QUESTIONS AND ANSWERS ON THE COPES PROGRAM

SOLID GROUND – BENEFITS LEGAL ASSISTANCE APRIL 2024

THIS PAMPHLET IS ACCURATE AS OF ITS DATE OF REVISION. THE RULES CHANGE FREQUENTLY.

1. What is COPES?

COPES is a Home and Community Based Services (HCBS) waiver program that pays for services for people in community settings. These services help people who would otherwise need to be in nursing homes. "COPES" stands for Community Options Program Entry System.

The services offered through the COPES program are administered by Home and Community Services (HCS), a division of the Washington State Department of Social and Health Services (DSHS) . DSHS determines whether you are eligible.
HCS has 2 other Home and Community Based Services (HCBS) Waivers called New Freedom in King and Pierce Counties and the Residential Support Waiver. The financial eligibility rules for these programs are the same as COPES. For an overview of all HCS long term services and supports see: Medicaid and Options for Long-Term Services for Adults found at www.dshs.wa.gov/sites/default/files/publications/documents/22-619.pdf
The Aging and Long Term Supports Administration website has information on all long term care services and information at www.dshs.wa.gov/altsa/long-term-care-services-information

Important Note About COPES: People on COPES are eligible for the Qualified Medicare Beneficiary (QMB) Medicare Savings Program. QMB pays your Medicare premiums, co-payments and deductibles. If you are on COPES, you are QMB-eligible even if your income would ordinarily be too high to qualify. See Medicare Savings Programs: Help Paying for Medicare Costs at Medicare Savings Programs on WashingtonLawHelp.org for more information about QMB.

How to Apply:

Apply for COPES one of three ways: by filing an application online; submitting a paper application to a local DSHS Home and Community Services (HCS) office; or by calling your local HCS office.

The website for filing an online application is Washington Connection

www.washingtonconnection.org

The website for downloading a paper application [form HCA 18-005, Washington Apple Health Application for Long-Term Care/Aged, Blind, Disabled Coverage] is

www.hca.wa.gov/assets/free-or-low-cost/18-005.pdf

You may also pick up the application form at an HCS office. A paper application may be returned to PO Box 45826 Olympia WA 98504 or to your local HCS office. To find the right office, call 1-800-422-3263 or use the online tool to find the HCS office in your county www.dshs.wa.gov/altsa/resources

2. How is COPES eligibility determined?

To get COPES you must be financially eligible (see Questions 5-7). Also, you must need help, because of a physical or cognitive disability, with certain activities of daily living. Those activities are eating, bathing, transfer (e.g., moving from a bed to a chair), bed mobility (positioning), locomotion (walking or moving around), using the toilet, and medication management.

To qualify for COPES, you must need extensive help with two or more of the listed activities of daily living, or at least some help with three or more. A person who needs supervision because of a cognitive impairment may qualify for COPES if extensive help with one of the listed activities is needed. Finally, HCS must determine that you need the help described above and that your needs can be met adequately by services available through COPES.

Individuals under age 65 who are not on or eligible for Medicare may be eligible for health care, known as MAGI Medicaid, through the Health Benefit Exchange (wahbexchange.org). MAGI Medicaid includes nursing facility coverage but does not include COPES coverage. The information and rules in this publication apply to MAGI Medicaid individuals that need COPES services. A disability determination is required for a MAGI individual needing COPES services and the individual must meet the income and resource requirements of the COPES program.

Note: The Washington State Health Care Authority (HCA) uses the term "Apple Health" to refer to all Medicaid and state medical programs, including long-term care programs. MAGI Medicaid refers to Medicaid medical for qualifying individuals under age 65 who are not on or eligible for Medicare. Classic Medicaid, also known as SSI-related Medicaid, is Medicaid medical for qualifying individuals age 65 and over. These are both Apple Health programs.

3. How much does COPES pay?

What COPES will pay for depends on the service(s) you are assessed to need help with and how much help you need with them. Almost everyone receiving services through COPES will also receive services through the Community First Choice (CFC) program. CFC pays for personal care (and some other services), while COPES may pay for other "wrap-around" services, including home-delivered meals, home health aides, skilled nursing care, adult day care, and training to help you increase what you can do for yourself.

Medicaid may also pay for care in a group facility or home. Payment depends on the type of facility and its location. The maximum COPES pays for an adult family home ordinarily ranges from about $3,368 to $7,002 per month. For an assisted living facility, the payment ordinarily ranges from about $2,940 to $6,511 per month. The actual amount depends on the county and level of care needed. Under rare circumstances, when more intensive care is needed, Medicaid may pay a higher rate. A growing number of adult family homes and assisted living facilities are requiring residents to privately pay for a specified number of months, or years, before allowing a resident to convert to a Medicaid status. It is important to be aware of this practice when looking for a facility.

All COPES recipients get Medicaid coverage for other medical expenses, including physician services, prescription drugs and home health services. In addition, they get case management services—help in planning and monitoring their care.

4. When does COPES coverage begin?

COPES coverage does not begin until HCS approves a plan that describes your needs and the services that will meet them. The *medical* coverage you get with COPES is effective as of the first day of the month in which your COPES coverage begins.

5. How are income and resources defined for purposes of COPES?

To get COPES services, both your income and your resources must be within set limits. In counting your *income* for a month, DSHS looks at what you *received that month*. Income typically includes such things as Social Security, VA benefits, pension payments and wages, in the month they are received.

In counting your resources for a month, DSHS essentially takes a snapshot of your resources as of the first moment of the first day of the month. Whatever resources exist at that exact moment are the resources counted. Resources typically include such things as real estate, funds in bank accounts (but not including this month's income) and stocks. Funds from a payment that counted as income last month will count as resources this month if you still have them as of the first of this month. Not all resources count for purposes of determining resource eligibility.

The income and resource standards for Medicaid programs are adjusted yearly and can be found here

www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources

6. Am I "income eligible" for COPES?

An applicant is income eligible if the applicant's monthly income is no greater than $10,427 after reducing income by the amounts below.

- Income from certain sources (see WAC 182-513-1340)
- General disregard ($20)
- Earned income disregard (first $65 of earned income and one-half of any additional earned income)
- Health insurance premiums, other than Medicare (prorated monthly over a 12-month certification period); and
- Outstanding allowable medical bills

For married applicants, this applies only to the applicant's income and not to the income of the non-applicant spouse.

If you are income eligible for COPES, you will be allowed to keep a specified amount of income and will be required to use any additional amounts for certain purposes (see Questions 8-9).

7. Am I "resource eligible" for COPES?

The limit for resources (assets, property, and savings) that a single person may have is $2,000. Certain "exempt" resources are not counted in determining whether you fall within this limit. Exempt resources are described in Question 11.

A spouse of a COPES recipient is allowed to keep substantially more resources. What resources a spouse can keep is explained in the answer to Question 10. Rules about the consequences of giving away your resources are described in the answer to Question 12.

Note: A regulation, effective April 16, 2015, considers resources transferred to another individual or entity to pay for your long-term care as available to you, which will usually make you ineligible because you have excess resources. (see Question 12).

8. What *income* can I keep if I go on COPES?

If you are on COPES, you will be allowed to keep a specified amount of income, called a "personal needs allowance." As described in detail below, if you have more than the allowable amount, you must use the rest for certain purposes, such as paying for care services.

