N.J.A.C. 10:70

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 70. MEDICALLY NEEDY PROGRAM

Title 10, Chapter 70 -- Chapter Notes

Statutory Authority

CHAPTER AUTHORITY:

N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq.

History

CHAPTER SOURCE AND EFFECTIVE DATE:

Effective: July 6, 2021.

See: 53 N.J.R. 1279(b).

CHAPTER HISTORICAL NOTE:

Chapter 70, Medically Needy Program, was adopted as R.1986 d.237, effective June 16, 1986 (operative July 1, 1986). See: 18 N.J.R. 831(a), 18 N.J.R. 1294(a).

Pursuant to Executive Order No. 66(1978), Chapter 70, Medically Needy Program, was readopted as R.1991 d.331, effective June 7, 1991. See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Pursuant to Executive Order No. 66(1978), Chapter 70, Medically Needy Program, was readopted as R.1996 d.263, effective May 9, 1996. See: 28 N.J.R. 1463(a), 28 N.J.R. 3001(a).

Pursuant to Executive Order No. 66(1978), Chapter 70, Medically Needy Program, was readopted as R.2001 d.183, effective May 8, 2001. See: 33 N.J.R. 977(a), 33 N.J.R. 1918(b).

Chapter 70, Medically Needy Program, was readopted as R.2006 d.364, effective September 12, 2006. See: 38 N.J.R. 2368(a), 38 N.J.R. 4480(c).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 70, Medically Needy Program, was scheduled to expire on September 12, 2013. See: 43 N.J.R. 1203(a).

Chapter 70, Medically Needy Program, was readopted, effective July 31, 2013. See: 45 N.J.R. 2041(b).

In accordance with N.J.S.A. 52:14B-5.1, Chapter 70, Medically Needy Program, was scheduled to expire on July 31, 2020. Pursuant to Executive Order Nos. 127 (2020) and 244 (2021) and P.L. 2021, c. 104, any chapter of the New Jersey Administrative Code that would otherwise have expired during the Public Health Emergency originally

declared in Executive Order No. 103 (2020) is extended through January 1, 2022. Chapter 70, Medically Needy Program, was readopted, effective July 6, 2021. See: Source and Effective Date.

Chapter 70, Medically Needy Program, was updated by administrative change, effective November 4, 2024, to change all references to county welfare agencies (CWA) and county welfare boards to county social service agencies (CSSA) and county social services boards, respectively. See: *56 N.J.R. 2299(a)*.

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Research References & Practice Aids

CHAPTER EXPIRATION DATE:

Chapter 70, Medically Needy Program, expires on July 6, 2028.

End of Document

N.J.A.C. 10:70-1.1

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§ 10:70-1.1 Program scope

(a) The Medically Needy Program, enacted by P.L. 1985, Chapter 371, extends limited Medicaid program benefits to certain groups of medically needy persons whose income and/or resources exceeds the standards for the Medicaid program but are within the standards for the Medically Needy Program, or whose income exceeds the standards for the Medically Needy Program but is insufficient to meet their medical expenses as determined in this chapter.

(b) Eligibility for the Medically Needy Program is limited to the following eligibility groups within the family and adult eligibility categories:

1. AFDC-related:

i. Pregnant women; and

ii. Children under 21 years of age.

2. SSI-related:

i. Persons 65 years of age or older;

ii. Persons who are blind; and

iii. Persons who are disabled.

(c) The medical services covered under the Medically Needy Program are limited to eligibility group and by the spend-down provisions of N.J.A.C. 10:70-6. All restrictions and limitations on services applicable to the Medicaid program apply to services for the Medically Needy. The services covered under the Medically Needy Program (by eligibility group) are described in N.J.A.C. 10:49-5.3.

(d) Retroactive eligibility for the Medically Needy Program is available beginning with the third month prior to the month of application, if members of an eligibility group have incurred expenses for covered services within that period which have not yet been paid and the members would have been eligible for the Medically Needy coverage in the month in which the services were received. Members of the eligibility group need not be eligible for the program at the time of application in order to be eligible for retroactive eligibility. Application for retroactive eligibility may be made on behalf of a deceased person so long as the person was alive during a portion of the retroactive eligibility period and he or she incurred medical expenses for covered services.

1. Retroactive coverage is not available for any period prior to July 1, 1986, the effective date of the Medically Needy Program.

History

HISTORY:

Amended by R.1996 d.263, effective June 3, 1996.

See: 28 N.J.R. 1463(a), 28 N.J.R. 3001(a).

Amended by R.2006 d.364, effective October 16, 2006.

See: 38 N.J.R. 2368(a), 38 N.J.R. 4480(c).

In (c), substituted "N.J.A.C. 10:70-" for "subchapter" and updated N.J.A.C. reference at end.

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Lawyers who were conservators for an elderly man who was applying for Medicaid nursing home disabled benefits were acting in good faith to transmit all required documentation to a county social services board and their conduct also reflected cooperation and proactive efforts to comply with the board's requests. Those efforts constituted "exceptional circumstances" within the meaning of Medicaid Communication 10-09 and justified an order reversing the benefit denial and requiring a review of the application. H.P. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 01118-18, 2018 N.J. AGEN LEXIS 271, Initial Decision (May 11, 2018).

Per N.J.A.C. 10:70-5.3, where a case involving an application for Medicaid implicates SSI per N.J.A.C. 10:70-1.1, the resource provisions of the Medicaid Only Program, N.J.A.C. 10:71-1.1 to 10:71-9.5, apply in determining countable resources and resource eligibility for the Medically Needy Program. H.M. v. Union Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 10869-14, 2016 N.J. AGEN LEXIS 1246, Final Administrative Determination (December 16, 2016).

Eligibility date that was established for a Medicaid applicant was correct. Even though a Qualified Income Trust was established by her as of March 4, 2015, the QIT was not properly funded with the applicant's pension and Social Security payments until March 2016. That being so, the applicant did not qualify for Medicaid until March 2016. R.C. v. Gloucester Cnty. Div. of Social Servs., OAL DKT. NO. HMA 05451-16, 2016 N.J. AGEN LEXIS 531, Initial Decision (June 16, 2016).

Medicaid applicant who was advised, in March of 2015, to establish a Qualified Income Trust (QIT) to handle her excess income but did not accomplish the same until January 2016 was not entitled to an eligibility date that was retroactive to the date of her January 2015 application because she was not income-eligible for Medicaid until the QIT was established. G.S. v. Hudson Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 20755-15, 2016 N.J. AGEN LEXIS 457, Initial Decision (June 7, 2016).

Determination by a county board of social services (CBSS) denying a petitioner's request for Medically Needy Nursing Home Medicaid per N.J.A.C. 10:70-1.1 et seq. was reversed. That determination had been based on a CBSS calculation of amounts held in four bank accounts, two of which were in the name of a business that the applicant had owned. However, the applicant established that the business had stopped operations, would not be reopening for the next school year, had no employees, owed amounts to former employees, to a landlord and to some trade vendors. That being so, a recalculation of the applicant's resources in accord with *N.J.A.C. 10:71-5.1(b)* and N.J.A.C. 10:71-4.1 was appropriate, and eligibility thus established. F.P. v. Middlesex Cnty. Bd. of Social Servs., OAL DKT. NOS. HMA 03183-14 and HMA 05622-14, AGENCY DKT. NO. 1215061428 (Consolidated), 2014 N.J. AGEN LEXIS 475, Initial Decision (August 6, 2014).

§ 10:70-1.1 Program scope

Determination by a county board of social services (CBSS) denying a petitioner's request that she be found eligible for nursing home disabled benefits per *N.J.A.C. 10:70-1.1* et seq. was affirmed. CBSS took the position that ineligibility was the proper outcome because petitioner not only failed to provide all documents requested by CBSS within the 45-day period described in *N.J.A.C. 10:71-2.3* but that petitioner's submission was still incomplete on December 9, 2013, which was more than four months after the 45 day period had expired and more than six months after the date of the application. Moreover, the fact was that petitioner effectively had produced little to no information until she received the denial letter on December 9, 2009 and was inspired to make a real effort to provide the documents only after the denial was received. Such facts did not establish exceptional circumstances that would justify an extension of the applicable time limits. *G.G. v. Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 1127-14, AGENCY DKT. NO. 1510041726-01, 2014 N.J. AGEN LEXIS 377*, Initial Decision (June 27, 2014).

An Administrative Law Judge (ALJ) concluded that a county agency had acted improperly in imposing a nine-month and 17-day penalty against the Medicaid eligibility of a 100-year old woman based on the agency's claim that there were unexplained expenditures during the five-year look-back period imposed under *N.J.A.C. 10:70-1.1*. The evidence indicated that the woman's financial condition was dire, principally because she had spent a large amount of money in response to mailed solicitations that purportedly reflected that she had won one or more lotteries. She also apparently became convinced that she owed money on certain reverse mortgages. Though acknowledging that some unexplained expenditures remained, the ALJ found that the preponderance of the credible evidence supported the petitioner's argument that she lost funds on lottery schemes and similar scams that preyed on the elderly and that the funds were neither gifted nor transferred without value in anticipation of establishing Medicaid eligibility. *F.W. v. Morris Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 13978-13, 2014 N.J. AGEN LEXIS 258*, Initial Decision (May 12, 2014).

Initial Decision (2006 N.J. AGEN LEXIS 980) adopted, which found that although the term "gross income" is not specifically defined for the Medically Needy program found at *N.J.A.C. 10:70-1.1* et seq., the Medicaid Only program does contain definitions for earned and unearned income under *N.J.A.C. 10:71-5.1(b)* and both *N.J.A.C. 10:71-5.4* and *N.J.A.C. 10:71-5.6* make reference to gross income; thus, while not a paradigm of clarity, the regulations imply that gross income is the proper figure to use in making eligibility determinations for the Medically Needy program as well as the Medicaid Only program. *J.O. v. DMAHS, OAL Dkt. No. HMA 4407-06, 2006 N.J. AGEN LEXIS 935*, Final Decision (October 24, 2006).

End of Document

N.J.A.C. 10:70-1.2

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§ 10:70-1.2 Purpose of the Medically Needy Manual

(a) Purpose of the regulations contained within this chapter is to:

1. Set forth eligibility for the Medically Needy Program;

2. Establish policy for calculating spend-down liability for persons whose income exceeds the Medically Needy Income Level; and

3. Specify the rights and responsibilities of program applicants and eligible persons.

(b) Circumstances which are neither specifically nor generally addressed in these regulations shall be referred to designated staff of the Division of Medical Assistance and Health Services for resolution.

(c) The directors of the county boards of social services shall assign copies of this manual to administrative staff, all Medically Needy Program staff working with applicants and beneficiaries, and to social services staff as appropriate and shall ensure that each staff member is thoroughly familiar with its contents in order to apply the required policy and procedures consistently.

(d) The Division of Medical Assistance and Health Services will issue revisions to the Manual as necessary. It is the responsibility of each holder of the Manual to maintain its accuracy by inserting new material and removing obsolete pages promptly.

1. At least one administrative copy of all obsolete pages of the Manual must be maintained by the county board of social services.

(e) This manual is a public document. It is important that all copies in use be absolutely accurate and up-to-date. The manual is available as follows:

1. Copies are available in the State office of the Division of Medical Assistance and Health Services and in each county board of social services office for examination or review during regular office hours.

2. Specific policy material necessary for an applicant or beneficiary or his or her representative to determine whether a fair hearing is to be requested or to prepare for a fair hearing shall be provided to such persons without charge.

3. All public and university libraries which have agreed to keep the manual up-to-date will have a copy available under their regulations.

4. Each legal services office will be furnished with a copy of this manual.

5. Welfare, social service, and other nonprofit organizations will be furnished with a copy of this manual at no cost upon an official written request on agency letterhead to the Division of Medical Assistance and Health Services.

6. A current up-to-date copy of the manual or any part of it is available from the Division of Medical Assistance and Health Services at the cost of printing and mailing to anyone who requests it in writing.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (c), substituted "directors" for "director" and "beneficiaries" for "recipients"; in (c), (d)1 and (e)1, substituted "board of social services" for "welfare agency"; and in (e)2, substituted "beneficiary" for "recipient".

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N.J.A.C. 10:70-1.3

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§ 10:70-1.3 Administrative organization

The Medically Needy Program is administered by the county social service agencies under the supervision of the Division of Medical Assistance and Health Services of the Department of Human Services.

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N.J.A.C. 10:70-1.4

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§ 10:70-1.4 Principles of administration

(a) The following principles of administration apply in the Medically Needy Program.

1. Any individual who believes he or she is eligible shall be afforded an opportunity to make application (or reapplication) for the Medically Needy Program without delay.

2. Program applicants or eligible persons are the primary source of information concerning program eligibility and spend-down liability. The county board of social services shall, when necessary, in the process of determining eligibility and spend-down liability, use secondary sources of information with the knowledge and consent of the applicant or eligible person.

3. There shall be strict adherence to law and complete conformity with regulations and administrative policy. Requirements other than those established by law or regulation shall not be imposed as a condition of receiving assistance under the Medically Needy Program.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a)2, substituted "board of social services" for "welfare agency".

Annotations

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Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. *D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546*, Final Decision (June 11, 2007).

