



February 24, 2026

RE: [REDACTED] v. WV DoHS/BFA
ACTION NO.: 26-BOR-1147

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: Elizabeth Padlow, DoHS

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

[REDACTED]

Appellant,

v.

Action Number: 26-BOR-1147

**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 [REDACTED]. 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 February 18, 2026.

The matter before the Hearing Officer arises from the Respondent's decision on December 31, 2026, to deny the Appellant's eligibility for Adult Group Medicaid benefits.

At the hearing, the Respondent appeared by Elizabeth Padlow, DoHS. The Appellant appeared by [REDACTED]. All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

D-1 West Virginia Income Maintenance Manual (WVIMM) excerpts from Chapters 1, 4, 7, and Chapter 4, Appendix A

Appellant's Exhibits:

A-1 Typed Statements by [REDACTED] dated February 7 and February 13, 2026; WVIMM excerpts from Chapters 1, 4, 7, and Chapter 4, Appendix A

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 Adult Medicaid for a one-person Assistance Group (AG).
- 2) On June 16, 2025, the Appellant's representative informed the Respondent of the onset of employer sponsored coverage.
- 3) In 2025, the Appellant contributed funds to 401(k) and Traditional IRA accounts.
- 4) On December 29, 2025, the Appellant submitted a Medicaid review form and self-reported earned income and self-employment income amounts. The Appellant's representative supplied the most recent paystub to the Respondent, which reflected the year-to-date amount of the Appellant's 401(k) contributions.
- 5) On December 31, 2025, the Respondent issued a notice denying the Appellant's eligibility for Adult Medicaid, effective after January 31, 2026, because the Appellant's income exceeded the income eligibility limit.
- 6) The Respondent considered \$2,182.03 in earned income, and \$41.66 in self-employment income when making the December 31, 2025 eligibility decision.
- 7) The Respondent did not consider any self-employment expenses and calculated a \$0.00 MAGI income amount.
- 8) The MAGI income limit at the time of the December 31, 2025 denial was \$1,735.
- 9) After the eligibility denial on December 31, 2025, the Appellant's representative contacted the Respondent and inquired about the consideration of 401(k) contributions when determining eligibility.
- 10) On January 20, 2026, the Respondent issued a verification checklist requiring the Appellant to submit verifications by January 31, 2026.
- 11) On January 23, 2026, the Respondent issued a notice denying the Appellant's eligibility for Adult Medicaid, effective after January 31, 2026, because the Appellant failed to submit requested verifications.
- 12) The Respondent did not consider any employer sponsored coverage insurance premiums, self-employment expenses, or contributions to 401(k) and Traditional IRA accounts when determining the Appellant's Adult Medicaid eligibility on December 31, 2025, or January 23, 2026.

APPLICABLE POLICY

West Virginia Income Maintenance Manual (WVIMM) § 23.10.4 Adult Group provides that to be eligible for Adult Group Medicaid, the income cannot exceed 133% of the Federal Poverty Level (FPL). There is no asset limit. Medicaid coverage in the Adult Group is provided to individuals who meet the following requirements:

- They are age 19 or older and under age 65;
- They are not eligible for another categorically mandatory Medicaid coverage group;
- They are not entitled to or enrolled in Medicare Part A or B; and
- The income eligibility requirements described in Chapter 4 are met.

Parents living with a dependent child under the age of 19 are not eligible for Medicaid in the Adult Group unless the child is receiving benefits under Medicaid, WVCHIP, or otherwise enrolled in minimum essential health coverage (MEC).

WVIMM Chapter 4, Appendix A Income Limits provides that for a one-person Assistance Group (AG), 133% FPL is \$1,735.

WVIMM § 4.2 Definitions provides:

Adjusted Gross Income is the amount of taxable income of a household minus specific deductions allowed under federal law. See Section 4.7 for instructions on calculating the adjusted gross income.

Countable Income is the amount of income after all allowable exclusions, disregards, and deductions have been applied. The eligibility and level of benefit are based on this amount. For MAGI Medicaid coverage groups, eligibility is not based on countable income, it is based on the MAGI calculated as outlined in Section 4.7.