If you are on COPES and live at home, you will be allowed to keep the following amount of countable income for your personal needs allowance (which includes home maintenance): if you are single, $2,829, a month; if you are married and your spouse is *not* on COPES, $943 a month; if you are married and your spouse is also on COPES, $2,829 for each spouse.

If you are on COPES and live in an adult residential care facility, assisted living facility or adult family home, you can keep a personal needs allowance of $100 per month (or $38.84 for certain residents on the state-funded Aged, Blind, Disabled (ABD) cash program). The next $ 843 must be paid to the facility for room and board. ($100 + $ 843= $943.)

The spouse of a COPES recipient may be allowed to keep some of the income of the COPES recipient, as explained in Question 9. This amount is called a "spousal income allowance."

However, a spousal allowance can only be allocated if your spouse is not in a medical institution and meets the income requirements for receiving the allowance, and if you have sufficient income remaining after other allowable deductions. Deductions from income are allowed in a hierarchy.
After allowing for the personal needs allowance (including room and board), deductions from income are allowed in the following order:

(1) An amount allowed for an earned income deduction (currently $65), and ½ of your remaining earned income (if you are working);
(2) an amount for guardianship fees and administrative costs;
(3) an amount for current and/or back child support garnished or withheld from the current month's income according to a child support order;
(4) an amount for your spouse, if you have one;
(5) an amount for dependent family members; and
(6) an amount for unpaid allowable medical expenses.

The total amount of the deductions for your personal needs allowance, earned income, and guardianship fees/costs cannot exceed $2,829. The number and amount of deductions actually allowed will depend on the individual's income and the amount of each deduction.

Any remaining income must be used to pay for part of the cost of the services you were approved for. This includes both the cost of COPES and CFC services. The part of the cost you pay is called your "participation." DSHS covers the rest. You are only responsible to pay participation up to the *actual* cost of the care services that are provided.

Example 1
You are approved for long term care services in your own home and your participation is $500. However, your CARE plan only calls for 30 hours of help at $10.00 per hour. In this example, you pay only $300 to your provider, not $500.

Example 2
You are approved for long term care services in an assisted living facility and

your participation is $3,000. However, your assisted living facility state rate is $2,635 per month. In this example, you pay only $2,635 to your provider, not $3,000.

If the actual cost of services is lower than your participation amount, you should be careful that the difference does not raise your resources over the $2,000 limit on the first of the following month.

Your COPES eligibility and personal needs allowance usually will not be affected by items or services that are given to you or that you receive because someone else pays for them.

9. What *income* can we keep if my spouse goes on COPES?

If your spouse goes on COPES and you are not on COPES or Medicaid, your spouse is allowed to keep $943 per month and you are allowed certain additional income.

You (the spouse not on COPES) can always keep all income paid in your name, no matter how much. In addition, if the income paid in your name is less than $2,465 you can keep as much of your spouse's income exceeding the $943 as is necessary to bring your income up to $2,465 per month. And, if your housing costs (rent or mortgage, maintenance fee for a condominium or cooperative, property taxes, homeowner's insurance, and utilities) exceed $740 per month, the $2,465 can be increased up to $3,716 by the amount of this excess. (In calculating housing costs, your actual costs for rent, mortgage, maintenance fee for a condominium or cooperative, taxes, and insurance are used. For utilities, however, a standard figure of $483 per month is used.)

If your COPES-recipient spouse is in an adult family home or other residential facility, then all but $100 of the first $943 of his or her income must be paid to the facility for room and board. If this does not leave the couple with enough income to allow you (at home) the amount you would otherwise get, as described in the last paragraph, there is a special problem. You can ask HCS to make what is called "an exception to rule" to lower the amount of room & board paid to the facility, so that the money can be available to the spouse instead. (There is a dispute about whether denial of such a request would be allowed under federal law. If that problem affects you, you may wish to seek legal advice.)

Whether or not you can receive an allowance from your spouse's income will depend on the amount of your spouse's income; other deductions allowed, if any; and the amount of other deductions. Deductions from your income are allowed in a hierarchy order (see Section 8).

Examples

Your spouse is at home and on COPES.

- If $2,400 is paid in your name and $950 is paid in your spouse's name, you can keep $2,400. Your spouse can keep $943 of his or her income and would pay $7 to the COPES provider.

- If $943 is paid in your name and $2,400 is paid in your spouse's name, you can keep your $943 plus you may be able to keep at least $1,551 of your spouse's income ($2,465- $943= $1,522). And if your housing costs are $800 per month, you can keep an **additional** $60 of your spouse's income because the $2,465 level is increased by the excess of your housing costs over $740 ($800 - $740 = $60). Whether or not you can receive an allowance from your spouse's income will depend on the amount of

your spouse's income; other deductions allowed, if any; and the amount of other deductions. Deductions from your spouse's income are allowed in a hierarchy order (see Section 8).

A spouse of a COPES recipient may be allowed to keep more of a COPES recipient's income if a superior court judge orders higher support (for example, in a legal separation proceeding) or if an administrative law judge decides that there are "exceptional circumstances resulting in extreme financial duress."

A COPES recipient may also be entitled to an additional allowance for the care of a dependent family member.

10. What *resources* can we have when my spouse applies for COPES?

When your spouse applies for COPES, the two of you can have any resources that are "exempt" – a home and a car, for example. Exempt resources are explained in the answer to Question 11.

You can also have non-exempt resources up to a certain value. (Non-exempt resources include such things as cash, most funds in bank accounts, and investments.) The limit includes the $2,000 that a single COPES recipient is permitted to have plus an amount established by the "Community Spouse Resource Allowance" or "CSRA."

The CSRA is $68,301. When your spouse applies for COPES, you and your spouse can have $70,301 of non-exempt resources ($68,301 allowed for you and $2,000 allowed for your spouse) and possibly more. At the time of application, it does not matter which spouse owns what resource or whether the $68,301 or any part of it is community or separate property. All resources of both spouses will be added together to determine eligibility.

Sometimes the CSRA can be more than $68,301. It can be more if one of the following exceptions applies:

(1) If your spouse is currently institutionalized (in a hospital or nursing home), and you can show that the combined resources of both spouses were more than $136,602 when their current period of institutionalization began, then you may be entitled to a CSRA of more than $68,301. If this applies, the CRSA is increased to half of the combined resources that the couple had at the time the period of institutionalization began. The maximum amount that the CSRA can be increased to is $154,140.

(2) You *may* be allowed to keep more non-exempt resources if the combined *income* of both spouses is not enough to give you what is allowed by the rules explained in the answer to Question 9 above ($2,465 to $3,716). To do this, a spouse who is not on COPES must request a decision from HCS, at the time of application, that more resources are necessary to produce the permitted income level.

(3) If your spouse is currently institutionalized (in a hospital or nursing home) and the current period of institutionalization began before August 1, 2003, then your CSRA is $148,620.

You can reduce excess resources that make your spouse ineligible for COPES in various ways. You can spend the excess resources on such things as medical care, on home repair, on the purchase of exempt resources, or on consumable goods or services, so long as you receive fair value for your money. Or you can buy an annuity that converts the excess resources to monthly income, *if the annuity satisfies the requirements of Health Care*

Authority (HCA) regulations. To determine whether a particular annuity satisfies HCA requirements and whether a particular financial plan makes sense in your particular case, you should consult a lawyer familiar with Medicaid law.

