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

[redacted] **2021**
Signature Confirmation

Case ID# [redacted]
Client ID # [redacted]
Request # 151333

NOTICE OF AMENDED DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2019, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA) indicating the amount of applied income he must pay towards his long-term cost of care effective [redacted] 2019.

On [redacted] 2020, the Appellant's Conservator of Person and Estate requested an administrative hearing to contest the Department's calculation of the applied income.

On [redacted] 2020, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2020.

On [redacted] 2020, the counsel for the Appellant requested a continuance of the hearing, which was granted.

On [redacted] 2020, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2020.

On [redacted] 2020, counsel for the Appellant did not appear at the scheduled hearing.

On [redacted] 2020, counsel for the Appellant requested a continuance of the hearing citing he never received notice of the re-scheduled hearing date of [redacted] 2020 and due to the pandemic, assumed all hearing were postponed.

On [redacted] 2020, OLCRAH granted his request.

On [redacted] 2020, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2020.

On [redacted] 2020, 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] Appellant's Conservator of Person and Estate
Kristen Bert, Department Representative
Almelinda McLeod, Hearing Officer

[redacted] was not present due to his institutionalization.

The hearing officer held the record open for the submission of additional evidence for review and response by [redacted] 2020. On [redacted] 2020 the hearing record closed.

On [redacted] 2020, the hearing officer issued a decision.

On [redacted] 2020, the decision was appealed to the Superior Court.

On [redacted] 2021, Judge A. Susan Peck ordered a remand for the limited purpose of including two subsequent notices showing a patient liability of zero issued to the Appellant on [redacted] 2020 and [redacted] 2020 to determine the effect, if any, of these NOA's on the final decision.

On, [redacted] 2021, the hearing officer reconvened the administrative hearing and reopened the record to allow for the inclusion of two subsequent notices for the limited purpose of determining the effect, if any, on the Notices of Action dated [redacted] 2020 and [redacted] 2020.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly calculated the Appellant's applied income used to determine the amount he is responsible to pay toward the cost of his long-term care.

FINDINGS OF FACT

1. As of [redacted] 2020, the date of this hearing, the Appellant is [redacted] years old (DOB- [redacted]) who suffers with dementia and currently residing at the [redacted], a skilled nursing facility ("SNF"). (Exhibit 1)

2. The Appellant has never married; thus, has no community spouse. (Hearing record)

3. Sometime in [redacted] 2019, the Appellant was hospitalized where his leg was amputated due to complications with diabetes. (Conservator testimony)

4. On [redacted] 2019, the Appellant was admitted into the SNF from the hospital. (Hearing summary)

5. In the month of [redacted]2019, [redacted] was court appointed to be the Appellant's conservator of person and estate. (Conservator testimony)

6. On [redacted] 2019, ASCEND, the Department's contractor for level of care determinations, determined the Appellant was short term stay, which was to expire [redacted] 2019. (Hearing summary)

7. The 30th continuous day of LTCF care for the Appellant occurred in the month of [redacted]2019, specifically [redacted] 2019. (Hearing record)

8. On [redacted] 2019, the Department received the W-1 LTC application requesting long term facility Medicaid assistance. (Exhibit 1)

9. On [redacted] 2019, Ascend updated the Appellant's level of care ("LOC") which resulted in long term care approval. (Hearing record)

10. On [redacted] 2019, the SNF wrote a letter indicating that the Appellant planned on being discharged to return to the community within 6 months. His anticipated return would have been approximately [redacted] 2020. (Exhibit 4 and Appellant testimony)

11. This letter from the facility doctor was necessary to prevent the Appellant from listing his home property for sale as a condition of eligibility and to prevent the state from placing a lien against his property. (Department testimony)

12. At the time of the Appellant's application, the Appellant's income consists of $1309.50 Social Security income ("SSA") and $1507.00 [redacted] Pension. (Hearing summary)

13. The Appellant pays for two [redacted] Insurance premiums for $246.75 and $72.00 per month and pays $135.50 for his Medicare Part B premiums. (Hearing summary)