Deduction is a specific amount subtracted from income. Allowable deductions are different, depending upon the program involved.

Disregard is the portion of income that is not counted when determining countable income. Allowable disregards are different, depending upon the program involved.

Earned Income is the income of an individual which is derived, at least in part, from compensation for physical or mental activity as part of a trade or business. Earnings include gross income from employment and gross profit from self-employment.

Employment is a situation in which a wage, salary, or commission is paid to an individual for services rendered. The employer usually takes the responsibility for withholding income taxes and FICA taxes from the wages. However, if this is not done, the employee may pay these taxes himself without affecting his status as an employee. The employer controls such things as hours worked, what is done, and where the work is located.

Exclusion is income or assets that are treated as if they do not exist.

Gross Income is the amount of monthly income received before any deductions.

MAGI Disregard is an income disregard that equals 5% of the Federal Poverty Level (FPL) for the family size, applicable only to Medicaid Groups and WVCHIP that use MAG income-based methodologies. See Section 4.7.

Modified Adjusted Gross Income (MAGI) is an income figure used to determine eligibility for specific Medicaid eligibility groups and WVCHIP. The MAGI is calculated by making adjustments to the adjusted gross income. See Section 4.7.

Self-Employment is a situation in which an individual has an investment in a business, has costs involved in producing income from this business, and could suffer a loss. He is usually responsible for his own income taxes and Federal Insurance Contribution Act (FICA) taxes. A self-employed individual usually has to provide his own equipment, supplies, and materials needed to do a job or produce the income. He controls to some extent his hours of work and where the work is done.

WVIMM § 4.3 *Charts of Income Sources* provides that because the calculation of MAGI relies on a base adjusted gross income figure, it is necessary to list the income sources used by the Internal Revenue Service (IRS) to calculate the adjusted gross income. These income sources are the basis of the calculation of the household's MAGI, and therefore apply to certain Medicaid coverage groups, including the Adult Group.

WVIMM § 4.3.2 *Chart 2* provides: For determining eligibility for the Adult Group, self-employment, wages, salaries, and tips are counted as income.

WVIMM § 4.7.5.A *Special Situations – Income from Self-Employment* provides that when a member of the MAGI household IG receives self-employment income, the instructions in this policy section must be used to arrive at the gross profit, which is used to calculate countable income. Countable income is determined by subtracting allowable business expenses from the gross income.

WVIMM § 4.7.5.E *Irregular Income* provides that regardless of the source, irregular income is not counted because it cannot be anticipated.

WVIMM § 4.7 *MAGI Methodology* provides that the Modified Adjusted Gross Income (MAGI) methodology is used to determine financial eligibility for the Adult Group.

WVIMM § 4.7.1 *Determining Income Counted for the MAGI Household* provides that the income of each member of the individual's MAGI household is counted. The MAGI household is determined using the MAGI methodology established in Chapter 3.

WVIMM § 4.7.2 *Calculating MAGI (What Income is Counted)* provides that MAGI-based income includes:

- Adjusted gross income (taxable income less deductions/adjustments), excluding:
 - Certain taxable American Indian/Alaska Native income
 - Taxable scholarships/awards used for educational purposes

- Non-taxable Social Security benefits
- Tax-exempt interest
- Foreign earned income

To calculate the MAGI, determine the adjusted gross income amount for each member of the MAGI household whose income will count, for the current month. The MAGI differs from the adjusted gross income, because MAGI accounts for additions and adjustments. The Worker uses the budgeting method established in Section 4.6.1, Budgeting Method, to anticipate future income amounts, consider past income sources, and build monthly income amounts based upon the applicant's reported income.

WVIMM § 4.7.2.A Step 1- Determine the Income provides that taxable income is the portion of your gross income that is subject to federal, state, and local taxes. The calculation starts with your total annual earnings and then subtracts any eligible deductions to arrive at the final taxable amount.

