WEST VIRGINIA OFFICE OF INSPECTOR GENERAL
BOARD OF REVIEW

[redacted],

Appellant,

v. **Action Number: 26-BOR-2675**

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 September 30, 2026, on an appeal filed on September 3, 2026.

The matter before the Hearing Officer arises from the Respondent's denial of the Appellant's application for the Aged and Disabled Waiver Medicaid program.

At the hearing, the Respondent appeared by Tracey Grassi, Economic Service Worker, Department of Human Services. Appearing as a witness for the Respondent was Alicia Lyons, Department of Human Services. The Appellant was not present and was represented by her son, [redacted] All witnesses were placed under oath, and the following documents were admitted into evidence.

Department's Exhibits:

D-1 Summary of events related to this case
D-2 WV Department of Health and Human Resources Referral Form for Medicaid Aged and Disabled Waiver Program Potential Financial Eligibility from ACENTRA to Berkeley Department of Human Services scanned on June 17, 2026, and WV Department of Health and Human Resources Referral Form for Medicaid Aged and Disabled Waiver Program Potential Financial Eligibility with Economic Service Worker Response dated July 31, 2026
D-3 Application for Long Term Care Medicaid and Children with Disabilities Community Service Program for [redacted] dated June 25, 2026
D-4 Verification Checklist from Department of Human Services (DoHS) to [redacted] dated June 29, 2026, with due date of July 8, 2026

D-5 Notice from DoHS to [redacted] dated July 13, 2026, that the application for Medicaid was denied
D-6 West Virginia proof of registration of a 1997 GMC/PK and West Virginia Certificate of Title to a Motor Vehicle identified as a 2012 Ford CW
D-7 Written statement by [redacted] dated December 30, 2024
D-8 Proof of surrender of a [redacted] Life Insurance Company policy with check date April 7, 2026, and a [redacted] policy dated May 1, 2026
D-9 Notice from DoHS to [redacted] dated July 28, 2026, that information is still required to evaluate for eligibility the Aged and Disabled Waiver Program
D-10 West Virginia Income Maintenance Manual Section 7.2.3
D-11 Hearing Request dated July 21, 2026

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) On June 17, 2026, the Respondent received a yellow DHS-2.FRM form from ACENTRA titled "Referral Form for Medicaid Aged and Disabled Waiver Program Potential Financial Eligibility," that indicated that the Appellant had applied for the Aged and Disabled Waiver (ADW) Medicaid program. (Exhibit D-2)

2) The expiration date on the DHS-2.FRM form was July 20, 2026. (Exhibit D-2)

3) The Appellant submitted an Application for Long Term Care Medicaid on June 25, 2026, on which she reported one (1) checking account asset. (Exhibit D-3)

4) On June 29, 2026, the Respondent notified the Appellant by mail that documentation was necessary to determine her eligibility. The documents requested were proof of life insurance policy cash surrender value, proof of the value of personal property of unusual value, and proof of identity, due by July 8, 2026. The notice also requested documentation of proof of citizenship, due by September 26, 2026. (Exhibit D-4)

5) The June 29, 2026, notice states, "You must get the information to our office by the due date. If you do not, your benefits may be denied or closed." (Exhibit D-4)

6) On July 6, 2026, the Appellant submitted bank statements, proof of identity, and proof of authorized representative. (Exhibit D-1)

7) On July 10, 2026, the Appellant had not returned proof of life insurance policy cash surrender value and proof of the value of personal property of unusual value. (Exhibit D-1)

8) On July 13, 2026, the Respondent notified the Appellant that her application for ADW Medicaid was denied because she did not turn in all requested information. (Exhibit D-5)

9) On July 27, 2026, the Appellant submitted proof of registration of a vehicle, proof of title to a vehicle, cash surrender value of the life insurance policy, and a statement that farm equipment had been gifted. (Exhibit D-1, Exhibit D-6, Exhibit D-7, Exhibit D-8)

10) On July 28, 2026, the Respondent requested additional verification of the value of the farm equipment at the time it was gifted, and verification of how $13,920.14 received from cashing out the life insurance policy was spent. (Exhibit D-9)

11) On September 3, 2026, the Appellant submitted appraisals for the farm equipment, a pre-paid (irrevocable) burial contract from [redacted] Funeral Home, [redacted] bank statements, and a written statement of expenses. (Exhibit D-1)

APPLICABLE POLICY

West Virginia Income Maintenance Manual (IMM) Chapter 1 describes the Application/Redetermination Process. Section 1.2.10 describes Reapplications, in pertinent part:

1.2.10.B WV WORKS and Medicaid

If an applicant AG fails to provide the verifications requested on the DFA-6 or verification checklist within the specified time limit and the application is denied, the AG must be given an opportunity to have its eligibility established for up to 60 days from the date of application without completion of a new form.

