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

[redacted] 2022
Signature Confirmation
Corrected to Include Order

Client ID [redacted]
Case ID [redacted]
Request # 183899

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2021, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA) granting her medical benefits under the Husky C - Home and Community Based Services Medicaid Program ("W01"), also known as the Connecticut Home Care Program for Elders Medicaid Waiver ("CHCPE") effective [redacted] 2021 .

On [redacted] 2021, [redacted] ("AREP"), daughter and authorized representative for the Appellant, requested an administrative hearing on behalf of the Appellant to contest the Department's decision to authorize payment for caregiver services under the CHCPE starting [redacted], 2021.

On [redacted] 2021, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2021 via teleconference.

On [redacted] 2021, 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 via teleconference. During the administrative hearing it became clear to the fair hearing officer that I needed to continue the hearing to another day. Both the Department and the AREP agreed to the continuance.

The following individuals called in for the [redacted] 2021 administrative hearing:

[redacted], Daughter, and Authorized Representative for the Appellant ("AREP")
Brenda Arrington, Department Representative
Lisa Nyren, Fair Hearing Officer
Jessica Gulianello, Fair Hearing Officer, Observation Only

On [redacted] 2021, the OLCRAH issued a notice reconvening the administrative hearing for [redacted] 2021 via teleconference.

On [redacted], 2021, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-189 inclusive of the Connecticut General Statutes, OLCRAH reconvened the administrative hearing via teleconference.

The following individuals called in for the [redacted] 2021 hearing:

[redacted], AREP
Pamela Adams, Department of Social Services, Community Options Representative
Melissa Juliano, Department Representative
Lisa Nyren, Fair Hearing Officer

On [redacted] 2021, the Fair Hearing Officer mailed via first class mail through the United States Postal Service a copy of the hearing summary and exhibits submitted by the Department to the AREP.

The record remained open for the submission of additional evidence by the Department and the AREP. On [redacted], 2021, the Department submitted additional evidence. On [redacted] 2021, the AREP on behalf of the Appellant submitted additional evidence. On [redacted] 2021, the record closed.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly determined the Appellant's date of eligibility for payment of caregiver services under the CHCPE Category 3 as [redacted] 2021.

FINDINGS OF FACT

1. As of [redacted], 2018, the Department implemented the Appellant's plan of care which included care for the following supports:
    - Personal Care Assistant provided by [redacted] (the "daughter")

for 0.5 hours per week, funding source in-kind
- Financial Management services provided by the daughter for 2.0 hours per month, funding source in-kind
- Care Management services received by the Appellant from Colonial Cooperative Care ("CCC"), funding source as the Department. (Exhibit 16: Department Memos and Universal Care Plan)

2. The CHCPE helps eligible individuals remain at home by paying for community and home-based services that assist the individual in the community to remain in their home and avoid institutionalization. Providers of caregiver services must be enrolled and approved by the Department to receive payment from the Department. (Hearing Record)

3. CCC is the Department's access agency which provides care manager services for recipients of CHCPE. (Community Options Representative's Testimony)

4. There are three different categories in which funding for services under the CHCPE are provided and two separate funding sources: Category 5, formerly Category 1, and Category 2 are state funded categories and Category 3 is funded through eligibility for the W01 program. (Community Options Representative's Testimony)

5. The Alternate Care Unit ("ACU") is the clinical division of the Department which administers the CHCPE for which community and home-based services are authorized under the state funded program or Medicaid/W01 program. (Community Options Representative's Testimony)

6. In 2019, the Appellant's plan of care implemented by the Department included the following services under the CHCPE program funded through the state, category 2:

    - Personal Care Assistant provided by the daughter for 0.5 hours per week, funding source in-kind,
    - Financial Management services provided by the daughter for 2.0 hours per month, funding source in-kind,
    - Live-in Personal Care Assistant seven (7) days per week, funding source client,
    - Care Management services provided by CCC, funding source Department.