End of Document

N.J.A.C. 10:70-1.5

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§ 10:70-1.5 Confidentiality of information

(a) No member, officer, or employee of a county board of social services shall produce or disclose any confidential information to any person, except as authorized below.

1. Information considered confidential includes, but is not limited to, the following:

i. Names and addresses;

ii. Medical services provided;

iii. Social and economic conditions or circumstances;

iv. County board of social services evaluation of personal information; and

v. Medical data, including diagnosis and past history of disease or disability.

2. The county board of social services may disclose information concerning an applicant or eligible person to persons and agencies directly related to the administration of Medicaid, including the Medically Needy Program. Persons and agencies directly related to program administration are those that are properly authorized to be involved in the:

i. Establishment of eligibility;

ii. Determination of the amount and scope of medical assistance;

iii. Provision of services for beneficiaries; and

iv. Conduct or assisting in the conduct of an investigation, prosecution, or civil or criminal proceeding related to the Medically Needy Program.

3. The county board of social services may release information whenever the applicant or eligible person waives confidentiality, but only to the extent authorized by the waiver.

4. If a court issues a subpoena for a case record or any other confidential information or for any agency representative to testify concerning an applicant or eligible person, the county board of social services, personally or through counsel, shall make a statement substantially as follows:

i. "Under provisions of the Social Security Act, information concerning applicants and beneficiaries of Medical Assistance must be restricted to persons directly connected with the administration of such assistance. The authorities of the Federal government have advised that this includes a requirement of nondisclosure of such information in response to a subpoena. If a disclosure is made of this information, either by personal testimony or by production of records, this is considered nonconformance with Federal requirements and may subject the State to loss of Federal financial participation in the Medical Assistance program."

5. In no instance is it intended that any officer or employee of the agency place him or herself in contempt of court through refusal to follow the orders of a court. However, the above action as appropriate shall be taken in all instances, and a report of the results shall be entered in the case record.

6. Pertinent information and records may be released in conjunction with an administrative hearing conducted by the Office of Administrative Law regarding action or inaction by the county board of social services affecting an applicant's or eligible person's eligibility or entitlement under the Medically Needy Program.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Substituted "board of social services" for "welfare agency" throughout; in (a), substituted "a" for "the"; in (a)2iii, substituted "beneficiaries" for "recipients"; and in (a)4i, substituted "beneficiaries" for "recipient".

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N.J.A.C. 10:70-1.6

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§ 10:70-1.6 Materials distributed to program applicants or eligible persons

(a) All materials distributed to applicants or eligible persons must:

1. Directly relate to the administration of the Medicaid program;

2. Have no political implications;

3. Contain names only of individuals directly connected with the administration of the Medicaid program; and

4. Identify those individuals only in their official capacity with the State or the county board of social services.

(b) The county board of social services shall not distribute materials such as "holiday" greetings, general public announcements, voting information, or alien registration notices.

(c) The county board of social services may distribute materials directly related to the health and welfare of program applicants and eligible persons, such as announcements of free medical examinations, availability of surplus food, voter registration and consumer protection information.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a)4 and (c), substituted "board of social services" for "welfare agency"; in (b), substituted "board of social services shall" for "welfare agency must"; and in (c), inserted "voter registration".

Annotations

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N.J.A.C. 10:70-1.7

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§ 10:70-1.7 Nondiscrimination

(a) Title VI of the Federal Civil Rights Act of 1964 (Public Law 88-352), the Americans with Disabilities Act, P.L. 101-336, and Section 504 of the Rehabilitation Act of 1973 prohibits discrimination on the ground of race, color, national origin, or handicap in the administration of any program for which Federal funds are received. Strict compliance with the provisions of this Act and any regulations based thereon is required as a condition of eligibility to receive Federal funds for assistance programs administered through the county boards of social services. These principles apply to the Medically Needy Program in New Jersey.

1. The county board of social services shall inform all staff members of their obligations in regard to Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, P.L. 101-336, and Section 504 of the Rehabilitation Act of 1973.

2. All persons seeking medical assistance shall be informed of Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, P.L. 101-336, and Section 504 of the Rehabilitation Act of 1973.

3. All persons seeking or receiving medical assistance shall be afforded an opportunity to file a complaint alleging discrimination on the ground of race, color, national origin, or handicap. Such complaints may be filed directly with the Regional Manager, U.S. Department of Health and Human Services, Office for Civil Rights, Jacob Javits Federal Building, 26 Federal Plaza, Suite 3312, New York, New York 10007, or with the Director, Division of Medical Assistance and Health Services, P.O. Box 712, Trenton, New Jersey 08625-0712.

4. In any instance in which a complaint of alleged discrimination is filed with a State or county agency, the complaint shall be forwarded immediately to the Director, Division of Medical Assistance and Health Services. The Director, upon receipt of any such complaint, will take whatever action he or she deems appropriate to the situation. This action may include, but is not limited to, the securing of reports from whatever sources may have knowledge pertinent to the situation and referral to the Division of Civil Rights of the New Jersey Department of Law and Public Safety, for investigation, evaluation, and recommendation by that agency.

5. The county board of social services shall afford full cooperation in the investigation of complaints of discrimination as may be requested by the Federal Department of Health and Human Services, the Division of Medical Assistance and Health Services, or the Division of Civil Rights.

6. The Director, Division of Medical Assistance and Health Services, will be responsible for all final determinations as to whether or not the fact of discrimination has been established and for all decisions as to the disposition of the complaint. In arriving at such determinations, the Director will take into consideration relevant decisions or actions on the part of a court or governmental agency.

7. Each county board of social services shall comply with the decision of the Director of the Division of Medical Assistance and Health Services on any complaint of discrimination, including the imposition of disciplinary action as found necessary and reasonable in the case of discrimination by a staff member.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Inserted ", the Americans with Disabilities Act, P.L. 101-336," and substituted "board of social services" for "welfare agency" throughout; in the introductory paragraph of (a), substituted "boards of social services" for "welfare agencies"; and in (a)3, updated address.

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N.J.A.C. 10:70-1.8

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§ 10:70-1.8 Assignment of medical support rights

(a) Any person who applies for the Medically Needy Program, by virtue of the application for benefits, is deemed to have assigned to the Commissioner of the Department of Human Services any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for care from any third party. It is required that program applicants and beneficiaries cooperate in the identification of and the obtainment of any such rights.

1. The county board of social services shall advise applicants and beneficiaries of the terms of the assignment and the consequences thereto.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In the introductory paragraph of (a) and in (a)1, substituted "beneficiaries" for "recipients"; and in (a)1, substituted "board of social services" for "welfare agency".

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N.J.A.C. 10:70-2.1

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§ 10:70-2.1 Application

(a) Application for the Medically Needy Program shall be accomplished by the completion and signing of Form PA-1G for SSI-related cases and Form PA-1J for AFDC-related cases, as well as, any addenda to those forms as prescribed by the Division of Medical Assistance and Health Services.

1. Application for the Program shall be executed by:

i. A parent, caretaker relative, or guardian for cases with children under the age of 21 residing with a parent or caretaker relative;

ii. A child age 18 or older when not residing with a parent or caretaker relative;

iii. A pregnant woman age 18 or older;

iv. The parent or caretaker relative of a disabled or blind child;

v. The adult seeking benefits as aged, blind, or disabled.

2. For cases which, because of confinement, illness, incapacity, disability, or lack of competence of the person(s) required to execute the application, and for children who not yet attained the age of 18, the application may be executed on such person's behalf by:

i. A relative by blood or marriage;

ii. A staff member of a public or private welfare agency of which the person seeking program benefits is a client, who has been designated by the agency to so act;

iii. The attorney or physician of the person seeking program benefits;

iv. A staff member of an institution or facility in which the person is receiving care, who has been designated by the institutional facility to so act.

3. A legal guardian shall be recognized as an authorized agent to initiate an application for the Medically Needy Program.

(b) The county board of social services, under policies and procedures established by the Division of Medical Assistance and Health Services, has the direct responsibility in the application process to:

1. Inform applicants of the purpose and the eligibility requirements for the Medically Needy Program, their rights and responsibilities under the Program, and of their right to a fair hearing;

2. Receive applications and review them for completeness, consistency, and reasonableness;

3. Assist program applicants in exploring their eligibility for program benefits;

4. Make known to program applicants, the appropriate resources and services both within the agency and the community; and

5. Assure the prompt and accurate submission of eligibility data to the Medicaid Status File for eligible persons and prompt notification to ineligible persons of the reasons for their ineligibility.

(c) As part of the application process, the program applicant has the responsibility to:

1. Complete, with assistance from the county board of social services as needed, any forms required as part of the application process;

2. Assist the county board of social services in securing evidence that verifies his or her statements;

3. Report any change in circumstances that may affect program eligibility or amount of benefits;

4. Provide the county board of social services evidence, as requested, of incurred medical expenses and liability for payment; and

5. If applicable, submit to examinations or tests and provide such medical and other evidence as may be necessary to determine disability or blindness.

(d) With the exceptions noted below, disposition of an application for the Medically Needy Program must be accomplished within 30 days of the date of application (or the date of the inquiry form PA-1C, if applicable) for AFDC-related cases and for persons applying on the basis of being aged. The disposition standard for the disabled and blind is 60 days from the date of application (or the date of the inquiry form PA-1C, if applicable).

1. "Disposition of the application" means the official determination by the county board of social services of application approval or rejection.

2. Disposition of the application may exceed the applicable processing standards when substantially reliable evidence of eligibility or entitlement is lacking at the end of the processing period. In such circumstances, the application may be continued in pending status. The county board of social services shall document that the delay in application processing resulted from one of the following:

i. Circumstances wholly within the applicant's control;

ii. A determination to afford the applicant, whose evidence of eligibility or entitlement is inconclusive, additional time to provide sufficient evidence of eligibility before final action on his or her application;

iii. An administrative or other emergency that could not reasonably be avoided; or

iv. Circumstances wholly outside the control of both the applicant and the county board of social services.

3. When application processing is delayed beyond the processing standards, the county board of social services shall provide to the program applicant written notification prior to the expiration of the processing period setting forth the specific reasons for the delay.

4. Each county board of social services director shall establish appropriate operational controls to expedite the processing of applications and assure maximum compliance with the processing standards.

i. The county board of social services shall maintain control records which identify all pending applications which did not meet the processing standards and the reason therefor. That record shall be adequate to make possible the preparation of reports of such information as may be requested by the Division of Medical Assistance and Health Services.

(e) The following actions on an application qualify as disposition of an application for purposes of the processing standards:

1. Approved: The applicant(s) has been determined eligible for participation in the Medically Needy Program;

2. Denied: The applicant(s) has been determined ineligible for participation in the Medically Needy Program;

3. Eligible pending spend-down: The applicant(s) is eligible for participation in the Medically Needy Program in all respects except that the countable income of the budget unit exceeds the medically needy income levels. Eligibility for program benefits may be established through medical spend-downs (see subchapter 6);

4. Dismissed: A decision by the county board of social services that the application process need not be completed because:

i. The death of the applicant(s) (the application process must be completed if there are unpaid medical bills for covered services incurred in either the retroactive coverage period or subsequent to program application or inquiry);

ii. The applicant(s) cannot be located;

iii. The application was registered in error;

iv. The applicant(s) moved out of the State during the application process (see *N.J.A.C. 10:70-2.4* for a move to another county within the State during the application process).

5. Withdrawn: The applicant(s) request that eligibility for the Medically Needy Program not be considered further.

(f) The county board of social services is required by law (*N.J.S.A. 30:6-1.2*) to report to the Department of Human Services, Commission for the Blind and Visually Impaired, every individual coming to its attention who is known to be, or is believed likely to become, permanently blind. Such information shall be reported on a form prescribed by the Commission.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Word "collaborates" deleted in (c)2.

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Substituted "board of social services" for "welfare agency" throughout; in (b)4 and (c)4, added "and" at the end; in (d)2, inserted "applicable"; in (d)4i, substituted "board of social services shall" for "welfare agency will" and deleted "will" preceding "identify"; and in (f), updated N.J.S.A. reference.

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§ 10:70-2.1 Application

Community spouse (applicant) who represented to a county temporary support office that the applicant's son was paying the applicant's housing expenses was not entitled to any relief from his payment obligations. Though the applicant originally advised the agency that his son was paying his expenses, presumably as a gift, after consulting a different elder law attorney, the applicant asserted that the son was "lending" the funds to the applicant. On these facts, which included the applicant's submission of a promissory note that appeared to have been backdated, the applicant was not entitled to relief on his claim that the funds were a loan or that the agency should have counseled the applicant from the outset that characterizing the son's funds as a "loan" would be financially advantageous. *E.B. v. Morris Cnty. Office of Temporary Assistance, OAL DKT. NO. HMA 14388-16, 2017 N.J. AGEN LEXIS 94*, Initial Decision (February 10, 2017).

Medicaid recipient's benefits were properly terminated on findings that he did not demonstrate, as required, that he in fact was not the owner of an LLC in whose name a utility bill was received because the recipient had the responsibility to complete any forms required as part of the application process but had failed to do so. *A.F. v. Middlesex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 09620-16, 2016 N.J. AGEN LEXIS 824*, Initial Decision (October 3, 2016).

