WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted]

Appellant,

v. **Action Number: 26-BOR-2371**

WV 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 August 25, 2026.

The matter before the Hearing Officer arises from the June 26, 2026 decision by the Respondent to deny the Appellant's April 26, 2026 application for Long-Term Care (LTC) Medicaid benefits.

At the hearing, the Respondent appeared by Julie Haines, Economic Service Worker, LTC unit. Appearing as a witness for the Respondent was Alicia Lyons, Economic Service Supervisor, LTC unit. The Appellant was not present but was represented by [redacted]. Appearing as a witness for the Appellant was [redacted] the Appellant's granddaughter. The witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

- D-1 Case Overview
- D-2 Quarterly Statement, Resident Fund Statement ([redacted]), January 1 thru March 31, 2026; [redacted] Bank Statement ([redacted], December 15, 2025 thru January 14, 2026; [redacted] Bank Statement ([redacted], December 9, 2025 thru January 8, 2026
- D-3 Screen print of Assets Determination Summary from PATH IE Production
- D-4 WV Income Maintenance Manual (IMM) Chapter 24, §24.8
- D-5 WV IMM Chapter 5, §5.4
- D-6 WV IMM Chapter 5, §5.3.1.B (excerpt)

D-7 Screen print of email exchanges: between [redacted] Drema Berry and Cynthia Brown dated July 1, 6, 7, 15, 2026

D-8 Quarterly Statement, Resident Fund Statement ([redacted]), January 1 thru March 31, 2026; [redacted] Bank Statement [redacted]), February 15 thru March 4, 2026; [redacted] Bank Statement ([redacted], February 7 thru March 6, 2026

Appellant's Exhibits:

A-1 Fair Hearing Request form (IG-BR-29; Notice of Decision dated June 26, 2026; DFA-FH-1 signed and dated July 17, 2026

A-2 Complete Care at [redacted] resident ledger, statement date July 8, 2026

A-3 [redacted] Bank Statement ([redacted], January 9 thru February 6, 2026

A-4 [redacted] Bank Statement ([redacted]), February 7 thru March 6, 2026

A-5 [redacted] Bank Statement ([redacted], March 7 thru April 8, 2026

A-6 [redacted] Bank Statement ([redacted], April 9 thru May 8, 2026

A-7 [redacted] Bank Statement ([redacted], May 9 thru June 8, 2026

A-8 [redacted] Bank Statement ([redacted]), June 9 thru July 8, 2026

A-9 [redacted] Bank Statement ([redacted]), March 15 thru April 14, 2026

A-10 [redacted] Bank Statement ([redacted]), April 15 thru May 14, 2026

A-11 [redacted] Bank Statement [redacted]), May 15 thru June 14, 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

1) The Appellant is a resident at [redacted] a nursing facility.

2) On April 28, 2026, the Respondent received an application for Long-Term Care (LTC) Medicaid for the Appellant. Backdating for three months was requested.

3) On May 26, 2026, the Respondent's worker processed the April 2026 application.

4) As part of the Respondent's request for verifications, the Appellant's January and February March 2026 bank statements were submitted and were processed on June 25, 2026 by the Respondent's worker. (Exhibits D-2, D-8)

5) On June 26, 2026, the Respondent issued a denial of the Appellant's April 2026 LTC Medicaid application based on excessive assets with calculated assets of $2,999.71 for the month of January 2026. (The denial notice is part of the administrative record)

6) The Appellant subsequently reapplied for LTC Medicaid benefits in July 2026 and was approved beginning April 2026.

7) The Appellant's representative conceded that the Appellant was over the allowable asset limit for the months of January and February 2026 but asserts that the Appellant was under the asset limit in the month of March.

APPLICABLE POLICY

WV IMM, Chapter 1, §1.2.8 Completion of the Application Process: The application process is completed when the following have occurred:

1) The Worker has:
   - Approved the application when all eligibility requirements are met; or
   - Denied the application when at least one eligibility requirement is not met, or the client has failed to establish eligibility.
2) The client is notified of the action taken.

The client receives his initial benefit, if eligible.

