RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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DATE: January 29, 2025
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WSR 25-04-040

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is amending various sections of chapters 182-513 and 182-515 WAC so that they use "guardian," "guardianship," "conservator," and "conservatorship" as those terms are defined and used in chapter 11.130 RCW.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-513-1100, 182-513-1367, 182-513-1380, 182-513-1530, 182-515-1509, 182-515-1514
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 24-24-008 on November 21, 2024 (date).

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

	New	____	Amended	____	Repealed	____

The number of sections adopted on the agency's own initiative:

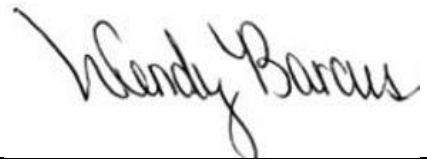
	New	____	Amended	____	Repealed	____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

	New	____	Amended	6	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	6	Repealed	____

Date Adopted: January 29, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 24-02-036, filed 12/27/23, effective 1/27/24)

WAC 182-513-1100 Definitions related to long-term services and supports (LTSS). This section defines the meaning of certain terms used in chapters 182-513 and 182-515 WAC. Within these chapters, institutional, home and community-based services (HCBS) waiver, program of all-inclusive care for the elderly (PACE), and hospice in a medical institution are referred to collectively as long-term care (LTC). Long-term services and supports (LTSS) is a broader definition which includes institutional, HCBS waiver, and other services such as medicaid personal care (MPC), community first choice (CFC), PACE, and hospice in the community.

• See chapter 182-516 WAC for definitions related to trusts, annuities, life estates, and promissory notes.

• See chapter 388-106 WAC for long-term care services definitions.

• See WAC 182-513-1405 for long-term care partnership definitions.

• See chapter 182-500 WAC for additional apple health eligibility definitions.

"Adequate consideration" means that the fair market value (FMV) of the property or services received, in exchange for transferred property, approximates the FMV of the property transferred.

"Administrative costs" or **"costs"** means necessary costs paid by the guardian or conservator including attorney fees.

"Aging and long-term support administration (ALTSA)" means the administration within the Washington state department of social and health services (DSHS).

"Alternate living facility (ALF)" is not an institution under WAC 182-500-0050; it is one of the following community residential facilities:

(a) Adult family home (AFH) licensed under chapter 70.128 RCW.

(b) Adult residential care facility (ARC) licensed under chapter 18.20 RCW.

(c) Assisted living facility (AL) licensed under chapter 18.20 RCW.

(d) Behavioral health adult residential treatment facility (RTF) licensed under chapter 246-337 WAC.

(e) Intensive behavioral health treatment facility (IBHTF) is an RTF licensed under chapter 246-337 WAC.

(f) Developmental disabilities administration (DDA) group home (GH) licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW.

(g) Enhanced adult residential care facility (EARC) licensed as an assisted living facility under chapter 18.20 RCW.

(h) Enhanced service facility (ESF) licensed under chapter 70.97 RCW.

(i) Facility for children and youth 20 years of age and younger where a state-operated living alternative program, as defined under chapter 71A.10 RCW, is operated.

(j) Group care facility for medically complex children licensed under chapter 74.15 RCW.

(k) Staffed residential facility licensed under chapter 74.15 RCW.

"Assets" means all income and resources of a person and of the person's spouse, including any income or resources which that person or that person's spouse would otherwise currently be entitled to but does not receive because of action:

(a) By that person or that person's spouse;

(b) By another person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or

(c) By any other person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

"Authorization date" means the date payment begins for long-term services and supports (LTSS) under WAC 388-106-0045.

"Clothing and personal incidentals (CPI)" means the cash payment (under WAC 388-478-0090, 388-478-0006, and 388-478-0033) issued by the department for clothing and personal items for people living in an ALF or medical institution.

"Community first choice (CFC)" means a medicaid state plan home and community-based service developed under the authority of section 1915(k) of the Social Security Act under chapter 388-106 WAC.

"Community options program entry system (COPES)" means a medicaid home and community-based services (HCBS) waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-106 WAC.

"Community spouse (CS)" means the spouse of an institutionalized spouse.

