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

[redacted] **2015**
Signature Confirmation

Request # 640125
Client ID # [redacted]

NOTICE OF DECISION

PARTY

[redacted]
C/O [redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2014, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying his application for L01 Long Term Care Medicaid ("L01") because he did not return all of the required verification.

On [redacted] 2014, the Appellant requested an administrative hearing to contest the Department's decision to deny his application for Medicaid.

On [redacted] 2014, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted], 2014.

On [redacted] 2014, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted], Appellant's spouse
[redacted], Appellant's authorized representative
Ellen Croll, Department's Representative
James Hinckley, Hearing Officer

The Hearing record was held open for the submission of additional evidence. On [redacted] 2014, the record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to deny the Appellant's application for Medicaid because he failed to provide all the required verification was correct.

FINDINGS OF FACT

1. On [redacted], 2014, the Appellant was admitted to the Montowese Health Care Center, a long term care nursing facility. (Record)

2. On [redacted] 2014, the Appellant applied to the Department for L01 Medicaid. (Record)

3. The Appellant named [redacted] (the "Auth. Rep"), an employee of Montowese Health Care Center, to act as his authorized representative during the application process. (Record)

4. The Appellant's spouse, [redacted] (the "Spouse"), resides in the community. (Record)

5. When an applicant for long term care Medicaid has a community spouse, the Department must assess the total assets owned by the couple as of the date of institutionalization (the "DOI"). (Department testimony)

6. The Appellant's DOI is [redacted], 2014. (Record)

7. During the application process, the Department sent several W-1348LTC "Verification We Need" forms to the Appellant, requesting information needed to process the case. (Summary, Record)

8. During the application process, most of the information needed to process the case was provided by the Appellant; the information included financial records for the couple covering a five year look back period. (Summary, Ex. 4: Narrative screens)

9. On [redacted], 2014, the Auth. Rep submitted a [redacted] 2014 annuity statement to the Department. (Ex. 4)

10. On [redacted] 2014, the eligibility worker called both the Auth. Rep and the Spouse and explained that in addition to the current statement, the

Department needed a copy of the annuity contract and proof of the value of the annuity as of the DOI. (Ex. 4)

11. On [redacted] 2014, the Appellant signed a notarized form requesting a duplicate contract from the insurance company that issued the annuity. (Ex. C: Vantis Life Insurance Company, Request for Duplicate Contract)

12. The Appellant's spouse has a specific recollection that she requested and received from the insurance company, both a duplicate copy of the annuity contract, and proof of its value as of the DOI, and submitted both to the Department. (Spouse's testimony)

13. On [redacted], 2014, the Department sent a W-1348LTC "Verification We Need" form requesting: "Please provide a copy of the annuity policy and specification page. The value of the annuity for DOI of [redacted]/14 is also needed in order to complete the spousal assessment". The due date to provide the information was [redacted] 2014. (Ex. 3: W-1348LTC form)

14. The Auth. Rep and the Spouse were confused regarding what additional information was being requested by the Department on the [redacted], 2014 W-1348LTC; the Spouse had already provided the Department with a copy of the annuity contract and proof of its value as of the DOI. (Testimony)

15. On [redacted] 2014, the eligibility worker spoke to the Spouse by telephone and informed her that the Department needed a copy of the annuity contract and proof of the annuity's value as of the DOI; the Spouse explained to the eligibility worker that she had already provided this information, and the eligibility worker explained that the Department had no record of receiving the information. (Ex. 4)

16. After the [redacted], 2014 phone call, the Spouse requested the information regarding the annuity from the insurance company again. (Spouse's testimony)

17. On [redacted] 2014, the Department sent the Appellant a NOA advising him that his application for L01 Medicaid was denied because he did not return all of the verification the Department asked for. (Ex. 5: [redacted] 2014 NOA)

18. The Spouse received a new letter from the insurance company verifying the annuity contract number, its current interest rate, its current value, and its value as of the [redacted] 2014 DOI. (Spouse's testimony, Ex. A: [redacted] 2014 letter from Vantis Life)

CONCLUSIONS OF LAW

1. Section 17b-2 and § 17b-260 of the Connecticut General Statutes, authorizes the Department of Social Services to administer the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Uniform Policy Manual ("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 that the Department requires to determine eligibility and calculate the amount of benefits.

