Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)
16 **DE Admin. Code** 13000, 14000, 16000, 17000 & 20000

FINAL

ORDER

DSSM: Amendments relating to the use of respectful language as required by House Bill 91

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Division of Social Services Manual (DSSM) regarding *respectful language*. The Department's proceedings to amend its regulations were initiated pursuant to **29 Delaware Code Section 10113** and its authority as prescribed by **31 Delaware Code Section 512**.

NATURE OF THE EXEMPT REGULATION:

The proposed is an exempt regulation that provides notice to the public that the Division of Medicaid and Medical Assistance (DMMA) intends to amend certain provisions of the Division of Social Services Manual (DSSM) to align with House Bill 91 relating to the use of *respectful language* when referring to individuals with disabilities.

Exempt Regulation

The following regulatory action is exempt from the Administrative Procedures Act in accordance with 29 Delaware Code, Ch 101, §10113(b)(4), which exempts from the procedural requirements of the Administrative Procedures Act (APA) regulations for nonsubstantive changes in existing regulations to alter style or form or to correct technical errors.

Citation

29 Del.C. §10113, *Adoption of Regulations; Exemptions*

Statutory Authority

This regulatory action is in compliance with the legislative intent of the 146th General Assembly's House Bill 91 affecting various administrative rules of the state of Delaware.

Summary of Proposal

Consistent with House Bill 91 and the Department's focus on respectful language, the Division of Medicaid and Medical Assistance proposes replacing obsolete terminology as clerical revisions to the Administrative Code. For example, previous references to "disabled person" and "developmentally disabled individuals" now say "individual with a disability" and "individuals with a developmental disability". These changes do not alter the sense, meaning or intent of the rules.

The proposed changes affect the following policy sections:

13110, *National Perspective*
13433, *Recipients of Mandatory State Supplementary Payments*
13436, *1619(b) Eligibles*
13438, *Disabled Widows/Widowers (Age 50-59)*
13439, *Adult Disabled Children*
13441, *Disabled Children*
13640, *The Social Security Administration*
13760, *The Division of Developmental Disabilities Services (DDDS)*
14100.5, *Timely Determination of Eligibility*
14530, *Medicaid Eligibility/Disability*
14920.5, *Retroactive Eligibility Determination*
16240, *Composition of Budget Units*
17130, *1619(b) Eligibles*
17140, *"Pickle Amendment" – Loss of SSI Benefits Due to COLA Increases*
17140.1, *Eligibility Determination*
17155, *Disable Widows/Widowers (Age 50-59)*

17160, *Adult Disabled Children*
17170, *Section 4913 Disabled Children*
17909, *Earned Income Exclusions*
20102.2.2, *Medical Review Team*
20350.1.6, *For the Sole Benefit of*
20350.10.2, *Exceptions to Transfer of an Asset*
20400.9.1.1, *Treatment of Special Needs Trust*
20400.9.2, *Pooled Trust for the Disabled*
20400.9.2.1, *Conditions to Qualify as Exempted Pooled Trust*
20400.10, *Treatment of Funds Entering and Leaving an Exempted Trust for a Disabled Individual*
20400.10.1, *Exempted Trust for a Disabled Individual Established with the Individuals Own Income; and,*
20400.10.2, *Exempted Trust for a Disabled Individual Established in Part or in Whole with Resources.*

Fiscal Impact Statement

The proposed revisions impose no increase in cost on the General Fund.

FINDINGS OF FACT:

The Department finds that these changes are exempt from the procedural requirements of the Administrative Procedures Act (Title 29 Chapter 101).

THEREFORE, IT IS ORDERED, that the proposed revisions to make minor, technical and conforming changes to replace obsolete terminology with *people first - respectful language* be adopted informally as an exempt regulation and shall become effective August 10, 2011.

Rita M. Landgraf, Secretary, DHSS

DMMA PROPOSED REGULATION #11-31
REVISION:

13110 National Perspective

In 1933, the Federal Relief Administration made funds available to states to pay for the medical expenses of the unemployed in need of medical care. When the Social Security Act was passed in 1935, it did not include any dollars specifically targeted for medical care. By the end of the 1930's, the Social Security Act had been amended to provide federal funds for medical care to specific segment of the population such as maternal and child health and aid to the aged**.**

The Social Security Act was amended in 1965 to include Medicare and Medicaid. The Medicaid program was created by Title XIX of the Social Security Act "for the purpose of enabling each State to furnish medical assistance on behalf of families with dependent children and of aged, blind or ~~disabled~~ individuals with a disability whose income and resources are insufficient to meet the cost of necessary medical services...".