14. The conservator was responsible to pay for the Appellant's mortgage, rental of land, solar mortgage, federal and state income tax to the city of [redacted], utilities, insurances, conservator fees and property maintenance obligations to keep his home in the community. (Conservator testimony)

15. The Department determined the Appellant was eligible for a one-time 6- month diversion of $650.00 for maintaining a home in the community from [redacted] 2019 to [redacted] 2019 as level 1 housing. There is no extension to the 6 months diversion. (Hearing Summary and Departmental testimony)

16. The Department allowed $60.00 for the personal needs allowance ("PNA") deduction.

17. On [redacted] 2019, the Department issued a NOA to the Appellant stating that he was approved Medicaid effective [redacted] 2019 and that he must pay $1727.67 for the benefit period of [redacted] 2019 to [redacted], 2019 and $2377.67 effective [redacted] 2019 and ongoing per month towards the cost of his care. (Exhibit 6)

18. On [redacted] 2019, the Department determined the Appellant had reduced his assets to below the $1600 asset limit in [redacted] 2019 and was therefore eligible Medicaid effective [redacted] 2019. (Department testimony)

19. On [redacted] 2019, the Department re-calculated the Appellant's A.I. from [redacted] 2019 to [redacted] 2019 as $**1652.67**: [$1309.50 (SSA) + $1507.52 (Pension) - $60.00 (PNA) - $246.75 -$72.10 ([redacted] [redacted] Ins premiums.)- $650.00 (diversion) -$135.50 (Med part B premium]. (Hearing summary)

20. On [redacted] 2019, the Department re-calculated the Appellant's A.I. excluding the diversion from [redacted] 2019 to [redacted] 2019 as $**2302.67**: [$1309.50 (SSA) +$1507.52 (Pension) - $60.00 (PNA) - $246.75 - $72.10 ([redacted] Ins. Premiums- $135.50 (Med Part B premium)] (Hearing summary)

21. The Appellant claims exceptional circumstances due to the carrying cost of all his living expenses to maintain his residence and his property in the community, plus the added liability of paying the conservator's fee. The A.I. of $2302.67 leaves him with only $400.00 per month to maintain his home in the community. (Appellant testimony)

22. As of the date of this hearing, [redacted] 2020, the Appellant had not returned to the community. (Appellant testimony)

23. On [redacted] 2020, the Department issued a NOA regarding his application for Husky C ("LTCF") Long Term Care Facility Residents- Spend-down. The notice indicated under the subtitle "EXPENSES" the Appellant has the expense for LTCF cost of care in the amount of $9405.00 monthly.

    - The NOA indicated "Although Medicaid pays for most of your nursing home costs or the cost of your home care services, you are required to pay some of your income towards the cost of your care. The Patient Liability amount is the portion of your income that you must pay each month." The NOA incorrectly included a patient liability chart which indicated the Appellant's patient liability was $0.00 from [redacted]19 to [redacted]/20. (Appellant's Exhibit B)

24. On [redacted] 2020, the Department issued a NOA in response to a different medical program Husky C- ("HCBS") Home and Community Based Services. The notice indicated under the subtitle "EXPENSES" the Appellant has the expense for LTCF cost of care in the amount of $9405.00 monthly.

    - The NOA indicated "Although Medicaid pays for most of your nursing home costs or the cost of your home care services, you are required to pay some of your income towards the cost of your care. The Patient Liability amount is the portion of your income that you must pay each month." The patient liability chart on this NOA incorrectly indicated the Appellant's patient liability was $0.00 from [redacted]/19 to [redacted]/20, [redacted]20 to [redacted]/20 and [redacted]20 to [redacted]21. (Appellant's Exhibit C)

25. The NOA's were faulty and currently have an outstanding ticket on this IT issue computer glitch. The Department determined the NOA's in both instances were computer generated glitch due to the NOA's not counting diversions which gives the incorrect A.I. The Department's work around for this issue is to suppress the notice and explain to family members, if they have a question regarding the A.I, that the Appellant is responsible for the patient liability owed to the facility. In this case, both NOA's were incorrect for the following reasons:

