

Secretary of State
Certificate and Order for Filing
PERMANENT ADMINISTRATIVE RULES

I certify that the attached copies* are true, full and correct copies of the PERMANENT Rule(s) adopted on June 30, 2006 by the

Department of Human Services - Children, Adults and Families 461
Agency and Division Administrative Rules Chapter Number

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Rules Coordinator Address Telephone

to become effective July 1, 2006. Rulemaking Notice was published in the May 2006 *Oregon Bulletin*.**

RULE CAPTION

Changing OARs affecting public assistance, medical assistance or food stamp clients
Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.

FILED
JUN 30 2006
ARCHIVES DIVISION SECRETARY OF STATE

RULEMAKING ACTION

- ADOPT:** 461-145-0022, 461-145-0108, 461-155-0175, 461-155-0180
- AMEND:** 461-025-0310, 461-025-0315, 461-105-0190, 461-110-0110, 461-110-0370, 461-110-0410, 461-110-0630, 461-115-0210, 461-135-0095, 461-135-0096, 461-135-0505, 461-135-0730, 461-135-0830, 461-135-1110, 461-140-0040, 461-140-0210, 461-140-0220, 461-140-0242, 461-140-0296, 461-140-0300, 461-145-0020, 461-145-0088, 461-145-0180, 461-145-0220, 461-145-0250, 461-145-0310, 461-145-0330, 461-145-0340, 461-155-0030, 461-155-0150, 461-155-0225, 461-155-0250, 461-160-0055, 461-160-0415, 461-160-0580, 461-160-0620, 461-165-0030, 461-170-0025, 461-170-0103, 461-175-0220, 461-175-0230, 461-180-0080, 461-190-0195, 461-195-0511, 461-195-0521, 461-195-0561
- REPEAL:** 461-110-0630(T), 461-135-0095(T), 461-135-0096(T), 461-140-0295, 461-155-0030(T), 461-155-0150(T), 461-155-0175(T), 461-160-0580(T)

ORS 183.341, 409.050, 410.070, 411.060, 411.070, 411.095, 411.101, 411.660, 411.710, 411.816, 414.032, 414.042, 414.342, 418.100

Stat. Auth.

7 CFR 272.4(e); 7 CFR 273.1 (b)(4); 7 CFR 273.9(c)(1)(vii); 7 CFR 273.9(d); 7 CFR 273.10(c)(2)(ii); 7 CFR 273.10(d)(3); 7 CFR 273.12; 7 CFR 273.13(b)(11); 7 CFR 273.15(g); 20 CFR 416.112(d); 28 CFR 35.101 et seq.; 45 CFR Parts 98 & 99; 7 U.S.C. 2012(h); 7 U.S.C. 2014(e); 7 U.S.C. 2015 (c)(1); 7 U.S.C. 2020(e); Social Security Act § 1925, 42 U.S.C. 1396r-6; 42 USC 12132; Centers for Medicare and Medicaid Services, State Medicaid Manual § 3308 and 3258.10; Sections 1612(a)(2)(F) and 1902(a)(10)(E)(iv) of the Social Security Act; 42 USC 1396a(a)(10)(E)(iv) as amended by Section 101 of Public Law 109-91, the "QI, TMA, and Abstinence Programs Extension and Hurricane Katrina Unemployment Relief Act of 2005"; Sections 1634(c) and 1935(a)(2)(D) of the Social Security Act; P.L. 99-643; Employment Opportunities for Disabled Americans Act of 1986; Social Security Program Operations Manual System (POMS) section SI 00815.050; Food and Nutrition Services Administrative Notices 04-21 and 04-39; Medicare Modernization Act; Section 711 of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360); Americans with Disabilities Act of 1990; Section 504 of the Rehabilitation Act of 1973; Section 1924 of the Social Security Act (42 U.S.C. 1396r-5(d)) as amended by the Deficit Reduction Act (DRA) of 2005 (sections 6011, 6012, 6013, 6014, and 6016)

Other Authority

ORS 183.341, 409.050, 410.070, 411.060, 411.070, 411.095, 411.099, 411.101, 411.117, 411.122, 411.630, 411.632, 411.635, 411.660, 411.700, 411.710, 411.816, 414.032, 414.042, 414.342, 418.100

Stats. Implemented

SSP 10-2006

RULE SUMMARY

OAR 461-025-0310 about hearing requests is being amended to implement HB 3268 on the subject of hearings for reduction or termination of services. This rule is also being amended to reflect current federal regulations regarding the time period for requesting hearings for the Food Stamp program.

OAR 461-025-0315 is being amended so that clients who are older adults or people with physical disabilities who receive Medicaid paid Title XIX Home and Community based care waived services will be have a right to an expedited hearing on the denial of the continuation of their services while they are waiting for a non-expedited hearing on an action by the Department. This change gives the client access to an immediate review of a Department denial to maintain the individual's services at the current level in the period between a hearing request and a non-expedited hearing on the Department's proposed action.

OAR 461-105-0190 is being amended so that the rule is consistent with the new Department-wide rules about prohibiting discrimination against individuals with disabilities.

OAR 461-110-0110 is being amended to clarify the definitions of a standard living arrangement and nonstandard living arrangements. These terms are primarily used in the eligibility rules for the Food Stamp, OSIP, and OSIPM programs.

OAR 461-110-0370 is being amended to follow federal food stamp regulations which state that a person in foster care, along with their spouse or a child under age 22 and living with them, may only receive food stamps if their foster care provider applies for benefits for them.

OAR 461-110-0410 is being amended to clarify who is considered a member of the filing group for the OSIP (Oregon Supplemental Income Program) and OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities) programs. The circumstances of members of a filing group are considered in the eligibility determination process.

OAR 461-110-0630 is being amended to make permanent temporary rule amendments that became effective on April 1, 2006. These amendments establish that the need group for the Extended Medical Assistance (EXT) program consists of all members of the EXT financial group. The income and resources of members of a financial group count toward determining eligibility. The basic and special needs of members of a need group are considered in determining eligibility.

OARs 461-115-0210 and 461-180-0080 are being amended to clarify the application processing time frames and the effective dates for starting benefits in the Food Stamp at certification and recertification.

OAR 461-135-0095 is being amended to make permanent temporary rule amendments that became effective on April 1, 2006. These amendments change the eligibility requirements for the Extended Medical Assistance (EXT) program as follows: to incorporate a requirement that a filing group must have been found eligible for and received Medical Assistance Assumed (MAA) or Medical Assistance to Families (MAF) for at least three of the six months prior to the beginning date of the EXT eligibility period; to require that the filing group must meet certain employment, earnings, and reporting requirements to continue EXT eligibility beyond six months; to clarify that a filing group may become eligible for EXT due to a combination of increased earnings and increased child support; and to clarify that EXT eligibility is limited to members of the MAA or MAF benefit group when those benefits ended. The filing group is the people whose circumstances are considered in the eligibility determination process.

OAR 461-135-0096 is being amended to make permanent temporary rule amendments that became effective on April 1, 2006. These amendments indicate that the eligibility period for the Extended Medical Assistance (EXT) program which results from an increase in the earnings of the caretaker relative is six months, and may be

extended for up to an additional six months if the filing group meets certain employment, earnings, and reporting requirements. The filing group is the people whose circumstances are considered in the eligibility determination process. This rule is also being amended to clarify specific situations in which eligibility for EXT is characterized as based on increased earnings.

OARs 461-135-0505, 461-155-0150, 461-155-0225, and 461-195-0561 are being amended to reference the new income standard rule (OAR 461-155-0180) instead of referencing other rules or repeating income standards. OAR 461-155-0180 is being adopted to identify the current poverty level monthly income standard as well as other monthly income standards that are based on this poverty level income standard. These income standards determine eligibility for some public assistance and medical assistance programs. This approach will eliminate some \$1 discrepancies between some programs for these income standards. OAR 461-155-0150 is also being amended to set the eligibility standard in the Employment Related Day Care (ERDC) program for need groups larger than eight at the standard for need groups of eight (currently \$4,200 per month).

OAR 461-135-0730 is being amended to re-open the QI-1 program in Oregon. These changes were originally adopted by temporary rule in February 2006. QI-1 is a program that pays the Part B Medicare premium for eligible clients. Each state has a fixed allocation from the federal government to pay these premiums. In April 2004, the program was closed to new clients because Oregon exceeded its allocation. Subsequently, the number of individuals in the program dropped (from 5,800 to 4,100). Starting in February 2006, a new allocation allowed the Department to have significantly more clients (about 6,100 depending on the application rate) enrolled. The allocation has recently risen from \$4,424,000 to \$5,339,000 and is 100% federal funding for the program benefits. These two changes allowed the Department to open the program once again.

OAR 461-135-0830, which concerns eligibility for disabled adult children in the OSIPM program (Oregon Supplemental Income Program Medical, providing medical coverage for elderly and disabled individuals) is being amended to incorporate the language from federal law to clarify who is considered an adult disabled child.

OAR 461-135-1110, concerning the eligibility requirements for students in the OHP-OPU program (Oregon Health Plan for adults who qualify with incomes below 100 percent of the poverty standard), is being amended to update the years for which the Student Aid Report may be used in the eligibility process. The 2006-2007 eligibility standard based on the amount of expected family remains unchanged from 2005-2006.

OAR 461-140-0040 and 461-145-0088 are being amended to resolve potential conflicts between the two rules about whether certain expenditures by a business entity on behalf of a principal may be considered for determining the eligibility of a client for the Oregon Health Plan (OHP), and for all programs whether certain income may be considered for eligibility purposes if held by a corporation to which a member of financial group has a legal right. OAR 461-140-0040 is also being amended to indicate for the OHP and ERDC (Employment or Education-Related Day Care) programs the situations in which money withheld or returned to the source are considered available income for eligibility purposes. OAR 461-145-0088 is also being amended to include certain expenditures by a business entity on behalf of a principal as available income for clients of the Food Stamp program and to describe how income from business entities and corporations is treated in the Food Stamp program.

OAR 461-140-0210 concerning the GA (General Assistance, currently closed), GAM (General Assistance Medical, currently closed), OSIP (Oregon Supplemental Income Program), OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and QMB (Qualified Medicare Beneficiaries) programs is being amended to clarify the rule, make the rule consistent with other rules, remove unnecessary language, and implement a 60-month look back period for all transfers of assets that occur on or after July 1, 2006. This amendment expands the situations in which a transfer of resources will disqualify an individual from program eligibility.

OAR 461-140-0220 is being amended to clarify the rule, cross-reference the new rule (461-145-0022) about annuities affecting clients of OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and clarify when the purchase of an annuity on or after July 1, 2006 is a transfer of resources that disqualifies a client from eligibility.

OAR 461-140-0242, which identifies transfers of resources that disqualify clients from some public and medical assistance programs, is being amended to clarify the strength of the presumption that an action was taken in order to maintain eligibility if a Medicaid recipient transfers an excluded resource (such as a home or other real property) for less than fair market value. The rule is also being rewritten and reorganized to merge duplicative provisions.

OAR 461-140-0295 -- concerning the groups that filed an application for benefits between October 1, 1993, and September 30, 1998 for the GA (General Assistance, currently closed), GAM (General Assistance Medical, currently closed), OSIP (Oregon Supplemental Income Program), OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and QMB (Qualified Medicare Beneficiaries) programs -- is being repealed because there are no longer any clients affected by this rule. In addition, the one divisor amount that may still apply to calculating a disqualification penalty for a transfer of resources for less than fair market value is being moved to OAR 461-140-0296 where the other pertinent divisors are located.

OAR 461-140-0296 is being amended to extend the duration of disqualification from eligibility due to a resource transfer in the GA (General Assistance, currently closed), GAM (General Assistance Medical, currently closed), OSIP (Oregon Supplemental Income Program), OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and QMB (Qualified Medicare Beneficiaries) programs. This amendment establishes partial month penalties for disqualifying transfers of resources that do not currently exist; and for OSIPM clients who receive long-term care or home- or community-based services, states the penalty will be served either at the time the transfer was made or when the client would have been eligible for medical benefits but for the disqualifying transfer, whichever is later. In addition, one divisor amount for calculating a disqualification penalty for a transfer of resources for less than fair market value was moved from OAR 461-140-0295 which was repealed, to this rule.

OAR 461-140-0300 is being amended to establish criteria in the GA (General Assistance, currently closed), GAM (General Assistance Medical, currently closed), OSIP (Oregon Supplemental Income Program), OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and QMB (Qualified Medicare Beneficiaries) programs for deciding whether a disqualification penalty due to a transfer of resources must be waived because of the undue hardship it would cause for the client.

OAR 461-145-0020 -- concerning the treatment of annuities, interest, dividends, and royalties to determine eligibility for public assistance, medical assistance and food programs -- is being amended to reduce its scope to cover only annuities in programs other than OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities). This rule is also being amended to clarify certain terms such as annuity, commercial annuity, and child. The policies about the treatment of dividends, interest and royalties are being moved to a new rule (OAR 461-145-0108). The policies about the treatment of annuities for OSIPM clients are being moved to a new rule (OAR 461-145-0022).

OAR 461-145-0022 is being adopted to describe the policies about the treatment of annuities to determine eligibility for clients in the OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities) program. For OSIPM clients and spouses of these clients who purchase an annuity on or after July 1, 2006, there are stricter requirements than in the current rule (461-145-0020). The new rule requires a client and spouse to declare any annuity on each application and redetermination of eligibility. By signing the application, the client and spouse agree that the Department

becomes a remainder beneficiary on the annuity for providing medical benefits. For any annuity declared, the Department will notify the annuity issuer that the Department is a preferred remainder beneficiary. In order for an annuity to not be considered a disqualifying transfer of resources for the client and the spouse of the client, the annuity must name the Department as the first remainder beneficiary unless there is a spouse or minor child or child with a disability that meets the Social Security Administration (SSA) disability criteria to name as the first remainder beneficiary. In addition, in order for an annuity to not be considered a disqualifying transfer of resources for a client, it must be irrevocable and non-assignable, provide for payments in equal amounts over the annuitant's lifetime and be purchased from a business. In addition, in order for the annuity to not be considered a countable resource, the annuity must meet all of these criteria for both the client and the spouse of the client. For an OSIPM client (and their spouse) who receives long-term care or home- or community-based services and for all other OSIPM clients (and their spouses) who purchase an annuity prior to July 1, 2006, the new rule continues the requirements for OSIPM clients set out in OAR 461-145-0020 prior to this amendment.

OAR 461-145-0108 is being adopted to describe the policies about the treatment of dividends, interest, and royalties to determine eligibility for public assistance, medical assistance and food stamp programs in a separate rule from one that also covers annuities. These policies are being moved to this rule from OAR 461-145-0020.

OAR 461-145-0180 is being amended to ease the eligibility and client contribution requirements in the OSIP (Oregon Supplemental Income Program), OSIPM (Oregon Supplemental Income Program), and QMB (Qualified Medicare Beneficiaries) programs. This amendment will exclude from the income counted toward eligibility and client contribution requirements any family support payments distributed by state or local agencies to or on behalf of families who are caring for persons with extraordinary care needs in their home.

OAR 461-145-0220 is being amended to set out the new requirements about the treatment of home equity in determining eligibility for clients in the OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities) program who receive long-term or home- or community-based care services. Under these requirements (which take effect on July 1, 2006), a client whose initial application for services is on or after January 1, 2006 and who has a home with equity of \$500,000 or less is excluded (from consideration in determining eligibility) when the client resides there. A home with equity of more than \$500,000 is counted (to determine eligibility) unless a spouse or minor child or child with a disability that meets the SSA criteria resides there, or the property produces income consistent with its equity value that is essential to the client's self-support, or the client is legally unable to convert the home equity to cash. A client has a new initial application for services whenever there has been a break in assistance of at least one full calendar month.

OAR 461-145-0250 is being amended to clarify that an individual that rents out a room or other space will have that space considered as income-producing property. This rule is also being amended to indicate that income-producing property is excluded as a resource in the Food Stamp program if its value is under \$1,500. This rule is also being amended to treat income-producing property for grandfathered OSIP and OSIPM clients in the same manner as other OSIP and OSIPM clients. It is also being reorganized for easier reading.

OAR 461-145-0310 is being amended to clarify the rule and to implement the new requirements about the treatment of life estates in determining eligibility for clients in the OSIP (Oregon Supplemental Income Program), OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and QMB (Qualified Medicare Beneficiaries) programs. Under these requirements, if a client purchases an interest in a life estate in another person's home on or after July 1, 2006, the transaction is a disqualifying transfer of resources, unless the purchaser lives in the home for at least 12 consecutive months after the date of the purchase.

OAR 461-145-0330 is being amended to clarify the rule and to implement the new requirements about the treatment of loans and loan payments for purposes of determining eligibility for the in the GA (General Assistance, currently closed), GAM (General Assistance Medical, currently closed), OSIP (Oregon

Supplemental Income Program), OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and QMB (Qualified Medicare Beneficiaries) programs. Under these requirements, if a client purchases a promissory note, loan or mortgage, the transaction is considered a disqualifying transfer of resources unless the repayment plan occurs over the client's lifetime in equal installments and does not have a provision for cancellation if the client should die. The penalty for a transaction that does not meet these requirements is to count the entire balance of the payments owing as a disqualifying transfer of resources that may result in a penalty period. After the penalty period has been served, the entire balance owing is counted as an available resource for purposes of eligibility.

OAR 461-145-0340 is being amended to treat lodger income as self-employment income in all medical and public assistance programs to provide program simplification and adherence to the federal guidelines related to income. In the current rule, this income is excluded for Medicaid and public assistance; this amendments will count the income for eligibility purposes.

OAR 461-155-0030 is being amended to raise the Adjusted Income/Payment Standard for the TANF, MAA, MAF, REF and SAC programs. The payment standard for these programs is being increased by 2.4% effective April 1, 2006. This standard is used as the adjusted income limit and to calculate cash benefits for need groups with an adult.

OAR 461-155-0150 is also being amended to implement a legislatively approved 2.4 percent cost of living adjustment for child care providers in the ERDC (Employment or Education-Related Day Care), JOBS, JOBS Plus, and TANF programs.

OAR 461-155-0175, "Income Standard; EXT", is being adopted to make permanent a temporary rule adopted effective April 1, 2006. This rule establishes income standards or limits that apply to eligibility for the Extended Medical Assistance (EXT) program.

OAR 461-155-0250 is being amended to correct the earnings standard for attachment to the workforce for the OSIP-EPD and OSIPM-EPD programs.

OAR 461-160-0055 is being amended to remove language that allows a deduction for the cost of the Medicare-approved Drug Discount card. The Medicare-approved Drug Discount card expires May 15, 2006.

OAR 461-160-0415 about medical deductions in the Food Stamp program is being amended to update its terminology and to change the policy on when to allow income deductions for unanticipated medical costs. The purpose of this amendment is to simplify policy on budgeting unanticipated medical costs for elderly clients and clients with disabilities, and to allow more of the medical cost to be deducted from countable income.

OAR 461-160-0580 – which concerns clients in the OSIP (Oregon Supplemental Income Program) and OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities) programs -- is being amended to be consistent with the new federal requirement that available income of the Medicaid client receiving long term care or home- or community-based services (after required deductions for personal needs, etc.) and income of the spouse of the client must be used to meet the spouse's monthly maintenance needs before any additional resources may be transferred to the spouse to generate interest income to meet the need. This amendment makes permanent a temporary rule amendment adopted in March of 2006. Prior to enactment of the Deficit Reduction Act of 2005, using the income first was optional. Under the new federal law, using income first is mandatory in all situations. Although the Department's calculation for the needs of the spouse of the client used income first, court actions filed by attorneys on behalf of spouses for transfers of resources and spousal support orders were not required to use income first.

OAR 461-160-0620 is being amended to make a required, annual adjustment to the income protection requirements for Medicaid offered to married couples where one spouse remains at home. The amount of protection is based on 150% of the federal poverty level for a two person household.

OAR 461-165-0030 is being amended to clarify that no person in a filing group for cash, medical, or food stamp benefits is allowed duplicate benefits in the same month.