At its inception, the Medicaid program defined eligible groups and services that were mandated for coverage in order to receive any Federal funding. In addition, individual States could elect to cover a limited number of optional groups and services for which they would receive a federal match on State dollars. With the passage of years, the Federal government has expanded the pool of mandatory and optional groups and services for Medicaid coverage.

(Break in Continuity of Sections)

13433 Recipients Of Mandatory State Supplementary Payments

When the Federal SSI program was implemented in 1974, states were mandated to provide supplemental payments to individuals aged, blind ~~and~~ or disabled ~~individuals~~ who would get less money under SSI than they got under the Old Age Assistance (OAA), Aid to the Blind (AB), and Aid to the Disabled (AD) programs formerly administered by the states. Delaware still has a few individuals who get mandatory state payments and they are eligible for Medicaid.

(Break in Continuity of Sections)

13436 1619(B) Eligibles

Prior to 1981, some ~~severely disabled~~ individuals with severe disabilities lost SSI and Medicaid due to employment. The loss of Medicaid often meant that the individuals could no longer afford their medical care and were forced to quit their jobs and go back on SSI to assure Medicaid coverage. An amendment to the Social Security Act, Section 1619(b) was passed to allow these individuals to retain their Medicaid coverage while they continued working. These clients are referred to as “1619(b)s.” The Social Security Administration determines eligibility for this group.

(Break in Continuity of Sections)

13438 ~~Disabled~~ Widows/Widowers with Disabilities (Age 50-59)

These are certain ~~disabled~~ widow(er)s with disabilities who lose SSI/SSP because they began receiving Title II Social Security disabled widows benefits. They are deemed to be SSI recipients for Medicaid purposes until they are entitled to Medicare. They must meet SSI income and resource limits. The widow/widower benefit is disregarded.

13439 Adult ~~Disabled~~ Children with Disabilities

Individuals eligible under this category are over age 18 and became disabled before the age of 22. They lost SSI due to income drawn from the SSA account of an aged, blind disabled or deceased parent.

Eligibility is the same as for SSI except that the SSA benefit is disregarded for Medicaid eligibility.

(Break in Continuity of Sections)

13441 ~~Disabled~~ Children with Disabilities

~~Disabled c~~Children with disabilities under age 19 who require an institutional level of care, but can be cared for cost-effectively at home, may be covered.

(Break in Continuity of Sections)

13640 The Social Security Administration (SSA)

The Social Security Administration (SSA) is responsible for determining Medicaid eligibility under Section 1634 of Title XVI of the Social Security Act for individuals aged, blind ~~and~~ or disabled ~~individuals~~. This is accomplished by determining eligibility for Supplemental Security Income (SSI) which automatically qualifies an eligible individual for Medicaid in Delaware. SSA also determines eligibility for State Supplementary Payments (SSP) for individuals residing in adult residential care arrangements.

In addition, DHSS has an agreement with SSA for Medicaid to purchase Medicare coverage on behalf of certain Medicaid eligible persons. This is known as the "Buy-In Agreement.

SSA's responsibilities include providing any needed information on an SSI or SSP applicant to:

A. determine retroactive Medicaid eligibility,
B. make appropriate payments for Medicare Part B, and in some cases, Part A premiums,
C. assure that Medicaid has complete third party insurance information, and
D. give DHSS accurate and up-to-date information on the amount of SSA, SSI and SSP benefits for each eligible individual.

(Break in Continuity of Sections)

13760 The Division of Developmental Disabilities Services (DDDS)

This division is administratively responsible for the care of patients in Stockley Center ICF/MR Group Homes. Medicaid is primary funding source for much of this care. The Division also manages the Home and Community-Based Waiver for the ~~Mentally Retarded~~ developmentally disabled, a Medicaid funded program that has as its goal the deinstitutionalization of ~~develop-mentally disabled~~ individuals with a developmental disability who can be maintained in a supportive community setting.

