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

[redacted] 2024
Signature Confirmation

Client ID [redacted]
Case ID [redacted]
Request # 238754

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, [redacted] ("access agency") on behalf of the Department of Social Services (the "Department") issued a Revised CFC Individual Budget notice and Notice of Action to [redacted] (the "participant") reducing the number of Personal Care Attendants ("PCA") service hours under the Community First Choice ("CFC") program from 80 hours per week plus seven (7) overnights to forty-three and three quarters (43.75) hours per week with zero (0) overnights.

On [redacted] 2024, [redacted] (the "Appellant") on behalf of the participant requested an administrative hearing to contest the Department's decision to limit service hours under the PCA program to 43.75 hours per week and deny overnight care.

On [redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted] 2024, the Appellant requested a continuance which OLCRAH granted.

On [redacted] 2024, the OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted] 2024, 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 by teleconference at the Appellant's request.

The following individuals called in for the hearing:

[redacted], Appellant
[redacted], Witness for the Participant
[redacted], Participant's Case Manager, [redacted]
Randell Wilson, CFC Program Manager, Department Representative
Janette Steward, CFC Nurse Consultant, Department Representative
Lisa Nyren, Fair Hearing Officer

On [redacted] 2024, the fair hearing officer reopened the hearing record after receiving additional evidence from the Department on [redacted] 2024 and the Appellant's response to such evidence on [redacted] 2024. The hearing record closed on [redacted] 2024. No further comments were accepted.

STATEMENT OF THE ISSUE

The issue to be decided is whether the decision to limit PCA services under the CFC program to 43.75 hours per week with no overnights for the participant was correct.

FINDINGS OF FACT

1. The participant is a recipient of Medicaid under the Husky C Home and Community Based Services ("HCBS") Department of Developmental Services ("DDS") Waiver program. (Hearing Record)

2. The participant receives Personal Care Attendant ("PCA") services under the CFC program. (Hearing Record)

3. The CFC program is a Medicaid program that provides in-home services and supports to Medicaid recipients residing in the community who without such supports and services may be institutionalized. Participants under a Medicaid waiver program, such as the DDS waiver program, can qualify for CFC services and supports but their CFC budget is based solely on activities of daily living ("ADLs") since instrumental activities of daily living ("IADLs") are addressed under the waiver programs. CFC will not pay for duplicative services. (Randell Wilson Testimony)

4. [redacted] ("case manager"), [redacted] (access agency) is the participant's case manager for the CFC program.

The access agency is the Department's contractor for completing annual assessments under the CFC program. The case manager completes an assessment using the universal assessment tool ("UA") with the participant and their family members and/or caregivers as appropriate, to determine the CFC budget. (Hearing Record)

5. The participant's PCA services and supports are dually funded through the CFC program and the DDS waiver program. (Randell Wilson Testimony)

6. The participant's care plan which was last approved by the Department on [redacted] 2021 included 72 hours PCA services with 7 overnights per week approved under the CFC program through a request for a budget exception submitted by the access agency. Each overnight is a 12 hour shift in addition to the 72 hours PCA services. The total cost of all services equaled $184,703.03. (Hearing Record)

7. On [redacted] 2024, the access agency telephoned and emailed the Appellant requesting written justification from a medical doctor supporting the need for 80 PCA service hours per week, 7 overnights, and 2:1 staffing prior to the annual review of PCA service hours under the CFC program. CFC can include overnights, however the participant must provide medical documentation supporting the medical need for overnights, such as overnight medication schedule, documentation of overnight seizures with intensity and frequency documentation, and documentation of the need for such overnight care. (Janette Steward Testimony and Randell Wilson Testimony)

8. On [redacted] 2024, the Appellant notified the Department she was unable to obtain medical documentation on the participant's behalf supporting the need for 80 PCA service hours and 7 overnights. (Janette Steward Testimony)

9. On [redacted] 2024, the case manager, completed an annual review with the participant and the Appellant to review and revise as appropriate the participant's care plan. The access agency completed a review of the participant's ADLs using the UA tool and determined the participant requires extensive hands-on assistance for all five (5) ADLs. The case manager determined the participate requires extensive hands-on assistance to complete ADLs. Because the participant requires extensive hands-on assistance for five (5) ADLs and is a recipient of the DDS Medicaid waiver program, the participant qualifies for 43.75 PCA service hours under the CFC program based on the CFC budget C. The participant's ability to complete IADLs were not considered for the CFC program because IADL's are considered under the DDS waiver program services. 43.75 hours per week equals a monthly budget of $5,380.38 under the CFC program. Although the Department approved additional

