



April 7, 2026

[REDACTED]

RE: [REDACTED] v. WV DoHS/BFA
ACTION NOS.: 26-BOR-1570 and 26-BOR-1571

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: Haley Cosner, DoHS

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

██████████
Appellant,

v.

**Action Numbers: 26-BOR-1570 and
26-BOR-1571**

**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 April 1, 2026.

The matter before the Hearing Officer arises from the Respondent's decision on March 11, 2026, to deny the Appellant's eligibility for the Low-Income Energy Assistance Program (LIEAP), and decision on February 3, 2026, to deny the Appellant's eligibility for Medicare Premium Assistance.

At the hearing, the Respondent appeared by Haley Cosner, DoHS. The Appellant appeared and was self-represented. All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

NONE

Appellant's Exhibits:

- A-1 U.S. Individual Income Tax Return 2024, Form 1040 and Schedule C
Appellant's Email Correspondence, dated February 12, 2026
- A-2 U.S. Individual Income Tax Return 2023, Form 1040 and Schedule C
- A-3 West Virginia Income Maintenance Manual Chapter 7 excerpts
- A-4 Appellant's Email Correspondence, dated January 27, 2026
Fair Hearing Request Forms
- A-5 Appellant's Email Correspondence, dated November 7, 2025

- DoHS Verification Checklist, dated October 24, 2025
Appellant's written statement, dated October 7, 2025
Paystubs, dated March 21, March 28, April 4, and April 11, 2025
Estimated Income Statement for ██████████ LLC
- A-6 DoHS Notice, dated March 11, 2026
DoHS Notice, dated February 3, 2026
DoHS Notices, dated November 5, 2026

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

LIEAP

- 1) The Appellant resides in a four-person household that includes the Appellant, his wife Mrs. ██████████ and their mutual children, Child ██████████ and Child ██████████ (Exhibit A-6).
- 2) On March 11, 2026, the Respondent denied the Appellant's eligibility for LIEAP because he did not provide all information needed (Exhibit A-6).
- 3) The *Statement of Calculation* on the notice issued on the March 11, 2026 reflected \$2,451 total countable income (Exhibit A-6).
- 4) On February 12, 2026, the Appellant submitted a copy of his 2024 Schedule C form via email (Exhibit A-1).
- 5) On October 24, 2025, the Respondent requested the Appellant submit, "proof of gross earned income, such as paystubs/employer statements/██████████ 03-21-2025; 03-28-2025; 04-04-2025; 04-11-2025," by November 2, 2025 (Exhibit A-5).
- 6) On November 7, 2025, the Appellant submitted paystubs to verify Mrs. ██████████ earned income in March and April 2025, Estimated Income Statements to verify self-employment from January through March 2025 (Exhibit A-5).

Medicare Premium Assistance

- 7) On February 3, 2026, the Respondent issued a notice advising the Appellant his Medicare Premium Assistance was denied because his income exceeded the eligibility limit (Exhibit A-6).
- 8) The *Statement of Calculation* provided on the February 3, 2026 notice reflected \$0 gross earned income and \$1,678.90 gross unearned income. The Respondent applied a \$1,469.28 "\$65 ½ Disregard" and a \$20 Disregard, to arrive at the Assistance Group's (AG) countable net income of \$3,063.18 (Exhibit A-6).

APPLICABLE POLICY

LIEAP

West Virginia Income Maintenance Manual (WVIMM) § 21.1 *Introduction* provides in relevant sections:

The Low-Income Energy Assistance Program (LIEAP) provides financial assistance to eligible Assistance Groups (AGs) responsible for a home heating cost. It is not the purpose of this program to meet the entire cost of home heating during the winter season; it is designed to partially offset the cost.

The program is time-limited and dependent on the availability of federal funds. It is subject to closure without prior notice when funds are deemed to have been exhausted.

WVIMM § 21.3.1 *Regular LIEAP* provides specifies in relevant parts: LIEAP eligibility is based on income, AG size, vulnerability to the cost of home heating, residence, and citizenship.

WVIMM § 23.3.1.A *Income*, § 21.3.1.A.1 *Determining the Month Income is Counted*, and § 23.3.1.A.2 *Determining Gross Monthly Income* provide that the total monthly gross income of the AG must not be more than the maximum allowable gross income amounts in the chart in Chapter 4, Appendix A. No income deductions or disregards apply, except in the determination of gross profit for self-employment. When the gross monthly income of the AG exceeds the maximum allowable income amounts, the group is eligible for LIEAP and the application is denied.