(Break in Continuity of Sections)

14100.5 Timely Determination Of Eligibility

The following Federal standards have been established for determining eligibility and informing applicants of the decision:

a. Ninety days for applicants who apply for Medicaid on the basis of disability. This includes long term care and ~~Disabled Children~~ Children's Community Alternative Disability Program.
b. Forty-five days for all other applicants.

These standards equal the period from the application filing date or stamping of application to the date that the notice of decision is mailed. The standards must be met except in unusual circumstances, such as:

a. A decision cannot be made because the applicant, his representative or his physician delays or fails to take a required action.
b. There is an administrative or other emergency beyond the Division's control.

The time standards must not be used as a waiting period before determining eligibility or as a reason for denying eligibility (because a decision has not been reached within the required time). Decision on applications should be made as quickly as possible, but if the final determination does not fall within the prescribed limits, the record must have

documentation of the reasons for delay.

(Break in Continuity of Sections)

14530 Medical Eligibility/Disability

Certain eligibility groups require a medical professional to certify that an applicant meets the specific program definition of medical need or disability. Examples are:

- pregnant women must have proof of pregnancy
- ~~disabled~~ children with a disability must meet disability and level of care requirements
- long term care applicants must meet level of care requirements

(Break in Continuity of Sections)

14920.5 Retroactive Eligibility Determination

If the client is potentially eligible for or enrolled in the *Diamond State Health Plan* or *Diamond State Partners*, the worker will not do an eligibility determination.

If the individual is eligible for retroactive coverage, the worker must determine that the date of service falls within the three months prior to the month of application and that the individual meets the financial and technical eligibility requirements under MAO, TANF/AFDC, SSI, or GA. The individual does not have to meet the TANF/AFDC requirement to cooperate with child support. Retroactive coverage for ~~disabled children~~ Children's Community Alternative Disability Program must be approved by the Medical Review Team. Verify income or resources on DCIS if available. If information is not on DCIS, accept the individual's declaration on the application.

Obtain information about third party liability information and forward to the TPL Unit.

A notice of Retroactive Medicaid Approval or Denial will be used to inform the client of the agency's disposition of the request for retroactive coverage. The client should be aware that even those bills submitted for payment may not be reimbursed by Medicaid (i.e., service not covered by Medicaid).

(Break in Continuity of Sections)

16240 Composition of Budget Units

The budget unit is composed of various adults who are legally/financially responsible for each other and various children (related or unrelated) for whom the adults have legal responsibility or for whom the adults have accepted parental-like responsibility.

One family and/or household may be composed of one or more budget units and an individual may belong to more than one budget unit. The budget unit must exclude any individual who is receiving SSI. Any individual who is receiving assistance under TANF, GA, ~~Disabled Children~~ Children's Community Alternative Disability Program, HCBS, QMB, SLMB, or other Medicaid only group may be included or excluded from the budget unit. If the income of the individual who is receiving medical assistance under another eligibility group makes another individual ineligible, we will exclude the individual who is receiving assistance under another eligibility group.

- The budget unit may be modified to exclude related individuals with income except:
- a parent is always financially responsible for the minor (under age 18) natural/adopted, non-emancipated child,
- a spouse is always financially responsible for a spouse,
- unmarried partners with a mutual child (child in common) are always financially responsible for the child. Neither partner is responsible for the other, even though both parents are responsible for their mutual child.

NOTE: The parent, spouse, or partner may be excluded from the poverty level budget unit if he or she is receiving assistance under another Medicaid group.

(Break in Continuity of Sections)

17130 1619 (b) Eligibles

~~Disabled i~~Individuals with Disabilities* who lose their financial eligibility for SSI due to obtaining employment may continue to be eligible for Medicaid if:

- the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be eligible for SSI, and
- the individual, except for his earnings, continues to meet all non- disability- related requirements for eligibility for SSI, and
- the loss of Medicaid benefits would seriously inhibit his ability to continue employment, and

- the individual's earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits available under Medicaid.

*Effective May 1991, the age restriction was lifted. 1619(b)'s will not lose their Medicaid eligibility at age 65.