In some situations, pre-tax deductions must also be deducted from MAGI gross income. Pre-tax deductions are taken from an employee's paycheck before any taxes are withheld. Pre-tax deductions can be tax-deferred or tax-exempt amounts that are deducted from the gross amount shown on an individual's pay stub but will not be shown on the W-2 or IRS form 1040. When an individual has a pre-tax deduction, federally taxable wages will be less than gross wages on the pay stub.

Pre-tax deductions include, but are not limited to:

- Premiums for health, dental, vision, and life insurance
- Contributions to flexible spending accounts and health savings accounts
- Contributions to certain 401(k) and other retirement accounts
- Short-term disability insurance

EXAMPLE 1: Rosebud's pay stub shows weekly earnings of \$400, and a tax-deferred 401K contribution of \$24 per week. You start with the gross weekly pay and subtract the tax-deferred 401K contribution. $400 - \$24 = \376 . The amount counted as income for MAGI Medicaid is \$376 per week.

EXAMPLE 2: Elmer's pay stub shows a weekly salary of \$550. His employer automatically deducts a pre-tax amount of \$35 for his health insurance premium. You start with the gross weekly pay and subtract the non-taxable health insurance premium. $550 - \$35 = \515 . The amount counted as income for MAGI Medicaid is \$515 per week.

EXAMPLE 3: Kale is paid bi-weekly and has a gross pay of \$1,300 per paycheck. She has two pre-tax deductions: \$70 for her 401(k) contribution and \$50 for her Flexible Spending Account (FSA). You start with the gross bi-weekly pay and subtract all pre-tax deductions. $1,300 - \$70 - \$50 = \$1,180$. The amount counted as income for MAGI Medicaid is \$1,180 per bi-weekly paycheck.

NOTE: Contributions to designated Roth 401(k)s and Roth IRAs are not pre-tax deductions, because they are made after tax earnings.

The Worker next adds all of the individual's income from any of the income sources listed in "Countable Sources of Income" of Section 4.3, Chart 2, and exclude income listed in "Excluded Sources of Income" of Section 4.3, Chart 2.

WVIMM § 4.7.2.B Step 2 – Make the Adjustments/Deductions provides that after the income has been determined, the Worker must determine if any adjustments/deductions are applicable and subtract them from the income determined in Step 1. The Worker must incorporate allowable deductions in the calculation of MAGI-based income. These adjustments/deductions can be found on page one of IRS form 1040

The following items are subtracted from the individual's income: ...

- Health savings account deductions
- Deductible part of self-employment tax
- IRA deductions

WVIMM § 10.4.2.B.4 Unclear Information provides that unclear information is any information received from any source which the Worker cannot readily determine the effects of the reported information on the household's benefits. The Worker must pursue clarification and required verification of unclear information related to these reported changes.

WVIMM § 7.2.1 When Verification is Required provides that verification of a client's statement is required when the information provided is questionable. To be questionable, it must be:

- Inconsistent with other information provided; or
- Inconsistent with the information in the case file; or
- Inconsistent with information received by the Department of Human Services from other sources; or
- Obviously inaccurate; or
- Outdated.

WVIMM § 7.2.3 Client Responsibilities provides that the primary responsibility for providing verification rests with the client. It is an eligibility requirement that the client cooperate in obtaining necessary verifications. The client is expected to provide information to which he has access and to sign authorizations needed to obtain other information.

WVIMM § 7.2.4 Worker Responsibilities provides that in the verification process, the Worker has the following responsibilities:

- At application, redetermination, and anytime a DFA-6 is used, the Worker must list all required verification known at the time. The Worker should only request additional verification if information provided is incomplete or additional information is necessary to determine eligibility.
- If the client is unsuccessful in obtaining information ... the Worker must document attempts to obtain the verification.
- The Worker must accept any reasonable documentary evidence as verification and must not require a specific kind or source of verification. Verification may be submitted in person, by mail, by fax, or electronically.

WVIMM § 9.2.1 DFA-6, Notice of Information Needed and § 9.2.1.C Medicaid and WVCHIP provides that the DFA-6 may be used during any phase of the eligibility determination process. At the time of application, it is given or mailed to the applicant to notify him of information or verification he must supply to establish eligibility. When the DFA-6 is mailed at the time of application, the client must receive the DFA-6 within five working days of the date of application.

