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]
Reconsideration Hearing ID # 832704
Original Hearing ID# 815214

NOTICE OF DECISION

AFTER RECONSIDERATION

PARTY

[redacted]
C/O [redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") denying her application for long-term care medical assistance under the Medicaid program.

On [redacted] 2017, the Appellant requested an administrative hearing to contest the denial of LTSS benefits.

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

The hearing was rescheduled at the Appellant's request. On [redacted] 2017, OLCRAH issued a Notice scheduling the administrative hearing for [redacted] 2017.

On [redacted], 2017, in accordance with sections 17b-60, 17b-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 ("POA") and Daughter

[redacted], Appellant's Witness and Daughter
Lisa Maynard, Accounts Receivable, Colonial Health Center, Plainfield, Connecticut
Kaila Rubin, Department's Representative (observer)
Doris Hare, Department's Representative
Sybil Hardy, Hearing Officer

On [redacted] 2017, a Notice of Decision was issued on this matter. On [redacted], 2018, the Appellant's Conservator requested a reconsideration of the decision issued on [redacted] 2017. OLCRAH granted reconsideration based on the evidence and testimony presented at the original hearing.

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 failure to submit information needed to establish eligibility.

FINDINGS OF FACT

1. [redacted] is the Appellant's daughter and POA. (POA's Testimony, Exhibit 4: Long-term Care/Waiver Application Form, [redacted]/16).

2. The Appellant is an 80 years old (DOB [redacted]/36) and widow. (Exhibit 4: Long-term Care/Waiver Application Form, [redacted]/16)

3. On [redacted], 2016, the Appellant was admitted to Colonial Health and Rehabilitation in [redacted]Connecticut (the "nursing facility") for a short term stay of 120 days. (Exhibit B: Letter from Colonial Health and Rehabilitation Center, [redacted]/16, Exhibit 5: Ascend Approval)

4. The Appellant resides in the nursing facility. (Exhibit 4)

5. The Appellant is the owner of the property located at [redacted], Connecticut. (Exhibit 4)

6. The Appellant's doctor determined that the she could not return safely to the community because she was unable to ambulate. (POA's Testimony)

7. On [redacted], 2016, the Department received a Long-term-care/Waiver Application form on behalf of the Appellant from the POA. (Hearing Record, Exhibit 4. Exhibit 6: Eligibility Management System ["EMS"] Narrative Screen).

8. On [redacted], 2016, the Department mailed the POA a Verification We Need ("W-1348") form requesting the following information: Proof of gross pension amount from the Veteran's Administration ("VA"), bank statements for all bank accounts,

cash value and surrender values of all life insurance policies, admission date into nursing facility. This information was due back to the Department by [redacted] 2016. (Exhibit 1:Verification We Need Form ("W-1348LTC"), [redacted]/16, Exhibit 6)

9. As of [redacted] 2016, the POA expected that the Appellant would return home after her short-term stay in the nursing facility. (POA's Testimony)

10. On [redacted], 2016, Ascend approval for the Appellant's long-term care in the nursing facility switched from short term to long-term. (Exhibit 5)

11. On [redacted], 2016, the Department reviewed verifications submitted by POA and determined the required additional information. The Department sent the POA another W-1348 form requesting the following information: Ascend level of care approval; Appellant's primary residence has been placed on the market to sell. This information was due back to the Department no later than [redacted], 2016. (Exhibit 2: W-1348LTC, [redacted]/16, Exhibit 6)

12. Richard Wilcon, M.D. (the "medical provider") of [redacted] Connecticut is the Appellant's medical provider. (Exhibit B: Letter from Richard Wilcon, M.D., [redacted]/16)

13. On [redacted], 2016, the Appellants medical provider sent a letter to the Department advising them that the Appellant would be going home in six months. (POA's Testimony, Exhibit A: Letter from Richard Wilcon, M.D., [redacted]/16)

14. On [redacted], 2017, the Department had not received the requested verifications and denied the Appellant's application (Exhibit 6)

15. The POA did not contact the Department or request additional assistance obtaining any of the missing verification. (Hearing Record, Appellant's Testimony)

16. As of [redacted] 2017, the home sale information was the only missing information needed to complete the Appellant's LTSS application. (Department's Representative's Testimony)

17. On [redacted] 2017, the Department sent a NOA to the POA denying the Appellant's application for long-term care medical assistance under the Medicaid program because they did not receive all the required verification needed to establish eligibility. (Exhibit 3: NOA, [redacted]/17, Exhibit 6)

