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

[redacted] 2019
SIGNATURE CONFIRMATION

HEARING REQUEST #147468

CASE ID [redacted]
CLIENT ID [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2019, the Department of Social Services (the "Department"), sent [redacted] (the "Appellant") a Notice of Action stating that her application for medical assistance under the Medicaid ("HUSKY C- LTC") program had been denied, because she did not return all of the required proofs requested by the due date, and she does not meet program requirements.

On [redacted] 2019, the Appellant's representative, [redacted], requested an administrative hearing on behalf of the Appellant to contest the Department's denial of the Appellant's request for medical assistance.

On [redacted] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 2019, @ 10:00 AM to address the Department's denial of the Appellant's application for medical assistance.

On [redacted] 2019, 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:

[redacted], Representative for the Appellant
Christine Morin, Representative for the Department
Leigh Hunt, Representative for the Department
Hernold C. Linton, Hearing Officer

The closing of the record was extended for the submission of additional evidence from the Department and the Appellant's Representative. On [redacted] 2019, the Appellant's Representative provided additional evidence, which was shared with the Department for review and comments by [redacted] 2019. No additional comment was received from the Department or the Appellant's Representative. The hearing record was schedule was closed on [redacted] 2019.

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 Husky C for long-term care ("LTC") program.

FINDINGS OF FACT

1. On [redacted] 2019, the Department received the Appellant's application for medical assistance under the Medicaid Husky C program. (Hearing Summary; Dept.'s Exhibit #1: W-1LTC)

2. On [redacted] 2019, the Department sent the Appellant's representative a Verification We Need (Form "W-1348LTC") requesting information or verification regarding the Appellant's assets and financial transactions (bank statements for all accounts from [redacted] 2014 to present; verification of all large transactions from all bank accounts; funeral contracts, copy of deed for real estate, life insurance policy, and copy of death certificate for spouse) needed by [redacted] 2019, to determine her eligibility for medical assistance under the Medicaid Husky C program. (Dept.'s Exhibit #2: [redacted]19 W-1348LTC)

3. On [redacted] 2019, the Department received some of the requested verifications from the Appellant's Representative, but still needed additional information regarding Appellant's closed accounts and assets. (Hearing Summary; Dept.'s Exhibit #7: Case Notes)

4. On [redacted] 2019, the Department sent the Appellant's Representative a follow up W-1348LTC requesting the additional verifications (bank statements for all accounts and verification of all large transactions from all bank accounts from [redacted]17 to [redacted]17; bank statements from [redacted]19 to present; proof of face value for life insurance policy; and copy of deed for property) needed by [redacted] 2019, to determine the Appellant's eligibility for medical assistance. (Dept.'s Exhibit #3: [redacted]19 W-1348LTC)

5. On [redacted] 2019, the Department received some of the requested verifications from the Appellant's Representative, but still needed additional information regarding Appellant's closed accounts and assets. (Hearing Summary; Dept.'s Exhibit #7)

6. On [redacted] 2019, the Department sent the Appellant's Representative a third W-1348LTC requesting the additional verifications (bank statements for all accounts and verification of all large transactions for all bank accounts from [redacted]17 to

[redacted]17; bank statements from [redacted]19 to present; proof of face value for life insurance policy; and copy of deed for property) needed by [redacted] 2019, to determine the Appellant's eligibility for medical assistance. (Dept.'s Exhibit # 4: [redacted]19 W-1348LTC)

7. The W-1348LTC informed the Appellant's Representative of the outstanding verifications still needed to process her application for medical assistance, and the due date by which to provide the requested information, or else the application may be delayed or denied. (Dept.'s Exhibit #2; Dept.'s Exhibit #3; Dept.'s Exhibit #4)

8. The W-1348LTC informed the Appellant's Representative to call the Case Worker, if needing assistance or more time to obtain the requested information, and provided the contact information for the Case Worker, such as her telephone number, email address, and fax number. (Dept.'s Exhibit #2; Dept.'s Exhibit #3; Dept.'s Exhibit #4)

9. There is no evidence that the Appellant's Representative provided the Department with the requested outstanding information by the final due date of [redacted] 2019. (Hearing Summary)

10. There is no evidence that the Appellant's Representative requested an extension of the final due date by which to provide the Department with the outstanding information needed to process the Appellant's application for medical assistance. (See Facts # 1 to 9)

11. On [redacted] 2019, the Department denied the Appellant's application for medical assistance under the Medicaid Husky C program for failure to return all of the required verifications requested by the due date. (Hearing Summary; Dept.'s Exhibit #5: [redacted]19 Notice of Action)