    - The granting worker failed to suppress the [redacted] 2021 notice after making necessary updates on the Impact system in preparation for the initial administrative hearing which resulted in the creation of the NOA showing a patient liability of $0.00 from [redacted] 2019 to [redacted] 2020. That notice was sent in error. (Hearing summary)

    - A different medical program (Husky C – Home and Community Based Services) was processed and granted for the Appellant once he was discharged to his home in the community. The worker, at the time, failed to remove the income diversion authorized for the paying of the unpaid bill owed to the facility, thus creating a patient liability of $0.00 from [redacted] 2019 to [redacted] 2020, [redacted] 2020 to [redacted] 2020 and [redacted] 2020 to [redacted] 2021. The notice issued on [redacted] 2021 was incorrect.

    - The [redacted], 2021 indicated the end of the Husky C, LTCF resident Medicaid was [redacted] 2020 and the commencement of the Husky C, HCBS was [redacted] 2020.

    - Both the [redacted], 2020 and the [redacted] 2020 NOA's under the subtitle of "EXPENSES" clearly show the Appellant was responsible for the $9405 expense towards his LTC cost of care.

- The Department re-iterates the A.I. calculation listed under FOF 19 as $1652.67 from [redacted]2019 to [redacted] 2019 and FOF 20 as $2302.67 from [redacted] 2019 and ongoing are correct and remains the responsibility of the Appellant as his patient liability while on Medicaid and a resident at the facility. (Hearing summary, Department's testimony)

26. The original hearing decision due date was [redacted] 2020 in accordance with section 17b-61 (a) of the Connecticut General Statutes. However, on [redacted] 2021, the hearing officer reopened the hearing record due to a court order. The hearing reconvened on [redacted] 2021; therefore, the final decision is due no later than [redacted] 2021.

CONCLUSIONS OF LAW

1. Section l7b-260 to 17b-264 of the Connecticut General Statutes authorizes the Commissioner of Social Services to administer the Title XIX Medical Assistance Program to provide medical assistance to eligible persons in Connecticut.

2. Section 17b-261r (a) of the Connecticut General Statutes provides for the Determination of applied income. (a) For purposes of this section, "applied income" means the income of a recipient of medical assistance, pursuant to section 17b-261, that is required, after the exhaustion of all appeals and in accordance with state and federal law, to be paid to a nursing home facility for the cost of care and services.

3. UPM 1500 defines applied income as that portion of the assistance unit's countable income that remains after all deductions and disregards are subtracted.

4. The Department's uniform policy manual ("UPM") is the equivalent of 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).

5. Uniform Policy Manual ("UPM") § 5045.20 pertains to assistance units who are residents of Long- Term Care Facilities ("LTCF") or receiving community-based services ("CBS") are responsible for contributing a portion of their income toward the cost of their care. For LTCF cases only, the amount to be contributed is projected for a six-month period.

6. **The Department correctly determined the Appellant was a resident of a LTCF and is responsible for contributing a portion of his income toward the cost of his care.**

7. UPM ("UPM") § 5000.01 provides Treatment of Income definitions.

Available income- is all income from which the assistance unit is considered to benefit, either through actual receipt or by having the income deemed to exist for its benefit. Applied Income- Available income is that portion of the assistance unit's countable income that remains after all deductions and disregards are subtracted. Counted income- is that income which remains after excluded income is subtracted from the total of available income. Deductions- are those amounts which are subtracted as adjustments to counted income and which represent expenses paid by the assistance unit.

8. UPM § 5005 (A) provides that in consideration of income, the Department counts the assistance unit's available income, except to the extent that it is specifically excluded. Income is considered available if it is: 1. Received directly by the assistance unit; or 2. Received by someone else on behalf of the assistance unit and the unit fails to prove that is inaccessible; or 3. Deemed by the Department to benefit the assistance unit.