OAR 461-170-0025 is being amended to indicate that clients in the EXT (Extended Medical) program are required to report a change in school status for children in the benefit group who are age 18.

OAR 461-170-0103 is being amended to describe more accurately when the Department closes or reduces benefits to Food Stamp clients in response to changes that a client is required to report, including income exceeding the allowed limit.

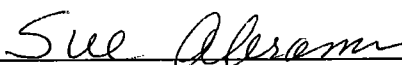
OAR 461-175-0220 is being amended to clarify the rule and state new requirements for certain notices of disqualification of clients in the GA (General Assistance, currently closed), GAM (General Assistance Medical, currently closed), OSIP (Oregon Supplemental Income Program), OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities), and QMB (Qualified Medicare Beneficiaries) programs. Under these new requirements, a notice of a disqualification due to a transfer of resources for less than fair market value will advise the client that they (or the facility in which they reside on their behalf) may apply for a hardship waiver.

OAR 461-175-0230 – which concerns the types of decision notices required for clients of all public assistance, food stamp, and medical assistance programs who are in a nonstandard living situation -- is being amended to clarify the rule, remove outdated language, keep the rule consistent with pending amendments to OAR 461-110-0110, modify the situations in which no decision notice is required in the Food Stamp program, describe the type of decision notice that applies when benefits are suspended, and add unique requirements that apply to the OSIP (Oregon Supplemental Income Program) and OSIPM (Oregon Supplemental Income Program Medical, providing medical coverage to the elderly and individuals with disabilities) programs.

OAR 461-190-0195 is being amended to make changes to the DCI (JOBS Program Degree Completion Initiative) application process.

OAR 461-195-0511 is being amended to update and clarify the rule and to include language to protect individuals from a child care overpayment when an aspect of a documented disability caused the overpayment and the individual would have otherwise been eligible.

OAR 461-195-0521 which concerns the special rules for calculating overpayments -- is being amended to clarify the rule, remove outdated language, and identify what is included in the overpayment calculation for clients who receive benefits in the OSIPM program (Oregon Supplemental Income Program Medical, medical coverage for elderly and disabled individuals) and do not pay their share of the costs of service.


Authorized Signer

Sue Abrams
Printed Name

6/14/06
Date

* With this original, file one photocopy of certificate one paper copy of rules listed in Rulemaking Actions, and electronic copy of rules.

** The *Oregon Bulletin* is published on the 1st of each month and updates the rule text found in the Oregon Administrative Rules Compilation. Notice forms must be submitted to the Administrative Rules Unit, Oregon State Archives, 800 Summer Street NE, Salem, Oregon 97310 by 5:00 pm on the 15th day of the preceding month unless this deadline falls on a Saturday, Sunday or legal holiday when Notice forms are accepted until 5:00 pm on the preceding workday.

ARC 930-2005

461-025-0310

Hearing Requests

- (1) A claimant has the right to a contested case hearing in the following situations upon the timely completion of a request for hearing:
- (a) The Department has not acted on a request or application for public assistance within 45 days of the application.
 - (b) The Department has not acted timely on an application as follows:
 - (A) An application for food stamps — within 30 days of the filing date.
 - (B) An application for a JOBS support service payment—within the time frames established in OAR 461-115-0190(3).
 - (c) The Department acts to deny, reduce, close, or suspend food stamp benefits, a *grant of public assistance*, a *grant of aid*, a support service payment authorized in the JOBS program by OAR 461-190-0211, medical assistance, or child care benefits authorized under Division 160 or 165 of this chapter of rules in the ERDC or TANF child care programs. When used in this subsection, *grant of public assistance* and *grant of aid* mean the grant of cash assistance calculated according to the client's need.
 - (d) The Department claims that an earlier public assistance payment was an overpayment, or that an earlier issuance of food stamps was an overissuance.
 - (e) The claimant claims that the Department previously underissued public assistance or food stamps and the Department denies the claim.
 - (f) The household disputes its current level of food stamp benefits.
 - (g) The filing group is aggrieved by any action of the Department that affects the participation of the filing group in the Food Stamp program.
 - (h) The claimant asks for a hearing to determine if the waiver of an Intentional Program Violation hearing was signed under duress.
 - (i) The Department establishes or changes the client's premium for the Oregon Health Plan.
 - (j) In the Assessment program, the Department denies payment for a basic living expense (see OAR 461-135-0475).
 - (k) The right to a hearing is provided for the TA-DVS program (see OAR 461-135-1235).
 - (l) A service re-assessment of a client conducted in accordance with OAR Division 411-015 has resulted in a reduction or termination of Nursing Home services, *Home and Community Based Care Waivered Services* (defined at OAR 411-015-0005), Spousal Pay services (see OAR 411-030-0080), or Independent Choices services (see OAR Division 411-036).
 - (m) The right to a hearing is otherwise provided by statute or rule.
- (2) A client is not entitled to a hearing on the question of the contents of a *case plan* (defined in OAR 461-190-0151) unless the right to hearing is specifically authorized by the Department's rules. For a dispute about an activity in the JOBS program, the client is entitled to use the Department's conciliation process (see OAR 461-190-0231).
- (3) There is no right to a hearing to dispute a program requirement established by law. Examples are the closure of a program or a change to a payment standard.
- (4) A request for hearing is complete:
- (a) In public assistance programs, when the Department's Administrative Hearing Request form (form DHS 443) is completed and signed by the claimant or the claimant's representative and is received by the Department.
 - (b) In the Food Stamp program when—

- (A) The Department receives the claimant's oral or written statement that he or she wishes to appeal a decision affecting the claimant's food stamp benefits to a higher authority; or
 - (B) The Department's Administrative Hearing Request form (form DHS 443) is completed and signed by the claimant or the claimant's representative and is received by the Department.
 - (c) In the case of a provider of child care, when a written request for hearing from the provider is received by the Department.
 - (5) In the event a request for hearing is not timely, the Department will determine whether the failure to timely file a request for hearing was beyond the reasonable control of the party and enter an order accordingly. The Department may refer an untimely request to the Panel for a hearing on the question of timeliness.
 - (6) In the event the claimant has no right to a contested case hearing on an issue, the Department may enter an order accordingly. The Department may refer a hearing request to the Panel for a hearing on the question of whether the claimant has the right to a contested case hearing.
 - (7) To be timely, a completed hearing request must be received by the Department not later than:
 - (a) The 45th day following the date of the decision notice in public assistance and medical programs.
 - (b) The 90th day following the date of the decision notice in the Food Stamp program, except:
 - (A) A filing group may submit a hearing request at any time within a certification period to dispute its current level of benefits.
 - (B) A filing group may submit a hearing request within 90 days of the denial of a request for restoration of benefits if less than one year has expired since the loss of benefits.
 - (c) The 30th day following the date of notice from the Oregon Department of Revenue in cases covered by ORS 293.250.
 - (d) In a case described in section (1)(h) of this rule, the request must be made within 90 days of the date the waiver was signed.
 - (8) In determining timeliness under section (7) of this rule, delay caused by circumstances beyond the control of the claimant is not counted.
 - (9) In computing the time periods provided by this rule, if the last day of the time period falls on a Saturday, Sunday, or legal holiday, the period is extended until the next working day.
- Stat. Auth.: ORS 411.060, 411.816, 418.100
 Stats. Implemented: ORS 411.060, 411.095, 411.816, 414.055, 418.100, 418.125

461-025-0315

Expedited Hearings

- (1) A claimant has the right to an expedited hearing in each of the following situations:
 - (a) The Department denies or fails to issue a timely decision on claimant's request for TA-DVS or emergency assistance.
 - (b) The claimant contests the form or amount of a TA-DVS or an emergency assistance payment.
 - (c) The claimant has the right to a hearing over a reduction, suspension, or closure and disagrees with the Department's decision to deny the continuation of one or more of the following pending a requested hearing:
 - (A) Cash benefits.
 - (B) Food stamp benefits.
 - (C) Medical benefits.

(D) Nursing Home, Title XIX Home and Community Based Care waived, Spousal Pay, or Independent Choices Program services that have been reduced or closed as a result of a service re-assessment conducted in accordance with OAR Division 411-015.

(d) The claimant's request for expedited food stamp service is denied, or the claimant is aggrieved by an action of the Department that affects the expedited participation of the household in the Food Stamp program.

(e) In the JOBS program, the Department denies an application for a support service payment or a payment for a basic living expense authorized by OAR 461-190-0211, or the Department reduces or closes a support service payment authorized by OAR 461-190-0211, or the Department does not issue a JOBS support service payment within the time frames required under OAR 461-115-0190.

(2) Public Assistance programs: An expedited hearing is a telephone hearing held within five working days of the Department's receipt of the written hearing request, unless the claimant requests more time. The claimant is entitled to reasonable notice of the hearing either through personal service or by certified mail. In the TANF program, if the claimant requests a face-to-face hearing, the hearing may be postponed or continued as necessary to accommodate the claimant. However, the hearing must be held not later than 21 days following the receipt by the Department of the request for hearing if the claimant lives within 100 miles of Salem, Oregon, and not later than 35 days in all other cases. The final order must be issued within three working days from the date the hearing closes.

(3) Food Stamp program: An expedited hearing is a telephone hearing held within five working days of the receipt of a verbal or written hearing request, unless the claimant requests more time. The claimant is entitled to reasonable notice of the hearing either through personal service or by certified mail. Following the expedited hearing, a final order must be issued not later than the ninth working day after the hearing was requested.

Stat. Auth.: ORS 411.060, 411.095, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.095, 411.099, 411.816, 418.100

461-105-0190

Discriminatory Actions

(1) The rules of the Department protecting individuals with disabilities against discrimination are set out at OAR 407-005-0000 to 407-005-0030.

(2) The following acts of discrimination on grounds of race, color, sex, political beliefs, age, religious creed or national origin are specifically prohibited:

(a) Denying an individual any service, financial aid, or other benefit provided under any program.

(b) Providing any service, financial aid, or other benefit to an individual that is different, or is provided in a different way, from that provided to others under the program, unless such action is necessary to provide individuals with disabilities with aids, benefits or services that are as effective as those provided to others.

(c) Subjecting an individual to segregation or separate treatment in any way related to receipt of any service, financial aid, or other program benefit.

(d) Restricting an individual in any way from any advantage or privilege enjoyed by others receiving any service, financial aid, or other benefit under any program.

(e) Treating an individual differently from others in determining whether they satisfy any admission, enrollment, quota, eligibility, membership or other requirement or condition

individuals must meet to be provided any service, financial aid, or other benefit provided under any program.

(f) Denying an individual an opportunity to participate in any program or afford them an opportunity to do so that is different from that afforded others under the program.

(g) Denying a person the opportunity to participate as a member of a planning or advisory body that is an integral part of the program.

Stat. Auth.: ORS 409.050, ORS 411.060, 411.070, 411.816, 418.100

Stats. Implemented: ORS 409.050, 411.060, 411.070, 411.816, 418.100

461-110-0110

Terms Used in Determining Eligibility

The following terms are used in the eligibility determination process:

(1) *Child* includes natural, step, and adoptive children. The term *child* does not include an unborn.

(a) For EXT, MAA, MAF, REFM, and TANF, the term *dependent child* means the following:

(A) A person who is not a caretaker relative of a child in the household, is unmarried or married but separated, and is under the age of 18, or 18 years of age and a full time student in secondary school or the equivalent level of vocational or technical training; or

(B) A minor parent whose parents have chosen to apply for benefits for the minor parent. This does not apply to a minor parent who is married and living with his or her spouse.

(b) For ERDC, a *child* need not have a biological or legal relationship to the caretaker but must be in the care and custody of the caretaker, must meet the citizenship or alien status requirements of OAR 461-120-0110, and must be:

(A) Under the age of 18; or

(B) Under the age of 19 and in secondary school or vocational training at least half time.

(c) For FS, a *child* is an adult and minor children living with their parent(s).

(d) For GA, GAM and OSIP, a *child* is a person under the age of 18.

(e) For OHP, *child* means a person, including a minor parent, under the age of 19.

(f) For OSIPM and QMB, *child* means an unmarried person living with a parent who is:

(A) Under the age of 18; or

(B) Under the age of 21 and attending full time secondary, post-secondary or vocational-technical training designed to prepare the person for employment.

(2) *Community-based care* is any of the following:

(a) Adult foster care - Room and board and 24-hour care and services for the elderly or for disabled people 18 years of age or older. The care is contracted to be provided in a home for five or fewer clients.

(b) Assisted living facility - A program approach, within a physical structure, which provides or coordinates a range of services, available on a 24-hour basis, for support of resident independence in a residential setting.

(c) In-home Services - People living in their home receiving services determined necessary by the Department.

(d) Residential care facility - A facility that provides residential care in one or more buildings on contiguous property for six or more individuals who have physical disabilities or are socially dependent.

(e) Specialized living facility - Identifiable services designed to meet the needs of persons in specific target groups which exist as the result of a problem, condition or dysfunction resulting

from a physical disability or a behavioral disorder and require more than basic services of other established programs.

(f) Independent choices - In-home Services recipients in demonstration sites who receive a cash benefit to coordinate in-home services under a section 1115 (42 U.S.C. 1315) demonstration waiver.

(3) *Custodial parents* means parents who have physical custody of their child(ren). Custodial parents may be receiving benefits as dependent children or as caretaker relatives for their own children.

(4) In the FS program, a *disabled* person or a person with a *disability* means a person who meets any of the following requirements:

(a) Receives SSI benefits under title XVI of the Social Security Act.

(b) Receives SSB benefits based on blindness or disability criteria under title I, II, X, XIV, or XVI of the Social Security Act.

(c) Receives OSIP or other state or federal supplement under section 1616(a) of the Social Security Act based on disability or blindness criteria.

(d) Receives state general assistance benefits based upon disability or blindness criteria under title XVI of the Social Security Act.

(e) Receives disability-related medical assistance under title XIX of the Social Security Act.

(f) Receives a state or federally administered supplemental benefit under section 212(a) of Public Law 93-66.

(g) Receives an annuity payment under Section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and is determined to be eligible for Medicare by the Railroad Retirement Board.

(h) Receives an annuity payment under Section 2(a)(1)(iv) of the Railroad Retirement Act of 1974 and meets the disability criteria used under title XVI of the Social Security Act.

(i) Receives VA benefits for non-service or service-connected disability rated or paid as total under title 38 of the United States Code.

(j) Receives disability retirement benefits from a governmental agency because of a disability considered permanent under section 221(i) of the Social Security Act.

(k) Has a disability considered permanent under 221(i) of the Social Security Act section and is the surviving spouse or surviving child of a veteran and considered by the VA to be entitled to compensation for a service-connected death or pension benefits for a non-service connected death under title 38 of the United States Code.

(l) Is a veteran or surviving spouse of a veteran considered by the VA to be in need of Aid and Attendance benefits or permanently housebound under title 38 of the United States Code.

(m) Is a surviving child of a veteran and considered permanently incapable of self-support under title 38 of the United States Code.

(5) *Disqualified* means an individual cannot receive program benefits because they have not cooperated in fulfilling some eligibility requirement. Actions that can disqualify an individual include not cooperating with JOBS, JOBS Plus or OFSET, failing to provide an SSN or failure to pursue assets. In some cases, a disqualified individual can make their filing group ineligible for benefits.

(6) *Domestic violence shelters* are public or private nonprofit residential facilities providing services to victims of domestic violence. If the facility serves other people, a portion must be used solely for victims of domestic violence.

(7) For FS, *elderly* means a person 60 years of age or older.

- (8) In the FS program, a person is *homeless* if the person does not have a fixed or regular nighttime residence or has a primary residence that is one of the following:
- (a) A supervised shelter that provides temporary accommodations.
 - (b) A halfway house or residence for people who may become institutionalized.
 - (c) A temporary accommodation in another person's or family's residence for 90 days or less.
 - (d) A place not designed to be or ordinarily used as a place for people to sleep, such as a hallway, bus station, or similar place.
- (9) *Ineligible* means a person cannot receive program benefits because they do not meet some eligibility requirement that is beyond their control; not because they refuse to fulfill the requirement. A person may be ineligible for benefits because of age, alien status, student status (for FS) or because a disqualified member of the filing group makes them ineligible.
- (10) *Long-term care* is the system through which the Department provides required financial benefits, specialized living arrangements, and a broad range of social and health services to eligible aged, blind or disabled adults for extended periods of time. This includes nursing homes and state hospitals (Eastern Oregon and Oregon State Hospitals).
- (11) *Marriage* means legal marriage uniting two people. Legal marriage is:
- (a) One recognized as legal by state statute of the state where the marriage occurred, including common-law marriage if recognized as legal in a state where the couple previously resided.
 - (b) A *cultural marriage* if it occurred in a country that recognizes it as legal.
- (12) For FS, a *migrant farmworker* is an individual who regularly travels away from their permanent residence overnight, usually with a group of laborers, to seek employment in an agriculturally related activity. If any member of an FS household fits the definition of migrant farmworker at any time during the redetermination period, budget the household according to the policy on migrant farmworkers.
- (13) A *nonstandard living arrangement* is defined as follows:
- (a) In the GA, GAM, OSIP, OSIPM, and QMB programs, a client is considered to be in a *nonstandard living arrangement* when the client is applying for or receiving services in any of the following locations:
 - (A) A nursing facility.
 - (B) An intermediate care facility for the mentally retarded (ICF/MR).
 - (C) A psychiatric institution, if the person is not yet 21 years of age or has reached the age of 65.
 - (D) A community-based setting covered by a waiver under Title XIX of the Social Security Act.
 - (b) In all programs except GA, GAM, OSIP, OSIPM, and QMB, a *nonstandard living arrangement* means each of the following locations:
 - (A) Foster care.
 - (B) Residential Care Facilities.
 - (C) Drug or Alcohol Residential Treatment Facilities.
 - (D) Homeless or Domestic Violence Shelters.
 - (E) Lodging house if paying for room and board.
 - (F) Correctional facilities.
 - (G) Medical institutions.
- (14) *Parent* means the biological or legal (step or adoptive) mother or father of a person or unborn child.
- (a) If the mother lives with a male and either she or the male claims that he is the father of the child or unborn, and no one else claims to be the father, he is treated as the father even if paternity has not been legally established.

(b) A stepparent relationship exists if:

(A) The person is legally married to the child's biological or adoptive parent; and

(B) The marriage has not been terminated by legal separation, divorce or death.

(c) A legal adoption erases all prior legal and blood relationships and establishes the adoptive parent as the legal parent. However, the biological parent is also considered a parent if both of the following are true:

(A) The child lives with the biological parent; and

(B) The legal parent (the adoptive parent) has given up care, control and supervision of the child.

(15) For all programs except FS, *primary person* means the filing group member who is responsible for providing information necessary to determine eligibility and calculate benefits.

The primary person for individual programs is as follows:

(a) For EXT, MAA, MAF and TANF, the parent or caretaker relative.

(b) For ERDC, the caretaker.

(c) For GA, GAM, OSIP, OSIPM and QMB, the client or their spouse.

(d) For OHP, REF and REFM, the applicant, caretaker, caretaker relative or parent.

(16) For FS, *primary person* means:

(a) An adult in the filing group who is designated by the group to serve as the primary person.

(A) A child of any age cannot be the primary person when more than one generation lives together, and an adult who is the parent or fulfilling the role of parent is employed, work-registered for FS or receiving TANF or UC.

(B) Where there is no adult, the group can designate another responsible person in the filing group.

(b) Once the primary person has been designated, the filing group cannot choose a different person to be the primary person during the same certification period or during an OFSET or job quit disqualification period, unless there is a change in the composition of the household group.

(17) *Safe homes* are private homes that provide a few nights lodging to victims of domestic violence. The homes must be recognized as such by the local domestic violence agency, such as crisis hot lines and shelters.