The explanation above responds to the question "What resources can I have when my spous*e applies* for COPES?" An entirely different rule applies once your spouse is *already on* COPES. After an application is approved, continuing eligibility of the spouse on COPES will not be affected by increases in the resources of the spouse who is not on COPES. In other words, if one spouse is already on COPES, the other spouse's resources can increase above the limit that applied at the time of the eligibility determination. The increase will not affect the COPES eligibility of the spouse on COPES.

At the time of application, it does not matter which spouse owns resources. But, within a year after a COPES application is approved, anything over $2,000 must be transferred to the non-COPES spouse. Then, the spouse on COPES must not have more than $2,000 worth of non-exempt resources in his or her name.

11. What resources are not counted to determine COPES eligibility?

A. What are exempt resources?

Some resources are considered exempt and are not counted toward the $2,000 and $68,301 to $154,140 resource limits that were discussed in the previous section. Exempt resources can include your home, household goods and personal effects, some real estate sales contracts, a car, life insurance with a face value of $1,500 or less, most burial plots and prepaid burial plans, and certain other property and items used for self-support. Some of these are discussed in more detail below.

Also, *non-exempt* resources that cannot be sold within 20 working days are temporarily disregarded while being sold.

B. When is a home exempt?

A home (which may be a house and surrounding land, a condominium or a mobile home) may be an exempt resource. The exemption applies if the COPES recipient lives in the home, or is temporarily absent but intends to return to it. It also applies as long as the recipient's spouse or, in some cases, a dependent relative continues to live in the home.

The exemption does not apply to a home in which the COPES recipient has an equity interest of more than $1,071,000 unless one of the following exceptions applies: (1) the recipient is receiving services based on an application for Medicaid long-term care services filed before May 1, 2006; or (2) the recipient's spouse or the recipient's child who is under 21 or blind or disabled resides in the home. (The disability criteria for this purpose are the same as those used for Social Security disability determinations.)

Even when a home is exempt, a married Medicaid applicant or recipient still may wish to transfer his or her interest in it to a spouse. Such a transfer may be made to prevent future recovery of Medicaid costs from a Medicaid recipient's estate (see Question 13), or to make it easier for the spouse to sell or otherwise dispose of the home. But, such a transfer is not always a good idea. It may, for example, have adverse tax or other consequences in some cases. Before making such a transfer, you should consult with a lawyer familiar with Medicaid rules and estate planning.

The proceeds from the sale of an exempt home are also exempt if, within three months of when they are received, they are used to purchase a new exempt home.

C. When is a sales contract exempt?

The seller's interest in any sales contract entered into before December 1, 1993 is an exempt resource unless it is transferred. A sales contract entered into after November 30, 1993 is exempt only if it is a contract for the sale of the seller's home and includes fair market terms. A sales contract entered into after May 2004 is exempt only if it is for the sale of the seller's principal residence at the time he or she began a period in a medical facility (including a nursing home) or on COPES and if it requires repayment of the principal within the seller's "anticipated life expectancy." The *payments* received under an exempt sales contract will be treated as *income*.

D. When is a car exempt?

One car is exempt, no matter how much it is worth, if it is used for transportation for the COPES recipient or for a member of the recipient's household.

E. When is life insurance exempt?

The cash surrender value of life insurance may be claimed as exempt if the total *face* value (amount payable at death) is not more than $1,500. For couples, each spouse may claim $1,500. If the face value of an individual's life insurance is more than $1,500, the entire *cash surrender* value (the amount payable if the policy is canceled) is counted as a non-exempt resource. (It will count as part of the $2,000 or $68,301 to $130,380 resource limits discussed in the previous section.) Life insurance with no cash surrender value has no effect on COPES eligibility.

F. When are burial funds and burial spaces exempt?

A burial fund of $1,500 for an individual (and an additional $1,500 for a spouse) may be claimed as exempt if set aside in a clearly designated account to cover burial or cremation expenses. If an individual has life insurance that is claimed as exempt, then the face value of the life insurance will count as part of the individual's burial fund. So, for example, if a COPES recipient has exempt life insurance with a face value of $1,000, then only $500 may be exempted in a designated account for burial expenses.

An *irrevocable trust* for burial expenses or a *pre-paid burial plan* may be claimed as exempt as long as it does not exceed reasonably anticipated burial expenses. The value of such a trust or plan will count against the exemption for burial funds or life insurance.

Burial spaces for COPES recipients and immediate family members are exempt no matter how much they are worth.

G. When are household goods and personal effects exempt?

Household furniture and other household goods, as well as clothing, jewelry and personal care items are exempt regardless of value.

H. When is an entrance fee paid to a continuing care retirement community or life care community exempt?

An entrance fee paid by a long term care Medicaid applicant to a continuing care retirement community or life care community is still considered a resource available to the applicant to the extent that: (1) the applicant has the right to use the fee (including using it to pay for care); (2) the contract allows for the refund of any remaining entrance fee on death or termination of the contract and

leaving the community; and (3) the fee does not convey an ownership interest in the community.

I. When is the dollar value of insurance proceeds paid out under a long-term care policy considered exempt?

The dollar value of insurance proceeds paid out for long-term care expenses, under a Long-Term Care Partnership insurance policy, will be deemed exempt at the time of Medicaid application and will not be subject to Medicaid estate recovery at death (the exemption applies only to the value of insurance proceeds paid out under a qualified Long-Term Care Partnership insurance policy).

12. Can I transfer resources without affecting COPES eligibility?

A. Rules for transfers of a home

A *home* may be transferred without penalty to any of the individuals described below. (The person making the transfer does not need to live in the home at the time of the transfer.)

- A *spouse*

- A *brother* or *sister* who has an equity interest in the home and has lived there at least one year immediately before the date when their sibling's COPES coverage or institutionalization began.

- A *child* who has lived in the home and cared for the parent for two years immediately before the date of the parent's current COPES coverage or institutionalization. (If this requirement is met, it does not matter *when* the property is transferred to the child.) The care must have enabled the parent to remain in the home and it must be verifiable, and it must not have been paid for by Medicaid. A physician's statement of needed care is required.

- A *child* who is under 21, or blind or disabled. (The disability criteria for this purpose are the same as those used for Social Security disability determinations.)

B. Rules for other transfers to a spouse or disabled child

There is no penalty for transferring resources to a spouse or a disabled child. (Again, the disability criteria are the same as those used for Social Security disability determinations.)

Remember that the resources of both spouses are added together in determining initial COPES eligibility. So, if a couple has more resources than are permitted at the time of application, a transfer from one spouse to the other will not solve that problem.

A transfer to a spouse or to a disabled child may be made without penalty either before or after an individual qualifies for COPES or Medicaid.

C. Rules for other transfers to someone other than a spouse or disabled child

(1) Transfers without penalty

(a) There is no penalty if you sell your resources for their fair market value.

(b) *Exempt* resources (see Question 11), *other than the home or a sales contract*, may be given to anyone without penalty.

(c) There is no penalty for gifts made after April 2006 as long as the total amount in any calendar month is $391 or less. (Different rules apply if you made gifts before May 2006 *and* you applied for COPES or Medicaid for nursing home care before May 2009.)

