§ 366. Eligibility. 1. (a) Definitions. For purposes of this section:

(1) "benchmark coverage" refers to medical assistance coverage defined in subdivision one of section three hundred sixty-five-a of this title;

(2) "caretaker relative" means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care and who is one of the following:

(i) the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece; or

(ii) the spouse of such parent or relative, even after the marriage is terminated by death or divorce;

(3) "family size" means the number of persons counted as members of an individual's household; with respect to individuals whose medical assistance eligibility is based on modified adjusted gross income, in determining the family size of a pregnant woman, or of other individuals who have a pregnant woman in their household, the pregnant woman is counted as herself plus the number of children she is expected to deliver;

(4) "federal poverty line" means the poverty line defined and annually revised by the United States department of health and human services;

(5) "household", for purposes of determining the financial eligibility of individuals whose medical assistance eligibility is based on modified adjusted gross income, shall mean:

(i) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to clause (v) of this subparagraph, all persons whom such individual expects to claim as a tax dependent;

(ii) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with clause (iii) of this

subparagraph in the case of:

(A) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and

(B) Individuals under nineteen years of age, or under twenty-one years of age if a full-time student, who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and

(C) Individuals under nineteen years of age, or under twenty-one years of age if a full-time student, who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this subclause:

(1) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(2) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights;

(iii) Rules for individuals who neither file a tax return nor are claimed as a tax dependent. In the case of individuals who do not expect to file a Federal tax return and do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, or who are described in subclauses (A), (B), or (C) of clause (ii) of this subparagraph, the household consists of the individual and, if living with the individual:

(A) The individual's spouse;

(B) The individual's children under nineteen years of age, or under twenty-one years of age if a full-time student; and

(C) In the case of an individual under nineteen years of age, or under twenty-one years of age if a full-time student, the individual's parents and the individual's siblings under nineteen years of age, or under twenty-one years of age if a full-time student;

(iv) Married couples. In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section six thousand thirteen of the internal revenue code or whether one spouse expects to be claimed as a tax dependent by the other spouse.

(v) For purposes of clause (i) of this subparagraph, if a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the

inclusion of such individual in the household of the taxpayer is determined in accordance with clause (iii) of this subparagraph.

(6) "MAGI" means modified adjusted gross income;

(7) "MAGI-based income" means income calculated using the same methodologies used to determine MAGI under section 36B(d)(2)(B) of the Internal Revenue Code, with the exception of lump sum payments, certain educational scholarships, and certain American Indian and Alaska Native income, as specified by the commissioner of health consistent with federal regulation at 42 CFR 435.603 or any successor regulation;

(8) "MAGI household income" means, with respect to an individual whose medical assistance eligibility is based on modified adjusted gross income, the sum of the MAGI-based income of every person included in the individual's MAGI household, except that it shall not include the MAGI-based income of the following persons if such persons are not expected to be required to file a tax return in the taxable year in which eligibility for medical assistance is being determined:

(i) a biological, adopted, or step child who is included in the individual's MAGI household; or

(ii) a person, other than a spouse or a biological, adopted, or step child, who is expected to be claimed as a tax dependent by the individual;

(9) "standard coverage" refers to medical assistance coverage defined in subdivision two of section three hundred sixty-five-a of this title.

(b) MAGI eligibility groups. Individuals listed in this paragraph are eligible for medical assistance based on modified adjusted gross income. In determining the eligibility of an individual for the MAGI eligibility group with the highest income standard under which the individual may qualify, an amount equivalent to five percentage points of the federal poverty level for the applicable family size will be deducted from the household income.

(1) An individual is eligible for benchmark coverage if his or her MAGI household income does not exceed one hundred thirty-three percent of the federal poverty line for the applicable family size and he or she is:

(i) age nineteen or older and under age sixty-five; and

(ii) not pregnant; and

(iii) not entitled to or enrolled for benefits under parts A or B of

title XVIII of the federal social security act; and

(iv) not otherwise eligible for and receiving coverage under subparagraphs two and three of this paragraph; and

(v) not a parent or other caretaker relative of a dependent child under twenty-one years of age and living with such child, unless such child is receiving benefits under this title or under title 1-A of article twenty-five of the public health law, or otherwise is enrolled in minimum essential coverage.

(2) A pregnant person or an infant younger than one year of age is eligible for standard coverage if their MAGI household income does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the secretary of the United States department of health and human services.

(3) A child who is at least one year of age but younger than nineteen years of age is eligible for standard coverage if such child's MAGI household income does not exceed the MAGI-equivalent of one hundred thirty-three percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the Secretary of the United States department of health and human services.

(4) An individual who is a pregnant woman or is a member of a family that contains a dependent child living with a parent or other caretaker relative is eligible for standard coverage if their MAGI household income does not exceed one hundred thirty-three percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the Secretary of the United States department of health and human services; for purposes of this subparagraph, the term dependent child means a person who is under eighteen years of age, or is eighteen years of age and a full-time student, who is deprived of parental support or care by reason of the death, continued absence, or physical or mental incapacity of a parent, or by reason of the unemployment of the parent, as defined by the department of health.

(5) A child who is under twenty-one years of age and who was in foster care under the responsibility of the state on his or her eighteenth birthday is eligible for standard coverage; notwithstanding any

provision of law to the contrary, the provisions of this subparagraph shall be effective only if and for so long as federal financial participation is available in the costs of medical assistance furnished hereunder.

(6) An individual who is not otherwise eligible for medical assistance under this section is eligible for coverage of family planning services reimbursed by the federal government at a rate of ninety percent, and for coverage of those services identified by the commissioner of health as services generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement, including treatment for sexually transmitted diseases, if his or her income does not exceed the MAGI-equivalent of two hundred percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the secretary of the United States department of health and human services; provided further that the commissioner of health is authorized to establish criteria for presumptive eligibility for services provided pursuant to this subparagraph in accordance with all applicable requirements of federal law or regulation pertaining to such eligibility.

* (7) A child who is nineteen or twenty years of age living with his or her parent will be eligible for standard coverage if the sum of the MAGI-based income of every person included in the child's MAGI household exceeds one hundred thirty-three percent, but does not exceed one hundred fifty percent, of the federal poverty line for the applicable family size.

* NB Repealed October 1, 2029

(7-a) An individual is eligible for benchmark coverage if his or her MAGI household income exceeds one hundred thirty-three percent of the federal poverty line for the applicable family size and he or she:

(i) was eligible or would have been eligible for the family health plus program without federal financial participation in the costs of medical care and services under such program; and

(ii) is not eligible to enroll in a qualified health plan offered through the state health benefit exchange established pursuant to the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(c) Non-MAGI eligibility groups. Individuals listed in this paragraph are eligible for standard coverage. Where a financial eligibility determination must be made by the medical assistance program for individuals in these groups, such financial eligibility will be determined in accordance with subdivision two of this section.

(1) An individual receiving or eligible to receive federal supplemental security income payments and/or additional state payments pursuant to title six of this article; any inconsistent provision of this chapter or other law notwithstanding, the department may designate the office of temporary and disability assistance as its agent to discharge its responsibility, or so much of its responsibility as is permitted by federal law, for determining eligibility for medical assistance with respect to persons who are not eligible to receive federal supplemental security income payments but who are receiving a state administered supplementary payment or mandatory minimum supplement in accordance with the provisions of subdivision one of section two hundred twelve of this article.

(2) An individual who, although not receiving public assistance or care for his or her maintenance under other provisions of this chapter, has income and resources, including available support from responsible relatives, that does not exceed the amounts set forth in paragraph (a) of subdivision two of this section, and is (i) sixty-five years of age or older, or certified blind or certified disabled or (ii) for reasons other than income or resources, is eligible for federal supplemental security income benefits and/or additional state payments.

(3) An individual who, although not receiving public assistance or care for his or her maintenance under other provisions of this chapter, has income, including available support from responsible relatives, that does not exceed the amounts set forth in paragraph (a) of subdivision two of this section, and is (i) under the age of twenty-one years, or (ii) a spouse of a cash public assistance recipient living with him or her and essential or necessary to his or her welfare and whose needs are taken into account in determining the amount of his or her cash payment, or (iii) for reasons other than income, would meet the eligibility requirements of the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six.

(4) A child in foster care, or a child described in section four

hundred fifty-four or four hundred fifty-eight-d of this chapter.

(5) A disabled individual at least sixteen years of age, but under the age of sixty-five, who: would be eligible for benefits under the supplemental security income program but for earnings in excess of the allowable limit; has net available income that does not exceed two hundred fifty percent of the applicable federal income official poverty line, as defined and updated by the United States department of health and human services, for a one-person or two-person household, as defined by the commissioner in regulation; has household resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, other than retirement accounts, that do not exceed one hundred fifty percent of the income amount permitted under subparagraph seven of paragraph (a) of subdivision two of this section, for a one-person or two-person household, as defined by the commissioner in regulation; and contributes to the cost of medical assistance provided pursuant to this subparagraph in accordance with subdivision twelve of section three hundred sixty-seven-a of this title; for purposes of this subparagraph, disabled means having a medically determinable impairment of sufficient severity and duration to qualify for benefits under section 1902(a)(10)(A)(ii)(xv) of the social security act.

(6) An individual at least sixteen years of age, but under the age of sixty-five, who: is employed; ceases to be in receipt of medical assistance under subparagraph five of this paragraph because the person, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be eligible for supplemental security income program benefits or disability insurance benefits under the social security act; continues to have a severe medically determinable impairment, to be determined in accordance with applicable federal regulations; and contributes to the cost of medical assistance provided pursuant to this subparagraph in accordance with subdivision twelve of section three hundred sixty-seven-a of this title; for purposes of this subparagraph, a person is considered to be employed if the person is earning at least the applicable minimum wage under section six of the federal fair labor standards act and working at least forty hours per month; or

(7) An individual receiving treatment for breast or cervical cancer who meets the eligibility requirements of paragraph (d) of subdivision

four of this section or the presumptive eligibility requirements of subdivision four of section three hundred sixty-four-i of this title.

(8) An individual receiving treatment for colon or prostate cancer who meets the eligibility requirements of paragraph (e) of subdivision four of this section or the presumptive eligibility requirements of subdivision four of section three hundred sixty-four-i of this title.

(9) An individual who:

(i) is under twenty-six years of age; and

(ii) was in foster care under the responsibility of the state on his or her eighteenth birthday; and

(iii) was in receipt of medical assistance under this title while in foster care; and

(iv) is not otherwise eligible for medical assistance under this title.

(10) A resident of a home for adults operated by a social services district, or a residential care center for adults or community residence operated or certified by the office of mental health, and has not, according to criteria promulgated by the department consistent with this title, sufficient income, or in the case of a person sixty-five years of age or older, certified blind, or certified disabled, sufficient income and resources, including available support from responsible relatives, to meet all the costs of required medical care and services available under this title.

(d) Conditions of eligibility. A person shall not be eligible for medical assistance under this title unless he or she:

(1) is a resident of the state, or, while temporarily in the state, requires immediate medical care which is not otherwise available, provided that such person did not enter the state for the purpose of obtaining such medical care; and

(2) assigns to the appropriate social services official or to the department, in accordance with department regulations: (i) any benefits which are available to him or her individually from any third party for care or other medical benefits available under this title and which are otherwise assignable pursuant to a contract or any agreement with such third party; or (ii) any rights, of the individual or of any other person who is eligible for medical assistance under this title and on whose behalf the individual has the legal authority to execute an

assignment of such rights, to support specified as support for the purpose of medical care by a court or administrative order; and

(3) cooperates with the appropriate social services official or the department in establishing paternity or in establishing, modifying, or enforcing a support order with respect to his or her child; provided, however, that nothing herein contained shall be construed to require a payment under this title for care or services, the cost of which may be met in whole or in part by a third party; notwithstanding the foregoing, a social services official shall not require such cooperation if the social services official or the department determines that such actions would be detrimental to the best interest of the child, applicant, or recipient, or with respect to pregnant women during pregnancy and during the one year period beginning on the last day of pregnancy, in accordance with procedures and criteria established by regulations of the department consistent with federal law; and

(4) applies for and utilizes group health insurance benefits available through a current or former employer, including benefits for a spouse and dependent children, in accordance with the regulations of the department.

