STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3725

[redacted] 2014
SIGNATURE CONFIRMATION

REQUEST #631143

CLIENT ID #[redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2014, the Department of Social Services (the "Department"), sent [redacted] (the "Appellant") a Notice of Denial stating that his application for medical assistance under the Medicaid program had been denied because he did not return all of the required verifications requested.

On [redacted] 2014, a caseworker reviewed additional information provided by the Appellant's representative and sent out a Verification We Need ("W-1348") to the Appellant's representative requesting additional information.

On [redacted] 2014, the Appellant's representative, [redacted], submitted an unsigned request for an administrative hearing on behalf of the Appellant to contest the Department's denial of the Appellant's application for medical assistance under the Medicaid program.

On [redacted] 2014, the unsigned request was returned to the Appellant's representative with a Notice for Request for Signature or Authorization.

On [redacted] 2014, the Appellant's representative submitted a signed request for an administrative hearing on behalf of the Appellant to contest the Department's denial of the Appellant's application for medical assistance under the Medicaid program.

On [redacted] 2014, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice of Administrative Hearing scheduling a hearing for [redacted] 2014 @ [redacted] to address the Department's denial of the Appellant's application for medical assistance under the Medicaid program. OLCRAH granted the Appellant's representative a continuance.

On [redacted] 2014, in accordance with sections 17b-60, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing to address the Department's denial of the Appellant's application for medical assistance under the Medicaid program.

The following individuals were present at the hearing:

[redacted], Representative for the Appellant
Janice A. Kopchik, Representative for the Department
Hernold C. Linton, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Appellant failed, without good cause, to provide the Department with requested verification or information necessary to establish his eligibility for medical assistance under the Medicaid program.

FINDINGS OF FACT

1. On [redacted] 2013, the Department received the Appellant's application for medical assistance under Medicaid program to help with the cost of nursing home. (Hearing Summary; Dept.'s Exhibit A: W-1F Application Part 2)

2. On [redacted] 2013, the Department sent the Appellant's representative a Verification We Need (Form "W-1348") requesting additional information or verifications needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit C: W-1348)

3. The W-1348 informed the Appellant's representative of the outstanding verifications needed to process his application for medical assistance, and the due date of [redacted] 2013, by which to provide the requested information, or else his application would be denied. (Hearing Summary; Dept.'s Exhibit C)

4. On [redacted], 2013, the Appellant's representative provided the Department with the additional requested information. (Dept.'s Exhibit E: Narrative Screens)

5. On [redacted] 2013, the Department reviewed the additional information provided by the Appellant's representative. (Dept.'s Exhibit E)

6. On [redacted] 2013, the Department sent the Appellant's representative another W-1348 requesting additional information or verifications still needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit D: W-1348)

7. The [redacted] 2013 W-1348 informed the Appellant's representative of the outstanding verifications still needed to process his application for medical

assistance, and the due date of [redacted] 2013, by which to provide the requested information, or else his application may be delayed or denied. (Dept.'s Exhibit D)

8. On [redacted] 2013, the Appellant's representative contacted the Department's Benefit Center by telephone to check on the status of the Appellant's application for medical assistance, and was directed to contact the worker in the Manchester Office assigned to process the Appellant's application with her inquiry. The Appellant left a voice mail for the caseworker to contact her. (Dept.'s Exhibit E)

9. On [redacted] 2013, the caseworker contacted the Appellant's representative and advised the representative to fax over the requested information to the Department. (Hearing Summary; Dept.'s Exhibit E)

10. On [redacted] 2014, the Department denied the Appellant's application for medical assistance for failure to provide all of the required verifications requested. (Hearing Summary; Dept.'s Exhibit E)

11. On [redacted] 2014, the Department reviewed additional information provided by the Appellant's representative. (Dept.'s Exhibit E)

12. The Appellant died on [redacted] 2014. (Appellant Representative's testimony)

13. On [redacted] 2014, the Department received a voice mail message from the Appellant's representative regarding the additional information that she provided. (Dept.'s Exhibit E)

14. The Department advised the Appellant's representative that she would receive another W-1348 listing the verifications that were still needed and that the original application would be rescreened once the requested information was received. (Dept.'s Exhibit E)

15. On [redacted] 2014, the Department sent the Appellant's representative another W-1348 requesting additional information or verifications still needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit F: [redacted]/14 W-1348)

16. The [redacted] 2014 W-1348 informed the Appellant's representative of the outstanding verifications still needed to process his application for medical assistance, and the due date of [redacted] 2014, by which to provide the requested information, or else his benefits may be delayed or denied. (Dept.'s Exhibit F)