(18) For FS, *seasonal farmworkers* are people employed in agricultural employment of a seasonal or temporary nature. If any member of an FS household fits the definition of seasonal farmworker at any time during the redetermination period, budget the household according to policy on seasonal farmworkers. Seasonal farmworkers are not required to be absent overnight from their permanent residence when:

(a) Employed on a farm or ranch performing field work related to planting, cultivation, or harvesting operations; or

(b) Employed in a canning, packing, ginning, seed conditioning, or related research or processing operation, and transported to or from the place of employment by means of a day-haul operation.

(19) *Sibling* means the brother or sister of a person. "Blood-related" means they share at least one biological or adoptive parent. "Step" means they are not related by blood, but are related by the marriage of their parents.

(20) *Spouse* means a person who is legally married to another person. In the ERDC and FS programs, *spouse* includes a person who is not legally married to another, but is presenting themselves to the community as the husband or wife by:

(a) Representing themselves as husband and wife to relatives, friends, neighbors or tradespeople; and

(b) Sharing living expenses or household duties.

(21) *Standard living arrangement* means a location that does not qualify as a *nonstandard living arrangement*.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-110-0370

Filing Group; FS

In the Food Stamp program:

(1) Except as provided in this rule, the filing group is composed of members of a household group who customarily purchase and prepare meals together.

(2) Except as provided in sections (3), (6), and (7) and subsection (5)(b) of this rule, the following persons, if they are in the same household group, must be in the same filing group, even if they do not customarily purchase and prepare meals together:

(a) Each spouse.

(b) A *parent* (as defined in OAR 461-110-0110) and their child under age 22 who is living with them.

(c) A household group member and child under age 18 who lives with and is under *parental control* of that household group member. For the purposes of this subsection, *parental control* means the adult is responsible for the care, control, and supervision of the child or the child is financially dependent on the adult.

(3) Notwithstanding sections (1) and (2) of this rule, a person is excluded from the filing group if, during the month the group applied for food stamps, the person received food-stamp benefits or SSI benefits through the state of California that included food-stamp benefits. This exclusion applies only in the initial month and, if necessary to meet notice requirements, in the month following the initial month. This exclusion does not apply to a person who was the head of household in the prior household.

(4) The following persons may form a separate filing group if they purchase and prepare food with other members of the household group, unless they are required by section (2) of this rule to be in the same filing group:

(a) A paid live-in attendant and the attendant's minor children may choose not to be in the filing group with the people for whom they are providing services.

(b) An *elderly* person (as defined in OAR 461-110-0110) may be considered a separate filing group from the others with whom the *elderly* person purchases and prepares meals, if:

(A) The elderly person is unable to purchase and prepare food because of a permanent and severe disabling condition; and

(B) The combined income of the other members of the household group does not exceed the following limit:

Other Household Members	Monthly Countable Income
1	\$ 1,316
2	1,765
3	2,213
4	2,661
5	3,109
6	3,558

7	4,006
8	4,454
Each additional person	449

(5) The following persons who are paying to have meals provided are not eligible to participate in the Food Stamp program independently of the care or service provider. However, they may be included in the care or service provider's filing group if the provider chooses to apply for benefits for them.

(a) A person in foster care along with his or her spouse and each child under age 22 living with them.

(b) A member of the household group who pays the filing group a reasonable amount for room and board (lodger). A reasonable amount is:

(A) An amount that equals or exceeds the Thrifty Food Plan for the person and anyone in that person's filing group (see OAR 461-155-0190(2)), if more than two meals a day are provided; or

(B) An amount that equals or exceeds two-thirds of the Thrifty Food Plan for the person and anyone in that person's filing group, if two or fewer meals a day are provided.

(6) Notwithstanding section (2) of this rule, the following household group members may form a separate filing group from other members of the household group:

(a) A resident of an alcohol or drug treatment and rehabilitation program certified by the Department for which an employee of the facility is the authorized representative.

(b) A resident of a nonprofit public or private residential care facility.

(c) A resident of a homeless or domestic violence shelter.

(d) A member of the household group who is not paying the filing group a reasonable amount for room and board (lodger), as defined in subsection (5)(b) of this rule.

(7) The following household group members are excluded from the filing group:

(a) A resident of a commercial boarding house.

(b) An ineligible student, as defined in OAR 461-135-0570.

Stat. Auth.: ORS 411.816

Stats. Implemented: ORS 411.816

461-110-0410

Filing Group; OSIP, OSIPM, QMB

(1) In the OSIP and OSIPM programs (except OSIP-EPD, OSIPM-EPD, and OSIPM-IC):

(a) For applicants age 18 and older who live in a *standard living arrangement* as defined in OAR 461-110-0110, the filing group consists of applicants and the spouse of an applicant.

(b) For applicants who are under the age of 18 living in a *standard living arrangement* and are not assumed eligible, the filing group consists of applicants and each *parent* (defined in OAR 461-110-0110) of these applicants.

(2) In the OSIP and OSIPM programs (except OSIP-EPD, OSIPM-EPD, and OSIPM-IC), when people live in a *nonstandard living arrangement* as defined in OAR 461-110-0110, the filing group consists only of the person applying for benefits.

(3) In the OSIP-EPD, OSIPM-EPD, and OSIPM-IC programs, the filing group consists only of the person applying for benefits.

(4) In the QMB program, whether in a standard or nonstandard living arrangement, the filing group consists of applicants and the following household members:

(a) The spouse of an applicant.

(b) Each *parent* of children under age 21, if the children are applying and are not assumed eligible.

(c) Children under age 21, if the *parent* wants to include these children in the need group.

Stat. Auth.: ORS 411.060, 411.070, 414.042

Stats. Implemented: ORS 411.060, 411.070, 414.042

461-110-0630

Need Group

(1) In the MAA and TANF programs, the need group is formed as follows:

(a) Except as provided in section (1)(b) of this rule, the need group consists of the financial group members who meet all nonfinancial eligibility requirements other than the citizenship and alien status requirements of OAR 461-120-0110.

(b) The need group cannot include:

(A) A parent who is in foster care and for whom foster care payments are being made.

(B) An unborn child.

(C) In the TANF program, a person who cannot be in the need group because of a disqualification penalty.

(2) In the MAF program, the need group consists of the financial group members who meet all nonfinancial eligibility requirements, except for the following people:

(a) A parent who is in foster care and for whom foster care payments are being made.

(b) The father of an unborn child who has no eligible dependent children.

(3) In the EA, REF, and REFM programs, the need group consists of the financial group members who meet all nonfinancial eligibility requirements, except that members disqualified for an intentional program violation are not in the need group.

(4) In the EXT program, the need group consists of all members of the financial group.

(5) In the SAC program, the need group consists of the person in the financial group.

(6) In the ERDC program, the need group consists of each member of the financial group.

(7) In the FS program, the need group consists of the financial group members who meet all nonfinancial eligibility requirements, except the following people are not in the need group:

(a) A member disqualified for an intentional program violation.

(b) A client fleeing to avoid prosecution, or custody or confinement after conviction, under the law of the place from which the client is fleeing, for a crime that is a felony under the law of the place from which the client is fleeing or that, in the case of New Jersey, is a high misdemeanor under the law of New Jersey.

(c) A person violating a condition of parole or probation imposed under a state or federal law.

(8) In the GA and GAM programs, the need group consists of each member of the financial group except that the following people may not be in the need group:

(a) A client fleeing to avoid prosecution, or custody or confinement after conviction, or fleeing after trying to commit a crime, under the law of the place from which the client is fleeing, for a crime that is a felony under the law of the place from which the client is fleeing or that, in the case of New Jersey, is a high misdemeanor under the law of New Jersey.

(b) A person in violation of a condition of parole or probation imposed under a state or federal law.

(9) In the OHP program, the need group consists of each member of the financial group. An unborn child of a pregnant female is included in the need group.

(10) In the OSIP and OSIPM programs, the need group consists of each member of the financial group.

(11) In the QMB program, the need group consists of each member of the financial group, except for the following:

(a) A person who does not meet the citizenship or alien status requirements.

(b) A person disqualified from TANF for noncooperation in the JOBS program.

(c) A person disqualified for failure to meet the requirements of OAR 461-120-0345(2) or for not providing a social security number (SSN).

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-115-0210

Application Processing Time Frames; FS

(1) This rule applies in the Food Stamp program to an initial application and at recertification.

(2) The Department will determine eligibility and provide the benefit group the opportunity to participate as soon as possible. The application processing time frame for regular service is the 30 days immediately following the *filing date* (see OAR 461-115-0040) and not later than the 7th day following the *filing date* for expedited service.

(3) The application processing time frame for regular service includes:

(a) An interview as soon as possible but not later than 20 days after the *filing date* (see OAR 461-115-0230 regarding interviews);

(b) Completion of required verification; and

(c) The eligibility determination.

(4) The *filing date* remains effective for 60 days in both of the following situations:

(a) If the Department is not able to complete the application process within 30 days (for example, unable to schedule an interview by the 20th day following the filing date).

(b) If the applicant contacts the Department before the 30th day following the *filing date* and informs the Department that verification cannot be provided by the 30th day due to reasons beyond his or her control.

(5) If, for a reason within his or her control, the client fails to attend an interview by the 20th day following the *filing date*, and the interview occurs between the 20th and 30th days following the *filing date*, all verification must be provided not later than the 30th day following the *filing date*. If required verification is received after the 30th day, a new *filing date* is established as of the date the verification is received.

(6) If a client scheduled for an interview for expedited service fails to attend the interview without good cause, the client's application is processed for regular service.

Stat. Auth: ORS 411.816

Stats. Implemented: ORS 411.816

461-135-0095

Specific Requirements; EXT

(1) To be eligible for EXT benefits, at least one member of the filing group must have been eligible for and received MAA or MAF for at least three of the six months prior to the beginning date of the EXT eligibility period (see OAR 461-135-0096(3) to determine the beginning date), and then become ineligible because of---

(a) An increase in the earnings of the caretaker relative;

- (b) An increase in child support received; or
- (c) A combination of an increase in both the earnings of the caretaker relative and child support received.
- (2) If the filing group becomes ineligible for MAA or MAF when another change occurs in conjunction with the increase in earned income or child support, the filing group is not eligible for EXT if the other change, by itself, makes the group ineligible for MAA or MAF.
- (3) Eligibility for EXT is limited to the members of the MAA or MAF benefit group at the time that those benefits end.
- (4) Subject to the time periods established in OAR 461-135-0096(1):
 - (a) Once eligibility for EXT is established, members of the benefit group are ineligible if the filing group contains no dependent child.
 - (b) A benefit group may regain EXT eligibility after becoming ineligible, even if eligibility was lost due to moving out of state, whenever the group again meets EXT eligibility requirements.
 - (c) Persons who have lost EXT eligibility because they leave the household during the EXT eligibility period may regain eligibility when they return to the household.
- (5) For purposes of this rule, "good cause" means a circumstance beyond the reasonable control of the client.
- (6) To be considered for EXT benefits in the seventh month, unless *good cause* exists, the filing group must report the following information by the 21st day of the fourth month for each of the preceding three months:
 - (a) The gross earned income of the financial group; and
 - (b) Costs for child care necessary for the employment of the caretaker relative.
- (7) Unless *good cause* exists, to be considered for EXT benefits in the eighth through tenth months, all of the following requirements must be met:
 - (a) The filing group must have met the requirements of section (6) of this rule.
 - (b) By the 21st day of the seventh month, the filing group must report all of the following information for each of the preceding three months:
 - (A) The gross earned income of the financial group.
 - (B) Costs for child care necessary for the employment of the caretaker relative.
 - (c) The caretaker relative must have had earnings in each of the preceding three months of the EXT period.
 - (d) The average adjusted earned income of the financial group for the reporting period must be below 185% of the federal poverty level (see OAR 461-155-0175).
- (8) Unless *good cause* exists, to be considered for EXT benefits in the eleventh and twelfth months, all of the following requirements must be met:
 - (a) The filing group must have met the requirements of section (7) of this rule.
 - (b) By the 21st day of the tenth month, the filing group must report all of the following information for each of the preceding three months:
 - (A) The gross earned income of the financial group.
 - (B) Costs for child care necessary for the employment of the caretaker relative.
 - (c) The caretaker relative must have had earnings in each of the preceding three months of the EXT period.
 - (d) The average adjusted earned income of the financial group for the reporting period must be below 185% of the federal poverty level (see OAR 461-155-0175).

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-135-0096

Eligibility Period; EXT

(1) For a client who meets the eligibility requirements for EXT, the period of eligibility is one of the following:

(a) If eligibility for EXT results from increased child support, the period of eligibility is four months and may not be extended.

(b) If eligibility for EXT results from an increase in the caretaker relative's earnings:

(A) The period of eligibility is six months.

(B) The period of eligibility may be extended for no more than six additional months if the filing group meets the specific EXT requirements in OAR 461-135-0095 and the earned income of the filing group is below the EXT income standard in OAR 461-155-0175.

(2) The period of eligibility for EXT is based on the increase in the caretaker relative's earnings and is described in subsection (1)(b) of this rule in each of the following situations:

(a) A client meets the eligibility requirements for EXT based on an increase in the caretaker relative's earnings and also meets the eligibility requirements based on an increase in child support in the same month.

(b) A client meets the eligibility requirements for EXT based on a combination of increased income from the caretaker relative's earnings and child support, although either increase by itself does not make the filing group ineligible for MAA or MAF.

(3) The EXT eligibility period begins the first of the month following the month eligibility for MAA or MAF ends. If a benefit group received MAA or MAF benefits when they were eligible for EXT, the MAA or MAF benefits are not an overpayment. However, any month in which the client receives MAA or MAF benefits when eligible for EXT is counted as a month of EXT eligibility.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-135-0505

Categorical Eligibility for FS

(1) A person is categorically eligible for food stamps if the person:

(a) Receives or is authorized to receive GA or SSI benefits or cash benefits funded by TANF;

(b) Receives or is authorized to receive in-kind benefits or services funded by TANF;

(c) Is deemed to be receiving SSI under Section 1619(a) or 1619(b) of the Social Security Act (42 U.S.C. 1382h(a) or (b)); or

(d) Is a member of a financial group with *countable income* less than 185 percent of the federal poverty level as described in OAR 461-155-0180(5) – and has received a pamphlet about Information and Referral Services.

(2) A benefit or service is "funded by TANF" (*see* section (1) of this rule) if it is provided as part of the ADC-PLS, Assessment, EA, ERDC, JOBS, TA-DVS, transition, or other TANF-funded program.

(3) For an entire filing group to be categorically eligible for food stamps, it must contain only clients who are categorically eligible for food stamps. For the purpose of determining who is categorically eligible for food stamps, in some programs all members of the filing group are considered receiving the benefits of the program even if not all members receive the benefit.

Those programs are the ERDC and TA-DVS programs and any housing assistance or transition service funded by TANF.

(4) A filing group that is eligible for transition services or the TA-DVS program is considered receiving benefits for the entire period of eligibility even if benefits are not received during each month of that period.

(5) A person categorically eligible for the Food Stamp program is presumed to meet the eligibility requirements for resources and countable and adjusted income limits. The person is also presumed to meet the requirements for a social security number, sponsored alien information, and residency, if verified in a public assistance program.

(6) When a filing group contains both members who are categorically eligible for food stamps and those who are not, a resource owned in whole or in part by a categorically eligible member is excluded.

(7) A person cannot be categorically eligible for food stamps in either of the following circumstances:

(a) The person is disqualified from receiving food stamps because of an intentional program violation.

(b) The person is a *primary person* disqualified from receiving food stamps for failure to comply with an OFSET activity or component contained in an OFSET *case plan*.

Stat. Auth.: ORS 411.816

Stats. Implemented: ORS 411.816

461-135-0730

Specific Requirements; QMB

(1) The following requirements apply to QMB-BAS:

(a) To qualify for QMB-BAS, a person must be receiving Medicare hospital insurance under Part A. This includes people who must pay a monthly premium to receive coverage.

(b) Clients who qualify for QMB-BAS are not eligible to receive the full range of the Department's medical services. QMB-BAS benefits are limited to payments toward Medicare cost-sharing expenses. These expenses are—

(A) Medicare Part A and Part B premiums; and

(B) Medicare Part A and Part B deductibles and coinsurance up to the Department's fee schedule.

(2) The following requirements apply to QMB-DW:

(a) To qualify for QMB-DW program, a person must be eligible for Part A of Medicare as a qualified disabled worker under Section 1818(A) of the Social Security Act. These are people under age 65 who have lost eligibility for Social Security disability benefits because they have become substantially gainfully employed, but can continue to receive Part A of Medicare by paying a premium.

(b) QMB-DW clients are eligible only for payment of their premiums for Part A of Medicare. They are not eligible for MAA, MAF, or OSIPM at the same time they are eligible for QMB benefits.

(3) The following requirements apply to QMB-SMB:

(a) To qualify for QMB-SMB, a person must be receiving Medicare hospital insurance under Part A. This includes people who must pay a monthly premium to receive coverage.

(b) Clients who qualify for QMB-SMB are not eligible to receive the full range of the Department's medical services. QMB-SMB benefits are limited to payment of Medicare Part B premiums.

(c) Clients who are institutionalized (reside in a nursing facility, an intermediate care facility for the mentally retarded (ICF/MR), or a hospital) are not eligible for QMB-SMB if they have income equal to or greater than 120% of the Federal Poverty Level (FPL).

(d) A need group with income equal to or greater than 120% of the FPL (*see* OAR 461-155-0295) may receive QMB-SMB benefits on or after December 1, 2005, except as provided in subsection (3)(e) of this rule.

(e) The QMB-SMB program is subject to an enrollment cap based on the federal allocation. If the enrollment in this program (of clients with income greater than 120% of the FPL) exceeds the federal allocation for that group, the program may be closed.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-135-0830

Eligibility for Disabled Adult Children; OSIPM

A client is eligible for OSIPM as a Disabled Adult Child if the client meets all of the following requirements:

(1) The client is age 18 or older.

(2) The client became blind or a person with a disability as defined by SSA before reaching the age of 22.

(3) The client lost SSI benefits on or after July 1, 1987 because the client became eligible for Social Security benefits as a result of a parent's retirement, death, or disability, or because of an increase in such benefits.

(4) The client would continue to be eligible for SSI in the absence of the Social Security disabled adult child benefit or increases to that benefit.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-135-1110

Eligible and Ineligible Students; OHP-OPU

(1) In the OHP-OPU program, a person who is enrolled *full time* in *higher education* is ineligible to receive benefits, unless the requirements of one of the following subsections are met:

(a) The student:

(A) *Meets the income requirements for a Pell grant;*

(B) Is not currently covered by private major medical health insurance or an HMO; and

(C) Has not been covered by private major medical health insurance or by an HMO for the six months immediately preceding the date of application.

(b) The student is in a program serving displaced workers under Section 236 of the Trade Act of 1974 (19 U.S.C. § 2296).

(2) For the purposes of this rule:

(a) *Higher education* includes the following:

(A) Any public or private university, college or community college.

(B) Any post-secondary vocational or technical school that is eligible to accept Pell grants.

(b) *Full time* is defined by the school.

(c) *Meets the income requirements for a Pell grant* means—

(A) The student's Student Aid Report shows an "expected family contribution" less than \$3,851 for the 2005-2006 or 2006-2007 school year; or

(B) The student is eligible for a Pell grant and provides documentation of eligibility from the school's financial aid office.

(3) A student's enrollment status continues during school vacation and breaks. A student's *higher education* status ends when the student graduates, drops out (as verified by their disenrolling), reduces their credit or attendance hours below full-time status, is suspended or expelled, or does not intend to register for the next school term (excluding summer term).

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-140-0040

Determining Availability of Income

(1) This rule describes the date income is considered available, what amount of income is considered available and situations in which income is considered unavailable.

(2) Income is considered available the date it is received or the date a member of the financial group has a legal right to the payment and the legal ability to make it available, whichever is earlier, except as follows:

(a) Income usually paid monthly or on some other regular payment schedule is considered available on the regular payment date if the date of payment is changed because of a holiday or weekend.

(b) Earned income withheld or diverted at the request of an employee is considered available on the date the wages would have been paid without the withholding or diversion.

