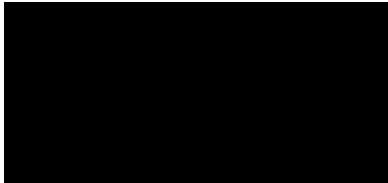




February 3, 2026



RE: [REDACTED] v. WV DoHS/BFA
ACTION NO.: 26-BOR-1009

Dear [REDACTED]:

Enclosed is a copy of the decision resulting from the hearing held in the above-referenced matter.

In arriving at a decision, the State Hearing Officer is governed by the Public Welfare Laws of West Virginia and the rules and regulations established by the DEPARTMENT OF HUMAN SERVICES (DoHS). These same laws and regulations are used in all cases to ensure that all persons are treated alike.

You will find attached an explanation of possible actions you may take if you disagree with the decision reached in this matter.

Sincerely,

Tara B. Thompson, MLS
Certified State Hearing Officer
Member, State Board of Review

Encl: Recourse to Hearing Decision
Form IG-BR-29

cc: Erin Nelson, DoHS

**WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW**

████████████████████

Appellant,

v.

Action Number: 26-BOR-1009

**WEST VIRGINIA DEPARTMENT OF
HUMAN SERVICES
BUREAU FOR FAMILY ASSISTANCE,**

Respondent.

DECISION OF STATE HEARING OFFICER

INTRODUCTION

This is the decision of the State Hearing Officer resulting from a fair hearing for ██████████. This hearing was held in accordance with the provisions found in Chapter 700 of the Office of Inspector General Common Chapters Manual. This fair hearing was convened on January 21, 2026.

The matter before the Hearing Officer arises from the decision on December 4, 2025, to deny the Appellant's eligibility for Medicaid benefits.

At the hearing, the Respondent appeared by Erin Nelson, DoHS. The Appellant appeared by ██████████, her mother. Appearing as a witness for the Appellant was ██████████, the Appellant's brother. All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 DoHS Notice, dated November 7, 2025
- D-2 DoHS Verification Checklist, dated November 20, 2025
- D-3 DoHS Notice, dated December 4, 2025
- D-4 Handwritten Note, by ██████████, received on December 5, 2025
- D-5 Appellant's Bank Transaction History Account ██████████
- D-6 West Virginia Income Maintenance Manual (WVIMM) Chapter 5 excerpts

Appellant's Exhibits:

None

After a review of the record, including testimony, exhibits, and stipulations admitted into evidence at the hearing, and after assessing the credibility of all witnesses and weighing the evidence in consideration of the same, the Hearing Officer sets forth the following Findings of Fact.

FINDINGS OF FACT

- 1) The Appellant was a recipient of Supplemental Security Income (SSI) Medicaid and Qualified Medicare Beneficiary (QMB) coverage (Exhibit D-1).
- 2) On November 6, 2025, the Respondent received an alert to evaluate the Appellant's Social Security benefits.
- 3) During the hearing, the Respondent's representative testified that she closed the Appellant's SSI Medicaid benefits because the Appellant was no longer eligible for SSI, based on information received from the Social Security Administration (SSA).
- 4) On November 7, 2025, the Respondent terminated the Appellant's eligibility for SSI Medicaid and QMB, effective on December 1, 2025. The reason for terminating the Appellant's SSI Medicaid coverage was because she no longer received SSI. The Reason for terminating the Appellant's QMB was because her income exceeded the eligibility limit (Exhibit D-1).
- 5) On November 6, 2025, the Respondent mailed the Appellant applications for Home and Community Based Services Waiver Medicaid and Medicare Premium Assistance.
- 6) On November 20, 2025, the Respondent issued a *Verification Checklist* requesting that the Appellant submit verification of, "Checking Account/ Proof of the Value of this asset," to determine the Appellant's eligibility for Home and Community Based Services Waiver (HCBS) Medicaid, and Specified Low Income Medicare beneficiary (SLIMB) (Exhibit D-2). Verifications were due by November 29, 2025 (Exhibit D-2).
- 7) On December 4, 2025, the Respondent issued a notice advising the Appellant's Medicaid and Medicare Premium Assistance eligibility was denied because she did not submit all requested information by the required date (Exhibit D-3).
- 8) On December 5, 2025, the Appellant's representative submitted a financial statement and handwritten note that asserted that the large balance reflected on the Appellant's bank statement was due to preparing to replace an alternator on the Appellant's "Mobility Works Van" (Exhibit D-4).
- 9) On October 15, 2025, the Appellant's bank account balance was \$9,618.11 (Exhibit D-5).
- 10) On November 26, 2025, the Appellant's bank account balance was \$10,046.18 (Exhibit D-5).
- 11) No other bank account transactions occurred between November 26 and December 2, 2025 (Exhibit D-5).

