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

[redacted] **2017**
Signature Confirmation

Client ID # [redacted]
Request # 813873

NOTICE OF DECISION

PARTY

[redacted]
For [redacted]
[redacted]
[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Department of Social Services (the "Department") sent [redacted] (the Appellant) a notice of action ("NOA") denying benefits to [redacted] (the "Applicant") under the Medicaid for Long Term Care program.

On [redacted] 2017, [redacted], the Applicant's daughter requested an administrative hearing to contest the Department's decision to deny such benefits.

On [redacted] 2017, the Appellant requested an administrative hearing.

On [redacted] 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, the Appellant requested a continuance of the hearing.

On [redacted] 2017, OLCRAH issued a notice rescheduling the administrative hearing for [redacted], 2017.

On [redacted] 2017, 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], the Appellant, wife and power of attorney ("POA") for [redacted] the Applicant
[redacted], the Applicant's daughter
Shawn Hardy, Department's representative
Maureen Foley-Roy, Hearing Officer

The hearing officer held the hearing record open for the submission of additional evidence. On [redacted] 2017, the record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to deny the Applicant's application for medical assistance for failing to provide information was correct.

FINDINGS OF FACT

1. In [redacted] of 2015, the Applicant sent a letter to Barclay's bank in the UK. requesting that the funds in that account, which consist of a monthly pension directly deposited, be transferred to an account which he holds in the United States. (Exhibit 4: Letter to Barclay's bank and Exhibit G: Barclay's bank statement)

2. On [redacted], 2015, Barclay's bank responded to the Applicant's request by sending a letter asking that he contact them by telephone no later than [redacted], 2015. (Exhibit 5: Letter of [redacted] 2015)

3. On [redacted] 2015, the Department determined that the Applicant was eligible for Medicaid. The Department informed the Appellant (who is the community spouse) that she was entitled to keep $53,273.25 of the couple's joint assets but they needed to be transferred to her name by the next redetermination of eligibility. The notice also advised her that any portion of assets not transferred to her name would be counted to her spouse when determining eligibility for Medicaid. (Exhibit A: Notices to Community and Institutionalized Spouse of Eligibility for Medicaid)

4. The Applicant has a diagnosis of end stage dementia and he cannot speak or assist with his affairs at this time. (Appellant's testimony)

5. The Appellant did transfer the couple's home to her name alone. (Exhibit L: Case Narrative)

6. On [redacted] 2016, the Appellant completed a redetermination of eligibility form for her husband. (Exhibit B: Renewal of Eligibility Document)

7. On [redacted] 2016, the Department reviewed the eligibility renewal document and sent a Verification We Need form with a due date of [redacted] 2016 to the Appellant requesting proof of current income, all pages of all current bank accounts and statement regarding health insurance premium. (Exhibit L and Exhibit C1: Verification We Need Request dated [redacted], 2016)

8. The Appellant mailed documents to the Department in response to the Verification We Need form. (Exhibit L)

9. On [redacted] 2016, the Department discontinued the Applicant's medical assistance because he had failed to complete the review process. (Exhibit M: Notice of Discontinuance)

10. On [redacted] 2016, the Department reopened the case for medical assistance in a pending status and sent a W1348-Verification We Need form requesting verification of the Applicant's UK pension for the previous six months, a copy of his resident trust account and most recent Santander bank account and verification of the Appellant's income. The form also advised that the Applicant's assets exceeded the allowable limit of $1600 and that they should send proof that the assets had been spent down below the limit. The deadline for submitting the information was [redacted] 2016. (Exhibit C2 and Exhibit H: Notice of Denial)

11. On [redacted] 2017, the Department sent a W1348-Verification We Need form advising the Appellant that the Applicant's assets exceeded the allowable limit of $1600 and that he needed to provide verification that his assets were less than the allowable limit by the deadline of [redacted] 2017. (Exhibit C3)

12. On [redacted] 2017, the Department denied the application for Medicaid for Long Term Care because it had not received the required verification. (Exhibit H: Notice of Denial)

13. On [redacted] 2017, the Appellant contacted the Department and advised that she was unable to obtain access to the funds in her husband's overseas account because British law did not recognize her power of attorney status. She was in the process of obtaining legal assistance. (Exhibit L)

14. The Appellant continues to pay the applied income to the facility where the Applicant resides. (Appellant's testimony)

15. The Applicant's family has contacted Barclay's bank, the Officer of the Public Guardian, and the Court of Protection in an effort to resolve the matter. (Appellant's testimony and Exhibit 2: Email exchanges)

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes authorizes the Commissioner of the Department of Social Services to administer the Medicaid program.