Income received or expected to be received during the month of application is used to determine eligibility. When the AG has income which is received on a regular basis and no changes are expected during the application month, the amount of earned and unearned income from each source must be converted to a monthly amount as follows:

- Convert weekly income by multiplying 4.3
- Convert biweekly (every two weeks) income by multiplying by 2.15
- Convert semimonthly (twice per month) income by multiplying 2...

WVIMM § 21.3.1.A.3 *Sources of Income* provide that all sources of income are considered in determining income eligibility.

- Self-employed clients are entitled to a 20% deduction from gross sales or receipts to determine monthly gross income.

WVIMM Chapter 4, Appendix A *Income Limits* provides that for a four-person AG, \$4,720 is the LIEAP income limit.

Verification

WVIMM § 7.2.1 *When Verification is Required* provides that verification of a client's statement is required when:

- Policy requires routine verification of specific information

- The information provided is questionable. To be questionable, it must be:
 - Inconsistent with other information provided; or
 - Inconsistent with information in the case file; or
 - Inconsistent with information received by DoHS from other sources; or
 - Incomplete; or
 - Obviously inaccurate; or
 - Outdated
- Past experiences with the client reveals a pattern of providing incorrect information or withholding information. A case recording must substantiate the reason the Worker questions the client's statement.
- The client does not know the required information

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 verification ... The client is expected to provide information to which he has access and to sign authorizations needed to obtain other information.

Failure of the client to provide necessary information or to sign authorizations for release of information results in denial of the application or closure of the active case, provided the client has access to such information and is physically and mentally able to provide it.

For Medicaid Coverage Groups and WV CHIP Only:

- Client self-attestation is verified by electronic data sources.
- The client must not be required to provide verification unless information cannot be obtained electronically or by self-attestation, and electronic data sources are not reasonably compatible.

Refusal to cooperate, failure to provide necessary information, or failure to sign authorizations for release of information, provided the client has access to such information and is physically and mentally able to provide it, may result in one of the following:

- Denial of the application
- Closure of the assistance group (AG)
- Determination of ineligibility
- Disallowance of an income deduction or an incentive payment

No case may be determined ineligible when a person outside the AG or income group (IG) fails to cooperate with verification.

WVIMM § 7.2.4 *Worker Responsibilities* provides that the Worker had the following responsibilities in the verification process:

- 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

WVIMM § 7.3 Verification Requirements provides that for all programs, earned income must be verified prior to initial approval, at application, and at redetermination. Potential sources of earned income must verify source and amount, and include paystubs, written statement from employer, and self-employment records. For all programs, unearned income must be verified prior to initial approval, at redetermination, and when a change in the source amount is reported. Potential sources of unearned income must verify source and amount, and include award letters, computer matches, written statements from source, and eligibility system data exchanges.

WVIMM § 9.2.1 DFA-6, Notice of Information Needed 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 her application will be denied, or a deduction disallowed, if she 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.

WVIMM § 9.2.1.C Medicaid and Chip provides that 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. See Due Date of Additional Information in Section 1.6.4.

WVIMM § 21.4.9 LIEAP Verification provides that verification is the process of documenting statements and information provided by the client The Worker may request verification of any information provided by the client in determining eligibility for LIEAP benefits ... The Worker must decide when and what information must be verified or when additional information must be obtained, particularly when information provided by the client is questionable or more information is needed to complete the eligibility determination or payment process.

Failure or refusal on the part of the client to obtain verification when required or requested by the Worker as outlined in the instructions below will result in a denial of the application. Income from all sources for the AG must be verified when the client indicates a source of income for any AG member. Documentation may include paycheck stubs, award letters, and written statements from employers.

Although documentation should include earnings from the month of application, the Worker may use paycheck stubs and other documents showing earnings during the month prior to the month of

application, provided the client indicates no change is expected. No verification from an earlier period is used.

Medicare Premium Assistance

WVIMM § 4.3 *Charts of Income Sources*, Chart 1 lists sources of income and how they are treated for Medicare Premium Assistance Groups:

73. *Retirement, Survivors, and Disability Insurance* (RSDI) is counted as unearned income. Count the amount of the client's entitlement. This includes any amount deducted for Medicare, if applicable.

82. *Social Security Payments* are counted as unearned income (See RSDI).

85. *Supplemental Security Income* (SSI) is not counted when determining Medicare Premium Assistance eligibility.

WVIMM § 3.15.2.C *Eligible Individual with Ineligible Spouse* provides that the Respondent must consider the income of the ineligible spouse to determine if it must be deemed. See Chapter 4.

