effective April 1, 2012 home and community based services authorized by home and community services (HCS) combines the categorically needy and medically needy programs described in WAC 388-515-1505 and 388-515-1508.

This section describes the financial eligibility requirements for waiver services under the medically needy residential waiver (MNRW) and the rules used to determine a client's responsibility in the total cost of care.

(1) To be eligible for MNRW, a client must meet the following conditions:

(a) Does not meet financial eligibility for medicaid personal care or the COPES program;

(b) Is eighteen years of age or older;

(c) Meets the SSI related criteria described in WAC 182-514-0050;

(d) Requires the level of care provided in a nursing facility as described in WAC 388-106-0355;

(e) In the absence of waiver services described in WAC 388-106-0400, would continue to reside in a medical facility as defined in WAC 388-513-1301, or will likely be placed in one within the next thirty days;

(f) Has attained institutional status as described in WAC 388-513-1320;

(g) Has been determined to be in need of waiver services as described in WAC 388-106-0410;

(h) Lives in one of the following department-contracted residential facilities:

(i) Licensed adult family home (AFH);

(ii) Assisted living (AL) facility; or

(iii) Enhanced adult residential care (EARC) facility.

(i) Is not subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363, 388-513-1364, and 388-513-1365; and

(j) Meets the resource and income requirements described in subsections (2) through (6).

(2) The department determines a client's nonexcluded resources under MNRW as described in WAC 388-513-1350;

(3) Nonexcluded resources, after disregarding excess resources described in (4), must be at or below the resource standard described in WAC 388-513-1350 (1) and (2).

(4) In determining a client's resource eligibility, the department disregards excess resources above the standard described in subsection (3) of this section:

(a) In an amount equal to incurred medical expenses such as:

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

(ii) Necessary medical care recognized under state law, but not covered under the state's medicaid plan; or

(iii) Necessary medical care covered under the state's medicaid plan.

(b) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Have not been used to satisfy a previous spend down liability;

(iii) Have not previously been used to reduce excess resources;

(iv) Have not been used to reduce client responsibility toward cost of care; and

(v) Are amounts for which the client remains liable.

(5) The department determines a client's countable income under MNRW in the following way:

(a) Considers income available described in WAC 388-513-1325 and 388-513-1330 (1), (2), and (3);

(b) Excludes income described in WAC 388-513-1340;

(c) Disregards income described in WAC 388-513-1345;

(d) Deducts monthly health insurance premiums, except medicare premiums.

(6) If the client's countable income is:

(a) Less than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW subject to availability per WAC 388-106-0435;

(b) More than the residential facility's department-contracted rate, based on an average of 30.42 days in a month the client may qualify for MNRW when they meet the requirements described in subsections (7) through (9), subject to availability per WAC 388-106-0435.

(7) The portion of a client's countable income over the department-contracted rate is called "excess income."

(8) A client who meets the requirements for MNRW chooses a three or six month base period. The months must be consecutive calendar months.

(9) A client who has or will have "excess income" is not eligible for MNRW until the client has medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown." The excess income from each of the months in the base period is added together to determine the total "spenddown" amount.

(10) Medical expenses described in subsection (4) of this WAC may be used to meet spenddown if not already used in subsection (4) of this WAC to disregard excess resources or to reduce countable income as described in subsection (5)(d).

(11) In cases where spenddown has been met, medical coverage begins the day services are authorized.

(12) The client's income that remains after determining available income in WAC 388-513-1325 and 388-513-1330 (1), (2), (3) and excluded income in WAC 388-513-1340 is paid towards the cost of care after deducting the following amounts in the order listed:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Personal needs allowance (PNA) described in WAC 388-515-1505. (Long-term care standards can be found at

http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml);

(c) Medicare and health insurance premiums not used to meet spenddown or reduce excess resources described in WAC 388-513-1350;

(d) Incurred medical expenses described in (4) not used to meet spenddown or reduce excess resources described in WAC 388-513-1350.

[13-01-017, recodified as WAC 182-515-1540, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). 12-21-091, § 388-515-1540, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. 08-11-047, § 388-515-1540, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-515-1540, filed 5/17/05, effective 6/17/05. Statutory Authority: 2001 c 269, RCW 74.09.700, 74.08.090, 74.04.050, 74.09.575 and chapter 74.39 RCW. 03-13-052, § 388-515-1540, filed 6/12/03, effective 7/13/03.]

**WAC 182-515-1550 Medically needy in-home waiver (MNIW) effective May 1, 2004 through March 31, 2012.** Effective April 1, 2012 home and community based services authorized by home and community services (HCS) combines the categorically needy and medically needy programs described in WAC 388-515-1505 and 388-515-1508.

This section describes the financial eligibility requirements for waiver services under the medically needy in-home waiver (MNIW) and the rules used to determine a client's responsibility in the total cost of care.