(c) An advance or draw of earned income is considered available on the date it is received.

(d) Income that is averaged, annualized, converted, or prorated is considered available throughout the period for which the calculation applies.

(e) A payment due to a member of the financial group, but paid to a third party for a household expense, is considered available when the third party receives the payment.

(3) The following income is considered available even if not received:

(a) Deemed income.

(b) In the ERDC, GA, GAM, MAA, MAF, OHP, OSIP, OSIPM, QMB, and TANF programs, the portion of a payment from an assistance program, such as public assistance, unemployment compensation, or social security, withheld to repay an overpayment.

(4) The amount of income considered available is the gross before deductions, such as garnishments, taxes, or other payroll deductions.

(5) The following income is not considered available:

(a) Wages withheld by an employer in violation of the law.

(b) Income received by another person who does not pay the client his or her share.

(c) Income received by a member of the financial group after he or she has left the household.

(d) Moneys withheld from or returned to the source of the income to repay an overpayment from that source unless the repayment is countable—

(A) In the FS program, under OAR 461-145-0105; or

(B) In the ERDC, GA, GAM, MAA, MAF, OHP, OSIP, OSIPM, and TANF programs, under subsection (3)(b) of this rule.

(e) For a client who is not self-employed, income required to be expended on an ongoing, monthly basis on an expense necessary to produce the income, such as supplies or rental of work space.

(f) In the FS program, income received by the financial group but intended and used for the care of someone not in the financial group as follows:

(A) If the income is intended both for someone in the financial group and someone not in the financial group, the portion of the income intended for the care of the person not in the financial group is considered unavailable.

(B) If the portion intended for the care of the person not in the financial group cannot readily be identified, the income is prorated evenly among the people for whom the income is intended.

The prorated share intended for the care of the person not in the financial group is then considered unavailable.

(g) In the FS, MAF, and OHP programs, income controlled by the client's abuser if the client is a victim of domestic violence, the client's abuser controls the income and will not make the money available to the filing group, and the abuser is not in the client's filing group.

(h) In the MAA and TANF programs, the client is a victim of domestic violence and the client's abuser controls the income and will not make the money available to the filing group.

(6) The availability of lump-sum income is covered in OAR 461-140-0120.

Stat. Auth.: ORS 409.050, 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.117, 411.816, 418.100

461-140-0210

Asset Transfer; General Information and Timelines

(1) OAR 461-140-0210 to 461-140-0300 regulate the effect of a transfer of an asset on a client.

(2) If an asset is transferred during the periods of time listed in section (4) or (5) of this rule and if the transfer is made in whole or in part for the purpose of establishing or maintaining eligibility for benefits:

(a) In the GA, GAM, OSIP, OSIPM, and QMB programs, the need group is disqualified if a member of the financial group or the spouse of a client transferred the asset.

(b) In the FS, MAA, MAF, REF, REFM, SAC, and TANF programs, the filing group is disqualified if the asset was a resource and a member of the financial group transferred the resource.

(3) In all programs except ERDC and OHP, clients in financial groups whose members transfer a resource within the time periods listed in section (4) of this rule or an asset within the time periods listed in section (5) of this rule must report the transfer as soon as practicable and must provide information requested by the Department concerning the transfer.

(4) In the FS, MAA, MAF, REF, REFM, SAC, and TANF programs, a transfer of resource may be disqualifying if the transfer occurs:

(a) In the Food Stamp program, during the three months preceding the filing date or during a certification period.

(b) In the MAA, MAF, REF, REFM, SAC, and TANF programs, during the three years preceding the *date of request* (as defined in OAR 461-115-0030).

(5) In the GA, GAM, OSIP, OSIPM, and QMB programs, a transfer of an asset may be disqualifying if the transfer occurs:

(a) On or before June 30, 2006 and as described in one of the following paragraphs:

- (A) On or after the date that is 60 months prior to the *date of request*—for assets that are transferred without compensation equal to or greater than fair market value from a revocable trust (see OAR 461-145-0540(8)(c)).
- (B) On or after the date that is 60 months prior to the *date of request* —for assets that are transferred without compensation equal to or greater than fair market value to an irrevocable trust (see OAR 461-145-0540(9)(a)).
- (C) On or after the date that is 60 months prior to the *date of request* — when there is a change in circumstances that makes assets in an irrevocable trust unavailable to the client (see OAR 461-145-0540(9)(d)).
- (D) On or after the date that is 36 months prior to the *date of request* — for assets transferred without compensation equal to or greater than fair market value from an irrevocable trust (see OAR 461-145-0540(9)(b) and (c)).
- (E) On or after the date that is 36 months prior to the *date of request* — for other asset transfers made without compensation equal to or greater than fair market value.

(b) On or after---

(A) July 1, 2006; and

(B) The date that is 60 months prior to the *date of request*.

(6) The duration of the period of disqualification or ineligibility is set out in OAR 461-140-0260 to 461-140-0300.

Stat. Auth: ORS 411.060, 411.710, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.710, 411.816, 418.100

461-140-0220

Determining if a Transfer of an Asset is Disqualifying

A transfer of an asset is not *disqualifying* if the requirements of one of the following sections are met:

(1) Except as otherwise provided in OAR 461-140-0242, the transferred item was either---

(a) An excluded asset other than a home or real property; or

(b) Personal property such as jewelry or furniture.

(2) The asset was sold or traded:

(a) In all programs except the Food Stamp program, for compensation equal to or greater than fair market value.

(b) In the Food Stamp program, for compensation near, equal to or greater than fair market value.

(3) The asset was transferred between members of the same financial group, including members who are ineligible aliens or disqualified people.

(4) The transfer settled a legally enforceable claim against the asset or client.

(5) Except in the OSIP, OSIPM and QMB programs, a court ordered the transfer.

(6) In the OSIP, OSIPM and QMB programs, a court ordered the transfer and:

(a) The transfer occurs more than 36 months or 60 months before the *date of request* (as defined in OAR 461-115-0030), whichever is applicable under OAR 461-140-0210(5); or

(b) There is an institutionalized spouse, and — after performing the calculations required in OAR 461-160-0580(2) — the amount of resources allocated to a community spouse does not exceed the largest of the four amounts set forth in OAR 461-160-0580(2)(f).

(7) The client was a victim of fraud, misrepresentation, or coercion, and legal steps have been taken to recover the asset.

(8) In the OSIP, OSIPM and QMB programs, the asset is an annuity purchased on or before December 31, 2005, the client or the spouse of the client is the annuitant, and the entire amount of principal and earned interest is paid in equal installments during the actuarial life expectancy of the annuitant. For purposes of this section, the actuarial life expectancy is established by the life expectancy table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9(B).

(9) In the OSIP, OSIPM and QMB programs, for a client in a *standard living arrangement* (as defined in OAR 461-110-0110), the asset is an annuity purchased on or after January 1, 2006, and the client or the spouse of the client is the annuitant.

(10) In the OSIP, OSIPM and QMB programs, for a client in a *nonstandard living arrangement* (as defined in OAR 461-110-0110):

(a) The asset is an annuity purchased from January 1, 2006 through June 30, 2006, and the client or the spouse of the client is the annuitant.

(b) The asset is an annuity purchased on or after July 1, 2006, and the annuity meets the requirements of OAR 461-145-0022(11).

Stat. Auth: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-140-0242

Disqualifying Transfer of Assets Including Home; GA, GAM, OSIP, OSIPM, and QMB

(1) A transfer of an asset (including a home) by a client or the spouse of the client is a disqualifying transfer unless the requirements of at least one of the following subsections are met:

(a) The transfer was made exclusively for purposes other than establishing eligibility or maintaining benefits.

(b) The title to the asset was transferred to the person's spouse.

(c) The title to the asset was transferred to the person's child who is blind or has a disability under the criteria of the Social Security Administration.

(d) The title to the asset was transferred to another for the sole benefit of the spouse or a child who is blind or has a disability under the criteria of the Social Security Administration. This transfer must be arranged in such a way that no individual or entity except this spouse or child can benefit from the asset transferred in any way, whether at the time of transfer or any time in the future. A direct transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse or child who is blind or has a disability under the criteria of the Social Security Administration is not considered to be established for the benefit of one of those individuals. In order for a transfer or a trust to be considered for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual based on the life expectancy of the individual.

(e) The transfer was made to a trust described in OAR 461-145-0540(10).

(f) The transfer is a transfer described in OAR 461-160-0580(2).

(g) The resource is transferred by the community spouse after the Department has determined the community spouse's resource allowance in accordance with OAR 461-160-0580 and the resource has not been attributed to the institutionalized spouse. Notwithstanding this subsection, a transfer of a resource by a community spouse who is receiving or applying for benefits remains subject to all rules regarding the transfer of an asset by a client.

(2) A transfer of a home by a client or the spouse of the client is a disqualifying transfer unless the title was transferred to the client's —

- (a) Child under age 21;
- (b) Sibling who has equity interest in the home and was residing in the home for at least one year immediately before the client's admission to long-term care; or
- (c) Son or daughter who resided with the client for at least two years immediately prior to the client's admission to long-term care and provided care that permitted the client to reside at home rather than in an institution or long-term care facility. A son or daughter provides the care required by this subsection by doing at least five of the following for the client on a regular basis, without receiving payment from the Department:
 - (A) Prepares meals.
 - (B) Shops for food and clothing.
 - (C) Helps maintain the home.
 - (D) Assists with financial affairs.
 - (E) Runs errands.
 - (F) Provides transportation.
 - (G) Provides personal services.
 - (H) Arranges for medical appointments.
 - (I) Assists with medication.

(3) If a transfer described in subsection (1)(a) of this rule is made for less than fair market value, there is a rebuttable presumption that the asset was transferred for the purpose of establishing or maintaining eligibility.

(4) To rebut the presumption in section (3) of this rule, the client must present evidence other than his or her own statement and must provide to the Department the information it requests for the purpose of evaluating the purpose of the transfer. To meet the burden, it is sufficient for the client to show one of the following:

- (a) The decision to make the transfer was not within the client's control;
- (b) At the time of transfer, the client could not reasonably have anticipated applying for medical assistance;
- (c) Unexpected loss of resources or income occurred between the time of transfer and the application for medical assistance;
- (d) Because of other, similarly convincing, circumstances, it appears more likely than not that the transfer was not made, in whole or in part, for the purpose of establishing or maintaining eligibility for benefits.

(5) The fact that a recipient was already eligible for benefits is not sufficient to rebut the presumption in section (3) of this rule because the asset may not always be excluded and if the client had received full compensation for the asset, the compensation received would have been used to determine future eligibility.

Stat. Auth: ORS 411.060, 411.710

Stats. Implemented: ORS 411.060, 411.710

461-140-0296

Length of Disqualification Due to An Asset Transfer; GA, GAM, OSIP, OSIPM or QMB

In the GA, GAM, OSIP, OSIPM, and QMB programs:

(1) A financial group containing a member disqualified due to the transfer of an asset is disqualified from receiving benefits. The length of a disqualification period resulting from the

transfer is the number of months equal to the uncompensated value (*see* OAR 461-140-0250) for the transfer divided by the following dollar amount:

(a) If the *initial month* (defined in OAR 461-150-0010) is on or after October 1, 1993 and prior to October 1, 1998---\$2,595.

(b) If the *initial month* is on or after October 1, 1998 and prior to October 1, 2000—\$3,320.

(c) If the *initial month* is on or after October 1, 2000 and prior to October 1, 2002—\$3,750.

(d) If the *initial month* is on or after October 1, 2002 and prior to October 1, 2004—\$4,300.

(e) If the *initial month* is on or after October 1, 2004—\$4,700.

(2) For transfers by a client and the spouse of a client that occurred before July 1, 2006:

(a) Add together the uncompensated value of all transfers made in one calendar month, and treat this total as one transfer.

(b) If the uncompensated value of the transfer is less than the applicable dollar amount identified in subsections (1)(a) to (1)(e) of this rule, there is no disqualification.

(c) If there are multiple transfers in amounts equal to or greater than the applicable dollar amount identified in subsections (1)(a) to (1)(e) of this rule, each disqualification period is calculated separately.

(d) The number of months resulting from the calculation in section (1) of this rule is rounded down to the next whole number.

(e) Except as provided in subsection (2)(f) of this rule, the first month of the disqualification is the month the asset was transferred.

(f) If disqualification periods calculated in accordance with this section overlap, the periods are applied sequentially so that no two penalty periods overlap.

(3) For transfers by a client and the spouse of a client that occurred on or after July 1, 2006:

(a) If there are multiple transfers by the client and the spouse of the client, including any transfer less than the applicable dollar amount identified in subsections (1)(a) to (1)(e) of this rule, the value of all transfers are added together before dividing by the applicable dollar amount identified in subsections (1)(a) to (1)(e) of this rule.

(b) The quotient resulting from the calculation in section (1) of this rule is not rounded. The whole number of the quotient is the number of full months the financial group is disqualified. The remaining decimal or fraction of the quotient is used to calculate an additional partial month disqualification. This remaining decimal or fraction is converted to an additional number of days by multiplying the decimal or fraction by the number of days in the month following the last full month of the disqualification period. If this calculation results in a fraction of a day, the fraction of a day is rounded down.

(c) For a client in a *standard living arrangement* (defined in OAR 461-110-0110), the first month of the disqualification is the month following the month of the first asset transfer.

(d) If a client is in a *nonstandard living arrangement* (defined in OAR 461-110-0110), the first month of the disqualification is the later of ---

(A) The month following the month the asset was transferred.

(B) The *date of request* (as defined in OAR 461-115-0030) for medical benefits as long as the client submits an application, and would otherwise be eligible but for this disqualification period.

(4) If an asset is owned by more than one person, by joint tenancy, tenancy in common, or similar arrangement, the share of the asset owned by the client is considered transferred when any action is taken either by the client or any other person that reduces or eliminates the client's control or ownership in the client's share of the asset.

(5) For an annuity that is a disqualifying transfer under section (11) of OAR 461-145-0022, the disqualification period is calculated based on the *uncompensated value* as calculated under OAR 461-140-0250, unless the only requirement that is not met is that the annuity pays beyond the actuarial life expectancy of the annuitant. If the annuity pays beyond the actuarial life expectancy of the annuitant, the disqualification is calculated according to section (6) of this rule.

(6) A disqualification period is assessed for the value of an annuity beyond the actuarial life expectancy of the annuitant if subsections (a) and (b) of this section both apply:

(a) Either --

(A) A client or the spouse of a client purchase an annuity on or before December 31, 2005; or

(B) An OSIPM client who is in a *nonstandard living arrangement* purchases an annuity on or after July 1, 2006.

(b) If the annuity pays benefits beyond the actuarial life expectancy of the annuitant, as determined by the life expectancy table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9(B), a disqualification period is assessed for the value of the annuity beyond the actuarial life expectancy of the annuitant.

(7) A single transfer of an asset may cause a disqualification for both a medical assistance program under this rule and the SSI cash grant. The period of the disqualification is likely to be longer for SSI than for the medical assistance program, so a person may be eligible again for the medical assistance program while still disqualified from receiving SSI. The provisions of this rule are applied without regard to the related disqualification for SSI.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-140-0300

Adjustments to the Disqualification for Asset Transfer

(1) The disqualification imposed under OAR 461-140-0260 is not adjusted once applied in the Food Stamp program.

(2) In all other programs, the disqualification ends if the transfer that caused the disqualification is rescinded. The duration of the disqualification is recalculated if the terms of the transfer are modified.

(3) In the GA, GAM, OSIP, OSIPM and QMB programs, the Department may waive the disqualification if the disqualification would create an undue hardship on the client. For purposes of this section, the disqualification would create an undue hardship if the requirements of subsections (a) and (b) of this section are met:

(a) The client has no other means for meeting his or her needs. The client has the burden of proving that no other means exist by---

(A) Exploring and pursuing all reasonable means to recover the assets to the satisfaction of the Department, including legal remedies and consultation with an attorney; and

(B) Cooperating with the Department to take action to recover the assets.

(b) The disqualification would deprive the client of---

(A) Medical care such that the client's health or life would be endangered; or

(B) Food, clothing, shelter, or other necessities of life without which the health or life of the client would be endangered.

(4) As authorized by ORS 411.620, the Department retains the authority to bring a civil suit or action to set aside a transfer of assets for less than fair market value and may seek recovery of all costs associated with such an action.

(5) Notwithstanding the granting of an undue hardship waiver under section (3) of this rule, the Department is not precluded from recovering public assistance from any assets in which the client held an interest, or in which the client previously held an interest, at the time the undue hardship waiver was granted.

Stat. Auth: ORS 411.060

Stats. Implemented: ORS 411.060, 411.632

461-145-0020

Annuities; Not OSIPM

(1) For the purposes of this rule:

(a) An annuity does not include benefits that are set up and accrued in a regularly funded retirement account while an individual is working, whether maintained in the original account or used to purchase an annuity, if the Internal Revenue Service recognizes the account as dedicated to retirement or pension purposes. (The treatment of pension and retirement plans is covered in OAR 461-145-0380)

(b) The definition of "child" in OAR 461-110-0110 does not apply.

(c) "Child" means a biological or adoptive child who is:

(A) Under age 21; or

(B) Any age and meets the Social Security Administration criteria for blindness or disability.

(d) "Commercial annuities" mean contracts or agreements (not related to employment) by which an individual receives annuitized payments on an investment for a lifetime or specified number of years.

(2) An annuity is counted as a resource if---

(a) The annuity does not make regular payments for a lifetime or specified number of years; or

(b) The annuity does not qualify for exclusion as a resource under subsection (4)(c) of this rule.

(3) If an annuity is a countable resource under this rule, the cash value is equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular payments already received, minus any early withdrawals, and minus any surrender fees.

(4) *Commercial annuities* and payments from such annuities are counted as follows:

(a) In all programs except OSIP, OSIPM, and QMB, annuity payments are counted as unearned income.

(b) In the OSIP and QMB programs:

(A) If a client or the spouse of a client purchases or transfers an annuity prior to January 1, 2006, the transaction may be subject to the rules on asset transfers at OAR 461-140-0220 and following. For an annuity that is not disqualifying but meets the criteria of OAR 461-140-0220, the annuity payments are counted as unearned income.

(B) If a client or the spouse of a client purchases an annuity on or after January 1, 2006, the annuity is counted as a resource unless it is excluded under paragraph (C) of this subsection.

(C) An annuity described in paragraph (B) of this subsection is excluded as a resource if the criteria in subparagraphs (i), (ii), and (iii) of this paragraph are met, except that if an unmarried client is the annuitant, the requirements of subparagraph (iv) of this paragraph must also be met and if a spouse of a client is the annuitant, the requirements of subparagraph (v) of this paragraph must also be met.

(i) The annuity is irrevocable.

(ii) The annuity pays principal and interest out in equal monthly installments within the actuarial life expectancy of the annuitant. For purposes of this subparagraph, the actuarial life expectancy is established by the life expectancy table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9(B).

(iii) The annuity is issued by a business that is licensed and approved to issue *commercial annuities* by the state in which the annuity is purchased.

(iv) If an unmarried client is the annuitant, the annuity must specify that upon the death of the client, the first remainder beneficiary is either of the following:

(I) The Department, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.

(II) The child of the client, if the Department is the next remainder beneficiary (after this child), up to the amount of medical benefits provided on behalf of the client, in the event that the child does not survive the client.

(v) If a spouse of a client is the annuitant, the annuity must specify that, upon the death of the spouse of the client, the first remainder beneficiaries are either of the following:

(I) The client, in the event that the client survives the spouse; and the Department, in the event that the client does not survive the spouse, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.

(II) A child of the spouse; and the client in the event that this child does not survive the spouse.

(D) If an annuity is excluded under paragraph (C) of this subsection, annuity payments are counted as unearned income.

(c) For OSIPM, see OAR 461-145-0022.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-145-0022

Annuities; OSIPM

In the OSIPM program:

(1) For the purposes of this rule:

(a) An annuity does not include benefits that are set up and accrued in a regularly funded retirement account while an individual is working, whether maintained in the original account or used to purchase an annuity, if the Internal Revenue Service recognizes the account as dedicated to retirement or pension purposes. (The treatment of pension and retirement plans is covered in OAR 461-145-0380.)