PCA hours under a request for a budget exception in 2021, new guidance from the Department prevented the access agency from submitting a request for a budget exception. (Case Manager Testimony Randell Wilson Testimony, Janette Steward Testimony, Exhibit 4: Budget Categories, and Exhibit 7: LON Assessment)

10. The Department reviews all requests for a budget exception as submitted by an access agency however, medical documentation supporting the participant's need for additional hours is required in addition to the request for a budget exception provided by the access agency for the Department to determine eligibility for additional hours above the CFC program standard budget category hours. (Janette Steward Testimony)

11. On [redacted] 2024, the case manager proposed a revised CFC individual budget of 43.75 PCA hours with zero (0) overnights that equaled $59,417.40 and issued the Appellant on behalf of the participant a Notice of Action. The notice states, "The [Department] previously authorized a CFC individual budget for you of $184,703.23. Today, we reassessed your Level of Need and your revised CFC Individual Budget is $59,417.40. This budget amount is equal to about 43.75 hours of Personal Care Assistance (PCA) per week. … Effective date of budget reduction [redacted]/2024." (Exhibit 2: Revised CFC Individual Budget)

12. The Appellant is the participant's guardian. (Appellant Testimony)

13. The participant is age [redacted] born on [redacted]. (Hearing Record)

14. The participant lives at home with the Appellant and [redacted] ("Appellant's Adult Daughter"), the Appellant's daughter. (Appellant Testimony)

15. The participant's medical diagnoses include seizure disorder, Von Willebrand disease, blindness, allergy, asthma, dysphagia, GERD, severe scoliosis, pressure ulcers, underweight, and unable to retain iron levels. (Exhibit 7: DDS LON Assessment)

16. The participant's developmental disability diagnoses include intellectual disability, cerebral palsy, and anoxic brain injury ("ABI"). (Exhibit 7: DDS LON Assessment)

17. The participant's mental health diagnoses include depression and anxiety. The participant's increased anxiety can cause a greater occurrence of seizures. The participant is monitored for signs of agitation, disorientation, delirium, staring, and/or changes in mood which can lead to a seizure. Caregivers must know warning signs and administer

medications to possibly avert a seizure. Medication is administered as needed to calm the participant down and avert a seizure. (Exhibit 7: DDS LON Assessment, Appellant Testimony and Appellant's Adult Daughter Testimony)

18. The participant requires hands on assistance with activities of daily living ("ADLs") which include bathing, dressing, personal hygiene, toileting, transferring, and eating. The participant is totally dependent on his caregivers. (Exhibit 7: DDS LON Assessment and Appellant Testimony)

19. The participant's diet is high calorie and in pudding form. All food must be coarsely chopped or pureed for 72 hours after a seizure. The participant is at risk for dehydration. (Exhibit 7: DDS LON Assessment)

20. The participant is not mobile without the use of his wheelchair. The participant operates his motorized wheelchair when outside of the home. The home is not large enough for the operation of the motorized wheelchair inside of the home. The home is equipped with a Lift System in the living room which can move the participant from his wheelchair to the loveseat in the living room. (Exhibit 7: DDS LON Assessment)

21. The Appellant has requested financial help to install bathroom modifications which include a lift to transfer the participant from his wheelchair to the bathtub for daily baths. The cost of modification continues to be reviewed and eligibility for funds are being reviewed by the Department and DDS. (Hearing Record)

22. The participant requires direct assistance with his medications. The participant is unable to complete household chores. The participant requires direct assistance with meal preparation, cooking, money management, and transitioning from one activity to another. (Exhibit 7: DDS LON Assessment)

23. The participant's behaviors and diagnosed mental health conditions require monitoring. Such behaviors include opposes supports/assistance, disruptive, verbal aggression/emotional outbursts, and both mild and severe physical assault/aggression. Caregivers must accompany the participant continuously. The participant should never be left alone, and caregivers must always have the participant within sight. (Exhibit 7: DDS LON Assessment)