"Community spouse resource allocation (CSRA)" means the resource amount that may be transferred without penalty from:

(a) The institutionalized spouse (IS) to the community spouse (CS); or

(b) The spousal impoverishment protections institutionalized (SIPI) spouse to the spousal impoverishment protections community (SIPC) spouse.

"Community spouse resource evaluation" means the calculation of the total value of the resources owned by a married couple on the first day of the first month of the institutionalized spouse's most recent continuous period of institutionalization.

"Comprehensive assessment reporting evaluation (CARE) assessment" means the evaluation process defined under chapter 388-106 WAC used by a department designated social services worker or a case manager to determine a person's need for long-term services and supports (LTSS).

"Conservator" has the same meaning given in RCW 11.130.010.

"Conservatorship" means the process outlined in chapter 11.130 RCW for appointing a conservator and a conservator's carrying out of any duties pursuant to an order entered under RCW 11.130.360 through 11.130.575.

"Conservatorship fees" or **"fees"** means necessary fees charged by a conservator for services rendered on behalf of a client.

"Continuing care contract" means a contract to provide a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services, which is conditioned upon the transfer of property, the payment of an entrance fee to the provider of such services, or the payment of periodic charges for the care and services involved.

"Continuing care retirement community" means an entity which provides shelter and services under continuing care contracts with its

members and which sponsors or includes a health care facility or a health service.

"Dependent" means a minor child, or one of the following who meets the definition of a tax dependent under WAC 182-500-0105: Adult child, parent, or sibling.

"Developmental disabilities administration (DDA)" means an administration within the Washington state department of social and health services (DSHS).

"Developmental disabilities administration (DDA) home and community-based services (HCBS) waiver" means a medicaid HCBS waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-845 WAC authorized by DDA. There are five DDA HCBS waivers:

(a) Basic Plus;

(b) Core;

(c) Community protection;

(d) Children's intensive in-home behavioral support (CIIBS); and

(e) Individual and family services (IFS).

"Equity" means the fair market value of real or personal property less any encumbrances (mortgages, liens, or judgments) on the property.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market in an agreement, made by two parties freely and independently of each other, in pursuit of their own self-interest, without pressure or duress, and without some special relationship (arm's length transaction), at the time of transfer or assignment.

"Guardian" has the same meaning given in RCW 11.130.010.

"Guardianship" means the process outlined in chapter 11.130 RCW for appointing a guardian and a guardian's carrying out of any duties pursuant to an order entered under RCW 11.130.265 through 11.130.355.

"Guardianship fees" or **"fees"** means necessary fees charged by a guardian for services rendered on behalf of a client.

"Home and community-based services (HCBS) waiver programs authorized by home and community services (HCS)" means medicaid HCBS waiver programs developed under the authority of Section 1915(c) of the Social Security Act under chapter 388-106 WAC authorized by HCS. There are three HCS HCBS waivers: Community options program entry system (COPES), new freedom consumer directed services (New Freedom), and residential support waiver (RSW).

"Home and community-based services (HCBS)" means LTSS provided in the home or a residential setting to persons assessed by the department.

"Institutional services" means services paid for by Washington apple health, and provided:

(a) In a medical institution;

(b) Through an HCBS waiver; or

(c) Through programs based on HCBS waiver rules for post-eligibility treatment of income under chapter 182-515 WAC.

"Institutionalized individual" means a person who has attained institutional status under WAC 182-513-1320.

"Institutionalized spouse" means a person who, regardless of legal or physical separation:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is legally married to a person who is not in a medical institution.

"Life care community" see continuing care community.

"Likely to reside" means the agency or its designee reasonably expects a person will remain in a medical institution for 30 consecutive days. Once made, the determination stands, even if the person does not actually remain in the facility for that length of time.

"Long-term care services" see "Institutional services."

"Long-term services and supports (LTSS)" includes institutional and noninstitutional services authorized by the department.

"Medicaid alternative care (MAC)" is a Washington apple health benefit authorized under Section 1115 of the Social Security Act. It enables the medicaid agency and the agency's designees to deliver an array of person-centered long-term services and supports (LTSS) to unpaid caregivers caring for a medicaid-eligible person who meets nursing facility level of care under WAC 388-106-0355 and 182-513-1605.

"Medicaid personal care (MPC)" means a medicaid state plan home and community-based service under chapter 388-106 WAC.