(b) The definition of "child" in OAR 461-110-0110 does not apply.

(c) "Child" means a biological or adoptive child who is:

(A) Under age 21; or

(B) Any age and meets the Social Security Administration criteria for blindness or disability.

(d) "Commercial annuity" means a contract or agreement (not related to employment) by which an individual receives annuitized payments on an investment for a lifetime or specified number of years.

(2) An annuity that does not make regular payments for a lifetime or specified number of years is a resource.

(3) When a client applies for medical benefits, both initially and at periodic redetermination (see OAR 461-115-0050 and 461-115-0430), the client must report any annuity owned by the client or a spouse of the client.

(4) By signing the application for assistance, a client and the spouse of a client agree that the Department, by virtue of providing medical assistance, becomes a remainder beneficiary as described in sections (8) and (10) of this rule, under any *commercial annuity* purchased on or after February 8, 2006, unless the annuity is included in the community spouse's resource allowance under OAR 461-160-0580(2)(c).

(5) If the Department is notified about a *commercial annuity*, the Department will notify the issuer of the annuity about the right of the Department as a preferred remainder beneficiary, as described in sections (8) and (10) of this rule, in the amount of medical assistance provided to the client.

(6) If a client or the spouse of a client purchases or transfers a *commercial annuity* prior to January 1, 2006, the transaction may be subject to the rules on asset transfers at OAR 461-140-0220 and following. For an annuity that is not disqualifying but meets the requirements in OAR 461-140-0220, the annuity payments are counted as unearned income.

(7) Sections 8 and 9 of this rule apply to a *commercial annuity* if---

(a) The client is in a *nonstandard living arrangement* (defined in OAR 461-110-0110), and the client or the spouse of the client purchases an annuity from January 1, 2006 through June 30, 2006; or

(b) The client is in a *standard living arrangement* (defined in OAR 461-110-0110), and the client or the spouse of a client purchase an annuity on or after January 1, 2006.

(8) A *commercial annuity* covered by section (7) of this rule is counted as a resource unless the annuity is excluded by meeting the following requirements:

(a) If an unmarried client is an annuitant, the annuity must meet the requirements of subsection (8)(c) of this rule, and the annuity must specify that upon the death of the client, the first remainder beneficiary is either of the following:

(A) The Department, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.

(B) The child of the client, if the Department is the next remainder beneficiary (after this child), up to the amount of medical benefits provided on behalf of the client, in the event that the child does not survive the client.

(b) If a spouse of a client is the annuitant, the annuity must meet the requirements of subsection (8)(c) of this rule, and the annuity must specify that, upon the death of the spouse of the client, the first remainder beneficiaries are either of the following:

(A) The client, in the event that the client survives the spouse; and the Department, in the event that the client does not survive the spouse, for all funds remaining in the annuity up to the amount of medical benefits provided on behalf of the client.

(B) A child of the spouse; and the client in the event that this child does not survive the spouse.

(c) An annuity covered by section (7) of this rule may not be excluded unless the annuity meets all of the following requirements:

(A) The annuity is irrevocable.

(B) The annuity pays principal and interest out in equal monthly installments within the actuarial life expectancy of the annuitant. For purposes of this paragraph, the actuarial life expectancy is established by the life expectancy table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9(B).

(C) The annuity is issued by a business that is licensed and approved to issue a *commercial annuity* by the state in which the annuity is purchased.

(9) If an annuity is excluded as a resource under section (8) of this rule, the annuity payments are counted as unearned income. If an annuity is a countable resource under section (8) of this rule, the cash value is equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular monthly payments already received, minus early withdrawals, and minus any surrender fees.

(10) This section lists the requirements for a *commercial annuity* purchased by the client or the spouse of the client on or after July 1, 2006, when a client is in a *nonstandard living arrangement*, and the annuity names the client or the community spouse as the annuitant. Annuities that meet all of the requirements of this section are counted as unearned income. The treatment of annuities that do not meet all requirements of this section is covered in sections (11) and (12) of this rule.

(a) The annuity must comply with one of the following paragraphs:

(A) The first remainder beneficiary is the spouse of the client, and in the event that the spouse transfers any of the remainder of the annuity for less than *fair market value* (as defined at OAR 461-145-0250(2)(a)(B)), the Department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the client.

(B) The first remainder beneficiary is the annuitant's child, and in the event that the child or a representative on behalf of the child transfers any of the remainder of the annuity for less than *fair market value*, the Department is the second remainder beneficiary for up to the total amount of medical benefits paid on behalf of the client.

(C) The first remainder beneficiary is the Department for up to the total amount of medical benefits paid on behalf of the client.

(b) The annuity must be irrevocable and nonassignable.

(c) The annuity pays principal and interest out in equal monthly installments within the actuarial life expectancy of the annuitant. For purposes of this subsection, the actuarial life expectancy is established by the life expectancy table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9(B).

(d) The annuity is issued by a business that is licensed and approved to issue a *commercial annuity* by the state in which the annuity is purchased.

(11) If the client is the annuitant and a *commercial annuity* does not meet all of the requirements of section (10) of this rule, or the spouse of the client is the annuitant and a *commercial annuity* does not meet the requirements of subsection (10)(a) of this rule, there is a disqualifying transfer of assets under OAR 461-140-0210 and following. See OAR 461-140-0296(5) and (6) for calculation of the disqualification period.

(12) Regardless of whether a *commercial annuity* is a disqualifying transfer of assets, if the annuity does not meet all of the requirements of section (10) of this rule, the annuity is counted as a resource with cash value equal to the amount of money used to establish the annuity, plus any additional payments used to fund the annuity, plus any earnings, minus any regular monthly payments already received, minus early withdrawals, and minus any surrender fees.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-145-0088

Corporations and Business Entities; Income and Resources

(1) The value of stocks or other ownership interest in a corporation is a resource.

(2) Assets of the corporation essential to the employment of a client are excluded. For instance, if the corporation owns equipment used by the client to produce income for the corporation, the equipment is an excluded resource. If a client must own stock in the corporation as a condition of working for the corporation, the stock is an excluded resource.

(3) Except as provided in OAR 461-140-0040(2) and section (4) of this rule, income of a corporation is not income of a client with an ownership interest in the corporation until the income is distributed to the client.

(4) In the FS and OHP programs, an expenditure by a business entity or corporation that benefits a *principal* – such as a car or housing payment -- is considered available when the expenditure is made. For purposes of this rule, a *principal* is a person with significant authority in a business entity or corporation, including a sole proprietor, a self-employed person (see OAR 461-145-0910), a partner in a partnership, a member or manager of a limited liability company, and an officer or principal stockholder of a closely held corporation.

(5) In the FS program:

(a) Income from business entities and corporations is treated as follows:

(A) If a client is actively working in a corporation, the income is treated as earned income.

(B) If a client is actively working in an unincorporated business entity, refer to OAR 461-145-0910 to determine if the income is treated as earned or as self-employment.

(C) If a client is no longer actively working to produce the income, the income is treated as unearned.

(b) Income from a limited liability company is treated as follows:

(A) If a client is a member or a manager member, the income is treated as self-employment income.

(B) If a client is a manager but not a member, the income is treated as earned income.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-145-0108

Dividends, Interest and Royalties

(1) Dividends are counted as unearned income, unless the dividends are from a trust described in OAR 461-145-0540(10), in which case the dividends are excluded.

(2) Interest income is counted as unearned income.

(3) Royalties are counted as unearned income, except that royalties are counted as earned income if the client is actively engaged in the activity from which the royalties are accrued.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-145-0180

Family Support Payments

Family Support program payments are social benefits distributed by state or local agencies to families caring for individuals with extraordinary care needs who live at home. Needs are typically caused by disability or advanced age. Payments are made to or on behalf of family members. These payments are treated as unearned income except as follows:

(1) In the MAA, MAF, SAC and TANF programs, shelter payments and payments for services or needs not covered by TANF are excluded.

(2) In the ERDC program, the payments are excluded unless they duplicate day care payments provided through a child care program operated by the Department.

(3) In the FS program, payments provided specifically as reimbursement for an identified expense are covered by OAR 461-145-0440. Lump-sum payments are covered in OAR 461-140-0120. All other payments are unearned income.

(4) In the OHP, OSIP, OSIPM, and QMB programs, the payments are excluded.

Stat. Auth.: ORS 411.060, 411.070

Stats. Implemented: ORS 411.060, 411.070

461-145-0220

Home

(1) Home defined: A home is the place where the filing group lives. A home may be a house, boat, trailer, mobile home, or other habitation. A home also includes the following:

(a) Land on which the home is built and contiguous property.

(A) In all programs except FS, property must meet all the following criteria to be considered contiguous property:

(i) It must not be separated from the land on which the home is built by land owned by people outside the financial group.

(ii) It must not be separated by a public right-of-way, such as a road.

(iii) It must be property that cannot be sold separately from the home.

(B) In the Food Stamp program, contiguous property is property not separated from the land on which the home is built by land owned by people outside the financial group.

(b) Other dwellings on the land surrounding the home that cannot be sold separately from the home.

(2) Exclusion of home and other property:

(a) For a client who has an *initial month* (defined in OAR 461-150-0010) of long-term care or waived services on or after January 1, 2006:

(A) For purposes of this subsection:

(i) The definition of "child" in OAR 461-110-0110 does not apply.

(ii) "Child" means a biological or adoptive child who is:

(I) Under age 21; or

(II) Any age and meets the Social Security Administration criteria for blindness or disability.

(B) The value of a home is excluded if the client or the spouse of the client occupies the home and the equity in the home is \$500,000 or less.

(C) The home is countable as a resource if the client has equity in the home of more than \$500,000, unless one of the following requirements is met:

(i) The spouse of the client occupies the home.

(ii) The child of the client occupies the home.

(iii) The client is legally unable to convert the equity value in the home to cash.

(iv) The home equity is excluded under OAR 461-145-0250.

(b) For all other filing groups, the value of a home is excluded when the home is occupied by any member of the filing group.

(c) In the Food Stamp program only, the value of land is excluded while the group is building or planning to build their home on it, except that if the group owns (or is buying) the home they live in and has separate land they intend to build on, only the home in which they live is excluded,

and the land they intend to build on is treated as real property in accordance with OAR 461-145-0420.

(3) Exclusion during temporary absence: If the value of a home is excluded under section (2) of this rule, the value of this home remains excluded in each of the following situations:

(a) In all programs except the GA, GAM, OSIP, OSIPM, and QMB programs, during the temporary absence of all members of the filing group from the property, if the absence is due to illness or uninhabitability (from casualty or natural disaster), and the filing group intends to return home.

(b) In the Food Stamp program, when the financial group is absent because of employment or training for future employment.

(c) In the GA, GAM, OSIP, OSIPM, and QMB programs, when the client is absent to receive care in a medical institution, if one of the following is true:

(A) The absent client is a single adult who has provided evidence that he or she will return to the home. The evidence must reflect the subjective intent of the client, regardless of the client's medical condition. A written statement from a competent client is sufficient to prove the intent.

(B) The home remains occupied by the client's spouse, child, or a relative dependent on the client for support. The child must be less than 21 years of age or, if over the age of 21, blind or an individual with a disability as defined by SSA criteria.

(d) In the MAA, MAF, REF, REFM, SAC, and TANF programs, when all members of the filing group are absent because:

(A) The members are employed in seasonal employment and intend to return to the home when the employment ends; or

(B) The members are searching for employment, and the search requires the members to relocate away from their home. If all members of the filing group are absent for this reason, the home may be excluded for up to six months from the date the last member of the filing group leaves the home to search for employment. After the six months, if a member of the filing group does not return, the home is no longer excluded.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-145-0250

Income-Producing Property

(1) Income-producing property is any real or personal property that generates income for the financial group. Examples of income-producing property are:

(a) Livestock, poultry, and other animals.

(b) Farmland, rental homes (including a room or other space in the home or on the property of a member of the financial group), vacation homes, condominiums.

(2) Income from income producing property is counted as follows:

(a) If a financial group member actively manages the property 20 hours or more per week, the income is treated in the same manner as self-employment income (see OAR 461-145-0910, 461-145-0920, and 461-145-0930).

(b) If a financial group member does not actively manage the property 20 hours or more per week, the income is counted as unearned income with exclusions allowed only in accordance with OAR 461-145-0920.

(3) The equity value of income-producing property is treated as follows:

(a) In the EA, ERDC, and OHP programs, it is excluded.

(b) In the FS program, it is counted as a resource except to the extent described in each of the following situations:

(A) If the property produces an annual countable income similar to other properties in the community with comparable market value, the equity value of the property is excluded.

(B) The equity value of income-producing livestock, poultry, and other animals is excluded.

(C) If selling the resource would produce a net gain to the financial group of less than \$1,500, the equity value is excluded.

(c) In the GA, GAM, OSIP, OSIPM, and QMB programs, it is counted as a resource, except:

(A) If the property produces an annual countable income of at least six percent of its equity value, the value of the property is excluded up to a maximum of \$6,000.

(B) The total equity value is excluded if all the following are true:

(i) The property is used in a trade or business.

(ii) The property is essential to the client's self-support.

(iii) The property produces an annual countable income of at least six percent of its equity value.

(d) In the MAA, MAF, REF, REFM, SAC, and TANF programs, it is counted as a resource.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.700, 411.816, 418.100

461-145-0310

Life Estate

(1) A *life estate* is the right to property limited to the lifetime of the person holding it or the lifetime of some other person. In general, a *life estate* enables the owner of the life estate to possess, use and obtain profits from property during the lifetime of a designated person while actual ownership of the property is held by another individual. A *life estate* is created when an individual owns property and then transfers their ownership to another while retaining, for the rest of their life, certain rights to that property. In addition, a life estate is established when a member of the financial group purchases a life estate interest in the home of another individual.

(2) For all programs except OSIP, OSIPM and QMB, if a financial group is living in real property while a member holds a *life estate* in this property, the property is treated as a home (see OAR 461-145-0220). In all other situations, a *life estate* is treated as real property (see OAR 461-145-0420).

(3) In the OSIP, OSIPM and QMB programs:

(a) A transfer for less than fair market value (see OAR 461-140-0050) in which a member of the financial group retains a *life estate* is a disqualifying transfer. A transfer is considered for less than fair market value if the fair market value of the transferred resource on the day prior to the transfer is greater than the sum of the value of the rights conferred by the life estate plus the compensation received for the transfer. For purposes of this subsection, the value of the rights conferred by the *life estate* is established by the Life Estate and Remainder Interest Table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9(A).

(b) If a member of the financial group purchases a *life estate* interest in the home of another individual on or after July 1, 2006, the purchase is considered a transfer of resources unless the client resides in this home for at least 12 consecutive months after the date of the purchase. The value of the transfer for a client who does not reside in the home for at least 12 consecutive months is calculated by using the purchase price of the *life estate*.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.700, 411.816, 418.100

461-145-0330

Loans and Interest on Loans

- (1) This rule covers proceeds of loans, loan repayments, and interest earned by a lender. If the proceeds of a loan are used to purchase an asset, the asset is evaluated under the other rules in this division of rules.
- (2) For purposes of this rule, "reverse-annuity mortgage" means an arrangement in which a homeowner borrows against the equity in the home and receives regular monthly tax-free payments from the lender. A "reverse-annuity mortgage" is sometimes referred to in the private sector as a reverse mortgage or a home equity conversion mortgage.
- (3) The proceeds of a home equity loan or *reverse-annuity mortgage* are considered loans under this rule.
- (4) For payments that a member of the financial group receives as a borrower to be treated as a loan:
 - (a) In the GA, GAM, OHP, OSIP, OSIPM, and QMB programs, there must be an oral or written loan agreement, and this agreement must state when repayment of the loan is due to the lender.
 - (b) In all other programs, there must be a written loan agreement, and this agreement must be signed by the borrower and lender, dated before the borrower receives the proceeds of the loan, and state when repayment of the loan is due to the lender.
- (5) When a member of a financial group receives cash proceeds from a loan:
 - (a) In all programs, educational loans are treated according to OAR 461-145-0150.
 - (b) In the ERDC, EXT, FS, MAA, MAF, OHP, REF, REFM, SAC and TANF programs, the loan is excluded. If retained after the month of receipt, the loan is treated in accordance with OAR 461-140-0070.
 - (c) In the GA, GAM, OSIP, OSIPM and QMB programs, a loan is excluded as income. The loan is a resource if retained in the month following the month of receipt (notwithstanding OAR 461-140-0070).
- (6) Except as provided in section (7) of this rule, if a member of a financial group has made a loan and is receiving return payments as a result:
 - (a) The interest payment is unearned income.
 - (b) The payment of principal is excluded.
- (7) In the GA, GAM, OSIP, OSIPM and QMB programs, if a client or a spouse of a client uses funds to purchase a promissory note, loan, or mortgage in a transaction occurring on or after July 1, 2006, the balance of the payments owing to the client or spouse of the client is a transfer of assets for less than fair market value, unless all of the following requirements are met:
 - (a) The total value of the transaction is being repaid to the client or spouse of the client within that person's actuarial life expectancy as established by the life expectancy table of the federal Centers for Medicare and Medicaid Services, State Medicaid Manual, section 3258.9B.
 - (b) Payments are made in equal amounts over the term of the transaction without any deferrals or balloon payments.
 - (c) The contract is not cancelled upon the death of the client or the spouse of the client (who made the transaction).

Stat. Auth: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-145-0340

Lodger Income

(1) A lodger is a member of the household group who---

- (a) Is not a member of the filing group; and
- (b) Pays the filing group for room and board.

(2) Lodger income is the amount a lodger pays the filing group for room (rent) and board (meals).

(3) Lodger income is self-employment income.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-155-0030

Income and Payment Standards; MAA, MAF, REF, SAC, TANF

For MAA, MAF, REF, SAC and TANF, the income standards are as follows:

(1) The Countable Income Limit Standard is the amount set as the maximum countable income limit.

(a) For need groups in the REF and TANF programs containing an adult and for all need groups in the MAA, MAF and SAC programs, the following table is used:

Countable Income Limit

Need Group

<u>No. in Need Group</u>	<u>Amount</u>
1	\$ 345
2	499
3	616
4	795
5	932
6	1,060
7	1,206
8	1,346
9	1,450
10	1,622
Each additional person	172

(b) In the REF and TANF programs, when the need group contains no adults, the "no-adult countable income limit standard" is calculated as follows:

(A) Refer to the Countable Income Limit Standard for need groups with adults. Use the standard for the number of people in the household group.

(B) Divide the standard in paragraph (A) of this subsection by the number of people in the household group. Round this figure down to the next lower whole number if the figure is not a whole number.

(C) Multiply the figure from paragraph (B) of this subsection by the number of people in the need group. The result is the standard.

(2) The Adjusted Income/Payment Standard is used as the adjusted income limit and to calculate cash benefits for need groups with an adult.

(a) For need groups containing an adult in the REF and TANF programs and for all need groups in the MAA, MAF and SAC programs, the following table is used:

Adjusted Income/Payment Standard Need Group	
<u>No. in Need Group</u>	<u>Amount</u>
1	\$ 317
2	404
3	471
4	578
5	675
6	773
7	860
8	947
9	1,008
10	1,116
Each additional person	107

(b) For the REF and TANF programs, when the need group contains no adult, the No-Adult Adjusted Income/Payment Standard is calculated as follows:

(A) Refer to the Adjusted Income/Payment Standard for need groups with adults. Use the standard for the number of people in the household group.

(B) Divide the standard in paragraph (A) of this subsection by the number of people in the household group. Round this figure down to the next lower whole number if the figure is not a whole number.

(C) Multiply the figure from paragraph (B) of this subsection by the number of people in the need group.

(D) Add \$12 to the figure calculated in paragraph (C) of this subsection.