17. On [redacted] 2014, the Department received an envelope from the Appellant's representative resubmitting verifications previously provided, and the Department decided not to rescreen the Appellant's application for medical assistance. (Dept.'s Exhibit E)

18. The Department did not advise the Appellant's representative to reapply for medical assistance, and the representative was led to believe that the original application was still being processed by the Department. (See Facts # 1 to 16; Appellant Representative's testimony)

19. The Department did not send the Appellant's representative an additional W-1348 after the receipt of some of the information that had been previously requested. (See Facts # 1 to 18)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes (CGS) authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. Section 17b-60 of the Connecticut General Statutes provides that an aggrieved person authorized by law to request a fair hearing on a decision of the Commissioner of Social Services or the conservator of any such person on his behalf may make application for such hearing in writing over his signature to the commissioner and shall state in such application in simple language the reasons why he claims to be aggrieved. Such application shall be mailed to the commissioner within sixty days after the rendition of such decision. The commissioner shall thereupon hold a fair hearing within thirty days from receipt thereof and shall, at least ten days prior to the date of such hearing, mail a notice, giving the time and place thereof, to such aggrieved person, or if the application concerns a denial of or failure to provide emergency housing, the commissioner shall hold a fair hearing within four business days from receipt thereof, and shall make all reasonable efforts to provide notice of the time and place of the fair hearing to such aggrieved person at least one business day prior to said hearing. A reasonable period of continuance may be granted for good cause. The aggrieved person shall appear personally at the hearing, unless his physical or mental condition precludes appearing in person, and may be represented by an attorney or other authorized representative.

3. Uniform Policy Manual ("UPM"), Section 1570.05(B) provides that subject to the conditions described in this chapter, the requester has the right to a Fair Hearing if:

    1. the Department denies the assistance unit's application for benefits; or
    2. the Department does not take action on the assistance unit's application within the time limits specified in Section 1500; or

    3. the requester feels that the Department has either failed to take a required action or has taken an erroneous action. Such actions include:

a. suspending, reducing, discontinuing, or terminating benefits; or
b. imposing conditions upon eligibility; or
c. issuing benefits in a manner other than directly to the assistance unit; or
d. taking any other action affecting the receipt of benefits, such as computing the amount of benefits.

4. UPM § 1570.05(C) provides that the Department denies or dismisses a request for a Fair Hearing if:

1. the request for the Fair Hearing is not made within the time limits described in this section; or

5. UPM § 1570.05(H) provides that the request for a Fair Hearing must be made within a specified period of time from the date that the Department mails a notice of action.

a. For all programs except Food Stamps, this period is 60 days.

b. For the Food Stamp program, this period is 90 days.

6. UPM § 1599.10(A) provides that the Department requires verification of good cause claims by the assistance unit which has failed to comply with the time limits in the eligibility process if:

1. the circumstances are questionable; and

2. taking good cause into consideration would affect eligibility or benefit level for a current or retroactive period of time, or otherwise alter the Department's actions.

7. UPM § 1599.10(B) provides that a claim of good cause for requesting an extension of the time limit for filing an appeal of a Fair Hearing must be accompanied by evidence substantiating the claim.

UPM § 1599.10(C) provides that failure to provide required verification of good cause circumstances results in non-consideration of the claim

8. The record contained verification of the Appellant's good cause for not filing an appeal within the time limit.

9. The Department continued to request additional information needed to process the Appellant's [redacted] 2013 application for medical assistance, after the [redacted], 2014 denial.

10. The Appellant's representative had good cause for not requesting a Fair Hearing within the specified time limit in order to address the Department's

[redacted], 2014 denial of the Appellant's application for medical assistance under the Medicaid program, as the Department continued to process the application after [redacted] 2014, thus giving the impression that the denial was voided and that he did not need to complete a reapplication.

11. UPM § 1010.05(A)(1) provides that the assistance unit must supply the Department in an accurate and timely manner as defined by the Department, all pertinent information and verification which the Department requires to determine eligibility and calculate the amount of benefits.

12. UPM § 1010.05(A)(2) provides that the assistance unit must permit the Department to verify information independently whenever the unit is unable to provide the necessary information, whenever verification is required by law, or whenever the Department determines that verification is necessary (Cross reference: 1540).

13. UPM § 1010.05(B)(1) provides that the assistance unit must report to the Department, in an accurate and timely manner as defined by the Department, any changes which may affect the unit's eligibility or amount of benefits (cross reference 1555).

