To: County Welfare Agency Directors

Subject: Addendum to PA-1G Medicaid Application
Transfer of Assets Self-Attestation Form

The New Jersey Comprehensive Medicaid Waiver (CMW) was submitted to the Centers for Medicare and Medicaid Services (CMS) and was approved on October 1, 2012. This is a five year demonstration which reforms our current delivery system by: 1) offering Managed Long Term Services and Supports through a Managed Care Organization; 2) establishes a managed adult behavioral health system; and 3) streamlines eligibility. This collection of reforms will help to rebalance the system and reduce costs by building capacity for Home and Community Based Service options.

To streamline the eligibility process, the CMW permits self-attestation of resources for individuals who have income that is equal to or below 100% of the Federal Poverty Level (FPL) and are applying for institutional or Home and Community Based Services. This self-attestation process is for new applicants and current Medicaid recipients who require these levels of care. In response to this policy change, the Division of Medical Assistance and Health Services (DMAHS) developed a Transfer of Assets Self-Attestation form which will serve as an Addendum to the PA-1G Medicaid Application. This form must be completed when an individual: 1) has income equal to or below 100% FPL; 2) is applying for institutional care or Home and Community Based Services; and 3) has stated that no assets or resources have been transferred in the previous 60 months for less than fair market value. The addendum is a sworn statement that also outlines that anyone who reports false information will be required to reimburse the State of New Jersey for any benefits received or be subject to a period of ineligibility and/or civil and criminal prosecution.
It is important to note that the addendum cannot be completed by anyone other than the individual, spouse, domestic partner, guardian or Power of Attorney. These are the people who would know if someone has transferred an asset. If none of the above can complete this form and/or, if they cannot meet for a face to face interview with a caseworker, then a five year look back will be required. The caseworker will serve as the witness to this sworn statement.

If you have any questions regarding this Medicaid Communication, please refer them to the Division’s Office of Eligibility Policy field service staff for your agency at 609-588-2556.

Sincerely,

Valerie Harr
Director

VH:m

c: Jennifer Velez, Commissioner
   Department of Human Services
   Dawn Apgar, Deputy Commissioner
   Division of Developmental Disabilities
   Lowell Arye, Deputy Commissioner
   Aging and Community Services
   Lynn Kovich, Assistant Commissioner
   Division of Mental Health and Addiction Services
   Joseph Amoroso, Director
   Division of Disability Services
   Kathleen M. Mason, Director
   Division of Aging Services
   Jeanette Page-Hawkins, Director
   Division of Family Development
   Allison Blake, Commissioner
   Department of Children and Families
   Mary E. O'Dowd, Commissioner
   Department of Health
Applicant Name: _______________________________________________________________

Date of Birth: __________________________ Social Security No. _______________________

County: _______________________________

This addendum is to be completed, signed and dated by all individuals who are applying for institutional or Home and Community Based Services with income levels at or below 100% of the Federal Poverty Level and has stated that no assets or resources have been transferred in the previous 60 months for less than fair market value. **This addendum cannot be completed by anyone other than the individual, spouse, domestic partner, guardian, or Power of Attorney.**

Please initial:

_______ I certify that my monthly income is equal to or below $____________ (100% of the Federal Poverty Level).

_______ I certify that I, my spouse, my domestic partner or anyone acting at my direction or on my behalf **have not** transferred any assets or resources for **less than fair market value** or waived the right to receive any assets or resources during the **60 month** period prior to ________________ (Date of request for institutional or Home and Community Based Services). Please see Page 4 of the application for examples of assets.

I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, would be required to reimburse the State of New Jersey for any benefits the Medicaid beneficiary received incorrectly or would cause the beneficiary to be subject to a period of ineligibility. I understand this does not prevent any other civil or criminal penalties that may arise from a false or misleading statement.

_______________________________________________________________

Print Name

__________________________
Signature

Date

____________________________________

Relationship to beneficiary

____________________________________

Witness Print Name

Signature