Stat. Auth.: 411.060, 418.100

Stats. Implemented: 411.060, 418.100

461-155-0150

Child Care Eligibility Standard, Payment Rates, and Copayments

The following provisions apply to child care in the ERDC, JOBS, JOBS Plus, and TANF programs:

(1) The following definitions apply to the rules governing child care rates:

(a) Infant: A child aged birth through 12 months.

(b) Toddler: A child aged 1 year through 30 months.

(c) Preschool Child: A child aged 31 months through 5 years.

(d) School Child: A child aged 6 years or older.

(e) *Special needs child*: A child who meets the age requirement of the program (ERDC or TANF) and who requires a level of care over and above the norm for his or her age due to a physical, behavioral or mental disability. The need for a higher level of care must be determined by the provider and the disability must be verified by one of the following:

(A) A physician, nurse practitioner, licensed or certified psychologist or clinical social worker.

(B) Eligibility for Early Intervention and Early Childhood Special Education Programs, or school-age Special Education Programs.

(C) Eligibility for SSI.

(2) The following definitions apply to the types of care specified in the child care rate charts:

(a) The *Standard Family Rate* applies to child care provided in the provider's own home or in the home of the child when the provider does not qualify for the enhanced rate allowed by subsection (b) of this section.

(b) The *Enhanced Family Rate* applies to child care provided in the provider's own home or in the home of the child when the provider meets:

(A) The training requirements of the Oregon Registry entry level, established by the Oregon Center for Career Development in Childhood Care and Education; or

(B) The training requirements established by the Child Care Division for registered family providers who apply to become registered after October 1, 1999.

(c) The *Enhanced Group Rate* applies to child care provided in a residential dwelling that is certified by the Child Care Division as a Certified Family Home. To earn this designation, the facility must be inspected, and both provider and facility are required to meet certain standards not required of a registered family provider.

(d) The *Standard Center Rate* applies to child care provided in a facility that is not located in a residential dwelling and is exempt from Child Care Division Certification rules (*see* OAR 414-300-0000).

(e) The *Enhanced Center Rate* applies to child care provided in a center that is certified by the Child Care Division or in an exempt center whose staff meet the training requirements of the Oregon Registry entry level established by the Oregon Center for Career Development in Childhood Care and Education. Eligibility to receive the enhanced center rate for care provided in an exempt center is subject to the following requirements:

(A) A minimum of one staff member for every 20 children in care must meet the Oregon Registry entry level training requirements noted in paragraph (2)(b)(A) of this rule.

(B) New staff must meet the Oregon Registry entry level training requirements within 90 days of hire, if necessary to maintain the trained staff-to-children ratio described in paragraph (2)(e)(A) of this rule.

(C) There must be at least one person present where care is provided who has a current certificate in infant and child CPR and a current American Red Cross First Aid card or an equivalent.

(f) An exempt center is eligible to receive the enhanced rate for a maximum of six months while in the process of meeting the requirements of subsection (2)(e) of this rule if it files a statement of intent to meet the requirements on a form prescribed by the Department.

(g) An enhanced rate will become effective not later than the second month following the month in which the Department receives verification that the provider has met the requirements of subsection (2)(b), (c), (e), or (f) of this rule.

(3) Subject to the provisions in section (6) of this rule, the monthly limit for each child's child care payments is the lesser of the amount charged by the provider or providers and the following amounts:

(a) The monthly rate provided in section (6) of this rule.

(b) The product of the hours of care, limited by section (4) of this rule, multiplied by the hourly rate provided in section (6) of this rule.

(4) The number of payable billable hours for a child is limited as follows:

(a) For the ERDC-BAS and TANF programs, the total in a month may not exceed:

(A) The number of hours of care necessary for the client to maintain his or her job including, for clients in the JOBS Plus program, the time the client searches for unsubsidized employment and for which the employer pays the client, or to participate in activities included in a *case plan* (see OAR 461-190-0161 and OAR 461-190-0310); or

(B) 125 percent of the time the client is at work or participating in an approved activity of the JOBS program.

(b) For the ERDC-SBG program, the total may not exceed the number of hours of care necessary for the client to maintain his or her education, training or employment. The total may not exceed 125 percent of the sum of 200 percent of class hours and the time the client is at work.

(c) In the ERDC-BAS and TANF programs, for a client who earns less than state minimum wage, the total may not exceed 125 percent of the anticipated earnings divided by the state minimum wage. The limitation of this subsection is waived for the first three months of the client's employment.

(5) The following provisions apply to all programs:

(a) Providers not eligible for the enhanced rate will be paid at an hourly rate for children in care less than 158 hours per month subject to the maximum full-time monthly rate.

(b) Providers eligible for the enhanced rate will be paid at an hourly rate for children in care less than 136 hours a month unless the provider customarily bills all families at a part-time monthly rate subject to the maximum full-time monthly rate.

(c) At their request, providers eligible for the enhanced rate may be paid at the part-time monthly rate if they provide 63 or more hours of care in the month and customarily bill all families at a part-time monthly rate.

(d) Unless required by the client's or child's circumstances, the Department will not pay for care at a monthly rate to more than one provider for the same child for the same month.

(e) The Department will pay at the hourly rate for less than 63 hours of care in the month subject to the maximum full-time monthly rate.

(f) The Department will pay for up to five days each month the child is absent if:

(A) The child was scheduled to be in care and the provider bills for the amount of time the child was scheduled to be in care;

(B) The absent child's place is not filled by another child; and

(C) It is the provider's policy to bill all families for absent days.

(g) The Department will not pay for more than five consecutive days of scheduled care for which the child is absent.

(6) The limit in any month for child care payments on behalf of a child whose caretaker has special circumstances, defined in section (7) of this rule, is the lesser of the following:

(a) The amount billed by the provider or providers; and

(b) The monthly rate established in section (8) of this rule multiplied by a factor, limited to 1.5, determined by dividing the number of hours billed by 215.

(7) The limit allowed by section (6) of this rule is authorized once the Department has determined the client has special circumstances. For the purposes of this rule, a client has special circumstances when it is necessary, in order for the client to perform the requirements of his or her employment or training, to obtain child care for a child in excess of 215 hours in a month.

(8) The payment available for care of a child who meets the special needs criteria described in subsection (1)(e) of this rule is increased in accordance with OAR 461-155-0151 if:

- (a) The child requires significantly more direct supervision by the child care provider than normal for a child of the same age; and
- (b) The child is enrolled in a local school district Early Intervention or Early Childhood Special Education program or school-age Special Education Program. The enrollment required by this subsection is waived if determined inappropriate by a physician, nurse practitioner, licensed or certified psychologist, clinical social worker, or school district official.

(9) The following are the child care rates. The rates are based on the type of provider, the location of the provider (shown by zip code), the age of the child, and the type of billing used (that is, hourly or monthly).

(a)

Group Area A
Hourly Rates
(subject to maximum monthly rate)

	Standard Family Rate	Enhanced Family Rate	Standard Center Rate	Enhanced Center Rate	Enhanced Group Home Rate
Infant	\$2.44	\$2.62	\$3.36	\$3.60	\$2.91
Toddler	\$2.17	\$2.32	\$3.25	\$3.48	\$2.62
Preschool	\$2.17	\$2.32	\$2.39	\$2.56	\$2.43
School	\$2.17	\$2.32	\$2.39	\$2.56	\$2.32
Special Need	\$2.44	\$2.62	\$3.36	\$3.60	\$2.91

Group Area A
Monthly Rates

	Standard Family Rate	Enhanced Family Rate		Standard Center Rate	Enhanced Center Rate		Enhanced Group Home Rate	
	Full time	Part time	Full time	Full time	Part time	Full time	Part time	Full time
Infant	\$402	\$322	\$431	\$537	\$431	\$575	\$348	\$464
Toddler	\$369	\$296	\$395	\$521	\$417	\$558	\$314	\$418
Preschool	\$348	\$279	\$372	\$380	\$306	\$407	\$294	\$393
School	\$348	\$279	\$372	\$380	\$306	\$407	\$279	\$372
Special Need	\$402	\$322	\$431	\$537	\$431	\$575	\$348	\$464

Zip Codes for Group Area A:
Portland, Eugene, Corvallis, Beaverton, Springfield, Monmouth and Ashland areas

97005	97006	97007	97008	97009	97013	97015	97019	97022	97023	97024
97027	97030	97034	97035	97036	97045	97055	97060	97062	97068	97070
97075	97076	97077	97078	97080	97113	97116	97119	97123	97124	97133
97201	97202	97203	97204	97205	97206	97207	97208	97209	97210	97211
97212	97213	97214	97215	97216	97217	97218	97219	97220	97221	97222
97223	97224	97225	97227	97228	97229	97230	97231	97232	97233	97236

97238	97239	97240	97242	97251	97253	97254	97255	97256	97258	97266
97267	97268	97269	97272	97280	97281	97282	97283	97286	97290	97291
97292	97293	97294	97296	97298	97299	97329	97330	97331	97333	97339
97361	97401	97402	97403	97404	97405	97408	97440	97455	97477	97478
97482	97520									

(b)

**Group Area B
Hourly Rates
(subject to maximum monthly rate)**

	Standard Family Rate	Enhanced Family Rate	Standard Center Rate	Enhanced Center Rate	Enhanced Group Home Rate
Infant	\$1.89	\$2.02	\$2.82	\$3.02	\$2.62
Toddler	\$1.89	\$2.02	\$2.77	\$2.96	\$2.21
Preschool	\$1.68	\$1.81	\$2.01	\$2.16	\$2.21
School	\$1.68	\$1.81	\$2.01	\$2.16	\$2.21
Special Need	\$1.89	\$2.02	\$2.82	\$302	\$2.62

**Group Area B
Monthly Rates**

	Standard Family Rate	Enhanced Family Rate		Standard Center Rate	Enhanced Center Rate		Enhanced Group Home Rate	
	Full time	Part time	Full time	Full time	Part time	Full time	Part time	Full time
Infant	\$354	\$284	\$378	\$450	\$361	\$482	\$315	\$420
Toddler	\$325	\$261	\$348	\$445	\$357	\$476	\$262	\$349
Preschool	\$304	\$243	\$325	\$320	\$257	\$343	\$262	\$349
School	\$304	\$243	\$325	\$320	\$257	\$343	\$262	\$349
Special Need	\$354	\$284	\$378	\$450	\$361	\$482	\$315	\$420

Zip Codes for Group Area B:
Salem, Bend, Medford, Roseburg, Albany, Brookings and areas outside the metropolitan areas in Eugene and Portland

97004	97016	97018	97038	97048	97051	97053	97054	97056	97064
97101	97106	97111	97114	97115	97127	97128	97132	97140	97148
97301	97302	97303	97304	97305	97306	97307	97308	97309	97310
97311	97312	97313	97314	97321	97322	97325	97327	97338	97344
97351	97370	97378	97381	97383	97385	97392	97396	97415	97470
97501	97502	97503	97504	97535	97701	97702	97707	97708	97709

(c)

**Group Area C
Hourly Rates
(subject to maximum monthly rate)**

	Standard Family Rate	Enhanced Family Rate	Standard Center Rate	Enhanced Center Rate	Enhanced Group Home Rate
Infant	\$1.89	\$2.02	\$2.17	\$2.32	\$2.32
Toddler	\$1.63	\$1.75	\$2.17	\$2.32	\$2.02

Preschool	\$1.63	\$1.75	\$1.84	\$1.97	\$2.08
School	\$1.63	\$1.75	\$1.84	\$1.97	\$1.81
Special Need	\$1.89	\$2.02	\$2.17	\$2.32	\$2.32

**Group Area C
Monthly Rates**

	Standard Family Rate	Enhanced Family Rate		Standard Center Rate	Enhanced Center Rate		Enhanced Group Home Rate	
	Full time	Part time	Full time	Full time	Part time	Full time	Part time	Full time
Infant	\$353	\$283	\$377	\$401	\$322	\$429	\$283	\$377
Toddler	\$325	\$261	\$348	\$401	\$322	\$429	\$261	\$348
Preschool	\$260	\$208	\$278	\$297	\$239	\$318	\$251	\$334
School	\$260	\$208	\$278	\$297	\$239	\$318	\$214	\$284
Special Need	\$353	\$283	\$377	\$401	\$322	\$429	\$283	\$377

Zip Codes for Group Area C: Balance of State, Other State Zips

97001	97002	97010	97011	97014	97017	97020	97021	97026	97028	97029	97031
97032	97033	97037	97039	97040	97041	97042	97044	97049	97050	97057	97058
97063	97065	97067	97071	97102	97103	97107	97108	97109	97110	97112	97117
97118	97121	97122	97125	97130	97131	97134	97135	97136	97137	97138	97141
97143	97144	97145	97146	97147	97149	97324	97326	97327	97335	97336	97341
97342	97343	97345	97346	97347	97348	97350	97352	97355	97357	97358	97359
97360	97362	97364	97365	97366	97367	97368	97369	97371	97372	97373	97374
97375	97376	97377	97380	97384	97386	97388	97389	97390	97391	97394	97406
97407	97409	97410	97411	97412	97413	97414	97416	97417	97419	97420	97423
97424	97425	97426	97427	97428	97429	97430	97431	97432	97434	97435	97436
97437	97438	97439	97441	97442	97443	97444	97446	97447	97448	97449	97450
97451	97452	97453	97454	97456	97457	97458	97459	97461	97462	97463	97464
97465	97466	97467	97469	97472	97473	97476	97479	97480	97481	97483	97484
97486	97487	97488	97489	97490	97491	97492	97493	97494	97495	97496	97497
97498	97499	97522	97523	97524	97525	97526	97527	97528	97530	97531	97532
97533	97534	97536	97537	97538	97539	97540	97541	97543	97544	97601	97602
97603	97604	97620	97621	97622	97623	97624	97625	97626	97627	97630	97632
97633	97634	97635	97636	97637	97638	97639	97640	97641	97710	97711	97712
97720	97721	97722	97730	97731	97732	97733	97734	97735	97736	97737	97738
97739	97741	97750	97751	97752	97753	97754	97756	97758	97759	97760	97761
97801	97810	97812	97813	97814	97817	97818	97819	97820	97823	97824	97825
97826	97827	97828	97830	97833	97834	97835	97836	97837	97838	97839	97840
97841	97842	97843	97844	97845	97846	97848	97850	97856	97857	97859	97861
97862	97864	97865	97867	97868	97869	97870	97873	97874	97875	97876	97877
97880	97882	97883	97884	97885	97886	97901	97902	97903	97904	97905	97906
97907	97908	97909	97910	97911	97913	97914	97917	97918	97920		

- (10) This section establishes the ERDC eligibility standard and the client's copayment (copay).
(a) The ERDC eligibility standard is met for need groups of eight or less if monthly income for the need group is less than 150 percent of the federal poverty level, as described in OAR 461-

155-0180(4). The eligibility standard for a need group size of eight applies to any need group larger than eight. The ERDC copay is \$25 or the amount determined by the formula in subsection (b) of this section, whichever is greater.

(b) The maximum copay equals the constant determined by the table in subsection (c) of this section, added to the product of a constant determined by the table in subsection (d) of this section times the constant determined by the table in subsection (e) of this section raised to a power equal to the family's gross income, expressed in dollars. The formula is as follows:

$$y = k + (b \times m^x)$$

(c) The constant k is determined by the number of people in the need group, as follows:

(A) 2 persons: k = -30

(B) 3 persons: k = -55

(C) 4 persons: k = -50

(D) 5 persons: k = -51

(E) 6 persons: k = -80

(F) 7 persons: k = -92

(G) 8 or more persons: k = -103

(d) The constant b is determined by the number of people in the need group, as follows:

(A) 2 persons: b = 18.0

(B) 3 persons: b = 23.0

(C) 4 persons: b = 20.9

(D) 5 persons: b = 20.6

(E) 6 persons: b = 33.2

(F) 7 persons: b = 33.2

(G) 8 or more persons: b = 40.4

(e) The constant m is determined by the number of people in the need group, as follows:

(A) 2 persons: m = 1.001885

(B) 3 persons: m = 1.001550

(C) 4 persons: m = 1.001380

(D) 5 persons: m = 1.001250

(E) 6 persons: m = 1.000990

(F) 7 persons: m = 1.000910

(G) 8 or more persons: m = 1.000795

(11) Effective October 1, 2003, a client's copay is limited to \$25 during the first month the client is eligible for ERDC. This limitation cannot be used in more than one month in any 12 consecutive months.

(12) The limit in any month for child care payments on behalf of a child whose caretaker is away from the child's home for more than 30 days because the caretaker is a member of a reserve or National Guard unit that is called up for active duty is the lesser of the following:

(a) The amount billed by the provider or providers.

(b) The monthly rate established in this rule for 215 hours of care.

Stat. Auth.: ORS 411.060, 418.100

Stats. Implemented: ORS 411.060, 418.100

461-155-0175

Income Standard; EXT

(1) For the first seven months of EXT eligibility, there is no income limit.

(2) To continue EXT eligibility after the first seven months, the average adjusted earned income of the financial group must be below 185 percent of the federal poverty level as described in OAR 461-155-0180, using income from:

(a) The second three months of the EXT period to continue eligibility for the eighth through tenth months.

(b) The third three months of the EXT period to continue eligibility for the eleventh and twelfth months.

Stat. Auth.: ORS 411.060, 411.070

Stats. Implemented: ORS 411.060, 411.070

461-155-0180

Poverty Related Income Standards; Not OSIP, OSIPM, QMB, TANF

(1) A Department program may cite this rule if the program uses a monthly income standard based on the federal poverty level.

(2) A monthly income standard set at 100 percent of the 2006 federal poverty level is set at the following amounts:

Size of Group	Standard
1	\$ 817
2	1,100
3	1,384
4	1,667
5	1,950
6	2,234
7	2,517
8	2,800
9	3,084
10	3,367
+1	+284

(3) A monthly income standard set at 133 percent of the 2006 federal poverty level is set at the following amounts:

Size of Group	Standard
1	\$ 1,087
2	1,463
3	1,840
4	2,217
5	2,594
6	2,971
7	3,348
8	3,724
9	4,101
10	4,478
+1	+377

(4) A monthly income standard set at 150 percent of the 2006 federal poverty level is set at the following amounts:

Size of Group	Standard
---------------	----------

1	\$1,225
2	1,650
3	2,075
4	2,500
5	2,925
6	3,350
7	3,775
8	4,200

(5) A monthly income standard set at 185 percent of the 2006 federal poverty level is set at the following amounts:

Size of Group	Standard
1	\$1,511
2	2,035
3	2,560
4	3,084
5	3,608
6	4,132
7	4,656
8	5,180
9	5,705
10	6,229
+1	+525

(6) A monthly income standard set at 200 percent of the 2006 federal poverty level is set at the following amounts:

Size of Group	Standard
1	\$1,634
2	2,200
3	2,767
4	3,334
5	3,900
6	4,467
7	5,034
8	5,600
+1	+567

Stat. Auth.: ORS 411.060, 411.070, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.070, 411.816, 418.100

461-155-0225

Income Standard; OHP

(1) If a financial group contains a person with significant authority in a business entity—a "principal" as defined in OAR 461-140-0040—the group is ineligible for the OHP program if the gross income of the business entity exceeds \$10,000. If the need group is not ineligible under this section, its eligibility is evaluated under section (2) of this rule.

