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

[REDACTED] 2016
Signature Confirmation

Client ID # [REDACTED]
Request # 782949

NOTICE OF DECISION

PARTY

[REDACTED]
For: [REDACTED]
[REDACTED]
[REDACTED]

PROCEDURAL BACKGROUND

On [REDACTED] 2016, the Department of Social Services (the "Department") granted Medicaid under the Long Term Care Program for [REDACTED] effective [REDACTED] 2016.

On [REDACTED] 2016, [REDACTED], Power of Attorney, on behalf of the Appellant requested an administrative hearing to contest the Department's determination of the effective date of Medicaid.

On [REDACTED] [REDACTED] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [REDACTED] 2016.

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.

The following individuals were present at the hearing:

[REDACTED], Power of Attorney for the Appellant
Kristen Bert, Department Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to grant Long Term Care Medicaid benefits effective [redacted] 2016 was correct.

FINDINGS OF FACT

1. In [redacted] 2015, Apple Rehabilitation of Colchester ("nursing facility") admitted the Appellant to their nursing facility. (Daughter's Testimony)

2. [redacted] [redacted] ("Daughter") is the Appellant's daughter and authorized representative for the Appellant. (Daughter's Testimony)

3. On [redacted] 2015, the Department received an application for Long Term Care ("LTC") Medicaid for the Appellant. (Department Representative's Testimony and Exhibit 1: Case Narrative)

4. The Appellant owned three life insurance policies with The Prudential Insurance Company of America ("insurance company"). Policy 1 [redacted] ("policy 1"): death benefit of $10,407.99, cash value $9,425.04 signed over to a funeral home. Policy 2 [redacted] ("policy 2"): death benefit of $00.00, cash value of $00.00. Policy 3 [redacted] ("policy 3"): death benefit of $4,352.91, cash value $3,926.56. (Exhibit 1: Case Narrative and Exhibit 3: Life Insurance)

5. The asset limit under LTC Medicaid for a household of one is $1,600.00. (Department Representative's Testimony)

6. On [redacted] 2015, the Department denied the Appellant's application for LTC Medicaid for failure to return required verification. (Exhibit 1: Case Narrative)

7. The Daughter made no administrative hearing request disputing the denial of the Appellant's application for LTC Medicaid. (Daughter's Testimony)

8. On [redacted] 2015, the Department received an application for LTC Medicaid for the Appellant. (Department Representative's Testimony and Exhibit 1: Case Narrative)

9. On [redacted] 2016, the Daughter received her appointment as Power of Attorney for the Appellant. (Daughter's Testimony)

10. On [redacted] 2016, the Department denied the Appellant's application for LTC Medicaid for failure to return the required verification. (Exhibit 1: Case Narrative)

11. The Daughter made no administrative hearing request disputing the denial of the Appellant's application for LTC Medicaid. (Daughter's Testimony)

12. On [redacted] 2016, the insurance company terminated life insurance policy 3 and issued the Appellant a check for $3,893.27. (Exhibit 1: Case Narrative and Exhibit 3: Life Insurance)

13. On [redacted] 2016, the Department received an application for LTC Medicaid for the Appellant. (Department Representative's Testimony and Exhibit 1: Case Narrative)

14. On [redacted] 2016, the Department issued the Daughter a W1348LTC Verification We Need form ("W1348LTC") requesting the following verification: Proof life insurance policy 3 cashed out, proof how money spent from policy 3, and copy of Vermont property deed. The requested information was due [redacted] 2016. (Exhibit 1: Case Narrative and Exhibit 9: W1348LTC)

15. On [redacted] 2016, the Appellant issued payment of $3,500.00 to the nursing facility. (Exhibit 1: Case Narrative and Exhibit 3: Life Insurance)

16. On [redacted] 2016, the Appellant died. (Hearing Record)

17. On [redacted] 2016, the Department issued the Daughter a W1348LTC form requesting the following verification: Proof how proceeds from life insurance policy 3 were spent and current bank statements. The requested information was due [redacted] 2016. (Exhibit 1: Case Narrative and Exhibit 11: W1348LTC)

18. On [redacted] 2016, the Department issued the Daughter a W1348LTC form requesting the following verification: Proof of face value of life insurance policy 3. The information was due [redacted] 2016. (Exhibit 1: Case Narrative and Exhibit 12: W1348LTC)