(e) Conditions of coverage. An otherwise eligible person shall not be entitled to medical assistance coverage of care, services, and supplies under this title while he or she:

(1) is an inmate or patient in an institution or facility wherein medical assistance may not be provided in accordance with applicable federal or state requirements, except for persons described in subparagraph ten of paragraph (c) of this subdivision or subdivision one-a or subdivision one-b of this section; or except for certain services provided to persons in a correctional institution or facility permitted by a waiver authorized pursuant to section eleven hundred fifteen of the federal social security act; if, so long as, and to the extent federal financial participation is available for such expenditures provided pursuant to such waiver; or

(2) is a patient in a public institution operated primarily for the treatment of tuberculosis or care of the mentally disabled, with the exception of: (i) a person sixty-five years of age or older and a patient in any such institution; (ii) a person under twenty-one years of age and receiving in-patient psychiatric services in a public

institution operated primarily for the care of the mentally disabled; (iii) a patient in a public institution operated primarily for the care of individuals with developmental disabilities who is receiving medical care or treatment in that part of such institution that has been approved pursuant to law as a hospital or nursing home; (iv) a patient in an institution operated by the state department of mental hygiene, while under care in a hospital on release from such institution for the purpose of receiving care in such hospital; (v) is a person residing in a community residence or a residential care center for adults; or (vi) certain services provided to persons in an institution for mental diseases permitted by a waiver authorized pursuant to section eleven hundred fifteen of the federal social security act; if, so long as, and to the extent federal financial participation is available for such expenditures provided pursuant to such waiver.

(f) Notwithstanding any inconsistent provision of this title, for an individual who has income in excess of an applicable income eligibility standard and is allowed to achieve eligibility for medical assistance under this title by incurring medical expenses equal to the amount of such excess income, the amount of excess income may be calculated by comparing the individual's MAGI household income to the MAGI-equivalent of the applicable income eligibility standard; provided, however, that medical assistance shall be furnished pursuant to this paragraph only if, for so long as, and to the extent that federal financial participation is available therefor. The commissioner of health shall make any amendments to the state plan for medical assistance, or apply for any waiver or approval under the federal social security act that are necessary to carry out the provisions of this paragraph.

(g) Coverage of certain noncitizens. (1) Applicants and recipients who are lawfully admitted for permanent residence, or who are permanently residing in the United States under color of law, or who are non-citizens in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15); who are MAGI eligible pursuant to paragraph (b) of this subdivision; and who would be ineligible for medical assistance coverage under subdivisions one and two of section three hundred sixty-five-a of this title solely due to their immigration status if the provisions of section one hundred twenty-two of this chapter were applied, shall only be eligible for assistance under this title if enrolled in a standard

health plan offered by a basic health program established pursuant to section three hundred sixty-nine-gg of this article or a standard health plan offered by a 1332 state innovation program established pursuant to section three hundred sixty-nine-ii of this article if such program is established and operating.

(2) With respect to a person described in subparagraph one of this paragraph who is enrolled in a standard health plan, medical assistance coverage shall mean:

(i) payment of required premiums and other cost-sharing obligations under the standard health plan that exceed the person's co-payment obligation under subdivision six of section three hundred sixty-seven-a of this title; and

(ii) payment for services and supplies described in subdivision one or two of section three hundred sixty-five-a of this title, as applicable, but only to the extent that such services and supplies are not covered by the standard health plan.

(3) Nothing in this subdivision shall prevent a person described in subparagraph one of this paragraph from qualifying for or receiving medical assistance while his or her enrollment in a standard health plan is pending, in accordance with applicable provisions of this title.

(4) (a) Applicants and recipients who are age sixty-five or older, who are otherwise eligible for medical assistance under this section, but for their immigration status, are eligible for medical assistance according to the following:

* (b) individuals eligible for medical assistance pursuant to subparagraph (a) of this paragraph shall participate in and receive covered benefits available through a managed care provider under section three hundred sixty-four-j of this article that is certified pursuant to section forty-four hundred three of the public health law; provided, however, to the extent that any covered benefits available through such managed care providers as of January first, two thousand twenty-three are transitioned to fee-for-service coverage, then such individuals shall continue to be entitled to these benefits in the fee-for-service program, rather than through a managed care provider.

* NB Effective until January 1, 2027

* (b) individuals eligible for medical assistance pursuant to clause (a) of this subparagraph shall receive the equivalent of the covered

benefits available through a managed care provider under section three hundred sixty-four-j of this article that is certified pursuant to section forty-four hundred three of the public health law through the fee-for-service program, including any covered benefits available through such managed care providers as of January first, two thousand twenty-three that were subsequently transitioned to fee-for-service coverage.

* NB Effective January 1, 2027

1-a. Notwithstanding any other provision of law, in the event that a person who is an incarcerated individual of a state or local correctional facility, as defined in section two of the correction law, or an eligible juvenile inmate of a public institution, as defined in subsection (nn) of section nineteen hundred two of the social security act, was in receipt of medical assistance pursuant to this title immediately prior to being admitted to such facility or public institution, or for juveniles determined eligible for such medical assistance while an inmate of a public institution, such person shall remain eligible for medical assistance while an incarcerated individual, except that no medical assistance shall be furnished pursuant to this title for any care, services, or supplies provided during such time as the person is an incarcerated individual; provided, however, that nothing herein shall be deemed as preventing the provision of medical assistance for inpatient hospital services furnished to an incarcerated individual at a hospital outside of the premises of such correctional facility or public institution, or pursuant to other federal authority authorizing the provision of medical assistance to an incarcerated individual of a state or local correctional facility during the thirty days prior to release, to the extent that federal financial participation is available for the costs of such services. Upon release from such facility or public institution, such person shall continue to be eligible for receipt of medical assistance furnished pursuant to this title until such time as the person is determined to no longer be eligible for receipt of such assistance. To the extent permitted by federal law, the time during which such person is an incarcerated individual shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in

accordance with this article. The state may seek federal authority to provide medical assistance for transitional services including but not limited to medical, prescription, and care coordination services for high needs incarcerated individuals in state and local correctional facilities during the thirty days prior to release.

1-b. Notwithstanding any other provision of law, in the event that a person who is an inpatient in an institution for mental diseases, as defined by federal law and regulations, and who was in receipt of medical assistance pursuant to this title immediately prior to being admitted to such facility, or who was directly admitted to such facility after being an inpatient in another institution for mental diseases and who was in receipt of medical assistance prior to admission to such transferring institution, such person shall remain eligible for medical assistance while an inpatient in such facility; provided, however, that no medical assistance shall be furnished pursuant to this title for any care, services, or supplies provided during the time that such person is an inpatient, except to the extent that federal financial participation is available for the costs of such care, services, or supplies. Upon release from such facility, such person shall continue to be eligible for receipt of medical assistance furnished pursuant to this title until such time as the person is determined to no longer be eligible for receipt of such assistance. To the extent permitted by federal law, the time during which such person is an inpatient in an institution for mental diseases shall not be included in any calculation of when the person must recertify his or her eligibility for medical assistance in accordance with this article.

2. (a) The following income and resources shall be exempt and shall not be taken into consideration in determining a person's eligibility for medical care, services and supplies available under this title:

(1) (i) for applications for medical assistance filed on or before December thirty-first, two thousand five, a homestead which is essential and appropriate to the needs of the household;

(ii) for applications for medical assistance filed on or after January first, two thousand six, a homestead which is essential and appropriate to the needs of the household; provided, however, that in determining

eligibility of an individual for medical assistance for nursing facility services and other long term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the homestead exceeds seven hundred fifty thousand dollars; provided further, that the dollar amount specified in this clause shall be increased, beginning with the year two thousand eleven, from year to year, in an amount to be determined by the secretary of the federal department of health and human services, based on the percentage increase in the consumer price index for all urban consumers, rounded to the nearest one thousand dollars. If such secretary does not determine such an amount, the department of health shall increase such dollar amount based on such increase in the consumer price index. Nothing in this clause shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the homestead. The home equity limitation established by this clause shall be waived in the case of a demonstrated hardship, as determined pursuant to criteria established by such secretary. The home equity limitation shall not apply if one or more of the following persons is lawfully residing in the individual's homestead: (A) the spouse of the individual; or (B) the individual's child who is under the age of twenty-one, or is blind or permanently and totally disabled, as defined in section 1614 of the federal social security act.

(2) essential personal property;

(3) a burial fund, to the extent allowed as an exempt resource under the cash assistance program to which the applicant is most closely related;

(4) savings in amounts equal to one hundred fifty percent of the income amount permitted under subparagraph seven of this paragraph, provided, however, that the amounts for one and two person households shall not be less than the amounts permitted to be retained by households of the same size in order to qualify for benefits under the federal supplemental security income program;

(5) (i) such income as is disregarded or exempt under the cash assistance program to which the applicant is most closely related for purposes of this subparagraph, cash assistance program means either the aid to dependent children program as it existed on the sixteenth day of July, nineteen hundred ninety-six, or the supplemental security income

program; and

(ii) such income of a disabled person (as such term is defined in section 1614(a)(3) of the federal social security act (42 U.S.C. section 1382c(a)(3)) or in accordance with any other rules or regulations established by the social security administration), that is deposited in trusts as defined in clause (iii) of subparagraph two of paragraph (b) of this subdivision in the same calendar month within which said income is received;

(6) health insurance premiums;

(7) income based on the number of family members in the medical assistance household, as defined in regulations by the commissioner consistent with federal regulations under title XIX of the federal social security act that does not exceed one hundred thirty-eight percent of the federal poverty line for the applicable family size, which shall be calculated in accordance with guidance issued by the United States secretary for health and human services and with other applicable provisions of this section;

(8) No other income or resources, including federal old-age, survivors and disability insurance, state disability insurance or other payroll deductions, whether mandatory or optional, shall be exempt and all other income and resources shall be taken into consideration and required to be applied toward the payment or partial payment of the cost of medical care and services available under this title, to the extent permitted by federal law.

(9) Subject to subparagraph eight, the department, upon the application of a local social services district, after passage of a resolution by the local legislative body authorizing such application, may adjust the income exemption based upon the variations between cost of shelter in urban areas and rural areas in accordance with standards prescribed by the United States secretary of health, education and welfare.

(10) (i) A person who is receiving or is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:

(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law, the amount of fifty-five dollars per month;

(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office for people with developmental disabilities or a patient of a hospital operated by the office of mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law, the amount of thirty-five dollars per month.

(ii) A person who neither receives nor is eligible to receive federal supplemental security income payments and/or additional state payments is entitled to a personal needs allowance as follows:

(A) for the personal expenses of a resident of a residential health care facility, as defined by section twenty-eight hundred one of the public health law, the amount of fifty dollars per month;

(B) for the personal expenses of a resident of an intermediate care facility operated or licensed by the office for people with developmental disabilities or a patient of a hospital operated by the office of mental health, as defined by subdivision ten of section 1.03 of the mental hygiene law, the amount of thirty-five dollars per month.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the personal needs allowance for a person who is a veteran having neither a spouse nor a child, or a surviving spouse of a veteran having no child, who receives a reduced pension from the federal veterans administration, and who is a resident of a nursing facility, as defined in section 1919 of the federal social security act, shall be equal to such reduced monthly pension but shall not exceed ninety dollars per month.