If the client fails to adhere to the requirements detailed on the DFA-6, the application is denied or the deduction disallowed, as appropriate. The client must be notified of the subsequent denial by form DFA-NL-A. This form also notifies the client that his application will be denied, or a disallowed deduction if he fails to provide the requested information by the date specified on the form. The Worker determines the date to enter to complete the sentence, “If this information is not made available to this office by ____...” as follows.

The date entered in the DFA-6 must be at least 10 days from the date of issuance or a time agreed upon with the applicant.

DISCUSSION

According to the submitted testimony and documentary evidence, the Respondent initially denied the Appellant’s Adult Medicaid eligibility on December 31, 2025, due to her income exceeding the eligibility limit. Subsequently, the Respondent denied the Appellant’s eligibility due to failure to submit requested verification. Both actions denied the Appellant’s Adult Medicaid eligibility, effective after January 31, 2026. The Appellant’s representative contested the Respondent’s calculation of income when determining her eligibility for Adult Medicaid benefits, specifically the Respondent’s consideration of 401(k) and Traditional IRA contributions. During the hearing, the Appellant’s representative did not contest the date of his review form submission or the notice dates asserted by the Respondent’s representative’s testimony.

The Board of Review must determine whether the Respondent correctly followed the policy when determining the Appellant’s Adult Medicaid eligibility after January 31, 2026. Exceptions to the policy may not be granted as the Board of Review lacks the authority to judge or make changes to the policy. The Respondent bears the burden of proof and had to demonstrate by a preponderance of evidence that the Appellant’s income exceeded the eligibility limit and that the Appellant failed to submit the required verification by the due date.

Income

Retirement Contributions

During the hearing, the Appellant’s representative testified that the Appellant contributed funds to a 401(k). The Respondent’s representative testified that non-taxable income is generally only considered when a client is close to the income limit. This interpretation of how to calculate the Appellant’s MAGI amount is incorrect and contrary to WVIMM § 4.7.2.A instructions and examples for determining an amount of taxable income to be considered. In this policy section, instructions and examples provide that pre-tax deductions must be subtracted to determine an amount of taxable income for assessing MAGI Medicaid eligibility. Pursuant to WVIMM §

4.7.2.A, pre-tax deductions may include premiums for health insurance and contributions to certain 401(k) and other retirement accounts. According to this policy section, pre-tax deductions are shown on an individual's pay stub but will not be shown on the W-2 or IRS form 1040. When an individual has pre-tax deductions, federally taxable wages will be less than gross wages on the pay stub.

The Respondent's representative testified that the Respondent Worker, Supervisor, and Policy Unit were unsure how to attribute the Appellant's 401(k) contributions due to the contributions equaling a "high amount;" however, no evidence was submitted to verify what amount they were considering. The policy does not reflect a maximum amount of pre-tax 401(k) contributions that may be deducted from the client's income when determining Adult Medicaid eligibility.

During the hearing, the Appellant's representative testified that the Appellant contributed funds to a Traditional IRA. The Respondent's witness testified that the Respondent did not know how to enter the Appellant's 401(k) amount into the system "so it is correct," and that she did not know if an IRA and 401(k) were the same thing. However, WVIMM § 4.7.2 provides clear instructions and examples to explain how to deduct the pre-tax contribution amounts. According to WVIMM § 4.7.2.B, the Worker must incorporate allowable deductions in the calculation of MAGI-based income and stipulates that applicable adjustments/deductions can be found on page one of IRS form 1040. Pursuant to this policy, allowable deductions may include the deductible portion of self-employment tax and IRA deductions.

The submitted evidence failed to demonstrate that the Respondent evaluated whether the Appellant's Traditional IRA contributions were pre-tax or post-tax and did not establish an amount of contributions. Although pre-tax 401(k) contributions are shown on an individual's pay stub and the Appellant submitted a December 2025 paystub demonstrating the year-to-date amount of contributions, the submitted evidence established that the Respondent failed to consider the amount of the Appellant's pre-tax 401(k) contributions or Traditional IRA contributions when determining Adult Medicaid eligibility in December 2025 and January 2026. Being unsure of how to process the Appellant's retirement contributions is not a sufficient reason for terminating the Appellant's Adult Medicaid benefits on the basis that her income exceeded the eligibility limit.