WV IMM, Chapter 24, §24.4.1.C.6 Agency Time Limits: The Worker must give the applicant at least 10 days for any requested information to be returned. The Worker must take eligibility system action to approve, deny, or withdraw the application within 30 days of the date of application.

WV IMM, Chapter 24, §24.4.1.C.7 Agency Delays:

If the DOHS failed to request necessary verification, the Worker must immediately send a verification checklist or form DFA-6 and DFA-6a, if applicable, to the client and note that the application is being held pending. When the information is received, benefits are retroactive to the date eligibility would have been established had the DOHS acted in a timely manner.

If the DOHS simply failed to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the DOHS acted in a timely manner.

For these cases, timely processing may mean acting faster than the maximum allowable time. If an application has not been acted on within a reasonable period of time and the delay is not due to factors beyond the control of the DOHS, the client is eligible to receive direct reimbursement for out-of-pocket medical expenses. See Chapter 10.

WV IMM, Chapter 24, §24.4.1.C.10 Beginning Date of Eligibility, in part:

Medicaid Eligibility

Medicaid eligibility begins on the first day of the month in which eligibility is established. Eligibility may be backdated up to three months prior to the month of application, when all eligibility requirements were met, and the client has medical expenses for which he seeks payment.

WV IMM, Chapter 9, §9.2 NOTIFICATION OF ACTION TAKEN ON AN APPLICATION

§9.2.4.B Denials, in part:

The Worker completes the DFA-NL-A by indicating:

- The program for which benefits are being denied
- The reason for denial
- The name of the person whose income, assets, or other circumstances prevent approval
- The Manual section on which the denial is based.

If the denial is due to excessive assets, the notification letter must specify:

- The asset limit
- The total value counted for all the client's assets

WV IMM, Chapter 5, §5.4 Maximum Allowable Assets are $2,000 for a one-person assistance group for SSI-Related Medicaid, AFDC-Related, Medicaid, PAC, and CDCSP categories.

DISCUSSION

An application for Long-Term Care (LTC) Medicaid for the Appellant was received by the Respondent on April 28, 2026, and was processed on May 26, 2026. Backdating coverage for three months was requested. The Respondent's worker determined that the Appellant was over the allowable asset limit for the months of January and February 2026. On June 26, 2026, the Respondent issued a denial notice to the Appellant citing income in excess of 300% of the SSI limit but less than the facility's monthly Medicaid rate in addition to the amount of assets being more than is allowed for the benefit.

The Appellant appeals the Respondent's decision. The Respondent must show by a preponderance of evidence that it followed the policy in determining that the Appellant was ineligible for LTC Medicaid benefits.

The Appellant's representative, [redacted] conceded that the Appellant was over the allowable asset limit for the months of January and February 2026. However, [redacted] contends that the Appellant was asset-eligible for the month of March 2026. It was noted during the hearing that the Appellant reapplied for LTC Medicaid benefits in July 2026 and was approved beginning April 2026.

[redacted] asserted that had the Appellant received the denial letter earlier, she would have been eligible for March 2026. The Respondent's representative, Julie Haines, explained that because there was a need for more verifications, the application could not have been completed until after all the verifications were received. However, in reviewing the submitted verifications for March, Ms. Haines testified that the Appellant still would have been over the asset limit for March.

Action on Application

Per policy, action must be taken in the eligibility system to approve, deny, or withdraw an LTC application within 30 days of the date of application. If the Respondent simply fails to act promptly

on the information already received, benefits are retroactive to the date **eligibility would have been established** had the Respondent acted in a timely manner. The evidence presented was unclear regarding when the Appellant's asset verifications were requested or received. However, the testimony and documentary evidence presented clearly shows that had the Respondent's worker taken action to approve or deny the application within the 30-day timeframe as mandated by policy, the Appellant would not have been eligible for the month of March.

Eligibility is established on the first day of the first month in which eligibility is established. Thus, the Appellant's assets would have had to be under the $2,000 allowable asset limit on March 1, 2026, for an assistance group of one. They were not.