18. During [redacted] 2017, the Appellant applied for the Money Follows the Person ("MSP") program because it the Appellant was expected to return to her home. (Appellant's Daughter's Testimony)

19. The Appellant was not approved for sufficient funds for home care services through the MSP program to allow the Appellant to reside safely in her own home. (Appellant's Daughter's Testimony)

20. During [redacted] 2017, the Appellant decided that she would not be able to return to her home safely. (POA's Testimony)

21. On [redacted] 23, 2017, the Department received a new Application for Long-term care medical assistance from the Appellant. (Exhibit 6)

22. On [redacted] 2017, the Department granted long-term care medical assistance under the Medicaid program for the Appellant effective [redacted] 2017. (Exhibit 6)

CONCLUSIONS OF LAW

1. 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.

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 § 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.

4. The Department correctly sent the Appellant Verification We Need lists requesting information needed to establish eligibility.

5. UPM § 1505.25(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: the client has good cause for not submitted verification by the deadline or the client has been granted a 10 day extension to submit verification which has not elapsed.

6. UPM § 1505.40(B)(5) provides for delays in application processing due to insufficient verification in the AFDC, AABD and MA programs.

7. UPM § 1505.40(B)(5)(a) provides that regardless of the standard of promptness, no eligibility determination is made when there is insufficient verification to determine eligibility when the Department has requested verification and 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.

8. UPM § 1505.40(B)(5)(b) provides that an additional 10 day extension 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.

9. The Department correctly issued an additional W-1348 form when at least one of the requested items of verification was submitted by the Appellant.

10. UPM § 1505.40(B)(1)(c) provides that the applicant's failure to provide verification by the processing date causes one or more members of the assistance unit to be ineligible if the unverified circumstance is a condition of eligibility.

11. UPM § 1505.35(C)(1)(2) provides that a standard of promptness is established as the maximum time period for processing applications. For applicants for Medical Assistance on the basis of age; that standard is forty-five calendar days.

12. UPM § 1505.40(B)(1)(b)(1) provides if assistance cannot be granted, Medicaid applications are denied between the thirtieth day and the last day of the appropriate promptness standard for processing the application.

13. UPM § 4030.20(A) provides in part that home property owned by a member of the assistance unit is not counted in the determination of the unit's eligibility for assistance as long as the unit uses the property as its principal residence.

14. UPM 4030.20(D)(2) provides that if the individual enters a long-term care facility and none of the persons listed above is lawfully residing in the individual's home, the home's status as an excluded asset depends upon the expectation of the individual to return to the home.

    a. If the individual can reasonably be expected to return to the home, the home continues to be excluded as home property.
    b. If the individual cannot reasonably be expected to return to the home, the home is considered non-home property, and is subject to the policies and procedures described in this chapter.

15. The Department determines whether the individual can be expected to discharged from the long-term care facility to return home based on the following:
    a. Diagnosis of the individual's medical condition as documented by the long-term care facility's authorizing physician; and
    b. The physician's prognosis for the individual's recovery; and
    c. Availability of private care which the individual could receive at home as an alternative to institutionalization; and
    d. Statement from the individual, if he or she is competent, regarding the intent to return home; and

e. The individual's financial ability to maintain the home.

16. The Department incorrectly determined that the Appellant's home should not be treated as home property at the time of her application because she was expected to return to her home within six months and provided documentation for her medical provider to support this expectation.

17. The Department incorrectly determined that the Appellant did not provide verification that the Appellant's home must be placed on the market for sale because it was considered home property.

18. The Department incorrectly denied the applicant's application for long-term care Medicaid assistance for failure to provide the required verifications needed to determine eligibility.

DISCUSSION

The Department correctly requested missing information from the Appellant to determine eligibility. The Department incorrectly requested verification that the Appellant's home was put up for sale when her stay in the nursing facility because the Appellant was expected to return to her home within six months. It was not until [redacted] 2017 that the Appellant decided she could safely return home with the limited services that would be available to her through the MSP program.

DECISION

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

ORDER

1. The Department is ordered reopen the Appellant's long-term care Medicaid application effective [redacted] 2016 and grant LTSS as the Department indicated there was no other missing information.

2. Compliance of this order is due back to the undersigned no later than [redacted], 2017.

Sybil Hardy
Hearing Officer

Pc: Tonya Cook-Beckford, Operations Manager, DSS RO # 42, Willimantic
Doris Hare, Fair Hearings Liaison, DSS RO # 20, New Haven

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 Legal Counsel, Regulations, and Administrative Hearings, 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 06105-3725. 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.