19. On [redacted] 2016, the Department denied the Appellant's application for LTC Medicaid for the Appellant for failure to return the required verification effective [redacted] 2016. (Department Representative's Testimony and Exhibit 1: Case Narrative)

20. On [redacted] 2016, the Department reviewed the Appellant's [redacted] 2016 application for LTC Medicaid. The Department determined the Daughter returned the required verification timely and denied the

Appellant's application for LTC Medicaid effective [redacted] 2016 in error. (Department Representative's Testimony and Exhibit 1: Case Narrative)

21. On [redacted] 2016, the Department rescinded the [redacted] 2016 denial of benefits because the Appellant submitted all information needed to determine eligibility timely. (Department Representative's Testimony and Exhibit 1: Case Narrative)

22. On [redacted] 2016, the Department determined the Appellant asset eligible for LTC Medicaid effective [redacted] [redacted] 2016. (Department Representative's Testimony and Exhibit 1: Case Narrative)

23. On [redacted] 2016, the Department granted the Appellant's application for LTC Medicaid effective [redacted] 2016. (Department Representative's Testimony and Exhibit 1: Case Narrative)

24. The Daughter on behalf of the Appellant is seeking a LTC Medicaid effective date of [redacted] 2015. (Daughter's Testimony)

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes ("Conn. Gen. Stats.") provides that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Statute provides that for the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support. If the terms of a trust provide for the support of an applicant, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable asset. Notwithstanding the provisions of this subsection, the availability of funds in a trust or similar instrument funded in whole or in part by the applicant or the applicant's spouse shall be determined pursuant to the Omnibus Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of this subsection shall not apply to a special needs trust, as defined in 42 USC 1396p(d)(4)(A). For purposes of determining whether a beneficiary under a special needs trust, who has not received a disability determination from the Social Security Administration, is disabled, as defined in 42 USC 1382c(a)(3), the Commissioner of Social Services, or the commissioner's designee, shall independently make such determination. The commissioner shall not require such beneficiary to apply for Social Security disability benefits or

obtain a disability determination from the Social Security Administration for purposes of determining whether the beneficiary is disabled. [Conn. Gen. Stats. § 17b-261(c)]

3. Uniform Policy Manual ("UPM") § 1010 provides that the assistance unit, by the act of apply for or receiving benefits assumes certain responsibilities in its relationship with the Department.

4. UPM § 1505.15(A)(1) provides that applicants may apply for and be granted assistance on their own behalf or, under certain conditions, be represented by other qualified individual who act responsibly for them.

   UPM § 1505.15(A)(4) provides that a responsible individual applying for assistance on the behalf of others must:

   a. Be familiar with household circumstances to the extent that questions concerning need and eligibility can be answered with reasonable accuracy;
   b. Have a basic understanding of the assistance program(s) for which application is being made;
   c. Understand the responsibilities which they assume;
   d. Be able to communicate with members of the assistance unit in order to obtain information and explain rights and responsibilities;
   e. Have an interest in the well-being of the entire assistance unit.

   UPM § 1505.15(C)(1)(a)(3) provides for the following individuals are qualified to request cash or medical assistance, be interviewed and, complete the application process on the behalf of others who they represent: a conservator, guardian or other court appointed fiduciary.

   UPM § 1505.15(C)(1)(b)(2) provides that if none of the above individuals are available, the following persons may file the application on the assistance unit's behalf: an authorized representative. (cross reference: 1525)

5. UPM § 1525.05(A) provides that an assistance unit may be represented in various aspects of the eligibility process by a responsible individual who has been given prior authorization to act as the assistance unit's representative.

   UPM § 1525.05(C)(2) provides that an authorized representative must be designated in writing by one of the following individuals: in the AABD and MA programs, by the applicant, or if the applicant is a child, incompetent or incapacitated, by the parent, custodian, or court appointed fiduciary.

6. The Department correctly determined the Daughter as the Appellant's authorized representative.

7. UPM § 1525.05(G) provides that the appointment of an authorized representative does not relieve the assistance unit of any responsibilities. Both the assistance unit and the representative may be held responsible for assistance improperly obtained through action by the authorized representative.

8. UPM § 1505.10(D)(1) provides that for AFDC, AABD and medical applications, except for the Medicaid coverage groups noted below in 15105.10(D)(2), the date of application is considered to be the date that a signed application form is received by any office of the Department.