(11) subject to the availability of federal financial participation, any amount, including earnings thereon, in a qualified NY ABLE account as established pursuant to article eighty-four of the mental hygiene law, any contributions to such NY ABLE account, and any distribution for qualified disability expenses from such account; provided however, that such exemption shall be consistent with section 529A of the Internal Revenue Code of 1986, as amended.

* (b) (1) In establishing standards for determining eligibility for and amount of such assistance, the department shall take into account only such income and resources, in accordance with federal requirements, as are available to the applicant or recipient and as would not be required to be disregarded or set aside for future needs, and there shall be a reasonable evaluation of any such income or resources. There

shall not be taken into consideration the financial responsibility of any individual for any applicant or recipient of assistance under this title unless such applicant or recipient is such individual's spouse or such individual's child who is under twenty-one years of age. In determining the eligibility of a child who is categorically eligible as blind or disabled, as determined under regulations prescribed by the social security act for medical assistance, the income and resources of parents or spouses of parents are not considered available to that child if she/he does not regularly share the common household even if the child returns to the common household for periodic visits. In the application of standards of eligibility with respect to income, costs incurred for medical care, whether in the form of insurance premiums or otherwise, shall be taken into account. Any person who is eligible for, or reasonably appears to meet the criteria of eligibility for, benefits under title XVIII of the federal social security act shall be required to apply for and fully utilize such benefits in accordance with this chapter.

(2) (a) Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, upon the request of the social services district the commissioner shall, subject to the approval of the director of the budget and the procurement of the applicable federal waiver, authorize demonstration projects in up to five social services districts, or portions thereof, for the purpose of testing the feasibility of utilizing a special medical assistance income eligibility standard for certain persons in general hospitals on alternate care status who have been determined medically eligible for care in the community, in order to ease the financial burden of the legally responsible relatives. For any person sixty-five years of age or older residing in such social services districts, who is in a general hospital on alternate care status awaiting placement in a nursing home or intermediate care facility, as to whom it has been determined by the social services district that such person can be sustained in the community with in-home services at a cost not exceeding seventy-five percent of the average cost of care in a nursing home or intermediate care facility, and who meets such other criteria as the commissioner may establish, the social services district may, where it is beneficial to the applicant and legally responsible relatives, make a separate

eligibility determination for such person, by adding the income of such person and support considered available from the legally responsible relative determined in accordance with regulations of the department, and comparing this sum to the medical assistance income exemption level for a household of one.

(b) In addition to the authorization provided for in clause (a), the commissioner shall, upon request of a social services district, authorize one social services district, or a portion thereof, to use the special medical assistance income eligibility standard established in clause (a) for persons: who are sixty-five years of age or older in general hospitals or in the community and who are medically eligible for placement in a nursing home or intermediate care facility; and who it has been determined by the social services district can be sustained in the community with in-home services at a cost not to exceed the average cost of care in a nursing home or intermediate care facility.

(c) No provision of this subparagraph shall be construed so as to deny any benefit to a person otherwise eligible for medical assistance in accordance with this chapter.

(d) Resource eligibility shall be established in accordance with the requirements of paragraph (a) of this subdivision.

(e) This subparagraph shall be effective if, and as long as, federal financial participation is available.

* NB Expired March 31, 1988

* NB There are 2 sb 2 ¶(b)'s

* (b) (1) In establishing standards for determining eligibility for and amount of such assistance, the department shall take into account only such income and resources, in accordance with federal requirements, as are available to the applicant or recipient and as would not be required to be disregarded or set aside for future needs, and there shall be a reasonable evaluation of any such income or resources. The department shall not consider the availability of an option for an accelerated payment of death benefits or special surrender value pursuant to paragraph one of subsection (a) of section one thousand one hundred thirteen of the insurance law, or an option to enter into a viatical settlement pursuant to the provisions of article seventy-eight of the insurance law, as an available resource in determining eligibility for an amount of such assistance, provided, however, that

the payment of such benefits shall be considered in determining eligibility for and amount of such assistance. There shall not be taken into consideration the financial responsibility of any individual for any applicant or recipient of assistance under this title unless such applicant or recipient is such individual's spouse or such individual's child who is under twenty-one years of age. In determining the eligibility of a child who is categorically eligible as blind or disabled, as determined under regulations prescribed by the social security act for medical assistance, the income and resources of parents or spouses of parents are not considered available to that child if she/he does not regularly share the common household even if the child returns to the common household for periodic visits. In the application of standards of eligibility with respect to income, costs incurred for medical care, whether in the form of insurance premiums or otherwise, shall be taken into account. Any person who is eligible for, or reasonably appears to meet the criteria of eligibility for, benefits under title XVIII of the federal social security act shall be required to apply for and fully utilize such benefits in accordance with this chapter.

(2) In evaluating the income and resources available to an applicant for or recipient of medical assistance, for purposes of determining eligibility for and the amount of such assistance, the department must consider assets held in or paid from trusts created by such applicant or recipient, as determined pursuant to the regulations of the department, in accordance with the provisions of this subparagraph.

(i) In the case of a revocable trust created by an applicant or recipient, as determined pursuant to regulations of the department: the trust corpus must be considered to be an available resource; payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

(ii) In the case of an irrevocable trust created by an applicant or recipient, as determined pursuant to regulations of the department: any portion of the trust corpus, and of the income generated by the trust corpus, from which no payment can under any circumstances be made to

such applicant or recipient must be considered, as of the date of establishment of the trust, or, if later, the date on which payment to the applicant or recipient is foreclosed, to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section; any portion of the trust corpus, and of the income generated by the trust corpus, from which payment could be made to or for the benefit of such applicant or recipient must be considered to be an available resource; payments made from the trust to or for the benefit of such applicant or recipient must be considered to be available income; and any other payments from the trust must be considered to be assets disposed of by such applicant or recipient for purposes of paragraph (d) of subdivision five of this section.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, in the case of an applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act, the department must not consider as available income or resources the corpus or income of the following trusts which comply with the provisions of the regulations authorized by clause (iv) of this subparagraph: (A) a trust containing the assets of such a disabled individual which was established for the benefit of the disabled individual while such individual was under sixty-five years of age by the individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, if upon the death of such individual the state will receive all amounts remaining in the trust up to the total value of all medical assistance paid on behalf of such individual; (B) and a trust containing the assets of such a disabled individual established and managed by a non-profit association which maintains separate accounts for the benefit of disabled individuals, but, for purposes of investment and management of trust funds, pools the accounts, provided that accounts in the trust fund are established solely for the benefit of individuals who are disabled as such term is defined in section 1614(a)(3) of the federal social security act by such disabled individual, a parent, grandparent, legal guardian, or court of competent jurisdiction, and to the extent that amounts remaining in the individual's account are not retained by the trust upon the death of the individual, the state will receive all such remaining amounts up to the total value of all medical assistance paid on behalf of such individual.

Notwithstanding any law to the contrary, a not-for-profit corporation may, in furtherance of and as an adjunct to its corporate purposes, act as trustee of a trust for persons with disabilities established pursuant to this subclause, provided that a trust company, as defined in subdivision seven of section one hundred-c of the banking law, acts as co-trustee.

(iv) The department shall promulgate such regulations as may be necessary to carry out the provisions of this subparagraph. Such regulations shall include provisions for: assuring the fulfillment of fiduciary obligations of the trustee with respect to the remainder interest of the department or state; monitoring pooled trusts; applying this subdivision to legal instruments and other devices similar to trusts, in accordance with applicable federal rules and regulations; and establishing procedures under which the application of this subdivision will be waived with respect to an applicant or recipient who demonstrates that such application would work an undue hardship on him or her, in accordance with standards specified by the secretary of the federal department of health and human services. Such regulations may require: notification of the department of the creation or funding of such a trust for the benefit of an applicant for or recipient of medical assistance; notification of the department of the death of a beneficiary of such a trust who is a current or former recipient of medical assistance; in the case of a trust, the corpus of which exceeds one hundred thousand dollars, notification of the department of transactions tending to substantially deplete the trust corpus; notification of the department of any transactions involving transfers from the trust corpus for less than fair market value; the bonding of the trustee when the assets of such a trust equal or exceed one million dollars, unless a court of competent jurisdiction waives such requirement; and the bonding of the trustee when the assets of such a trust are less than one million dollars, upon order of a court of competent jurisdiction. The department, together with the department of financial services, shall promulgate regulations governing the establishment, management and monitoring of trusts established pursuant to subclause (B) of clause (iii) of this subparagraph in which a not-for-profit corporation and a trust company serve as co-trustees.

(v) Notwithstanding any acts, omissions or failures to act of a

trustee of a trust which the department or a local social services official has determined complies with the provisions of clause (iii) and the regulations authorized by clause (iv) of this subparagraph, the department must not consider the corpus or income of any such trust as available income or resources of the applicant or recipient who is disabled, as such term is defined in section 1614(a)(3) of the federal social security act. The department's remedy for redress of any acts, omissions or failures to act by such a trustee which acts, omissions or failures are considered by the department to be inconsistent with the terms of the trust, contrary to applicable laws and regulations of the department, or contrary to the fiduciary obligations of the trustee shall be the commencement of an action or proceeding under subdivision one of section sixty-three of the executive law to safeguard or enforce the state's remainder interest in the trust, or such other action or proceeding as may be lawful and appropriate as to assure compliance by the trustee or to safeguard and enforce the state's remainder interest in the trust.

(vi) The department shall provide written notice to an applicant for or recipient of medical assistance who is or reasonably appears to be eligible for medical assistance except for having income exceeding applicable income levels. The notice shall inform the applicant or recipient, in plain language, that in certain circumstances the medical assistance program does not count the income of disabled applicants and recipients if it is placed in a trust described in clause (iii) of this subparagraph. The notice shall be included with the eligibility notice provided to such applicants and recipients and shall reference where additional information may be found on the department's website. This clause shall not be construed to change any criterion for eligibility for medical assistance.

* NB There are 2 sb 2 ¶(b)'s

(3) (a) Social services officials shall authorize medical assistance for persons who would be eligible for such assistance except that their incomes exceed the applicable medical assistance income eligibility standard, which is determined according to paragraph (a) of subdivision two of this section, to become eligible for medical assistance by paying to their social services districts the amount by which their incomes exceed such income eligibility levels.

(b) Social services districts shall safeguard, by deposit in special accounts, any amounts paid to them by such recipients of medical assistance benefits. The amount of any medical assistance payments made to providers of medical assistance on behalf of such recipients, shall be charged against the amount in recipients' accounts. Districts shall, in accordance with their approved plans, periodically refund the amounts, if any, by which the amounts in recipients' accounts exceed the amounts of any medical assistance payments made on their behalf. Districts shall report to the department amounts in recipients' accounts that are equal to the amount of medical assistance payments made on recipients' behalf.

(c) Eligibility under this subparagraph shall be authorized only in accordance with plans submitted by social services districts and approved by the commissioner. Plans must be submitted by social services districts to the commissioner no later than February first, nineteen hundred ninety-six. The commissioner shall only approve plans that include a detailed description of how the district will administer the program, enroll recipients, safeguard monies in recipients' accounts, reconcile payments made to providers of medical assistance services with account balances and refund the amounts by which recipients' account funds exceed the amounts paid to providers on their behalf.