(1) To be eligible for MNIW, a client must:

(a) Not meet financial eligibility for medicaid personal care or the COPES program;

(b) Be eighteen years of age or older;

(c) Meet the SSI-related criteria described in WAC 182-512-0050(1);

(d) Require the level of care provided in a nursing facility as described in WAC 388-106-0355;

(e) In the absence of waiver services described in WAC 388-106-0500, continue to reside in a medical facility as defined in WAC 388-513-1301, or will likely be placed in one within the next thirty days;

(f) Have attained institutional status as described in WAC 388-513-1320;

(g) Have been determined to be in need of waiver services as described in WAC 388-106-0510;

(h) Be able to live at home with community support services and choose to remain at home;

(i) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363, 388-513-1364 and 388-513-1365; and

(j) Meet the resource and income requirements described in subsections (2) through (6) of this section.

(2) The department determines a client's nonexcluded resources under MNIW as described in WAC 388-513-1350.

(3) Nonexcluded resources, after disregarding excess resources described in subsection (4) of this section, must be at or below the resource standard described in WAC 388-513-1350.

(4) In determining a client's resource eligibility, the department disregards excess resources above the standard described in subsection (3) of this section:

(a) In an amount equal to incurred medical expenses such as:

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

(ii) Necessary medical care recognized under state law, but not covered under the state's medicaid plan; or

(iii) Necessary medical care covered under the state's medicaid plan.

(b) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Are not the result of medical and remedial care expenses that were incurred as the result of imposition of a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364 and 388-513-1365.

(iii) Have not been used to satisfy a previous spenddown liability;

(iv) Have not previously been used to reduce excess resources;

(v) Have not been used to reduce client responsibility toward cost of care; and

(vi) Are amounts for which the client remains liable.

(5) The department determines a client's countable income under MNIW in the following way:

(a) Considers income available described in WAC 388-513-1325 and 388-513-1330 (1), (2), and (3);

(b) Excludes income described in WAC 388-513-1340;

(c) Disregards income described in WAC 388-513-1345;

(d) Deducts monthly health insurance premiums, except medicare premiums, not used to reduce excess resources in subsection (4) of this section;

(e) Allows an income deduction for a nonapplying spouse, equal to the effective one-person medically needy income level (MNIL) less the nonapplying spouse's income, if the nonapplying spouse is living in the same home as the applying person.

(6) A client whose countable income exceeds the effective one-person MNIL may become eligible for MNIW:

(a) When they have or expect to have medical expenses to offset their income which is over the effective one-person MNIL; and

(b) Subject to availability in WAC 388-106-0535.

(7) The portion of a client's countable income over the effective one-person MNIL is called "excess income."

(8) A client who has or will have "excess income" is not eligible for MNIW until the client has medical expenses which are equal in amount to that excess income. This is the process of meeting "spenddown." The excess income from each of the months in the base period is added together to determine the total "spenddown" amount.

(9) The following medical expenses may be used to meet spenddown if not already used in subsection (4) of this section to disregard excess resources or to reduce countable income as described in subsection (5)(d) of this section:

(a) An amount equal to incurred medical expenses such as:

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

(ii) Necessary medical care recognized under state law, but not covered under the state's medicaid plan; and

(iii) Necessary medical care covered under the state's medicaid plan.

(b) The cost of waiver services authorized during the base period.

(c) As long as the incurred medical expenses:

(i) Are not subject to third-party payment or reimbursement;

(ii) Are not the result of medical and remedial care expenses that were incurred as the result of imposition of a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364 and 388-513-1365.

(iii) Have not been used to satisfy a previous spenddown liability;

(iv) Have not been used to reduce client responsibility toward cost of care; and

(v) Are amounts for which the client remains liable.

(10) Eligibility for MNIW is effective the first full month the client has met spenddown.

(11) In cases where spenddown has been met, medical coverage and MNIW begin the day services are authorized.

(12) A client who meets the requirements for MNIW chooses a three or six month base period. The months must be consecutive calendar months.

(13) The client's income that remains after determining available income in WAC 388-513-1325 and 388-513-1330 (1), (2), (3) and excluded income in WAC 388-513-1340 is paid towards the cost of care after deducting the following amounts in the order listed:

(a) An earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Personal needs allowance (PNA) in an amount equal to the one-person federal poverty level (FPL) described in WAC 182-505-0100;

(c) Medicare and health insurance premiums not used to meet spenddown or reduce excess resources;

(d) Incurred medical expenses described in subsection (4) of this section not used to meet spenddown or reduce excess resources.

[13-01-017, recodified as WAC 182-515-1550, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). 12-21-091, § 388-515-1550, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.520, 74.09.530 and 2004 c 276 § 206 (6)(b). 07-03-087, § 388-515-1550, filed 1/18/07, effective 2/18/07. Statutory Authority: RCW 74.08.090, 74.09.520. 05-11-082, § 388-515-1550, filed 5/17/05, effective 6/17/05. Statutory Authority: 2004 c 276 § 206 (6)(b) and *Townsend vs. DSHS,* U.S. District Court, Western District of Washington, No. C 00-0944Z. 04-16-029, § 388-515-1550, filed 7/26/04, effective 8/26/04.]