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For purposes of the homestead exclusion only, a dependent relative is one who is dependent financially, medically or as otherwise determined dependent upon the institutionalized person. The following are considered relatives of the institutionalized person: child, stepchild or grandchild; parent, stepparent or grandparent; aunt, uncle, niece or nephew; brother or sister, including relations of step or half; cousin or in-law.

It is not necessary that the client be medically able to return home to apply the exclusion. The exclusion is based solely on the client's intended action, should he be discharged from the facility. See Section 11.4 when an individual does not have intent to return due to domestic abuse. The Worker must record the client's statement of intent in the case record. A written statement may be requested, but no action may be taken to deny or stop benefits for failure to provide a written statement when the client has expressed his intent verbally or by gesture.

If the client's homestead is a multi-unit dwelling, such as an apartment building, the entire property is excluded, not just the portion of the value which corresponds to the portion of the property in which he actually lived.

The homestead property may not be in West Virginia. The homestead exclusion applies, regardless of the state in which it is located. The client's expressed intent to return to the homestead property does not necessarily affect his West Virginia residency. See Chapter 8.

NOTE: Once Medicaid eligibility is established, the assets of the community spouse are not counted for the institutionalized spouse. In addition, when assets such as the home and attributed assets legally transferred to the community spouse are subsequently transferred by him, no penalty is applied to the institutionalized spouse.

D. HOME EQUITY

When the equity value of an individual's home exceeds **$506,000**, he is ineligible for Medicaid payment for nursing home care or HCB Waiver Services, unless his spouse, child under 21 or disabled adult child resides in the home.

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17.11 ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS AND THE MEDICAL NECESSITY FOR NURSING FACILITY CARE

A. ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS

When the applicant for nursing facility services is not a recipient of Medicaid under a full Medicaid coverage group, categorical Medicaid eligibility, as well as financial eligibility, must be established.

Incapacity, disability or blindness, when not already established by the receipt of RSDI or Railroad Retirement benefits based on disability, must be established by MRT.

All procedures in Chapter 12 for a MRT referral for the appropriate coverage group are applicable, and a presumptive approval may be made according to the guidelines in that Chapter.

NOTE: The PAS does not establish incapacity or disability. However, a copy of the PAS may be submitted to MRT as medical information.

B. ESTABLISHING MEDICAL NECESSITY, THE PAS

1. When The PAS Is Completed

Before payment for nursing facility services can be made, medical necessity must be established. The PAS is used for this purpose. The PAS is signed by a physician and is evaluated by a medical professional of the State's contracted level of care evaluator. The PAS is valid for 60 days from the date the physician signs the form. The 60-day validity period applies, regardless of the reason for completion, i.e., new admission, transfer to a different facility. See item C below for situations when a PAS is not completed and payment for nursing facility care is requested for a prior period.

NOTE: There is no requirement that the name of the facility in which the individual resides appear on the PAS.

NOTE: The date the PAS is completed for the purpose of establishing medical necessity is the date the physician signs the form, not the date of any other determination made using the PAS.