(d) By January first, nineteen hundred ninety-five, the department shall submit to the governor and the legislature a report evaluating the demonstration programs effect on enrollees' access to medical assistance care and services and any other subjects the commissioner deems relevant.

(e) Notwithstanding any other provision of law, administrative expenditures incurred by local social services districts in relation to this section shall be reimbursable as provided in subdivision one of section three hundred sixty-eight-a of this article.

3. (a) Medical assistance shall be furnished to applicants in cases where, although such applicant has a responsible relative with sufficient income and resources to provide medical assistance as determined by the regulations of the department, the income and resources of the responsible relative are not available to such applicant because of the absence of such relative or the refusal or

failure of such relative to provide the necessary care and assistance. In such cases, however, the furnishing of such assistance shall create an implied contract with such relative, and the cost thereof may be recovered from such relative in accordance with title six of article three and other applicable provisions of law.

(b) (i) When a legally responsible relative agrees or is ordered by a court or administrative tribunal of competent jurisdiction to provide health insurance or other medical care coverage for his or her dependents or other persons, and such dependents or other persons are applicants for, recipients of or otherwise entitled to receive medical assistance pursuant to this title, the department and social services officials shall be subrogated to any rights that the responsible relative may have to obtain reimbursement from a third party for the costs of medical care for such dependents or persons.

(ii) Upon receipt of an application, or upon a determination of eligibility, for assistance pursuant to this title, the department and social services officials shall be deemed to have furnished assistance to any such dependent or person entitled to receive medical assistance pursuant to this title and shall be subrogated to any rights such person may have to third party reimbursement as provided in paragraph (b) of subdivision two of section three hundred sixty-seven-a of this title.

(iii) For purposes of determining whether a person is legally responsible for a person receiving assistance under this title, the following shall be dispositive: a copy of a support order issued pursuant to section four hundred sixteen or five hundred forty-five of the family court act or section two hundred thirty-six or two hundred forty of the domestic relations law; an order described in paragraph (h) of subdivision four of this section; an order of a court or administrative tribunal of competent jurisdiction pursuant to the provisions of this subdivision; or any other order of a court or administrative tribunal of competent jurisdiction subject to the provisions of this subdivision. If a notice of subrogation as described in paragraph (b) of subdivision two of section three hundred sixty-seven-a of this title is accompanied by dispositive documentation that a person is legally responsible for a person receiving assistance under this title, any third party liable for reimbursement for the costs of medical care shall accord the department or any social services

official the rights of and benefits available to the responsible relative that pertain to the provision of medical care to any persons entitled to medical assistance pursuant to this title for whom the relative is legally responsible.

(c) The provisions of this subdivision shall not be construed to diminish the authority of a social services official to bring a proceeding pursuant to the provisions of this chapter or other provisions of law (1) to compel any responsible relative to contribute to the support of any person receiving or liable to become in need of medical assistance, or (2) to recover from a recipient or a responsible relative the cost of medical assistance not correctly paid.

4. Special eligibility provisions.

(a) Transitional medical assistance.

(1) Notwithstanding any other provision of law, each family which was eligible for medical assistance pursuant to subparagraph four of paragraph (b) of subdivision one of this section in at least one of the six months immediately preceding the month in which such family became ineligible for such assistance because of income from the employment of the caretaker relative shall, while such family includes a dependent child, remain eligible for medical assistance for twelve calendar months immediately following the month in which such family would otherwise be determined to be ineligible for medical assistance pursuant to the provisions of this title and the regulations of the department governing income and resource limitations relating to eligibility determinations for families described in subparagraph four of paragraph (b) of subdivision one of this section.

(2) (i) Upon giving notice of termination of medical assistance provided pursuant to subparagraph four of paragraph (b) of subdivision one of this section, the department shall notify each such family of its rights to extended benefits under subparagraph one of this paragraph and describe the conditions under which such extension may be terminated.

(ii) The department shall promulgate regulations implementing the requirements of this subparagraph and subparagraph one of this paragraph relating to the conditions under which extended coverage hereunder may be terminated, the scope of coverage, and the conditions under which coverage may be extended pending a redetermination of eligibility. Such

regulations shall, at a minimum, provide for: termination of such coverage at the close of the first month in which the family ceases to include a dependent child; notice of termination prior to the effective date of any terminations; coverage under employee health plans and health maintenance organizations; and disqualification of persons for extended coverage benefits under this paragraph for fraud.

(3) Notwithstanding any inconsistent provision of law, each family which was eligible for medical assistance pursuant to subparagraph four of paragraph (b) of subdivision one of this section in at least three of the six months immediately preceding the month in which such family became ineligible for such assistance as a result, wholly or partly, of the collection or increased collection of spousal support pursuant to part D of title IV of the federal social security act, shall, for purposes of medical assistance eligibility, be considered to be eligible for medical assistance pursuant to subparagraph four of paragraph (b) of subdivision one of this section for an additional four calendar months beginning with the month ineligibility for such assistance begins.

(b) Pregnant women and children.

(1) A pregnant woman eligible for medical assistance under subparagraph two or four of paragraph (b) of subdivision one of this section on any day of her pregnancy will continue to be eligible for such care and services for a period of one year beginning on the last day of pregnancy, without regard to any change in the income of the family that includes the pregnant woman, even if such change otherwise would have rendered her ineligible for medical assistance.

(2) A child born to a woman eligible for and receiving medical assistance on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance on the date of such birth and to remain eligible for such assistance for a period of one year, so long as the child is a member of the woman's household and the woman remains eligible for such assistance or would remain eligible for such assistance if she were pregnant.

(3) A child under the age of nineteen who is determined eligible for medical assistance under the provisions of this section, shall, consistent with applicable federal requirements, remain eligible for such assistance until the earlier of:

(A) the last day of the month which is twelve months following the

determination or renewal of eligibility for such assistance; or

(B) the last day of the month in which the child reaches the age of nineteen.

(4) An infant eligible under subparagraph two or four of paragraph (b) of subdivision one of this section who is receiving medically necessary in-patient services for which medical assistance is provided on the date the child attains one year of age, and who, but for attaining such age, would remain eligible for medical assistance under such subparagraph, shall continue to remain eligible until the end of the stay for which in-patient services are being furnished.

(5) A child eligible under subparagraph three of paragraph (b) of subdivision one of this section who is receiving medically necessary in-patient services for which medical assistance is provided on the date the child attains nineteen years of age, and who, but for attaining such age, would remain eligible for medical assistance under this paragraph, shall continue to remain eligible until the end of the stay for which in-patient services are being furnished.

(6) A woman who was pregnant while in receipt of medical assistance who subsequently loses her eligibility for medical assistance shall have her eligibility for medical assistance continued for a period of twenty-four months from the end of the month in which the sixtieth day following the end of her pregnancy occurs, but only for Federal Title X services which are eligible for reimbursement by the federal government at a rate of ninety percent; provided, however, that such ninety percent limitation shall not apply to those services identified by the commissioner as services, including treatment for sexually transmitted diseases, generally performed as part of or as a follow-up to a service eligible for such ninety percent reimbursement; and provided further, however, that nothing in this paragraph shall be deemed to affect payment for such Title X services if federal financial participation is not available for such care, services and supplies.

(c) Continuous coverage for adults. Notwithstanding any other provision of law, a person whose eligibility for medical assistance is based on the modified adjusted gross income of the person or the person's household, and who loses eligibility for such assistance for a reason other than citizenship status, lack of state residence, or failure to provide a valid social security number, before the end of a

twelve month period beginning on the effective date of the person's initial eligibility for such assistance, or before the end of a twelve month period beginning on the date of any subsequent determination of eligibility based on modified adjusted gross income, shall have his or her eligibility for such assistance continued until the end of such twelve month period, provided that federal financial participation in the costs of such assistance is available.

(d) Breast and cervical cancer treatment.

(1) Persons who are not eligible for medical assistance under the terms of section 1902(a)(10)(A)(i) of the federal social security act are eligible for medical assistance coverage during the treatment of breast or cervical cancer, subject to the provisions of this paragraph.

(2) (i) Medical assistance is available under this paragraph to persons who are under sixty-five years of age, have been screened for breast and/or cervical cancer under the Centers for Disease Control and Prevention breast and cervical cancer early detection program and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the federal public health service act; provided however that medical assistance shall be furnished pursuant to this clause only to the extent permitted under federal law, if, for so long as, and to the extent that federal financial participation is available therefor.

(ii) Medical assistance is available under this paragraph to persons who meet the requirements of clause (i) of this subparagraph but for their age and/or gender, who have been screened for breast and/or cervical cancer under the program described in title one-A of article twenty-four of the public health law and need treatment for breast or cervical cancer, and are not otherwise covered under creditable coverage as defined in the federal public health service act; provided however that medical assistance shall be furnished pursuant to this clause only if and for so long as the provisions of clause (i) of this subparagraph are in effect.

(3) Medical assistance provided to a person under this paragraph shall be limited to the period in which such person requires treatment for breast or cervical cancer.

(4) (i) The commissioner of health shall promulgate such regulations as may be necessary to carry out the provisions of this paragraph. Such

regulations shall include, but not be limited to: eligibility requirements; a description of the medical services which are covered; and a process for providing presumptive eligibility when a qualified entity, as defined by the commissioner, determines on the basis of preliminary information that a person meets the requirements for eligibility under this paragraph.

(ii) For purposes of determining eligibility for medical assistance under this paragraph, resources available to such individual shall not be considered nor required to be applied toward the payment or part payment of the cost of medical care, services and supplies available under this paragraph.

(iii) An individual shall be eligible for presumptive eligibility for medical assistance under this paragraph in accordance with subdivision four of section three hundred sixty-four-i of this title.

(5) The commissioner of health shall, consistent with this title, make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, in order to ensure federal financial participation in expenditures under this paragraph. Notwithstanding any provision of law to the contrary, the provisions of clause (i) of subparagraph two of this paragraph shall be effective only if and for so long as federal financial participation is available in the costs of medical assistance furnished thereunder.

(e) Colon and prostate cancer treatment.

(1) Notwithstanding any other provision of law to the contrary, a person who has been screened or referred for screening for colon or prostate cancer by the cancer services screening program, as administered by the department of health, and has been diagnosed with colon or prostate cancer is eligible for medical assistance for the duration of his or her treatment for such cancer.

(2) Persons eligible for medical assistance under this paragraph shall have an income of two hundred fifty percent or less of the comparable federal income official poverty line as defined and annually revised by the federal office of management and budget.

(3) An individual shall be eligible for presumptive eligibility for medical assistance under this paragraph in accordance with subdivision four of section three hundred sixty-four-i of this title.

(4) Medical assistance is available under this paragraph to persons

who are under sixty-five years of age, and are not otherwise covered under creditable coverage as defined in the federal Public Health Service Act.

5. (a) In determining the initial or continuing eligibility of any person for assistance under this title, there shall be included in the amount of resources considered available to such person the uncompensated value of any resource transferred prior to the date of application for medical assistance as specified in paragraphs (b), (c), (d) and (e) of this subdivision, and such person shall be ineligible for such assistance for such period or periods as specified in this subdivision.

