65A-1.712 SSI-Related Medicaid Resource Eligibility Criteria.
(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during
the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule
65A-1.716, F.A.C., with the following exceptions:
(a) For MEDS-AD Demonstration Waiver an individual whose income is equal to or below 88 percent of the federal poverty
level must not have resources exceeding the current Medically Needy resource limit specified in Rule 65A-1.716, F.A.C.
(b) For QMB, an individual cannot have resources exceeding the Medically Needy resource limit.
(c) For WD, an individual cannot have resources exceeding the Medically Needy resource limit.
(d) For SLMB, an individual cannot have resources exceeding the Medically Needy resource limit.
(e) For Medically Needy, an individual or couple cannot have resources exceeding the applicable Medically Needy resource
level set forth in subsection 65A-1.716(3), F.A.C.
(f) For the Traumatic Brain Injury and Spinal Cord Injury Waiver Program an individual cannot have countable resources that
exceed $2,000. If the individual's income falls within the MEDS-AD Demonostration Waiver limit, the individual can have
resources up to $5,000. No penalties apply to transfers of assets or resources made to spouses. But penalties may apply to transfers
to others. Spousal impoverishment policies do not apply.
(2) Exclusions. The department follows SSI policy prescribed in 20 C.F.R. Part 416 in determining what is counted as a
resource with the following exceptions, as mandated by federal Medicaid policies, or additional exclusions, as adopted by the
department under section 42 U.S.C. § 1396a(r)(2). SSI policy requires resources in a blocked account to be countable resources.
This applies regardless of whether the individual or their representative is required to petition the court to withdraw funds for the
individual's care. A blocked account is one in which state law protects an individual's funds by specifically requiring that the funds
be made available for the care and maintenance of the individual.
(a) Resources of a comatose applicant (or recipient) are not considered as available when there is no known legal guardian or
other individual who can access and expend the resource(s).
(b) The value of a life estate interest in real property is excluded.
(c) The cash surrender value of life insurance policies is excluded as resources if the combined face value of the policies is
$2,500 or less.
(d) The individual, and their spouse, may designate up to $2,500 each of their resources for burial funds for any month,
including the three months prior to the month of application. The designated funds may be excluded regardless of whether the
exclusion is needed to allow eligibility. The $2,500 is not reduced by the value of excluded life insurance policies or irrevocable
burial contracts. The funds may be commingled in the retroactive period.
(e) One automobile is excluded, regardless of value.
(f) Property that is essential to the individual's self-support shall be excluded from resources if it is producing income available
to the individual which is consistent with its fair market value. This includes real and personal property used in a trade or business;
non-business income-producing property; and property used to produce goods or services essential to an individual's daily

activities. Liquid resources other than those used as part of a trade or business are not property essential to self-support. For the
purpose of this section, mortgages are considered non-liquid resources, if they were entered into on or before September 30, 2004.

(3) Transfer of Resources and Income. According to 42 U.S.C. § 1396p(c), if an individual, the spouse, or their legal
representative, disposes of resources or income for less than fair market value on or after the look back date, the department must
presume that the disposal of resources or income was to become Medicaid eligible and impose a period of ineligibility for nursing
facility care services or HCBS waiver services. The look back period is 36 months prior to the date of application, except in the
case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. These transfer
policies apply to actual transfers made by applicants for institutional Hospice services that occur on or after October 1, 1998.
(a) The department follows the policy for transfer of assets mandated by 42 U.S.C. §§ 1396p and 1396r. For transfers prior to
October 1, 1993, transfer policies apply only to transfers of resources. For transfers on or after October 1, 1993, transfer policies
apply to the transfer of income and resources.
(b) When funds are transferred to a retirement fund, including annuities, within the transfer look back period the department
must determine if the individual will receive fair market compensation in their lifetime from the fund. If fair compensation will be
received in their lifetime there has been no transfer without fair compensation. If not, the establishment of the fund must be
regarded as a transfer without fair compensation. Fair compensation shall be calculated based on life expectancy tables published
by the Office of the Actuary of the Social Security Administration. See Rule 65A-1.716, F.A.C.
(c) No penalty or period of ineligibility shall be imposed against an individual for transfers described in 42 U.S.C. §
1396p(c)(2).
1. In order for the transfer or trust to be considered to be for the sole benefit of the spouse, the individual's blind or disabled
child, or a disabled individual under age 65, the instrument or document must provide that: (a) no individual or entity except the
spouse, the individual's disabled child, or disabled individual under age 65 can benefit from the resources transferred in any way,
either at the time of the transfer or at any time in the future; and (b) the individual must be able to receive fair compensation or
return of the benefit of the trust or transfer during their lifetime.
2. If the instrument or document does not allow for fair compensation or return within the lifetime of the individual (using life
expectancy tables noted in paragraph (b) above), it is not considered to be established for the sole benefit of the indicated individual
and any potential exemption from penalty or consideration for eligibility purposes is void.
3. A transfer penalty shall not be imposed if the transfer is a result of a court entering an order against an institutional spouse
for the support of the community spouse.
4. A transfer penalty shall not be imposed if the individual provides proof that they disposed of the resource or income solely
for some purpose unrelated to establishing eligibility.
5. A transfer penalty shall not be imposed if the department determines that the denial of eligibility due to transferred resources