"Most recent continuous period of institutionalization (MRCPI)" means the current period an institutionalized spouse has maintained uninterrupted institutional status when the request for a community spouse resource evaluation is made. Institutional status is determined under WAC 182-513-1320.

"Noninstitutional medicaid" means any apple health program not based on HCBS waiver rules under chapter 182-515 WAC, or rules based on a person residing in an institution for 30 days or more under chapter 182-513 WAC.

"Nursing facility level of care (NFLOC)" is described in WAC 388-106-0355.

"Participation" means the amount a person must pay each month toward the cost of long-term care services received each month; it is the amount remaining after the post-eligibility process under WAC 182-513-1380, 182-515-1509, or 182-515-1514. Participation is not room and board.

"Penalty period" or **"period of ineligibility"** means the period of time during which a person is not eligible to receive services that are subject to transfer of asset penalties.

"Personal needs allowance (PNA)" means an amount set aside from a person's income that is intended for personal needs. The amount a person is allowed to keep as a PNA depends on whether the person lives in a medical institution, ALF, or at home.

"Presumptive eligibility (PE)" for long-term services and supports is described in WAC 182-513-1110.

"Program of all-inclusive care for the elderly (PACE)" provides long-term services and supports (LTSS), medical, mental health, and substance use disorder (SUD) treatment through a department-contracted managed care plan using a personalized plan of care for each enrollee.

"Roads to community living (RCL)" is a demonstration project authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).

"Room and board" means the amount a person must pay each month for food, shelter, and household maintenance requirements when that person resides in an ALF. Room and board is not participation.

"Short stay" means residing in a medical institution for a period of 29 days or fewer.

"Significant financial duress" means, but is not limited to, threatened loss of, or financial burden from, basic shelter, food, or medically necessary health care. It means that a member of a couple has established to the satisfaction of a hearing officer that the com-

munity spouse needs income above the level permitted by the community spouse maintenance standard to provide for medical, remedial, or other support needs of the community spouse to permit the community spouse to remain in the community.

"Special income level (SIL)" means the monthly income standard that is 300 percent of the supplemental security income (SSI) federal benefit rate.

"Spousal impoverishment protections" means the financial provisions within Section 1924 of the Social Security Act that protect income and assets of the community spouse through income and resource allocation. The allocation process is used to discourage the impoverishment of a spouse due to the other spouse's need for LTSS. This includes services provided in a medical institution, HCBS waivers authorized under 1915(c) of the Social Security Act, and through September 30, 2027, services authorized under 1115 and 1915(k) of the Social Security Act.

"Spousal impoverishment protections community (SIPC) spouse" means the spouse of a SIPI spouse.

"Spousal impoverishment protections institutionalized (SIPI) spouse" means a legally married person who qualifies for the noninstitutional categorically needy (CN) Washington apple health SSI-related program only because of the spousal impoverishment protections under WAC 182-513-1220.

"State spousal resource standard" means the minimum CSRA standard for a CS or SIPC spouse.

"Tailored supports for older adults (TSOA)" is a federally funded program approved under Section 1115 of the Social Security Act. It enables the medicaid agency and the agency's designees to deliver person-centered long-term services and supports (LTSS).

"Third-party resource (TPR)" means funds paid to or on behalf of a person by a third party, where the purpose of the funds is for payment of activities of daily living, medical services, or personal care. The agency does not pay for these services if there is a third-party resource available.

"Transfer" means, in the context of long-term care eligibility, the changing of ownership or title of an asset, such as income, real property, or personal property, by one of the following:

(a) An intentional act that changes ownership or title; or

(b) A failure to act that results in a change of ownership or title.

"Uncompensated value" means the fair market value (FMV) of an asset on the date of transfer, minus the FMV of the consideration the person receives in exchange for the asset.

"Undue hardship" means a person is not able to meet shelter, food, clothing, or health needs. A person may apply for an undue hardship waiver based on criteria under WAC 182-513-1367.

AMENDATORY SECTION (Amending WSR 23-04-034, filed 1/25/23, effective 2/25/23)

WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care in a medical institution. This rule describes how the agency or the agency's designee allocates in-

come and excess resources when determining participation in the cost of care in a medical institution.

(1) The agency or the agency's designee defines which income and resources must be used in this process under WAC 182-513-1315.