(b) For transfers made on or after April tenth, nineteen hundred eighty-two and prior to October first, nineteen hundred eighty-nine:

(1) a nonexempt resource shall mean any resource which if retained by such person would not be exempt from consideration under the provisions of subdivision two of this section;

(2) any transfer of a nonexempt resource made within twenty-four months prior to the date of a person's application for medical assistance shall be presumed to have been made for the purpose of qualifying for such assistance; however, if such person furnishes evidence to establish that the transfer was exclusively for some other purpose, the uncompensated value shall not be considered available to such person in determining his or her initial or continued eligibility for medical assistance;

(3) the uncompensated value of any such resource shall be the fair market value of such resource at the time of transfer, minus the amount of the compensation received by the person in exchange for the resource;

(4) any person determined to have excess resources of twelve thousand dollars or less because of the application of this paragraph shall remain ineligible for assistance under this title for a period of twenty-four months from the date of the transfer, or until such person can demonstrate that he or she has incurred medical expenses after the date of transfer in the amount of such excess above otherwise allowable resources, whichever period is shorter;

(5) any person determined to have excess resources of more than twelve thousand dollars because of the application of this paragraph shall

remain ineligible for assistance under this title for a period which exceeds twenty-four months, which period shall be determined by adding an additional month of ineligibility for each two thousand dollars in excess of twelve thousand dollars, or until such person can demonstrate that he or she has incurred medical expenses after the date of transfer in the amount of such excess above otherwise allowable resources, whichever period is shorter.

(c) For transfers made on or after October first, nineteen hundred eighty-nine:

(1) (i) "institutionalized person" means any person who is an in-patient in a nursing facility, or who is an in-patient in a medical facility and is receiving a level of care provided in a nursing facility, or who is receiving care, services or supplies pursuant to a waiver pursuant to subsection (c) of section nineteen hundred fifteen of the federal social security act.

(ii) "resources" includes any resources which would not be considered exempt from consideration under the provisions of subdivision two of this section, without regard to the exemption provided for in subparagraph one of paragraph (a) of such subdivision.

(iii) "nursing facility" means a nursing home as defined by section twenty-eight hundred one of the public health law.

(iv) "nursing facility services" means nursing care and health related services provided in a nursing facility, a level of care provided in a hospital which is equivalent to the care which is provided in a nursing facility and care, services or supplies provided pursuant to a waiver pursuant to subsection (c) of section nineteen hundred fifteen of the federal social security act.

(2) the uncompensated value of a resource shall be the fair market value of such resource at the time of transfer, minus the amount of the compensation received in exchange for the resource.

(3) any transfer of a resource by a person or such person's spouse for less than fair market value made within or after the thirty months immediately preceding the date the person becomes an institutionalized person or the date of application for medical assistance while an institutionalized person, if later, shall render the person ineligible for nursing facility services for a period specified in subparagraph four of this paragraph; however, an institutionalized person shall not

be ineligible for nursing facility services solely by reason of any such transfer to the extent that:

(i) the resource transferred was a home and title to the home was transferred to: (A) the spouse of such person; or (B) a child of such person who is under the age of twenty-one years or certified blind or certified permanently and totally disabled, as defined by section two hundred eight of this title; or (C) a sibling of such person who has an equity interest in such home and who resided in such home for a period of at least one year immediately before the date the person became an institutionalized person; or (D) a son or daughter of such person who was residing in such home for a period of at least two years immediately before the date such person became an institutionalized person, and who provided care to such person which permitted such person to reside at home rather than in an institution or facility; or

(ii) the resource was transferred to or for the sole benefit of such person's spouse, or from such person's spouse to or for the sole benefit of such person, or to his or her child who is certified blind or certified permanently and totally disabled; or

(iii) a satisfactory showing is made that: (A) the person or such person's spouse intended to dispose of the resource either at fair market value, or for other valuable consideration, or (B) the resource was transferred exclusively for a purpose other than to qualify for medical assistance; or

(iv) denial of eligibility would work an undue hardship, as defined by the commissioner which definition shall include the inability of the institutionalized person or such person's spouse to retrieve the resource or to obtain fair market value therefor despite his or her best efforts.

(4) Any transfer made by a person or the person's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for nursing facility services, for services at a level of care equivalent to that of nursing facility services for the lesser of (i) a period of thirty months from the date of transfer, or (ii) a period equal to the total uncompensated value of the resources so transferred, divided by the average cost of nursing facility services to a private patient for a given period of time at the time of application as determined by the commissioner. For purposes of this subparagraph the

average cost of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing facilities within the region as established pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law wherein the applicant resides.

(d) For transfers made after August tenth, nineteen hundred ninety-three:

(1) (i) "assets" means all income and resources of an individual and of the individual's spouse, including income or resources to which the individual or the individual's spouse is entitled but which are not received because of action by: the individual or the individual's spouse; a person with legal authority to act in place of or on behalf of the individual or the individual's spouse; a person acting at the direction or upon the request of the individual or the individual's spouse; or by a court or administrative body with legal authority to act in place of or on behalf of the individual or the individual's spouse or at the direction or upon the request of the individual or the individual's spouse.

(ii) "blind" has the same meaning given to such term in section 1614(a)(2) of the federal social social security act.

(iii) "disabled" has the same meaning given to such term in section 1614(a)(3) of the federal social security act.

(iv) "income" has the same meaning given to such term in section 1612 of the federal social security act.

(v) "resources" has the same meaning given to such term in section 1613 of the federal social security act, without regard, in the case of an institutionalized individual, to the exclusion provided for in subsection (a)(1) of such section.

(vi) "look-back period" means the thirty-six month period, or, in the case of payments from a trust or portions of a trust which are treated as assets disposed of by the individual pursuant to department regulations, the sixty-month period, immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance.

(vii) "institutionalized individual" means any individual who is an

in-patient in a nursing facility, including an intermediate care facility for individuals with developmental disabilities, or who is an in-patient in a medical facility and is receiving a level of care provided in a nursing facility, or who is receiving care, services or supplies pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal social security act.

(viii) "intermediate care facility for individuals with developmental disabilities" means a facility certified under article sixteen of the mental hygiene law and which has a valid agreement with the department for providing intermediate care facility services and receiving payment therefor under title XIX of the federal social security act.

(ix) "nursing facility" means a nursing home as defined by section twenty-eight hundred one of the public health law and an intermediate care facility for individuals with developmental disabilities.

(x) "nursing facility services" means nursing care and health related services provided in a nursing facility; a level of care provided in a hospital which is equivalent to the care which is provided in a nursing facility; and care, services or supplies provided pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal social security act.

(2) The uncompensated value of an asset is the fair market value of such asset at the time of transfer, minus the amount of the compensation received in exchange for the asset.

(3) In determining the medical assistance eligibility of an institutionalized individual, any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for nursing facility services for the period of time specified in subparagraph four of this paragraph. Notwithstanding the provisions of this subparagraph, an individual shall not be ineligible for services solely by reason of any such transfer to the extent that:

(i) in the case of an institutionalized individual, the asset transferred was a home and title to the home as transferred to: (A) the spouse of the individual; or (B) a child of the individual who is under the age of twenty-one years or blind or disabled; or (C) a sibling of the individual who has an equity interest in such home and who resided in such home for a period of at least one year immediately before the

date the individual became an institutionalized individual; or (D) a child of the individual who was residing in such home for a period of at least two years immediately before the date the individual became an institutionalized individual, and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility; or

(ii) the assets: (A) were transferred to the individual's spouse, or to another for the sole benefit of the individual's spouse; or (B) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse; or (C) were transferred to the individual's child who is blind or disabled, or to a trust established solely for the benefit of such child; or (D) were transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled; or

(iii) a satisfactory showing is made that: (A) the individual or the individual's spouse intended to dispose of the assets either at fair market value, or for other valuable consideration; or (B) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or (C) all assets transferred for less than fair market value have been returned to the individual; or

(iv) denial of eligibility would cause an undue hardship, as determined pursuant to the regulations of the department in accordance with criteria established by the secretary of the federal department of health and human services.

(4) Any transfer made by an individual or the individual's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for services for a period equal to the total, cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average monthly costs of nursing facility services provided to a private patient for a given period of time at the time of application, as determined pursuant to the regulations of the department. The period of ineligibility shall begin with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other periods of ineligibility under this paragraph. For purposes of this subparagraph, the average monthly costs of nursing facility services to a private patient for a given period of time at the

time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing facilities within the region wherein the applicant resides, as established pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law.

(5) In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(6) In the case of a trust established by the individual, as determined pursuant to the regulations of the department, any payment, other than a payment to or for the benefit of the individual, from a revocable trust is considered to be a transfer of assets by the individual and any payment, other than to or for the benefit of the individual, from the portion of an irrevocable trust which, under any circumstance, could be made available to the individual is considered to be a transfer of assets by the individual and, further, the value of any portion of an irrevocable trust from which no payment could be made to the individual under any circumstances is considered to be a transfer of assets by the individual for purposes of this section as of the date of establishment of the trust, or, if later, the date on which payment to the individual is foreclosed.

(e) For transfers made on or after February eighth, two thousand six:

(1)(i) "assets" means all income and resources of an individual and of the individual's spouse, including income and resources to which the individual or the individual's spouse is entitled but which are not received because of action by: the individual or the individual's spouse; a person with legal authority to act in place of or on behalf of the individual or the individual's spouse; a person acting at the direction or upon the request of the individual or the individual's spouse; or by a court or administrative body with legal authority to act in place of or on behalf of the individual or the individual's spouse or at the direction or upon the request of the individual or the individual's spouse;

(ii) "blind" has the same meaning given to such term in section 1614(a)(2) of the federal social security act.

(iii) "disabled" has the same meaning given to such term in section 1614(a)(3) of the federal social security act.

(iv) "income" has the same meaning given to such term in section 1612 of the federal social security act.

(v) "resources" has the same meaning given to such term in section 1613 of the federal social security act, without regard to the exclusion provided for in subsection (a)(1) of such section.

* (vi) "look-back period" means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance, or in the case of a non-institutionalized individual, subject to federal approval, the thirty-month period immediately preceding the date that such non-institutionalized individual applies for medical assistance coverage of long term care services. Nothing herein precludes a review of eligibility for retroactive authorization for medical expenses incurred during the three months prior to the month of application for medical assistance.

* NB Effective until January 1, 2027

* (vi) "look-back period" means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance, or in the case of a non-institutionalized individual, subject to federal approval, the thirty-month period immediately preceding the date that such non-institutionalized individual applies for medical assistance coverage of long term care services. Nothing herein precludes a review of eligibility for retroactive authorization for medical expenses incurred during the maximum allowable retroactive eligibility period under federal law.

* NB Effective January 1, 2027

(vii) "institutionalized individual" means any individual who is an in-patient in a nursing facility, including an intermediate care facility for individuals with developmental disabilities, or who is an in-patient in a medical facility and is receiving a level of care provided in a nursing facility, or who is described in section 1902(a)(10)(A)(ii)(VI) of the federal social security act.

(viii) "intermediate care facility for individuals with developmental disabilities" means a facility certified under article sixteen of the mental hygiene law and which has a valid agreement with the department for providing intermediate care facility services and receiving payment therefor under title XIX of the federal social security act.

(ix) "nursing facility" means a nursing home as defined by section twenty-eight hundred one of the public health law and an intermediate care facility for individuals with developmental disabilities.

(x) "nursing facility services" means nursing care and health related services provided in a nursing facility; a level of care provided in a hospital which is equivalent to the care which is provided in a nursing facility; and care, services or supplies provided pursuant to a waiver granted pursuant to subsection (c) of section 1915 of the federal social security act or successor federal waiver.

(xi) "non-institutionalized individual" means an individual who is not an institutionalized individual, as defined in clause (vii) of this subparagraph.

(xii) "long term care services" means home health care services, private duty nursing services, personal care services, assisted living program services and such other services for which medical assistance is otherwise available under this chapter which are designated as long term care services in the regulations of the department.