The documentary evidence showed that the Appellant's [redacted] Bank Account [redacted] had a balance of $2,684.07, less $360.50 pension income, which leaves a balance of $2,323.57 at the end of February with the next movement in the account as a money transfer from [redacted] Bank Acct [redacted] on March 5, 2026. The total of account [redacted] alone puts the Appellant over the asset limit for March eligibility. The Appellant had another [redacted] Bank Account, [redacted] which showed a balance of $309.86, less $299.93 pension income, which leaves a balance of $9.93 at the end of February with the next movement in the account as a money transfer to [redacted] Bank Account [redacted] on March 5, 2026. Thus, the total amounts in the Appellant's [redacted] Bank accounts on March 1, 2026, was $2,333.50. The Appellant also had a Resident Fund which showed a balance of $100 as of February 3, 2026, with no activity until March 3, 2026. Consideration of the March 3, 2026 balance of $2,331 is irrelevant since the Appellant's balance in the Resident Fund as of March 1, 2026, of $100 is only counted for consideration of her March eligibility, as per policy. The Appellant was over the allowable asset limit of $2,000 for LTC Medicaid eligibility for the month of March 2026.

Notification of Action Taken

Policy requires that notification be issued to an applicant indicating the program for which benefits are being denied, the reason for denial, the name of the person whose income, assets, or other circumstances prevent approval, and the Manual section on which the denial is based. Additionally, if the denial is due to excessive assets, the notification letter must specify the asset limit and the total value counted for all the client's assets. The evidence was unclear whether a denial notice for the month of February was issued as required by policy. However, regarding the month of March 2026, Ms. Haines testified that because the Appellant was found to be ineligible for two consecutive months, the computer system does not issue a denial for the third month. This does not seem to align with policy requirements.

The documentary evidence showed that the submitted documents for the application prior to the June 26, 2026 denial did not include the banking information for March eligibility determination, which was not submitted until July 2026. As discussed above, the evidence showed that the Appellant would not have been asset-eligible for the month of March 2026. Because the Appellant exercised her right for an appeal of the April 2026 LTC Medicaid application denial (conceding the Respondent's asset determinations for January and February 2026), the failure of the Respondent to issue a proper denial notice for March 2026 did not prejudice the Appellant.

The Respondent failed to approve or deny the Appellant's April 28, 2026 LTC Medicaid application within the policy mandated timeframe of 30 days. Policy states that agency delays based on a failure to act on information already received within the 30-day timeframe require benefits be retroactive to the date eligibility would have been established had the Respondent acted in a timely manner. However, the documentary evidence suggests that the information needed for March 2026 eligibility determination was not received until after the June 26, 2026 denial. Additionally, based on the evidence presented, the Appellant would not have been asset-eligible for the month of March 2026. Because the Appellant was not asset-eligible for the month of March, the Appellant cannot be granted LTC benefits retroactive to March 2026, based on the Respondent's delay.

CONCLUSIONS OF LAW

1) Policy states that the worker must take eligibility system action to approve, deny, or withdraw a LTC Medicaid application within 30 days of the date of application.

2) The Appellant applied for LTC Medicaid on April 28, 2026, however action to deny the application was not taken until June 26, 2026.

3) The Appellant does not contest the eligibility determinations for the months of January and February 2026.

4) Policy allows that if the Respondent delays to act promptly on the information already received, benefits are retroactive to the date eligibility would have been established had the Respondent acted in a timely manner.

5) It is unclear when, if any, requested information was received, however, the Respondent did not take eligibility system action to approve or deny the Appellant's application within the 30-day timeframe.

6) Because the Appellant would not have been asset-eligible for the month of March 2026, the LTC Medicaid benefit cannot be retroactive to March based on the agency delay.

7) Policy requires that notification be issued to an applicant indicating the program for which benefits are being denied, the reason for denial, the name of the person whose income, assets, or other circumstances prevent approval, and the Manual section on which the denial is based. If the denial is due to excessive assets, the notification letter must specify the asset limit and the total value counted for all the client's assets.

8) Although the evidence was unclear whether the Respondent issued a denial notification for the month of February 2026 determination, it clearly did not issue a denial notification for the month of March 2026.

9) The Appellant's rights to be heard on the issues of the February and March determinations were not prejudiced by the lack of notification by the Respondent.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the Respondent's action to deny the Appellant's April 28, 2026 LTC Medicaid application.

ENTERED this 2nd day of September 2026.

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Lori Woodward**,** Certified State Hearing Officer