(d) There is no penalty for gifts of any value made more than 60 months before applying for COPES or Medicaid for nursing homes.

(e) No matter when a transfer is made, there is no penalty if you can demonstrate that the transfer was not made to qualify for COPES or Medicaid for nursing home care, or made to avoid estate recovery.

(2) Transfers resulting in penalties

There may be a penalty if you transfer *non-exempt* resources, or sales contracts, or a home (except to one of the people listed above), for less than fair market value within **60** months of applying for Medicaid. The penalty is a period of ineligibility for COPES or Medicaid for long-term care services. The length of ineligibility depends on the value and timing of the transfer. There is no maximum length for a period of ineligibility.

(3) Calculating periods of ineligibility

The process of calculating periods of ineligibility is slightly complicated. After reading the following explanation, if you are left with questions about the effects of gifts you have made or are considering, you should talk with a lawyer who knows Medicaid rules.

Note: The explanations below apply to COPES applications made between October 1, 2023 and September 30, 2024. (The numbers change each October.)

To determine the period of ineligibility, take the total of all gifts made within 60 months before applying and divide the total by 391. The number of days of ineligibility is the result of this division. This divisor of 391 is the daily statewide average of private nursing facility rates (currently $391).

The period of ineligibility does not begin to run until an applicant for Medicaid-funded long-term care services is eligible in all other respects except for the period of ineligibility. This means that the applicant must satisfy the income and resource eligibility requirements and must meet the level-of-care requirements for COPES or Medicaid for nursing home care. Also, in order to start running the period of ineligibility, the Department requires that an individual make an application—in effect, seeking a determination by the Department that he or she is "otherwise eligible."

Example:

If you made gifts totaling $20,000 between May and August 2023 and applied for COPES in October 2023, you would calculate the period of ineligibility by dividing 20,000 by 391 to produce 51 days of ineligibility resulting from those gifts. (20,000 ÷ 391 = 51.15, which rounds down to 51). The period of ineligibility would begin on October 1, 2023, assuming that you were otherwise eligible for COPES on that day.

If the gift is made when an individual is already receiving COPES coverage, then the period of ineligibility normally begins on the first day of the month following a notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery by the agency of the transfer. There is one exception to this norm. The penalty period will begin later if another penalty period is already in progress. In that case the new penalty period starts after the current one is completed.

Generally, before you apply for COPES or Medicaid for nursing home care, the same restrictions apply to transfers by you or your spouse. If you or your spouse gives away resources, either gift may result in a period of ineligibility for you. Once you are receiving COPES or Medicaid for nursing-home care,

however, gifts made by your spouse will not affect your continuing eligibility.

(4) Transfers Affecting Resource Eligibility

A regulation, effective April 16, 2015, provides that the transfer of cash and other resources by an applicant or current recipient of long-term care services (or his or her spouse) to another person or entity to pay for the applicant's or recipient's long-term care services are considered resources available to the applicant or recipient, unless otherwise excluded. This will usually make you ineligible because you have excess resources. In that situation, the period of ineligibility will not begin to run.

(5) **Eligibility for Community First Choice**

If you are ineligible for COPES services due to a transfer of resources, you may still be eligible to receive personal care services through a program called Community First Choice (CFC), if you meet the income and resource standards for that program. See the pamphlet entitled Questions and Answers on Community First Choice Program, which is available on the website WashingtonLawHelp.org.

(6) Waiver of periods of ineligibility

Home and Community Services may waive a period of ineligibility if it finds that denial of benefits would cause undue hardship. A hardship waiver may be granted in cases where there has been denial or termination of benefits based on transfer of assets or excess home equity. Such a waiver may lead to imposition of a civil fine on the recipient of a gift if the recipient "was aware, or should have been aware," that the gift was made for the purpose of qualifying for Medicaid.

A hardship waiver may be granted for transfers between couples who are married or for transfers between registered domestic partners.

13. Will COPES payments result in a lien or claim against my estate?

DSHS may be entitled to recover, from a Medicaid client's estate, the amount the State of Washington paid for the client's care. Whether or not Medicaid is entitled to recover depends on the type of services the client received and the dates when the services were provided to the client. See the Columbia Legal Services publication entitled Estate Recovery for Medical Services Paid for by the State, which is available on the website WashingtonLawHelp.org.

Recovery will be delayed if, at the time of death, the COPES recipient has a surviving spouse, registered domestic partner, or surviving child who is under 21 or blind or disabled.

The DSHS estate-recovery claim only applies to property owned at death by a COPES recipient. *No claim can be made against property solely owned by a spouse or child.* This may be an important reason to consult a lawyer familiar with COPES and Medicaid rules about permissible transfers of property.

14. Can I get help with the application process?

Many people need help applying for COPES or Medicaid. Often there are family members or friends, or staff members of a hospital or nursing home or other agency, who are able to help. Help is also available from HCS staff, especially for people who have physical or mental impairments that make it hard to get through the application process on their own.

If you need help in the application process from HCS, you or someone else should tell the HCS representative that you need help.

DSHS rules require what are called "necessary supplemental accommodation services" when they are needed. These services include help filling out forms and help finding information or papers needed for your application.

Important Note: People on COPES can hire an Individual Provider (IP) to provide care. If you do, your decision about which IP to hire has to go through the state or a stand-in for the state called a Consumer Directed Employer or CDE. IPs have to pass background checks. If they can't pass, you can't hire them. Sometimes, the state or the CDE may decide not to let you hire the IP you want, even though the IP passed a background check. You get a hearing if the state says you can't have the IP you want, but you don't get a hearing if the CDE makes that decision. There is a question whether this is legal. If this happens to you, you can talk to a lawyer for free. Outside King County, call the CLEAR Hotline at 1-888-201-1014 weekdays between 9:15 am - 12:15 pm. In King County call 2-1-1 weekdays between 8:00 am - 6:00 pm. They will refer you to a legal aid provider. Seniors (age 60 and over) can also call CLEAR*SR at 1-888-387-7111, statewide.

COPES rules are complicated. Before taking steps you don't understand, you should get individualized legal advice. A helpful resource is the Washington Academy of Elder Law Attorneys website at waela.org.

COPES 4-2024

Solid Ground – Benefits Legal Assistance
1501 N. 45th St., Seattle, WA 98103

This is for clients who are anticipating long-term care in 2 or 3 years.