WVIMM § 4.6.1. *Consideration of Past Income* provides that the Worker must follow the steps provided for each old income source. The year-to-date amounts on check stubs may only be used when the client has verification of all payment amounts whether used or not but is missing one.

Step 1: Determine the amount of income received by all persons in the Income Group (IG) in the 30 calendar days prior to the application date. The appropriate time is determined by counting back 30 days beginning with the calendar day prior to the date of application. The income from this 30-day period is the minimum amount of income that must be considered. When in the Worker's judgement, future income may be more reasonably anticipated by considering the income from a longer period, the Worker considers income for the time period he determines to be reasonable. Whether the Worker considers income from the prior 30 days, or from a longer period, all the income received from that source during that time period must be considered. All pay periods during the appropriate time must be considered and must be consecutive

WVIMM § 4.12.1 *Medicaid for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLIMB), or Qualifying Individuals (QI-1) — Determining Eligibility* provides that countable income is determined by subtracting any allowable disregards and deductions from the total countable gross income as follows:

Step 1: Determine the total countable gross unearned income ...

Step 2: Determine the total countable gross earned income ...

Step 3: Add the results from Step 1 and Step 2 to achieve the total monthly countable income

Step 4: Compare the amount in Step 3 to the QMB, SLIMB, or QI-1 income levels ...

If the amount is less than or equal to the QMB, SLIMB, or QI-1 income levels, the client is eligible.

The following Medicare Premium Assistance income eligibility limits for a one-person Assistance Group (AG), as consistent with Appendix A:

- QMB- Income is less than or equal to 100% FPL
- SLIMB- Income is greater than 100% FPL, but less than or equal to 120% FPL.
- QI-1- Income is greater than 120% FPL, but less than or equal to 135% FPL.

WVIMM § 4.12.2.A *Self-Employment* provides that gross profit is determined the same way it is for Aid to Families with Dependent Children (AFDC)-Related Medicaid. See Section 4.16.

WVIMM § 4.16.4.A *Aid to Families with Dependent Children (AFDC)-Related Medicaid, Special Situations, Income from Self-Employment and § 4.16.4.A.2 *Determining Gross Profit** provides that when the AG member receives self-employment income, the instructions below must be used to arrive at the gross profit, which is used to calculate countable income. This is determined by subtracting allowable business expenses from the gross income Gross profit from self-employment is the remaining income after deducting any identifiable costs of doing business from the gross income.

DISCUSSION

The Respondent denied the Appellant’s eligibility for LIEAP because he did not submit all requested information by the required date. During the hearing, the Appellant contended that he submitted the information that he was requested to submit, and argued that he did not receive the Respondent’s verification checklist that specified certain documents must be submitted to verify the household’s 2026 income. During the hearing, the Respondent’s representative argued that the Appellant’s LIEAP was denied because he submitted 2025 income verification, not the requested income verification from the preceding 30 days.

During the hearing, the Respondent’s representative testified that the Appellant’s Medicare Premium Assistance benefits were denied and that all possible MAGI deductions were applied to the Appellant’s income. However, the Respondent’s representative also testified that if the Appellant had submitted verification of 2026 income, then he may have been found income eligible. The notice denying the Appellant’s Medicare Premium Assistance eligibility only reflected the income amount as the basis for the denial, not a failure to supply verification of his income. The Appellant argued that the Respondent miscalculated his income amount and that he should be income eligible.

Authority has not been granted to the Board of Review to change the income limits established by the policy. The Hearing Officer cannot judge the policy and can only determine if the Respondent followed the policy when deciding the Appellant’s eligibility for LIEAP and Medicare Premium Assistance. The Respondent bears the burden of proof and had to demonstrate by a preponderance of evidence that the Appellant was correctly denied LIEAP due to a failure to submit requested verifications, and that Medicare Premium Assistance eligibility was correctly denied because the AG’s income exceeded the eligibility limit.

Both parties were provided with an opportunity to submit documentary evidence to support their case. The Respondent did not submit any case comments, copies of notices, calculation sheets, or other documentary evidence. Pursuant to the Appellant’s evidence, he submitted 2025 income

verification to the Respondent in November 2025, in response to the Respondent's October 2025 request for paystub verification. The Respondent's reason for basing the Appellant's eligibility on this income verification is unclear.

The Appellant's evidence contained copies of the Respondent's November 5, 2025, denials of Medicaid eligibility for the Appellant and Mrs. [REDACTED]. That issue was not addressed during this hearing and is scheduled for a separate hearing.

