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

, 2017
Signature Confirmation

Client ID #
Request # 830757

NOTICE OF DECISION

PARTY

for

PROCEDURAL BACKGROUND

On 2017, the Department of Social Services (the "Department") sent (the "Appellant") a Notice of Action ("NOA") granting Long Term Care Medicaid benefits effective 2017.

On , 2017, the Appellant requested an administrative hearing to contest the effective date of the Long Term Care Medicaid benefits as determined by the Department.

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

On 2014, 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:

Accounts Manager at Montowese Health & Rehab Center, Authorized Representative ("AREP") for the Appellant,
Noah Cass, Department's representative, via telephone conference call
Amy Cherrez, DSS LTSS Eligibility Staff, New Haven Regional Office
Maureen Foley-Roy, Hearing Officer

The hearing record remained open for the submission of additional evidence. On ██████ 2017, the record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department's decision to grant Long Term Care benefits effective ███ 2017 was correct.

FINDINGS OF FACT

1. In ██████ of 2017, the Appellant was admitted to the facility for a short term stay. Initially, Medicare was initially paying for the Appellant's stay. (AREP's testimony)

2. On ██████ 2017, the Department received an application for both care at the facility and home care, completed by the Appellant which authorized the AREP to represent her with regards to the application. The Appellant needed Medicaid for Long Term Care Services to pay for her stay at the facility beginning in █████ of 2017. (Exhibit A: Long Term Care application stamped ██████, 2017 and AREP's testimony)

3. On the application, the Appellant stated that her only asset was a credit union account. (Exhibit A)

4. On █████, 2017 and █████ 2017, the Department sent W1348-Verification We Need forms requesting specific statements from the Appellant's credit union account. (Exhibits B1 and B2: W1348 forms sent on █████ and █████ 2017)

5. On █████, 2017, the Department reviewed the credit union statements submitted by the Appellant and discovered payments made to insurance companies. The Department sent a W1348-Verification We Need form to the Appellant requesting information on the policies. The Department stated that if they were life insurance policies, it would need verification of the face value and cash surrender value. (Exhibit B3: W1348-Verification Form Request #3, sent █████ 2017)

6. The Appellant's initial response to questions regarding the insurance policies was that they were automobile insurance policies. (AREP's testimony)

7. On █████ 2017, the AREP and the Department learned that one of the policies was a life insurance policy. The Department sent a W1348-Verification We Need form requesting the face value and cash surrender value of the life insurance policy. (Exhibit 4: W1348-Verification We Need form Request # 4 sent █████ 2017 and Exhibit C: Case Narrative)

8. The Appellant had a life insurance policy through the Columbian Financial Group with a face value of $10,000 and a cash surrender value of $1,933.56. (Exhibit D page 1: Letter from Columbian Financial Group dated [redacted] 2017)

9. On [redacted] 2017, the Appellant sent a letter to the life insurance company requesting a loan against the cash value of her life insurance policy. (Exhibit D, page 2: Letter from Appellant to Life Insurance Company dated [redacted] 2017)

10. On [redacted] 2017, [redacted], 2017, [redacted] 2017 and [redacted] 2017, the Department sent W1348-Verification We Need forms to the Appellant requesting verification of the loan against the cash surrender value of her life insurance policy and verification of how such funds were used. (Exhibits B5-B8.)

11. On [redacted], 2017, the Appellant completed policy change forms to authorize a partial surrender withdrawal of $1,800 from her life insurance. (Exhibit D, pgs 9-12: Application for Policy Changes part I)

12. On [redacted] 2017, the AREP sent the completed policy change forms to the life insurance company via Fed EX.(Exhibit D, pg 5)

13. Within a few days of sending the forms to the life insurance company on [redacted] 2017, the Appellant contacted the life insurance company by telephone to amend her request for changes to her policy.(AREP's testimony)

14. There was no evidence presented that the Appellant was pursuing a surrender of her life insurance policy.

15. On [redacted], 2017 the Appellant received a check for $1,949.50 (representing the entire cash value of her life insurance policy) from the insurance company and signed it over to the facility as partial payment for her stay. (Appellant's Exhibit 2: Copy of check, front and back)