If the client brings in the verifications before the 60-day period has expired, the Worker determines the AG's eligibility based on the original application, noting in Case Comments any changes which have occurred since the form was completed. If the application is approved, WV WORKS benefits are not retroactive to the date of application because the approval delay was the fault of the client. Benefits are issued from the date the client provides the verification. The Worker provides benefits using information reported during the original application and any other pertinent information provided prior to approval when the following conditions are met:

IMM Section 1.3.1 describes Common Application Forms for all programs, in pertinent part:

1.3.1.A.3 Related Forms

➢ **Request for Information and/or Verification Checklist DFA-6**

When the Worker does not have sufficient information to make a decision, it is necessary to complete form DFA-6 or verification checklist to inform the applicant of the additional information needed. All requests for verification must be made using the DFA-6 form and/or verification checklist.

The Worker must clearly state on the form what items must be returned by the applicant, as well as the date by which the information must be returned.

The applicant's failure to return information or the return of incomplete or incorrect information that prevents a decision from being made on the application will be considered failure to provide verification and will result in a denial of the application.

IMM Section 1.6.4 describes the Medicaid Application Process, in pertinent part:

1.6.4 Due Date of Additional Information
The client must be given at least 10 days after the date the verification checklist or DFA-6 is mailed to return the information.

IMM Chapter 5 describes Assets, in pertinent part:

5.3.1.B Supplemental Security Income (SSI) Medicaid Groups
The SSI Medicaid Groups include: SSI-Related Medicaid, CDCSP, PAC, QDWI, QMB, SLIMB, and QI1.

The asset eligibility determination for these applications must be made as of the first moment (defined as 12:00 a.m. of the first day) of the month of eligibility.

The client is not eligible for any month in which countable assets are in excess of the limit, as of the first moment of the month.

IMM Section 5.5.4 states that checking accounts are counted as assets for SSI Medicaid groups.

IMM Section 5.5.6.B states that burial spaces that are intended for the use of the client are excluded.

IMM Section 5.5.27 states that, for SSI Medicaid Groups, if the face value of all life insurance policies for one individual totals $1,500 or less, the cash surrender values are not counted as an asset. If the face value of all life insurance policies for an individual is in excess of $1,500, the cash surrender values are counted as an asset. The life insurance policy must be owned by the client or by a person whose assets are deemed to him to be counted. If the consent of another individual is needed to surrender a policy for its full cash surrender value, and the consent cannot be obtained, the policy is not an asset. Assignment of a life insurance policy to another individual means consent of that individual is required before it can be cashed.

IMM Section 5.5.48 states that vehicles are counted as assets for SSI Medicaid groups. The trade-in value is usually used as the current market value for SSI Medicaid Groups.

IMM Section 23.11.5 describes Specific Medicaid Requirements for Long Term Care

23.11.5.C Individuals Receiving Home and Community-Based Services under Title XIX Waivers

Income	Assets
300% SSI Payment Level	$2,000 Individual

The DOHS has elected to provide Medicaid to individuals who would be eligible for Medicaid if institutionalized and who would require institutionalization was it not for the availability of home and community-based services. To qualify, an individual must be aged/disabled, intellectually/ developmentally disabled, or have a traumatic brain injury. The waiver programs are:

- ADW (Aged and Disabled Waiver) (Code: MALH, MALW – pending waiver slot)
- I/DD (Intellectual/Developmental disability) Waiver (Code: MALM)
- TBI (Traumatic Brain Injury) Waiver (Code: MALH w/reason code 709)
- CSED (Children with Serious Emotional Disorder) Waiver (Code: MALM w/reason code 730)

Details about the AD (aged/disabled) Waiver, I/DD (intellectual/developmental disability) Waiver, CSED (Children with Serious Emotional Disorder) Waiver, and TBI (traumatic brain injury) Waiver are found in Chapter 24.

The determination of which income to count is the same as SSI-Related Medicaid, see Chapter 4. No income is deemed to the client. The client's monthly gross non-excluded income is compared to 300% of the maximum SSI payment for a single individual.

The determination of countable assets is the same as for SSI-Related Medicaid, see Chapter 5. The SSI-Related Medicaid asset limit for one person is used.

IMM Section 24.37 describes the Application/Redetermination process for the Aged and Disabled Waiver (ADW), in pertinent part:

24.37 Application/Redetermination

The West Virginia Department of Human Services (DOHS) Referral Form for Medicaid Aged and Disabled Waiver (ADW) Program, Initiate Financial Eligibility (DHS-2.FRM) must be presented to begin the ADW financial eligibility determination process.

The DHS-2.FRM form has two versions, one yellow and one white.

- The yellow DHS-2.FRM instructs the Worker to determine financial eligibility. Financial eligibility is determined for the ADW program before medical eligibility is initiated.
- The white DHS-2.FRM, along with the Notice of Decision letter, confirms the client is medically-eligible and that a funded waiver slot is available for the ADW program.