2. 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 which the Department requires to determine eligibility and calculate the amount of benefits.

3. UPM § 1545.40 B 1 a provides for continuing eligibility on incomplete cases in processing redeterminations and states that If eligibility has not been reestablished by the end of the redetermination period, the Department continues to provide assistance under the following conditions if it appears that the assistance unit will remain eligible: (1) when the agency is responsible for not completing the redetermination; or (2) when the assistance unit fails to act timely but completes the redetermination form and any required interview by the last day of the redetermination month; or (3) when the assistance unit demonstrates good cause for failing to complete the redetermination process.

4. UPM § 1545.40 B 1c provides that eligibility may be continued and the redetermination held pending, as long as circumstances beyond the control of the assistance unit delay completion of the redetermination process and the assistance unit appears to be eligible for assistance.

5. UPM § 1545.40 B 1d 4 provides that good cause may include, but is not limited to circumstances beyond the control of the assistance unit.

6. The Department was incorrect when it discontinued medical assistance because the agency was responsible for not completing the redetermination in a timely manner.

7. The Department was incorrect when it reopened the medical assistance application and kept it in a pending status effective [redacted] 2016 because it should never have discontinued the medical assistance.

8. The Department was incorrect when it denied the Applicant's medical assistance program because the medical assistance program should have been granted and continue pending the completion of a redetermination.

9. The Department failed to act on the Appellant's notification that she was having difficulty accessing the account in the U.K..

DISCUSSION

Per the regulations, the Department continues to provide medical assistance when the redetermination process is initiated but not completed. The Appellant returned her renewal form in [redacted] and the Department did not review it until 10 days before the end of the redetermination period. The Department requested information and the Appellant did provide some of the requested information but the Department did not review the documents prior to discontinuing the medical assistance effective [redacted] 2016. The correct procedure is to continue the benefits and to keep the redetermination pending as long as circumstances beyond the Appellant's control delay the completion of the redetermination process and there appears to be eligibility.

One year previously, the Department had determined that the couple's assets were within the acceptable limits for the Applicant to receive Medicaid for long term care benefits so it would appear that he was still eligible for assistance. At the time of the initial grant, the Appellant was advised that the assets should be transferred to her name only. The Appellant did transfer her home into her name alone, but she encountered difficulty with the overseas bank account. She made the Department aware of such difficulty in [redacted] 2017. If the redetermination procedures had been handled per the regulations, the benefits would have still been in place and eligibility could have continued under the provisions regarding circumstances beyond the Appellant's control.

It would appear that at that point, the Appellant was advising the Department that the asset in question was now inaccessible. The Department would need to follow the procedures established in UPM § 4015.05 P which include having the Appellant provide proof that the asset is inaccessible and cooperate with the Department in attempting to gain access to the asset. The procedures also state that the Department must refer the case to its Resource Unit. The Appellant has provided documentation of her attempts to gain access to this asset and would most likely welcome the assistance of the Resource Unit. As long as she continues to cooperate in attempting to gain access to the asset, the redetermination should remain pending with the benefits in place.

DECISION

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

ORDER

The Department is to reopen and grant the medical assistance back to [redacted] 2016, keeping the [redacted] 2016 redetermination pending until the overseas accounts is proven to be available or inaccessible or the Appellant stops cooperating in attempting to gain access to it. Compliance with this order is due by [redacted] 2017 and shall consist of proof that medical benefits were reinstated beginning with the month of [redacted] of 2016 and continuing through the present.

Maureen Foley-Roy

Maureen Foley-Roy,
Hearing Officer

CC: Musa Mohamud, Judy Williams, Operations Managers
DSS R.O. #10, Hartford
Tricia Morelli, Social Service Program Manager, Hartford
Shawn Hardy, Eligibility, DSS, Hartford

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.