9. UPM 5050.13 provides, in part, that Social Security Benefits, Veteran's Benefits are income that is treated as unearned income in all programs.

10. UPM 5050.09 provides that (A) Payments received by the assistance unit from annuity plans, pensions and trusts are considered unearned income.

The Department correctly determined that the Appellant's SSA of $1309.50 and pension of $1507.52 are available unearned income.

11. UPM 4520.15 (a) pertains to Level 1 Housing and provides that an applicant or recipient is considered to be living in Level 1 Housing in the following situations: (1) he or she is living in commercial housing or in a Department of Mental Health (DMH) sanctioned supervised apartment and not sharing a bedroom with any other individual; (2) he or she is living in a shelter for the homeless or for battered women; **(3)** he or she is living in any type of housing not mentioned in (1) or (2) above, and is not sharing his or her bedroom, bathroom or kitchen with another individual.

The Department correctly determined the Appellant was in Level 1 Housing.

12. UPM § 5035.20 (A) provides that for residents of long-term facilities ("LTCF") without a spouse living in the community, the total gross income is adjusted by certain deductions to calculate the amount of income which is to be applied to the monthly cost of care. The following deductions described are subtracted from income: 1. beginning with the month in which the 30th day of continuous LTCF care or the receipt of community-based services occurs; and 2. ending with the month in which the unit member is discharged from the LTCF or community-based services are last received.

13. UPM § 5035.20 (B) (7) provides the cost of maintaining a home in the community for the assistant unit is subject to the following conditions: **a**. the amount is not deducted for more than six months; and **b**. the likelihood of the

institutionalized individual will return to the community within six months is certified by a physician; and **c**. the amount deducted is the lower of either (1) the amount the unit member was obligated to pay each month in his former community arrangement; or **(2)** $650.00 per month if the arrangement was Level 1 Housing; or (3) $400 per month if the arrangement was Level 2 Housing; and **d**. the amount deducted includes the following: (1) heat; (2) hot water; (3) electricity; (4) cooking fuel; (5) water; (6) laundry; (7) property taxes; (8)interest on the mortgage; (9) fire insurance premiums and (10) amortization.

The Department correctly determined the Appellant was eligible for a one- time diversion of $650.00 of no more than 6 months for the cost of maintaining his home in the community, in accordance with policy.

The Department incorrectly determined the diversion was from [redacted] 2019 to [redacted] 2019. Because the Appellant was admitted in [redacted] 2019, the 30th day of continuous care would be in the month of [redacted] 2019; therefore, the correct diversion should be [redacted] 2019 to [redacted] 2019. *

14. Conn. Gen. Stat. § 17b-272. (Formerly Sec. 17-134m). Personal fund allowance. Effective July 1, 2011, the Commissioner of Social Services shall permit patients residing in nursing homes, chronic disease hospitals and state humane institutions who are medical assistance recipients under sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive, to have a monthly personal fund allowance of sixty (60) dollars.

15. UPM 5035.20 (B) (2) provides a personal needs allowance of $50.00 for all other assistance units which, effective July 1, 1999 and annually thereafter, shall be increased to reflect the annual cost of living adjustment used by the Social Security Administration.

16. UPM 5035.20 (B) (4) provides Medicare and other health insurance premiums, deductibles, and coinsurance costs when not paid for by Medicaid or any other third party.

The Department correctly deducted the Appellant's PNA of $60.00 in the calculation of the A.I.
[1]

The Department correctly deducted the Appellant's [redacted] Insurance premiums [$246.75 & $72.10] and the cost of his Medicare Part B [$135.50] premium) in the calculation of the A.I.

[1] * The Department concluded post hearing; the Appellant was eligible for the month of [redacted] 2019. See FOF13.

17. UPM § 1500.01 provides for the definition of exceptional circumstances. Exceptional circumstances are conditions that are unusual or extreme for a community spouse, and which either directly threatens the community spouse's ability to remain in the community or pose some other type of unusual or extreme hardship for the community spouse, such as caring for a disabled child, sibling or other immediate relative.