(2) The uncompensated value of an asset is the fair market value of such asset at the time of transfer less any outstanding loans, mortgages, or other encumbrances on the asset, minus the amount of the compensation received in exchange for the asset.

(3) In determining the medical assistance eligibility of an institutionalized individual, any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for nursing facility services for the period of time specified in subparagraph five of this paragraph. In determining the medical assistance eligibility of a non-institutionalized individual, any transfer of an asset by the individual or the individual's spouse for less than fair market value made within or after the look-back period shall render the individual ineligible for community based long term care services for the period of time specified in subparagraph five of

this paragraph. For purposes of this paragraph:

(i) the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless: the state is named as the beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant, or the state is named in the second position after a community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value; and the annuity meets the requirements of section 1917(c)(1)(G) of the federal social security act;

(ii) the purchase of a life estate interest in another person's home shall be treated as the disposal of an asset for less than fair market value unless the purchaser resided in such home for a period of at least one year after the date of purchase;

(iii) the purchase of a promissory note, loan, or mortgage shall be treated as the disposal of an asset for less than fair market value unless such note, loan, or mortgage meets the requirements of section 1917(c)(1)(I) of the federal social security act.

(4) Notwithstanding the provisions of this paragraph, an individual shall not be ineligible for services solely by reason of any such transfer to the extent that:

(i) in the case of an institutionalized individual the asset transferred was a home and title to the home was transferred to: (A) the spouse of the individual; or (B) a child of the individual who is under the age of twenty-one years or blind or disabled; or (C) a sibling of the individual who has an equity interest in such home and who resided in such home for a period of at least one year immediately before the date the individual became an institutionalized individual; or (D) a child of the individual who was residing in such home for a period of at least two years immediately before the date the individual became an institutionalized individual, and who provided care to the individual which permitted the individual to reside at home rather than in an institution or facility; or

(ii) the assets: (A) were transferred to the individual's spouse, or to another for the sole benefit of the individual's spouse; or (B) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse; or (C) were transferred to the individual's

child who is blind or disabled, or to a trust established solely for the benefit of such child; or (D) were transferred to a trust established solely for the benefit of an individual under sixty-five years of age who is disabled; or

(iii) a satisfactory showing is made that: (A) the individual or the individual's spouse intended to dispose of the assets either at fair market value, or for other valuable consideration; or (B) the assets were transferred exclusively for a purpose other than to qualify for medical assistance; or (C) all assets transferred for less than fair market value have been returned to the individual; or

(iv) denial of eligibility would cause an undue hardship, such that application of the transfer of assets provision would deprive the individual of medical care such that the individual's health or life would be endangered, or would deprive the individual of food, clothing, shelter, or other necessities of life. The commissioner of health shall develop a hardship waiver process which shall include a timely process for determining whether an undue hardship waiver will be granted and a timely process under which an adverse determination can be appealed. The commissioner of health shall provide notice of the hardship waiver process in writing to those individuals who are required to comply with the transfer of assets provision under this section. If such an individual is an institutionalized individual, the facility in which he or she is residing shall be permitted to file an undue hardship waiver application on behalf of such individual with the consent of the individual or the personal representative of the individual.

(5) Any transfer made by an individual or the individual's spouse under subparagraph three of this paragraph shall cause the person to be ineligible for services for a period equal to the total, cumulative uncompensated value of all assets transferred during or after the look-back period, divided by the average monthly costs of nursing facility services provided to a private patient for a given period of time at the time of application, as determined pursuant to the regulations of the department. For purposes of this subparagraph, the average monthly costs of nursing facility services to a private patient for a given period of time at the time of application shall be presumed to be one hundred twenty percent of the average medical assistance rate of payment as of the first day of January of each year for nursing

facilities within the region where the applicant resides, as established pursuant to paragraph (b) of subdivision sixteen of section twenty-eight hundred seven-c of the public health law. The period of ineligibility shall begin the first day of a month during or after which assets have been transferred for less than fair market value, or the first day the otherwise eligible individual is receiving services for which medical assistance coverage would be available based on an approved application for such care but for the provisions of subparagraph three of this paragraph, whichever is later, and which does not occur in any other periods of ineligibility under this paragraph.

(6) In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, shall be considered transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(7) In the case of a trust established by the individual, as determined pursuant to the regulations of the department, any payment, other than a payment to or for the benefit of the individual, from a revocable trust is considered to be a transfer of assets by the individual and any payment, other than to or for the benefit of the individual, from the portion of an irrevocable trust which, under any circumstance, could be made available to the individual is considered to be a transfer of assets by the individual and, further, the value of any portion of an irrevocable trust from which no payment could be made to the individual under any circumstances is considered to be a transfer of assets by the individual for purposes of this section as of the date of establishment of the trust, or, if later, the date on which the payment to the individual is foreclosed.

(f) The commissioner shall promulgate such rules and regulations as may be necessary to carry out the provisions of this subdivision.

* 6. a. The commissioner of health shall apply for a home and community-based services waiver pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act in order to provide home and community-based services, not included under the medical assistance program.

b. A person eligible for participation in the waiver program shall:

(i) be twenty-one years of age or under;

(ii) be physically disabled, according to the federal supplemental security income program criteria, including but not limited to a person who is multiply disabled;

(iii) require the level of care provided by a nursing facility or by a hospital;

(iv) be capable of being cared for in the community if provided with case management services and/or other services specified in paragraph f of this subdivision, in addition to other services provided under this title, as determined by the assessment required by paragraph d of this subdivision;

(v) meet the requirements of paragraph i of this subdivision; and

(vi) meet such other criteria as may be established by the commissioner as may be necessary to administer the provisions of this subdivision in an equitable manner.

c. Social services districts shall assess the eligibility of persons in accordance with the provisions of paragraphs b and d of this subdivision and shall refer persons who appear to meet the criteria set forth in such paragraphs to the commissioner of health for consideration for participation in the waiver program and final determinations of their eligibility for participation in the waiver program.

d. The commissioner of health shall designate persons to assess the eligibility of persons in accordance with paragraphs b and c of this subdivision under consideration for participation in the waiver program. Persons designated by such commissioner may include the person's physician, a representative of the social services district, a representative of the provider of a long term home health care program or certified home health agency and, where appropriate, the discharge coordinator of the hospital or nursing facility and such other persons as such commissioner deems appropriate. The assessment shall include, but need not be limited to, an evaluation of the medical, social, habilitation, and environmental needs of the person and shall serve as the basis for the development and provision of an appropriate plan of care for the person.

e. Prior to a person's participation in the waiver program, the social services district or the commissioner of health, as appropriate, shall undertake or arrange for the development of a written plan of care for the provision of services consistent with the level of care determined by the assessment, in accordance with criteria established by the commissioner of health.

f. Home and community-based services which may be provided to persons specified in paragraph b of this subdivision include: (i) case management services; (ii) respite services; (iii) home adaptation; (iv) hospice and palliative care services; and (v) such other home and community-based services, other than room and board, as may be approved by the secretary of the federal department of health and human services.

g. Social services districts shall designate who may provide the home and community-based services identified in paragraph f of this subdivision, subject to the approval of the commissioner of health.

h. Notwithstanding any other provision of this chapter or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph b of this subdivision, the income and resources of responsible relatives shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

i. Before a person may participate in the waiver program specified in paragraph a of this subdivision, the department of health shall determine that the annual medical assistance expenditures for home and community-based services for all persons participating in the waiver program would not exceed the annual medical assistance expenditures for nursing facility and hospital services for all such persons had the waiver not been granted.

j. The commissioner shall review the plans of care and expenditure estimates determined by social services districts prior to the participation of any person in the waiver program.

k. This subdivision shall be effective only if, and as long as, federal financial participation is available for expenditures incurred under this subdivision.

* NB Repealed March 31, 2028

6-a. a. The commissioner of health shall apply for a nursing facility transition and diversion medicaid waiver pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act in order to provide home and community based services to individuals who would otherwise be cared for in a nursing facility and who would be considered to be part of an aggregate group of individuals who, taken together, will be cared for at less cost in the community than they would have otherwise and to provide reimbursement for several home and community based services not presently included in the medical assistance program. The initial application shall provide for no less than five thousand persons to be eligible to participate in the waiver spread over the first three years and continue to increase thereafter.

b. A person eligible for participation in the nursing facility transition and diversion medicaid waiver program shall:

(i) be at least eighteen years of age;

(ii) be eligible for and in receipt of medicaid authorization for long term care services, including nursing facility services;

(iii) have resided in a nursing facility and/or have been assessed and determined to require the level of care provided by a nursing facility;

(iv) be capable of residing in the community if provided with services specified in paragraph f of this subdivision, in addition to other services provided under this title, as determined by the assessment required by paragraph d of this subdivision; and

(v) meet such other criteria as may be established by the commissioner of health as may be necessary to administer the provision of this subdivision in an equitable manner.

c. The department of health shall develop such waiver application in conjunction with independent living centers, representatives from disability and senior groups and such other interested parties as the

department shall determine to be appropriate.

d. The commissioner of health shall contract with not-for-profit agencies around the state that have experience with providing community based services to individuals with disabilities, hereinafter referred to as regional resource development specialists, who shall be responsible for initial contact with the prospective waiver participant, for assuring the waiver candidates have choice in selecting a service coordinator and other providers, and for assessing applicants including decisions for eligibility for participation in the waiver, which contain the original service plan and all subsequent revised service plans. Regional resource development specialists shall be responsible for approving service plans and the department of health shall provide technical assistance and oversight.

e. Prior to the person's participation in the waiver program, a service coordinator approved by the department of health shall undertake the development of a written plan of care for the provision of services consistent with the level of care determined by an initial assessment, in accordance with criteria established by the commissioner of health. Such plans shall set forth the type of services to be furnished, the amount, the frequency and duration of each service and the type of providers to furnish each service.

f. Nursing facility transition and diversion services which may be provided to persons specified in paragraph b of this subdivision shall be established and defined as part of the waiver application development process specified in paragraph c of this subdivision and may include: (i) case management services; (ii) personal care; (iii) independent living skills training; (iv) environmental accessibility adaptations; (v) costs of community transition services; (vi) assistive technology; (vii) adult day health; (viii) staff for safety assurance; (ix) non-medical support services needed to maintain independence; (x) respite services; and (xi) such other home and community based services as may be approved by the secretary of the federal department of health and human services.

g. The department of health shall designate who may provide the nursing facility transition and diversion services identified in paragraph f of this subdivision, subject to the approval of the commissioner of health.

h. Before a person may participate in the nursing transition waiver program specified in this subdivision, the regional resource development specialists shall determine that:

(i) the individual is at least eighteen years of age and eligible for and in receipt of medicaid authorization for long term care services, including nursing facility services; and

(ii) the individual resides in a nursing facility and/or has been assessed and determined to require nursing facility care.