(2) The countable income standards for OHP are as follows:

- (a) The countable income standard for OHP-OPC and OHP-OPU is 100 percent of the federal poverty level, as listed in OAR 461-155-0180(2), based on the size of the need group.
 - (b) The countable income standard for OHP-OP6 is 133 percent of the federal poverty level, as listed in OAR 461-155-0180(3), based on the size of the need group.
 - (c) The countable income standard for OHP-OPP and OHP-CHP is 185 percent of the federal poverty level, as listed in OAR 461-155-0180(5), based on the size of the need group.
- Stat. Auth.: ORS 409.050, 411.060
 Stats. Implemented: ORS 411.060, 411.070

461-155-0250

Income and Payment Standard; OSIP, OSIPM

- (1) For an OSIP (except OSIP-EPD) or OSIPM (except OSIPM-EPD) client in long-term care or in a waived *nonstandard living arrangement* (defined in OAR 461-110-0110), the countable income limit standard is 300 percent of the SSI standard. The one-person SSI standard is used for an individual who has no income and is living alone in the community to compute the countable income limit. Other OSIP and OSIPM clients do not have a countable income limit.
- (2) The non-SSI OSIP and OSIPM (except OSIP-EPD and OSIPM-EPD) adjusted income standard takes into consideration the need for shelter (housing and utilities), food, clothing, personal incidentals, and household supplies. The standard is itemized as follows:

Non-SSI/OSIP and OSIPM Standards				
Items of Need				
	One Person in Need Group		Two People in Need Group	
Adjusted No. in Household	One	Two or More	Two	Three or More
Shelter	377.00	175.00	460.00	169.00
Food	148.30	147.60	280.00	269.34
Clothing	37.00	37.00	74.00	74.00
Personal incidentals	27.40	27.40	58.00	58.00
Household supplies	15.00	15.00	33.00	33.00

- (3) The payment standard is used as the adjusted income limit and to calculate cash benefits for non-SSI OSIP clients. The OSIP-AB adjusted income standard includes a transportation allowance. The total standard is:

Non-SSI/OSIP and OSIPM				
Adjusted Income Standards				
	One Person in Need Group		Two People in Need Group	
Adjusted No. in Household	One	Two or More	Two	Three or More
AD/OAA	604.70	402.00	904.00	603.34
AB	629.70	427.00	929.00	628.34

(4) The payment standard for SSI/OSIP clients living in the community is the SIP (supplemental income payment) amount. The SIP is a need amount added to any other special or service needs to determine the actual payment. In some cases, the need amount is zero.

(a) For clients whose unearned income minus any SSI or Veterans Nonservice-Connected Disability Benefits is less than \$20:

SSI/OSIP and OSIPM Payment Standard (Unearned Income Less Than \$20)		
No. in Need Group	AD/OAA	AB
	SIP (need)	SIP (need)
1	1.70	26.70
2	0.00	25.60

(b) For clients whose unearned income minus any SSI or Veterans Nonservice-Connected Disability Benefits is \$20 or more:

SSI/OSIP and OSIPM Payment Standard (Unearned Income \$20 or More)		
No. in Need Group	AD/OAA	AB
	SIP (need)	SIP (need)
1	0.00	18.70
2	0.00	17.60

(c) The SSI/OSIP-AB standard includes a transportation allowance. The standard for two assumes one individual is blind and the other is not. If both are blind, \$20 is added to the SIP amount.

(d) For spouses who each receive SSI and live in an AFC, ALF or RCF, an amount is added to each person's SIP payment that equals the difference between the individual's income (including SSI and other income) and the OSIP standard for a one-person need group.

(5) For OSIP and OSIPM clients in long-term care, the following amounts are allowed for clothing and personal incidentals:

(a) For clients who receive a VA pension based on unusual medical expenses (UME), \$90 is allowed.

(b) For all other clients, \$30 is allowed.

(6) In the OSIP-EPD and OSIPM-EPD programs, the adjusted income limit is 250 percent of the 2006 federal poverty level for a family of one. This 250 percent limit equals \$2,042 per month or \$24,500 per year.

(7) In the OSIP-EPD and OSIPM-EPD programs, \$970 in earnings is needed to meet the requirement in OAR 461-110-0115 for "sufficient earnings" in the definition of "attached to the workforce."

Stat. Auth.: ORS 411.060, 411.070

Stats. Implemented: ORS 411.060, 411.070

461-160-0055

Medical Costs That are Deductible

For FS clients who are *elderly* (defined in OAR 461-110-0110) or persons with a *disability* (defined in OAR 461-110-0110), and for clients in the GA, GAM, OSIP and OSIPM programs,

medical costs are deductible to the extent a deduction is authorized in OAR 461-160-0415 and 461-160-0430 and as follows:

(1) Health and hospitalization insurance premiums and coinsurance are deductible. In the FS and OSIPM programs, health insurance premiums paid less frequently than monthly may be prorated over the period covered by the premium.

(2) The cost of a medical service is deductible if it is—

(a) Provided by, prescribed by, or used under the direction of a licensed medical practitioner; or

(b) Except in the Food Stamp program, a medical necessity approved by the Department.

(3) Medical deductions are also allowed for, among other things, the cost of:

(a) Medical and dental care, including psychotherapy, rehabilitation services, hospitalization, and outpatient treatment.

(b) Prescription drugs and over-the-counter medications prescribed by a licensed practitioner, the annual fee for a drug prescription card, medical supplies and equipment, dentures, hearing aids, prostheses, and prescribed eyeglasses.

(c) In the FS program, such items as the following:

(A) Nursing care, nursing home care, and hospitalization, including payments for a person who was a member of the household group immediately prior to entering a hospital or a nursing home certified by the state.

(B) Services of an attendant, home health aid, housekeeper or provider of dependent care necessary due to the client's age or illness, including an amount equal to a one-person FS benefit group if the client furnishes the majority of an attendant's meals.

(C) Prescribed, companion animals and assistance animals (such as a Seeing Eye Dog, Hearing Dog, or Housekeeper Monkey), including the cost of acquiring the animals, their training, food, and veterinarian bills.

(D) Reasonable costs for transportation and lodging needed to obtain medical treatment or services.

(E) Installment plan arrangements made before a bill becomes past due. The expense is not deducted if the client defaults and makes a second agreement.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.816, 418.100

461-160-0415

Medical Deduction; FS

(1) This rule explains how to calculate the deduction for medical costs in the Food Stamp program allowed under OAR 461-160-0055 when incurred by an *elderly* (defined in OAR 461-110-0110) member of a household or by a household member with a *disability* (defined in OAR 461-110-0110).

(2) For each certification period, the Department estimates the amount of the client's medical deduction and apportions the amount evenly among the months in the certification period. For medical costs payable during the month of certification, the client may choose to deduct each cost in the month of certification or to average the cost over the certification period.

(3) For medical costs that were not anticipated when the deduction was estimated but are incurred and reported to the Department during the certification period, the client may choose to deduct each cost:

(a) In the month after the cost is reported; or

(b) By averaging the cost over the period from the month after the cost was reported to the end of the certification period.

(4) If the client is billed in the last month of a certification period for a medical cost that is due after the certification period, and the client does not pay the bill during the certification period, the cost may be used to compute the deduction in the next certification period.

(5) A medical cost is not deductible in any of the following situations:

(a) The client reports a paid medical cost in the last month of the redetermination period, but reports this cost after their benefits for that month have already been issued.

(b) The medical cost is past due or is an amount carried forward from a previous billing period.

(c) The client and creditor have agreed on a monthly payment amount, but the client defaults on the agreement.

Stat. Auth.: ORS 411.816

Stats. Implemented: ORS 411.816

461-160-0580

Excluded Resource; Community Spouse Provision (OSIP and OSIPM except OSIP-EPD and OSIPM-EPD)

(1) In the OSIP and OSIPM programs, this rule applies to an institutionalized spouse who has applied for benefits because he or she is in or will be in a *continuous period of care* (defined in OAR 461-160-0560).

(2) Whether a couple lives together or not, the determination of whether the value of the couple's resources exceed the eligibility limit for the institutionalized spouse for OSIPM program is made as follows:

(a) The first step is the determination of what the couple's combined countable resources were at the beginning of the most recent continuous period of care. (The beginning of the continuous period of care is the first month of that continuous period.)

(A) Division 461-160 rules applicable to OSIP describe which of the couple's resources are countable resources. Division 461-160 rules applicable to OSIP clients are applicable to determine whether a community spouse's resources are countable, even if the rule only applies to OSIP clients.

(B) The countable resources of both spouses are combined.

(C) At this point in the computation, the couple's combined countable resources are considered available equally to both spouses.

(b) The second step is the calculation of one half of what the couple's combined countable resources were at the beginning of the continuous period of care. The community spouse's half of the couple's combined resources is treated as a constant amount when determining eligibility.

(c) The third step is the determination of the community spouse's resource allowance. The community spouse's resource allowance is the largest of the four following amounts:

(A) The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care, but not more than \$99,540.

(B) \$19,908 (the state community-spouse resource allowance).

(C) A court-ordered community spouse resource allowance. In this rule (OAR 461-160-0580(2)(c)(C) and (2)(f)(C)), the term *court-ordered community spouse resource allowance* means a court-ordered community spouse resource allowance that, in relation to the income generated, would raise the community spouse's income to a court-approved monthly maintenance needs allowance. In cases where the client became an institutionalized spouse on or

after February 8, 2006, this resource allowance must use all of the client's available income and the community spouse's income to meet the community spouse's monthly maintenance needs allowance before any resources are used to generate interest income to meet the allowance.

(D) After considering the income of the community spouse and the income available from the institutionalized spouse, an amount which, if invested, would raise the community spouse's income to the monthly maintenance needs allowance. The amount described in this paragraph (D) is considered only if the amount described in subparagraph (i) of this paragraph is larger than the amount described in subparagraph (ii); it is the difference between the following:

(i) The monthly income allowance computed in accordance with OAR 461-160-0620.

(ii) The difference between—

(I) The sum of gross countable income of the community spouse and the institutionalized spouse; and

(II) The applicable need standard under OAR 461-160-0620(1)(d).

(d) The fourth step is the determination of what the couple's current combined countable resources are when a resource assessment is requested or the institutionalized spouse applies for OSIPM. The procedure in subsection (2)(a) (first step) of this rule is used.

(e) The fifth step is the subtraction of the community spouse's resource allowance from the couple's current combined countable resources. The resources remaining are considered available to the institutionalized spouse.

(f) The sixth step is a comparison of the value of the remaining resources to the OSIP resource standard for one person (under OAR 461-160-0015(6)(a)). If the value of the remaining resources is at or below the standard, the institutionalized spouse meets this eligibility requirement. If the value of the remaining resources is above the standard, the institutionalized spouse cannot be eligible until the value of the couple's combined countable resources is reduced to the largest of the four following amounts:

(A) The community spouse's half of what the couple's combined countable resources were at the beginning of the continuous period of care (but not more than \$99,540) plus the OSIP resource standard for one person.

(B) \$19,908 (the state community-spouse resource allowance), plus the OSIP resource standard for one person.

(C) A court-ordered community spouse resource allowance plus the OSIP resource standard for one person. (*See paragraph (2)(c)(C) of this rule for a description of the court-ordered community spouse resource allowance.*)

(D) The OSIP resource standard for one person plus the amount described in the remainder of this paragraph. After considering the income of the community spouse and the income available from the institutionalized spouse, add an amount which, if invested, would raise the community spouse's income to the monthly maintenance needs allowance. Add this amount only if the amount described in subparagraph (i) of this paragraph is larger than the amount described in subparagraph (ii); it is the difference between the following:

(i) The monthly income allowance computed in accordance with OAR 461-160-0620.

(ii) The difference between—

(I) The sum of gross countable income of the community spouse and the institutionalized spouse; and

(II) The applicable need standard under OAR 461-160-0620(1)(d).

(3) Once eligibility has been established, resources equal to the community spouse's resource allowance (under subsection (2)(c) of this rule) must be transferred to the community spouse if

those resources are not already in that spouse's name. The institutionalized spouse must indicate his or her intent to transfer the resources and must complete the transfer to the community spouse within 90 days. This period may be extended for good cause. These resources are excluded during this period. After this period, resources owned by the institutionalized spouse but not transferred out of that spouse's name will be countable and used to determine ongoing eligibility.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060, 411.700

461-160-0620

Income Deductions and Client Liability; Long-Term Care or Waivered Services

(1) Deductions from income in the OSIP and OSIPM programs are made for a client specified in subsection (a) of this section as explained in subsections (a) through (i) of this section. The liability of the client is determined according to subsection (j).

(a) Deductions are made in the order below for a client who resides in or is entering a long-term care facility or receives Title XIX waived services, except that there is no client liability for ---

(A) A client who receives SSI or is deemed to receive SSI under section 1619(b) of the Social Security Act (42 U.S.C. § 1382h(b)).

(B) A client in one of the following categories who receives only waived services:

(i) A client in OSIPM-IC.

(ii) An adult disabled child as described at OAR 461-135-0830.

(iii) A disabled widow or widower under OAR 461-135-0811.

(iv) A widow or widower under OAR 461-135-0820.

(b) One standard earned income deduction of \$65 is made from the earned income in the OSIP-AD, OSIP-OAA, OSIPM-AD, and OSIPM-OAA programs. The deduction is \$85 in the OSIP-AB and OSIPM-AB programs.

(c) In the OSIP and OSIPM programs, the deductions under the plan for self-support is made as allowed by OAR 461-140-0420.

(d) One of the following need standards is deducted:

(A) A \$30 personal needs allowance for a client in long-term care.

(B) A \$90 personal needs allowance for a client in long-term care who is eligible for VA benefits based on unusual medical expenses. The \$90 allowance is allowed only when the VA benefit has been reduced to \$90.

(C) The OSIP maintenance standard for a client who receives waived services.

(e) A community spouse monthly income allowance is deducted from the income of the institutionalized spouse if the income is made available to (or for the benefit of) the community spouse. If neither spouse is eligible for SSI and both receive waived services through the home- and community-based care program in the same residence or facility, and if the countable income of either spouse is less than the one-person OSIPM payment standard, an allowance is calculated separately using calculation methods 1 and 2 below. The result that is better for the couple is the allowance. For all other couples, the amount calculated using method 2 is the allowance.

(A) Calculation method 1: The allowance is the difference between the one-person payment standard of the OSIPM program (*see* OAR 461-155-0250) and the countable income of the spouse with the lesser countable income.

(B) Calculation method 2:

(i) Step 1—Determine the maintenance needs allowance. \$1,650 is added to the amount over \$495 that is needed to pay monthly shelter expenses for the principal residence of the couple.

This sum or \$2,488.50, whichever is less, is the maintenance needs allowance. For the purpose of this calculation, shelter expenses are the rent or home mortgage payment (principal and interest), taxes, insurance, required maintenance charges for a condominium or cooperative, and the full standard utility allowance for the Food Stamp program (*see* OAR 461-160-0420).

(ii) Step 2—Compare maintenance needs allowance with community spouse's gross income. The gross income of the community spouse is subtracted from the maintenance needs allowance determined in step 1. The difference is the income allowance unless the allowance described in step 3 is greater.

(iii) Step 3—If a spousal support order or exceptional circumstances resulting in significant financial distress require a greater income allowance than that calculated in step 2, the greater amount is the allowance.

(f) A dependent income allowance is deducted for each eligible dependent as follows:

(A) For a case with a community spouse, a deduction is permitted only if the monthly income of the eligible dependent is below \$1,650. To determine the income allowance of the eligible dependent:

(i) The monthly income of the eligible dependent is deducted from \$1,650.

(ii) One-third of the amount remaining after the subtraction in paragraph (A) of this subsection is the income allowance of the eligible dependent.

(B) For a case with no community spouse:

(i) The allowance is the TANF adjusted income standard for the client and eligible dependents.

(ii) The TANF standard is not reduced by the income of the dependent.

(g) Costs for maintaining a home are deducted if the client meets the criteria in OAR 461-160-0630.

(h) In the OSIPM program, medical deductions allowed by OAR 461-160-0055 are made for costs not covered under the state plan. This includes the public and private health insurance premiums of the community spouse and the client's dependent.

(i) After taking all the deductions allowed by this rule, the remaining balance is the adjusted income.

(j) The client liability is determined as follows:

(A) For a client receiving waived services (except a client identified in subsection (1)(a) of this rule), the liability is the actual cost of the waived service or the adjusted income of the client, whichever is less. This amount must be paid to the Department each month as a condition of being eligible for waived services. In OSIPM-IC, the liability is subtracted from the gross monthly benefit.

(B) For a client who resides in a nursing facility, an acute hospital, a state hospital, an Intermediate Care Facility for the Mentally Retarded, or a non-waivered mental health facility, there is a liability as described at OAR 461-160-0610.

(2) The deduction used to determine adjusted income for a GA and GAM client in long-term care or waived services is as follows:

(a) One standard earned income deduction of \$65 is made from the earned income for a client who is not blind; or

(b) One standard earned income deduction of \$85 is made from the earned income for a client who is blind.

Stat. Auth.: ORS 411.060, 411.070

Stats. Implemented: ORS 411.060, 411.070

461-165-0030

Concurrent and Duplicate Program Benefits

(1) A person may not receive benefits from the Department of the same type (that is, cash, medical, or food stamp benefits) for the same month as a member of two different benefit groups or from two separate programs, except as noted in this rule. This provision includes a prohibition against an individual receiving TANF concurrently with another cash assistance program funded under Title IV-E of the Social Security Act.

(a) If a GA client becomes eligible for TANF, the client's benefits are supplemented during the first month of eligibility for TANF to the TANF payment standards.

(b) A TANF recipient may receive ERDC for children who are in the household group but may not be included in the TANF filing group.

(c) A client may receive EA, HSP, and TA-DVS benefits and cash payments from other programs for the same time period.

(d) A child who is a member of an ERDC benefit group may also be a member of one of the following benefit groups:

(A) A TANF benefit group when living with a nonneedy caretaker relative, if the caretaker relative is not the child's parent.

(B) An OSIP-AB benefit group.

(C) A TANF benefit group when living with a needy caretaker relative receiving SSI.

(e) Clients in the Food Stamp program who leave a filing group that includes a person who abused them and enter a shelter or safe home for victims of domestic violence may receive food stamp benefits twice during the month they enter the shelter or safe home.

(f) A QMB-BAS client may also receive medical benefits from EXT, MAA, MAF, OSIPM, or SAC.

(2) A person may not receive benefits of the same type (that is, cash, medical, or food stamp benefits) for the same period from both Oregon and another state or tribal food distribution program, except as follows:

(a) Medical benefits may be authorized for an eligible client if the client's provider refuses to submit a bill to the Medicaid agency of another state and the client would not otherwise receive medical care.

(b) Cash benefits may be authorized for a client in the Assessment Program if benefits from another state will end by the last day of the month in which the client applied for TANF.

(3) In the FS program, each person who has been included as a member of the filing group in Oregon or another state is subject to all of the restrictions in section (2) of this rule.

(4) A person may not receive benefits from the EXT, MAA, MAF, OHP, OSIPM, or SAC program while receiving a subsidy through the Family Health Insurance Assistance Program (FHIAP) established by ORS 735.720 to 735.740.

Stat. Auth.: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.117, 411.816, 418.100

461-170-0025

Changes That Must be Reported; EXT

Clients in the EXT program are required to report each of the following within 10 days of occurrence:

(1) A change in address of anyone who is receiving benefits.

(2) A change of name of anyone who is receiving benefits.

- (3) A change in health-insurance coverage available to anyone who is receiving benefits.
- (4) A report of pregnancy of anyone who is receiving benefits.
- (5) A birth to anyone who is receiving benefits.
- (6) A report that a member of the filing group who is 18 years of age is no longer a full-time student in secondary school or in vocational or technical training.

Stat. Auth.: ORS 411.060

Stats. Implemented: ORS 411.060

461-170-0103

Actions Resulting From Changes in Household Circumstances; Simplified Reporting System (SRS); FS

In the Food Stamp program, benefits may be changed for a client using SRS --- based on information obtained other than through the interim change report --- only as follows:

- (1) The benefit level will be increased if the information demonstrates the client is eligible for greater benefits.
- (2) The benefits will be closed or reduced if any of the following subsections apply:
 - (a) The household requests a closure of benefits.
 - (b) The action is based on information that is *verified upon receipt*. Information is considered *verified upon receipt* if---
 - (A) It is not questionable and the person making the report has first-hand knowledge of the information reported; or
 - (B) Verification is provided with the reported change in accordance with OAR 461-115-0651.
 - (c) The client reports information that results in loss of eligibility for the FS program.
 - (d) The client reports financial group income exceeding the countable income limit.
- (3) The Department acts on information reported through computer matches when the interim change report is processed, when the client is recertified, or when the monthly match with the Employment Department generates an Unemployment Compensation (UC) hold.