    The Appellant has never been married; thus, there is no community spouse. The Appellant does not fit the criteria for exceptional circumstances. The Department is correct not to consider exceptional circumstances.

18. Sec. 17b-261r. of the Conn. Gen. Stats. Provides for the determination of applied income. Notice.

19. UPM § 5045.20 B (1) (a) provides that the amount of income to be contributed in LTCF cases at initial calculation for each month in the six-month period for which the contribution is projected, monthly gross income is established as follows: total gross monthly income which was paid or payable to the applicant or recipient, in the six months prior to the period for which the contribution is projected, is divided by six.

20. UPM § 5045.20 (B) (1) (b) provides that the total gross income is reduced by post-eligibility deductions (Cross reference: 5035-"Income Deductions") to arrive at the amount of income to be contributed.

21. UPM 5045.20 B. (2) provides the recalculation of the amount to be contributed in any month of the six-month period is required under the following conditions. a. significant change occurs in income which amounts to an increase or decrease in monthly income of $15 or more per month; or b. a change occurs, in any amount, in any deduction.

    The Department correctly calculated the Appellant's initial monthly A.I. as $1652.67 ($1309.50 SSA + $1507.52 pension = $2817.02 – minus $60.00 PNA - $650.00 diversion for maintaining a home in the community, - $246.75 - $72.10, [redacted] Insurance Premiums - $135.50, Medicare Part B premium).

    The Department incorrectly determined that the period of the initial A.I. was from [redacted] 2019 to [redacted] 2019.

    The correct period of the initial monthly A.I. is from [redacted] 2019 to [redacted] 2019.

    The Department correctly re-calculated the Appellant's monthly A.I. without the diversion as $2302.67. ($1309.50 SSA + $1507.52 pension = $2817.02 – minus $60.00 PNA - $246.76 - $72.10 [redacted] Insurance premiums - $135.50, Medicare Part B premium.

The Department incorrectly determined that the re-calculated A.I. was from [redacted] 2019 to [redacted] 2019.

The correct period of the re-calculated A.I. is from [redacted] 2019 to [redacted] 2019. **

22. Section 17b-80 of the Conn. Gen. Stats provides in part that **…** The commissioner shall make periodic investigations to determine eligibility and may, at any time, modify, suspend, or discontinue an award previously made when such action is necessary to carry out the provisions of the state supplement program, medical assistance program, temporary family assistance program, state-administered general assistance program or supplemental nutrition assistance program.

23. 1015.10 (C) provides the Department must send the assistance unit a notice regarding the Department's determination of the unit's initial eligibility, and, subject to conditions described in Section 1570, adequate notice before taking action to change the unit's eligibility status or the amount of benefits.

24. UPM 1500 defines adequate notice as a notice of denial, discontinuance, or reduction of assistance which includes a statement of the Department's intended action, the reasons for the intended action, the specific regulations supporting such action, an explanation of the assistance unit's right to request a Fair Hearing to contest the action, and the circumstances under which benefits are continued if the unit requests a Fair Hearing.

25. **The Department admittedly has an existing IT issue regarding certain NOA's issued with wrong A.I. or patient liability information as the system does not recognized diversions. The Department has devised a work around to address that issue specifically, which is to suppress the notices and to communicate the patient liability responsibility with the client, family members or responsible party. In this case, however, it seems that neither notices issued to the Appellant dated [redacted] 2020 or [redacted] 2020 were suppressed and neither of the notices were followed up with a corrected notice.**

[1]**The Department has concluded post hearing, the re-calculated AI is from [redacted] 2019 and ongoing. See COL 21.

26. **According to Section 17b-80 of the Conn. Gen. Stats**, **the Department, at any time, has the authority to modify a previously issued award when such action is necessary to carry out the provisions of the Husky C LTC. In this case, the Department may modify the NOA to represent the Appellant's true patient liability.**

DISCUSSION

The Conservator's main argument was that the expenses to maintain the Appellant's home in the community in addition to his conservator's fees makes the applied income unrealistic and claimed exceptional circumstances; especially since the Appellant intends to return to his home in the community. The hearing record shows that the Appellant does not have a community spouse; therefore, exceptional circumstances, in this case, do not apply. In addition, as of the date of this administrative hearing, the Appellant was still a resident of the SNF; thus, he is responsible to pay a portion for his cost of care.

