NEW YORK STATE
OFFICE OF TEMPORARY AND DISABILITY ASSISTANCE
40 NORTH PEARL STREET
ALBANY, NEW YORK 12243-0001

Eliot Spitzer
Governor

David A. Hansell
Commissioner

(518) 473-4968

September 19, 2007

Valerie Bogart, Esq.
Selphelp Community Services
520 8th Avenue
New York, New York 10018

Re: E[redacted] G[redacted]
F.H. #4433606Z

Dear Ms. Bogart:

This is in response to your June 8, 2007 letter on behalf of E[redacted] G[redacted], requesting that we review the fair hearing record and the decision of April 24, 2007, which affirmed the March 14, 2006 determination of the Rockland County Department of Social Services to deny the appellant's application for Medical Assistance on the grounds that he has non-exempt resources which exceed the applicable Medical Assistance resources which exceed the applicable Medical Assistance resources level. Thereafter, the agency was afforded the opportunity to respond to the reconsideration request.

Based on our review of all correspondence, together with the fair hearing record, we have determined that the decision was incorrect. Accordingly, the April 24, 2007 decision has been vacated and this amended decision is being substituted therefor.

The amended decision now states that:

1. The agency agreed to withdraw it September 5, 2005 Notice of Intent to deny the appellant's application for Medical Assistance for failure to provide eligibility documentation;

2. The Agency's determination dated March 14, 2006 to deny the Appellant's application for Medical Assistance for the Appellant on the grounds that the Appellant has non-exempt resources which exceed the applicable Medical Assistance resource levels was not correct and is reversed; and

3. The Agency's determination dated March 14, 2006 to deny the Appellant's application for Medical Assistance for failure to provide documentation necessary to determine the Appellant's eligibility for such benefits was correct when made.

We trust this addresses the concerns raised in your recent letter.

Sincerely,

Philip Nostramo
Principal Administrative Law Judge

PN:KLH
cc: H[redacted]G[redacted]
Vincent Mancino, Esq., Littman Krooks, LLP
Gary C. Samuels, Esq., Rockland County Department of Social Services

OAH-4482/30B (Rev. 6/06)

From: **New York State Office of Temporary and Disability Assistance**
P.O. Box 1930
Albany, NY 12201 - 1930

TRANSMITTAL OF FAIR HEARING DECISION TO SOCIAL SERVICES AGENCY

Fair Hearing #: **4433606Z**
Hearing Date: **01/18/07**
Decision Date: **09/19/07**
Case #: **M0025207**
Category/Subcategory: **MA**

Primary Agency: **ROCKLAND**
Appellant: **E[redacted]**
4 TREETOP LANE [redacted]
MONSEY, NY 10952-2000
Representative: **SELFHELP COMMUNITY SERVICES**
VALERIE BOGART, ESQ.
520 8TH AVENUE
NEW YORK, NY 10018
Other Agencies:

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*** ***
*** ENCLOSED IS THE DECISION RENDERED ***
*** IN THE ABOVE FAIR HEARING ***
*** ***
****

If this decision reverses or does not affirm the action intended to be taken by your Agency and directs your Agency to take certain other action, you must do so and so notify the Appellant forthwith (as quickly as possible). The Appellant has been advised to contact the state's Compliance Unit if compliance is not effected within ten (10) days after receipt of this decision.

In accordance with the provisions of Title 18 NYCRR, if this decision indicates that the social services official has misapplied provisions of the law, State regulation, or such official's own state-approved policy, the social services official is required to review other cases with similar facts for conformity with the principles and findings in the decision.

If you have questions about directions contained in this decision, please contact:

New York State Office of Temporary and Disability Assistance
Office of Administrative Hearings
Compliance Unit
P. O. Box 1930
Albany NY 12201 - 1930

The following agencies have been notified of the issuance of this fair hearing decision:

ROCKLAND CO DEPT OF SOCIAL SERVICES,SUSAN SHERWOOD, COMMISSIONER
ROCKLAND CO DEPT OF SOCIAL SERVICES,

State OF NEW YORK
DEPARTMENT OF HEALTH

REQUEST: November 3, 2005
CASE #: M0025207
AGENCY: Rockland
FH #: 4433606Z

In the Matter of the Appeal of

[redacted]

from a determination by the Rockland County Department of Social Services

AMENDED 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 18, 2007, in Rockland County, before James Ryan III, Administrative Law Judge. The following persons appeared at the hearing:

For the Appellant

Vincent Mancino, Esq., of Counsel, Littman Krooks LLP; Adrianne Arkontaky, Esq., of Counsel, Littman Krooks LLP; and Rivkah K[redacted], Daughter and Power of Attorney

For the Social Services Agency

Lynne Davidson, Fair Hearing Representative; Sandra Molatch, Principal Examiner

ISSUE

Was the Agency's determination to deny the Appellant's application for Medical Assistance for failure to provide documentation necessary to determine the Appellant's eligibility for such benefits correct?