12. The Department did allow for a three day grace period after the specified due date of [redacted] 2019, before denying the Appellant's application for failure to provide requested information, and did extend its final due date on two previous occasions. (See Facts # 1 to 11)

13. On [redacted] [redacted] 2019, the Department received some of the requested verifications, and determined that the requested information was not received from the Appellant's Representative within the specified final due date, and the Appellant would need to reapply for Medical assistance. (Hearing Summary)

14. The Appellant's Representative agreed to complete a reapplication for medical assistance under the Medicaid Husky C program on behalf of the Appellant. (Testimony of the Appellant's Representative)

15. The issuance of this hearing decision is timely under Section 17b-61(a) of the Connecticut General Statutes, which requires that the Hearing Officer issue a decision no later than ninety days after the date on which hearing record closed. Ninety days from [redacted] 2019 is [redacted] 2020. Therefore, this hearing decision is due no later than [redacted] 2020.

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. "The Department's Uniform Policy Manual is the equivalent of a state regulation and, as such, carries the force of law." *Bucchere v. Rowe*, 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat. § 17b-10; *Richard v. Commissioner of Income Maintenance,* 214 Conn. 601, 573 A.2d 712 (1990)).

4. Uniform Policy Manual ("UPM"), Section 2540.88(A) provides that this group includes residents of long term care facilities ("LTCF"), who:

    1. meet the categorical requirements of age, blindness or disability, and

    2. reside in the LTCF for at least thirty (30) consecutive days; and

    3. have income below a special income level.

5. UPM § 2540.88(B) provides that individuals qualify as categorically needy under this coverage group beginning with the first day of the thirty (30) continuous days of residence, for so long as the conditions above are met.

6. 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.

7. 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).

8. The Appellant's representative failed to provide the Department with verification regarding the Appellant's assets and financial transactions over the look back period by the specified final due date of [redacted] 2019.

9. 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.

10. 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.

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

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

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

14. 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.

15. 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.

16. 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.

17. The Department did not receive the requested information still needed to determine the Appellant’s eligibility for medical assistance by the final due date, after the granting of two previous extensions.

18. 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.

19. 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.

20. UPM § 1540.15(G)(1) provides that affidavits are accepted for review by the Department:

    a. in addition to any documentary evidence or verification through collateral contacts or home visits; or

    b. when documentary proof is required, and the assistance unit cannot provide it after good faith efforts; or

    c. when submitted as proof of the nonexistence of an eligibility factor.

21. UPM § 1540.15(G)(2) provides that when an affidavit is reviewed by the Department, it is evaluated along with all other evidence relative to the eligibility factor.

22. UPM § 1540.15(G)(3) provides that the Department uses all the available evidence, including the affidavit, to determine whether it is more likely than not that the eligibility factor has been established.

23. In reviewing the affidavit provided by the Appellant's Representative along with all other evidence, its claims are not supported by available evidence, and failed to establish that the requested documentary proofs still outstanding by the final due date could not be provided by the Appellant's Representative after making good faith efforts to obtain the requested information, as the Appellant's Representative failed to contact the Department to request another extension of the final due date by which to provide the outstanding verifications, or to request the Department's assistance in obtaining the requested information.

24. On [redacted] 2019, the Appellant's Representative could have made his submission to the Department via fax, or as an attachment to an email, or to contact the Case Worker by telephone to request another extension of the final due date.

25. The Department did send follow up W-1348LTC's to the Appellant's Representative extending the final due date on two previous occasions, when the Department did not receive all of the requested information needed to determine the Appellant's eligibility for medical assistance.

26. The Appellant's Representative did receive proper notice of the remaining outstanding information still needed prior to the Department's denial of the Appellant's application for medical assistance.

27. The Department did not have sufficient information regarding the Appellant's countable assets and financial transactions during the look back period to determine her eligibility for medical assistance under the Medicaid Husky C program.

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

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 had been provided. In the present case the Department did provide the Appellant's Representative with W-1348LTC's; thus giving proper notice of what information was needed to determine the Appellant's eligibility.

The Appellant's Representative did not provide the Department with the outstanding verification regarding the Appellant's assets and financial transaction during the look back period by the specified final due date. The Department provided the Appellant's Representative with written requests of the information that was needed. Consequently, the undersigned finds that the Department correctly denied the Appellant's application for medical assistance, for failure to provide requested verification needed to establish her eligibility.

DECISION

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

[redacted]

Hernold C. Linton
Hearing Officer

Pc: **Rachel Anderson,** Social Service Operations Manager, DSS, R.O. #20, New Haven

Cheryl Stuart, Social Service Operations Manager, DSS, R.O. #20, New Haven

Lisa Wells, Social Service Operations Manager, DSS, R.O. #20, New Haven

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