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DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
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STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
AND HEALTH SERVICES

F.K. PETITIONER, v. DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES AND MORRIS COUNTY BOARD OF SOCIAL SERVICES, RESPONDENTS.	:	**ADMINISTRATIVE ACTION** **FINAL AGENCY DECISION** **OAL DKT. NO. HMA 00490-15**

As Director of the Division of Medical Assistance and Health Services, I have reviewed the record in this case, including the Initial Decision and the documents in evidence. Neither Party submitted exceptions. Procedurally, the time period for the Agency Head to file a Final Agency Decision in this matter is February 11, 2016 in accordance with an Order of Extension. The Initial Decision was received on November 10, 2015.

This matter arises from the denial of Petitioner's May 12, 2014 Medicaid application for failure to provide documentation needed to determine eligibility. On May 12, 2014, the Morris County Board of Social Services (MCBSS) issued to Petitioner, through his wife, J.K., a request for verifications which included health insurance policies, life insurance policies, and bank account records. The notice provided that the documents were required to be mailed by June 25, 2014. MCBSS issued four additional requests for missing verifications on May 29, 2014; August 12, 2014; October 8, 2014 and October 22, 2014 with a final due date of November 1, 2014. Petitioner did not provide the missing verifications and MCBSS denied his application on November 25, 2014.

Based on my review of the record and the applicable rules, I REVERSE the Initial Decision and FIND that Petitioner had not demonstrated by a preponderance of credible evidence that he provided all verifications necessary for MCBSS to make a determination and the MCBSS' denial was appropriate.

The issue below is whether Petitioner timely provided the necessary verifications for MCBSS to make an eligibility determination. Both the County Welfare Agency (CWA) and the applicant have responsibilities with regard to the application process. N.J.A.C. 10:71-2.2. Applicants must complete any forms required by the CWA; assist the CWA in securing evidence that corroborates his or her statements; and promptly report any change affecting his or her circumstance. N.J.A.C. 10:71-2.2(e). The CWA exercises direct responsibility in the application process to inform applicants about the process, eligibility requirements and their right to a fair hearing; receive applications; assist applicants in exploring their eligibility; make known the appropriate resources and services; assure the prompt accurate submission of data; and promptly notify applicants

of eligibility or ineligibility. N.J.A.C. 10:71-2.2(c) and (d). CWAs must determine eligibility for Aged cases within 45 days and Blind and Disabled cases within 90 days. N.J.A.C. 10:71-2.3(a); MedCom No. 10-09, and Fed. Reg. 42 CFR 435.91. The time frame may be extended when "documented exceptional circumstances arise" preventing the processing of the application within the prescribed time limits. N.J.A.C. 10:71-2.3(c). The regulation does not require MCBSS to grant an extension beyond the designated time period when the delay is due to circumstances outside the control of both the applicant and the CWA. At best, an extension is permissible. N.J.A.C. 10:71-2.3; S.D. vs. DMAHS and Bergen County Board of Social Services, No. A-5911-10 (App. Div. February 22, 2013). There is simply nothing in the record to demonstrate exceptional circumstances warranting additional time to provide the requested verifications.

Here, Petitioner, assisted by his wife and Lincoln Park Care Center Business Office Manager David Silberstein, filed his second application for Medicaid benefits. Petitioner was then given five opportunities to submit a complete document production to MCBSS. There is no documentary evidence that Petitioner submitted the necessary documents to MCBSS prior to the denial, or attempted to communicate to MCBSS any difficulty or delay in obtaining the remaining documents. By November 25, 2014, more than six months after application, Petitioner had failed to provide MCBSS with specific financial information. The credible evidence in the record indicates that Petitioner failed to provide MCBSS with the information needed to establish eligibility. Without this information, MCBSS was unable to complete its eligibility determination and the denial was appropriate.

Finally, as stated above, this matter concerns Petitioner's second application for Medicaid benefits.[1] Petitioner's first application was also denied for failure to provide verifications. The matter of Petitioner's eligibility based on that first application was part of a prior appeal for which the Petitioner failed to appear.[2] Yet, it is addressed at length by the ALJ. Specifically, the ALJ took testimony from J.K. and Silberstein with regard to the first application to the exclusion of the MCBSS case manager for that application.[3] Then, unsupported by any evidence, the ALJ concluded that MCBSS advised Petitioner to reapply, failed to inform Petitioner's wife that she needed to appear at the hearing and even suggested that MCBSS "affirmatively advised" Petitioner's wife that she need not attend the hearing. (ID at 8.) Finally, even though the ALJ ultimately found that she was foreclosed from reopening the merits of the first application, she used testimony regarding the first application as a reason to reverse the agency.[4] (ID at 10)

The matter of Petitioner's first application for Medicaid is no longer a contested case. Petitioner had an opportunity to appeal that denial and exercised his right to do so. Petitioner's failure to appear at the May 27, 2014 hearing does not now entitle him to a second bite at the apple. The facts before me are clear. Petitioner re-applied for Medicaid on May 12, 2014. Petitioner was given multiple opportunities to provide the requested verifications. He was unable to make a complete and timely submission and

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[1] A third application for benefits was filed in April 2015.
[2] ALJ Cookson utilized the OAL case management system to confirm Petitioner's failure to appear at the prior hearing.
[3] As this matter did not concern Petitioner's first application, the case manager who handled Petitioner's initial application was not present at the hearing.
[4] The ALJ's reasoning for reversing MCBSS' denial included agency delay for over nine months, an unreasonable demand for documents over the holiday season and denial of the application after "just a two-month gap between the September demand and the November adverse action." These are all actions alleged to have occurred during Petitioner's first application. As this transmitted matter does not concern Petitioner's first application, there is no record from which to draw any conclusion regarding that application process. As such, these conclusions cannot apply to the Petitioner's second application for Medicaid which is the subject of this fair hearing.

could not demonstrate exceptional circumstances warranting additional time to provide the requested documentation.

The credible evidence in the record indicates that Petitioner failed to provide MCBSS with the information needed to establish eligibility. Without this information, MCBSS was unable to complete its eligibility determination and the denial was appropriate.

THEREFORE, it is on this 26th day of JANUARY 2016,

ORDERED:

That the Initial Decision is hereby REVERSED; and

That Petitioner's May 2014 application remains denied.

Valerie Harr, Director
Division of Medical Assistance
and Health Services