    The Appellant declined payment for live-in personal care assistant services under the CHCPE because the caregiver provider was not an authorized provider under the CHCPE's list of authorized providers and continued to spenddown her assets to qualify for such services under the W01 program at a future date rather than accept partial payment of such services from the

Department. (AREP's Testimony, Exhibit 11: Notice of Action, and Exhibit 16: Department Memos and Universal Care Plan)

7. Funding for a live-in personal care assistant is limited under the CHCPE funded through Category 5 and Category 2 with maximum funding reaching up to eleven (11) days per month. (Community Options Representative's Testimony)

8. Beginning [redacted] 2019, the [redacted] (the "caregiver provider") began providing live-in caregiver and support services to the Appellant in her home. The Appellant paid for the live-in caregiver and support services from her private funds. (AREP's Testimony and Exhibit 14: Caregiver Agreement)

9. Recipients of the CHCPE Category 3 must qualify for Medicaid under the W01 program meeting the Medicaid asset and financial criteria before services can be authorized under the CHCPE. (Community Options Representative's Testimony)

10. On [redacted] 2021, the AREP, on behalf of the Appellant, submitted an Long-term Care/Waiver Application ("W-1 LTC") requesting home care services to CCC. (AREP's Testimony and Exhibit 13: W-1 LTC Application)

11. On [redacted] 2021, the Department received the Appellant's W-1 LTC application requesting medical benefits under the W01 program from CCC. (Appellant's Testimony, Exhibit 13: W-1 LTC Application, and Exhibit A: AREP's Written Statement)

12. On [redacted] 2021, the Department denied the Appellant's [redacted], 2021 application for medical benefits under the W01 program effective [redacted] 2021 because the Appellant's assets exceed the Medicaid asset limit. (Exhibit A: AREP's Written Statement and AREP's Testimony)

13. On [redacted] 2021, [redacted] ("state authorized provider"), a state authorized provider of home care services under the CHCPE, replaced the Appellant's caregiver provider so that payment by the Department on behalf of the Appellant for the live-in personal care assistant could begin under the CHCPE. (AREP's Testimony, Exhibit 10: ComForcare Deposit Receipt and Exhibit D: ComForcare Invoices)

14. On [redacted] 2021, the Department received proof of reduction in life insurance asset to within the Medicaid threshold. (Exhibit B: AREP Email and Supporting Documents)

15. On [redacted] 2021, the Department received additional asset documentation confirming the Appellant's reduction in assets to within the

Medicaid threshold and a request for approval of the W01 via email. (AREP's Testimony and Exhibit C: AREP Email and Supporting Documents)

16. On [redacted], 2021, the AREP telephoned the Department to determine the status of the Appellant's request for homecare services. (AREP's Testimony)

17. On [redacted] 2021, the Department requested documentation from the ACU to restart the W01 application process necessary to move the payment source for services from state funded to Medicaid. Ascend had not updated the Appellant's Level of Care for services under Medicaid. (Department Representative's Testimony, Exhibit 1: Application Email, Exhibit 2: Case Notes)

18. Ascend is the Department's contractor which determines Level of Care for Medicaid payment for nursing home placement and home care services. (Department Representative's Testimony and Exhibit 1: Application Email)

19. On [redacted], 2021, the Department determined the Appellant's new application for the W01 program as [redacted] 2021. (Hearing Record)

20. On [redacted] 2021, the Department determined the Appellant eligible for Medicaid under the W01 program effective [redacted] 2021 and notified the AREP and ACU. (Exhibit 11: Notice of Action, AREP's Testimony and Department Representative's Testimony)

21. On [redacted] 2021, the Department issued a notice of action to the Appellant. The notice stated the Department approved Medicaid under the W01 effective [redacted] 2021. The notice stated, "You are on the Connecticut Home Care Program for Elders Medicaid Waiver." (Exhibit 11: Notice of Action)

22. On [redacted] 2021, the ACU determined Category 3 payment for the Appellant's personal care assistant services under the CHCPE to begin [redacted], 2021. (Hearing Record)

23. On [redacted] 2021, the ACU notified CCC to authorized payment for home care services for the Appellant beginning [redacted] 2021 under the CHCPE as category 3. (Department Representative's Testimony and Exhibit 16: Department Memos and Universal Care Plan)

24. On [redacted], 2021, CCC revised the Appellant's Care Plan for the period [redacted] 2021 through [redacted] 2022. The Care Plan included the following supports:

- Personal Care Assistant for 0.5 hours per week funding source in-kind,
- Financial Management services for 2.0 hours per month funding source in-kind,
- Personal Care Assistant by the state authorized provider daily 7-days per week funding source listed as the Department,
- Care Management services provided by CCC funding source listed as the Department.