(2) The agency or the agency's designee allocates nonexcluded income in the following order, and the combined total of (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) under WAC 182-513-1105.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program under WAC 182-512-0050(1); and

(ii) Receives the wages as part of an agency-approved or department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction, employment expenses are not deducted.

(d) Guardianship fees, conservatorship fees, and administrative costs, including any attorney fees paid by the guardian or conservator, as allowed under chapter 388-79A WAC.

(3) The agency or the agency's designee allocates nonexcluded income after deducting amounts under subsection (2) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is:

(i) For the current month;

(ii) For the time period covered by the PNA; and

(iii) Not counted as the dependent member's income when determining the dependent allocation amount under WAC 182-513-1385.

(b) A monthly maintenance needs allowance for the community spouse as determined using the calculation under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income up to the PNA.

(c) A dependent allowance for each dependent of the institutionalized client or the client's spouse, as determined using the calculation under WAC 182-513-1385.

(d) Medical expenses incurred by the institutionalized individual and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 182-513-1350.

(e) Maintenance of the home of a single institutionalized client or institutionalized couple:

(i) Up to 100 percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client or couple is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income deduction.

(4) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the participation.

(5) A client is responsible to pay only up to the state rate for the cost of care. If long-term care insurance pays a portion of the state rate cost of care, a client pays only the difference up to the state rate cost of care.

(6) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has in a month.

(7) Standards under this section for long-term care are found at www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 18-04-037, filed 1/30/18, effective 3/2/18)

WAC 182-513-1367 Hardship waivers. (1) This section defines undue hardship for long-term services and supports (LTSS) and specifies the request, approval, denial, and other processes for hardship waivers.

(2) Undue hardship.

(a) Undue hardship exists when, without LTSS benefits, the client is unable to obtain:

(i) Medical care to the extent that health or life is endangered; or

(ii) Food, clothing, shelter or other basic necessities of life.

(b) Undue hardship does not exist when:

(i) The denial or termination of LTSS inconveniences the client or restricts the client's lifestyle but does not seriously deprive the client of the items described under (a) of this subsection;

(ii) The denial or termination of LTSS is because of a period of ineligibility under WAC 182-513-1363, and the asset was transferred by a person or entity handling the financial affairs of the client denied or terminated from LTSS, unless the department has found evidence of financial exploitation; or

(iii) The client's situation meets undue hardship under (a) of this subsection because of restrictions placed in a trust by that client, either personally or through a spouse, guardian, conservator, court, or another person authorized to act on behalf of that client through a power of attorney document (attorney-in-fact).

(3) A hardship waiver may be requested when a client is denied or terminated from LTSS under the following scenarios:

(a) A period of ineligibility under WAC 182-513-1363 was established for a client, and that client, who transferred the assets, or on whose behalf the assets were transferred, either personally or through a spouse, guardian, conservator, or another person authorized to act on behalf of that client through a power of attorney document (attorney-in-fact), has exhausted all reasonable means including legal remedies to recover the assets or the value of the transferred assets that caused the period of ineligibility;

(b) A client was denied or terminated from LTSS due to exceeding the home equity standard under WAC 182-513-1350, and the client cannot legally access the excess equity; or

(c) The client was denied or terminated from LTSS due to the application of rules regarding trusts under chapter 182-516 WAC, except that if the application of rules regarding trusts under chapter 182-516 WAC results in a period of ineligibility under WAC 182-513-1363, then (a) of this subsection applies instead of (c) of this subsection.

(4) Process to request a hardship waiver.

(a) A hardship waiver may be requested by:

(i) The client;

(ii) The client's spouse;

(iii) The client's authorized representative; or

(iv) With the consent of the client, a representative of the medical institution in which the client resides.

(b) The hardship waiver request must:

(i) Be in writing;

(ii) State the reason for requesting the hardship waiver;

(iii) Be signed by the requestor and include the requestor's name, address, and telephone number. If the request is being made on behalf of a client, then that client's name, address, and telephone number must be included;

(iv) Be made within ((~~thirty~~)) 30 days of the date of denial or termination of LTSS; and

(v) Returned to the originating address on the denial or termination letter.