The steps in the application process are outlined in below.

24.37.2 STEPS IN THE APPLICATION PROCESS

Steps in the application process are as follows.

24.37.2.A Step One: Receipt of the DOHS Referral Form for Medicaid Aged and Disabled Waiver Program, Initiate Financial Eligibility (DHS-2.FRM) YELLOW FORM

The yellow DHS-2.FRM will originate from the ADW Utilization Management Contractor (UMC). The current UMC contact information is found in Appendix E.

The yellow DHS-2.FRM may be submitted by the client or a case management agency and instructs the worker to determine financial eligibility. The client must also submit an appropriate Medicaid application form. General application procedures above must be followed.

24.37.2.A.1 Expired Yellow DHS-2.FRM

If the yellow DHS-2.FRM is expired, the Worker checks the box indicating it is expired and faxes the form back to the ADW UMC.

24.37.2.A.3 Current (Not Expired) Yellow DHS-2.FRM

If the yellow DHS-2.FRM is not expired:

• The Worker completes the financial eligibility determination following the general application procedures above. A Medicaid application must be received by the Worker prior to the DHS-2.FRM expiration date.

24.37.2.A.4 Client Is Determined Financially Eligible

If the client is determined financially eligible for the ADW:

• The Worker confirms the pending ADW category. Financial eligibility for the ADW category is pended up to 90 days in the data system awaiting verification of medical eligibility and availability of a funded ADW slot. The client is notified by a system generated letter.

• The Worker checks the box on the yellow DHS-2.FRM indicating the client is financially eligible and faxes the form back to the UMC. This will initiate medical eligibility to be determined by the UMC.

24.37.2.A.5 Client Is Determined Financially Ineligible

If the client is determined financially ineligible for the ADW:

• The Worker checks the box on the yellow DHS-2.FRM indicating the client is ineligible and faxes the form back to the UMC.

• The Worker then evaluates for all other Division of Family Assistance (DFA) programs. The client will be sent a denial letter by the eligibility system.

24.37.2.B.3 Current (Not Expired) White DHS-2.FRM

If the white DHS-2.FRM is not expired:

• The Worker updates financial eligibility.

If ADW financial eligibility was determined in the last 90 days and is in pending status, the Worker updates the system and approves Medicaid ADW program eligibility.
o If more than 90 days have passed since financial eligibility was determined, the client must be reevaluated for financial eligibility. Medicaid ADW is not approved. The client must submit a new application prior to the expiration date on the white form.
• The Worker checks the appropriate box on the white DHS-2.FRM indicating whether the client is eligible or ineligible for Medicaid ADW and faxes the form back to the originating agency.
• The client has only 60 days after acquiring a waiver slot to establish eligibility and be enrolled in the waiver program, or they will lose their slot. Timely financial eligibility determinations are critical.

DISCUSSION

The Appellant has appealed the July 13, 2026 decision of the Respondent to deny her application for the Aged and Disabled Waiver (ADW) Medicaid program. The Respondent determined that the Appellant's application must be denied because she did not submit requested verifications by the due date. The Respondent bears the burden of proof and must show by a preponderance of the evidence that it correctly denied the Appellant's application.

The Aged and Disabled Waiver (ADW) Medicaid coverage group is one of many West Virginia Medicaid Programs that provide payment for covered medical services to certified medical providers for eligible individuals. ADW Medicaid is in a category called Long-Term Care services. The application process for ADW Medicaid is a multiple-step process which includes both financial and medical eligibility. The Respondent determines an applicant's financial eligibility, while medical eligibility is determined by other government entities and contracted agencies.

On June 17, 2026, the Respondent received a yellow DHS-2.FRM form indicating that the Appellant had applied for ADW Medicaid. The form had an expiration date of July 20, 2026. On June 25, 2026, the Appellant submitted the required Long Term Care Medicaid application. On June 29, 2026, the Respondent requested documentation including proof of life insurance policy cash surrender value, proof of the value of personal property of unusual value, and proof of identity. The documents were due July 8, 2026.

The Respondent was represented at the hearing by Tracey Grassi, Economic Service Worker. During the hearing, Ms. Grassi explained the multiple-step application process to the Appellant. Policy states that the countable assets of a one-person Aged/Disabled Waiver Medicaid Assistance Group must not exceed $2,000. Pursuant to policy, vehicles, life insurance policies, and bank accounts are counted as assets. The Respondent was required to determine if the Appellant's assets were under the eligibility limit.

Ms. Grassi testified that the Appellant was required to establish financial eligibility by submitting the appropriate Medicaid application form. Police explains that if the client does not submit the appropriate Medicaid application form prior to the yellow DHS-2.FRM expiration date, the Worker must check the box indicating the application was not completed and fax the form back to

ACENTRA. The preponderance of the evidence showed that the Appellant submitted the Medicaid application form on June 25, 2026, which was before the expiration date.