LIEAP

The Respondent's representative testified that a verification checklist was issued on February 17, 2026, requesting that the Appellant submit paystubs to verify the household's income by March 4, 2026; however, the Appellant argued he did not receive a verification checklist for either program, or he would have provided records as requested. The Appellant's testimony and email to the Respondent on February 12, 2026, indicated that he was submitting his Schedule C because the Respondent had requested it from him on that day.

Documentary evidence was not provided to corroborate the Respondent's issuance of a *Notice of Information Needed*. As the preponderance of evidence did not verify that the Respondent requested income verification according to the policy, the Respondent's denial of the Appellant's LIEAP eligibility cannot be affirmed.

Medicare Premium Assistance

During the hearing, the Respondent's representative testified that the Appellant applied for Medicare Premium Assistance on February 4, 2026, and that income from the thirty preceding days was required to establish eligibility. However, the Respondent's denial notice was dated February 3, 2026, a day before the date of application asserted by the Respondent. The Appellant's application was not provided for review. During the hearing, the Respondent's representative testified that if current paystubs had been received to verify Mrs. [REDACTED] earned income, the Appellant may have been eligible. No evidence was submitted to indicate that verification of Mrs. [REDACTED] income had been requested to establish Medicare Premium Assistance eligibility. During the hearing, the Respondent's representative could not state which type of Medicare Premium Assistance the Appellant was denied.

Testimony by the Respondent's representative indicated that the Respondent relied on WVIMM § 4.12.2.A and § 4.7.5.A.2 when making the Appellant's eligibility decision; however, § 4.7.5.A.2 relates to determining gross profit for MAGI Medicaid groups, not Medicare Premium Assistance. WVIMM § 4.12.2.A instructs the Respondent to see § 4.16 for instructions regarding self-employment income. Pursuant to that section, the Respondent is provided with instructions for deducting allowable business costs and arriving at the gross profit amount. According to the testimony provided, the verified type of unearned income received by the Appellant was not clarified.

Pursuant to the policy, the Respondent must consider the amount of income received by all people in the income group (IG) in the thirty days before the application date. The Respondent's representative testified that the AG's 2025 paystubs were entered to determine Medicare Premium

Assistance eligibility, which was denied. However, the February 3, 2026, *Statement of Calculation* reflects \$0 earned income. The submitted evidence was insufficient to establish how the Respondent arrived at a countable net income of \$3,063.18, and failed to verify that the AG's income from the 30 days preceding the application date was requested for consideration.

Testimony provided by the Respondent's representative was insufficient to determine what amount of income was used to determine the Appellant's eligibility for Medicare Premium Assistance. The preponderance of evidence failed to establish that the Respondent followed the policy when assessing the AG's income and determining the Appellant's Medicare Premium Assistance eligibility. Therefore, the matter must be remanded for issuance of a new request for income verification for the thirty days preceding the application, and a new determination of the Appellant's eligibility for Medicare Premium Assistance.

CONCLUSIONS OF LAW

- 1) The Respondent may deny Medicare Premium Assistance when the AG's income exceeds the eligibility limit.
- 2) The preponderance of evidence failed to establish a reliable amount of income for the AG.
- 3) Because the evidence failed to establish a reliable amount of income for the AG, the Respondent's decision to deny the Appellant's Medicare Premium Assistance eligibility was incorrect, and the matter must be remanded for proper evaluation of the Appellant's income eligibility for Medicare Premium Assistance.
- 4) At the time of application, the *DFA-6 Notice of Information Needed* is provided to the applicant to notify him of information or verification he must supply to establish eligibility.
- 5) For all programs earned and unearned income must be verified prior to initial approval, at application, and redetermination. When a client fails to provide necessary information, the Respondent may deny the application or close the active case, provided the client has access to such information and is physically and mentally able to provide it.
- 6) Because the preponderance of evidence failed to verify that the Respondent issued a verification checklist to the Appellant to verify his income, the Respondent's decision to deny his eligibility for LIEAP due to failure to submit requested verification cannot be affirmed.

DECISION

It is the decision of the State Hearing Officer to **REVERSE** the Respondent's decisions to deny the Appellant's eligibility for LIEAP and Medicare Premium Assistance. The matter is **REMANDED** for issuance of a *Notice of Information Needed* to verify the AG's income, and for evaluation of the Appellant's income eligibility based on the verification provided.

ENTERED this 7th day of April 2026.

Tara B. Thompson, MLS
Certified State Hearing Officer