Medicaid recipient was denied relief from a county board's termination of her benefits on the ground that her income now exceeded the statutory limit. The recipient now was receiving VA benefits, survivor Social Security Act (SSA) benefits and SSA disability benefits, and her gross monthly income of $ 2,293.19 exceeded the applicable ceiling on income, which was *$ 990. D.R. v. Morris Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 11139-16, 2016 N.J. AGEN LEXIS 749*, Initial Decision (August 29, 2016).

Widow was properly denied relief on her challenge to the effective date of Medicaid eligibility for her now-deceased husband. The agency representative fulfilled his duty to notify the couple of the status of the application and of the steps that the couple had to take in order to complete the process. Once all of the needed information was provided, the agency acted reasonably in determining countable resources and spend-down requirements. Moreover, even if the agency should have notified the couple about the status, the fact was that the couple had excess resources until November 2012, thereby authorizing an eligibility date of *December 2012. E.C. v. DMAHS and Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00149-13, 2016 N.J. AGEN LEXIS 451*, Initial Decision (June 9, 2016).

Determination by a county board of social services (CBSS) that a penalty of two months and 12 days was properly imposed on the eligibility of an applicant for Medicaid was correct because applicant had transferred $ 24,034 for less than fair value during the five year look back period. Those funds were principally spent on wedding reception expenses for a granddaughter, pharmacy school tuition and graduation gifts for a granddaughter, and some traditional gifting to family members for Christmas, birthdays and similar events. Though the applicant insisted that these expenditures were consistent with her past practices and were not properly included in an eligibility penalty, the Administrative Law Judge (ALJ) reasoned that once applicant's health took a turn for the worse and she required institutionalization, it no longer remained credible that applicant did not anticipate seeking public assistance at some point in the future. It was untenable for her to argue that she did not in part know that spending monies on her granddaughter's education or wedding or for family gifts that would in earlier times have been perfectly normal meant that she would not have funds to pay for her medical care and might thus qualify for public assistance. D.B. v. Warren Cty. Bd. of Social Servs., OAL DKT. NO. HMA 00529-15, AGENCY REF. NO.W-13781 (Slip Opinion), Initial Decision (May 18, 2015).

Determination by a county board of social services (CBSS) that a 42-day transfer penalty was properly imposed on the eligibility of an applicant for Medicaid was incorrect because the preponderance of the credible evidence showed that the applicant's daughter, who was generally responsible for her care, made some of the challenged transfers for a reason other than to qualify for Medicaid eligibility. Because the daughter convincingly rebutted the presumption that the transfers were made to establish Medicaid eligibility, the transfers on which a penalty was properly imposed totaled *$ 12,437.33. B.J.H. v. Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13823-14, 2015 N.J. AGEN LEXIS 208*, Initial Decision (February 13, 2015).

§ 10:70-2.1 Application

Transfer penalty was properly imposed on the Medicaid eligibility of an 84-year old nursing home resident who suffered from dementia but because the Morris County Board of Social Services (MCBSS) failed to subtract $ 8000 that was deposited into the resident's account during the look-back period, the length of the penalty was properly recalculated. The case was complicated by the fact that, by reason of her medical status, the resident was unable to provide any explanation as to the purpose served by the challenged expenditures. With respect to one such expenditure, which was a $ 13,412 item allegedly used to pay college expenses for a great-niece, the resident's representative did not provide any documentation that corroborated that explanation. *J.M. v. Morris Cty. Bd. of Social Servs., OAL DKT. NO. HMA 04773-14, 2015 N.J. AGEN LEXIS 126*, Initial Decision (January 28, 2015).

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. *D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546*, Final Decision (June 11, 2007).

End of Document

N.J.A.C. 10:70-2.2

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§ 10:70-2.2 Interview

A personal face-to-face interview with the program applicant(s) or the authorized agent is required as part of the process of determining program eligibility.

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N.J.A.C. 10:70-2.3

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§ 10:70-2.3 Collateral verification

(a) Collateral verification is the use of third-party information (both documentary and nondocumentary) from agencies or individuals other than members of the applicant's household to substantiate the accuracy of statements made on the application and during the interview.

1. Program applicants have the primary responsibility for providing verification of factors of eligibility. If it would be difficult or impossible for the applicants to provide necessary verification in a timely manner, the county board of social services shall provide assistance in obtaining the evidence.

2. In the absence of credible verification of all eligibility factors, eligibility for the Medically Needy Program may not be established.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a)1, substituted "board of social services" for "welfare agency".

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In reviewing an application for Medicaid benefits filed by a 50-year old quadriplegic, a county social services board could not determine the propriety of distributions from a special needs trust account without the testimony of the trustee or some other person knowledgeable about the uses of the funds held therein. In the absence of such information, which could only be obtained from the applicant or his representative, the application was appropriately denied. *E.M. v. DMAHS et al., OAL DKT. NO. HMA 14679-15, 2017 N.J. AGEN LEXIS 670*, Initial Decision (September 6, 2017).

§ 10:70-2.3 Collateral verification

Denial of an application for Medicaid was affirmed when the applicant failed to provide verification of his address in the form requested pursuant to *N.J.A.C. 10:70-2.3(a)*1, *N.J.A.C. 10:71-2.2(e)*2, and *N.J.A.C. 10:72-2.3(b)*. A letter from the landlord that was almost a year old was too old to verify the applicant's current address. *A.M. v. Union Cnty. Bd. of Social Serv., OAL Dkt. No. HMA 07033-14, 2014 N.J. AGEN LEXIS 346*, Initial Decision (July 16, 2014).

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. *D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546*, Final Decision (June 11, 2007).

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N.J.A.C. 10:70-2.4

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§ 10:70-2.4 Case transfer

(a) When individuals move permanently to another county within the State, responsibility for the case shall be transferred in accordance with the provisions of this section. The case transfer shall be accomplished in a manner so not to adversely affect the rights of any individual to program entitlement. In a case transfer, the existing eligibility period, as established by the county of origin, does not change.

1. A temporary visit out-of-county shall not be considered to be a change of county residence until the visit has continued for longer than three calendar months.

(b) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in accordance with (c) and (d) below.

(c) For persons who move from the county in which application for the Medically Needy Program is made prior to a determination of eligibility or ineligibility:

1. The county in which the application was made has the responsibility to:

i. Complete the eligibility determination process;

ii. If determined eligible for the Program, add the eligible persons to the Medicaid Status File (MSF) with the correct effective date of Medically Needy eligibility and the new address (in the receiving county); and

iii. If the case is determined eligible, within five working days of the eligibility determination, transfer the case record material to the receiving county in accordance with (e)1i through iv below.

2. The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized agent upon receipt of the case material to advise of continued program entitlement or when the case has been determined eligible pending spend-down, to advise that the client should report to the receiving county upon achieving spend-down liability; and

ii. Immediately notify the county of origin, in writing, of the date the case material was received.

(d) For cases which are eligible for the Medically Needy Program and those which have been determined eligible pending spend-down:

1. The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent application form (including all verification), Social Security numbers, the new address in the receiving county, and, if applicable, all necessary spend-down information.

ii. Send with the above case material, a cover letter specifying that the case is being transferred and requesting written acknowledgment of receipt;

iii. Forward promptly to the receiving county, copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any case material described in i. or iii. above.

2. The receiving county has the responsibility to:

i. Communicate promptly with the client and/or the client's authorized representative when case material is received;

ii. Immediately notify the county of origin, in writing, of the date the initial case material was received;

iii. Review eligibility for the case. If questions regarding case eligibility exist because of information provided by the county of origin, that county shall be consulted for resolution of the issues;

iv. Accept responsibility for the case (provided application to transfer has been made) effective for the next month if the initial case material has been received before the 10th of the month;

v. Accept responsibility for the case (provided application to transfer has been made) for the second month after the month of receipt of initial case material when such material is received on or after the 10th of the month;

vi. Update the Medicaid Status File (MSF), as necessary. If the case is determined eligible for Medically Needy in the receiving county, there shall be no interruption of entitlement. If the case is determined ineligible for Medically Needy in the receiving county, eligibility shall be terminated, subject to timely and adequate notice, and the previously eligible persons deleted from the MSF; and

vii. Notify the county of origin of the date eligibility for Medically Needy will begin or will be terminated in the receiving county;

(e) Any case for which the transfer procedures in (b) through (d) above are not begun within 30 days of the date of original referral, shall be promptly reported by the county of origin to the Division of Medical Assistance and Health Services by letter, setting forth the pertinent available facts.

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N.J.A.C. 10:70-2.5

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§ 10:70-2.5 Redetermination of eligibility

(a) Eligibility for the Medically Needy Program shall be redetermined as follows:

1. When required, on the basis of information the county board of social services (CBOSS) has obtained previously about anticipated changes in the case situation, or when additional information is necessary to adjust the best estimate of income when such income is subject to significant fluctuation;

2. Promptly, after information is obtained by the CBOSS which indicates changes in the case circumstances that may affect program eligibility or the amount of benefits received under the Program;

3. For cases not subject to medical spend-down, a full redetermination of program eligibility, no later than six months from the date eligibility was first established or from the date of the last full redetermination;

4. For cases subject to spend-down, a full redetermination of program eligibility, by the completion of the current prospective six-month budget period.

(b) For redeterminations of eligibility required by (a)1 and 2 above, the completion of a Form PA-1G-NJR2 (Redetermination Form) and a face-to-face interview are required only if, on the basis of the information obtained, in conjunction with existing case information, the CBOSS is unable to arrive at a decision regarding eligibility or ineligibility.

(c) Full redeterminations of eligibility ((a)3 and 4 above) require the completion of a Form PA-1G-NJR2 (Redetermination Form). The CBOSS may require that the form be completed during a face-to-face interview. However, at the option of the CBOSS, and with the approval of the beneficiary, the face-to-face interview may be eliminated. Form PA-1G-NJR2 (Redetermination Form) may be mailed to and completed by the beneficiary and mailed to the CBOSS. All factors of eligibility subject to change (with the exception of disability and blindness factors; see *N.J.A.C. 10:70-2.6*) must be verified or reverified.

1. When a loss of assistance will result, the face-to-face interview shall be required, unless the agency documents a clear refusal by the beneficiary to have a face-to-face meeting. Before benefits are terminated, a beneficiary shall be offered a face-to-face home visit. The visit shall not be required to be in the office, but at the beneficiary's request, in the home.

(d) The responsibilities of the client(s) in the process of eligibility redetermination are the same as those delineated for program applicants at *N.J.A.C. 10:70-2.1(c)*.

History

HISTORY:

Amended by R.2000 d.396, effective October 2, 2000.

See: *32 N.J.R. 2420(a)*, *32 N.J.R. 3570(a)*.

In (a) and (b), substituted references to CBOSS for references to welfare agencies; in (b), substituted a reference to Redetermination Forms for a reference to new application forms; and rewrote (c).

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N.J.A.C. 10:70-2.6

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§ 10:70-2.6 Redetermination of medical factors

(a) Except for persons receiving Social Security benefits as a result of disability or blindness, the factors of disability and blindness will be redetermined at intervals established by the Division of Medical Assistance and Health Services, Disability Review Section.

(b) Any person whose eligibility for the Program is based on a determination of disability or blindness is required to submit to examinations or tests and provide medical and other evidence necessary for the purpose of determining continued disability or blindness.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Disability determinations shifted from Division of Public Welfare, Bureau of Medical Affairs to Division of Medical Assistance and Health Services, Disability Review Section.

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N.J.A.C. 10:70-2.7

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§ 10:70-2.7 Post-application client responsibilities

(a) Upon a determination of eligibility for the Medically Needy Program, members of the eligibility group (or their authorized agent) have on-going responsibility for the reporting of changes in circumstances and the provision of information as delineated at N.J.A.C. 10:70-2.1(c). Further, as requested by the county board of social services during the eligibility period, additional or updated information must be provided. At any time the county agency lacks sufficient information to confirm continuing program eligibility because of the unwillingness of the eligibility group to provide necessary information, the agency shall commence action to terminate the case.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: 38 N.J.R. 2368(a), 38 N.J.R. 4480(c).

In (a), substituted "board of social services" for "welfare agency".

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N.J.A.C. 10:70-3.1

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§ 10:70-3.1 General provisions

(a) Eligibility must be established in relation to each legal requirement of the Medically Needy Program to provide a valid basis for granting or denying medical assistance.

(b) The applicant's statements regarding his or her eligibility, as set forth in application form, are evidence. The statements must be consistent and meet prudent tests of credibility. Incomplete or questionable statements shall be supplemented and substantiated by corroborative evidence from other pertinent sources, either documentary or nondocumentary.

1. Documentary sources of evidence present factual information recorded at some previous date by a disinterested party and filed as part of a record. Examples: certificates, legal papers, insurance policies, licenses, bills, receipts, notices of RSDI benefits, and so forth.

2. Nondocumentary sources of evidence are factual oral statements, which appear to be reliable, made by individuals based on their observation and personal knowledge of applicant's circumstances.

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N.J.A.C. 10:70-3.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-3.2 Citizenship and alien status

(a) In order to be eligible for the Medically Needy program, an individual must be a citizen of the United States, an alien who has been lawfully admitted for permanent residence for the five years prior to the application or an alien who can be classified as an eligible alien in accordance with this subchapter.

1. The term "citizen of the United States" includes person born in Puerto Rico, Guam, the Virgin Islands, Swains Island, American Samoa, and the Northern Mariana Islands.