24. The participant receives overnight support because he is at risk for seizures and wakes during the night. A caregiver watches for signs of seizures to ensure the participant's safety and administer medication as appropriate during the overnight hours. If the participant wakes during the overnight hours (usually between 1:00 am and 4:30 am), the caregiver

directs the participant back to sleep. (Exhibit 7: DDS LON Assessment and Appellant Testimony)

25. The participant requires a two-person transport: the driver and caregiver due to the possibility of seizures during transport. (Exhibit 7: DDS LON Assessment and Appellant Testimony)

26. The participant attended a day program through DDS, however the program ended in [redacted] 2020 at the start of the pandemic. The participant does not attend a day program currently. (Hearing Record)

27. The participant took part in adaptive sports such as downhill skiing, waterskiing, biking and kayaking in the past, but transportation to and from such activities is limited and the costs to continue is high. Additionally, the participant received physical therapy weekly which the Appellant paid for out of pocket. Budget limitations have prevented recent enrollment. (Appellant Testimony and Exhibit 7: DDS LON Assessment)

28. The Department has been working with the DDS Regional Planning and Resource Allocation Team ("PRAT") to reallocate appropriate funding to the participant for services and supports under both the DDS waiver program and the CFC program to address his needs. (Janette Steward Testimony and Randell Wilson Testimony)

29. On [redacted] 2024, the Department confirmed the following current care plan for the participant:

- 57 hours personal support – DDS waiver
- 36 hours personal support – DDS waiver
- 30 hours individualized day supports – DDS waiver
- 43.75 hours - CFC
- 166.75 total DDS & CFC services and supports hours

(Exhibit 8: Department Email)

30. The issuance of this decision is timely under Connecticut General Statutes § 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2024. However, the hearing which was originally scheduled for [redacted] 2024 was rescheduled for [redacted] 2024 which caused a [redacted]-day delay. In addition, the Department and the Appellant submitted additional evidence after the closure of the record, therefore the hearing record was reopened and remained open for an additional 7-days. Because to the [redacted]-day delay, this decision is due not later than [redacted] 2024.

CONCLUSIONS OF LAW

1. Section 17b-2(6) of the Connecticut General Statutes ("Conn. Gen. Stat.") provides as follows:

   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.

   "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)

2. Title 42 of the Code of Federal Regulations ("CFR") § 441.500(a) provides as follows:

   This subpart implements section 1915(k) of the Act, referred to as the Community first Choice option (hereafter Community First Choice), to provide home and community-based attendant services and supports through a State plan.

   Federal regulation provides as follows:

   Community First Choice is designed to make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related tasks through hands-on assistance, supervision, or cueing.

   42 CFR § 441.500(b)

   Federal regulation provides as follows:

   States must provide Community First Choice to individuals in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires to lead an independent life.

   42 CFR § 441.515(b)

   Federal regulation defines *Activities of Daily Living (ADLs)* as basic personal every day activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring. 42 CFR § 441.505

Federal regulation defines *Instrumental Activities of Daily Living (IADLS)* as activities related to living independently in the community, including but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other medica, and traveling around and participating in the community. 42 CFR § 441.505

3. Federal regulation provides as follows:

   States must conduct a face-to-face assessment of the individual's needs, strengths, preferences, and goals for the services and supports provided under Community First Choice in accordance with the following:

   a. States may use one or more processes and techniques to obtain information, including telemedicine, or other information technology medium, in lieu of a face-to-face assessment if the following conditions apply.
      1. The health care professional(s) performing the assessment meet the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology;
      2. The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff; and
      3. The individual is provided the opportunity for an in-person assessment in lieu of one performed via telemedicine.
   b. Assessment information supports the determination that an individual requires Community First Choice and also supports the development of the person-centered service plan and, if applicable, service budget.
   c. The assessment of functional need must be conducted at least every 12 months, as needed when the individual's support needs or circumstances change significantly necessitating revisions to the person-centered service plan, and at the request of the individual.
   d. Other requirements as determined by the Secretary.

   42 CFR § 441.535

   Connecticut State Plan Amendment ("SPA") Transmittal No 15-012 effective July 1, 2015 § 1(B) provides as follows:

   The State determines initially, and at least annually, that individual require the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. The institutional level of care screen is completed by staff of the Department of

Social Services on each individual referred to the program. Once an individual successfully completes the screen, the Department refers the individual to contracted entities for assessment. Staff at contracted entities completes the universal assessment for each individual. The universal assessment confirms institutional level of care and individual level of need.

