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 #707079

CLIENT ID #[redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2015, the Department of Social Services (the "Department"; or "DSS"), sent [redacted] (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 [redacted], 2015, the Appellant's representative, [redacted], requested an administrative hearing on behalf of the Appellant to contest the Department's denial of the Appellant's application for medical assistance.

On [redacted], 2015, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice of Administrative Hearing scheduling a hearing for [redacted], 2015 @ 10:00 AM to address the Department's denial of the Appellant's application for medical assistance.

On [redacted], 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.

The following individuals were present at the hearing:

[redacted] Appellant's Representative/Son
Nancy Sciascia, 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 her eligibility for medical assistance under the Medicaid program.

FINDINGS OF FACT

1. On [redacted], 2015, the Appellant was admitted to [redacted] Health Care Center for long-term care ("LTC"). (Hearing Summary)

2. On [redacted], 2015, the Appellant's representative signed a request to change the beneficiary of the Appellant's Prudential Life insurance policy to [redacted] Funeral Home. (Appellant's Exhibit B: Request to Change Beneficiary)

3. On [redacted], 2015, the Department received the Appellant's application for medical assistance under Medicaid program. (Hearing Summary; Dept.'s Exhibit #1: W-1LTC Application)

4. On [redacted], 2015, the Department sent the Appellant's representative a We Need Verification from You (Form "W-1348LTC") requesting information or verifications regarding her financial status needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit #2: W-1348LTC)

5. The Department requested verification of the beneficiary for the Appellant's Prudential Life insurance policy, and noted that the [redacted] Funeral Home was also contacted for this information. (Dept.'s Exhibit #2)

6. The W-1348 LTC informed the Appellant and her representative of the outstanding verifications needed to process her application for medical assistance, and the due date of [redacted] 2015, by which to provide the requested information, or else her application would be denied. (Hearing Summary; Dept.'s Exhibit #2)

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

8. On [redacted] 2015, the Department sent the Appellant's representative another W-1348 LTC requesting the remaining information or verifications still needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit #2)

9. The second W-1348 LTC requested verification that the Appellant's total assets were below $1,600.00, and noting that Prudential had confirmed that the

Appellant owned a life insurance policy with a face value of $5,000.00 and a cash value of $10,643.84. (Dept.'s Exhibit #2)

10. The second W-1348 LTC extended the due date to [redacted], 2015, by which to provide the requested information, or else the Appellant's application would be denied. (Hearing Summary; Dept.'s Exhibit #2)

11. The Appellant's representative did not provide the Department with verification that her total assets had been reduced to $1,600.00. (Hearing Summary; Dept.'s Exhibit #2)

12. On [redacted] 2015, the Department denied the Appellant's application for medical assistance under the Medicaid program for failure to provide all of the required verification requested. (See Facts # 1 to 11; Hearing Summary; Dept.'s Exhibit #4: [redacted]/15 Notice of Denial)

13. The Appellant's representative did not request an extension of the due date by which to provide the Department with the outstanding verifications still needed to process the Appellant's application for medical assistance. (See Facts # 1 to 12)

14. The Appellant's representative did not request the Department's assistance in securing the outstanding verifications still needed to process the Appellant's application for medical assistance. (See Facts # 1 to 13)

15. The Appellant died on [redacted] 2015. (Hearing Summary

16. On [redacted], 2015, the Appellant's representative executed an Assignment of Proceeds of Insurance transferring the proceeds of the Appellant's Prudential Life insurance policy to [redacted] Funeral Home as payment for funeral services and merchandise for the Appellant. (Appellant's Exhibit C: Assignment of Proceeds of Insurance)

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-260 of the Connecticut General Statutes authorizes the commissioner of social services to take advantage of the medical assistance programs provided in Title XIX, entitled "grants to States for Medical Assistance Programs," contained in the Social Security Amendments of 1965.

3. 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.

4. 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).

5. The Appellant's representative did not provide the Department with verification of the named beneficiary of the Appellant's Prudential Life insurance policy by the specified due date.

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 the Appellant's representative two W-1348LTC's requesting the information needed to determine her eligibility for medical assistance.

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 Department did send an additional W-1348LTC to the Appellant's representative after receiving some of the information previously requested.

16. The Appellant's representative did not submit the outstanding information regarding the named beneficiary of the Appellant's Prudential Life insurance policy to the Department prior to the denial of the Appellant's application for medical assistance.

17. The Department correctly denied the Appellant's application for medical assistance, for failure to provide requested information, as the Appellant's representative did not submit the requested information regarding the named beneficiary of the Appellant's Prudential Life insurance policy to the Department within the specified time frame, or prior to the denial of her application.

DISCUSSION

As a result of the Alvarez vs. Aronson lawsuit the Department made revisions to the 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 We Need Verification from You (W-1348LTC) 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 verifications. The policy also provides 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 W-1348LTC's; thus giving proper notice to the Appellant of what she needed to do in order to establish her eligibility.

The Appellant's representative did not provide the Department with the outstanding verification regarding the named beneficiary of the Appellant's Prudential Life insurance

policy. The Department did provide the Appellant's representative with a written request for the remaining information that was still needed regarding the Appellant's Prudential Life insurance policy. Consequently, the undersigned finds that the Department correctly denied the Appellant's application for medical assistance, for failure to provide requested verification needed to establish her eligibility.

DECISION

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

Hernold C. Linton

Hernold C. Linton
Hearing Officer

Pc: **Musa Mohamud,** Social Service Operations Manager,
DSS, R.O. #10, Hartford

Elizabeth Thomas, Social Service Operations Manager,
DSS, R.O. #10, Hartford

Patricia Ostroski, Social Service Program Manager,
DSS, R.O. #10, Hartford

Tricia Morelli, Social Service Program Manager,
DSS, R.O. #10, Hartford

Laurie Fillippini, Social Service Program Manager,
DSS, R.O. #10, Hartford

[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 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.