Medicaid Eligibility Rules and Steps in a Marital Setting

Revised 5/2024

A. General Medicaid Qualification Rules: Sometime in the future, should either spouse need to subsequently apply for Medicaid benefits, we know that in order to qualify the first spouse for Medicaid, the combined assets of both spouses (as determined on the 1st day of the month) are counted in determining eligibility, regardless of their "separate" or "community" property character. If those combined assets amount to less than: (1) a home of any value, (2) a vehicle of any value, and (3) $70,301 in other resources (up to $156,140, depending upon the circumstances), then the disabled spouse can qualify for Medicaid for the remainder of their lifetime. We also know that should their combined resources exceed the Community Spouse Resource Allocation (CSRA) limit of $68,301 plus $2,000 allowed for the disabled spouse ($70,301 combined total exempt amount), then we can shelter the non-exempt excess resources (the amount over our CSRA limit) through either: (1) paying down any mortgages against the home and paying off other debt, (2) purchasing other exempt assets (burial plans, burial plots, new car, etc.), (3) enhancing the value of previously exempt assets (i.e., remodel the home, etc.), (4) privately paying any required "private pay" requirement periods of any Medicaid eligible Adult Family Homes the disabled spouse may be living, and finally, (5) purchasing an immediate annuity in the name of the "Community Spouse" (i.e., the non-disabled spouse) immediately prior to submitting an Application for Benefits, or (6) purchasing an immediate annuity in the name of the disabled spouse immediately prior to submitting an Application for Benefits and transferring some of the disabled spouse's income to the Community Spouse. See illustrations attached. Once we are successful in obtaining Medicaid eligibility for the disabled spouse, then we would be required to transfer all of the remining assets from the disabled spouse's name into the sole name of the Community Spouse within one year of eligibility (i.e., Quit Claim Deed of the disabled spouse's interest in the home to the Community Spouse's name and opening new bank/investment accounts in the Community Spouse's sole name to hold the other assets), since the disabled spouse is required to own less than $2,000 to maintain their ongoing Medicaid eligibility. However, if we were planning to purchase an immediate annuity in the name of the Community Spouse to get the disabled spouse eligible, then we would need to transfer all of the assets into the sole name of the Community Spouse prior to eligibility and prior to the purchase of the annuity (i.e., necessary to purchase the annuity from a separate property account in the Community Spouse's sole name). Remember, **transfers or gifts from one spouse to another, is not subject to "gifting" penalties and is not subject to Medicaid's 5-year "look-back" period (nor are transfers at death, which are not deemed gifts or transfers during one's lifetime)**.

B. Standard "Spend-Down" Considerations: In order to properly reduce their excess funds down to the appropriate $70,301 combined threshold without simply spending down on care, any of the following options may be employed:

1. Pay off the mortgage on the home, which will simply enhance the value of the largest exempt asset.

2. Do capital improvements to "enhance the value" of previously existing exempt assets such as the home (new roof, repairs, new appliances, etc.), or car maintenance on the exempt vehicle, etc. Keep in mind that if you were to do capital improvements to the home, you cannot pre-pay the bid, unless the work has been "substantially completed" prior to Medicaid application, to avoid having the "unapplied" portion be deemed an available resource (i.e., right to be reimbursed).

3. Pay off debt (credit card debt, real estate taxes for the entire year, car and homeowner's insurance for the year, etc.). However, the debt must be incurred and billed in order to pay it. As such, you cannot pre-pay rent for a year if billed monthly (the right of reimbursement of additional months is viewed as a resource). If you receive a monthly bill (e.g., PUD, water/sewer, and other utilities, that bill only monthly), that is not a bill you can pre-pay. As for dental work, if the services are rendered before eligibility, then you can pay them. However, if you pre-pay for dental work that is not scheduled to be performed until after eligibility, then that will not work since you will have the right to be reimbursed. The same is true of home improvements. If you pre-pay for a new roof, then it is only okay if the work is substantially completed before eligibility, otherwise the work has yet to be completed and you have the right to be reimbursed. Another example is when an IRA account needs to be liquidated, then the tax would be owing when liquidated. In that case, you can withhold an amount that you will need to pay the taxes, provided that you get a letter from a CPA that states a reasonable estimate of what to withhold.

4. Purchase other exempt assets such as a newer vehicle, burial plots, pre-paid burial plans, clothes, personal property, etc.

5. IRA accounts in the name of a potential disabled spouse. If we are not sure which spouse may need to apply for Medicaid assistance in the future, we know that that particular spouse cannot own more than $2,000 in resources. Therefore, if we have, for an example, three (3) years before we anticipate needing to seek eligibility for either spouse, then consider:

(a) IRA account in the spouse **more likely** to need long term care first: Remember, the anticipated disabled spouse cannot own more than $2,000 in resources when they become eligible. As such, if the anticipated disabled spouse owns an IRA account (which cannot be transferred to the other spouse) and, for an example, we anticipate needing eligibility in three years, then consider liquidating the IRA over time (i.e., 1/3rd in year one, 1/3rd in year two, and the balance in year three), or converting the IRA to a Roth IRA over the same time span (i.e., convert 1/3rd in year one, 1/3rd in year two, and the balance in year three, and liquidating later, without tax consequences, when we need to apply for Medicaid for the disabled spouse), in order to spread out the income tax liability over multiple tax years, thereby avoiding higher marginal tax rates should you liquidate the entire IRA in the year of eligibility. Be sure to withhold for income taxes at the time of liquidation (rather than waiting until the time you file your 1040 return), since you will have "incurred a debt" to the IRS at the time of liquidation and can pay the debt (via withholding) at the time of liquidation. You may need to obtain a letter from a CPA to provide you with a reasonable recommended withholding percentage (i.e., you cannot withhold more than the anticipated tax to be paid simply to receive a larger refund after eligibility). If Medicaid is needed immediately, and if we don't expect the disabled spouse to live long due to some medical

issue, a useful strategy could be to purchase an IRA annuity with the IRA. Annuities purchased with the proceeds from an IRA (and other retirement vehicles) are not available resources under WAC 182-516-0201(3), even if the annuity is revocable.

(b) IRA account in the name of the spouse **less likely** to need long term care first: If the anticipated Community Spouse owns an IRA account, then you can still consider liquidating the IRA account in the anticipated Community Spouse's name as set forth above, but if the clients feel somewhat certain that the other spouse will need long term care first, then the Community Spouse's options are (i) converting the IRA into a "qualified" immediate annuity when the Medicaid application becomes necessary for the other spouse, or (ii) converting portions of the anticipated Community Spouse's IRA into a Roth IRAs to spread out the tax liability over three taxable years, so as to provide for a more suitable asset to subsequently pass into the testamentary special needs trust under the Last Will and Testament of the Community Spouse (if the Community Spouse were to die before the anticipated disabled spouse). Future distributions from a Roth IRA account are federally tax free as long as the funds have been in the Roth IRA for 5 years or longer. Once again, if Roth conversion is the option, then it will require you to pay the tax on the converted portion, which should be withheld at the time of conversion. In either case, you may still need to obtain a letter from a CPA to provide you with a reasonable recommended withholding percentage to prove to DSHS that you are not using the IRS to shelter excess funds (i.e., to receive a large refund after eligibility). Alternatively, if the Community Spouse obtains a Medicaid qualified annuity at the time the disabled spouse applies for Medicaid, the Community Spouse's IRA should be cashed out except for $1,000 remaining in the IRA. (The goal is to keep the original IRA account open). Then, within 60 days, the proceeds should be put into a Medicaid qualified annuity with five equal annual payments distributed over five years (You can set it longer or shorter than five years, but generally, five years is optimal). Then, if possible, set up the annuity payments to be directly deposited into the original IRA account. This takes advantage of the rule that allows you to withdraw from an IRA and put it back into an IRA within 60 days, without it being considered a taxable distribution. Thus, at the end of the five years, the Community Spouse's IRA is back to where it was originally. There is no guarantee that the Community Spouse will avoid taxes on the annuity payments, but this option is better than having to spend it all immediately to become qualified for Medicaid.