(Break in Continuity of Sections)

17140 "Pickle Amendment" - Loss of SSI Benefits Due to COLA Increases

Medicaid benefits are continued for certain aged, blind or ~~disabled~~ persons with disabilities who become ineligible for SSI benefits or State Supplementary Payments (SSP) due to cost of living adjustments (COLA) in RSDI benefits paid under Title II of the Act.

For purposes of this provision, "supplementary payments" include any optional or mandatory State Supplementary Payments.

17140.1 Eligibility Determination

Effective July 1, 1977, Medicaid coverage will be provided (under the same terms and conditions as for SSI/SSP recipients in the State) to an aged, blind or ~~disabled~~ person with a disability who:

- is currently eligible for RSDI benefits under Title II of the Act,
- becomes ineligible for SSI benefits or State Supplementary Payments (SSP),
- received SSI and Title II (SSA) benefits concurrently, and
- would still be eligible for SSI/SSP benefits if the amount of his/her (or spouse's) COLA were deducted from income.

Benefits under this regulation are limited to persons who received SSI/SSP and SSA concurrently and who would still be eligible for SSI/SSP but for their SSA COLAs received since they lost eligibility for SSI/SSP.

Only COLAs are disregarded; any other increase in RSDI benefits must not be disregarded.

Only those COLAs which occurred after April 1977, and which were received since loss of SSI/SSP eligibility will be disregarded in determining continuing Medicaid eligibility.

* Any COLA received by an ineligible spouse or responsible relative of the aged, blind or ~~disabled~~ person with a disability, since that individual lost SSI eligibility must also be disregarded.*

(Break in Continuity of Sections)

17155 ~~Disabled~~ Widows/Widowers with Disabilities (Age 50-59)

Section 5103 of the Omnibus Budget Reconciliation Act (OBRA) 1990 created this group of Medicaid eligibles effective January 1, 1991. These are certain ~~disabled~~ widow(er)s with disabilities who lose SSI/SSP because they began receiving Title II Social Security disabled widows benefits. They are deemed to be SSI recipients for Medicaid purposes until they are entitled to Medicare.

(Break in Continuity of Sections)

17160 Adult ~~Disabled~~ Children with Disabilities

Section 1634(c) of the Social Security Act states:

"(c) If any individual who has attained the age of 18 and is receiving benefits under this title on the basis of blindness or a disability which began before he or she attained the age of 22--

- becomes entitled, on or after the effective date of this subsection, to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable, and
- ceases to be eligible for benefits under this title because of such child's insurance benefits or because of the increase in such child's insurance benefits,
- such individual shall be treated for purposes of title XIX as receiving benefits under this title so long as he or she would be eligible for benefits under this title in the absence of such child's insurance benefits or such increase."

The policy allows for certain former recipients of Supplemental Security Income (SSI) to continue to receive Medicaid after their SSI benefits have terminated.

(Break in Continuity of Sections)

17170 Section 4913 ~~Disabled~~ Children with Disabilities

Section 4913 of the Balanced Budget Act (BBA) provides that children who were receiving SSI payments on August 22, 1996, and who but for the enactment of the new disability definition under § 211(a) of the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA), would continue to be paid SSI, are mandatory categorically eligible for Medicaid. This

provision is effective for those children who lose their SSI payment on or after July 1, 1997.

(Break in Continuity of Sections)

17909 Earned Income Exclusions

Monthly earned income exclusions are applied in the following order:

1. Earned income of ~~disabled student~~ children with disabilities that are also students (under age 18) up to the student earned income exclusion monthly limit, but not more than the student earned income exclusion yearly limit. These limits are updated annually by the Social Security Administration.
2. $20.00 general income exclusion
3. $65.00 of earned income
4. Earned income of ~~disabled~~ individuals with disabilities used to pay impairment-related work expenses. Expenses must be directly related to the individual's impairment. These are the costs paid by the individual for certain items and services that he or she needs in order to work even though such items and services are also needed for normal daily activities. Examples include but are not limited to the cost of certain attendant care services, dog guide, modified audio/ visual equipment, specialized keyboards, and vehicle modification. The expense cannot be one that a similar worker without a disability would have, such as uniforms. The expenses are subject to reasonable limits. The amount paid will be considered reasonable if it does not exceed the standard or normal cost for the same item or service in the individual's community.
5. One-half of remaining earned income

(Break in Continuity of Sections)

20102.2.2 Medical Review Team

The Medical Review Team determines the level of care for the following groups:

individuals seeking out of state inpatient rehabilitation hospital care,
superskilled Reimbursement level of care,
~~Disabled Children's Program~~ Children's Community Alternative Disability Program.