Was the Agency's determination to deny the application for Medical Assistance for the Appellant on the grounds that the Appellant's household has non-exempt resources which exceed the applicable Medical Assistance resource levels 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. On July 14, 2005, the Appellant, age 92, applied for Chronic Care Medical Assistance for himself. The application was filed on his behalf by Littman Krooks LLP, pursuant to an authorization from the Appellant's wife, [redacted], age 82.

2. At the time of application, the Appellant was a resident of Northern Metropolitan Nursing Home, Monsey, NY, where he has been residing since September 20, 2004.

3. The Appellant had been private pay at Northern Metropolitan Nursing Home through May 31, 2005 and he was seeking a pickup date of June 1, 2005.

4. The Appellant's Representative (Littman Krooks LLP) was advised by the Agency on July 14, 2005 to submit the following documentation to the Agency by August 4, 2005:

-copies of statements and/or passbooks for all financial accounts open or closed within the past 36 months;
-to review all financial accounts and document the purpose of all checks and/or withdrawals over $2,000.00;
-to review all deposits which exceed total income.
-copy of deed to property located at 4 Treetop Lane, Monsey, NY;
-copy of the Appellant's will;
-a letter verifying amount of pension which constitutes German Reparations;
-copy of German Social Security Benefits.

5. By notice dated September 7, 2005, the Agency determined to deny the Appellant's application for Medical Assistance benefits for failure to provide documentation necessary to determine the Appellant's eligibility for such benefits.

6. On November 3, 2005, the Appellant requested this fair hearing.

7. The Agency has withdrawn the Notice of Denial dated September 7, 2005 for failure to provide necessary eligibility documentation.

8. On January 31, 2006, a paralegal from Littman Krooks LLP advised the Agency that she believed that all of the documentation had been submitted.

9. The Agency advised Littman Krooks that the following documentation was still required:

-verification of German Reparations;
-the value of Trust Co. of New Jersey for the period July, 2002 through July, 2005, or date of closing;
-statements for all financial accounts for the past 36 months;
-an explanation and documentation of all transactions over $2,000 and all deposits that exceed total income.

10. The Agency further advised the Appellant's Representative that it would reconsider the application if all documentation was received by March 14, 2006.

11. The Appellant's representative submitted verification of the following: German Reparations payments; value of Trust Co. from July, 2002 through July, 2005; statements for a Comerica account (last four digits) #----0589; statements for Wachovia accounts (last four digits) #----8270; #----9376; #----9541; #----9677; and #----8553; and Smith Barney (last four digits) # 1015.

12. On March 14, 2006, the Agency advised the Appellant's Representative (Littman Krooks) that the application was denied because the following documentation had not been submitted: (1) an explanation of deposits to Comerica #----0589 for $2,000 on March 7, 2002; $3,000 on June 3, 2002; $2,000.00 on March 19, 2003; $3,157.75 on May 15, 2003; and $2,068.83 on December 4, 2003; (2) an explanation of deposits to Wachovia account (last four digits) #----8270 for $38,804.13 on November 29, 2004; and $44,000.00 on November 4, 2004; (3) an explanation of deposits to Wachovia account (last four digits) #----9376 for $3,900 on September 23, 2004; $5,000 on September 27, 2004; $7,000 on November 5, 2004; and $2,895.00 on November 15, 2004; (4) an explanation of deposits to Wachovia account (last four digits) #----9541 for $140,040.85 on December 21, 2004; and $24,040.85 from National City; (5) an explanation of deposits to Wachovia account (last four digits) #----9677 for $1,213.48 on October 14, 2004; $2,179.50 on November 8, 2004; $1,290.88 on December 1, 2004; $1,240.78 on December 13, 2004; $1,322.67 on January 3, 2005; and $1,284.72 on January 31, 2005; (6) an explanation of a withdrawal of $78,864.85 from Wachovia account (last four digits) #8553; (7) an explanation of a cash withdrawal of $10,000 on February 2, 2005 and a deposit of $13,464.28 to Wachovia account (last four digits) #1015; (8) statement for Alliance account (last four digits)#----4080 from July, 2002 through July, 2005; (9) statements for National City CD account (last four digits) #----2953 from January 15, 2003 through July, 2005, or closing; (10) statements for Smith Barney account (last four digits) #----1015 from January 4 through July, 2005, or closing.

