STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06106-5033

2024
Signature Confirmation

Hearing Request # 237866

NOTICE OF DECISION

PARTY

PROCEDURAL BACKGROUND

On 2024, the Health Insurance Exchange, Access Health CT (Access Health) sent (the "Appellant") an Application Results Notice ("W1301") that advised she no longer qualified her Husky A Medicaid medical coverage.

On 2024, the Appellant requested an Administrative Hearing to contest Access Health's determination that she was ineligible for Husky A Medicaid medical coverage.

On 2024, the OLCRAH issued a notice scheduling an Administrative Hearing for 2024.

On 2024, in accordance with sections 17b-60, 17-61 and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, and 45 C.F.R. §§ 155.505 (b) and 155.510 the OLCRAH held an Administrative Hearing by teleconference.

The following individuals participated in the hearing by telephone:

, Appellant
Cathy Davis, Access Health Appeals Coordinator
Jessica Gulianello, Hearings Officer

The hearing record was extended to allow both parties time to submit additional documentation. Additional information was received from both parties and on 2024, the hearing record closed accordingly.

STATEMENT OF THE ISSUE

The issue to be decided is whether Access Health correctly denied medical benefits under Husky A Medicaid for the Appellant.

FINDINGS OF FACT

1. On [redacted] 2024, Access Health issued the Appellant a renewal notice. *(Exhibit 6: Renewal Packet dated [redacted] 2024, Access Health Testimony)*

2. On [redacted] 2024, Access Health received the completed renewal form from the Appellant. *(Access Health Testimony)*

3. The Appellant is married and resides with her spouse. *(Exhibit B: Renewal Form: AHe-R: signed & dated [redacted]/2024, Exhibit 2: Application filing date: [redacted]/2024, Appellant's Testimony)*

4. The Appellant and her spouse have three common children and she is currently pregnant. *(Exhibit B: Renewal Form: AHe-R: signed & dated [redacted]/2024, Exhibit 2: Application filing date: [redacted]/2024, Appellant's Testimony)*

5. The Appellant is employed with [redacted] and she earns $3,845.92 monthly. *(Exhibit 2: Application filing date: [redacted]/2024, Access Health Testimony, Appellant's Testimony)*

6. The Appellant's Spouse is seasonally employed with [redacted]. and he currently earns $4,386.00 monthly. *(Exhibit 2: Application filing date: [redacted] 2024, Access Health Testimony, Appellant's Testimony)*

7. The Appellant and the Appellant's Spouse expect to file a tax status of married filing separately. The Appellant expects to claim two of their three children as tax dependents and the Appellant's Spouse expects to claim one of their three children as a tax dependent. *(Exhibit 2: Application filing date: [redacted] 2024, Access Health Testimony, Appellant's Testimony)*

8. The Appellant receives health insurance with [redacted] from her employer. She is responsible for an out-of-pocket insurance premium of $112.22 biweekly. *(Exhibit 2: Application filing date: [redacted]/2024, Appellant's Testimony)*

9. The Appellant's Spouse receives health insurance from his employer with [redacted]. He does not incur an out-of-pocket premium for the coverage. *(Appellant's Testimony)*

10. On [redacted] 2024, Access Health issued the Appellant an Application Results (W-1301) notice. The W-1301 notice informed the Appellant that she no longer qualified for Husky A – Transitional Medical Assistance ("TMA") because the

maximum coverage period is 12 months. *(Exhibit 5: W1301 Application Results Notice, Hearing Summary, Access Heath Testimony)*

11. The Appellant received Husky A Medicaid medical coverage under the TMA group for the certification period beginning ██████ 2023, and ending ██████ 2024. *(Exhibit 3: Eligibility Determination Results, Access Health Testimony)*

12. The Appellant is disputing Access Health's determination that she is ineligible for Husky A Medicaid medical coverage for pregnant women. The Appellant is not disputing the application results for her spouse or their common children. *(Appellant's Testimony)*

13. The monthly income limits for Husky A Medicaid medical coverage for pregnant women effective ██████ 2024, are as follows:

Family of 2 (smallest family size as unborn child always counts as one)	$4,480.00
Family of 3	$5,659.00
Family of 4	$6,838.00
Family of 5	$8,018.00
Family of 6	$9,197.00

(Exhibit B: CT Husky Health Program Monthly Income Guidelines – effective ██████ 2024)

