
In the Matter of the Appeal of
██████████
from a determination by the New York City
Department of Social Services

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**DECISION
AFTER
FAIR
HEARING**

JURISDICTION

Pursuant to Section 22 of the New York State Social Services Law (hereinafter Social Services Law) and Part 358 of Title 18 NYCRR, (hereinafter Regulations), a fair hearing was held on January 10, 2011, in New York City, before an Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

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For the Social Services Agency

Teo Izrailova, Fair Hearing Representative

ISSUE

Was Appellant's request for a hearing to review the Agency's determination to deny Appellant's application for a Medical Assistance authorization timely?

Assuming Appellant's request for a hearing was timely, was the Agency's determination to deny Appellant's application for a Medical Assistance authorization correct?

FINDINGS OF FACT

An opportunity to be heard having been afforded to all interested parties and evidence having been taken and due deliberation having been had, it is hereby found that:

1. In April 2010, Appellant, age 92, applied for Medical Assistance for herself.

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2. When applying, Appellant mentioned that she had medical bills from the preceding three months.
3. On June 14, 2010, the Agency issued a Notice of Denial to Appellant at her address, advising Appellant of the Agency's determination to deny the Medical Assistance application, because Appellant failed to provide information concerning three bank accounts.
4. On September 3, 2010, the Appellant requested this fair hearing.

APPLICABLE LAW

Section 22 of the Social Services Law provides that applicants for and recipients of Public Assistance, Emergency Assistance to Needy Families with Children, Emergency Assistance for Aged, Blind and Disabled Persons, Veteran Assistance, Medical Assistance and for any services authorized or required to be made available in the geographic area where the person resides must request a fair hearing within sixty days after the date of the action or failure to act complained of.

Section 366-a(1) of the Social Services Law provides that a personal interview with the applicant or with the person who made application on his or her behalf shall not be required as part of a determination of initial or continuing eligibility. Pursuant to Section 366-a(5)(c) of the Social Services Law, a personal interview with a recipient of Medical Assistance is not required as part of a redetermination of eligibility. Section 360-2.3 of the Regulations provides that the Medical Assistance applicant or recipient has a continuing obligation to provide accurate and complete information on income, resources and other factors which affect eligibility. An applicant or recipient is the primary source of eligibility information. However, the Agency must make collateral investigation when the recipient establishes that, after good faith efforts, he or she is unable to provide verification. The applicant's or recipient's failure or refusal to cooperate in providing necessary information is a ground for denying an application for a Medical Assistance Authorization or for discontinuing such benefits. Note that, pursuant to Section 366-a(2)(b) of the Social Services Law, an applicant or recipient may attest to the amount of his or her accumulated resources, unless such applicant or recipient is seeking Medical Assistance payment for long term care services. Note that pursuant to Section 366(1)(a) of the Social Services Law and 10 OHIP/ADM-1 there is no resources test for all Medicaid categories except for the SSI-related group, effective January 1, 2010.

Effective April 4, 2007, an applicant for, or recipient of, Medical Assistance must provide evidence of citizenship or status as a qualified immigrant or PRUCOL alien and a social security number or documentation that such person has applied for a social security number. This requirement does not apply to aliens seeking Medical Assistance for the treatment of an emergency medical condition and pregnant women for the duration of the pregnancy and the 60-day period beginning on the last day of the pregnancy and including, but not exceeding, the last day of the month in which the 60-day postpartum period ends. 18 NYCRR 360-3.2(j)(3) and 08 OHIP/INF-1.

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Medical Assistance applicants or recipients who are entitled to or enrolled in any part of Medicare or are receiving Supplemental Security Income or Social Security Disability are exempt from documenting citizenship and identity. 08 OHIP/INF-1.

Documentation of citizenship and identity is a one-time requirement for Medical Assistance and should only require re-documentation if later information calls into question an individual's citizenship or identity. Applicants and recipients who cannot provide satisfactory documentation of citizenship but are making a good faith effort to obtain the documentation cannot have their application denied or benefits discontinued. 08 OHIP/INF-1.

Administrative Directive 93 ADM-29 provides policy concerning obtaining documentation in Medical Assistance applications and recertifications. In part, this Directive states (speaking of the applicant/ recipient or "A/R"):

The district worker must:

1. check to see if the active case record, a closed case record, or the statewide computer system contains verification of eligibility factors not subject to change;
2. provide the A/R with a clear explanation of what information is desired, why it is needed, and how it will be obtained (if from collateral sources);
3. provide the A/R with a written list (in Spanish if requested), or Form DSS-2642 "Documentation Requirements", noting the required documents and a date for the A/R to return the form; and

A person who is sixty-five years of age or older, blind or disabled who is not in receipt of Public Assistance and has income or resources which exceed the standards of the Federal Supplemental Security Income Program (SSI) but who otherwise is eligible for SSI may be eligible for Medical Assistance, provided that such person meets certain financial and other eligibility requirements under the Medical Assistance Program. Social Services Law Section 366.1(a)(5).