13. On March 14, 2006 the Agency sent a Denial Notice setting forth its determination to deny the Appellant's application for Medical Assistance benefits for failure to provide documentation necessary to determine the Appellant's eligibility for such benefits.

14. Based on the bank statements previously provided by the Appellant, the Agency calculated the Appellant's excess resources as follows:

Non-Exempt Resources	**Equity Value**
Wachovia Account (last four digits) #----9677	$ 20,322.12
Wachovia Account (last four digits) #----9541	$195,075.13
Total	$215,397.25
Less the following deductions:	
Medical Assistance Resource Level for one Persons	-$4,000.00
Total Deductions-	$4,000.00
Excess Resources	$211,397.25

15. The Agency determined that the Appellant's household's non-exempt excess resources for the purposes of computing Medical Assistance eligibility is $211,397.25.

16. By notice dated March 14, 2006, the Agency informed the Appellant of its determination to deny the Appellant's Medical Assistance application for the Appellant on the grounds that that the Appellant's household has non-exempt resources which exceed the applicable Medical Assistance resource levels.

17. On April 7, 2006, the Appellant requested a fair hearing concerning the March 14, 2006 denial of Medical Assistance.

18. On April 24, 2007, a prior Decision After Fair Hearing was issued which affirmed the Agency's March 14, 2006 determination to deny the Appellant's application for Medical Assistance on the grounds that the Appellant has non-exempt resources which exceed the applicable Medical Assistance resources level. Subsequently, the Appellant's new representative, Valerie Bogart, Esq. from Selfhelp Community Services, Inc, requested reconsideration of the Decision. There-after, the Agency was afforded the opportunity to respond to the reconsideration request. Based on our review of all correspondence, together with the fair hearing record, we have determined that the Decision was incorrect. Accordingly, the April 24, 2007 Decision has been vacated and this Amended Decision is being substituted therefor.

APPLICABLE LAW

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 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 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. 91 ADM-17

Administrative Directive 91 ADM-17 advises local districts of procedures for the treatment of Medical Assistance applications in cases where an applicant/recipient has resources in excess of the applicable resource standard. Potential MA eligibility for all applicant/recipients who have resources above the applicable resource standard must be investigated when appli cant/recipients have outstanding medical bills. Eligibility determinations must include a snapshot comparison of excess resources as of the first of the month to viable bills. This comparison must be done for each month in which eligibility is sought, including each of the retroactive months. The client is not eligible until the amount of viable bills is equal to or greater than the amount of excess resources remaining after the purchase of burial-related items. Eligibility will be authorized after excess resources and any excess income are fully offset by viable bills. Excess resources must be offset by viable bills before such bills are used to offset excess income. Said Directive further provides that whenever a notice is sent to an applicant accepting the applicant with a spenddown requirement or denying an application because of excess resources, the Agency is required to include a copy of the "Explanation of the Excess Resource Program" along with the Notice.

Resources are defined in 18 NYCRR 360-4.4(a). It means property of all kinds, including real property and personal property. It includes both tangible and intangible property.

An applicant's/recipient's available resources include:

(1) all resources in the control of the applicant/recipient. It also includes any resources in the control of anyone acting on the applicant's/recipient's behalf such as a guardian, conservator, representative, or committee;

(2) certain resources transferred for less than fair market value as explained in subdivision (c) of section 360-4.4 of 18 NYCRR;

(3) all or part of the equity value of certain income-producing property, as explained in 18 NYCRR 360-4.4(d); and

(4) certain resources of legally responsible relatives, as explained in 18 NYCRR 360-4.3(f); and

(5) certain resources of an MA-qualifying trust, as explained in 18 NYCRR 360-4.5.

For those subject to resource limits, Regulations at 18 NYCRR 360-4.6 and 360-4.7 provide that certain resources be disregarded in determining eligibility for Medical Assistance. Certain of the following disregards are applicable to all persons; others are applicable only to certain categories of persons.

- a homestead which is essential and appropriate to the needs of the household.