2. An individual who cannot be classified as an eligible alien in accordance with this subchapter due to changes mandated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) but who was residing in a Medicaid-certified nursing facility prior to January 29, 1997, shall continue to be eligible for medical assistance until the individual is no longer eligible for long-term care services.

(b) The following aliens, if present in the United States prior to August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to Medically Needy benefits:

1. An alien lawfully admitted for permanent residence;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty in the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain legal aliens who are victims of domestic violence and when there is a substantial connection between the battery or cruelty suffered by an alien and his or her need for Medically Needy benefits, subject to certain conditions described below:

i. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent;

ii. The alien has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household of the alien and the spouse or parent acquiesced to such battery or cruelty;

iii. The alien's child has been battered or subjected to extreme cruelty in the United States by the spouse or the parent of the alien (without the active participation of the alien in the battery or cruelty);

iv. The alien's child has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household as the alien and the spouse or parent acquiesced to and the alien did not actively take part in such battery or cruelty;

v. In addition to the conditions described in (b)12i through iv above, if the individual responsible for the battery or cruelty continues to reside in the same household as the individual who was subjected to such battery or cruelty, then the alien shall be ineligible for Medically Needy benefits;

vi. The county board of social services shall apply the definitions "battery" and "extreme cruelty" and the standards for determining whether a substantial connection exists between the battery or cruelty and the need for Medicaid as issued by the Attorney General of the United States under his or her sole and unreviewable discretion, in accordance with *8 U.S.C. § 1641*.

(c) The following aliens entering the United States on or after August 22, 1996, and if otherwise meeting the eligibility criteria of this chapter, shall be entitled to Medically Needy benefits:

1. An alien lawfully admitted for permanent residence, but only after having been present in the United States for five years;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act but only after the alien has been present in the United States for five years;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980 but only after the alien has been present in the United States for five years;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the Untied States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty with the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain aliens who are victims of domestic violence as specified in (b)12 above, but only after the alien has been present in the United States for five years.

(d) Any alien who is not an eligible alien as specified in (b) and (c) above is ineligible for Medically Needy benefits. Any such alien, if a resident of New Jersey and if he or she meets all other Medically Needy eligibility requirements contained in this chapter, is entitled to Medically Needy coverage for the treatment of an emergency medical condition only. This coverage is limited to those emergency services which would otherwise be covered by Medically Needy. This coverage does not include inpatient hospital services.

1. An emergency medical condition is one of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

i. Placing the patient's health in serious jeopardy;

ii. Serious impairment to bodily functions; or

iii. Serious dysfunction of any bodily organ or part.

2. An emergency medical condition shall include all labor and delivery for a pregnant woman, but shall not include routine prenatal or routine post-partum care.

3. Services related to an organ transplant procedure are not covered under services available for treatment of an emergency medical condition.

(e) Persons claiming to be citizens and eligible aliens shall provide the county board of social services with documentation of citizenship or alien status, in accordance with (f) below.

(f) As a condition of eligibility, all applicants for the Medically Needy program, (except those applying solely for services related to the treatment of an emergency medical condition or for services related to labor and delivery for pregnant women) shall sign a declaration under penalty of perjury that they are a citizen of the United States or an alien in a satisfactory immigration status. In the case of a child or incompetent applicant, another individual on the applicant's behalf shall complete the same written declaration under penalty of perjury.

1. The following are acceptable documentation of United States citizenship:

i. A birth certificate;

ii. A religious record of birth recorded in the United States or its territories within three months of birth. The document must show either the date of birth or the individual's age at the time the record was created;

iii. A United States passport (not including limited passports which are issued for periods of less than five years);

iv. A Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);

v. A U.S. Citizen I.D. Card (INS Form-197), Naturalization Certificate (INS Form N-550 or N-570);

vi. A Certificate of Citizenship (INS Forms N-560 or N-561);

vii. A Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the United States who was born in the United States before November 3, 1986);

viii. An American Indian Card with a classification code "KIC" (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos); or

ix. A contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in any of these jurisdictions).

2. If an applicant presents an expired INS document or is unable to present any document demonstrating his or her immigration status, the county board of social services shall refer the applicant to the local INS district office to obtain evidence of status. If, however, the applicant provides an alien registration number, but no documentation, the county board of social services shall file INS Form G-845 along with the alien registration number with the local INS district office to verify status.

3. The following shall constitute acceptable documentation for eligible aliens.

i. Lawful Permanent Resident--INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94;

ii. Refugee--INS Form I-94 annotated with stamp showing entry as refugee under section 207 of the Immigration and Nationality Act and date entry into the United States; INS Form I-688B annotated "274a. 12(a)(3)," I-766 annotated "A3," or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the United States, but for purposes of determining Medically Needy eligibility, they are considered refugees. Refugees whose status has been adjusted will have INS Form I-551 annotated "RE-6," "RE-7," "RE-8," or "RE-9."

iii. Asylees--INS Form I-94 annotated with a stamp showing grant of asylum under section 208 of the Immigration and Nationality Act, a grant letter from the Asylum Office of the Immigration and Naturalization Service, Form-688B annotated "274a.12(a)(5)," or I-766 annotated "A5."

iv. Deportation Withheld--Order of an Immigration Judge showing deportation withheld under section 243(h) of the Immigration and Nationality Act and the date of the grant, or INS Form I-688B annotated "274a. 12 (a)(10)" or I-766 annotated "A10."

v. Parole for at Least a Year--INS Form I-94 annotated with stamp showing grant of parole under section 212(d)(5) of the Immigration and Nationality Act and a date showing granting of parole for at least a year.

vi. Conditional Entry under Law in Effect before April 1, 1980--INS Form I-94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or INS Form I-688B annotated "274a.12(a)(3)" or I-766 annotated "A3."

vii. Cuban Haitian Entrant--INS Form I-94 stamped "Cuban/Haitian Entrant" under section 212(d)(5) of the INA.

viii. An American Indian born in Canada--INS Form I-551 with code S13 or an unexpired temporary I-551 stamp (with code S13) in a Canadian passport or on Form I-94.

ix. A member of certain Federally recognized Indian tribes--Membership card or other tribal document showing membership in tribe.

x. Amerasian Immigrant--INS Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AM6, AM7, or AM8.

4. For aliens subject to the five-year waiting period before eligibility for Medically Needy can be established, the date of entry into the United States shall be determined as follows:

i. On INS Form I-94, the date of admission should be found on the refugee stamp. If missing, the county board of social services should contact the INS local district office by filing Form G-845, attaching a copy of the document;

ii. If the alien presents INS Form I-688B (Employment Authorization Document), I-766, or I-571 (Refugee Travel Document), the county board of social services shall ask the alien to present Form I-94. If that form is not available, the county board of social services shall contact the INS via the submission of Form G-845, attaching a copy of the documentation presented;

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the county board of social services shall contact the INS by submitting a Form G-845, attaching a copy of the document presented.

5. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following serve as documentation:

i. For discharge status, an original, or notarized copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original, or notarized copy, of the applicant's current orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps., or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self declaration under penalty of perjury may be accepted, pending receipt of acceptable documentation.

History

HISTORY:

Amended by R.1999 d.253, effective August 2, 1999.

See: *31 N.J.R. 97(a)*, *31 N.J.R. 2203(b)*.

Rewrote the section.

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Substituted "board of social services" for "welfare agency" throughout; in the introductory paragraph of (a), inserted "an alien who has been lawfully admitted for permanent residence for the five years prior to the application"; in (a)2, substituted "shall" for "will"; rewrote the introductory paragraph of (f); and in (f)3x, substituted "AM6" for "AN6".

Annotations

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End of Document

N.J.A.C. 10:70-3.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 70. MEDICALLY NEEDY PROGRAM > SUBCHAPTER 3. NONFINANCIAL ELIGIBILITY FACTORS

§ 10:70-3.3 Residency

(a) In order to be eligible for the Medically Needy Program, an individual must be a resident of the State of New Jersey. State residence shall be determined in accordance with the regulations at N.J.A.C. 10:71-3.5, 3.7, and 3.8.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Changed internal N.J.A.C. cites.

Annotations

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N.J.A.C. 10:70-3.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-3.4 Eligibility group criteria

(a) Eligibility for the Medically Needy Program is limited to groups of persons within two specified eligibility categories. An individual must meet the definition of one of the categories below to be eligible for the Medically Needy Program.

(b) The following eligibility groups are within the AFDC-related eligibility category:

1. Pregnant women: Needy pregnant women of any age during the term of a medically verified pregnancy, through the end of the month during which the 60th day from delivery occurs.

i. A child born to a woman eligible as a pregnant woman under the provisions of this chapter shall remain eligible for a period not less than 60 days from his or her birth, and up to one year so long as the mother remains eligible for Medicaid, or would remain eligible if pregnant, whether or not application has been made, if the child lives with his or her mother.

2. Children under the age of 21: Needy children under the age of 21.

i. Children under the age of 21 may be eligible regardless of: Parental deprivation; school attendance; emancipation; residence with parent(s) or other caretaker relative(s); or Work Incentive program (WIN) or other AFDC employment or training requirements.

ii. A child may be eligible for program benefits when temporarily absent from his or her family in accordance with the provisions of *N.J.A.C. 10:69-3.28* through *3.30*.

(c) The following eligibility groups are within the SSI-related eligibility category:

1. Aged: Needy persons who are 65 years of age or older.

2. Blind: Needy persons who are statutorily blind. Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends at an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

i. Persons who are receiving Social Security disability benefits as a result of blindness are presumed to be blind for purposes of this program.

ii. Except for persons described in (c)2i above, the determination of statutory blindness is the responsibility of the Division of Medical Assistance and Health Services, Disability Review Section.

3. Disabled: Needy persons who are disabled. Disability is the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. The severity of impairment must be such that the individual is unable to do his or her previous work or any other substantial gainful activity which exists in the national economy. In the determination of a person's ability to do any other work, residual functional capacity, age, education, and work experience are considered.

i. Disability for children under the age of 18 is any medically determinable physical or mental impairment which compares in severity to an impairment that would make an adult disabled.

ii. Persons who are receiving Social Security disability benefits are presumed to be disabled for purposes of this program.

iii. Except for persons described in (c)3ii above, the determination of disability is the responsibility of the Division of Medical Assistance and Health Services, Disability Review Section.

(d) Under certain circumstances, an individual may be considered for eligibility under both the SSI-related and AFDC-related categories (for example, a blind child under the age of 21). Such an individual may select the category under which he or she wishes to be considered for program eligibility upon being advised by the county board of social services of the option and the consequences thereof.

History

HISTORY:

Amended by R.1989 d.397, effective August 7, 1989.

See: 21 N.J.R. 965(a), 21 N.J.R. 2383(a).

Provisions on eligibility of newborn and specification of time limit of eligibility of mother after delivery added at (b).

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Shift in administrative functions from Division of Public Welfare, Bureau of Medical Affairs, Medical Review Team to Division of Medical Assistance and Health Services, Disability Review Section.

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In the introductory paragraph of (b), deleted "AFDC-related:" from the beginning; in (b)1, inserted "pregnant"; in (b)2ii, updated N.J.A.C. references; in the introductory paragraph of (c), deleted "SSI-related:" from the beginning; in (c)1, substituted "who are" for "aged"; and in (d), substituted "board of social services" for "welfare agency".

Annotations

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Case Notes

Appeal by applicant for eligibility under Medicaid Nursing Home Program as of August 31, 2014 was properly dismissed because while the applicant showed clinical eligibility and the applicant's income satisfied either the budget unit or the medical spend down requirements in governing regulations, the applicant did not satisfy the resource limits until April 2015 and thus did not have eligibility until then. *M.P. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02517-16, 2017 N.J. AGEN LEXIS 163*, Final Administrative Determination (March 16, 2017).

Initial Decision (2006 N.J. AGEN LEXIS 980) adopted, which found that receipt of disability-related Social Security benefits (RSDI or SSDI) did not qualify a Medically Needy program applicant for Medically Needy spend-down

analysis under *N.J.A.C. 10:70-6.1*; the regulation for spend-down eligibility requires the applicant to be a recipient of SSI (Supplemental Security Income), which is the Medicaid disability benefit available to low-income disabled individuals pursuant to *Title XVI of the Social Security Program. J.O. v. DMAHS, OAL Dkt. No. HMA 4407-06, 2006 N.J. AGEN LEXIS 935*, Final Decision (October 24, 2006).

End of Document

N.J.A.C. 10:70-3.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-3.5 Budget unit

(a) The term "budget unit" means those persons whose income and resources are counted in the determination of eligibility for persons applying for or eligible for the Medically Needy Program. Incurred medical expenses of all members of the budget unit are applied in meeting spend-down liability when applicable (see N.J.A.C. 10:70-6). Only those members of the budget unit who are either SSI-related or AFDC-related (see N.J.A.C. 10:70-3.4) may qualify for coverage under the Medically Needy Program.

(b) For AFDC-related persons (pregnant women and children under the age of 21), the budget unit shall be constituted as follows:

1. A pregnant woman shall comprise a budget unit of two (except in medically verified cases of multiple pregnancy, where the budget unit shall consist of the pregnant woman and the confirmed number of fetuses). If the pregnant woman is married and living with her husband, the budget unit shall consist of one additional person. The woman's natural or adoptive children under the age of 21, living in the same household, shall be included in the budget unit. If the pregnant woman is under the age of 21 and resides in the same household as her natural or adoptive parents, the parents shall be included in the budget unit.