16. On [redacted], 2017, the insurance company issued a letter accompanying the check which illustrated a breakdown of the cash surrender value. The breakdown showed that the total cash surrender value was $1949.50. There was no premium refund or outstanding loan applied so the Appellant's check was for the full amount of $1949.50. (Appellant's Exhibit 1: Letter from insurance company dated [redacted] 2017)

17. On [redacted] 2017, the Department sent the Appellant a letter advising her that she was eligible for Medicaid for long term care effective [redacted] 2017. The notice stated that she was responsible to pay $1110.66 in applied income each month but that she was allowed to use the applied income to pay her outstanding charges of $62,675.50 to the nursing facility. (Exhibit H: Notice of Approval for Long Term Medicaid)

18. On [redacted] 2017, the Appellant completed paperwork to change the beneficiaries of her life insurance policy and establish an irrevocable funeral contract. (Appellant's Exhibit 4: Estimate from [redacted] Funeral Services and Exhibit 5: Application for Policy Changes signed [redacted] 2017)

CONCLUSIONS OF LAW

1. Section 17b-2 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.

2. Uniform Policy Manual ("UPM") Section 4030 provides that the Department evaluates all types of assets available to the assistance unit when determining the unit's eligibility for benefits.

3. UPM § 4005.10 provides that the Medicaid asset limit for a needs group of one is $1,600.00 per month.

4. UPM § 4030.30 C 1 and 2 provides that unless the total value of all life insurance policies owned by an individual does not exceed $1500, the cash surrender value of life insurance policies owned by the individual is counted towards the asset limit.

5. UPM § 4005.05 (D) (1) provides that the Department compares the assistance unit's equity in counted assets with the program asset limit when determining whether the unit is eligible for benefits.

6. Section 17b-261h of the Connecticut General Statutes states in part that an institutionalized individual shall not be determined ineligible for Medicaid solely on the basis of the cash value of a life insurance policy worth less than ten thousand dollars provided [(1)] the individual is pursuing the surrender of the policy and (2) upon surrendering such policy all proceeds of the policy are used to pay for the institutionalized individual's long term care.

7. The Department was correct when it determined that the cash surrender value of the Appellant's life insurance policy was counted towards the asset limit.

8. UPM § 4005.15 provides that in the Medicaid 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.

9. The Department was correct when it determined that the Applicant was ineligible for Medicaid for Long Term Care for the months of [redacted] through [redacted] of 2017 because the cash surrender value of her life insurance policy exceeded the allowable asset limit and she was not pursuing the surrender of her policy.

10. The Department correctly determined that the Applicant's assets were reduced to below $1600 in ████ of 2017.

11. The Department correctly granted Medicaid for Long Term Care effective █████, 2017.

DISCUSSION

The Appellant did not initially admit to having a life insurance policy. After the policy was discovered and she learned that the cash value would preclude her from being eligible for Medicaid for Long Term Care, she agreed to use the funds from the cash value to pay towards her stay at the facility. When this occurred in ███ of 2017, she effectively reduced her assets and became eligible for Medicaid at that point.
The regulations state that the life insurance policy cash value will be excluded if an individual is pursuing the surrender of the policy. The Appellant was not pursuing the surrender of the policy. The evidence indicates that her intention was to take a loan against the policy. The Appellant initially requested a loan of $1800, then $1900 and it appears that she ultimately received the entire cash value amount. Although she received the funds, the policy was still in effect as evidenced by paperwork to change beneficiaries filed in ████████ of 2017.
The authorized representative testified that the Appellant was not forthcoming with information regarding the life insurance policy because she wanted to retain the funds for her final expenses. The Appellant was not pursuing the surrender of the policy. While this had the unfortunate result that the facility was not paid for the months of █████ through ████, the Department was correct in considering the cash surrender value of the policy and finding that the Appellant was ineligible until she reduced those assets in ███ of 2017.

DECISION

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

Maureen Foley-Roy

Maureen Foley-Roy,
Hearing Officer

Pc: Brian Sexton, Lisa Wells, Operations Managers, R. O. #20, New Haven
Cheryl Stuart, Program Manager, New Haven
Noah Cass, Eligibility Specialist, 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, 25 Sigourney Street, Hartford, CT 06106-5033.

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, 25 Sigourney Street, Hartford, CT 06106. 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.