(Exhibit 16: Department Memos and Universal Care Plan)

25. A recipient of home care services must meet both financial and functional eligibility under CHCPE Category 3 for the Department to provide payment for such services. (Community Options Representative's Testimony)

26. The Appellant seeks payment for home care services under the CHCPE program effective [redacted] 2021. (AREP's Testimony)

27. The issuance of this decision is timely under Connecticut General Statutes § 17b-61(a), which requires the agency to issue a decision within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2021. However, OLCRAH continued the [redacted] 2021 administrative hearing to [redacted] 2021, with the Appellant's AREP agreement, causing a 9-day delay. Additionally, the hearing record remained open until [redacted] 2021 for additional evidence from the Department and the Appellant's AREP, resulting in an additional [redacted]y delay. Due to the [redacted]y delay, the final decision is not due until [redacted], 2022 and is therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes provides that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

2. "The Department of Social Services shall be the sole agency to determine eligibility for assistance and services under programs operated and administered by said department." Conn. Gen. Stat. § 17b-261b(a)

3. State Statute provides as follows:

   The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be

eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection (i) of this section. For purposes of this section, a long-term care facility is a facility that has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The program shall be structured so that the net cost to the state for long-term facility care in combination with the services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has intellectual disability shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

Conn. Gen. Stat. § 17b-342(a)

“An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits pursuant to section 17b-260 when requested to do so by the department and shall accept such benefits if determined eligible.” Conn. Gen. Stat. § 17b-342(h)

State statute provides as follows:

The Commissioner of Social Services is authorized 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 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries.

Conn. Gen. Stat. § 17b-260

State statute provides as follows:

The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

Conn. Gen. Stat. § 17b-342(c)

Section 17b-342-1(a) of the Regulations of Connecticut State Agencies provides as follows:

The purpose of sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies is to describe non-financial program requirements, services available and limitations under the Connecticut Home Care Program for Elders. This program provides home health services, community based services and assisted living services funded under a waiver to the Medicaid program and under a program funded with an appropriation by the General Assembly. The financial

eligibility requirements for these three parts of the program differ and are specified under sections 2540.92 and 8040 to 8040.50, inclusive, of the Uniform Policy Manual of the Department of Social Services. This program includes all clients transferred from the following programs as of July 1, 1992: Promotion of Independent Living for the Elderly, Department on Aging Home Care Demonstration Project and Long Term Care Preadmission Screening and Community Based Services Program. Sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies also establish standards and requirements for access agencies and assisted living service agencies which operate under the Connecticut Home Care Program for Elders and the Connecticut Partnership for Long Term-Care.

"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))

Uniform Policy Manual ("UPM") § 8040 provides as follows:

This chapter describes the eligibility requirements for the Connecticut Home Care Program for Elders (CHC). This program provides home health and community based services under either a waiver to the Medicaid program or under an appropriation by the General Assembly. The financial eligibility requirements for these two parts of the program differ. The Medicaid waiver requirements are specified under UPM 2500 "Medical Coverage Groups" and other areas of the UPM. This section of the manual applies to the state-funded portion of the program. The state-funded portion is not an entitlement program and services and access to services may be limited based on available funding. The Department may place new applicants on a waiting list in order of their date of application within the program region.

The Connecticut Home Care Program for Elders provides an alternative to the elderly individual who is inappropriately institutionalized or at risk of institutionalization as long as the individual is not taking an unacceptable risk by putting his or her life and health and that of others in immediate jeopardy.

Department policy provides as follows:

Individuals Receiving Home and Community Based Services ("W01"). This group includes individuals who:

1. Would be eligible for MAABD if residing in a long-term care facility (LTCF); and

2. Qualify to receive home and community-based services under a waiver approved by the Centers for Medicare and Medicaid Services; and
3. Would, without such services, require care in an LTCF.