SPA No 15-012 § 1(C) provides in pertinent part as follows:

The Universal Assessment (UA) is a comprehensive and person-centered assessment, surveying the –individual's physical, cognitive, and psychosocial functioning, and identifying risk factors, individual choices, and preferences, and the status of service needs. The UA identifies needs that are met utilizing voluntary natural supports, and state plan and waiver services, thus allowing for a comprehensive assessment, including need for social supports, and services plan. The UA documents each individual's level of need and calculates that individual's budget allocation. Individuals are actively involved in the assessment process and have the opportunity to identify goals, strengths, and needs. Individuals affirm if they would like to identify anyone to participate in the planning process.

SPA No 15-012 § 7 provides in pertinent part as follows:

The UA is based on the InterRAI tool. The UA is a validation tool used to confirm level of care and calculate a level of need based on the identified needs of the Appellant. The UA assesses an Appellant's Activities of Daily living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs as well as taking into account their health, rehabilitation needs, and their natural supports.

On [redacted] 2024, the case manager correctly completed a face-to-face assessment with the Appellant, participant, and the Appellant's adult daughter using the UA identifying the participant's physical, cognitive, and psychosocial functioning, and identifying risk factors, individual choices and preferences, and the status of service needs.

4. State statute provides as follows:

For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible

scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

Conn. Gen. Stat. § 17b-259b(a)

State statute provides as follows:

Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

Conn. Gen. Stat. § 17b-259b(b)

5. Federal regulation provides as follows:

If the State elects to provide Community First Choice, the State must provide all of the following services:

1. Assistance with ADLs, IADLs, and health-related tasks through hands-on assistance, supervision, and/or cueing.
2. Acquisition maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.
3. Backup systems or mechanisms to ensure continuity of services and supports, as defined in § 441.505 of this subpart.
4. Voluntary training on how to select, manage and dismiss attendants.

42 CFR § 441.520(a)

SPA 15-012 § 1(A) provides in pertinent part as follows:

Individuals who are receiving medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10(A)(ii)(VI) of the Act must continue to meet all 19159c)

requirements and must receive at least one home and community-based waiver service per month. Individuals receiving services through CFC will not be precluded from receiving other home and community-based long-term services and supports through the Medicaid State plan, waiver, grant or demonstration but will not be allowed to receive duplicative services as between CFC and any other available source of Medicaid coverage for home and community-based services.

"Individuals receiving services through Community First Choice will not be precluded from receiving other home and community-based long-term care services and supports through other Medicaid State plan, waiver, grant or demonstration authorities." 42 CFR 441.510(e)

6. SPA 15-012 § 5(A) provides for Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs) and health-related tasks through hands-on assistance, supervision, and/or cueing.

   Attendant Care: Services Definition: The State will cover Attendant Care services, which are supports related to core activities of daily living including; physical assistance and/or verbal assistance to the individual in accomplishing any Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs). ADLs may include, but not limited to, bathing, dressing, toileting, transferring, and feeding. IADLs means activities related to living independently in the community, including, but not limited to, meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling to participate in the community. In accordance with section 20-101 of the Connecticut General Statute, attendants may complete health maintenance tasks. These tasks may include, but are not limited to, medication administration, wound care, and vital signs under the supervision of the CFC participant.

   …

   Limits on amount, duration or scope: The Department assigns an overall budget based on need grouping that is determined by algorithm. Natural supports are based on the individual's functional assessment, which will take into consideration the availability of natural supports. Natural supports are identified during the person-centered service planning process and utilized when available to the individual. Natural supports are defined as voluntary unpaid care provided on a regular and consistent basis by a parent, spouse, or other person.

7. Federal regulation provides as follows:

For a self-directed model with a service budget, a service budget must be developed and approved by the State based on the assessment of functional need and person-centered service plan and must include all of the following requirements:

1. The specific dollar amount an individual may use for Community First Choice services and supports.
2. The procedures for informing an individual of the amount of the service budget before the person-centered service plan is finalized.
3. The procedures for how an individual may adjust the budget including the following:
   i. The procedures for an individual to freely adjust amounts allocated to specific services and supports within the approved service budget.
   ii. The circumstances, if any, that may require prior approval by the State before a budget adjustment is made.
4. The circumstances, if any, that may require a change in the person-centered service plan.
5. The procedures that govern the determination of transition costs and other permissible services and supports as defined at § 441.520(b).
6. The procedures for an individual to request a fair hearing under Subpart E of this title if an individual's request for a budget adjustment is denied or the amount of the budget is reduced.