The applied income is based on available income minus allowable deductions.
The initial calculation and subsequent re-calculation of the applied income is correct since the applied income policy does not allow for a diversion beyond 6 months for maintaining a home in the community. The hearing record shows that the Department determined the Appellant was eligible for the diversion from [redacted] 2019 to [redacted] 2019; however, policy states that diversion as a deduction starts in the beginning with the month in which the 30th day of continuous LTC occurs. In this case, the 30th day of continuous care in a LTC facility occurs in the month of [redacted] 2019; therefore, the rental diversion starts in [redacted] 2019 and the 6 months was to expire in the month of [redacted] 2019. The Appellant is owed rental diversion for the month of [redacted] 2019.

It should also be noted that the conservator requested a decision on the effective date of the Appellant's Medicaid application on this scheduled administrative hearing. A thorough research did not show that a request for an administrative hearing had been requested for effective date; therefore, I am unable to issue a decision on this issue.

The Appellant disagrees he owes the Applied income and presented 3 patient liability bills from the SNF to the Appellant, [redacted] 20: [redacted] 20 and [redacted] /21.

Both the [redacted] 20 and [redacted] 20 bills show the total charge for patient liability was $1652.67 for each month from [redacted] 19 to [redacted] 19 and $2302.67 from [redacted] 19 to [redacted] /19, but neither bill reflected the daily rate.

The [redacted] 21 SNF reflected the daily rate- at $495.00 for 19 days = $9405.00, and $1652.67 from [redacted] 19 to [redacted] 19 and $2302.67 from [redacted] 19 to [redacted] 19 and $491.65 from [redacted] 19 to [redacted] 19 as patient liability diversion-UNPAID, however the bill did not reflect a total charge from [redacted] 19 to [redacted] 19.

Counsel for the Appellant asserts that the bills which reflect the daily rate but do not reflect a total charge per month would indicate that the SNF were fully paid by the State and therefore the Appellant has zero patient liability. In addition, counsel for the Appellant questioned why the SNF bill did not reflect a payment made by the State.

The Department has no control of the billing format used by the SNF to bill its patients but agrees the format of the bill is awkward; however, it does not absolve the Appellant from the responsibility of paying a portion of his income towards his cost of care. It should be noted that the [redacted] 21 bill has the following notation "NO FUNDS HAVE BEEN TURNED OVER TO THE NURSING HOME AT THIS POINT".

Counsel for the Appellant also disagrees that the AI is owed because the notices of [redacted] 2020 and [redacted] 2020 informs Appellant that the patient liability is zero. Appellant's counsel asserts that the public counts on accurate information provided by the Department in their Notice of Action and based on the information provided, the Appellant does not owe the AI and therefore the Appellant has no patient liability.

The Department admittedly has an existing issue with the agency's eligibility management system software (ImpaCT) as the system does not reflect AI when a diversion is read thereby producing an incorrect patient liability of "zero". The Department is aware of this issue and asserts that it is in the process of addressing this source of confusion through a software adjustment. Although, the patient liability chart shows zero liability, both NOA's reflect the Appellant has the EXPENSE and is responsible for the $9405.00 LTC towards his cost of care. The Department determined that calculation of the applied income remains the same.

The Department, however, did not follow up with a corrected notice to the Appellant.

DECISION

The Appellant's appeal was GRANTED in part and DENIED in part.

ORDER

1. The Department is ordered to provide the Appellant with a corrected notice showing the full calculation and the patient liability.

2. Compliance with the undersigned is due by [redacted] 2021.

Almelinda McLeod
Hearing Officer

CC: Musa Mohamud, SSOM Manchester
Kristen Bert, fair Hearing Liaison, New Haven Regional Office

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.

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 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.