6. IRA accounts in the name of the currently disabled spouse. If we are sure which spouse will need to apply for Medicaid assistance, we know that that particular spouse cannot own more than $2,000 in resources. If that spouse owns an IRA, since ownership of the account cannot be changed, typically the only option is to liquidate the IRA and transfer the funds to the Community Spouse or spend them. This will mean paying a large portion of the IRA (potentially up to almost 40 percent) in income taxes. However, in some circumstances, the disabled spouse should consider using their IRA to purchase an immediate IRA annuity in their name just before the time they need to seek Medicaid eligibility, thereby converting this otherwise non-exempt resource from a "resource characterization" into an "income characterization" without triggering the income taxes. Such annuity would be structured to last for the actuarial life expectancy of the disabled spouse. This strategy is useful if significant tax consequences for liquidating the IRA would result, if the couple has a low monthly income, and/or if the Community Spouse is expected to outlive the disabled spouse. The goal of this plan is to maximize the IRA annuity term to minimize the monthly income produced by the annuity, with the intent of shifting the annuity

income to the Community Spouse under rules allowing a spousal maintenance allowance. Such rules allow a married couple to shift income from the disabled spouse to the Community Spouse if the Community Spouse's monthly income is less than $2,465 per month before such income shifting. There are two down-sides to using an immediate annuity in this situation. First, should the disabled spouse (the annuitant/payee) die prior to the annuity's final payout, the Community Spouse would be the primary beneficiary, but by federal law the "State of Washington" would be the contingent beneficiary up to the extent the State (DSHS) has paid for the disabled spouse's care, unless the disabled spouse has a minor or disabled child. Therefore, if the Community Spouse dies prior to the disabled spouse, and then if the disabled spouse dies before the annuity's final payout, any remaining portion of the annuity will be paid to DSHS up to the amount it had spent on the disabled spouse's long-term care. Second, should the Community Spouse die prior to the disabled spouse, then while the disabled spouse is alive, any remaining portion of the annuity income will go directly to the Adult Family Home or Assisted Living Facility as the disabled spouse's Medicaid co-pay. Therefore, when deciding on this type of Medicaid planning, it is important to compare each spouse's longevity and health outlook with their actuarial life expectancy.

C. Other "Spend-Down" Considerations: Once the above items have been done, and if we still need to reduce their combined assets further in anticipation of eligibility in a number of years, then the two remaining "spend-down" methods may be considered prior to our anticipated eligibility date:

1. Privately pay for any Medicaid eligible Adult Family Home or Assisted facility you intend to move the disabled spouse into. Since most quality Medicaid eligible Adult Family Homes (AFH) and Assisted facilities have private-pay requirement periods (2-year, 3-year, or more) before they will allow a resident to apply for Medicaid, then it is always a consideration to move the spouse into a quality Medicaid AFH or Assisted facility earlier than later, while you still have available resources to pay, or "bank" their respective private pay requirement period. Then, once that private-pay requirement period has been met, then we can proceed towards application and the use of an immediate annuity to shelter the remaining excess non-exempt resources (purchased one to two months prior to our anticipated Medicaid eligibility date).

2. Immediate Annuities. If the anticipated disabled spouse has met their "private-pay" requirement period in a quality Medicaid eligible AFH or Assisted facility, or has subsequently moved into a Skilled Nursing Facility (which cannot require private-pay requirement periods), then the last remaining method to shelter excess resources (instead of simply spending down to Medicaid qualifying levels), is to purchase an immediate annuity just before the time we need to seek Medicaid eligibility, thereby temporarily converting otherwise non-exempt resources from a "resource characterization" into an "income characterization." The annuity will typically be in the name of the Community Spouse, but sometimes an annuity in the name of the disabled spouse is more advantageous.

a. Immediate Annuities in Name of Community Spouse. Converting excess resources into income for the Community Spouse is done using a special Medicaid annuity that is for a term of five years or the Community Spouse's actuarial life expectancy, whichever is shorter. Once the disabled spouse becomes eligible for Medicaid, then the Community Spouse is no longer required to meet the Community Spouse resource test of a home and CSRA limit of $68,301 (i.e.,

increases in the Community Spouse's resources over $68,301 through the subsequent receipt of annuity payments by the Community Spouse will have no effect on the disabled spouse's ongoing eligibility, since the receipt occurred after eligibility). See Immediate Annuity example below for a more complete illustration. There are two down-sides to using an immediate annuity in the name of the Community Spouse. First, by converting excess resources into an income stream in the Community Spouse's name, that spouse would be giving up any potential spousal maintenance allowance they might be entitled to receive from the disabled's spouse's income, should the Community Spouse's monthly income be less than $2,465 per month. This does not pose a problem if the Community Spouse's fixed income is already in excess of $2,465 per month, thereby negating any need for a spousal maintenance allowance. Second, should the Community Spouse (the annuitant/payee) die prior to the annuity's final five-year payout, by federal law the beneficiary of any remaining portion of the annuity would be the State of Washington, up to the extent the State (DSHS) has paid for the disabled spouse's care, unless the Community Spouse has a minor or disabled child. In any case, sometimes we have no choice but to use an immediate annuity. However, some of the "spend-down" options above merely assist us in reducing the amount of funds we may subsequently need to use to fund an annuity.

b. Immediate Annuities in Name of Disabled Spouse. Instead of putting the special Medicaid annuity in the name of the Community Spouse, another option is to put it in the name of the disabled spouse. This option is useful if the Community Spouse's income is too low to live on and therefore the Community Spouse needs a spousal maintenance allowance (i.e., needs to shift income from the disabled spouse to the Community Spouse). Any income the disabled spouse receives will be spent on the facility as a co-pay (i.e., "participation"). Therefore, if the term of the Medicaid annuity is longer than five years, the monthly payments to the disabled spouse will be kept low. This is helpful because the lower the disabled spouse's income, the less that they will have to give up to the facility as participation. Meanwhile, some of their income can be shifted to the Community Spouse under the spousal maintenance allowance rules, so long as the Community Spouse's own income is less than $2,465 per month. Another advantage of having the annuity in the name of the disabled spouse is that if the disabled spouse dies before the annuity term is up, the remaining funds in the annuity go to the Community Spouse first, if alive. Only if the Community Spouse is not alive do the remaining funds go to the State of Washington to pay back what was paid for the disabled spouse's long-term care.

D. Unavailable Resources. The following are lesser-known methods to shelter specific types of assets, given the right set of circumstances.

1. Rental homes or recreational properties. Generally speaking, a rental home or a recreational property is not an exempt resource and its value would count towards the Community Spouse Resource Allocation (CSRA) limit of $68,301 (or up to $154,140). However, there is a rule that states that non-exempt resources that cannot be sold within 20 days are temporarily disregarded while they are being sold. Therefore, if we were to transfer via Quit Claim Deed the anticipated disabled spouse's interest in the property to the Community Spouse and market the property for sale (must be marketed for fair market value) a few days prior to the first day of the month that we are seeking Medicaid benefits, then DSHS will disregard the asset. Once the disabled spouse is approved for benefits, and even if the non-exempt real property was not sold after eligibility was obtained, the property would have no effect on the disabled spouse's ongoing eligibility should the Community Spouse's resources exceed their CSRA limit of $68,301 after

eligibility is approved. This is because the Community Spouse has a "one-time snapshot" to meet their CSRA limit, and this occurs at the time of application only. If the Community Spouse later retains the property because they are unable to sell it, it will not affect the ongoing Medicaid eligibility of the disabled spouse.