14. The issuance of this decision is timely under Connecticut General Statutes (Conn. Gen. Stat.") 17b-61(a), which requires that a decision be rendered within 90 days of the request for an Administrative Hearing. The Appellant requested an Administrative Hearing on ██████, 2024. This decision, therefore, was due no later than ██████ 2024. However, the hearing record, which had been anticipated to close on ██████, 2024, did not close for the admission of evidence until ██████ 2024, at the Appellant's request. Because this seven██ day delay in the close of the hearing record arose from the Appellant's request, this final decision was not due until ██████, 2024, and is therefore timely. *(Hearing Record)*

CONCLUSIONS OF LAW

1. Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-2(6) 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. Conn. Gen. Stat § 17b-260 provides for the acceptance of federal grants for medical assistance. 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.

   The Department has the authority to administer and determine eligibility for the Medicaid program.

3. 45 Code of Federal Regulations ("C.F.R.") § 155.110(a) provides as follows: The State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are: (1) An entity: (i) Incorporated under, and subject to the laws of, one or more States; (ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and (iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or (2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

   Access Health is the Department's designated state entity to administer the Health Insurance Exchange Program.

4. 45 C.F.R § 155.505(c)(1) provides as follows: Exchange eligibility appeals may be conducted by a State Exchange appeals entity or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

5. 45 C.F.R § 155.505(d) provides as follows: An appeals process established under this subpart must comply with § 155.110(a).

6. 45 C.F.R § 155.110(a)(2) provides as follows: The State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are: the State Medicaid agency, or any other State agency that meets the qualification of paragraph (a)(1) of this section.

Access Health has the authority to participate in Administrative Hearings.

7. 42 United States Code § 1396r-6(a)(5) provides as follows: Requirement. In general: Notwithstanding any other provision of this subchapter but subject to subparagraph (B) and paragraph (5), each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 602(a)(8)(B)(ii)(II) [1] of this title (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this subchapter during the immediately succeeding 6-month period in accordance with this subsection. Option of 12-month initial eligibility period. A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.

8. Conn. Gen. Stat. §17b-261 (f) provides, to the extent permitted by federal law, Medicaid eligibility shall be extended for one year to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act due to income from employment by one of its members who is a caretaker relative or due to receipt of child support income. A family receiving extended benefits on July 1, 2005, shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits.

Access Health correctly discontinued the Appellant's TMA under the Husky A Medicaid Coverage group effective [redacted] 2024, as the Appellant had received twelve months of coverage.

9. 42 CFR § 435.110 provides as follows: Parents and other caretaker relatives.

(a) Basis. This section implements section 1931(b) and (d) of the Act.

(b) Scope. The agency must provide Medicaid to parents and other caretaker relatives, as defined in § 435.4, and, if living with such parent or other caretaker relative, his or her spouse, whose household income is at or below the income standard established by the agency in the State plan, in accordance with paragraph (c) of this section.

(c) Income standard. The agency must establish in its State plan the income standard as follows:

> (1) The minimum income standard is a State's AFDC income standard in effect as of May 1, 1988 for the applicable family size converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act.
>
> (2) The maximum income standard is the higher of—
>
>> (i) The effective income level in effect for section 1931 low-income families under the Medicaid State plan or waiver of the State plan as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or
>>
>> (ii) A State's AFDC income standard in effect as of July 16, 1996 for the applicable family size, increased by no more than the percentage increase in the Consumer Price Index for all urban consumers between July 16, 1996 and the effective date of such increase.

10. 42 CFR § 435.116 provides as follows: Pregnant women.

> (a) Basis. This section implements section 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Act.
>
> (b) Scope. The agency must provide Medicaid to pregnant women whose household income is at or below the income standard established by the agency in its state plan, in accordance with paragraph (c) of this section.
>
> (c) Income standard. The agency must establish in its State plan the income standard as follows:
>
>> (1) The minimum income standard is the higher of:
>>
>>> (i) 133 percent FPL for the applicable family size; or
>>>
>>> (ii) Such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989

for determining eligibility for women, or, as of July 1, 1989, had authorizing legislation to do so.

(2) The maximum income standard is the higher of-

(i) The highest effective income level in effect under the Medicaid State plan for coverage under the sections specified at paragraph (a) of this section, or waiver of the State plan covering pregnant women, as of March 23, 2010 or December 31, 2013, if higher, converted to MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or

(ii) 185 percent FPL.