UPM § 2540.92(A)

"To be eligible for this program [CHCPE] the individual must make application for Medicaid program when requested by the Department, cooperate in the eligibility process, and accept Medicaid benefits if eligible." UPM § 8040.30

"The following are the responsibilities of the applicant/recipient: he or she must apply for Medicaid and cooperate in the application process if requested by the Department." UPM § 8040.05

On [redacted] 2021, the Appellant correctly complied with state statute under the CHCPE by applying for Medicaid under the Individuals Receiving Home and Community Based Services ("W01") program as requested by CCC and later accepted such medical benefits when determined eligible by the Department.

4. State regulation provides as follows:

"Connecticut Home Care Program" or "the Program" means the program operated for elders pursuant to section 17b-342 of the Connecticut General Statutes. This program was formerly known as the Long Term Care Facility Preadmission Screening and Community Based Services Program and includes all home care clients who were transferred from the former Department on Aging and the department's Fairfield pilot program clients.

Regs., Conn. State Agencies § 17b-342-1(b)(1)

State regulation provides as follows:

The purposes of the Connecticut Home Care Program are to:

A. Assess whether cost-effective home care services can be offered to elders who are at risk of institutionalization;
B. Determine, prior to admission to a nursing facility whether the elder does or does not need nursing facility services;
C. Authorize department payment for elders for nursing facility care of home care services if appropriate; and
D. Provide a full range of community based services, home care services and assisted living services to eligible individuals who choose to remain in the community, if such services are appropriate, available and cost effective.

Regs., Conn. State Agencies § 17b-342-1(c)(1)

State regulation provides for the Determination of Need as follows:

A. The determination as to whether the elder is at risk of institutionalization or needs services that would otherwise require institutionalization shall be made by the department based upon an evaluation of the completed health screen and an assessment, if deemed appropriate.
B. The basis for determining the level, type, frequency and cost of services and funding source that an elder may receive under the program shall be determined by their financial and functional eligibility and need for services.
C. Functional eligibility means the elder must be at risk of institutionalization and needs assistance with at least one critical need. For the purposes of eligibility, critical needs are defined as "activities of daily living" which are hands-on-activities or tasks that are essential for a client's health and safety. These include, but are not limited to; bathing, dressing, transferring, toileting (bowel or bladder), feeding, meal preparation, administration of medication or ambulation.

Regs., Conn. State Agencies § 17b-342-1(c)(3)

State regulation provides for Category types as follows:

The following three category types define the funding sources which pay for the client's community based services and home health services. The category types apply to care managed cases, self-directed cases and the assisted living services program component." Regs., Conn. State Agencies § 17b-342-1(c)(4)

A. Category Type 1: This category applies to elders who are at risk of institutionalization but who might not immediately enter a hospital or nursing facility in the absence of the program. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in section 17b-10-1 of the Regulations of Connecticut State Agencies and the department's Uniform Policy Manual section 8040. Some clients under Category Type 1 may be Medicaid recipients because they do not meet the functional criteria for the Medicaid waiver portion of the program.
B. Category Type 2: This category applies to elders who would otherwise require admission to a nursing facility on a short or long term basis. This category type is available to elders who meet the financial and functional eligibility criteria for the state-funded portion of the program as defined in the department's Uniform Policy Manual section 8040.

C. Category Type 3: This category applies to elders who, but for the provision of home care services, would require nursing facility care funded by Medicaid. This category type is available to elders who meet the financial and functional eligibility criteria for Medicaid under the federal waiver as defined in the department's Uniform Policy Manual section 2540.92.
D. The program category type identifies the maximum funding level available for all program clients. The access agencies, department staff and assisted living service agencies shall specify the category type on the client's plan of care in the funding source section.

Regs., Conn. State Agencies § 17b-342-1(c)(4)

The Department correctly determined that the Appellant qualified for CHCPE with a funding level under Category 2 which later changed to Category 3 upon eligibility for the W01.

5. State regulation provides as follows:

The determination of services for the program's fee-for-service and assisted living services option consists of:

A. Completion of an initial assessment by the access agency or the department;
B. A determination if program participation is feasible;
C. A determination of what service options under the program are appropriate;
D. Development of a plan of care for care managed cases by the access agency or the department. For clients participating in the assisted living service option, the assisted living service agency shall develop the plan of care;
E. A determination as to the feasibility and cost-effectiveness of home care services, if deemed appropriate; and
F. Authorization for community based services and home health services in the community.

