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

[redacted] 2016
SIGNATURE CONFIRMATION

REQUEST #748266

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] 2016, the Appellant's representative, **Attorney** [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] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a Notice of Administrative Hearing scheduling a hearing for [redacted] 2016 @ [redacted] to address the Department's denial of the Appellant's application for medical assistance.

On [redacted] 2016, 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:

Attorney [redacted], Representative for the Appellant
Janet Giunti, Representative for the Department
Hernold C. Linton, Hearing Officer

The hearing record was closed on [redacted] 2016.

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] 2013, the Appellant was admitted to Cobalt Health and Rehabilitation Center for long-term care ("LTC"). (Appellant's Memorandum)

2. On [redacted] 2015, the Department received documents from the Appellant's representative on a previous application that was denied on [redacted] 2015, for failure to provide required verification requested. (Hearing Summary; Dept.'s Exhibit #1: [redacted]15 Notice of Denial)

3. The documents submitted to the Department included shares of [redacted] Company ESPP stocks, valued at $88.95 per share. (Appellant's Exhibit #10: [redacted]15 Letter)

4. On [redacted] 2015, the Department entered a reapplication for medical assistance under Medicaid program for the Appellant, as of the date the documents were received. (See Fact #2; Hearing Summary)

5. On [redacted] 2015, the Department sent the Appellant's representative a Verification We Need (Form "W-1348LTC") requesting information or verifications regarding her financial status (Proof of gross pension income, updated bank statements, and shelter expenses for the community spouse) needed to determine the Appellant's eligibility for medical assistance. (Hearing Summary; Dept.'s Exhibit #5: [redacted]15 W-1348LTC)

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

7. The W-1348LTC informed the Appellant's representative to call the Department, if assistance or more time were needed to obtain the requested information. (See Fact #4; Dept.'s Exhibit #5)

8. The Appellant's representative did not provide the Department with the requested information by [redacted] 2015, the 30th day of reapplication. (Hearing Summary)

9. The Appellant's representative did not contact the Department to request an extension of the due date by which to provide the Department with the outstanding information needed to process the Appellant's reapplication for medical assistance. (See Facts # 1 to 8)

10. The Appellant's representative did not request the Department's assistance in securing the outstanding information needed to process the Appellant's reapplication for medical assistance. (See Facts # 1 to 9)

11. On [redacted] 2015, the Department denied the Appellant's reapplication for medical assistance under the Medicaid program for failure to provide all of the required verification requested. (See Facts # 1 to 10; Hearing Summary; Dept.'s Exhibit #4: [redacted]15 Notice of Denial)

12. The Appellant's representative claimed that assistance was requested from the Department in obtaining the value of the Appellant's shares of [redacted] Company ESPP stocks. (See Facts # 1 to 11; Appellant's Memorandum)

13. The value of the Appellant's [redacted] Company stocks was not listed as a requested item on the Department's [redacted] 2015 W-1348LTC, requesting additional information from the Appellant. (See Facts # 1 to 11)

14. The Appellant's representative is requesting that the Department considers the outstanding debt to the facility of $95,902.07 as of [redacted] 2015, before determining the Appellant's available spousal asset. (Appellant's Memorandum)

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 gross pension income, bank statements, and shelter expenses for the community spouse by the specified due date of [redacted] 2015.

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 § 1505.35(A)(1) provides that prompt action is taken to determine eligibility on each application filed with the Department.

9. UPM § 1505.35(A)(2) provides that reasonable processing standards are established to assure prompt action on applications.

10. UPM § 1505.35(D)(1) provides that the Department determines eligibility within the standard of promptness without exception for the FS program.

11. 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; or

    c. the Department has assumed responsibility for obtaining verification and has had less than 10 days; or

    d. the Department has assumed responsibility for obtaining verification and is waiting for material from a third party.

12. 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.

13. 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.

14. The Department did not receive the requested information needed to determine the Appellant's eligibility for medical assistance.

15. 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.

16. UPM § 1540.10(C)(2)(c) provides that the Department obtains verification on behalf of the assistance unit when the assistance unit requested the Department's help in obtaining the verification.

17. The Department did not need to send an additional W-1348LTC to the Appellant's representative, as the Department did not receive any of the information previously requested.

18. The Appellant's representative could have contacted the Department to request assistance in obtaining the requested verifications (proof of pension income, updated bank statements, and shelter expenses for the community spouse), or an extension of the due date by which to provide the requested verifications.

19. The Appellant's representative did receive proper notice of the outstanding information needed prior to the Department's denial of the Appellant's reapplication for medical assistance.

20. The Appellant's representative is requesting that the Department considers the Appellant's unpaid debt to the facility when evaluating her countable assets. However, the policy does not allow for the Department to subtract the Appellant's unpaid debt from her available assets. The Appellant first would have to pay her debt to the facility from her available assets, before the payment could be taken into consideration with respect to reducing the total amount of her countable asset.

21. The Department correctly denied the Appellant's reapplication for medical assistance, for failure to provide requested information, as the Appellant's representative failed to submit requested information needed to determine her eligibility, within the specified time frame, or prior to the Department's denial of her reapplication.

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 Verification We Need (Form "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 of what was needed to determine the Appellant's eligibility.

The Appellant's representative did not provide the Department with the outstanding verification regarding pension income, financial transactions, and shelter expenses for the community spouse. The Department did provide the Appellant's representative with a written request for the information that was needed. Consequently, the undersigned finds that the Department correctly denied the Appellant's reapplication for medical assistance, for failure to provide requested verification needed to determine her eligibility.

The Appellant has to reapply for medical assistance as soon as possible, and to provide the Department with the requested information needed to determine her eligibility.

DECISION

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

Hernold C. Linton

Hernold C. Linton
Hearing Officer

Pc: **Tyler Nardine,** Social Service Operations Manager,
DSS, R.O. #50, Middletown

Fair Hearing Liaisons,
DSS, R.O. #50, Middletown

Attorney [redacted], [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.