11. 42 C.F.R § 435.603 provides the following: Application of modified adjusted gross income (MAGI). (a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act. (2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section. (3) In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 435.916 of this part, whichever is later. (b) Definitions. For purposes of this section - Child means a natural or biological, adopted or step child. Code means the Internal Revenue Code. Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver. Parent means a natural or biological, adopted or step parent. Sibling means natural or biological, adopted, half, or step sibling. Tax dependent has the meaning provided in § 435.4 of this part. (c) Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section. (d) Household income - (1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

12. 42 C.F.R § 435.603(c) provides as follows: Basic rule. Except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on “household income” as defined in paragraph (d) of this section.

13. 42 C.F.R § 435.603(d)(1) provides as follows: Household Income – General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual’s household.

14. 42 C.F.R § 435.603(e) provides as follows: MAGI-based income. For the purposes of this section, MAGI-based income is calculated using the same financial methodologies used to determine adjusted gross income as defined in section 36B(d)(2)(B) of the Code,

15. 42 C.F.R § 435.603(f) provides as follows: Household –

> (1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent.
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> (2) Basic rule for individuals claimed as a tax dependent. In the case of an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent, except that the household must be determined in accordance with paragraph (f)(3) of this section in the case of—
>
>> (i) Individuals other than a spouse or child who expect to be claimed as a tax dependent by another taxpayer; and
>>
>> (ii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed by one parent as a tax dependent and are living with both parents but whose parents do not expect to file a joint tax return; and
>>
>> (iii) Individuals under the age specified by the State under paragraph (f)(3)(iv) of this section who expect to be claimed as a tax dependent by a non-custodial parent. For purposes of this section—

(A) A court order or binding separation, divorce, or custody agreement establishing physical custody controls; or

(B) If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

16. 42 C.F.R § 435.603(f)(4) provides as follows: Married couples. In the case of a married couple living together, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return under section 6013 of the Code of whether one spouse expects to be claimed as a tax dependent by the other spouse.

    The Appellant and her spouse have three common children and she is currently pregnant. The Appellant expects to claim two of their children as tax dependents and her spouse expects to claim one of their children as a tax dependent. The Appellant and her spouse expect to each file a tax status of married filing separately.

    Access Health correctly determined the Appellant's spouse is included in the Appellant's household despite the tax filing status because they are married and reside together.

    Access Health correctly asserted that the Appellant's household consists of five individuals: the Appellant, the child she is expected to deliver, her spouse, and the two children she expects to claim as tax dependents.

17. 42 C.F.R § 435.603(h)(3) provides as follows: In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and eligibility verification requirements at § 435.940 through § 435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections.

18. 42 C.F.R § 435.814 provides as follows: Medically needy income standard: State plan requirements. The State plan must specify the income standard for the covered medically needy groups.

19. 42 C.F.R § 435.831(b)(1)(ii) provides as follows: Determining countable income. For purposes of determining medically needy eligibility under this part, the agency

must determine an individual's countable income as follows: For individuals under age 21, pregnant women, and parents and other caretaker relatives, the agency may apply — The MAGI-based methodologies defined in § 435.603(b) through (f). If the agency applies the MAGI-based methodologies defined in § 435.603(b) through (f), the agency must comply with the terms of § 435.602, except that in applying § 435.602(a)(2)(ii) to individuals under age 21, the agency may, at State option, include all parents as defined in § 435.603(b) (including stepparents) who are living with the individual in the individual's household for purposes of determining household income and family size, without regard to whether the parent's income and resources would be counted under the State's approved State plan under title IV-A of the Act in effect as of July 16, 1996, if the individual were a dependent child under such State plan.

20. 42 C.F.R § 435.831(c) provides as follows: Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than that applicable income standard under § 435.814, the individual is eligible for Medicaid.

Effective [redacted] 2024, the Husky A income limit for a pregnant woman with a household of five individuals is $8,018.00 per month.

Access Health correctly calculated the Appellant's total income as $8,231.92 per month (Appellant's income of $3,845.92 per month + Spouse's income of $4,386.00 per month = combined total monthly income of $8,231.92 per month).

21. 42 C.F.R § 435.831(d) provides as follows: Deduction of incurred medical expenses. If countable income exceeds the income standard, the agency must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party. An expense is incurred on the date liability for the expense arises. The agency must determine deductible incurred expenses in accordance with paragraphs (e), (f), and (g) of this section and deduct those expenses in accordance with paragraph (h) of this section.