  According to 18 NYCRR 360-4.7(a)(1), for persons under 21 years of age and persons ineligible for ADC solely because their income and resources are above the eligibility

limits, a homestead loses its exempt status if the owner is in a medical facility in permanent absence status and no spouse, child under 21 years of age, certified blind or certified disabled child, or other dependent relative is living in the home.

For persons who are 65 years of age or older, certified blind or certified disabled, a homestead loses its exempt status if the owner moves out of the home without the intent to return, and no spouse, child under 21 years of age, certified blind or certified disabled child, or other dependent relative is living in the home.

Note that, for applications for nursing facility services and other long term care services filed on or after January 1, 2006, the homestead exemption is limited to a home in which the applicant has an equity interest of $750,000 or less. This limitation will not apply, however, in the case of hardship, or if the home is occupied by the applicant's spouse or by the applicant's child who is under age 21, blind or disabled. Social Services Law 366(2)(a).

- Essential personal property including but not limited to clothing and personal effects, household furniture, appliances and equipment, tools and equipment necessary for a trade or business, an automobile, one burial plot or space per household member, savings equal to at least one-half of the appropriate allowed income exemption.

  Prior to April 1, 2005, if an automobile was not exempt, up to $4,500 of the current market value (i.e., its saleable value without deducting any encumbrances) of the automobile was excluded. This exclusion, of up to $4,500 of the current market value of one automobile not in use, has been eliminated effective April 1, 2005. GIS 05 MA/029 provides that:

  Effective April 1, 2005, there is a change in the treatment of an automobile that is NOT excluded as a resource.

  One automobile per household is excluded as a resource, regardless of its value, if it is used for transportation for the SSI-related individual/couple or a member of the individual's/couple's household. A second automobile may be exempt if there is a medical need for it or the automobile is needed for employment-related activities or a Plan for Achieving Self-Support (PASS). An automobile (i.e., a first automobile or a second automobile that meets the criteria for an exclusion) that is temporarily inoperable (e.g., needs repairs) may be excluded if it is expected to be used for transportation within 12 calendar months after the month of the Medicaid eligibility determination.

  Effective April 1, 2005, if an automobile does not meet any of the exception criteria described above, the full equity value of the automobile is a countable resource. The equity value of an automobile is the price it can reasonably be expected to sell for on the open market in a particular geographic area, minus any encumbrances.

- Payments provided as a preventive housing service under 18 NYCRR 423.4(l);

- Benefits received by eligible Japanese-Americans or Aleuts under the federal Civil Liberties Act of 1988 or the Aleutian and Pribilof Islands Restitution Act will be disregarded.

- Payments provided from the Agent Orange Settlement Fund, from any other fund established pursuant to the settlement in the In re Agent Orange product liability litigation, or from court proceedings brought for personal injuries sustained by veterans resulting from exposure to dioxin or phenoxy herbicides in connection with the war in Indochina in the period of January 1, 1962 through May 7, 1975.

- any payment received under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

- for the month of receipt and the following month, refunds or advance payments of the Federal Earned Income Tax Credit.

- Any federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974 (P.L. 93-288), as amended by the Disaster Relief and Emergency Assistance Amendments of 1988 (P.L. 100-707), and any comparable disaster assistance provided by states, local governments, and disaster assistance organizations will be disregarded.

- interests of individual Native Americans in trusts or restricted lands, from funds appropriated in satisfaction of judgments of the Indian Claims Commission of the United States Court of Federal Claims will be disregarded in determining eligibility.

In addition, a child's savings account of under $500 accumulated from gifts from non-legally responsible relatives or from the child's own wages will be disregarded in determining eligibility.

Retroactive SSI and Social Security benefit payments, federal child tax credit payments, federal earned income tax credit payments, and any advance payment of earned income credit made by an employer, which are received on or after March 2, 2004, are disregarded resources for nine months beginning the calendar month after the month of receipt for SSI-related applicant or recipient. GIS 04 MA/030

Regulations at 18 NYCRR 360-4.6 provides for resource disregards for applicants and recipients who are 65 years of age or older, certified blind or certified disabled:

The disregards for such persons include:

4. reparation payments received from the Republic of Germany provided that the reparation payments remain identifiable as such;

For certified blind or certified disabled MA applicants/recipients under 65 years of age, and for certified blind or certified disabled MA applicants/recipients age 65 or over who received SSI payments or aid under the State Plan for the blind or disabled for the month preceding the month of their 65th birthday, any remaining countable resources may be set aside for a plan to achieve self-support.