A MAP-25 (Comprehensive Medical Report) is completed by the attending physician and is submitted to the State Office Medical Review Team along with any supporting documentation for approval.

(Break in Continuity of Sections)

20350.1.6 For the Sole Benefit of Requirement

A transfer is considered to be for the sole benefit of a spouse, child who is blind or disabled ~~child~~, or an ~~disabled~~ individual with a disability if the transfer is arranged in such a way that no individual or entity except that spouse, child who is blind or disabled ~~child~~, or an ~~disabled~~ individual with a disability can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, child who is blind or disabled ~~child~~, or an ~~disabled~~ individual with a disability is not considered to be established for the sole benefit of one of these individuals. In order for a transfer to be considered to be for the sole benefit of one of these individuals, the instrument document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved.

An exception to the "for the sole benefit of" requirement exists for certain trusts. Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the State, up to the amount of Medicaid benefits paid on the individual's behalf. In these instances, it is a requirement that the State is also a beneficiary of the trust.

(Break in Continuity of Sections)

20350.10.2 Exceptions To Transfer Of An Asset

The transfer provision does not apply to ANY asset transferred:

a. to the individual's spouse, or to another for the sole benefit of the individual's spouse;
b. from the individual's spouse to another for the sole benefit of the individual's spouse (OBRA 93);
c. to the individual's child that is blind or totally and permanently disabled ~~child~~;
d. to a trust containing the assets of an individual under age 65 who is disabled as defined by the SSI program and which is established for the benefit of the individual by a parent, grandparent, legal guardian of the individual or a court if the trust contains a provision that upon the death of the individual the State will receive all amounts remaining in the trust

up to an amount equal to the total medical assistance paid on behalf of the individual (OBRA 93);

e. to a pooled trust containing the assets of an individual who is disabled as defined by the SSI program and that is established and managed by a non-profit association if the trust contains a provision that upon the death of the individual the State will receive all amounts remaining in the trust up to an amount equal to the total medical assistance paid on behalf of the individual (OBRA 93).

A transfer of assets or an establishment of a trust is considered to be for the sole benefit of a spouse, ~~disabled~~ child with a disability, or individual under age 65, if the transfer is arranged in such a way that no individual except the spouse, child or individual can benefit from the assets in any way, either at the time of the transfer, or at any time in the future. If a beneficiary is named to receive the asset at the time of the individual's death, the transfer or trust will nevertheless be considered to have been made for the sole benefit of the individual if Medicaid is named as the primary beneficiary of the asset, up to the amount paid for services provided to the individual.

To determine whether an asset was transferred for the sole benefit of a spouse, child, or ~~disabled~~ individual with a disability, obtain a legally binding, written document (such as a trust document). The document must clearly define the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document cannot be said to have been made for the sole benefit of the spouse, child, or ~~disabled~~ individual with a disability, since there is no way to establish, without a document, that only the individual will benefit from the transfer.

Where it is alleged that an asset was transferred to or for the benefit of an individual who is blind or totally and permanently disabled, a determination must be made that the individual in fact meets the definition of blindness or disability used by the SSI program. If the individual is receiving either SSI or Title II benefits, accept the disability determination made for those programs. If the individual is not receiving those benefits, a separate disability determination must be made. The individual who is claiming the disability must submit acceptable medical evidence he has been determined disabled according to the standards used by the SSI program (Title XVI). The individual will be given a reasonable amount of time to provide the medical evidence.