9. The Department correctly determined the Medicaid application date as [redacted] 2016.

10. UPM § § 3525.05(A)(1) provides that as a condition of eligibility, members of the assistance unit are required to cooperate in the initial application process and in reviews, including those generated by reported changes, redeterminations, and Quality Control. (Cross reference: Eligibility Process 1500) Applicants are responsible for cooperating with the Department in completing the application process by:

    a. Fully completing and signing the application form; and
    b. Responding to a scheduled appointment for an interview; and
    c. Providing and verifying information as required.

11. 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 (cross reference 1555).

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

12. UPM § 4000.01 defines <u>asset limit</u> as the maximum amount of equity in counted assets which an assistance unit may have and still be eligible for a particular program administered by the Department. An <u>available asset</u> is cash or any item of value which is actually available to the individual or which the individual has the legal right, authority or power to obtain, or to have applied for, his or her general or medical support. A <u>counted asset</u> is an asset which is not excluded and either available or deemed available to the assistance unit.

UPM § 4005.10(A)(2)(1) provides that the asset limit for AABD and MAABD. The asset limit $1,600.00 for a needs group of one.

13. UPM § 1540.05(C)(1) provides that the Department requires verification of information:

    a. When specifically required by federal or State law or regulations; and
    b. When the Department considers it necessary to corroborate an assistance unit's statements pertaining to an essential factor of eligibility.

    UPM § 4099.05(1) provides that the assistance unit must verify its equity in counted assets.

    UPM § 4099.05(B)(1) provides the assistance unit must verify that it has properly reduced its equity in counted assets to within the program limits.

14. UPM § 4030.30(C)(1) provides that if the total face value of all life insurance policies owned by the individual does not exceed $1,500, the cash surrender value of such policies is excluded. In computing the face value of life insurance, the Department does not count insurance such as term insurance which has no cash surrender value.

    UPM § 4030.30(C)(1) provides that except as provided above, the cash surrender value of life insurance policies owned by the individual is counted toward the asset limit.

15. The Department correctly determined life insurance policy 3 as a counted asset.

16. 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 § 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.

17. On [redacted] 2016, the Department correctly issued the Daughter the W1348LTC requesting information needed to establish eligibility under the LTC Medicaid program.

18. UPM § 1505.40(B)(5) provides for delays due to insufficient verification.

a. 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.
b. 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.

19. On [redacted] 2016, the Department correctly issued the Daughter the W1348LTC requesting information needed to establish eligibility under the LTC Medicaid program.

20. On [redacted] 2016, the Department correctly issued the Daughter the W1348LTC requesting information needed to establish eligibility under the LTC Medicaid program.

21. UPM § 1505.40(A)(4)(c) provides that the Department may complete the eligibility determination at any time during the application process when the application process is complete and all required verification has been obtained.

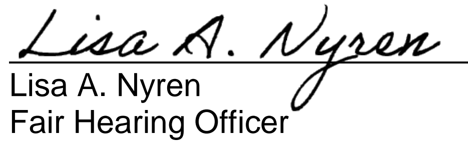
22. UPM § 1560.10(B) provides that the beginning date of assistance for Medicaid may be one of the following: the first day of the month of application when all non-procedural eligibility requirements are met during that month.

    UPM § 1560.10(A) provides that the beginning date of assistance for Medicaid may be one of the following: the first day of the first, second or third month immediately preceding the month in which the Department receives a signed application when all non-procedural eligibility requirements are met and covered medical services are received at any time during that particular month.

23. On [redacted] 2016, the Department correctly granted the Appellant's LTC Medicaid effective [redacted] 2016. The Department may backdate Medicaid eligibility a maximum of 90 days prior to the application month if all factors of eligibility are met. The Appellant's assets, specifically life insurance policy 3 with a cash value of $3,893.27 exceeded the $1,600.00 Medicaid asset limit until cashed in on [redacted] 2016 and payment issued to the nursing facility on [redacted] 2016. There is no eligibility 90 days prior to the [redacted] 2016 application date as the Appellant's assets exceeded the Medicaid asset limit.

DECISION

The Appellant's appeal is DENIED



Lisa A. Nyren
Fair Hearing Officer

CC: Cheryl Parsons, Social Services Operations Manager
Kristen Bert, Eligibility Services Worker

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.

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.