Administrative Directive 96 ADM-8 describes how to determine whether jointly held assets are considered available to an applicant or recipient on or after September 1, 1994. Section IV.I of this Administrative Directive provides:

I. Jointly Held Assets. The general rule is that joint property held by an applicant/ recipient is considered available to the applicant/recipient to the extent of his or her interest in the property. In the absence of documentation to the contrary, it is presumed that all joint owners possess equal shares. However, there are special rules for SSI-related applicant/recipients concerning the availability of financial institution accounts, which are described in paragraph 1 below. In addition, with respect to an applicant/ recipient who converts his or her assets into joint assets, OBRA '93 and Chapter 170 of the Laws of 1994 indicate when such a conversion constitutes a transfer of assets, as explained in paragraph 2 below.

1. Financial Institution Account Owned by an SSI-Related Applicant/Recipient

In accordance with SSI regulations (20 CFR 416.1208), ownership of financial institution accounts (including savings, checking, and time deposits or certificates of deposit) involving an SSI-related applicant/recipient must be determined as outlined below.

a. SSI-Related Applicant/Recipient is the Sole Owner

As long as an SSI-related applicant/recipient is designated as the sole owner by the account title, and can withdraw funds and use them for his or her support and maintenance, the applicant/recipient is presumed to own all of the funds in the account, regardless of their source. This presumption cannot be rebutted.

b. SSI-Related Applicant/Recipient is a Joint Owner

In the absence of evidence to the contrary, if an SSI-related applicant/recipient is a joint account holder, it is presumed that all of the funds in the account belong to the applicant/recipient. If there is more than one SSI-related applicant/recipient who is a holder of the joint account, it is presumed that the funds in the account belong to the applicant/recipients in equal shares. To rebut this presumption, the SSI-related applicant/recipient must:

i. submit a written statement, along with corroborating written statements from the other account holders, regarding who owns the funds, why there is a joint

account, who has made deposits and withdrawals, and how withdrawals have been spent;

ii. submit account records for the months for which ownership of funds is at issue; and

iii. separate the funds owned by the SSI-related applicant/recipient from the funds of the other account holders.

Department Regulations at 18 NYCRR 360-7.5(a) set forth how the Medical Assistance Program will pay for medical care. Generally the Program will pay for covered services which are necessary in amount, duration and scope to providers who are enrolled in the Medical Assistance program, at the Medical Assistance rate or fee which is in effect at the time the services were provided.

In instances where an erroneous eligibility determination is reversed by a social services district discovering an error, a fair hearing decision or a court order or where the district did not determine eligibility within required time periods, and where the erroneous determination or delay caused the recipient or his/her representative to pay for medically necessary services which would otherwise have been paid for by the Medical Assistance Program, payment may be made directly to the recipient or the recipient's representative. Such payments are not limited to the Medical Assistance rate or fee but may be made to reimburse the recipient or his/her representative for reasonable out-of-pocket expenditures. The provider need not have been enrolled in the Medical Assistance program as long as such provider is legally qualified to provide the services and has not been excluded or otherwise sanctioned from the Medical Assistance Program. An out-of-pocket expenditure will be considered reasonable if it does not exceed 110 percent of the Medical Assistance payment rate for the service. If an out-of-pocket expenditure exceeds 110 percent, the social services district will determine whether the expenditure is reasonable. In making this determination, the district may consider the prevailing private pay rate in the community at the time services were rendered, and any special circumstances demonstrated by the recipient. 18 NYCRR 360-7.5(a).

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).

Payment may be made to a recipient or the recipient's representative for reimbursement of paid medical bills for services received during the recipient's retroactive eligibility period, provided that the recipient was eligible in the month in which the services were received. For services received during the period beginning on the first day of the third month prior to the month of the Medical Assistance application and ending on the date the recipient applied for Medical Assistance payment can be made without regard to whether the provider of services was enrolled in the Medical Assistance program. However, if the services were furnished by a pro-

vider who was not enrolled, the provider must have been otherwise lawfully qualified to provide such services, and must not have been excluded or otherwise sanctioned from the Medical Assistance Program. If services were provided when the recipient was temporarily absent from the State, payment will be made if: Medical Assistance recipients customarily use medical facilities in the other state; or the services were obtained to treat an emergency medical condition resulting from an accident or sudden illness. 18 NYCRR 360-7.5(a).