2. Undivided interests in real property. If both spouses own an undivided 50% interest in a cabin (i.e., a recreational property) with their child, for example, and if we transferred the disabled spouse's interest in the cabin to the Community Spouse prior to submitting a Medicaid application, then the interest in this otherwise non-exempt asset will be viewed as an "unavailable resource" if the other owner (i.e., child) makes a statement that they do not intend to sell.

3. Retirement plans being funded by employed Community Spouse. If the Community Spouse is employed and is funding a retirement plan and/or 401(k) with the employer, and if such a plan is not accessible while the spouse is still employed and funding the plan (as established by a letter from the plan administrator), then the value of the retirement plan and/or 401(k) account will be deemed an "unavailable resource" and will not be counted towards the Community Spouse's CSRA limit.

4. Higher Community Spouse Resource Allocation (CSRA) limit of $154,140 (available to skilled nursing home residents only). If the anticipated disabled spouse is currently "institutionalized" (i.e., hospital or skilled nursing home only), and you can show that the combined non-exempt resources of both spouses were more than $154,140 on the first day of the month when the period of uninterrupted institutionalization began, then the Community Spouse may be entitled to a CSRA limit of more than $68,301. If this exception applies, then the CSRA limit is increased to half of the combined non-exempt resources that the couple had at the time the period of uninterrupted institutionalization began, provided that (a) it cannot exceed a maximum limit of $154,140, and (b) the Community Spouse was able to reduce the Community Spouse's non-exempt resources to below this higher CSRA limit before the 1st day of the month of the anticipated eligibility date (i.e., by paying off a mortgage, paying off debt, purchasing exempt assets, making home improvements, and/or purchasing an immediate annuity). If a higher CSRA is requested, then it would require (a) hospital and/or skilled nursing home admittance records to prove the start date of the spouse's uninterrupted "institutionalization", (b) the use of a special DSHS Community Resource Declaration form to list the values of their combined non-exempt resources as of the first day of the month when the period of uninterrupted institutionalization began, and (c) copies of statements in support of said valuations as of that date.

E. Medicaid Income Rules in a Spousal Setting.

1. Treatment of disabled spouse's income. Generally speaking, all of the disabled spouse's income must go towards their care. The following are the exceptions:

- $100 per month for their "personal needs" allowance;
- an amount necessary to pay for their supplemental medical insurance premiums;
- a "spousal income allowance" (also known as a "Community Spouse Maintenance allowance")[1], which allows the Community Spouse to shift some of the disabled spouse's income to themselves. This exception allows the Community Spouse to

[1] WAC 182-513-1385.

have as much of the disabled spouse's income as is needed to bring the Community Spouse's gross income up to $2,465 per month (the use of an immediate annuity would negate this option);

- an "excess housing cost" allocation of up to $1,388 for the Community Spouse. This exception allows the Community Spouse to shift even more of the disabled spouse's income to themselves if the Community Spouse's housing costs exceed $740 per month. Housing costs include utilities at the given amount of $483/month, rent, mortgage, real estate taxes, and homeowners insurance. If this exception applies, this excess housing cost allocation is added on top of the Community Spouse Maintenance allowance discussed above. Thus, the maximum income shifting allowed under these two exceptions is $2,465 + $1,388 = $3,853.

2. Treatment of the Community Spouse's income. Generally speaking, the Community Spouse is allowed to keep all income paid in their name (i.e., the "name on the check" rule), such as social security benefits, pension benefits, investment income from separate property accounts, and payments received from immediate annuities mentioned above. Again, if that amount is less than $2,465 per month, then the Community Spouse will be allocated portions of the disabled spouse's income to raise their income to that level, plus an "excess housing cost" allocation, if the disabled spouse has sufficient income and the Community Spouse's housing expenses exceed $740 per month (see above).

F. Necessary Estate Planning and Asset Transfer Documents to be Done **at the Time of Medicaid Eligibility**. If we were to get one spouse subsequently eligible for Medicaid/COPES benefits sometime in the future, then at that time we would be required to transfer the disabled spouse's interest in the home to the Community Spouse and remove the disabled spouse's name from all accounts and assets other than the disabled spouse's one checking and/or savings account receiving their monthly social security and pension benefits (with a combined balance of less than $2,000). Since only "gifts" of assets to non-spouses within five years from application result in periods of ineligibility, then these transfer/gifts between spouses will have no detrimental effect. Once done, then the Community Spouse will routinely execute a new Will that will provide that if the disabled spouse survives them, then the Community Spouse's entire estate will pass into a testamentary Special Needs Trust for disabled spouse's benefit for life (which would not disrupt the disabled spouse's Medicaid benefits as the disabled spouse would have no ownership interest in the trust). **Since "inheritances" are not deemed gifts, then transfers of the couples' assets via a Will, will trigger no period of ineligibility**. However, to give this new Will proper legal effect, at the time the Will is to be signed we would need to do the following additional steps and procedures (depending upon the circumstances):

1. Execute new Durable Powers of Attorney if the prior Durable Power of Attorney forms do not provide for the requisite powers we will need to implement our planning objectives.

2. Execute new Last Will and Testament for the anticipated Community Spouse, as indicated above, to provide for a testamentary Special Needs Trust for the benefit of the surviving spouse (i.e., the anticipated disabled spouse).

3. Transfer assets out of any Revocable Living Trusts clients may have. Since federal law only allows a spouse to provide for a testamentary special needs trust for the other spouse "under Will", then if the client has previously established a Revocable Living Trust, we will need to transfer all assets held in the trust's name back out to the spouses, then we will need to transfer the assets into the anticipated Community Spouse's sole name (this may include deeds for real property).

4. Quit Claim Deeds will be required to transfer the anticipated disabled spouse's interest in real property to the anticipated Community Spouse as the separate property of the Community Spouse (and if title to the real property is titled in the name of their Revocable Living Trust, then Quit Claim Deeds from Trust to both spouses will be required, followed by deeds from the disabled spouse to the Community Spouse).

5. Promissory Notes and Deeds of Trust. If the couple holds Promissory Notes (whether secured or unsecured) and Deeds of Trust, then we will be required to transfer the anticipated disabled spouse's interest in the Promissory Notes and Deeds of Trust to the anticipated Community Spouse, as the separate property of the Community Spouse (and if the Promissory Notes and Deeds of Trust are titled in the name of a Revocable Living Trust, then Assignments of Promissory Notes and Assignments of the Deeds from the Trust to both spouses, will be required before Assignments of Promissory Notes and Assignments of the Deeds of Trust, can be executed to the anticipated Community Spouse).

6. Execute a Revocation of all Prior Community Property Agreements. If the couple ever executed a "Community Property Agreement" (which automatically transfers the deceased spouse's entire estate upon death to the surviving spouse without the necessity of probate), then we will need to revoke this document since it will override the Community Spouse's new Will and pass everything "outright" to the disabled spouse (rather than via the Will to the testamentary special needs trust).