Other Income Considerations

Although the submitted evidence revealed that the Appellant's representative reported the onset of employer sponsored health coverage in June 2025, no evidence was submitted to establish whether the Respondent evaluated the Appellant's eligibility for pre-tax deductions for health insurance premiums when determining the Appellant's Adult Medicaid eligibility in December 2025 or January 2026.

No reliable evidence was submitted to establish a verified amount of the Appellant's self-employment income or how the Respondent determined whether the Appellant's self-employment income was received regularly. According to the policy, regardless of the source, irregular income is not counted because it cannot be anticipated. Pursuant to WVIMM § 4.7.5.A, when a member of the MAGI household IG receives self-employment income, the provided instructions must be used to arrive at the gross profit amount, which is used to calculate the Appellant's countable income. The presented evidence did not verify that the Respondent followed these steps when

calculating the amount of self-employment income used to determine the Appellant's income eligibility for Adult Medicaid.

Income Calculation

Pursuant to the policy, the Respondent must calculate Adult Medicaid using the MAGI methodology. The income verification relied upon by the Respondent when determining the Appellant's Adult Medicaid income eligibility on December 31, 2025, were not supplied for evidentiary review. The income chart provided as documentary evidence by the Respondent was not the accurate chart in effect at the time of the Respondent's December 31, 2025 decision, or consistent with the income limit reflected on the notice. During the hearing, the Respondent's representative was unable to provide reliable testimony regarding how the earned income amount was calculated as reflected on the notice. Because the preponderance of evidence failed to establish a verified amount of income for the Appellant in December 2025, the Respondent's denial of eligibility cannot be affirmed, and the matter must be remanded for issuance of a new income verification checklist and reconsideration of the Appellant's eligibility based on the new information supplied by the Appellant.

Verification

After the Appellant's eligibility denial on December 31, 2025, the Appellant's representative called to inquire about the application of 401(k) deductions. Because the Respondent was unsure how to handle the 401(k) deductions, the Respondent's worker testified that on January 20, 2026, a verification checklist was issued requesting paystubs from December 2025, or tax information from employment and self-employment, be submitted by January 31, 2026.

The Respondent's representative testified that because tax information was requested but the Appellant's W-2 form was not yet available, the Appellant could not supply the requested W-2 form and therefore, the Respondent issued a denial notice on January 23, 2026, due to the Appellant's failure to submit the requested verification. According to WVIMM § 7.2.3, a client can only be expected to supply information he has access to. The Respondent's expectation for the Appellant to supply information that he had no access to was incorrect.

During the hearing, the Respondent testified that after the January 23, 2025 denial was issued, the Appellant's representative supplied the requested W-2 form but the form was not considered for a new determination of eligibility. Although the Respondent requested the W-2 form, this form would not supply the retirement contribution information necessary pursuant to WVIMM § 4.7.2.A.

Pursuant to the policy, the due date of information must be at least 10 days from the date of issuance of the request. Although she testified that the denial was issued because the Appellant's representative failed to submit the required W-2 form, the Respondent's representative later testified that the checklist requested "self-employment and additional pays from December." The Respondent's representative testified that although verification was not due until January 31, 2026, she issued the denial on January 23, 2026, because the Appellant's representative had reported to her that he had already submitted the December 2025 year-to date retirement contributions on the supplied paystub.

During the hearing, the Appellant's representative testified that he had self-employment information available and could have supplied it to the Respondent, but the information was not requested. Pursuant to the policy, when requesting verification, the Respondent must list all required verification known at the time, accept any reasonable documentary evidence as verification, and not require a specific kind or source of verification. The verification checklist was not provided for evidentiary review and the Respondent's representative did not have the checklist present for review during her testimony. During the hearing, the Respondent's representative was unable to provide information regarding the specific wording of the verification checklist.