2. For children under the age of 21, the budget unit shall be composed of all blood-related or adoptive brothers and sisters under the age of 21 living in the same household, as well as the natural or adoptive parent(s) of the children when living in the same household.

i. In the event the children under the age of 21 reside with a stepparent, the stepparent may be included in the budget unit. If the stepparent is included in the budget unit, his or her income and resources will be included in the determination of Medically Needy eligibility and his or her medical expenses will apply in the determination of spend-down liability, if applicable. If the stepparent is not to be included in the budget unit, his or her income, resources, and medical expenses will not be included in the determination of Medically Needy eligibility.

ii. The option of including or not including the stepparent in the budget unit, and the consequences thereof, shall be fully explained to program applicants so that an informed decision may be made.

3. Any person who is in receipt of AFDC or SSI or who has applied for and been found eligible for regular Medicaid benefits related to those programs shall not be included in the budget unit of an AFDC-related case. Any person whose income and resources have been deemed to an eligible SSI beneficiary shall likewise not be included in the budget unit.

(c) For SSI-related persons (aged, blind, and disabled individuals), the budget unit shall be constituted as follows:

1. An aged, blind, or disabled adult not living with his or her spouse is a budget unit of one regardless of the number of other persons (related or unrelated) living in the same household.

2. An aged, blind, or disabled adult living with his or her spouse (whether or not the spouse is program eligible) is a budget unit of two regardless of other persons (related or unrelated) living in the same

household (see N.J.A.C. 10:70-4.6(d)1 for an exception to this rule in circumstances involving an SSI-related child).

3. For a blind or disabled child (under the age of 21), the budget unit shall consist of the child. Parental income is deemed to any such child under the age of 18 in accordance with provisions at N.J.A.C. 10:70-4.6(d).

4. For circumstances in which more than one sibling residing in the same household with their parent(s) apply as SSI-related, each such child will be a budget unit of one person and parental income deemed in accordance with provisions at N.J.A.C. 10:70-4.6(d).

5. Any person who is in receipt of AFDC or SSI or who has applied for and been found eligible for regular Medicaid benefits related to those programs shall not be included in the budget unit of an SSI-related case.

6. When one or more siblings of a Medically Needy SSI-related child apply for and are found eligible for the Medically Needy Program as AFDC-related, the SSI-related child will be considered in a budget unit of one. (Parental income and resources will be considered toward the AFDC-related children only.)

(d) In family groups living in the same household, some of the members may qualify as SSI-related and others as AFDC-related. The family's choice of persons for whom Medically Needy benefits are sought will vary the composition of the budget unit and affect eligibility for the program. Available options shall be fully explained to the family by the county board of social services so that the family may make an informed decision regarding application options.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Change to consider pregnant mother and medically verified number of fetuses in budget unit.

Amended by R.2006 d.364, effective October 16, 2006.

See: 38 N.J.R. 2368(a), 38 N.J.R. 4480(c).

In (b)3, substituted "beneficiary" for "recipient"; and in (d), substituted "board of social services" for "welfare agency".

Annotations

Notes

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Research References & Practice Aids

CROSS REFERENCES:

Special medicaid programs, household units, see N.J.A.C. 10:72-3.5.

End of Document

N.J.A.C. 10:70-3.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-3.6 Third party liability

Program applicants and beneficiaries shall identify to the county board of social services any third party (individual, entity, or program) that is or may be liable to pay all or part of the medical cost of injury, disease, or disability of an applicant or beneficiary.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Substituted "beneficiaries shall" for "recipients are required to", "board of social services" for "welfare agency", and "beneficiary" for "recipient".

Annotations

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N.J.A.C. 10:70-3.7

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:70-3.7 Eligibility under other Medicaid categories

Eligibility for the Medically Needy Program will not be established for any individual who is eligible for Medicaid Only, Medicaid Special, Medicaid for the Unborn, or extended Medicaid benefits resulting from the previous receipt of AFDC. Such individuals are eligible for payment of covered medical services under the categorically needy Medicaid program.

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:70-3.8

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NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 70. MEDICALLY NEEDY PROGRAM > SUBCHAPTER 3. NONFINANCIAL ELIGIBILITY FACTORS

§ 10:70-3.8 Persons sanctioned under AFDC rules

(a) Persons who are ineligible for AFDC due to the imposition of a sanction of ineligibility in that program may be eligible for the Medically Needy Program (with the exception below) without regard to the sanction.

1. Any person ineligible for AFDC solely as a result of being on strike is likewise ineligible for the Medically Needy Program. Because caretaker relatives are not eligible for the Medically Needy Program, participation in a strike by the caretaker relative will not affect the eligibility of children applying for the Medically Needy Program.

2. See N.J.A.C. 10:70-4.5(c) for persons ineligible for AFDC due to a period of ineligibility imposed as a result of the receipt of lump sum income.

Annotations

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Chapter Notes

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N.J.A.C. 10:70-3.9

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:70-3.9 Application for other benefits

(a) As a condition of eligibility for the Medically Needy Program, applicants and beneficiaries are required to take all necessary steps to obtain any annuities, pensions, retirement and disability benefits to which they are entitled, unless they can show good cause for not doing so. Applicants and beneficiaries shall avail themselves of any health insurance available to the budget unit at no cost, such as coverage provided at no cost by an employer.

1. Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, Social Security benefits, unemployment compensation.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: 38 N.J.R. 2368(a), 38 N.J.R. 4480(c).

In the introductory paragraph of (a), substituted "beneficiaries" for "recipients" and "beneficiaries shall" for "recipients must".

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:70-3.10

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:70-3.10 Inmates of public institutions

(a) Any person who is an inmate of a public institution is ineligible for the Medically Needy Program.

(b) Any person who is incarcerated in a Federal, State, or local correctional facility (prison, jail, detention center, reformatory, etc.) is not eligible for Medically Needy Program benefits.

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:70-4.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-4.1 Medically Needy Income Levels

(a) Income eligibility for the Medically Needy Program may be established by two methods. If the countable income of the budget unit (as determined in this subchapter) is equal to or less than the Medically Needy Income Level (MNIL) appropriate for the budget unit size, income eligibility is established and the eligible persons are entitled to Medically Needy Program payment for covered services. For cases in which the countable income of the budget unit exceeds the appropriate MNIL, income eligibility may only be established through medical spend-down (see N.J.A.C. 10:70-6).

1. The monthly MNIL for budget units consisting of two to 10 persons shall be based on the AFDC allowance standards (as set forth at *N.J.A.C. 10:69-10.3*). The allowance standard for the eligible unit size corresponding to the budget unit size will be multiplied by 1.333. The result of this computation shall be multiplied by 12 and the result rounded up to the next nearest $ 100.00. After rounding, the amount shall be divided by 12. Any cents resulting from this calculation are dropped and the remainder is the monthly MNIL.

2. To establish the monthly MNIL for budget units of more than 10 persons, the calculation in (a)1 above shall be applied to the AFDC increment applicable for each additional person in eligible units of more than 10 persons (see *N.J.A.C. 10:69-10.3*). The resulting amount for each additional budget unit member shall be added to the monthly MNIL for 10 persons.

3. For budget units of one person, the AFDC allowance standard for two persons shall be reduced by the increment for each additional person applicable to eligible units of more than 10 persons (see *N.J.A.C. 10:69-10.3*). The result of this computation shall be calculated as in (a)1 above. The resulting amount is the monthly MNIL for one person.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a)1, (a)2, and (a)3, deleted "-C and -F" following "AFDC", substituted "10" for "ten", and updated N.J.A.C. references; in (a)2, substituted "10" for "12"; and in (a)2 and (a)3, substituted "in (a)1 above" for "in 1. above".

Annotations

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Case Notes

Appeal by applicant for eligibility under Medicaid Nursing Home Program as of August 31, 2014 was properly dismissed because while the applicant showed clinical eligibility and the applicant's income satisfied either the budget unit or the medical spend down requirements in governing regulations, the applicant did not satisfy the resource limits until April 2015 and thus did not have eligibility until then. M.P. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02517-16, 2017 N.J. AGEN LEXIS 163, Final Administrative Determination (March 16, 2017).

Nursing home resident was Medicaid-eligible as of May 1, 2015 because her resources on that date totaled $ 719.63, well below the resource ceiling of $ 2,000. Her receipt of a $ 10,000 check later in that month on account of the settlement of a personal injury claim did not affect her eligibility for May 2015 as that was determined by law based on resources on the first day of the month. However, she became ineligible for Medicaid on June 1, 2015 because the account balance on that date exceeded the $ 2,000 ceiling. S.Y. v. Essex Cnty. Div. of Welfare, OAL DKT. NO. HMA 05261-16, 2016 N.J. AGEN LEXIS 250, Initial Decision (May 10, 2016).

Initial Decision (2006 N.J. AGEN LEXIS 980) adopted, which found that although the term "gross income" is not specifically defined for the Medically Needy program found at N.J.A.C. 10:70-1.1 et seq., the Medicaid Only program does contain definitions for earned and unearned income under *N.J.A.C. 10:71-5.1(b)* and both N.J.A.C. 10:71-5.4 and N.J.A.C. 10:71-5.6 make reference to gross income; thus, while not a paradigm of clarity, the regulations imply that gross income is the proper figure to use in making eligibility determinations for the Medically Needy program as well as the Medicaid Only program. J.O. v. DMAHS, OAL Dkt. No. HMA 4407-06, 2006 N.J. AGEN LEXIS 935, Final Decision (October 24, 2006).

End of Document

N.J.A.C. 10:70-4.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:70-4.2 Eligibility periods

(a) The retroactive eligibility period is the three calendar months immediately preceding the month in which application for benefits is made.

(b) The prospective eligibility period is the six calendar months beginning with the month of application. Once established, the prospective eligibility period will not be changed unless the case becomes ineligible for the Medically Needy Program during the eligibility period. Upon reapplication for the program, a new prospective eligibility period will be established.

1. Except for certain pregnant women, eligibility does not extend beyond the end of the eligibility period. A pregnant woman, who delivers her child near the end of the six-month eligibility period, may be eligible for a period exceeding six months if her post-partum extended eligibility exceeds the last day of the prospective eligibility period (see *N.J.A.C. 10:70-3.4(b)*1). In all other cases, continuation of program benefits is contingent upon a redetermination of all factors of eligibility (see *N.J.A.C. 10:70-2.5*). Any period of eligibility for a pregnant woman which exceeds the prospective eligibility period under the provisions of *N.J.A.C. 10:70-3.4(b)*1 shall be without regard to income or resources for such additional period of time.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Change in continued eligibility for pregnant women and newborns based on amendments to the Social Security Act (*42 U.S.C. 1396a*).

Annotations

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Chapter Notes

End of Document

N.J.A.C. 10:70-4.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-4.3 Computing income for six-month prospective period

(a) The county board of social services shall establish the best estimate of income that will be available in the six-month prospective eligibility period.

1. The best estimate of income shall be based on an average of the budget unit's income for the full two-month period prior to the date of application. Adjustments shall be made in the estimated income to reflect changes in income that either have occurred or are reasonably anticipated to occur which would affect countable income for the prospective budget period. Once established, the best estimate of monthly income shall be applied to each of the six months of the budget period. If the income for the full six-month period is less than or equal to the MNIL for the six-month period, eligibility for program benefits has been established. If the income for the period exceeds the six-month MNIL, eligibility for program benefits may be established through the medical spend-down process.

2. Income changes during the six-month eligibility period require an adjustment to the countable income for the month of the income change and a new best estimate of income must be established for the remaining months of the eligibility period if the change in income will continue.

i. For a case not subject to medical spend-down, an increase in countable income for the remaining months of the eligibility period, will result in the establishment of a spend-down liability if the income for those months exceeds the MNIL for the remaining months.

ii. For a case which has been determined eligible pending spend-down, changes in income during the eligibility period require a recomputation of spend-down liability for the eligibility period which may increase or decrease the liability of the budget unit. If a decrease in income is sufficient to reduce the budget unit's income below the six-month MNIL, eligibility is established without a spend-down liability for the remaining months of the eligibility period.

iii. For a case which has met the spend-down liability during the eligibility period, the recomputation of income for the remaining months of the eligibility period will result in the establishment of an additional spend-down liability if the countable income for the remaining months exceeds the MNIL for those months. Eligibility for the months in which the previously computed liability was met will not be retroactively affected by the new liability established for the remaining months of the eligibility period.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In the introductory paragraph of (a), substituted "board of social services" for "welfare agency".

Annotations

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Chapter Notes

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N.J.A.C. 10:70-4.4

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

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§ 10:70-4.4 Computing income for retroactive period

(a) In determining income eligibility for the retroactive eligibility period, countable income actually received in each month of the three-month period shall be compared to the budget unit's monthly MNIL for the same month. If the countable income for a month is less than or equal to the MNIL, eligibility for program benefits for that month has been established. If the income for a month exceeds the MNIL for that month, eligibility for program benefits may be established through the spend-down process (see N.J.A.C. 10:70-6).