Stat. Auth.: ORS 411.816

Stats. Implemented: ORS 411.816

461-175-0220

Notice Situation; Disqualification

- (1) If a benefit group or individual is disqualified for an FS voluntary job quit or for failure to apply for or provide an SSN, pursue assets, cooperate in the JOBS, JOBS Plus, or OFSET program, or assist the state's efforts to collect support, the Department sends the following type of notice:
 - (a) If benefits are reduced or closed because of the disqualification:
 - (A) A continuing benefit decision notice is used when changes are reported on the Monthly Change Report, Interim Change Report or Periodic Review forms.
 - (B) A timely continuing benefit decision notice is used when changes are not reported on the Monthly Change Report, Interim Change Report or Periodic Review forms.
 - (b) If benefits are opened without the disqualified individual in the benefit group or if the entire benefit group is denied assistance, a basic decision notice is used.
- (2) For a JOBS, JOBS Plus, or OFSET disqualification, and for an FS voluntary job quit by a person receiving food stamp benefits, the notice includes the following information:
 - (a) The client action that resulted in disqualification.

- (b) The length of the minimum disqualification period.
 - (c) The reduced benefit amount.
 - (d) How the client may end the disqualification after the minimum period.
 - (3) For a voluntary job quit by a person applying for food stamp benefits, the notice includes the following information:
 - (a) The action that resulted in the disqualification; and
 - (b) The length of the disqualification period.
 - (4) For an FS or TANF IPV disqualification:
 - (a) A basic decision notice is required if a person in the benefit group is disqualified for an IPV as the result of a court order or a final order from an administrative hearing.
 - (b) A continuing benefit decision notice is required if a person in the benefit group is disqualified for an IPV based on a signed waiver.
 - (5) For a GA, GAM, OSIP, OSIPM and QMB program disqualification due to a transfer of assets:
 - (a) The Department sends---
 - (A) A basic decision notice for a denial of benefits.
 - (B) A timely continuing benefit decision notice if benefits are reduced or closed.
 - (b) The notice sent under subsection (5)(a) of this rule includes each of the following items:
 - (A) The action that resulted in the disqualification, including the amount of uncompensated value used to calculate the disqualification period.
 - (B) The length of the disqualification.
 - (C) Information that the client, or the facility in which the client resides (on behalf of the client), may apply for a waiver of the disqualification on the basis of undue hardship.
- Stat. Auth.: 411.060, 411.816, 418.100
 Stats. Implemented: 411.060, 411.816, 418.100

461-175-0230

Notice Situation; Nonstandard Living Situations

- (1) In the Food Stamp program:
 - (a) A timely continuing benefit decision notice is sent to terminate, suspend, or reduce benefits if the notice occurs as a result of any of the following situations:
 - (A) A client has been admitted or committed to an institution.
 - (B) A client has been placed in foster care, skilled nursing care, intermediate care, or long term hospitalization.
 - (C) A client is placed in official custody or a correctional facility.
 - (D) A client enters a drug or alcohol residential treatment facility.
 - (E) A client leaves a drug or alcohol residential treatment facility without reapplying for FS benefits.
 - (b) No decision notice is required if the Department determines that a resident of a drug or alcohol treatment center or a residential care facility (RCF) is ineligible as a result of one of the following actions taken against the center or facility:
 - (A) Disqualification by Food and Nutrition Services (FNS) as an authorized representative.
 - (B) Loss of certification with the Department.
 - (c) A resident of an RCF that is disqualified or loses its certification as described in subsection (1)(b) of this rule may still qualify for Food Stamps through a separate application.

- (2) Except as provided in section (3) of this rule, for all programs except FS, a basic decision notice is sent to terminate, suspend, or reduce benefits in each of the following situations:
- (a) The client has been admitted or committed to an institution.
 - (b) The client has been placed in skilled nursing care, intermediate care, or long-term hospitalization.
 - (c) The client is placed in official custody or a correctional facility.
- (3) In the OSIP and OSIPM programs, a client receiving waived or long term care services is sent a timely continuing benefits decision notice in each of the following situations:
- (a) A reduction or closure of services occurs as the result of a process of reevaluating both the functional impairment levels of a client and the requirements of a client for assistance in performing activities of daily living.
 - (b) Services are closing because the client has not paid the client liability.
 - (c) The client receives benefits in the OSIP-IC or OSIPM-IC program, and benefits will end under OAR 411-036-0050.
 - (d) There is an increase in the client liability.
 - (e) There is a change in special needs as described in OAR 461-180-0040.
- Stat. Auth.: ORS 411.060, 411.101, 411.816, 418.100
Stats. Implemented: ORS 411.060, 411.095, 411.099, 411.101, 411.111, 411.816, 418.100

461-180-0080

Effective Dates; Initial Month FS Benefits

In the Food Stamp program:

- (1) Except as provided in section (2) of this rule, for a filing group making an initial application or applying after the end of its certification period, the effective date for starting benefits is the filing date (see OAR 461-115-0050 and 461-115-0210), as long as all eligibility requirements are met on the filing date. If all eligibility requirements are not met on the filing date, the effective date is the date all eligibility requirements are met.
- (2) For migrant and seasonal farmworkers that received FS benefits in another state the month before applying for FS in Oregon, the effective date for starting benefits is the first of the month.
- (3) If a filing group is applying for benefits during the last two months of a certification period, the effective date is the first of the month following the end of the certification period, unless the filing group fails to complete the application process within the time frames listed in OAR 461-115-0210.

Stat. Auth.: ORS 411.816

Stats. Implemented: ORS 411.816

461-190-0195

Degree Completion Initiative Component

- (1) The Degree Completion Initiative (DCI) assists TANF parents who are undergraduates to complete their education at a two- or four-year *educational institution*. DCI is a work-attached *component* of the JOBS program for certain TANF clients. A participant in the DCI *component* (participant) receives TANF cash assistance as well as support services provided through the JOBS program. JOBS support services does not pay for the cost of tuition, fees, books, or supplies associated with enrollment by a participant at an educational institution.
- (2) The following definitions apply to DCI:
 - (a) "DCI" refers to Degree Completion Initiative.

(b) "Educational institution" refers to any post-secondary educational institution approved or accredited by the Northwest Commission on Colleges and Universities, by its regional equivalent, or by the appropriate official, department, or agency of the state or nation in which the institution is located and which is--

(A) A two- or four-year college or university; or

(B) A community college.

(c) "Participant" refers to a participant in the DCI component of the JOBS program.

(3) The number of *participants* at any time may not exceed one hundred households receiving TANF.

(4) Applying for DCI; Waiting List

(a) A parent who is applying for or receiving TANF may apply for DCI by completing and signing the DCI application and submitting it to the Department. The application and other documentation required by this rule must be submitted to Department of Human Services JOBS Unit (DCI), 2nd Floor, 500 Summer Street NE E48, Salem, Oregon 97301.

(b) The Department will follow the following procedure for DCI applications received by the Department:

(A) For applications received prior to November 1, 2005, the Department will select participants in a random selection process of applicants, subject to the priority established in paragraph (E) of this subsection. The number of participants selected may not exceed the cap established in section (3) of this rule. The Department will notify all selected applicants who qualify that they have been selected to participate.

(B) For applications received prior to November 1, 2005, the Department will create a waiting list of applicants from the applicants who are not selected for participation in the random selection held pursuant to paragraph (A) of this subsection. The waiting list will be created through a random selection process in which the first application selected will be first on the waiting list. The Department will notify applicants that they have been placed on the DCI waiting list.

(C) For applications received on or after November 1, 2005, the Department will add applicants to the waiting list created pursuant to paragraph (B) of this subsection in the order of the date and time the completed application is received by the Department. The Department will notify applicants that they have been placed on the waiting list.

(D) When an opening in DCI becomes available, the Department will notify the next applicant on the waiting list.

(E) The priority population for the first 100 DCI slots will be applicants who are undergraduates and who require 12 months or less to complete a degree at an *educational institution*.

(F) If the department does not have 100 DCI slots filled, applications will be open to applicants who are undergraduates and who require between 13 and 24 months to complete a degree at an educational institution. Prior to November 1, 2005, a random selection process will be used if there are too many applicants in this category for the remaining slots available.

(c) The Department will inform each applicant for DCI who does not qualify or no longer qualifies for placement on the waiting list.

(5) Selection Requirements

(a) A DCI applicant must meet the financial and nonfinancial eligibility requirements for TANF.

(b) Subject to the priority established by paragraph (4)(b)(E) of this rule, a DCI applicant must demonstrate that they are an undergraduate who requires 24 months or less to complete a degree at an *educational institution*.

(c) A DCI applicant who is not applying for or receiving TANF at the time of selection may not participate in DCI or remain on the waiting list.

(d) A DCI application must include documentation that the DCI applicant has been accepted for full-time attendance into or is enrolled full-time at an educational institution. If the DCI applicant does not include such documentation with the DCI application, the applicant must submit documentation to the Department no later than 60 days from the date the application is submitted. An applicant who does not provide this documentation within 60 days is not eligible to participate in the DCI component. This deadline may be extended beyond 60 days in special circumstances beyond the control of the client.

(6) Requirements of Participants; Limitations

(a) A participant must provide documentation to the Department quarterly, or following completion of each academic term at the *educational institution*, that the participant is making satisfactory academic progress, as defined by the *educational institution*, toward a degree.

(b) A participant who does not provide the documentation required by subsection (6)(a) of this rule, or who is not making satisfactory academic progress as defined by the *educational institution*, is not eligible to continue to participate.

(c) A participant must attend classes full-time as defined by the *educational institution*, unless there is *good cause* (see OAR 461-130-0327) to limit attendance to less than full-time.

(d) Unless there is *good cause* (see OAR 461-130-0327) for not attending year round, a participant must either--

(A) Attend classes year round, including during the summer if classes are offered by the *educational institution*; or

(B) If not attending classes year round, participate in work experience related to the field of study of the participant when not attending classes.

(e) A participant must provide the Department, either verbally or in writing, with attendance information at least once per month.

(f) Eligibility for DCI is limited to 12 months and may not be extended.

(g) Upon completing the last semester or term of the educational program of the participant, the participant must engage in work preparation activities, which may include resume preparation, employment research, interviews, work experience, and other activities related to job placement.

(h) The following requirements apply to a participant who is required to participate in the JOBS program:

(A) A mandatory participant who does not attend classes year round may be required to participate in other activities of the JOBS program.

(B) A mandatory participant found to be ineligible to participate in DCI must meet the participation requirements of the JOBS program.

(i) A participant may not simultaneously receive services from both the ERDC-SBG program and from the TANF or JOBS program.

(j) Except as provided in subsection (6)(k) of this rule, a participant must remain eligible for TANF: if the participant becomes ineligible for TANF, the participant is ineligible for DCI.

(k) If a participant becomes temporarily ineligible for TANF during a period of four or fewer months due to income from a paid work experience, the applicant may retain their DCI slot when school resumes if the participant meets all of the following requirements:

(A) The time of the participant in DCI will be no longer than 12 months.

(B) The participant regains TANF eligibility.

(C) DCI is still an appropriate activity for the participant.

Stat. Auth.: ORS 411.060, 418.100
Stats. Implemented: ORS 411.060, 418.100

461-195-0511

Child Care Overpayments

This rule defines overpayments in the Department's child care programs and explains when clients and providers are liable for an overpayment.

(1) A *child care overpayment* is a payment for child care made by the Department to or on behalf of a client that is paid to an ineligible provider or exceeds the amount authorized by law for the care provided, except that it is not a *child care overpayment* if any of the following subsections apply:

(a) A client fails to make a required report of a change in income during a reporting period, other than the changes covered in OAR 461-170-0015.

(b) The total due and paid to two or more providers exceeds the monthly limit the Department may pay on behalf of the client. The exception provided by this subsection does not apply if—

(A) Two or more providers are paid at the full-time rate; or

(B) One of the providers provides child care under a contract with the Department.

(c) A client unintentionally provides an inaccurate estimate of prospective income or other information.

(d) A client would otherwise be eligible for a payment and provides inaccurate information due to an aspect of a documented disability of the client.

(2) A child care payment is a *client overpayment* if made for care provided when a client was not---

(a) Engaged in an activity that made the client eligible for child care, such as an activity of the JOBS program (*see* OAR 461-190-0110 and following); or

(b) Eligible for child care benefits.

(3) A *child care overpayment* occurring after November 30, 1999, not caused by the client or the provider is collectible as follows:

(a) The provider is liable for a *provider overpayment* made on behalf of a client eligible for child care payments.

(b) The client is liable for an overpayment if the client was not eligible for the payment.

(4) A client is liable for a *client overpayment*, and a provider is liable for an overpayment caused by the provider. The client and provider are jointly and severally liable for an overpayment caused by both. In the case of an alleged *provider overpayment*, a provider's failure to provide contemporaneous records of care provided creates a rebuttable presumption that the care was not provided.

(5) The Department may recover a *child care overpayment* for which a provider is liable by reducing up to 100 percent any future child care payments for which the provider bills the Department.

(6) An adult who cosigned an application with a minor provider applicant is responsible to repay an overpayment incurred by the minor provider.

Stat. Auth.: ORS 411.060, 418.100

Stats. Implemented: ORS 411.060, 411.122, 418.100

461-195-0521

Special Rules for Calculation of Overpayments

This rule contains special rules for calculating an overpayment.

(1) If a client directly receives support that should be, but is not, used to reimburse the Department for assistance or to reduce benefits, there is an overpayment for the amount of support the client received directly that should have been used to reimburse the Department or reduce benefits.

(2) If a client failed to comply with the requirements of OAR 461-120-0345 relating to medical insurance, an overpayment is calculated according to this section. The client is not included in the need group (*see* OAR 461-110-0630) during any period in which the client failed to meet a requirement of the OAR 461-120-0345 by withholding information or giving false information. Therefore, there is an overpayment equal to the difference between the benefits the group received and the reduced amount it would have received had the client been removed from the need group.

(3) If the benefit group was categorically eligible for food stamps, there is no Food Stamp overpayment based on resources, Social Security number, or residency. A Food Stamp overpayment may exist based on incorrect income.

(a) For a group found eligible for food stamps under OAR 461-135-0505(1)(a), (b) or (c), and the actual income made the group ineligible for the related program, the group remains categorically eligible for food stamps. Benefit groups of one or two persons would be entitled to at least \$10 in food stamp benefits.

(b) For a group found eligible for food stamps only under OAR 461-135-0505(1)(d), and the actual income equals or exceeds 185% Federal Poverty Level, the group is no longer categorically eligible and the overpayment is the food stamp benefit amount.

(4) When a client receives benefits in the OSIPM program and does not pay their share of the cost of service (client liability), the overpayment consists of all payments made by the Department on behalf of the client, including but not limited to capitation payments, all medical expenses for that period, waived service payments (including home-delivered meals and non-medical transportation), Medicare Buy-In, and mileage reimbursement.

(5) Credit against an overpayment is allowed as follows:

(a) In the GA, REF and TANF programs, a credit is allowed for a client's payment for medical services made during the period covered by the overpayment, in an amount not to exceed the Department fee schedule for the service, but credit is not allowed for an elective procedure unless it would have been authorized if requested.

(b) Credit is allowed for an underpayment of benefits.

(c) In the FS program, if the overpayment was caused by unreported earned income, verified child care costs are allowed as a credit to the extent the costs would have been deductible under OAR 461-160-0040 and 461-160-0430.

(6) Benefits paid during the notice period (*see* OAR 461-175-0050) are included in the calculation of the overpayment if:

(a) The client failed to report changes within the reporting time frame; and

(b) Benefits could have been adjusted in time to prevent the overpayment if the client had reported changes at any time within the reporting time frame.

(7) An overpayment is determined and calculated by assigning unreported income to the applicable budget month without averaging the unreported income. There is a rebuttable presumption that a client's earnings reported in a quarterly earnings report from the Employment Department were received by the client in equal amounts during the months identified in the report.

- (8) Earned income deductions are applied in calculating an overpayment except as follows:
- (a) For MAA, MAF, REF and TANF, no earned income deduction (*see* OAR 461-160-0160 and -0190) is allowed for a client who, without *good cause*, did either of the following:
 - (A) Failed to report all earned income within the reporting time frame.
 - (B) Under reported earned income.
 - (b) For FS, no deduction is applied to earned income not timely reported.
- (9) For the purposes of section (8) of this rule, *good cause* means circumstances beyond the client's reasonable control that caused the client to be unable to report income timely and accurately.
- (10) In the TANF program, the amount of support retained by the Department as current reimbursement each month is added to other income to determine ineligibility. In the case of a client not eligible for TANF, the overpayment is offset by support retained by the Department as current reimbursement.
- (11) When a client has incurred an overpayment due to both an *administrative error* and a *client error* in the same month, the *client error* overpayment is calculated by determining the total overpayment for the month and subtracting from it the portion due to *administrative error*.
- (12) In the medical programs:
- (a) There is no overpayment if the client was ineligible for financial assistance but, during the period in question, would have been eligible for EXT or any other medical program.
 - (b) When an overpayment is caused by *administrative error*, there is no corresponding overpayment if the client had been eligible to receive medical benefits under EXT, GAM, MAA, MAF, OSIPM or SAC. In such cases, the overpaid cash benefits are not counted as income in calculating eligibility for EXT, GAM, MAA, MAF, OSIPM or SAC and are not used in determining the client's *spend down* (*see* OAR 461-160-0080).
- Stat. Auth.: ORS 411.060, 411.660, 411.816, 418.100
Stats. Implemented: ORS 411.060, 411.630, 411.635, 411.660, 411.816, 418.100

461-195-0561

Compromise of Overpayment Claims

- (1) This rule establishes the Department's policy for compromising claims for overpayments in the Child Support, ERDC, Food Stamp, medical, and TANF programs. The Department will consider a request to compromise an overpayment claim only if the costs of administration and collection necessary to collect the account in full would likely exceed the current balance of the overpayment. In making the determination whether to compromise, the Department will consider the requester's ability to repay the overpayment in full within a reasonable time, as evidenced by such factors as:
- (a) Income less than 200% of the federal poverty level (*see* OAR 461-155-0180(6)); or
 - (b) Income and liquid assets that are small compared with the outstanding overpayment.
- (2) The following limitations and considerations apply to the Department's evaluation of a request to compromise an overpayment claim:
- (a) The Department's authority to compromise may be limited by federal or state law.
 - (b) The Department will allow a compromised claim to be paid in installments over a period not to exceed 90 days.
 - (c) The Department will compromise a claim only once it is a *liquidated claim*; *liquidated claim* is described in OAR 461-195-0551.

(d) The Department will compromise a claim that exceeds \$20,000 only to the extent permitted by the rules of the Secretary of State.

(e) Except for an overpayment in the child support program, the Department will not agree to compromise a claim for less than 75 percent of the total amount of the claim. In the child support program, the amount for which a claim will be compromised will be determined following the applicable standards in OAR 137-055-6120(1).

(f) During the 12 months following the date of the compromise agreement, the Department reserves the right to collect the original, unmitigated claim through benefit reduction (*see* OAR 461-195-0551). This subsection does not apply to claims in the child support program.

(3) The following limitations apply to a request to compromise an overpayment:

(a) A request for compromise will be considered only if 36 months have passed since the requester was first notified of the overpayment.

(b) A request for compromise will be considered only if 12 months have passed since the requester was last eligible for and received benefits of the program in which the overpayment occurred or last received a direct provider payment for child care (*see* the rules in division 165 of this chapter of rules). This subsection does not apply to claims in the child support program.

(c) An overpayment caused by the requester's conduct is subject to compromise only if caused by his or her inadvertent error or by circumstances beyond his or her reasonable control.

(d) The Department will not compromise a claim if the requester has not made a good faith effort to repay the overpayment.

(e) The Department is more likely to approve a request to compromise if the requester has not previously caused an overpayment in the same program.

Stat. Authority: ORS 411.060, 411.816, 418.100

Stats. Implemented: ORS 411.060, 411.635, 411.816, 418.100