(c) If additional information is needed to determine whether or not to approve a hardship waiver, then, within ((~~fifteen~~)) 15 days of receipt of the request for the hardship waiver, the agency or the agency's designee sends the client a written notice requesting additional information under WAC 182-503-0050.

(5) Standards to approve a hardship waiver request.

(a) Period of ineligibility: If a client was denied or terminated from LTSS under WAC 182-513-1363 (the scenario described in subsection (3)(a) of this section) and undue hardship under subsection (2) of this section is found to exist, then the agency or the agency's designee approves a hardship waiver.

(b) Excess home equity: If a client was denied or terminated from LTSS under WAC 182-513-1350 (the scenario described in subsection (3)(b) of this section) and undue hardship under subsection (2) of this section is found to exist, then the agency or the agency's designee approves a hardship waiver.

(c) Trusts.

(i) The client's home is in a revocable trust: If a client was denied or terminated from LTSS under chapter 182-516 WAC (the scenario described in subsection (3)(c) of this section), then the agency or the agency's designee approves a hardship waiver for up to ((~~ninety~~)) 90 days if the following conditions are met:

(A) The client is an institutionalized individual;

(B) The home would otherwise meet the exclusion criteria in WAC 182-512-0350 (1)(b), but it is in a revocable trust; and

(C) The client must submit in writing to the agency or the agency's designee that, in order to exclude the home under WAC 182-512-0350 (1)(b), the home will be retitled out of the revocable trust to the client, the client's spouse, or both, within ((~~ninety~~)) 90 days.

(ii) All other denials or terminations of LTSS due to trusts: If a client was denied or terminated from LTSS under subsection (3)(c) of this section, and undue hardship under subsection (2) of this section is found to exist, then the agency or the agency's designee approves a hardship waiver.

(6) If the hardship is approved:

(a) The agency or the agency's designee sends a notice within ((~~fifteen~~)) 15 days of receiving all information needed to approve the hardship waiver. The hardship waiver approval notice specifies a time period for which the undue hardship waiver is approved.

(b) Any changes in a client's situation that led to the approval of a hardship waiver must be reported to the agency or the agency's designee within ((~~thirty~~)) 30 days of the change per WAC 182-504-0110.

(c) If the hardship waiver is approved under subsection (5)(c)(i) of this section, the client must provide verification by the ((~~ninetieth~~)) 90th day after the hardship waiver approval that the home has been retitled out of the revocable trust to the client, the client's spouse, or both.

(7) If the hardship waiver is denied:

(a) The agency or the agency's designee sends a denial notice within ((~~fifteen~~)) 15 days of receiving the hardship waiver request or the request for additional information. The notice will state the reason why the hardship waiver was not approved.

(b) The denial notice has instructions on how to request an administrative hearing. The agency or the agency's designee must receive an administrative hearing request within ((~~ninety~~)) 90 days of the date of the adverse action.

(8) The agency or the agency's designee may revoke approval of an undue hardship waiver if any of the following occur:

(a) A client, or the client's authorized representative, fails to provide timely information or resource verifications as it applies to the hardship waiver when requested by the agency or the agency's designee per WAC 182-503-0050 and 182-504-0105;

(b) The lien or legal impediment that restricted access to home equity in excess of the home equity limit is removed; or

(c) Circumstances for which the undue hardship was approved have changed.

(9) If there is a conflict between this section and chapter 182-526 WAC, this section prevails.

AMENDATORY SECTION (Amending WSR 18-10-024, filed 4/24/18, effective 6/1/18)

WAC 182-513-1530 Maximum guardianship or conservatorship fee and related cost deductions allowed from a client's participation or room and board on or after June 1, 2018. (1) General information.

(a) This section sets the maximum guardianship or conservatorship fee and related cost deductions when:

(i) A court order was entered on or after June 1, 2018; or

(ii) The client under guardianship or conservatorship began receiving medicaid-funded long-term services and supports on or after June 1, 2018.

(b) This section only applies to a client who is:

(i) Eligible for and receives institutional services under this chapter ((~~182-513 WAC~~)) or home and community-based waiver services under chapter 182-515 WAC, and who is required to pay participation under WAC 182-513-1380, 182-515-1509, or 182-515-1514; or

(ii) Eligible for long-term services and supports under this chapter ((~~182-513~~)) or chapter 182-515 WAC, and who is required to pay only room and board.