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 3.13.1 *The Assistance Group (AG)* provides that only the Supplemental Security Income (SSI) recipient or an individual who is otherwise entitled to SSI, is included in the AG. This includes an individual who is otherwise entitled to an SSI payment but does not receive it due to a repayment.

WVIMM § 3.13.2 *Supplemental Security Income (SSI) Recipients — The Income Group (IG)* and § 23.11.1 *SSI Recipients* provide that the Social Security Administration (SSA) determines the income and assets that are counted for SSI. SSA's determination of eligibility for SSI is the sole eligibility determination for Medicaid. The Department depends upon SSA for the information needed to open, evaluate, and close continuing eligibility for SSI Medicaid cases. SSI Medicaid eligibility ends when SSI ends in most situations. The Worker uses information from a data exchange between DoHS and SSA to open the SSI Medicaid benefit. No additional income or asset test is made for Medicaid.

WVIMM § 10.14.1 *SSI Recipients and Deemed SSI Recipients AG Closures* provides that the Worker closes the SSI Medicaid AG after advance notice when the Worker receives a system alert and determines that the individual is no longer eligible for SSI Medicaid When the closure of the SSI Medicaid is for a reason other than a move to another state or death, the Worker must evaluate the individual for all other Medicaid coverage groups, including Deemed SSI Medicaid coverage and Medicare Premium Assistance.

WVIMM § 3.15.2.A *QMB, SLIMB, and QI-1* provides that for an eligible individual with no spouse, only the individual's income is counted.

WVIMM § 3.17.1 *SSI-Related Medicaid* and § 3.17.2 *The Income Group (IG)* provides that only the aged, blind, or disabled individual and his eligible aged, blind, or disabled spouse must be included, except when the spouse resides in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID). For individuals with no spouse, only the individual's income is counted.

WVIMM § 5.3.1.B *Supplemental Security Income (SSI) Medicaid Groups* include: SSI-Related Medicaid, QMB, SLIMB, and QI-1. The asset eligibility determination for these applications must be made as of the first moment of the month of eligibility. The client is not eligible for any month in which countable assets are more than the limit, as of the first moment of the month. Increases in countable assets for one month do not affect eligibility unless retained into the first moment of the following month.

EXAMPLE: Mr. Rose applies for SSI-Related Medicaid on April 21. On April 1, he had a savings account of \$1,500 and two automobiles: a vehicle that he used for obtaining medical treatment and a second vehicle valued at \$575. His total assets on April 1 were \$2,075. He advised the Worker that on April 10, he withdrew \$125 from his savings account to pay for automobile repairs. Even though on April 10 his assets decreased to \$1,950, which is under the \$2000 asset limit, his assets as of the first moment of the month were in excess of the asset limit; therefore, he is not eligible.

The Worker may use any of the following items to determine first of the month account balances:

- Printed or online bank statements and passbooks;
- The applicant's check register or any bank-issued document. This includes, but is not limited to ATM transaction receipts and/or deposits and/or withdrawal receipts; and/or
- The account transaction history on a bank's automated telephone customer service line that provides complete transaction information.

WVIMM § 5.3.2 *When Income Becomes an Asset* provides that money counted as income when received becomes an asset if retained within the month after the month of receipt.

WVIMM § 5.3.4 *Accessibility of Assets* provides that a client may not have access to some assets. To be considered an asset, the item must be owned by, or available to, the client and available for disposition. If the client cannot legally dispose of the item, it is not an asset ...

For Medicaid Only: Assets may be marked as inaccessible for clients who are currently declared incapacitated by a physician and have no legal financial power of attorney. Verification the physician declaration of incapacity and/or petition must be provided before entering the asset exclusion.

Joint ownership: The meaning of such ownership may be indicated in one of the following ways:

- AND – Joint ownership indicated by *and* between the names of the owners. Unless there is evidence to the contrary, each owner is assumed to own an equal, fractional share of the jointly owned asset.
If the fractional share of the asset is not available to either owner without the consent of the other, and such consent is withheld, the asset is excluded as being inaccessible.
- OR – Joint ownership indicated by *or* between the names of the owners. The asset is available to each owner in its entirety.
- AND/OR – Joint ownership indicated by *and/or* between the names of the owners. The assets are available to each owner in its entirety.

WVIMM § 23.11.3 *SSI Related* provides that individuals who meet the SSI definition of aged, blind, or disabled are eligible for Medicaid when all income and asset conditions are met, including the requirement for countable assets not to exceed the eligibility limits described in Chapter 5. For an individual, the asset limit is \$2,000.