42 CFR § 441.560(a)

"The State must have procedures in place that will provide safeguards to individuals when the budgeted services amount is insufficient to meet the individual's needs." 42 CFR § 441.560(f)

SPA No 15-012 § 1(C) provides in pertinent part as follows:

The assessors at contracted agencies who complete the universal assessment and confirm level of care assess the individual's service needs and level of care at least annually. The individual may be assessed more frequently if his or her function needs change or if he or she or an authorized representative of the individual so requests.

8. Federal regulation provides as follows:

   The budget methodology set forth by the State to determine an individual's service budget amount must:

   1. Be objective and evidence-based utilizing valid, reliable cost data.
   2. Be applied consistently to individuals.
   3. Be included in the State plan.

4. Include a calculation of the expect cost of Community First Choice services and supports, if those services and supports are not self-directed.
5. Have a process in place that describes the following:
   i. Any limits the State places on Community First Choice services and supports, and the basis for the limits.
   ii. Any adjustments that are allowed and the basis for the adjustments.

42 CFR § 441.560(b)

The Department correctly determined the participant requires supports and services with ADL's and IADL's through hands-on assistance, supervision, and/or cueing for a medical condition(s) requiring assistance daily.

Based on the CFC budget amounts as determined by UA level of need, the Department correctly determined the Appellant's medical needs support the medical necessity for CFC 43.75 hours per week.

Federal regulation allows that CFC recipients may receive additional services and supports through other Medicaid programs such as the DDS waiver programs, however, CFC recipients are not allowed to receive duplicative services from other available Medicaid sources. Under the DDS waiver programs, the participant receives 93 (57 and 36) hours of Personal Support and 30 hours Individualized Day Supports totaling 123 hours under the DDS waiver programs. When added to the CFC PCA hours of 43.75, the participant receives a total of 166.75 (123 DDS + 43.75 CFC) hours per week of services and supports through the CFC program and DDS waivers, just 1.25 hours shy of 168 hours which equals 7 days per week, 24 hours a day.

Testimony provided by the Department indicates if additional PCA hours are needed, the access agency may submit a budget exception request along with supporting medical documentation.[1] The hearing record does not support the medical need for overnight services hours under the CFC as requested by the Appellant. Although the UA indicates the participant requires a person to be awake and in sight of the participant during sleeping hours, there is a lack of medical documentation to support the medical necessity for the additional 7 night 12 hour overnight shift. The UA notes the participant sleeping better with the ability to return to sleep. There is no mention of reoccurring seizures during the overnight hours, the

[1] "Requests for exceptions to budget allocations must be submitted utilizing the CFC budget exception form with supporting justification." Exhibit 6: Section 4.8 Community First Choice Operating Manual 2/7/16.

frequency of such seizure(s), the length of the seizure(s), the intensity of a seizure(s), medication administered, or safety concerns. At this time, the Department's decision to limit PCA service hours under the CFC program is upheld. Should the participant's functional needs change, the participant or the Appellant may make a request for a new assessment to re-evaluate the participant's CFC budget.

9. "The State must have a method of notifying individuals of the amount of any limit that applies to an individual's Community First Choice Services and supports. Notice must be communicated in an accessible format, communicated in plain language, and needed auxiliary aids and services should be provided." 42 CFR § 441.560(d)

On [redacted] 2024, the access agency correctly issued a Revised CFC Individual Budget notice authorizing an annual budget of $59,417.40 equal to 43.75 hours per week under the CFC effective [redacted] 2024.

On [redacted] 2024, the access agency correctly issued a Notice of Action Service Budget Reduction letter to the participant informing him that his CFC budget and service hours have been reduced allowing 30-days between the notice of action and effective date.

DECISION

The Appellant's appeal is denied.

Lisa A. Nyren
Lisa A. Nyren
Fair Hearing Officer

CC: Randell Wilson, Manager, CFC, DSS
Cynthia Cartier, Staff Counsel, DSS
Community Options

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.