(c) All requirements of this section remain in full force whether or not the agency appears at a guardianship or conservatorship proceeding.

(d) In this section, the agency does not delegate any authority in determining eligibility or post-eligibility for medicaid clients.

(i) Under the authority granted by chapter 11.130 RCW ((~~11.92.180~~)), the agency does not deduct more than the amounts allowed by this section from participation or room and board.

(ii) The eligibility rules under Title 182 WAC remain in full force and effect.

(e) The agency does not reduce a client's participation or room and board under this section for guardianship or conservatorship fees or related costs accumulated during any month that a client was not required to pay:

(i) Participation under WAC 182-513-1380, 182-515-1509, or 182-515-1514; or

(ii) Room and board under this chapter ((~~182-513~~)) or chapter 182-515 WAC.

(f) If the client has another fiduciary, payee, or other principal-agency relationship and the agent is allowed compensation, any monthly guardianship or conservatorship fee approved under this section is reduced by the agent's compensation.

(2) Maximum guardianship or conservatorship fee and related cost deductions.

(a) The maximum guardianship or conservatorship fee and related cost deductions under this section include all guardianship or conservatorship services provided to the client, regardless of the number of guardians or conservators appointed to a client during a period of time, or whether the client has multiple guardians or conservators appointed at the same time.

(b) Maximum guardianship or conservatorship fees and related cost deductions are as follows:

(i) The total deduction for costs directly related to establishing a guardianship or conservatorship for a client cannot exceed $1,850;

(ii) The total deduction for all guardianship and conservatorship-related costs cannot exceed $1,200 during any three-year period; and

(iii) The amount of the monthly deduction for all guardianship and conservatorship fees cannot exceed $235 per month.

(3) For people under subsection (1)(b)(i) of this section – Participation deductions.

(a) After receiving the court order, the agency or its designee adjusts the client's current participation to reflect the deductions under WAC 182-513-1380, 182-515-1509, or 182-515-1514.

(b) The amounts of the participation deductions are the amounts under subsection (2) of this section, or the court order, whichever are less.

(c) For clients who pay room and board in addition to participation, if the client's amount of participation is insufficient to allow for the amounts under subsection (2) of this section, then, regardless of any provision of this chapter ((~~182-513~~)) or chapter 182-515 WAC, the client's room and board will be adjusted to allow the amounts under subsection (2) of this section.

(4) For people under subsection (1)(b)(ii) of this section - Room and board deductions.

(a) The agency adjusts the client's room and board after receiving the court order, regardless of any provision of this chapter ((~~182-513~~)) or chapter 182-515 WAC.

(b) The amounts of the room and board deductions are the amounts under subsection (2) of this section, or the court order, whichever are less.

AMENDATORY SECTION (Amending WSR 23-04-034, filed 1/25/23, effective 2/25/23)

WAC 182-515-1509 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility. (1) A client eligible for home and community based (HCB) waiver services authorized by home and community services (HCS) under WAC 182-515-1508 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a client's responsibility towards cost of care.

(b) Room and board is a term that refers to a client's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a client must pay toward the cost of care for HCB waiver services authorized by HCS when living in their own home:

(a) A single client who lives in their own home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to 300% of the federal benefit rate (FBR) for the supplemental security income (SSI) cash grant program and must pay the remaining available income toward cost of care after allowable deductions described in subsection (4) of this section. The Washington apple health income and resource standards chart identifies 300% of the FBR as the medical special income level (SIL).

(b) A married client who lives with the client's spouse in their own home (as defined in WAC 388-106-0010) keeps a PNA of up to the effective one-person medically needy income level (MNIL) and pays the remainder of the client's available income toward cost of care after allowable deductions under subsection (4) of this section.

(c) A married client who lives in their own home and apart from the client's spouse keeps a PNA of up to the SIL but must pay the remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living in their own home where each client receives HCB waiver services is each allowed to keep a PNA of up to the SIL but must pay remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(e) A married couple living in their own home where each client receives HCB waiver services, one spouse authorized by the developmental disabilities administration (DDA) and the other authorized by HCS, is allowed the following:

(i) The client authorized by DDA pays toward the cost of care under WAC 182-515-1512 or 182-515-1514; and

(ii) The client authorized by HCS retains the SIL and pays the remainder of the available income toward cost of care after allowable deductions under subsection (4) of this section.