   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.

   UPM § 1505.35 (C) provides that the following promptness standards be established as maximum times for processing applications: forty-five calendar days for AABD or MA applicants applying based on age or blindness.

   UPM § 1505.35 (D) (2) provides that the Department determines eligibility within the standard of promptness for the AFDC, AABD, and MA programs except when verification needed to establish eligibility is delayed and one of the following is true: a. the client has good cause for not submitting verification by the deadline, or b. the client has been granted a 10 day extension to submit verification which has not elapsed.

   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.
   A. The assistance unit bears the primary responsibility for providing evidence to corroborate its declarations.
   B. The assistance unit may submit any evidence which it feels will support the information provided by the unit.
   C. The Department obtains verification on behalf of the assistance unit when the following conditions exist:
      1. the Department has the internal capability of obtaining the verification needed through such means as case files, microfiche records, or direct access to other official records; or
      2. the Department has the capability to obtain the verification needed, and the assistance unit has done the following:
         a. made a reasonable effort to obtain the verification on its own; and
         b. been unable to obtain the verification needed; and
         c. requested the Department's help in obtaining the verification; and

d. continued to cooperate in obtaining the verification.

3. when the evidence necessary can only be obtained by payment of a fee, and the Department is able to obtain the evidence.

D. The Department considers all evidence submitted by the assistance unit or received from other sources.

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.

UPM § 1505.40 (B) (4) (b) provides that if the eligibility determination is delayed, the Department continues to process the application until:

(1) The application is complete; or

(2) Good cause no longer exists.

3. The Appellant provided the Department with the information it requested.

4. The Department did not receive some of the information the Appellant sent.

5. The Department had the capability of obtaining the missing verification needed by requesting it directly from the insurance company; it had a current annuity statement providing all of the relevant contract information, and the authority to request the information on behalf of the Appellant.

6. The Department had the option of either obtaining the verification it needed itself, or giving the Appellant good cause and allowing more time for him or his authorized representative to provide the information.

7. The Department was incorrect to deny the Appellant's application for L01 Medicaid for the reason that he did not return all of the required verification.

DISCUSSION

The Appellant's Spouse credibly testified that she submitted to the Department in [redacted] 2014 both a copy of the annuity contract and proof of its value as of the DOI. Her testimony is bolstered by the Department's narrative showing that the eligibility worker verbally requested the information on [redacted] 2014, and by a document located in the case file (Ex: C), which shows that a request for information from the insurance company was completed by the Appellant on [redacted] 2014, the day immediately following the Department's request.

The Appellant's application required the production of all of the couple's financial records covering a five year look back period; the Department sent eight requests for information during the process, and by its own account the Appellant was compliant throughout, providing all of the requested records except for the single piece of annuity information verifying its value as of the DOI. When the Spouse explained to the Department on [redacted] 2014 that she had already sent the information it was looking for, the Department had no reason to disbelieve her. The Department had in its possession a copy of the request for contract information that was completed by the Appellant on [redacted] 2014, and therefore knew that the Spouse had acted promptly on its last request.

There are myriad possible explanations for why just this one piece of verification failed to reach the Department, and assigning blame is unnecessary. When the Department learned on [redacted] 2014 that the Appellant had already sent the information it needed, but could not locate the information in its own files, it should have either requested the information itself directly from the company or given the Appellant good cause and allowed more time for the verification to be obtained and provided a second time.

DECISION

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

ORDER

1. The Department shall reopen the Appellant's L01 Medicaid application as of [redacted] 2014.

2. The Department shall provide proof of compliance with this order to the undersigned no later than [redacted], 2015.

_____
James Hinckley
Hearing Officer

cc: Peter Bucknall, SSOM, New Haven
[redacted]

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, law, and 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 Legal Counsel, Regulations, and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105.

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, if 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 his 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.