or income would work an undue hardship on the individual. Undue hardship exists when imposing a period of ineligibility would
deprive an individual of food, clothing, shelter or medical care such that their life or health would be endangered. All efforts to
access the resources or income must be exhausted before this exception applies.
(d) Except for allowable transfers described in 42 U.S.C. § 1396p(c)(2), in all other instances the department must presume the
transfer occurred to become Medicaid eligible unless the individual can prove otherwise.
1. An individual who disposes of a resource for less than fair market value or reduces the value of a resource prior to incurring
a medical or other health care related expense which was reasonably capable of being anticipated within the applicable transfer look
back period shall be deemed to have made the transfer, in whole or part, in order to qualify for, or continue to qualify for, medical
assistance.
2. In cases where resources are held by an individual in common with others in a joint tenancy, tenancy in common, or similar
arrangement, the individual is considered to have transferred resources or a portion thereof, as applicable, when action is taken by
the individual or any other person authorized to access the resources that reduces or eliminates the individual’s ownership or
control of such resource.
(e) Each individual shall be given the opportunity to rebut the presumption that a resource or income was transferred for the
purpose of qualifying for Medicaid eligibility. No period of ineligibility shall be imposed if the individual provides proof that they
intended to dispose of the resource or income at fair market value or for other valuable consideration, or provides proof that the
transfer occurred solely for a reason other than to become Medicaid eligible.
(f) The uncompensated value of a transferred resource is the difference between the fair market value of the transferred
resource at the time of the transfer, less any outstanding loans, mortgages or other encumbrances on the resource, and the amount of
compensation received at or after the time of the transfer.
(g) Periods of ineligibility based on transfer policy are calculated beginning with the month in which the transfer occurred. The
period of ineligibility cannot exceed 30 months if the transfer occurred prior to October 1, 1993. If the transfer occurred on or after
October 1, 1993, the period of ineligibility shall be equal to the actual computed period of ineligibility, rounded down to the nearest
whole number. There is no limit on the period of ineligibility for transfers which occur on or after October 1, 1993.
1. Monthly periods of ineligibility due to transferred resources or income are determined by dividing the total cumulative
uncompensated value of all transferred resources or income computed in accordance with paragraph 65A-1.712(3)(f), F.A.C., by
the average monthly private pay nursing facility rate at the time of application as determined by the department.
a. Where resources or income have been transferred in amounts or frequency or both that would make the calculated penalty
periods overlap, the value of all transferred resources or income is added together and divided by the average cost of private nursing
home care.

b. Where multiple transfers are made in such a way that the penalty periods for each would not overlap, each transfer is treated

as a separate event with its own penalty period.
2. If an institutionalized individual is ineligible for medical assistance due to a transfer of resources or income by the
community spouse, and the community spouse becomes potentially eligible for ICP, HCBS, or institutional hospice services, any
remaining penalty period must be apportioned between the spouses. The department shall apportion penalty periods by dividing
any new or remaining penalty periods by 2 and attribute the quotient to each spouse. Any excess months may be attributed to the
spouse that caused the penalty or according to the wishes of the couple or their representative.
3. Individuals who are ineligible due solely to the uncompensated value of a transferred resource or income are ineligible for
nursing home, institutional hospice or HCBS waiver services payment, but are eligible for other Medicaid benefits.
(4) Spousal Impoverishment. The department follows 42 U.S.C. § 1396r-5 for resource allocation and income attribution and
protection when an institutionalized individual, including a hospice recipient residing in a nursing facility, has a community spouse.
Spousal impoverishment policies are not applied to individuals applying for, or receiving, HCBS waiver services.
(a) When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband
and wife are considered in determining eligibility.
(b) At the time of application only those countable resources which exceed the community spouse's resource allowance are
considered available to the institutionalized spouse.
(c) The community spouse resource allowance is equal to the maximum resource allocation standard allowed under 42 U.S.C.
§ 1396r-5 or any court-ordered support, whichever is larger.
(d) After the institutionalized spouse is determined eligible, the department allows deductions from the eligible spouse's
income for the community spouse and other family members according to 42 U.S.C. § 1396r-5 and paragraph 65A-1.716(4)(c),
F.A.C.
(e) If either spouse can verify that the community spouse resource allowance provides income that does not raise the
community spouse's income to the State's MMMIA, the resource allowance may be revised through the fair hearing process to an
amount adequate to provide such additional income as determined by the hearing officer.
(f) Either spouse may appeal the amount of the income allowance through the fair hearing process and the allowance may be
adjusted by the hearing officer if the couple presents proof that exceptional circumstances resulting in significant inadequacy of the
allowance to meet their needs exist.
(g) The institutionalized spouse shall not be determined ineligible based on a community spouse's resources if all of the
following conditions are found to exist:
1. The institutionalized individual is not eligible for Medicaid institutional services because of the community spouse's
resources and the community spouse refuses to use the resources for the institutionalized spouse; and
2. The institutional spouse assigns to the State any rights to support from the community spouse by submitting the Assignment
of Support Rights formreferenced in Rule 65A-1.400, F.A.C., signed by the institutionalized spouse or their representative; and
3. The institutionalized spouse would be eligible if only those resources to which they have access were counted; and

4. The institutionalized spouse has no other means to pay for the nursing home care.

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