For services received during the period beginning after the date the recipient applied for Medical Assistance and ending on the date the recipient received his or her Medical Assistance identification card, payment may be made only if the services were furnished by a provider enrolled in the Medical Assistance program. 18 NYCRR 360-7.5(a).

Reimbursement is limited to the Medicaid rate or fee in effect at the time the services were provided. 18 NYCRR 360-7.5(a).

Section 360-2.2(f) of the Regulations requires that a personal interview be conducted with all applicants for Medical Assistance. Such personal interview shall be conducted before a decision on Medical Assistance eligibility is authorized or reauthorized. The State may grant a waiver of the personal interview requirement for recertification of aged, certified blind or certified disabled recipients when the Agency demonstrates that alternative procedures have been established to verify that recipients continue to meet all eligibility requirements for Medical Assistance. Section 360-2.3 of the Regulations provides that the Medical Assistance applicant and 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 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.

DISCUSSION

EXCESS RESOURCES

The Agency's determination is not correct. The uncontroverted evidence establishes that the Agency determined to deny the Appellant's application for Medical Assistance because the Appellant's non-exempt household resources of $211,397.25 exceed the applicable Medical Assistance resource level.

Counsel for the Appellant did not dispute the figures used by the Agency to calculate the resources. With respect to the Wachovia account (#----9677), he contended that these funds totaling $20,322.32 were used to pay a medical bill at Northern Metropolitan Nursing Home through May, 2005. He submitted a bank statement, cancelled check and a bill from Northern Metropolitan Nursing Home, into evidence.

Regarding the second Wachovia account (#----9541), counsel contended that these funds, which total $195,075.13, should be exempt because they are German Reparations Payments. He indicated that the Appellant has been receiving German Reparations Payments since 1952 from the Republic of Germany, which are separate and distinct, from his German Social Security Benefits. Counsel further indicated that he obtained documentation from the Republic of Germany documenting the total Reparations Payments made to the Appellant since 1952. He submitted a letter, dated December 11, 2004, from the Bunderverwaltungsamt, Cologne, Germany, with an English translation, into evidence. The letter refers to the German Federal Law for the regulation of compensation of National Socialist Injustice service in accord with "31d BWGoD" for "pension payments for [redacted] born on December 27, 1914", with reference number "11B 3-2218; 625/2545056." Counsel also submitted a printout, in Deutsche Marks and Euros, of payments made to the Appellant from October, 1952 through July, 2004, along with a conversion of the payments into US Dollars. Counsel further submitted a list of pension payments sent to the Appellant, pursuant to the "restitution of the National Socialist damage for members of the official service", from January through July, 2005, in euros. Finally, counsel submitted stubs for the period August, 2004 through April, 2006, from the Bundesamt Fuer Finanzen for reference number 625/2545056, in euros, converted to US Dollars. Counsel indicated that on October 14, 2004 the Appellant opened Wachovia account (#----9541), which is designated "[redacted] In Trust for [redacted], German War Reparations", and began depositing his monthly reparations payments, starting with the one from October, 2004, into the account. He submitted bank statements for the account from October 14, 2004 through June 7, 2005, into evidence. Counsel indicated that the Appellant also used funds from a Smith Barney account totaling $140,040.85 and deposited them into this Wachovia account and he used funds from a Franklin/Templeton Investments account totaling $46,071.15 and deposited them into the Wachovia German War Reparations account. He argued that the Appellant received total German War Reparations from October, 1952 through June, 2005 of $294,719.85. Counsel contended that in October, 2004 the Appellant set up this separate German War Reparations account and determined to use an equivalent amount of the reparations he had received since 1952 from other accounts and deposit the funds into the Wachovia German Reparations account. He asserted that the Appellant had over the years deposited his reparations payments into various accounts and they were unable to separate them. Counsel argued that this account was set up prior to the snapshot date for resources of June, 2005. He indicated that the Agency questioned a third deposit for $120,000.00 made on December 23, 2004. Counsel further indicated that the bank statement for December 8, 2004 through January 7, 2005 shows that the check was returned for insufficient funds and fees were charged by the bank. He submitted a copy of the returned check, drawn on Wachovia account (#----8270), into evidence. Counsel asserted that Mrs. [redacted] made out the check to the wrong Wachovia account. He stated that this information was provided with the original application.

Counsel for the Appellant waived the right to a home hearing pursuant to the Varshavsky Directive.