(3) The agency determines how much a client must pay toward the cost of care for HCB waiver services authorized by HCS and room and board when living in a department contracted alternate living facility (ALF) defined under WAC 182-513-1100. A client:

(a) Keeps a PNA of under WAC 182-513-1105;

(b) Pays room and board up to the room and board standard under WAC 182-513-1105; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available income must be paid toward the cost of care after it is reduced by deductions in the following order:

(a) An earned income deduction of the first $65 plus one-half of the remaining earned income;

(b) Guardianship fees, conservatorship fees, and administrative costs including any attorney fees paid by the guardian or conservator only as allowed under chapter 388-79A WAC;

(c) Current or back child support garnished or withheld from the client's income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse as determined under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income to the community spouse's PNA, as calculated under WAC 182-513-1385;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized client, or the client's spouse, as calculated under WAC 182-513-1385;

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are under WAC 182-513-1350.

(5) The total of the following deductions cannot exceed the special income level (SIL) defined under WAC 182-513-1100:

(a) The PNA allowed in subsection (2) or (3) of this section, including room and board;

(b) The earned income deduction in subsection (4)(a) of this section; and

(c) The guardianship fees, conservatorship fees, and administrative costs in subsection (4)(b) of this section.

(6) A client may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A client must pay the client's provider the sum of the room and board amount, and the cost of care after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

(8) A client on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has received in a month.

(10) Standards described in this section are found at www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 23-04-034, filed 1/25/23, effective 2/25/23)

WAC 182-515-1514 Home and community based (HCB) services authorized by the developmental disabilities administration (DDA)—Client financial responsibility. (1) A client eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) under WAC 182-515-1513 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a client's responsibility towards cost of care.

(b) Room and board is a term that refers to a client's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a client must pay toward the cost of care for home and community based (HCB) waiver services authorized by the DDA when the client is living at home, as follows:

(a) A single client who lives at home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to the special income level (SIL) defined under WAC 182-513-1100.

(b) A single client who lives at home on the roads to community living program authorized by DDA keeps a PNA up to the SIL but must pay any remaining available income toward cost of care after allowable deductions described in subsection (4) of this section.

(c) A married client who lives with the client's spouse at home (as defined in WAC 388-106-0010) keeps a PNA of up to the SIL but must pay any remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living at home where each client receives HCB waiver services, one authorized by DDA and the other authorized by home and community services (HCS) is allowed the following:

(i) The client authorized by DDA keeps a PNA of up to the SIL but must pay any remaining available income toward the client's cost of care after allowable deductions in subsection (4) of this section; and

(ii) The client authorized by HCS pays toward the cost of care under WAC 182-515-1507 or 182-515-1509.

(3) The agency determines how much a client must pay toward the cost of care for HCB wavier services authorized by DDA and room and board when the client is living in a department-contracted ALF defined under WAC 182-513-1100. A client:

(a) Keeps a PNA under WAC 182-513-1105;

(b) Pays room and board up to the room and board standard under WAC 182-513-1105; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available income must be paid toward the cost of care after it is reduced by allowable deductions in the following order:

(a) An earned income deduction of the first $65, plus one-half of the remaining earned income;

(b) Guardianship fees, conservatorship fees, and administrative costs including any attorney fees paid by the guardian or conservator only as allowed under chapter 388-79A WAC;

(c) Current or back child support garnished or withheld from the client's income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse under WAC 182-513-1385. If the community spouse is on long-term care services, the allocation is limited to an amount that brings the community spouse's income to the community spouse's PNA;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized client, or the client's spouse, as calculated under WAC 182-513-1385; and

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are under WAC 182-513-1350.

(5) The total of the following deductions cannot exceed the SIL defined under WAC 182-513-1100:

(a) The PNA described in subsection (2) or (3) of this section, including room and board;

(b) The earned income deduction in subsection (4)(a) of this section; and

(c) The guardianship fees<u>, conservatorship fees,</u> and administrative costs in subsection (4)(b) of this section.

(6) A client may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A client must pay the client's provider the sum of the room and board amount, the cost of care after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

(8) A client on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has received in a month.

(10) Standards described in this section are found at www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.