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

2016 Signature Confirmation

Request # 746922 Client ID #

NOTICE OF DECISION

PARTY



PROCEDURAL BACKGROUND

the attorney for Action ("NOA") denying the Appellant's Medicaid appellant's benefits.	(the "Appellant") a Notice of
On 2016, the Appellant requested contest the Department's decision to deny the Medicaid.	The second of the second secon
On 2016, the Office of Legal Administrative Hearings ("OLCRAH") issued administrative hearing for 2016	
On 2016, in accordance with sections to 4-189, inclusive, of the Connecticut General administrative hearing.	

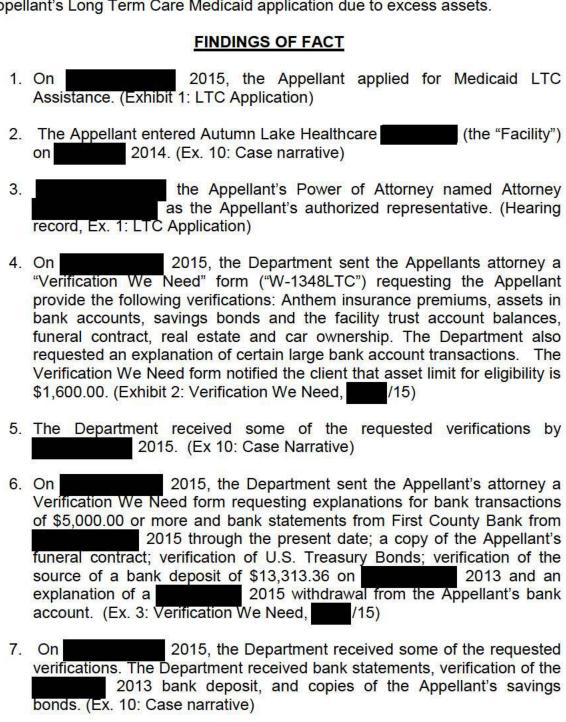
The following individuals were present at the hearing:

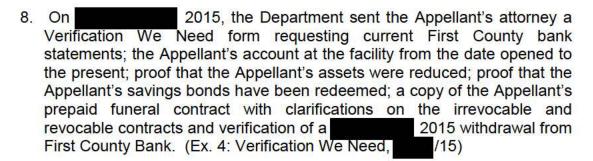
Attorney , for the Appellant , for the Appellant Natosha Douglas, Department's Representative Tierra McClain, Department's Representative

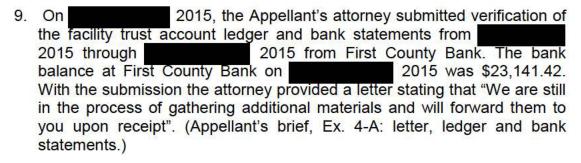
Thomas Monahan, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly denied the Appellant's Long Term Care Medicaid application due to excess assets.







- 10. On 2016, the Department denied the Appellant's LTC Medicaid application because her assets exceed the \$1,600.00 asset limit. (Ex. 9: Denial notice, 16)
- 11. On 2016, the Appellant's attorney submitted verification of the revocable and irrevocable funeral contracts, a copy of a check for \$24,180 issued by the Appellant and verification of the surrender of savings bonds. (Appellant's brief Ex. 7: Attorneys letter, 15)
- 12. The items submitted were not accepted as the Appellant's application was denied 2016, as there was no current pending application. (Hearing record)
- The Appellant is seeking an effective date of Medicaid. (Hearing record)

CONCLUSIONS OF LAW

- 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.
- Regulation provides that an assistance unit is not eligible for benefits under a particular program if the unit's equity in counted assets exceeds the asset limit for the particular program. Uniform Policy Manual ("UPM") § 4005.05 (D)

- 3. Regulation provides that the Medicaid asset limit for a needs group of one in the Medical Assistance for Aged, Blind or Disabled ("MAABD") program is \$1,600.00. UPM § 4005.10
- 4. Regulation provides that in the Medicaid MAABD program at the time of application, the assistance unit is ineligible until the first day of the month in which it reduces its equity in counted assets to within the asset limit. UPM § 4005.15
- 5. 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.
- Regulation 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 § 1015.10 (A)
- 7. The Department correctly sent the Appellant Application Verification Requirements lists on 2015, 2015, 2015 and 2015, 2015, requesting information needed to establish eligibility.
- 8. Regulation 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 (C)
- 9. Regulation 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 § 1505.35 (D) (2)
- 10. Regulation 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. The assistance unit bears the primary responsibility for providing evidence to corroborate its declarations. UPM § 1540.10 (A)
- 11. 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.

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. UPM § 1505.40(B)(5)

- 12. The Department did not issue a new verification request after receiving some of the items that were requested on the Need form.
- 13. The Department incorrectly denied the Appellant's LTC Medicaid application.

DISCUSSION

The Appellant complied with each Department request for verifications in a timely manner. The Department did not issue a new Verification We Need form after receiving the last submission by the Appellant on 2015. The letter from the attorney stated that he was still pursuing requested verifications. His most recent submission did indicate that the Appellant's assets were over the asset limit as of 2015, but the Appellant's attorney must be allowed to complete the verification process as long as he complies with the Department's regulations. The Appellant acknowledges that her assets exceeded the limit for and is seeking LTC Medicaid effective 2016.

DECISION

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

ORDER

- 1. The Department will reopen the Appellant's LTC application as of 2016, and request any outstanding verification necessary to complete the application.
- 2. The Department will submit to the undersigned verification of compliance with this order by providing a copy of the Appellant's EMS status screen no later than 15 days from the date of the decision.

Thomas Monahan
Thomas Monahan
Hearing Officer

C: Poonam Sharma, Operations Manager, Bridgeport Regional Office Fred Presnick, Operations Manager, Bridgeport Regional Office Yecenia Acosta, Program Manager, Bridgeport Regional Office Cheryl Stuart, Program Manager, Bridgeport Regional Office Natosha Douglas, Hearing Liaison

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 <u>specific</u> grounds for the request: for example, indicate <u>what</u> error of fact or law, <u>what</u> new evidence, or <u>what</u> 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.