Ms. Davidson, the Agency Representative, did not object to the medical bill from Northern Metropolitan Nursing Home and the cancelled check from Wachovia account (#----9677) provided by the Appellant. She argued that the funds in the second Wachovia account (#--

--9541), totaling $195,075.13, are not exempt German Reparations Payments and are an available resource for the Appellant.

Ms. Molatch, a Principal Examiner, indicated that the deposits from the Smith Barney account ($140,040.85) and a Franklin Templeton Investments account ($46,071.15) were not from a German War Reparations Account but were transferred into a German War Reparations Account set up in October, 2004, where the Appellant began depositing his monthly checks. She further indicated that the letter and documentation provided by counsel from the German Republic uses the terms "Pension payments" and "National Socialist damage for members of the official service" and does not call them reparations payments. Ms. Molatch did not dispute that the Appellant also receives a separate German Social Security payment.

Regarding the German Reparations Payments, the Agency's argument that the Appellant does not receive them is unpersuasive. A review of the documentation from the Republic of Germany shows that it refers to the law to "regulate the restitution of the National Socialist damage for members of the official service (paragraph) 31dBWGoD". Additionally, the printout of payments provided by the Republic of Germany from 1952 to 2004 has the same reference number "11B3-2218;625/2645056" as the check stubs and the letter of explanation from the Republic of Germany. Further, the Agency acknowledged that the Appellant also receives separate German Social Security payments. Based on the available evidence, it is reasonable to conclude that the Appellant has been in receipt of German Reparations Payments since October 1, 1952.

Additionally, the Appellant's contention that all of the funds in the designated Wachovia account ($195,075.13) are exempt war reparations is persuasive. It is undisputed that on October 14, 2004 the Appellant opened a separate Wachovia account designated "[redacted] In Trust for [redacted], German War Reparations." Additionally, the evidence shows that beginning with his October, 2004 reparations check the Appellant deposited each one he received from the Republic of Germany into this account. From October, 2004 through June, 2005, the evidence shows that the Appellant deposited each German Reparations check he received from the Republic of Germany for that period. These deposits total $12,538.36. The Appellant also made deposits of $140,040.85 from a Smith Barney account and $46,071.15 from a Franklin Templeton account into the designated German Reparations account. Counsel argues that these deposits should be exempt as German Reparations because the Appellant over the years deposited his reparations into various accounts and these deposits are an equivalent amount of the reparations payments he received from the Republic of Germany from 1952 until September, 2004.

Under the Medicaid Program, clearly identifiable reparations payments are considered exempt income and resources. Further, reparations payments do not have to remain physically apart from other funds or be retained in a separate bank account to be considered identifiable reparations payments. See, SI 01130.700 "Identifying Excluded Funds That Have Been Commingled with Nonexcluded Funds", Social Security Programs & Operations Manual for Services (POMS). The operating assumption with excluded funds is that "when withdrawals are made from an account with commingled funds in it, the nonexcluded funds are withdrawn first,

leaving as much of the excluded funds in the account as possible." The procedure as outlined in SI 01130.700 of the POMS is "to obtain a complete history of the account transactions back to the initial deposit of the excluded funds" and "to accept the individual's allegation as to the date and amount of a deposit of excluded funds if it agrees with the evidence in file on receipt of the funds." A review of the record shows that the Appellant received over his life time reparations payments of $294,719.85. Although the Appellant commingled funds during his lifetime into various accounts and did not open a specifically designed German War Reparations account until October 14, 2004, the two deposits at issue totaling $186,112.00, which the Appellant deposited from the Smith Barney and Franklin Templeton accounts into his Wachovia reparations account, are less than the total amount of his lifetime German War reparations. Therefore based on the policy in SI 01130.700 cited above, the funds in the Appellant's Wachovia account (#----9541) totaling $195,075.13 are exempt German War Reparations and are an unavailable resource for Medicaid eligibility. After excluding the German War Reparations account, the Appellant's available resources, based on the review of the accounts for which the Agency had received documentation from the Appellant, totaled $20,322.12 (Wachovia Account # 9677). The evidence shows that the Appellant used this account to pay a medical bill from Northern Metropolitan Nursing Home totaling $20,322.32.

FAILURE TO PROVIDE ELIGIBILITY DOCUMENTATION

The uncontroverted evidence establishes that the Appellant did not submit all of the requested documentation to the Agency by the deadline.