The Medicaid application submitted by the Appellant only listed one asset, "Checking Account(s)." On June 29, 2026, the Respondent requested documentation about the Appellant's life insurance policy cash surrender value and proof of the value of farm equipment, which was categorized as personal property of unusual value. The documents were due on July 8, 2026. According to policy, when a Worker does not have sufficient information to make a decision, it is necessary to complete form DFA-6 or verification checklist to inform the applicant of the additional information needed. The client must be given at least ten (10) days after the date the verification checklist or DFA-6 is mailed to return the information. The preponderance of the evidence showed that the Appellant was correctly notified that additional documentation was needed to determine the value of her assets and establish her financial eligibility, and she was given ten (10) days to submit it.

The Appellant did not submit the proof of life insurance policy cash surrender value and proof of the value of personal property of unusual value by the due date of July 8, 2026. On July 13, 2026, the Respondent notified the Appellant that her application for ADW Medicaid was denied because she did not turn in all requested information. On July 20, 2026, the yellow DHS-2.FRM form expired.

Pursuant to policy, if an applicant fails to provide the verifications requested on the DFA-6 or verification checklist within the specified time limit and the application is denied, the AG must be given an opportunity to have its eligibility established for up to sixty (60) days from the date of application without completion of a new form. The Appellant had the opportunity to establish eligibility by submitting documentation regarding the life insurance policy and farm equipment until August 24, 2026.

On July 27, 2026, the Appellant submitted registration of a vehicle, title to a vehicle, cash surrender value of the life insurance policy, and a statement that farm equipment had been gifted. On July 28, 2026, the Respondent requested additional verification of the value of the farm equipment at the time it was gifted, and verification of how $13,920.14 received from cashing out the life insurance policy was spent. On September 3, 2026, the Appellant submitted appraisals for the farm equipment, a pre-paid (irrevocable) burial contract from [redacted] Funeral Home, [redacted] bank statements, and a written statement of expenses. Because the documentation necessary to determine the value of the Appellant's assets were not submitted until after both the expiration of the DHS-2.FRM, and more than sixty (60) days after the Medicaid application, the Respondent correctly denied the Appellant's application for ADW Medicaid and determined that she must reapply.

The Appellant was represented at the hearing by her son, [redacted]. Mr. [redacted] did not refute any of the evidence presented by the Respondent. Mr. [redacted] argues that the information required to verify financial eligibility for the ADW Medicaid program is difficult to gather and is confusing. He argues that his mother needs assistance and would not have been able to take the steps necessary to apply for this program by herself. He also argues that he should not need to apply again for the program after having submitted all the requested documentation.

The Board of Review cannot judge the policy, but can only determine whether the Respondent acted correctly and followed the policy. Whether the policy is confusing or the requirements difficult to comply with is not a factor in determining whether the Respondent acted in accordance with the policy. The Respondent was required by policy to verify the value of the Appellant's assets to determine her financial eligibility. To establish eligibility, an applicant must submit requested verifications within the time frames set forth. The Respondent's determination is affirmed.

CONCLUSIONS OF LAW

1) The Respondent was notified on June 17, 2026, that the Appellant applied for ADW Medicaid, and the Appellant was required to establish financial eligibility by submitting a Medicaid application by July 20, 2026.

2) The Appellant submitted the Medicaid application on June 25, 2026, however, the application submitted did not list all of the Appellant's assets, and the Respondent was required to determine if the value of the Appellant's assets exceeded the limit of $2,000 to determine if she was financially eligible.

3) Additional information was necessary to determine the value of the Appellant's assets, and the Respondent correctly notified the Appellant on June 29, 2026, that she was required to submit documentation regarding her life insurance and farm equipment assets within ten (10) days.

4) If an applicant fails to return documentation, the application can be denied, and the Respondent correctly denied the Appellant's application on July 13, 2026, when she did not submit the requested verifications.

5) If an applicant submits requested verifications within sixty (60) days of the Medicaid application, she is given an opportunity to have her eligibility established without completion of a new form, and the Appellant had the opportunity to establish eligibility by submitting documentation regarding the life insurance policy and farm equipment until August 24, 2026.

6) The Appellant did not submit documentation showing how the cashout of her life insurance policies was spent and the value of the farm equipment until September 3, 2026, which was more than sixty (60) days after her application, and the Respondent correctly determined that the Appellant would have to reapply for the program.

DECISION

It is the decision of the State Hearing Officer to **UPHOLD** the actions of the Respondent in denying the Appellant's application for the Aged and Disabled Waiver Medicaid Program.

ENTERED this 8th day of October 2026.

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Amy Hayes
State Hearing Officer
Member, Board of Review