Regs., Conn. State Agencies § 17b-342-1(c)(5)

State regulations provides as follows:

For the Connecticut Home Care Program, all home care services shall be included as part of a written plan of care developed initially and updated regularly by the access agency, the assisted living service agency, department staff or department designee. The plan of care shall specify the start date of services, services to be provided, category type of services, frequency, cost, funding source and the providers of all home care services.

The type and frequency of services contained in the plan of care shall be based upon the documented needs found in the assessment of the elderly person's needs and shall be reimbursed by the department only when it is determined that each service is needed in order to avoid institutional placement. For any services where the client would be at risk if the schedule of the service varied, a back-up plan shall be identified in the total plan of care. Services not included as part of the approved plan of care or not covered by sections 17b-342-1 to 17b-342-5, inclusive, of the Regulations of Connecticut State Agencies are not eligible for reimbursement from the Connecticut Home Care Program.

Regs., Conn. State Agencies § 17b-342-1(d)(7)

“Services that shall be covered by another payer, including but not limited to, any covered services through Medicare, private insurance or long-term care insurance, shall be included in the plan of care.” Regs., Conn. State Agencies § 17b-342-1(d)(9)

“In-kind services performed by family members, volunteer groups, community action agencies or any other person or entity shall be included as part of the client’s plan of care.” Regs., Conn. State Agencies § 17b-342-1(d)(10)

“If the department determines that a plan of care is feasible and cost-effective under the program, the elderly person may remain in the community with assistance provided under the Connecticut Home Care Program. If home care is desired, the plan of care shall be authorized by the department.” Regs., Conn. State Agencies § 17b-342-1(d)(6)

“All home care services provided to individuals under the Connecticut Home Care Program shall be authorized in accordance with procedures established by the department prior to the delivery of the service.” Regs., Conn. State Agencies § 17b-342-3(a)(1)

“Reimbursement is not available from the department for any services provided prior to the assessment or the determination of program eligibility or not documented in an approved plan of care.” Regs., Conn. State Agencies § 17b-342-3(a)(7)

“Reimbursement is not available for services arranged by program clients or representatives, access agencies, assisted living service agencies or service providers without prior approval by the department or department designee.” Regs., Conn. State Agencies § 17b-342-3(a)(11)

The Appellant was a recipient of state-funded services and determined functionally eligible for community-based services under the CHCPE

at the time of her application for W01. Additionally, the Appellant complied with all medical assistance application requirements timely; therefore, the cost of her services under the CHCPE should be covered by the program.

Although the date of initial assessment is not known or the initial date the Department approved the plan of care authorizing services, evidence provided by the Department confirms personal care assistant services 7-days per week were authorized under the care plan as early as 2019; therefore, the services are reimbursable once the Appellant qualified for the W01.

Additionally, state regulation provides that all services covered by another payer or in-kind services must be included in the plan of care. The plan of care which included client paid services and in-kind services for the live-in personal care assistant and Department paid services were authorized under the state-funded program with a change in payee once Medicaid eligibility was determined. The live-in personal care assistant remained part of the Appellant's approved care plan; therefore, the personal care assistant service is subject to reimbursement.

The Department incorrectly determined home care services provided prior to the [redacted] 2021 authorization date for services under the CHCPE will not be paid for by the Department. The Appellant met both the financial and functional eligibility under CHCPE Category 3 for the Department to provide payment for such services as of [redacted] 2021.

The correct date for payment of home care services under the W01 is [redacted] 2021, the date the Appellant became eligible for benefits under the W01.

DECISION

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

DISCUSSION

There is nothing in the state statutes or state regulations which prevents the Department to retroactively pay for such services if the services were already implemented under the recipient's approved plan of care. In this case, such services were implemented, it was the payment source that changed.

ORDER

1. The Department must correct the authorization for home care services under the CHCPE from [redacted] 2021 to [redacted] 2021 and issue any payment due to the state authorized provider on behalf of the Appellant.

2. Compliance is due within 14-days from the date of this hearing decision.

Lisa A. Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: Community Options, DSS
Pamela J. Adams, DSS CO
Melissa Juliano, DSS RO #10

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, 165 Capitol Avenue, 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.