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

2015
SIGNATURE CONFIRMATION

REQUEST #664047

CLIENT ID #

NOTICE OF DECISION

PARTY

C/O

PROCEDURAL BACKGROUND

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

On 2015, the Appellant's representative, , requested 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 2015, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice of Administrative Hearing scheduling a hearing for 2015 @ 2:00 PM 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 2015, 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:

, Representative for the Appellant
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 verifications or information necessary to establish her eligibility for medical assistance under the Medicaid program.

FINDINGS OF FACT

1. The Appellant became a resident of Regency Heights of Windham, which is a long-term care facility ("LTCF"). (Hearing Summary; Dept.'s Exhibit A: W-1LTC Application)

2. The Appellant has a spouse residing in the community. (Hearing Summary)

3. On ████ 2014, the Department received the Appellant's application for medical assistance under Medicaid program to help with the cost of nursing home placement. (Hearing Summary; Dept.'s Exhibit A)

4. On ███ █ 2014, 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 B: W-1348)

5. The W-1348 informed the Appellant's representative of the outstanding verifications needed to process the application for medical assistance, and the due date of ████ 2014, by which to provide the requested information, or else the application would be denied. (Hearing Summary; Dept.'s Exhibit B)

6. The Appellant's representative provided the Department with some of the requested information. (Hearing Summary)

7. The Appellant expired on ████ 2014. (Hearing Summary)

8. On ████ 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 C: W-1348LTC)

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

10. On ████ 2014, the Department received some more requested information from the facility for the Appellant. (Hearing Summary)

11. On [redacted] 2014, the Department sent the Appellant's representative another W-1348 requesting asset verifications and information on home property still needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit D: W-1348LTC)

12. On [redacted] 2014, the Department received some of the requested information. (Hearing Summary)

13. On [redacted] 2014, the Department sent the Appellant's representative another W-1348 requesting asset verifications still needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit E: W-1348LTC)

14. On [redacted] 2014, the Department received the requested verifications. (Hearing Summary)

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

16. On [redacted] 2014, the Department received the requested verifications for the Appellant. (Hearing Summary; Dept.'s Exhibit K: Case Narrative)

17. On [redacted] 2014, the Department received the requested verifications on behalf of the Appellant. (Hearing Summary; Dept.'s Exhibit K)

18. The Appellant closed out two accounts and deposited the combined proceeds from both accounts of $6,386.16 into his account (#[redacted]) held at Wells Fargo Bank on [redacted] 2013. (Appellant's representative's testimony)

19. The Department determined the Appellant's date of institutionalization ("D.O.I.") as [redacted] 2014. (Hearing Summary; Dept.'s Exhibit K)

20. The minimum Community Spouse Protected Amount ("CSPA") allowed as of D.O.I. was $23,448.00. (Long Term Services and Supports Amounts)

21. The Department determined that the combined total of the Appellant and Community Spouse's non-exempt assets was less than $23,448.00 as of the D.O.I. (Hearing Summary; Dept.'s Exhibit K)

22. The Department determined that the Community Spouse could retain all of the combined spousal assets as of the D.O.I. (Dept.'s Exhibit K)

23. The Department determined that the Appellant's share of the non-exempt assets was within $1,600.00 as of the D.O.I. (Hearing Summary; Dept.'s Exhibit K)

24. The Department determined that the couple did not need to spend down their total combined non-exempt assets as of the D.O.I. in order for the Appellant to qualify for Medicaid. (Hearing Summary; Dept.'s Exhibit K)

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. Uniform Policy Manual ("UPM"), Section 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.

3. 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).

4. 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).

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

6. 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.

7. 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.

8. 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.

9. 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.

10. 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.

11. 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.

12. The Department did send additional W-1348's to the Appellant's representative where some of the information previously requested had been provided.

13. 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.

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

15. The Appellant's representative did submit the requested information regarding the Appellant's combined spousal assets and her financial status as of the D.O.I. to the Department prior to the [redacted] 2014 denial of her application for medical assistance under the Medicaid program.

16. The Department incorrectly denied the Appellant's application for medical assistance under the Medicaid, for failure to provide requested information, as the Department had sufficient information to determine the Appellant's eligibility for medical assistance under the Medicaid program.

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 date, 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 provide the Appellant's representative with additional W-1348's, after receiving some the information that had been previously requested; thus giving proper notice to the Appellant of what she still needed to do to establish her eligibility.

The Appellant's representative did provide the Department with the requested information regarding the Appellant's spousal assets and financial situation. The Department then determined that the Community Spouse was able to retain all of the spousal assets as of the D.O.I. 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 her 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] 2014 for medical assistance under the Medicaid program, based on the findings of this hearing decision.

2. Provided that all other factors of eligibility are met, the Department will grant the Appellant medical assistance to cover her LTC services.

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: **Tonya Cook-Bedford**, Social Service Operations Manager,
DSS, R.O. # 42, Willimantic

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.