7. a. The commissioner of health shall apply for a home and community-based waiver, pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act, in order to provide home and community-based services not presently included in the medical assistance program.

b. Persons eligible for participation in the waiver program shall:

(i) be twenty-one years of age or under;

(ii) have a developmental disability, as such term is defined in subdivision twenty-two of section 1.03 of the mental hygiene law;

(iii) demonstrate complex health care needs, as defined in paragraph c of this subdivision;

(iv) require the level of care provided by an intermediate care facility for the developmentally disabled;

(v) not be hospitalized or receiving care in a nursing facility, an intermediate care facility for the developmentally disabled or any other institution;

(vi) be capable of being cared for in the community if provided with case management services, respite services, home adaptation, and any other home and community-based services, other than room and board, as may be approved by the secretary of the federal department of health and human services, in addition to other services provided under this title, as determined by the assessment required by paragraph f of this

subdivision;

(vii) be ineligible for medical assistance because the income and resources of responsible relatives are deemed available to him or her, causing him or her to exceed the income or resource eligibility level for such assistance;

(viii) be capable of being cared for at less cost in the community than in an intermediate care facility for the developmentally disabled; and

(ix) meet such other criteria as may be established by the commissioner of health, in conjunction with the commissioner of the office for people with developmental disabilities, as may be necessary to administer the provisions of this subdivision in an equitable manner, including those criteria established pursuant to paragraph d of this subdivision.

c. For purposes of this subdivision, persons who "demonstrate complex health care needs", shall be defined as persons who require medical therapies that are designed to replace or compensate for a vital body function or avert immediate threat to life; that is, persons who rely on medical devices, nursing care, monitoring or prescribed medical therapy for the maintenance of life over a period expected to extend beyond twelve months.

d. The commissioner of health, in conjunction with the commissioner of the office for people with developmental disabilities, shall establish selection criteria to ensure that participants are those who are most in need and reflect an equitable geographic distribution. Such selection criteria shall include, but not be limited to, the imminent risk of institutionalization, the financial burden imposed upon the family as a result of the child's health care needs, and the level of stress within the family unit due to the unrelieved burden of caring for the child at home.

e. Social services districts, in consultation with the office for people with developmental disabilities, shall assess the eligibility of persons in accordance with the provisions of paragraph b of this subdivision, as well as the selection criteria established by the

commissioner of health and the commissioner of the office for people with developmental disabilities as required by paragraph d of this subdivision.

f. The commissioner of health, in conjunction with the commissioner of the office for people with developmental disabilities, shall designate persons to assess the eligibility of persons under consideration for participation in the waiver program. Persons designated by such commissioners may include the person's physician, a representative of the social services district, representative of the appropriate developmental disabilities services office and such other persons as the commissioners deem appropriate. The assessment shall include, but need not be limited to, an evaluation of the health, psycho-social, developmental, habilitation and environmental needs of the person and shall serve as the basis for the development and provision of an appropriate plan of care for such person.

g. Prior to a person's participation in the waiver program, the office for people with developmental disabilities shall undertake or arrange for the development of a written plan of care for the provision of services consistent with the level of care determined by the assessment, in accordance with criteria established by the commissioner of health, in consultation with the commissioner of the office for people with developmental disabilities. Such plan of care shall be reviewed by such commissioners prior to the provision of services pursuant to the waiver program.

h. Home and community-based services which may be provided to persons specified in paragraph b of this subdivision shall, in addition to those services otherwise authorized, include (i) case management services; (ii) respite services; (iii) home adaptation, and (iv) such other home and community-based services, other than room and board, as may be approved by the secretary of the federal department of health and human services.

i. The office for people with developmental disabilities shall designate who may provide the home and community-based services

identified in paragraph h of this subdivision, subject to the approval of the commissioner of health.

j. Notwithstanding any other provision of this chapter other than subdivision six of this section or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph b of this subdivision, the income and resources of a responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

k. Before a person may participate in the waiver program specified in paragraph a of this subdivision, the office for people with developmental disabilities shall determine that there is a reasonable expectation that the annual medical assistance expenditures for such person under the waiver would not exceed the expenditures for care in an intermediate care facility for the developmentally disabled that would have been made had the waiver not been granted.

l. The commissioner of health, in conjunction with the commissioner of the office for people with developmental disabilities, shall review the plans of care and expenditure estimates prior to the participation of any person in the waiver program.

m. Within one year of federal waiver approval, and on an annual basis thereafter, until such time as the waiver program is fully implemented, the commissioner of health, in conjunction with the commissioner of the office for people with developmental disabilities, shall report on the status of the waiver program to the governor and the legislature. Such report shall specify the number of children participating in the waiver program, the geographic distribution of those so participating, health profiles, service costs and length of time the children have participated in the waiver program. The report shall also provide follow-up information on children who have withdrawn from the waiver program, including data on residential program placements.

n. This subdivision shall be effective only if, and as long as, federal financial participation is available for expenditures incurred

under this subdivision.

7-a. a. The commissioner of health in consultation with the commissioner of developmental disabilities shall apply for a home and community-based waiver, pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act, in order to provide home and community-based services for a population of persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law.

b. Persons eligible for participation in the waiver program shall:

(i) have a developmental disability as such term is defined in subdivision twenty-two of section 1.03 of the mental hygiene law;

(ii) meet the level of care criteria provided by an intermediate care facility for the developmentally disabled;

(iii) be eligible for Medicaid;

(iv) live at home or in an individualized residential alternative, community residence or family care home, operated or licensed by the office for people with developmental disabilities;

(v) be capable of being cared for in the community if provided with such services as respite, home adaptation, or other home and community-based services, other than room and board, as may be approved by the secretary of the federal department of health and human services, in addition to other services provided under this title, as determined by the assessment required by paragraph c of this subdivision;

(vi) have a demonstrated need for home and community based waiver services; and

(vii) meet such other criteria as may be established by the commissioner of health and the commissioner of developmental disabilities, as may be necessary to administer the provisions of this subdivision.

c. The commissioner of developmental disabilities shall assess the eligibility of persons enrolled, or seeking to enroll, in the waiver program. The assessment shall include, but need not be limited to, an evaluation of the health, psycho-social, developmental, habilitation and environmental needs of the person and shall serve as the basis for the

development and provision of an appropriate person centered plan of care for such person.

d. The office for people with developmental disabilities shall undertake or arrange for the development of a written person centered plan of care for each person enrolled in the waiver. Such person centered plan of care shall describe the provision of home and community based waiver services consistent with the assessment for each person.

e. The office for people with developmental disabilities shall review the person centered plan of care and authorize those home and community based services to be included in the person centered plan of care, taking into account the person's assessed needs, valued outcomes and available resources.

f. The commissioners of developmental disabilities and health shall determine quality standards for organizations providing services under such waiver and shall authorize organizations that meet such standards to provide such services.

g. The commissioner of developmental disabilities or health may promulgate rules and regulations as necessary to effectuate the provisions of this section.

h. This subdivision shall be effective only if, and as long as, federal financial participation is available for expenditures incurred under this subdivision.

7-b. Services and needs assessment. The assessment completed pursuant to subdivision seven-a of this section shall be based upon a valid and reliable assessment tool. The assessment shall also include an evaluation of the individual's home environment, including but not limited to, the ability of family and/or caregivers to provide supports outside of those within the waiver, including but not limited to, activities of daily living.

7-c. The commissioner of health in consultation with the commissioner

of developmental disabilities is authorized to submit the appropriate waivers, including, but not limited to, those authorized pursuant to section eleven hundred fifteen of the federal social security act, in order to achieve the purposes of high-quality and integrated care and services for a population of persons with developmental disabilities, as such term is defined in section 1.03 of the mental hygiene law. Such waiver applications shall be executed consistent with subdivisions seven, seven-a, and seven-b of this section, to the extent those sections comply with the requirements of section eleven hundred fifteen of the federal social security act. Nothing in subdivision seven of this section shall prevent the commissioner of health, in consultation with the commissioner of developmental disabilities, from submitting waiver applications expanding eligibility under such waivers to children under eighteen years or age who are eligible for medical assistance.

8. Notwithstanding any inconsistent provision of this chapter or any other law to the contrary, income and resources which are otherwise exempt from consideration in determining a person's eligibility for medical care, services and supplies available under this title, shall be considered available for the payment or part payment of the costs of such medical care, services and supplies as required by federal law and regulations.

9. a. The commissioner shall apply for a general waiver, pursuant to subdivision (c) of section nineteen hundred fifteen of the federal social security act, in order to provide medical assistance for persons specified in paragraphs b and c of this subdivision and reimbursement for several home and community-based services not presently included in the medical assistance program. If granted the general waiver, the commissioner may authorize such persons to receive services under the general waiver to the extent funds are appropriated for transfer to the department for the state share of medical assistance payments for such waiver services from the budget of the office of mental health.

b. Persons eligible for inclusion in the general waiver shall:
(i) be under twenty-one years of age;
(ii) have a mental illness, as such term is defined in subdivision

twenty of section 1.03 of the mental hygiene law;

(iii) demonstrate complex health or mental health care needs, as defined in paragraph d of this subdivision;

(iv) require the level of care provided by a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law which provides intermediate or long-term care and treatment, or within the past six months have been hospitalized for at least thirty consecutive days, or have resided in such a hospital for at least one hundred eighty consecutive days;

(v) be capable of being cared for in the community if provided with case management services, clinical interventions, crisis services, social training, rehabilitation services, counseling, respite services, medication therapy, partial hospitalization, environmental modifications, educational and related services, and/or medical social services, in addition to other services, as determined by the assessment required by paragraph g of this subdivision and included in the written plan of care developed pursuant to paragraph h of this subdivision;

(vi) be eligible or, if discharged, would be eligible for medical assistance, or are ineligible for medical assistance because the income and resources of responsible relatives are or, if discharged, would be deemed available to such persons causing them to exceed the income or resource eligibility level for such assistance;

(vii) be capable of being cared for at less cost in the community than in a hospital, as defined in subdivision ten of section 1.03 of the mental hygiene law; and

(viii) meet such other criteria as may be established by the commissioner of mental health, in conjunction with the commissioner, as may be necessary to administer the provisions of this subdivision in an equitable manner, including those criteria established pursuant to paragraph e of this subdivision.

c. Persons eligible for inclusion in the general waiver shall meet all the requirements set forth in subparagraphs (i) through (viii) of paragraph b of this subdivision; and shall be eligible for, shall have applied for, or shall reside in an institutional placement including a hospital as defined in subdivision ten of section 1.03 of the mental hygiene law which provides intermediate or long-term care and treatment.

d. For purposes of this subdivision, persons who "demonstrate complex health or mental health care needs", shall be defined as persons who require medical or mental health therapies, care or treatments that are designed to replace or compensate for a vital functional limitation or to avert an immediate threat to life; that is, persons who rely on mental health care, nursing care, monitoring, or prescribed medical or mental health therapy for the maintenance of quality of life over a period expected to extend beyond twelve months.

e. The commissioner of mental health, in conjunction with the commissioner, shall establish selection criteria to ensure that participants are those who are most in need. Such selection criteria shall include, but not be limited to: the need for continued hospitalization or the risk of hospitalization; the financial burden imposed upon the family, or which would be imposed upon the family if an institutionalized participant were to be discharged, as a result of the child's health or mental health care needs; and the level of stress or the anticipated level of stress within the family unit due to the unrelieved burden of caring for the child at home.

f. Social services districts, in conjunction with the office of mental health and the local governmental unit as defined in section 41.03 of the mental hygiene law, shall determine the eligibility of persons in accordance with the provisions of paragraphs b and c of this subdivision, as well as the selection criteria established by the commissioner and the commissioner of mental health as required by paragraph e of this subdivision.

g. The commissioner of mental health, in conjunction with the commissioner, shall designate persons to undertake an assessment to determine the eligibility of persons under consideration for inclusion in the general waiver. Persons designated by such commissioners may include the potentially eligible person's physician, a representative of the local governmental unit as defined in section 41.03 of the mental hygiene law, a representative of the appropriate hospital or regional office of the office of mental health, and such other persons as the

commissioners deem appropriate. The assessment shall include, but not be limited to, an evaluation of the mental health, health, psycho-social, rehabilitation and environmental needs of the person, and shall serve as the basis for the development and provision of an appropriate plan of care for such person.