Annotations

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Chapter Notes

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N.J.A.C. 10:70-4.5

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 70. MEDICALLY NEEDY PROGRAM > SUBCHAPTER 4. INCOME ELIGIBILITY

§ 10:70-4.5 Countable income: AFDC-related cases

(a) Except as specified below, countable income for AFDC-related cases shall be determined in accordance with regulations applicable to income in the AFDC program (see *N.J.A.C. 10:69*).

1. The maximum income limits as provided for at *N.J.A.C. 10:69-10.3(a)*3 do not apply.

2. The $ 30.00 and the one-third disregard of earned income at *N.J.A.C. 10:69-10.13(c)*4 do not apply.

3. The deeming of stepparent income at *N.J.A.C. 10:69-10.33(d)* does not apply. See *N.J.A.C. 10:70-3.5(b)*2 regarding inclusion or exclusion of the stepparent from the budget unit.

4. The deeming of income of an alien's sponsor at *N.J.A.C. 10:69-10.43* does not apply.

(b) Nonrecurring lump sum income received by an AFDC-related budget unit shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months. The receipt of such income will require a recomputation of income eligibility for the remaining months of the eligibility period, except as follows:

1. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

(c) Any person who received AFDC or Medicaid based on AFDC rules and became ineligible for such assistance because of a period of ineligibility imposed as a result of the provisions of *N.J.A.C. 10:69-10.23* shall likewise be ineligible for the Medically Needy Program for the same period as determined in AFDC. Once imposed, the period of ineligibility may only be reduced in accordance with the provisions of *N.J.A.C. 10:69-10.23(a)*5.

(d) For AFDC-related cases, the following persons are legally responsible relatives to members of the AFDC-related eligibility group: parents of a child under the age of 18; parents of a child aged 18 to 21 unless the child is him or herself a parent; and the spouse of any member of the eligibility group. When a legally responsible relative resides in the same household as the member of the eligibility group, income of the legally responsible relative is counted in accordance with the structure of the budget unit and no additional evaluation of the relative is required. When the eligible group member does not reside in the same household as the legally responsible relative, the county board of social services shall pursue support from such relative in accordance with the provisions of *N.J.A.C. 10:69-3.31*.

1. Except when the legally responsible relative resides in the same household as the member of the eligibility group, income of the relative shall be counted only to the extent that the income is actually available.

History

HISTORY:

Amended by R.2002 d.124, effective April 15, 2002.

See: *33 N.J.R. 4188(a)*, *34 N.J.R. 1546(a)*.

Added (b)1.

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Updated N.J.A.C. references throughout; in the introductory paragraph of (a), deleted "-C" following the second occurrence of "AFDC"; and in the introductory paragraph of (d), substituted "board of social services" for "welfare agency".

Annotations

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Chapter Notes

Case Notes

Nursing home resident was Medicaid-eligible as of May 1, 2015 because her resources on that date totaled $ 719.63, well below the resource ceiling of $ 2,000. Her receipt of a $ 10,000 check later in that month on account of the settlement of a personal injury claim did not affect her eligibility for May 2015 as that was determined by law based on resources on the first day of the month. However, she became ineligible for Medicaid on June 1, 2015 because the account balance on that date exceeded the $ 2,000 ceiling. *S.Y. v. Essex Cnty. Div. of Welfare, OAL DKT. NO. HMA 05261-16, 2016 N.J. AGEN LEXIS 250*, Initial Decision (May 10, 2016).

End of Document

N.J.A.C. 10:70-4.6

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-4.6 Countable income: SSI-related cases

(a) Except as specified below, countable income for SSI-related cases shall be determined in accordance with regulations applicable to income in Medicaid Only--Aged, Blind, and Disabled (see N.J.A.C. 10:71-5).

1. The disregard of cost-of-living increases in Social Security benefits provided for in N.J.A.C. 10:71-5.3(a)7x and xi do not apply in the Medically Needy Program.

2. The deeming of the income of an alien's sponsor as provided for at N.J.A.C. 10:71-5.9 does not apply.

(b) Nonrecurring lump sum income received by an SSI-related budget unit shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months. The receipt of such income will require a recomputation of eligibility for the remaining months of the eligibility period, except as follows:

1. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

(c) In the following circumstances, an SSI-related case will have the value of in-kind support and maintenance counted as unearned income.

1. Any SSI-related adult, who would in accordance with rules at N.J.A.C. 10:71-5.6(c) be determined to be "living in the household of another", shall be considered to have unearned income in the amount specified at N.J.A.C. 10:71-5.4(a)12 less $ 20.00. The amount of income so assigned is not rebuttable.

2. Any SSI-related person other than those addressed in (c)1 above, to whom food or shelter is given or paid for by someone other than by a spouse, a parent, or a minor child residing in the same household, shall be presumed to receive in-kind support and maintenance. The presumed value of the support and maintenance will be the values specified at N.J.A.C. 10:71-5.4(a)12. The presumed value so assigned may be rebutted in accordance with provisions of that subsection.

(d) In accordance with the rules at N.J.A.C. 10:71-5.5, the income of an ineligible spouse shall be deemed to the eligible spouse when they are residing in the same household. Income of the parent(s) of an SSI-related child under the age of 18 residing in the same household shall be deemed available to the child in the determination of eligibility for Medically Needy benefits. Income shall not be deemed from any person whose income is counted in determining income eligibility for an AFDC-related case which is eligible for the Medically Needy Program.

1. When an ineligible spouse's income must be deemed to both an SSI-related spouse and an SSI-related child, the income of the ineligible spouse is deemed to the SSI-related spouse to the extent that the total income of the SSI-related spouse equals the MNIL for two persons. The excess income of the ineligible spouse is deemed to the SSI-related child. The eligibility of the SSI-related child is based on a budget unit of one person. Allowable incurred medical expenses of the ineligible spouse shall be applied to the spend-down liability, if any, of the SSI-related child.

2. When parental income must be deemed to more than one SSI-related child, income shall be deemed in accordance with the following model based on two SSI-related children. Income to child A is deemed to the extent that the child's total income equals the MNIL for a budget unit of one person. The remaining deemed income shall be deemed to child B. Child A's eligibility will be based on a budget unit of one person (with no spend-down liability) and child B's eligibility will be based on a budget unit of one and the allowable incurred medical expenses of the parents applied to child B's spend-down liability if any. For additional SSI-related children, deeming of income would be to the MNIL for one person for each additional child.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Internal N.J.A.C. cites changed.

Amended by R.2002 d.124, effective April 15, 2002.

See: *33 N.J.R. 4188(a)*, *34 N.J.R. 1546(a)*.

In (b), added ", except as follows:" at the end of the introductory paragraph and added 1.

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a)2, updated N.J.A.C. reference; and in (c)2, deleted ", clothing," following "to whom food".

Annotations

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N.J.A.C. 10:70-5.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 70. MEDICALLY NEEDY PROGRAM > SUBCHAPTER 5. RESOURCE ELIGIBILITY

§ 10:70-5.1 Resource eligibility limits

(a) Eligibility for the Medically Needy Program shall not exist for any month in which the total value of a budget unit's countable resources exceeds the limits below:

Resource Limits in the Medically Needy Program

Family Size	$ Resources
1	4,000
2	6,000
3	6,100
4	6,200
5	6,300
6	6,400
Each additional person	100

(b) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the cash reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded cash reward shall also be excluded.

History

HISTORY:

Amended by R.2002 d.124, effective April 15, 2002.

See: *33 N.J.R. 4188(a)*, *34 N.J.R. 1546(a)*.

Added (b).

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a), substituted "shall" for "does" and rewrote table.

Annotations

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Case Notes

Appeal by applicant for eligibility under Medicaid Nursing Home Program as of August 31, 2014 was properly dismissed because while the applicant showed clinical eligibility and the applicant's income satisfied either the budget unit or the medical spend down requirements in governing regulations, the applicant did not satisfy the resource limits until April 2015 and thus did not have eligibility until then. M.P. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02517-16, 2017 N.J. AGEN LEXIS 163, Final Administrative Determination (March 16, 2017).

Widow was properly denied relief on her challenge to the effective date of Medicaid eligibility for her now-deceased husband. Once all needed information was provided, the agency reasonably determined countable resources and spend-down requirements. Inasmuch as the couple had excess resources until November 2012, a December 2012 eligibility date was appropriate. E.C. v. DMAHS and Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00149-13, 2016 N.J. AGEN LEXIS 1138, Final Administrative Determination (July 18, 2016).

Widow was properly denied relief on her challenge to the effective date of Medicaid eligibility for her now-deceased husband. The agency representative fulfilled his duty to notify the couple of the status of the application and of the steps that the couple had to take in order to complete the process. Once all of the needed information was provided, the agency acted reasonably in determining countable resources and spend-down requirements. Moreover, even if the agency should have notified the couple about the status, the fact was that the couple had excess resources until November 2012, thereby authorizing an eligibility date of December 2012. E.C. v. DMAHS and Ocean Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 00149-13, 2016 N.J. AGEN LEXIS 451, Initial Decision (June 9, 2016).

Son's failure to obtain and provide, to a county board of social services, true copies of agreements and related documents concerning a trust of which his father, an elderly man who was disabled due to Alzheimers, dementia and Parkinson's disease, was the sole trustee afforded grounds for a denial of Medicaid benefits. This was notwithstanding the fact that the son had demonstrated that the documents were not provided because the son simply could not obtain them from the bank where the trust was established. A.T., Petitioner, v. Division of Medical Assistance & Health Services and Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 20582-15, 2016 N.J. AGEN LEXIS 156, Initial Decision (March 28, 2016).

Decision of the Division of Medical Assistance and Health Services to deny an applicant's eligibility for Medicaid was appropriate under N.J.A.C. 10:70-5.1. The income and corpus of a family trust was not specifically excludable for purposes of determining Medicaid eligibility and must be treated as countable assets for the purpose of determining Medicaid eligibility under *N.J.A.C. 10:71-4.11(e)(2)(i)*. As such, the applicant's countable income exceeded the resource limit of $ 4,000 for the Medically Needy program. K.L. v. Div. of Medical Assistance and Health Serv. and Gloucester County Bd. of Social Serv., OAL DKT. NO. HMA 11454-2014, 2015 N.J. AGEN LEXIS 37, Initial Decision (January 13, 2015).

Ocean County Board of Social Services and the Division of Medical Assistance and Health Services improperly denied an applicant Medicaid benefits on the grounds that she was over-resourced pursuant to N.J.A.C. 10:70-5.1(a). The resource value of the asset in question, a restaurant, less the encumbrances against it resulted in a negative value. However, her transfer of assets for less than fair market value triggered a Medicaid-eligibility penalty period pursuant to N.J.A.C. 10:71-4.10(c)4. The applicant essentially made a gift of the property at issue to her son by transferring it for one dollar consideration and then encumbering it with close to $ 3 million in liens to build a business that her son and his wife owned through their limited liability company (LLC). The transfer was a gift to her son for which his LLC was the sole beneficiary. The applicant did not meet her burden of rebutting the presumption that the purpose of this transfer was for reasons other than Medicaid planning. She presented no

explanation as to why she would give away her valuable interest in the property to her son's LLC for profit, leaving her with nothing but millions of dollars in debt. *C.S. v. Div. of Med. Assistance and Health Serv. and Ocean County Bd. of Social Serv., OAL DKT. NO. HMA 5957-14, 2014 N.J. AGEN LEXIS 584*, Initial Decision (November 6, 2014).

An Administrative Law Judge (ALJ) concluded that an adverse determination on an applicant's Medicaid only application based on a finding by a county board of social services that an eligibility penalty per N.J.A.C. 10:70-4(a) and *N.J.A.C. 10:70-5.1(a)* was properly imposed was improper. Though the board had found that the applicant had transferred resources in the amount of $ 72,930 as verified by checks on her account, the caseworker never sought any clarification from the applicant or her family as to the uses to which the funds allegedly had been put, never requested or reviewed tax returns and cancelled checks, never provided any information to the applicant or her family concerning the necessary spend-down, and never provided the applicant or her family with an itemized list identifying the transactions which were included in the $ 72,930 penalty. The caseworker also admitted that the proper procedures were not followed. The existence of significant procedural concerns as to the manner in which the application required that the order be vacated. *M.J. v. Essex Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 724-14, 2014 N.J. AGEN LEXIS 304*, Initial Decision (May 22, 2014).

N.J.A.C. 10:70-5.2

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§ 10:70-5.2 AFDC-related cases; resources

(a) The resource provisions contained in this section shall apply to AFDC-related applicants and beneficiaries under this chapter.

(b) Available resources shall include cash and other forms of assets that can produce income immediately obtainable to meet the needs of the eligible unit, including:

1. Real or personal property that is within the control of one or more members of the eligible unit, or to which such members may have a valid property interest; and

2. Benefits and other contributions of support which are available to one or more of the members of the eligible unit.

(c) Resources described in this rule shall be either countable or exempt.

1. All nonexempt property shall be counted in the determination of resource eligibility.

2. Exempt resources shall not be subject to any requirement for liquidation. When any resource is not or is no longer exempt, it shall be evaluated as a countable resource in accordance with this rule and considered in the determination of eligibility under this chapter.

(d) Countable resources shall be evaluated by their equity value, which is the current market value of the resource, less any encumbrances.

(e) The total equity value of all countable resources (including savings) shall not exceed the applicable amount specified in *N.J.A.C. 10:70-5.1*.