To determine eligibility, an applicant's or recipient's net income must be calculated. In addition, resources are compared to the applicable resource level. Net income is derived from gross income by deducting exempt income and allowable deductions. The result - net income - is compared to the statutory "standard of need" set forth in Social Services Law Section 366.2(a)(7) and 18 NYCRR Subpart 360-4. If an applicant's or recipient's net income is less than or equal to the applicable monthly standard of need, and resources are less than or equal to the applicable standard, full Medical Assistance coverage is available.

If the applicant's or recipient's resources exceed the resource standards, the applicant or recipient will be ineligible for Medical Assistance until he/she incurs medical expenses equal to or greater than the excess resource standards. 18 NYCRR 360-4.1. The applicant or recipient

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will be given 10 days from the date he or she is advised of the excess resource amount to reduce the excess resources by establishing either a burial fund. In addition, they will be advised that they may spend excess resources on exempt burial space items during this 10 day period.

Pursuant to GIS 08 MA/035, the resource levels for SSI-related budgeting effective January 1, 2009 are as follows:

Family Size	Resource Level
1	\$13,800
2	20,100
3	23,115
4	26,130
5	29,145
6	32,160
7	35,175
8	38,190
For each additional persons add	+3,015

GIS 09 MA/026 extended the resource limit at \$13,800.00 for one person.

An initial authorization for Medical Assistance will be made effective back to the first day of the first month for which eligibility is established. A retroactive authorization may be issued for medical expenses incurred during the three month period preceding the month of application for Medical Assistance, if the applicant was eligible for Medical Assistance in the month such care or services were received. 18 NYCRR 360-2.4(c).

DISCUSSION

On June 14, 2010, the Agency issued a Notice to Appellant, advising that the Agency had determined to deny the Appellant's Medical Assistance application. Appellant's grandson and Attorney In Fact did not request the present hearing until a posted date of September 1, 2010 regarding a letter which was processed by the Office of Administrative Hearings on September 3, 2010, which was more than 60 days following the Agency's determination.

At the hearing, however, Appellant's representative testified that Appellant is aged, and suffers from a variety of illnesses, including that, at the time the Notice would have most likely arrived, an eye infection. Moreover, Appellant's concentration on business matters is uneven these days. The representative further testified that he requested this hearing as soon as he, Appellant's Attorney In Fact under a Durable Power of Attorney, entered Appellant's home on or about August 31, 2010, and saw the Notice. The testimony of Appellant's representative is found to be credible based upon the representative's demeanor at the hearing, and based upon the general plausibility of said testimony. The statute of limitations is tolled under the particular circumstances of this case.

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The record establishes that the Agency determined to deny the application due to not receiving certain information concerning bank accounts. Although duly notified of the time and place of the hearing, however, the Agency failed to establish that it issued Appellant (or her representative) with a written request for any bank account information, or that the Agency allowed a reasonable time period for return of any such information prior to denying the application. The Agency thus failed to establish that it followed the procedures set forth at 93 ADM-29, and, its determination here at issue is not sustained.

DECISION AND ORDER

The Agency's determination to deny Appellant's application for a Medical Assistance authorization was not correct and is reversed.

1. The Agency is directed to continue to process the Appellant's April 2010 application, advising Appellant in writing of any particular documentation required to evaluate Appellant's eligibility for Medical Assistance for the period commencing January 1, 2010 (the first day of the month three months preceding the application month).

2. The Agency is directed to allow Appellant a reasonable opportunity in which to provide the information in question

3. The Agency is directed to supply copies of its requests for information to Appellant's Attorney in Fact:



4. The Agency is directed to, thereafter, make a new determination concerning Appellant's eligibility for Medical Assistance for January 1, 2010, onward, and to advise Appellant and her Attorney In Fact of the new determination.

Should the Agency need additional information from the Appellant in order to comply with the above directives, it is directed to notify the Appellant promptly in writing as to what documentation is needed. If such information is requested, the Appellant must provide it to the Agency promptly to facilitate such compliance.

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As required by 18 NYCRR 358-6.4, the Agency must comply immediately with the directives set forth above.

DATED: Albany, New York
02/04/2011

NEW YORK STATE
DEPARTMENT OF HEALTH

By

A handwritten signature in black ink, appearing to read "D.A. Traumm". The signature is written in a cursive style with a horizontal line above the letters "A" and "T".

Commissioner's Designee