WVIMM § 23.11.5.C *Individuals Receiving Home and Community-Based Services under Title XIX Waivers* provides that to qualify, an individual must be aged/disabled, intellectually/developmentally disabled, or have a traumatic brain injury. The determination of which income to count is the same as SSI-Related Medicaid. The determination of countable assets is the same as for SSI-Related Medicaid. The \$2,000 SSI-Related Medicaid asset limit for one person is used.

WVIMM § 23.12 through § 23.12.3 *Medicare Premium Subsidies* provide eligibility information for Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLIMB), and Qualified Individuals (QI). Medicaid coverage is limited to payment

of the Medicare Part A and Part B premium amounts and payment of all Medicare co-insurance and deductibles.

For QMB, SLIMB, and QI, the individual asset limit is \$9,950.

DISCUSSION

On November 7, 2025, the Respondent terminated the Appellant's SSI Medicaid benefits because she was no longer eligible for SSI payments after November 2025. The Appellant's representative did not dispute the Appellant's SSI ineligibility or the Respondent's termination of SSI Medicaid. The Appellant's witness testified that the Appellant's eligibility for Medicaid Waiver benefits was their primary concern.

According to the policy, the Respondent relies on the Social Security Administration (SSA) for information to open, evaluate, and close continuing eligibility for SSI Medicaid cases. As the SSA information provided to the Respondent indicated the Appellant was no longer eligible for SSI Medicaid, the Respondent's worker terminated the Appellant's SSI eligibility and mailed the Appellant's representative applications for Medicare Premium Assistance and Medicaid Home and Community-Based Waiver financial eligibility. Pursuant to the Respondent's representative's testimony, verification of the Appellant's assets was requested but not returned by the due date. Therefore, the Respondent issued a denial notice to the Appellant on December 4, 2025. The next day, the Appellant's representative supplied the requested verification.

Although the denial notices issued on December 4, 2025, indicated denial based on the Appellant's failure to submit requested verification, the Respondent was able to make an eligibility decision based on the information supplied by the Appellant the next day. Based on the supplied information, the Respondent determined that the Appellant's assets exceeded the eligibility limits for both programs applied for. The Respondent did not issue new denial notices as the eligibility decision was unchanged.

The Respondent bears the burden of proof and had to demonstrate by a preponderance of evidence that the Appellant's assets exceeded the applicable asset eligibility limits. To prove that the Appellant was ineligible for Medicare Premium Assistance, the Appellant's assets had to exceed the \$9,950 asset limit as of the first moment of the month of eligibility. Home and Community-Based Services Waiver eligibility is determined according to the SSI-Related Medicaid eligibility criteria. To prove that the Appellant was ineligible for Home and Community-Based Services Waivers, the Appellant's assets could not exceed the \$2,000 asset limit.

On November 26, 2025, the Appellant's bank account balance was \$10,046.18. According to the supplied account transaction statement, no other transactions occurred between November 26 and December 2, 2025. The Appellant's representative did not refute the amount of assets reflected in the statement. During the hearing the Appellant's witness testified that he believed a clerical error had occurred when the Appellant's representative lost track of the amount of assets in the bank account. The Appellant's representative testified that she allowed a balance to accumulate in the Appellant's account because they anticipated an expensive repair for the Appellant's wheelchair

accessible van that the Appellant did not end up needing. Because the Appellant's assets exceeded the \$9,950 asset limit as of December 1, 2025, the Respondent correctly denied the Appellant Home and Community-Based Services Waiver financial eligibility. As the Appellant's \$10,046.18 account balance exceeded the \$2,000 Medicare Premium Assistance eligibility limit, the Respondent correctly denied the Appellant's eligibility.

CONCLUSIONS OF LAW

- 1) To be eligible for Medicare Premium Assistance benefits, the Appellant's assets could not exceed \$9,950.
- 2) To be financially eligible for Home and Community-Based Services Waivers, the Appellant's assets could not exceed \$2,000.
- 3) The preponderance of evidence verified that the Appellant's \$10,046.18 assets exceeded the eligibility limit for Home and Community-Based Services Waivers and Medicare Premium Assistance.
- 4) Because the Appellant's assets exceeded the eligibility limits, the Respondent correctly denied the Appellant's eligibility.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's decision to deny the Appellant's financial eligibility for Home and Community-Based Services Waivers and Medicare Premium Assistance.

ENTERED this 3rd day of February 2026.

Tara B. Thompson, MLS
Certified State Hearing Officer