(f) Bank accounts in which the names of the owners are stated in the conjunctive ("and" accounts) shall be presumed to be in the possession of the eligible family member, in proportion to the number of owners listed on the account. This presumption may be rebutted if the eligible family member and/or the other owners of the account demonstrate to the Division that actual ownership of the funds is in a different proportion. If it can be demonstrated that the funds in the account are not legally owned by an eligible family member, such funds shall not be counted toward the resource maximum specified in *N.J.A.C. 10:70-5.1*.

(g) Bank accounts in which the names of the owners are stated in the disjunctive ("or" accounts) shall be presumed to be in the complete possession of the eligible family member, regardless of the source of the funds in the account. This presumption may be rebutted if the eligible family member and/or the other owners of the account demonstrate to the Division that actual ownership of the funds is in a different proportion, based on evidence of contributions by each party to the funds on deposit. If it can be demonstrated that the funds in the account are not legally owned by an eligible family member, such funds shall not be counted toward the resource maximum specified in *N.J.A.C. 10:70-5.1*.

(h) Exempt resources shall not be subject to liquidation requirements. At the time any such resources are determined no longer to be exempt, they shall be evaluated in accordance with (a) through (g) above. The exempt resources of an eligible unit shall be as follows:

1. Real property (house) owned by the eligible unit, used as a home by the eligible unit, together with so much of the land on which the house stands as is reasonably necessary for the maintenance of the house. Such property may remain in exempt status during the temporary absence of the entire eligible unit for a period of up to four months, at which time the Division shall review the status, and, if it is demonstrated to the Division's satisfaction that the eligible unit will return from their absence to use the property as their home within the four months following the initial period, may allow the property to remain in exempt status for an additional four months. Absence through the entire four-month or eight-month period shall be deemed to be permanent and shall result in the property being removed from exempt status;

2. Personal property which is used or is likely to be used by the eligible unit, including:

i. House furnishings and clothing in regular use. House furnishings and clothing in storage may be deemed to be exempt, if a reasonable plan for their use exists; and

ii. Personal effects if regularly used or of small intrinsic value. Personal effects of larger value which are not regularly used and are not essential to the physical health and safety of the eligible unit shall not be exempt;

3. One motor vehicle, the equity value of which does not exceed $ 9,500. Any excess equity value of a motor vehicle and the full equity of any other motor vehicle shall be countable toward the resource limit specified in *N.J.A.C. 10:70-5.1*.

i. The equity value of the vehicle shall be determined by the value of such vehicles as indicated in the Kelley's Blue Book, internet website *www.kbb.com*. The basic value of the vehicle shall not be increased by adding the value of low mileage or other factors such as optional equipment. If the vehicle is a new vehicle, which is not listed on the Kelley website, the Division shall determine the wholesale value by some other means such as, but not limited to, contacting a car dealer that sells that make of a vehicle.

ii. If a vehicle is especially equipped with apparatus for the handicapped, the apparatus shall not increase the value of the vehicle. The Kelley Blue Book internet website value shall be assigned as if the vehicle were not so equipped;

4. Livestock, machinery, tools, equipment and stock-in-trade which serve to produce some net income in cash or in kind or which serve as an incentive for self-help. Livestock or property owned or used by a child in connection with a group or school activity, such as 4-H, shall also be exempt;

5. Any asset, real or personal, the liquidation of which would produce no net revenue to the eligible unit;

6. Resources designated for special purposes, as follows:

i. Relocation adjustment payments which are made pursuant to the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) by public agencies and area development agencies engaged in urban renewal or by housing development projects;

ii. Any Highway Relocation Assistance paid under the Federal-Aid Highway Act of 1968;

iii. For any household participating in the Food Stamp Program of the U.S. Department of Agriculture, the value of the coupon allotment; or

iv. Funds held in trust for a member of any Indian tribe under Public Law 92-254 or 93-134, or funds which are tax-exempt positions as payments made pursuant to Public Law 92-203, the Alaska Native Claims Settlement Act;

7. Loans for specific purposes and personal loans, as follows:

i. Loans for specific purposes, such as loans and grants which are not to be used to meet current living costs and which are held and used in accordance with the conditions of the loan. For example: loans made by the Farmers Home Administration, U.S. Department of Agriculture, under

Title III of the Economic Opportunity Act, and loans made by the Farmers Home Administration under provisions in Title V of the Housing Act of 1949, as amended; or

ii. Personal loans, when such loans are evidenced by a document, signed by the client and the lender, and which state the amount of the loan and terms of repayment;

8. Funds received in repayment of verified costs of collection of a pending claim when the costs were incurred during a period of receipt of AFDC-related Medicaid;

9. Burial plots (limited to one for each member of the eligible unit) and bona fide funeral agreements to the extent that the equity value of any agreement does not exceed $ 1,500 for each member of the eligible unit.

i. Burial plots are conventional gravesites, crypts, mausoleums, urns or other repositories which are customarily and traditionally used for the remains of deceased persons.

ii. Funeral agreements are contractual arrangements to provide for the costs connected with burial, cremation, or other funeral arrangements; and

10. Prepaid irrevocable funeral trust funds, which are funds in an irrevocable trust or other irrevocable arrangement which are available for funeral and burial expenses, held in an irrevocable funeral contract and irrevocable funeral trust, or an amount in an irrevocable trust which is specifically identified for funeral and burial expenses.

(i) Members of the eligible family shall take all necessary and reasonable action to avail themselves of funds for support from others who owe or may owe money to them or who are holding funds for them. Any funds made available by such action shall be considered as income to the eligible family, except as follows:

1. The county board of social services shall not terminate eligibility when the proceeds from the sale of an exempt resource are promptly reinvested in another exempt resource of the same type. Funds designated by the client as being reserved for such reinvestment, including any interest accrued during the period, may be held for up to three months, provided the funds are held in escrow or are otherwise unavailable for daily living expenses. The three-month period may be extended upon written approval of the Division of Medical Assistance and Health Services.

(j) When a trust fund exists for a member of the eligible family, the county board of social services shall determine whether or not the funds are currently accessible.

1. If accessible, the funds represent a source of funds for support and shall be considered in determining eligibility.

2. If not accessible, the following shall apply:

i. When a trust fund is not currently accessible and it exists at the time of application, the client shall, as a condition of eligibility, make a bona fide presentation of a petition to the appropriate court for release of the funds for current and future support. The agency shall assist the client if necessary.

ii. When a trust fund is not currently accessible and the trust fund came into being during the term of the assistance case, the agency shall present a petition to the appropriate court for release of funds for current and future support. The client shall, as a condition of continuing eligibility, provide whatever cooperation as may be necessary in the presentation of the petition.

History

HISTORY:

Repeal and New Rule, R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Section was "AFDC-related cases".

Annotations

Notes

Chapter Notes

End of Document

N.J.A.C. 10:70-5.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 70. MEDICALLY NEEDY PROGRAM > SUBCHAPTER 5. RESOURCE ELIGIBILITY

§ 10:70-5.3 SSI-related cases

(a) For SSI-related cases, the resource provisions of the Medicaid Only (Aged, Blind, and Disabled) program shall apply in determining countable resources for the Medically Needy Program.

1. Medicaid Only provisions requiring the deeming of the resources of an alien's sponsor (*N.J.A.C. 10:71-4.6(f)*) do not apply in the Medically Needy Program.

(b) The provisions relating to deeming of resources found at *N.J.A.C. 10:71-4.6* apply in SSI-related cases. In the deeming of resources from one parent to a child, the countable parental resource in excess of the Medicaid Only resource limit for an individual shall be deemed to the child. When the resources of two parents must be deemed to the child, countable parental resources in excess of the Medicaid Only resource limit for a couple shall be deemed to the child.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Internal N.J.A.C. cites changed.

Annotations

Notes

Chapter Notes

Case Notes

Per *N.J.A.C. 10:70-5.3*, where a case involving an application for Medicaid implicates SSI per *N.J.A.C. 10:70-1.1*, the resource provisions of the Medicaid Only Program, *N.J.A.C. 10:71-1.1* to *10:71-9.5*, apply in determining countable resources and resource eligibility for the *Medically Needy Program. H.M. v. Union Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 10869-14, 2016 N.J. AGEN LEXIS 1246*, Final Administrative Determination (December 16, 2016).

Two month penalty was properly imposed on an applicant's Medicaid eligibility on account of her having transferred her two-thirds interest in certain real estate for less than market value within the look-back period.

Though other family members testified to their sincerely-held belief that the applicant did not own such an interest in the transferred property, such testimony was insufficient to overcome documentary evidence demonstrating otherwise. Moreover, even if the property had been placed in trust for the applicant, that would not change the result because the applicant had already transferred her interest for less than market value. *L.S. v. Somerset Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 15032-14, 2016 N.J. AGEN LEXIS 535*, Initial Decision (June 27, 2016).

Determination by a county board of social services (CBSS) that a 42-day transfer penalty was properly imposed on the eligibility of an applicant for Medicaid was incorrect because the preponderance of the credible evidence showed that the applicant's daughter, who was generally responsible for her care, made some of the challenged transfers for a reason other than to qualify for Medicaid eligibility. Because the daughter convincingly rebutted the presumption that the transfers were made to establish Medicaid eligibility, the transfers on which a penalty was properly imposed totaled *$ 12,437.33. B.J.H. v. Union Cty. Bd. of Social Servs., OAL DKT. NO. HMA 13823-14, 2015 N.J. AGEN LEXIS 208*, Initial Decision (February 13, 2015).

Parents of two profoundly disabled children won a waiver from a duty to repay Medicaid benefits paid on behalf of those two children, which reimbursement was sought because the father failed to report his ownership of a 401(k) plan. While the 401(k) plan account was not reported on certain forms, it was reflected on paystubs regularly submitted by the father to the county. It also was significant that the funds at issue were used to retrofit the family home with an elevator lift to accommodate one child's wheelchair, to modify the bathroom to improve access for the children, and to pay medical and other bills. The Commissioner of the Department of Human Services acted properly in waiving repayment on these facts. *M.B. et al v. DMAHS et al., OAL DKT. NO. HMA 15436-14, 2015 N.J. AGEN LEXIS 428*, Initial Decision (June 29, 2015).

Expert testimony demonstrated that an annuity could be converted to cash and thus was an available resource for purposes of a nursing facility resident's application for Medicaid benefits under the Medically Needy program; the annuity, purchased by the applicant, a widow, for $ 195,710, was to pay the applicant $ 1,740.85 per month for 10 years and stated on its face that it was non-assignable (adopting *2007 N.J. AGEN LEXIS 209*). *D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546*, Final Decision (June 11, 2007).

Initial Decision (2007 N.J. AGEN LEXIS 209) adopted, which concluded that an application for Medicaid benefits under the Medically Needy program was correctly denied for the applicant's failure to provide requested information regarding three attempts to sell the subject annuity, which the applicant claimed was an unavailable resource; while the Division may ultimately bear the burden of proving that a market exists, and that this particular annuity could be sold, this did not relieve the applicant of her obligation to produce information the Division requested. *D.M. v. DMAHS, OAL Dkt. No. HMA 6394-06, 2007 N.J. AGEN LEXIS 546*, Final Decision (June 11, 2007).

N.J.A.C. 10:70-5.4

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§ 10:70-5.4 Transfer of resources; pursuit of resources

(a) For AFDC-related cases, the provisions of this subsection shall apply to all members of the budget unit.

1. Applicants shall disclose promptly any transfer of property made within 24 months prior to the time of application. Beneficiaries shall promptly disclose any transfer of property made during the entire time the case is in active status.

2. The circumstances surrounding the transfer of property shall be evaluated and a determination will be made regarding whether the transfer was for adequate consideration.

3. If the transfer of the property was determined to have been made for adequate consideration, any proceeds remaining shall be evaluated as resources.

4. If the transfer of the property was determined to have been made without receipt of adequate consideration, the applicant or beneficiary may have legal rights to secure the return of the property or the payment of adequate consideration. The county board of social services shall assist the applicant or beneficiary in reclaiming the property or in obtaining adequate consideration for the property. Any proceeds resulting from such effort shall be evaluated as resources.

5. Applicants under this chapter shall pursue all legal rights to child support, including medical support, unless good cause exists, as specified at *N.J.A.C. 10:90-16.5*.

(b) For SSI-related cases, the Medicaid Only Program rules regarding the transfer of resources shall apply to all members of the budget unit. Such assignments and transfers shall be evaluated as follows:

1. Transfers made before June 1, 2001 shall be evaluated in accordance with *N.J.A.C. 10:71-4.7*.

2. Transfers made on and after June 1, 2001 shall be evaluated in accordance with *N.J.A.C. 10:71-4.10*.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Internal N.J.A.C. cite changed.

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Section was "Transfer of resources". Rewrote the section.

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N.J.A.C. 10:70-6.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-6.1 Eligibility under medical spend-down

(a) Persons who are eligible in all respects for the Medically Needy Program, except that the countable income of the budget unit as determined in subchapter 4 exceeds the medically needy income level, may establish eligibility for payment of covered services benefits through medical spend-down.

1. Medical spend-down is a process whereby the excess countable income of a budget unit is offset by the allowable incurred medical expenses of the budget unit.

2. Spend-down liability is the amount by which the countable income of the budget unit exceeds the medically needy income level as determined under the provisions of this subchapter.