7. Execute a Separate Property Agreement, to confirm that all assets titled in the name of each particular spouse is that spouse's "separate property" and not community property. Since Washington is a community property state, there is a presumption that all assets acquired during the marriage are deemed community property, regardless as to whether the disabled spouse's name is on the title to the asset or not. In other words, without an agreement between spouses (the Community Spouse signing for disabled spouse as agent under a power of attorney) confirming that all the assets transferred into the Community Spouse's sole name are the Community Spouse's "separate property" assets, then if Community Spouse died, their Will is only going to succeed in sheltering "half" of the total estate, and the other half will be deemed the disabled spouse's estate, which will subsequently bump the disabled spouse off Medicaid (and cause the disabled spouse to likely lose all of the disabled spouse's half towards costs of care).

8. Execute a General Assignment of Tangible Personal Property, transferring all of the disabled spouse's interest in items of tangible personal property to the Community Spouse.

G. Paper Trail. Clients should keep records of all financial transactions when doing Medicaid planning. When paying bills, clients should consider using paper checks. The use of paperless

billing and payment options in the modern age creates problems in the context of Medicaid planning. If any sort of complexity arises in financial planning, a paper trail is essential to filling in gaps when aspects of a plan come into question. In crisis Medicaid planning, in which complexities are less an aberration and more the norm, foregoing the paperless option is important for maintaining the file and ensuring completeness. Furthermore, in the event the local Medicaid office denies an application and the matter is reviewed at a fair hearing, a physical check can serve as powerful evidence.

MEDICAID/COPES
Exempt Resource Summary

	Community Spouse	Disabled Spouse
1.	**Home of any value** (includes all contiguous property plus related outbuildings)	$0.00
	Transfer to Community Spouse via Quit Claim Deed	
2.	**$68,301 Community Spouse Resource Allowance (CSRA)** OR **A CSRA of up to $154,140** (under certain circumstances) **$70,301 Total** **Up to $ 156,140 Total** Transfer all Asset Ownership to Community Spouse	$2,000 $2,000
3.	**Vehicle of any value** (anything used for transportation, i.e., boats, motor homes, snowmobiles, etc.)	**Vehicle of any value** if used for transportation of the resident (single person); no 2nd vehicle if married
4.	**Burial space of any value**	**Burial space of any value**
5.	**$1500 Burial Fund** **OR** **Irrevocable burial trust, or Pre-paid burial plan** (must be reasonably anticipated exp.)	**$1500 Burial Fund** **OR** **Irrevocable burial trust, or Pre-paid burial plan** (must be reasonably anticipated exp)
6.	**$1500 cash surrender value of Life Insurance,** except to the extent of any Burial plan or fund	**SAME**
7.	**Household goods, furniture, clothing, jewelry, and personal effects of any value**	**SAME**

* The disabled spouse has a continuous obligation to meet their $2,000 or less resource standard beginning one year after eligibility. However, the Community Spouse has a one-time obligation to meet their CSRA standard **at the time of application only**. It does not matter that the Community Spouse's resources exceed the CSRA standard after Medicaid benefits have been approved for the disabled spouse.

Example Medicaid use of an Immediate Annuity for Community Spouse

Facts:

- Spouse one has stroke; moves into nursing home
- No long-term care insurance

Income:

Spouse 1 (Disabled Spouse):	$500.00/mo. Social Security & Pension
Spouse 2 (Community Spouse):	$1,500.00/mo. Social Security & Pension $8,500.00/mo. Annuity Pmts (see below)

All of the disabled spouse's income must be spent towards their care (except personal needs allowance of $100/mo. and an amount necessary to pay their monthly health insurance premiums); the Community Spouse, however, may keep all of the income paid in the name of the Community Spouse name no matter how much (i.e., the "name on the check rule").

Resources (regardless of separate or community character):

-home (no debt)	$585,000 exempt
-car (no debt)	all exempt, regardless of value
-other assets (liquid)	$561,890
-less exempt CSRA portion	- $68,301 exempt*
-less amount for disabled spouse	- $2,000 exempt
Non-Exempt Excess	**=$500,000**

*CSRA or "Community Spouse Resource Allowance" of $68,301; it can be increased to as much as $154,140 depending upon additional factors.

QUESTION: How does the Community Spouse qualify their disabled spouse for Medicaid while at the same time protecting the $500,000 of non-exempt resources?

SOLUTION: Immediately prior to submitting disabled spouse's Medicaid application, Community Spouse temporarily **converts** the excess non-exempt resources (plus a little extra, i.e., $510,000) **from** a "resource/asset characterization" **into** an "income characterization" through the purchase of a $510,000 immediate annuity payable in Community Spouse's name only (i.e., "the name on the check rule") in 60 monthly installments (i.e., five years) of $8,500 per month (not including interest) with the first payment commencing three to six months later. At the time of disabled spouse's application, the one-time "snapshot" is taken of their combined marital assets showing a house and $49,890 (i.e., $10,000 less than the $68,301 max exempt resources). Hence, disabled spouse qualifies for Medicaid for the remainder of their lifetime even though Community Spouse will see the return of the full $510,000 over the next five years. Community Spouse keeps all the "income" paid in the name of the Community Spouse, no matter how much, which now includes the immediate annuity payments in addition to Social Security and pension benefits. Though DSHS views each entire payment as Community Spouse's "income" for Medicaid

purposes (i.e., under the Community Spouse's "name on the check rule"), for income tax purposes, however, only the nominal interest portion of each payment is subject to tax. Disabled spouse's income (other than $100 and an amount sufficient to pay their monthly medical insurance premiums) goes to the nursing home. **CAVEAT**: If Community Spouse dies before the five-year pay out, then the unpaid portion of the annuity is payable to the beneficiary named in the contract. The law requires the contract for these immediate annuities to (1) name the State of Washington as "primary beneficiary" (unless the Community Spouse has a disabled or minor child) to the extent the State has paid for disabled spouse's care under Medicaid, and (2) be limited in length to a term no shorter than five years (with a 60-month payout), unless the Community Spouse's actuarial lifespan is less than five years or if it is a "qualified" immediate annuity (Qualified annuities are used in connection with tax-advantaged retirement plans, such as defined benefit pension plans, Section 403(b) retirement plans (TSAs), or IRAs). **CAVEAT**: Another "downside" of purchasing an immediate annuity is the potential loss of having the Community Spouse being awarded a "Spousal Maintenance Allowance," which can be a very important factor, depending upon circumstances.

On the first day of the month in which we are seeking eligibility, to be deemed an "income source" in the eyes of DSHS (and not an available resource), the immediate annuity **must** be: (1) irrevocable (i.e., the "free look" period must have expired), (2) non-surrenderable (you cannot cash it in), (3) non-assignable (i.e., you cannot sell it or transfer it), (4) name the State of Washington as beneficiary to the extent DSHS has paid for the disabled spouse's care under Medicaid (unless there is a minor or disabled child), and (5) provide for the full return of the investment within the Community Spouse's actuarial life-span, pursuant to DSHS life-span tables (unless the actuarial lifespan is less than 5 years or the annuity is a "qualified" immediate annuity purchased from the Community Spouse's qualified funds). In any case, your attorney should review the form of the policy before a product is selected since most immediate annuities are "assignable." Furthermore, you may have a long-time financial advisor whose company may not have agreements with annuity companies that meet the Medicaid criteria and, as such, you may need to be prepared to move your investments to a financial advisor who can obtain an annuity product that meets Medicaid criteria.