h. Prior to a person's inclusion in the general waiver, the office of mental health and the local governmental unit as defined in section 41.03 of the mental hygiene law, shall undertake or arrange for the development of a written plan of care, including identification of service providers if known, for the provision of services in consultation with the individual and their family whenever clinically appropriate, consistent with the level of care determined by the assessment, in accordance with criteria established by the commissioner of mental health, in consultation with the commissioner. If a provider of services is identified in a written plan of care, such provider shall be designated pursuant to paragraph j of this subdivision. Such plan of care shall be reviewed by such commissioners and approved by the commissioner of mental health prior to the provision of services pursuant to the general waiver.

i. Home and community-based services which may be provided to persons specified in paragraphs b and c of this subdivision shall, in addition to those services otherwise authorized, include but are not limited to (i) case management services; (ii) clinical interventions; (iii) crisis services; (iv) social training; (v) rehabilitation services; (vi) counseling; (vii) respite services; (viii) medication therapy; (ix) partial hospitalization; (x) environmental modifications; (xi) educational and related services; (xii) medical social services; and other services included in the written plan of care developed pursuant to paragraph h of this subdivision.

j. The office of mental health, in conjunction with the social services district and the local governmental unit, shall designate who may provide the home and community-based services identified in paragraph i of this subdivision.

k. Notwithstanding any provision of this chapter other than subdivision six or seven of this section, or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraphs b and c of this subdivision, the income and resources of a responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision.

l. Before a person may participate in the general waiver specified in paragraph a of this subdivision, the social services district and the office of mental health shall determine that there is a reasonable expectation that the annual medical assistance expenditures for such person under the waiver would not exceed the expenditures for care in a hospital, as defined in subdivision ten of section 1.03 of the mental hygiene law, that would have been made had the waiver not been granted.

m. The commissioner, in conjunction with the commissioner of mental health, shall review the expenditure estimates determined by social services districts and the office of mental health, prior to the inclusion of any person in the general waiver.

n. Within one year of federal waiver approval, and on an annual basis thereafter, until such time as the waiver is fully implemented, the commissioner of mental health, in conjunction with the commissioner, shall report on the status of the general waiver to the governor, the legislature, including the respective chairpersons of the senate and assembly committees of mental health and the chairs of the senate finance and assembly ways and means committees and the director of the division of the budget. Such report shall specify the number of children included in the waiver, the geographic distribution of those included, health and mental health profiles, utilization and costs of services by region including costs avoided in residential treatment facilities and inpatient facilities operated by the office of mental health, the length of time the children have participated in the waiver and regional information on the status of waiting lists for waiver services and for services in residential settings, where appropriate. The report shall also provide follow-up information on children who have withdrawn from

the waiver, including data on residential program placements.

o. This subdivision shall be effective if, and as long as, federal financial participation is available for expenditures incurred under this subdivision.

p. Nothing herein shall be construed to create an entitlement to services under the approved general waiver implemented by the commissioner in accordance with this subdivision.

11. The commissioner of health shall, consistent with this title, make any necessary amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, in order to ensure federal financial participation in expenditures under subparagraphs twelve and thirteen of paragraph (a) of subdivision one of this section. Notwithstanding any other provision of law to the contrary, medical assistance under subparagraphs twelve and thirteen of paragraph (a) of subdivision one of this section shall be provided only to the extent permitted under federal law, if, for so long as, and to the extent that federal financial participation is available therefor.

12. (a) Notwithstanding any provision of law to the contrary, the commissioner of health, in consultation with the office of children and family services, shall develop and submit applications for waivers pursuant to section nineteen hundred fifteen of the federal social security act as may be necessary to provide medical assistance, including services not presently included in the medical assistance program, for persons described in paragraph (b) of this subdivision. If granted such waivers, the commissioner of health, on the advice and recommendation of the commissioner of children and family services, may authorize such persons to receive such assistance to the extent funds are appropriated therefor.

(b) Persons eligible for inclusion in the waiver program established by this subdivision shall be residents of New York state under the age of twenty-one years, who are eligible for care in a medical institution, who have had the responsibility for their care and placement transferred to the local commissioner of a social services district or to the office

of children and family services as adjudicated juvenile delinquents under article three of the family court act, where placement is in a non-secure setting, and who:

(i) have a diagnosis of a mental disorder under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders;

(ii) have a diagnosis of a developmental disability as defined in section 1.03 of the mental hygiene law; or

(iii) have a physical disability.

(c) Services which may be provided to persons specified in paragraph (b) of this subdivision, in addition to services otherwise authorized, may include but are not limited to:

(i) services that will permit children to be better served, prevent institutionalization, and allow utilization at lower-levels of institutional care;

(ii) case management services;

(iii) respite services;

(iv) medical social services;

(v) nutritional counseling;

(vi) respiratory therapy;

(vii) home adaptation and/or environmental modifications;

(viii) clinical interventions;

(ix) crisis services;

(x) social training;

(xi) habilitation and rehabilitation services;

(xii) counseling;

(xiii) medication therapy;

(xiv) partial hospitalization;

(xv) educational and related services; and

(xvi) other services included in the written plan of care.

(d) Notwithstanding any provision of this chapter or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph (b) of this subdivision, the income and resources of a legally responsible relative shall not be deemed available for as long as the person meets the criteria specified in this subdivision; provided, however, that such income shall continue to be deemed unavailable should responsibility for the care and placement of the person be returned to his or her parent or other legally responsible

person.

(e) Before a person may participate in the waiver program established by this subdivision, the social services district that is fiscally responsible for the person shall determine that there is a reasonable expectation that annual medical assistance expenditures for such person will not exceed federal requirements.

(f) The eligibility and benefits authorized by this subdivision shall be applicable if, and as long as, federal financial participation is available for expenditures incurred under this subdivision. The eligibility and benefits authorized by this subdivision shall not apply unless all necessary approvals under federal law and regulation have been obtained to receive federal financial participation in the costs of services provided pursuant to this subdivision.

(g) Nothing in this subdivision shall be construed to create an entitlement to services under the waiver program established by this subdivision.

(h) A person participating in the waiver program established by this subdivision may continue participation in the program until it is no longer consistent with the plan of care, or until age twenty-one, whichever occurs earlier, notwithstanding the person's status as having been discharged from the care and placement of the local commissioner of a social services district or the commissioner of children and family services, including adoption or participation in the kinship guardianship assistance program under title ten of article six of this chapter.

13. The commissioner of health, in consultation with the commissioner of the office of children and family services, shall make any available amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or, if an amendment is not possible, develop and submit an application for any waiver under the federal social security act that may be available to provide medical assistance for those children receiving kinship guardianship assistance payments under title ten of article six of this chapter who are not automatically eligible for such medical assistance under title IV-E of the federal social security act.

14. The commissioner of health may make any available amendments to the state plan for medical assistance submitted pursuant to section three hundred sixty-three-a of this title, or, if an amendment is not possible, develop and submit an application for any waiver or approval under the federal social security act that may be necessary to disregard or exempt an amount of income, for the purpose of assisting with housing costs, for individuals receiving coverage of nursing facility services under this title, other than short-term rehabilitation services, and for individuals in receipt of medical assistance while in an adult home, as defined in subdivision twenty-five of section two of this chapter, who: are (i) discharged to the community; and (ii) if eligible, enrolled or required to enroll and have initiated the process of enrolling in a plan certified pursuant to section forty-four hundred three-f of the public health law; and (iii) do not meet the criteria to be considered an "institutionalized spouse" for purposes of section three hundred sixty-six-c of this title.

15. The commissioner may contract with one or more entities to engage in education, outreach services, and facilitated enrollment activities for aged, blind, and disabled persons who may be eligible for coverage under this title.

16. (a) The commissioner of health is authorized to submit the appropriate waivers and/or any other required requests for federal approval, including but not limited to, those authorized in section eleven hundred fifteen of the federal social security act, in order to establish expanded medical assistance eligibility for working disabled individuals. Such waiver applications shall be executed consistent with paragraphs (b), (c), (d) and (e) of this subdivision, to the extent those sections comply with the requirements of section eleven hundred fifteen of the federal social security act. Notwithstanding subparagraphs five and six of paragraph (c) of subdivision one of this section and subdivision twelve of section three hundred sixty-seven-a of this title, or any other provision of law to the contrary, if granted such waiver, the commissioner of health may authorize eligible persons to receive medical assistance pursuant to the waiver if, for so long as, and to the extent that, financial participation is available therefor.

The waiver application shall provide for thirty thousand persons to be eligible to participate in such waiver.

(b) Individuals eligible for participation in such waiver shall:

(i) be a disabled individual, defined as having a medically determinable impairment of sufficient severity and duration to qualify for benefits under Titles II or XVI of the social security act;

(ii) be at least sixteen years of age;

(iii) be otherwise eligible for medical assistance benefits, but for earnings and/or resources in excess of the allowable limit;

(iv) have net available income, determined in accordance with subdivision two of this section, that does not exceed two thousand two hundred fifty percent of the applicable federal poverty line, as defined and updated by the United States department of health and human services;

(v) have resources, as defined in paragraph (e) of subdivision two of section three hundred sixty-six-c of this title, other than retirement accounts, that do not exceed three hundred thousand dollars;

(vi) contribute to the cost of medical assistance provided pursuant to this paragraph in accordance with paragraph (d) of this subdivision; and

(vii) meet such other criteria as may be established by the commissioner as may be necessary to administer the provisions of this subdivision in an equitable manner.

(c) An individual at least sixteen years of age who: is employed; ceases to be eligible for participation in such waiver pursuant to paragraph (b) of this subdivision because the person, by reason of medical improvement, is determined at the time of a regularly scheduled continuing disability review to no longer be certified as disabled under the social security act; continues to have a severe medically determinable impairment, to be determined in accordance with applicable federal regulations; and contributes to the cost of medical assistance provided pursuant to this paragraph in accordance with paragraph (d) of this subdivision, shall be eligible for participation in such waiver. For purposes of this paragraph, a person is considered to be employed if the person is earning at least the applicable minimum wage under section six of the federal fair labor standards act and working at least forty hours per month.

(d) Prior to receiving medical assistance pursuant to such waiver, a

person whose net available income is greater than or equal to two hundred fifty percent of the applicable federal poverty line shall pay a monthly premium, in accordance with a procedure to be established by the commissioner, provided that no enrollee shall pay a monthly premium that exceeds exceed eight and one-half percent of the enrollee's monthly income. The amount of such premium for a person whose net available income is greater than or equal to two hundred fifty percent of the applicable federal poverty line, but less than three hundred percent of the applicable federal poverty line shall be three hundred and forty-seven dollars but shall not exceed four percent of the enrollee's monthly income. The amount of such premium for a person whose net available income is greater than or equal to three hundred percent of the applicable federal poverty line, but less than four hundred percent of the applicable federal poverty line shall be five hundred eighteen dollars but shall not exceed six percent of the enrollee's monthly income. The amount of such premium for a person whose net available income is greater than or equal to four hundred percent of the applicable federal poverty line, but less than five hundred percent of the applicable federal poverty line shall be seven hundred and seventy-nine dollars but shall not exceed eight and one-half percent of the enrollee's monthly income. The amount of such premium for a person whose net available income is equal to or greater than five hundred percent of the applicable federal poverty line shall be one thousand thirty-three dollars but shall not exceed eight and one-half percent of the enrollee's monthly income. No premium shall be required from a person whose net available income is less than two hundred fifty percent of the applicable federal poverty line.

(e) Notwithstanding any other provision of this section or any other law to the contrary, for purposes of determining medical assistance eligibility for persons specified in paragraph (b) or (c) of this subdivision, the income and resources of responsible relatives shall not be deemed available for as long as the person meets the criteria specified in this subdivision.