(b) The retroactive eligibility period is the three calendar months immediately preceding the month in which application for benefits is made. For each of the three months, a monthly spend-down liability is established. The monthly spend-down liability shall be the amount by which actual countable income of the budget unit for that month exceeds the medically needy income level for that month.

1. Within the retroactive eligibility period, income eligibility is established for any month in which the allowable incurred medical expenses of the budget unit exceed the spend-down liability established for that month.

2. Eligibility for payment of covered services is established effective with the first day of each or any month in which the allowable incurred medical expenses of the budget unit exceed the spend-down liability only for those claims for services that are not covered under the Medically Needy Program and were not used to meet spend-down liability. (Note: The effective date to be entered in the Medicaid Status File is the day after the day that spend-down liability is met.)

(c) Except for retroactive eligibility, income eligibility for the Medically Needy Program is determined using a six-month prospective eligibility period. The six-month period begins with the month in which application for benefits is made. For the full six-month period, a six-month spend-down liability is established. The six-month spend-down liability shall be the amount by which the countable income of the budget unit, as determined at N.J.A.C. 10:70-4, exceeds the budget unit's medically needy income level for the full six-month period.

1. Eligibility for medically needy benefits is established effective with the first day of the month in which the allowable incurred medical expenses of the budget unit exceed the six-month spend-down liability only for those claims for services that are covered under the Medically Needy Program and were not used to meet spend-down liability. (Note: The effective date to be entered on the Medicaid Status File is the day after the day spend-down liability is met.)

2. Changes in the countable income of the budget unit and/or the size of the budget unit during the six-month prospective period require a recalculation of the six-month spend-down liability.

3. In order to receive program benefits, upon meeting the spend-down liability, all other factors of program eligibility must also be met.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In the introductory paragraph of (c), updated the N.J.A.C. reference.

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Appeal by applicant for eligibility under Medicaid Nursing Home Program as of August 31, 2014 was properly dismissed because while the applicant showed clinical eligibility and the applicant's income satisfied either the budget unit or the medical spend down requirements in governing regulations, the applicant did not satisfy the resource limits until April 2015 and thus did not have eligibility until then. *M.P. v. Camden Cnty. Bd. of Social Servs., OAL DKT. NO. HMA 02517-16, 2017 N.J. AGEN LEXIS 163*, Final Administrative Determination (March 16, 2017).

Though the agency failed to promptly process an application for Medicaid Only nursing home benefits and failed to advise the applicant of the reason for delay, the failure of the agency to advise the applicant of what needed to occur for eligibility to be determined was not grounds for an eligibility date that was earlier than that granted by the agency because the applicant was not resource-eligible earlier than the date awarded. *W.H. v. Monmouth Cnty. Div. of Social Servs., OAL DKT. NO. HMA 10917-16, 2016 N.J. AGEN LEXIS 862*, Initial Decision (October 19, 2016).

Initial Decision (2006 N.J. AGEN LEXIS 980) adopted, which found that receipt of disability-related Social Security benefits (RSDI or SSDI) did not qualify a Medically Needy program applicant for Medically Needy spend-down analysis under *N.J.A.C. 10:70-6.1*; the regulation for spend-down eligibility requires the applicant to be a recipient of SSI (Supplemental Security Income), which is the Medicaid disability benefit available to low-income disabled individuals pursuant to *Title XVI of the Social Security Program. J.O. v. DMAHS, OAL Dkt. No. HMA 4407-06, 2006 N.J. AGEN LEXIS 935*, Final Decision (October 24, 2006).

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N.J.A.C. 10:70-6.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

NJ - New Jersey Administrative Code > TITLE 10. HUMAN SERVICES > CHAPTER 70. MEDICALLY NEEDY PROGRAM > SUBCHAPTER 6. MEDICAL SPEND-DOWN

§ 10:70-6.2 Allowable incurred medical expenses

(a) Allowable incurred medical expenses which may be applied against spend-down liability are those which are:

1. Incurred by a member of the budget unit and for which a member of the budget unit has an express obligation for payment;

2. For necessary medical or remedial services recognized under state law, provided, prescribed, or recommended by a qualified and appropriately licensed medical practitioner; and

3. Submitted with sufficiently detailed information and documentation to determine the allowableness of the expense. Minimum necessary information includes: the date of the service, name of the provider, the nature of the service, the name of the individual to whom the service was provided, and the total amount of the bill, as well as the remaining balance outstanding.

(b) Medical expenses which have been paid in full prior to the retroactive budget period, shall not be applied against spend-down liability. However, medical expenses paid by a member of the budget unit during an eligibility period may be used in meeting spend-down liability so long as the expense met the criteria specified in (a) above.

(c) The county board of social services shall refer the submission of expenses for questionable medical services to designated staff of the Division of Medical Assistance and Health Services for a determination of allowableness.

(d) To the extent that payment of any bill for medical service is the responsibility of a third party (for example, a health insurer), the expense shall not be applied against spend-down liability. An exception would be made for any medical expense paid by a State or territory, or a subdivision of a State or territory (except for a Medicaid program), if the program is financed by a State or territory.

(e) Any bill for medical services rendered more than six months prior to the bill's submission to the county board of social services for application against spend-down liability must be accompanied by a statement from the provider that the expense remains an express obligation of a member of the budget unit and has not been forgiven by the provider or otherwise determined uncollectible.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

Modification of spend-down requirement at (d) based on federal Department of Health and Human Services, (HCFA) in the State Medicaid Manual, Part 3--Eligibility, Transmittal 48, Nov. 1990.

§ 10:70-6.2 Allowable incurred medical expenses

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (c) and (e), substituted "board of social services" for "welfare agency".

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N.J.A.C. 10:70-6.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-6.3 Application of medical expenses toward spend-down

(a) In determining eligibility under medical spend-down, expenses are applied in the following order against the spend-down liability:

1. Medicare and other health insurance premiums, deductibles, or coinsurance charges incurred by a member of the budget unit;

2. Expenses incurred by the members of the budget unit for allowable medical expenses for services not covered under the Medically Needy Program (including covered services provided to members of the budget unit who are not members of a medically needy eligibility category);

3. Expenses incurred by budget unit members, who are also members of a medically needy eligibility category, for services covered by the Medically Needy Program; and

4. Costs paid in whole or in part by a public program of the State or a political subdivision of the State, which involves no Federal funds may be counted as an incurred medical expense to establish eligibility under a Medicaid spend-down. If such costs are covered under Medicaid, the costs are not allowable under spend-down.

(b) Costs for health insurance premiums billed less often than monthly, shall be averaged over the period of coverage that the premium is intended to purchase and applied incrementally against spend-down liability. The applicant or beneficiary shall report to the county board of social services the cancellation of any such insurance.

(c) If a member of a budget unit has arranged to make monthly payments toward a previously incurred medical expense thereby modifying the terms of the liability for the expense, the amount of the monthly obligation rather than the outstanding balance shall be applied against spend-down liability.

(d) Any medical expenses may be applied against spend-down liability only once. However, incurred medical expenses in excess of those required to meet the spend-down liability for a budget period (which have not been applied against spend-down liability), may be applied against spend-down liability in future budget period so long as a member of the budget unit continues to have an express obligation for payment of the expense.

1. If, in any eligibility period, the budget unit does not meet its spend-down liability, the incurred medical expenses that were compared to that spend-down liability are not considered to have been used in meeting spend-down liability. Any such expenses may be applied to subsequent eligibility periods so long as the expenses remain allowable in accordance with *N.J.A.C. 10:70-6.2*.

(e) In certain circumstances, it may be beneficial to program applicants or beneficiaries to delay the application of incurred medical expenses against spend-down liability. For example: An individual has sufficient incurred medical expenses to establish eligibility under medical spend-down in each of the three months of the retroactive eligibility period. However, during that period, he has no or few incurred expenses for services covered under the Medically Needy Program. The individual may elect to forego eligibility for the months of retroactive coverage and apply the incurred medical expenses against spend-down liability

for the prospective eligibility period. In any such circumstances, the county board of social services shall fully explain the options available and the ramifications thereto.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a)3, substituted "; and" for a period at the end; added (a)4; rewrote (b); and in (e), substituted "beneficiaries" for "recipients" and "board of social services" for "welfare agency".

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N.J.A.C. 10:70-7.1

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-7.1 Notice of county board of social services decision

(a) The county board of social services shall promptly notify any applicant for, or recipient of, the Medically Needy Program in writing of any agency decision affecting the applicant or recipient. When a decision relates to any adverse action which may entitle a recipient to a fair hearing, the action may not be implemented until at least 10 days after the mailing of the notice (see (f) below for exceptions to the 10-day notice).

1. For notices of action adverse to a recipient, the date of mailing of the notice must appear on the notice.

2. Notices of any county board of social services action must contain the name, address, and telephone number of the legal services agency serving that county.

3. In the case of an applicant or recipient who cannot be located, the notice shall be mailed to his or her last known address.

(b) All notices of agency decision shall state in clear and simple language, the nature of the agency decision and an accurate factual and legal basis for the decision.

1. All notices of agency decision shall include an explanation of the right to a fair hearing.

2. Notices of agency decisions adverse to the applicant or recipient shall include the citation and title of the regulations upon which the agency decision is based.

(c) For cases which are determined eligible pending spend-down, the notice shall include a statement of the amount of spend-down liability and shall advise the applicant to notify the county board of social services when that liability is met. The notice shall also advise that the established spend-down liability is subject to a change based on changes in countable income or budget unit size or composition. Further, the notice must specify that eligibility under medical spend-down is contingent on all other factors of eligibility being met at the time that the spend-down liability is met.

(d) All notices of denial or termination shall include an explicit statement of the reason for program ineligibility and (except in the case of the death of an applicant or beneficiary) advise of the right to reapply whenever the applicant or beneficiary believes that circumstances have changed such that the reason for program ineligibility no longer exists.

(e) When the processing of an application will be delayed beyond the standards for disposition of an application as set forth in *N.J.A.C. 10:70-2.1(d)*, notice shall be mailed prior to the expiration of the disposition period notifying the applicant of the delay and the reasons for it.

(f) The 10-day notice requirement for actions adverse to a program beneficiary need not be adhered to when:

1. The county board of social services has factual information confirming the death of a beneficiary;

2. The county board of social services receives a clear written statement, signed by a beneficiary, that he or she no longer wishes to receive program benefits, or which gives information indicating a change in circumstances which requires a termination or reduction in benefits, and the beneficiary has indicated in writing, that he or she understands that this must be the consequence of supplying such information;

3. The beneficiary's whereabouts are unknown and agency mail directed to him or her has been returned by the post office indicating no forwarding address;

4. The beneficiary has been accepted for public or medical assistance in another state and that fact has been established by the county board of social services; or

5. A beneficiary child has been removed from the home as a result of a judicial determination, or voluntarily placed in foster care by his or her legal guardian.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

Section was "Notice of county welfare agency decision". Substituted "board of social services" for "welfare agency" and "beneficiary" for "recipient" throughout; in the introductory paragraph of (a), substituted "below" for "of this section" and "10" for "ten" two times; in the introductory paragraph of (f), substituted "10" for "ten"; and in (f)3, substituted "beneficiary's" for "recipient's".

Annotations

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N.J.A.C. 10:70-7.2

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-7.2 Fair hearings

(a) It is the right of every applicant for or beneficiary of the Medically Needy Program to be afforded the opportunity for a fair hearing in the manner set forth in N.J.A.C. 10:49-10, including when applicable, continuation of program benefits pending the results of the fair hearing.

(b) Any request for a fair hearing shall be forwarded to the Division of Medical Assistance and Health Services, P.O. Box 712, Trenton, New Jersey 08625.

History

HISTORY:

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a), substituted "beneficiary" for "recipient" and updated N.J.A.C. reference; and in (b), substituted "P.O. Box" for "CN".

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N.J.A.C. 10:70-7.3

This file includes all Regulations adopted and published through the New Jersey Register, Vol. 57 No. 12, June 16, 2025

§ 10:70-7.3 Case records

(a) The purpose of the case record is to provide a complete documentary record of county board of social services decisions and actions and the reasons thereto.

(b) The case record shall include:

1. A record of all county board of social services actions and decisions relating to the case, as well as, documentary evidence relating to such actions and decisions, including application forms;

2. All medical reports and a record of action of the Disability Review Section as appropriate;

3. All forms relating to financial eligibility including, when appropriate, spend-down liability; and

4. All case-related correspondence, memorandum, and documents except those required by law or regulation to be maintained elsewhere.

(c) No case record, or part thereof, shall be removed from its file location without a record identifying the person who has custody of it.

(d) No case record, or part thereof, shall be removed from the county board of social services offices except upon the specific authorization of the agency director, deputy director, or other person specifically designated by the agency director to authorize such removal.

(e) All case records shall be filed in a secure and fire-resistant location.

History

HISTORY:

Amended by R.1991 d.331, effective July 1, 1991.

See: 23 N.J.R. 964(a), 23 N.J.R. 2042(a).

In (b)2, "Medical Review Team" changed to "Disability Review Section."

Amended by R.2006 d.364, effective October 16, 2006.

See: *38 N.J.R. 2368(a)*, *38 N.J.R. 4480(c)*.

In (a), (b)1, and (d), substituted "board of social services" for "welfare agency".

Annotations

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