22. 42 C.F.R § 435.831(e) provides as follows: Determination of deductible incurred expenses: Required deductions based on kinds of services. Subject to the provisions of paragraph (g), in determining incurred medical expenses to be deducted from income, the agency must include the following:

(1) Expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, copayments, or deductibles imposed under § 447.51 or § 447.53 of this subchapter;

(2) Expenses incurred by the individual or family or financially responsible relatives for necessary medical and remedial services that are recognized under State law but not included in the plan;

(3) Expenses incurred by the individual or family or by financially responsible relatives for necessary medical and remedial services that are included in the plan, including those that exceed agency limitations on amount, duration, or scope of services.

23. 42 C.F.R § 435.917 (a) provides as follows: Notice of determinations. Consistent with §§ 431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice must—

(1) Be written in plain language;

(2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with § 435.905(b), and

(3) If provided in electronic format, comply with § 435.918(b).

24. 42 C.F.R § 435.917(b)(2) provides as follows: Notice of adverse action. Notice of adverse action including denial, termination, or suspension of eligibility or change in benefits or services. Any notice of denial, termination, or suspension of Medicaid eligibility, or, in the case of beneficiaries receiving medical assistance, denial of or change in benefits or services must be consistent with § 431.210 of this chapter.

25. 42 C.F.R § 435.917(c) provides as follows: Eligibility. Whenever an approval, denial, or termination of eligibility is based on an applicant's or beneficiary's having household income at or below the applicable modified adjusted gross income standard in accordance with § 435.911, the eligibility notice must contain—

(1) Information regarding bases of eligibility other than the applicable modified adjusted gross income standard and the benefits and services afforded to individuals eligible on such other bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and

(2) Information on how to request a determination on such other bases;

The Appellant reported on her renewal that she is pregnant. However, there is a lack of evidence to support that Access Health correctly evaluated her eligibility for health coverage under the Husky A Medicaid medical coverage group for pregnant women.

Furthermore, the Appellant reported an out-of-pocket health insurance premium with [redacted] of $112.22 biweekly equivalent to $241.27 monthly ($112.22 x 2.15 weeks= $241.27 monthly).

The Appellant's household's total combined monthly income of $8,231.92 - her reported health insurance premium deduction of $241.27 per month = $7,990.65. $7,990.65 is below the Husky A income limit of $8,018.00 for a pregnant woman with a household of five individuals.

There is a lack of evidence to substantiate that Access Health explored the Appellant's applicable medical deductions.

DECISION

The Appellant's appeal is REMANDED.

ORDER

1). Access Health shall evaluate the Appellant's eligibility for Husky A Medicaid medical coverage for pregnant women as of the date the Appellant lost coverage.

2). Access Health shall verify and review the Appellant's applicable medical deductions and issue the Appellant an updated W-1301 application results notice accordingly.

3). Proof of compliance with this order is due to the undersigned no later than [redacted] 2024.

Jessica Gulianello

Jessica Gulianello
Hearings Officer

Cc: Health Insurance Exchange; Access Health CT
Becky Brown, Danielle Valente, Shannon Laplante, Allison Doyle, & Christina Rodriguez

APTC/CSR

Right to Appeal

For APTC or CSR eligibility determinations, the Appellant has the right to appeal to the United States Department of Health and Human Services (HHS) within 30 days of the date of this decision. To obtain an Appeal Request Form, go to https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/ or call 1-800-318-2596 (TTY: 1-855-889-4325). HHS will let the Appellant know what it decides within 90 days of the appeal request. There is no right to judicial review of the decision by HHS.

There is no right to request reconsideration for denials or reductions of Advanced Primary Tax Credits (APTC) or Cost Sharing Reduction (CSR).

MEDICAID AND CHIP

Right to Request Reconsideration

For denials or reductions of MAGI Medicaid and CHIP, 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, 25 Sigourney Street, Hartford, CT 06106.

There is no right to request reconsideration for denials or reductions of Advanced Primary Tax Credits (APTC) or Cost Sharing Reduction (CSR).

Right to Appeal

For denials, terminations or reductions of MAGI Medicaid and CHIP eligibility, 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, 25 Sigourney Street, Hartford, CT 06106. 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.