As the verification checklist was not supplied for evidentiary review and the Respondent's representative's testimony was unreliable regarding the verification requested, it cannot be affirmed that the Appellant failed to comply with submitting requested verifications by the due date.

Remand

Because sufficient information was not supplied during the hearing to make a de novo determination regarding the amount of the Appellant's income, pre-tax income deductions, and post-tax income deductions, the Respondent's denial cannot be affirmed, and the matter must be remanded for a new determination. When conducting a re-evaluation of the Appellant's income eligibility, the Respondent must determine whether a 5% income disregard should be applied.

As the Appellant informed the Respondent of employer sponsored health coverage, the Respondent must determine if the Appellant is eligible for a pre-tax health insurance premium deduction. The submitted evidence failed to demonstrate the Respondent applied the contributions made to the Appellant's 401(k); therefore, the Respondent must verify the amount of pre-tax contributions made, and apply deductions as stipulated in WVIMM § 4.7.2.A.

The Respondent must determine whether the Appellant's Traditional IRA contributions were made from pre-tax income or made post tax. As post-tax Traditional IRA contributions may be eligible to be treated as a deduction on the Appellant's tax return, the Respondent will need to determine whether the conditions of the Appellant's IRA contributions are eligible for deduction according to WVIMM § 4.7.2.B.

Because the preponderance of evidence demonstrated that the Respondent did not verify the Appellant's self-employment income amount, self-employment expenses, or calculate the Appellant's countable self-employment income according to WVIMM §§ 4.7.5.A.1, 4.7.5.A.2, and 4.7.5.E, the matter must be remanded for verification to determine the regularity and amount of the Appellant's self-employment income.

CONCLUSIONS OF LAW

- 1) To be eligible for Adult Group Medicaid benefits, the Appellant's income could not exceed \$1,735.
- 2) The preponderance of evidence revealed that the Respondent did not consider the Appellant's pre-tax deductions for health insurance premiums or contributions to 401(k) retirement accounts.
- 3) The preponderance of evidence revealed that the Respondent did not evaluate whether the Appellant's Traditional IRA contributions or self-employment tax was eligible for deduction.
- 4) The preponderance of evidence established that the Respondent failed to verify the regularity or gross profit amount of the Appellant's self-employment income and did not consider the Appellant's self-employment expenses.
- 5) The preponderance of evidence failed to prove that the Appellant's income exceeded the eligibility limit in December 2025.
- 6) Because the submitted evidence failed to verify the Appellant's income amount, the matter must be remanded for new income verification, and calculation of the Appellant's income with consideration of the Appellant's pre-tax deductions, IRA contributions, and self-employment expenses.
- 7) As the evidence failed to demonstrate the Appellant's income exceeded the eligibility limit, the Respondent incorrectly terminated the Appellant's Adult Medicaid benefits after January 31, 2026, due to her income exceeding the eligibility limit.
- 8) The due date entered on the DFA-6 must be at least 10 days from the date of issuance.
- 9) If a client fails to supply requested verification by the deadline, the client's eligibility may be denied.
- 10) The preponderance of evidence proved that the Respondent denied the Appellant's Adult Group Medicaid eligibility before the 10-day verification period had ended.
- 11) The submitted evidence failed to establish what verification was requested of the Appellant.
- 12) As the preponderance of evidence failed to prove that the Appellant failed to supply requested verification by the deadline, the Respondent incorrectly terminated the Appellant's Adult Medicaid benefit eligibility after January 31, 2026.
- 13) Because the Respondent incorrectly terminated the Appellant's Adult Medicaid eligibility after January 31, 2026, the Appellant's benefits must be retroactively restored and a new determination must be made regarding the Appellant's income eligibility.
- 14)

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decision to terminate the Appellant's Adult Group Medicaid benefits after [REDACTED]. The matter is **REMANDED** to verify the amount of the Appellant's income, pre-tax income deductions, and post-tax income deductions, and for a new eligibility decision with consideration to the supplied verifications.

ENTERED this 24th day of February 2026.

**Tara B. Thompson, MLS
Certified State Hearing Officer**