14. The Appellant's representative did provide the Department with some of the requested information on [redacted] 2013, [redacted], 2014, and [redacted] 2014.

15. UPM § 1015.05(C) provides that the Department must tell the assistance unit what the unit has to do to establish eligibility when the Department does not have sufficient information to make an eligibility determination.

16. UPM § 1015.10(A) provides that the Department must inform the assistance unit regarding the eligibility requirements of the programs administered by the Department, and regarding the unit's rights and responsibilities.

17. UPM § 1505.40(A)(1) provides that prior to making an eligibility determination the Department conducts a thorough investigation of all circumstances relating to eligibility and the amount of benefits.

18. UPM § 1505.40(B)(4)(a) provides that the eligibility determination is delayed beyond the AFDC, AABD or MA processing standard if because of unusual circumstances beyond the applicant's control, the application process is incomplete and one of the following conditions exists:

    1. eligibility cannot be determined; or

    2. determining eligibility without the necessary information would cause the application to be denied.

19. UPM § 1505.40(B)(5)(a) provides that regardless of the standard of promptness, no eligibility determination is made when there is insufficient verification to determine eligibility when the following has occurred:

    1. the Department has requested verification; and

    2. at least one item of verification has been submitted by the assistance unit within a time period designated by the Department but more is needed.

20. UPM § 1505.40(B)(5)(b) provides that additional 10 day extensions for submitting verification shall be granted as long as after each subsequent request for verification at least one item of verification is submitted by the assistance unit within each extension period.

21. The Department did not send an additional W-1348 to the Appellant's representative where some of the information previously requested had been provided.

22. UPM § 1540.10 provides that the verification of information pertinent to an eligibility determination or a calculation of benefits is provided by the assistance unit or obtained through the direct efforts of the Department.

23. UPM § 1540.10(A) provides that the assistance unit bears the primary responsibility for providing evidence to corroborate its declarations.

24. The Appellant's representative did submit some of the requested information regarding his financial status to the Department prior to the [redacted] 2014 denial of his application for medical assistance under the Medicaid program.

25. The Department incorrectly denied the Appellant's application for medical assistance under the Medicaid, for failure to provide requested information, as the Department failed to mail to the Appellant's representative an additional W-1348, when some of the information previously requested had been provided.

DISCUSSION

As a result of the Alvarez vs. Aronson lawsuit the Department made revisions to policy and procedures concerning the process of verification, [See UP-90-26; UPM § P-1540.10(4); Verification and Documentation Guidelines, 10/90]. One of these changes was the requirement that a Verification We Need (W-1348) be used when requesting verifications from an applicant. This requirement was instituted to make sure that the applicant had a clear understanding of exactly what verification is needed, the due dates, and other acceptable forms of verification. The regulations also provide for the mailing of additional W1348 forms where some of the information previously requested has been provided. In the present case the Department did not provide the Appellant's representative with an additional W-1348, after receiving some the information that had been previously

requested; thus not giving proper notice to the Appellant of what he still needed to do to establish his eligibility.

The Appellant's representative did provide the Department with some of the requested information regarding the Appellant's financial situation. However the Department did not provide the Appellant's representative with a written notice of the additional verifications that were still outstanding regarding the Appellant's financial status. Consequently, the undersigned finds that the Department incorrectly denied the Appellant's application for medical assistance under the Medicaid program, for failure to provide requested verification regarding his financial status. The Department has to reopen the Appellant's application.

DECISION

The Appellant's appeal is **GRANTED**.

ORDER

1. The Department will reopen the Appellant's application of [redacted] 2013 for medical assistance under the Medicaid program, based on the findings of this hearing decision.

2. The Department will provide the Appellant's representative with another W-1348 outlining what additional verifications must be submitted in order to establish his eligibility for medical assistance under the Medicaid program.

3. No later than thirty (30) days from the date of this hearing decision, the Department will submit to the undersigned verification of the Department's compliance with this order.

Hernold C. Linton

Hernold C. Linton
Hearing Officer

Pc: **Poonam Sharma**, Social Service Operations Manager, DSS, R.O. # 30, Bridgeport

RIGHT TO REQUEST RECONSIDERATION

The appellant has the right to file a written reconsideration request within **15** days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a (a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Administrative Hearings and Appeals, 55 Farmington Avenue, Hartford, CT 06105-3725.

RIGHT TO APPEAL

The appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The 45 day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than 90 days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or the Commissioner's designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.