Ms. Davidson, the Agency Representative, noted that the Agency initially denied the Appellant's application by a notice dated September 7, 2005 for failure to provide documentation. She indicated that the Agency withdrew that notice and afforded the Appellant additional time to provide documentation and subsequently, issued a new denial notice dated March 14, 2006 for failure to provide eligibility documentation. Ms. Davidson and the Appellant's counsel agreed that the only notice at issue for the hearing was the one dated March 14, 2006.

Counsel for the Appellant contended that the Appellant's daughter had difficulty obtaining all of the documentation requested by the Agency because requests had to be made to Alliance to obtain bank statements from microfiche in Detroit, Michigan. He further contended that other documentation was faxed to the Agency after March 14, 2006, as the information was received. Counsel noted that the Agency advised him to file a new application, which he did on July 12, 2006. He indicated that he has now obtained all of the requested documentation and he submitted the documentation into evidence. Counsel acknowledged that some of the bank statements are being submitted for the first time at the hearing. Counsel also noted that the paralegal in his firm who handled the case was no longer employed by them.

Ms. K[redacted], the Appellant's daughter, indicated that she became involved in her father's financial affairs about a year ago and that her father was unable to offer any help due to his medical condition. She further indicated that began making requests for the documentation and bank statements and had to make multiple phone calls to obtain the information. Ms.

K[redacted] stated that many of the bank statements had been stored on microfiche and had to ordered. She further stated that it was a confusing process to obtain all of the documents.

Ms. Davidson, the Agency Representative, contended that the Agency denied the application because the Appellant failed to submit all of the requested bank statements and an explanation of deposits and withdrawals over $2,000.00, in order to determine eligibility for Chronic Care Medical Assistance.

The Agency's determination was correct when made. Based upon the new evidence at the hearing, that the Appellant's daughter had difficulty obtaining all of the requested bank statements and the documentation has been provided at the hearing, the determination cannot now be sustained. It is undisputed that the Appellant did not provide all of the requested documentation by the March 14, 2006 deadline. However, Ms. K[redacted]'s testimony that she had difficulty obtaining the documents was credible because it was detailed, consistent and plausible. It is reasonable to believe that there could be delays in obtaining bank statements, particularly if they had to be retrieved from microfiche by the banks. Based on Ms. K[redacted]'s credible testimony, the Appellant has established a valid reason for not obtaining the required information by the deadline. Since all of the requested documentation has been provided. the Agency can now review all of the resources, excluding the German War Reparations in Wachovia Account #----9541 totaling $195,075.13), of the Appellant and the Community Spouse and re-determine the Appellant's eligibility for Chronic Care Medical Assistance.

Accordingly, the case is remanded back to the Agency to re-determine eligibility for Chronic Care Medical Assistance.

DECISION AND ORDER

In accord with its agreement at the hearing, the Agency is directed to take the following actions, if it has not already done so, with respect to the notice dated September 7, 2005:

1. Withdraw the notice dated September 7, 2005 to deny the Appellant's application for Medical Assistance for failure to provide eligibility documentation.

2. Take no further action on the notice dated September 7, 2005 to deny the Appellant's application for Medical Assistance for failure to provide eligibility documentation.

The Agency's determination dated March 14, 2006 to deny the Appellant's application for Medical Assistance for the Appellant on the grounds that the Appellant has non-exempt resources which exceed the applicable Medical Assistance resource levels was not correct and is reversed.

The Agency's determination dated March 14, 2006 to deny the Appellant's application for Medical Assistance for failure to provide documentation necessary to determine the Appellant's eligibility for such benefits was correct when made.

3. The Agency is directed to continue to process the Appellant's application and afford the applicant the opportunity to submit any other documents necessary to establish eligibility.

4. The Agency is directed to redetermine the Appellant's eligibility for Medical Assistance and, if the Appellant is eligible, to provide Medical Assistance retroactive to the month of application and three months prior thereto, if otherwise eligible.

5. The Agency is directed to provide the Appellant with a reasonable opportunity to submit verification of paid and unpaid medical bills for the period beginning three calendar months prior to the month of application and ending when the Appellant's Medical Assistance card is issued.

6. The Agency is directed to reimburse the Appellant for medical services covered by the Medical Assistance program, if the Appellant was otherwise eligible for Medical Assistance benefits, in accordance with the provisions of 18 NYCRR 360-7.5(a).

7. The Agency is directed to advise the Appellant in writing 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.

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

DATED: Albany, New York
09/19/2007

NEW YORK STATE
DEPARTMENT OF HEALTH

By

Commissioner's Designee