10 DE Reg. 558 (09/01/06)

(Break in Continuity of Sections)

20400.9.1.1 Treatment of Special Needs Trusts

For individuals under age 65 the exceptions to the Medicaid eligibility rules continue even after the individual becomes age 65. No additional assets may be added to the trust after the individual reaches age 65. If assets are added they will not be exempted and are subject to penalties. To qualify as a special needs trust, the following conditions must exist:

- The trust must be established solely for the needs of an ~~disabled~~ individual with a disability who is under age 65.
- The individual is disabled as defined by the SSI program in 1614(a)(3) of the Act.
- The trust must be established by the ~~disabled individual's~~ parent(s), grandparent(s), legal guardian(s) of an individual with disabilities or a court.

In addition to the above criteria, the trust **must state** that upon the individual's death all remaining assets and funds should be paid to the State agency up to the amount paid in Medicaid benefits on the individual's behalf.

10 DE Reg. 1302 (02/01/07)

20400.9.2 Pooled Trusts for ~~the Disabled~~ Individuals with Disabilities

A pooled trust contains the assets of an ~~disabled~~ individual with disabilities as defined by the Supplemental Security Income (SSI) Program and meets the following conditions:

The trust is established and managed by a non-profit association

A separate account is maintained for each beneficiary of the trust; for purposes of investment and management of funds, the trust pools the funds in these accounts.

Accounts in the trust are established solely for the benefit of the ~~disabled~~ individual with disabilities, by the parent, grandparent, legal guardian of the individual, or by the court.

To the extent that the amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State the amount remaining in the account up to an amount equal to the total amount of medical assistance paid on behalf of the beneficiary. The trust must include a provision specifically providing for such payment to the State.

20400.9.2.1 Conditions to Qualify as Exempted Pooled Trust

a. The trust account must be established for an ~~disabled~~ individual with disabilities.

b. The individual is receiving either Title II or SSI benefits as an ~~disabled~~ individual with disabilities. (In this case we would accept the disability determination made for those programs.)

c. The Medical Review Team (See Section 20102.2.2) has determined that the individual is disabled using the State of Delaware's Determination of Disability for Medicaid procedure.

20400.10 Treatment Of Funds Entering And Leaving An Exempted Trust For a~~Disabled~~n Individual with Disabilities

While trusts for ~~the disabled~~ an individual with disabilities are exempt from treatment under the trust rules, funds entering and leaving them are not exempt from treatment under the rules of the appropriate cash assistance program. The following are rules applicable to funds entering and leaving both kinds of exempt trusts for ~~the disabled~~ an individual with disabilities. (see DSSM 20400.1.1, trusts established with income and DSSM 20400.10.2, trusts established with resources).

20400.10.1 Exempted Trust For ~~A~~an ~~Disabled~~ Individual with Disabilities Established With The Individual's Own Income

- For eligibility purposes, do not count income before it is placed in the trust.
- If a transfer of assets into a trust for an ~~disabled~~ individual with disabilities is not exempted under the exceptions to the transfer of assets' rules, a penalty must be enacted.
- Post-eligibility income rules may be applied to income placed in the trust.
- Funds paid out of the trust to or for the benefit of the individual would count as income
- Spousal impoverishment provisions are also applicable as they apply to exempted trusts.

Note: When the right to income placed in a trust actually belongs to the trust and not the individual, the income does not count under SSI rules as income received by the individual.

Most trusts for ~~the disabled~~ an individual with disabilities are created using the individual's resources~~,~~; some may be created using the individual's income or a combination of income (Income as defined by the SSI program.) and resources. When income is placed in the trust see Section 20400.11.1- Income Trusts (Miller Trusts) for treatment of income.

20400.10.2 Exempted Trust for an ~~Disabled~~ Individual with Disabilities Established in Part or in Whole With Resources

- Resources placed in an exempt irrevocable trust for an ~~disabled~~ individual with disabilities are counted as resources only during the months in which they are in the possession of the individual. Beginning with the month the resources are placed in the trust, they are exempt from being counted as resources to the individual.
- Resources placed in an exempted trust for an ~~disabled~~ individual with disabilities are subject to imposition of a penalty under the transfer of assets provisions unless:
  the transfer is specifically exempt from penalty,
  or unless the resources placed in the trust are used to benefit the individual,
  and the trust purchases items and services for the individual at fair market value.

NOTE: These rules apply to both income and resources placed in an exempt trust.

15 DE Reg. 202 (08/01/11) (Final)