

STATE OF VERMONT
HUMAN SERVICES BOARD

In re) Fair Hearing No. 11,470
)
Appeal of)

INTRODUCTION

The petitioner appeals a decision by the Department of Social Welfare to deny his application for Medicaid for failure to cooperate in verifying information essential to his application.

FINDINGS OF FACT

1. On or about June 1, 1992, the petitioner applied for Medicaid assistance in order to get help with medications. The petitioner had a face to face interview with a worker and was told that in order to establish his eligibility he would need to provide written verification of the current cash value of his life insurance policy (which the petitioner reported was worth \$14,000), to return a filled in social report containing information about his illness and his treating sources, and return three signed medical release forms. The petitioner was told that this information was needed to figure out if he was financially eligible and to get information from his doctors about his medical problems. The petitioner was asked to return the forms and report by June 8 and the other proof by June 15, 1992. He received this same request in a written notice which further informed him that his benefits would be "terminated" on June 30, 1992 if these forms, which

were referred to by number, were not returned by the above dates.

2. On June 16, 1992, when the petitioner had not responded to the request, the DSW worker sent him a second notice asking him to return the same information by June 29, 1992, or face denial of his Medicaid application on the 30th day after application. The petitioner was also advised in this notice that he should contact his worker if he was having trouble getting the information and told that he would be assisted. He was also told that he may have a good reason for not providing the proof but needed to let the Department make that determination.

3. At no time between June 1 and June 29, 1992, did the petitioner attempt to contact his worker or to provide any information. On July 1, 1992, the worker notified the petitioner that his Medicaid application would be denied because he did not provide information necessary to determining his eligibility. He was advised that he could reapply at any time and could appeal the decision.

4. On August 20, 1992, the petitioner notified his worker that he wished to appeal all past decisions made against him for "Medicaid, fuel assistance, disability and phone" since August 1991.

5. On August 21, 1992, the petitioner applied for General Assistance to help with his medications, and his room

rent and utilities. He was granted assistance with the medication but not the rent and utilities. Again on August 27, 1992, he was granted GA assistance with medications, based on the emergency essential nature of that request. He was told, however, that in order to get GA assistance with other items, he would have to return a form signed by his doctor showing that he was disabled. The petitioner did not appeal these decisions or file any other GA applications.

5. The petitioner's appeal hearing was set for September 29, 1992. As of that date, the petitioner had still failed to provide any of the verifications requested by the Department for either GA or Medicaid. On that date the petitioner did not appear but called at the scheduled time of the appeal to complain that verification was useless because he had no treating physicians and no one could figure out what was wrong with him. At that time, the Department's attorney explained the requirements for verification and indicated the Department would give the petitioner an additional opportunity to submit the information and also consider his needs under the GA program. The following day, the Department's attorney sent a letter to the petitioner detailing the requested verification which is attached hereto as Exhibit One and incorporated herein by reference.

6. On that same day, the Department's attorney requested medical information from a physician the petitioner had

reported seeing recently. That physician agreed to fill out a form which was returned to the Department on October 14, 1992, indicating a "yes" to the question of whether the petitioner should be exempted from training or employment due to a physical or mental condition but giving no details on his condition due to a "very vague history and symptoms" which needed further evaluation for diagnosis. The form also indicated that the petitioner was under treatment for this illness by a community mental health organization but implied that he either was unable or chose not to follow through with appointments at the health center in order to obtain a full diagnosis and prognosis of his condition.

7. On the date of the rescheduled hearing, December 1, 1992, the petitioner had still failed to provide the verification requested for Medicaid processing. He could not recall if he had seen any of the notices set forth above but asserted in any event that he had no intention of supplying information about his life insurance policy because he has never been given a satisfactory explanation for its need. After the worker testified as to the reason for evaluating the life insurance policy--to see if it was a countable resource--the petitioner professed to not see the relevance and stated that he would not cash in his life insurance policy for a prescription. He also stated that he refused to bring back the signed medical release forms because there was no one who

could make a full evaluation of his medical condition. He further stated that he refused to bring back and sign the social report form because he did not know who would see it and felt that his privacy would be violated by filling out the information on that form as well as by signing the medical releases. The petitioner admitted, however, that he had never revealed these reasons to anyone prior to his refusal and that he had never asked for further explanation of the need for any of the above information.

8. The petitioner raised no other issues at his appeal hearing. It does not appear from the evidence that he has a pending GA denial under appeal. However, it does appear from the evidence that the petitioner, based on his physician's letter, could meet the eligibility criteria for disability under the GA program.

9. Based on the above, it is found that the petitioner has expressly refused to return signed medical release forms, a signed filled out Social Report, and verification of the cash value of his life insurance policy after being specifically and repeatedly requested to do so, and with full knowledge of the consequence (denial of his application) which would result therefrom.

ORDER

The decision of the Department of Social Welfare denying the petitioner's Medicaid application for failure to cooperate

in providing needed information is affirmed.

REASONS

In order to determine eligibility for Medicaid, the Department must determine both that the applicant is disabled (or aged or blind) and is financially eligible in terms of income and resources. See generally Medicaid Manual Sec. 200 et seq. Under the Department's regulations regarding the determination of disability:

Disability and blindness determinations are made in accordance with the applicable requirements of the Social Security Act by the disability determination agent based on information supplied by the applicant and by reports obtained from the physician(s) and other health care professionals who have treated the applicant.

The Department explains the disability determination process to an applicant, helps the applicant complete a Social Report and a Medical Release Form, completes the worker assessment portion of the Medical Eligibility Decision form and forwards all of this information to the disability determination agent.

. . .

The Department has primary responsibility, through its disability determination agent, for assuring that adequate information is obtained upon which to base the determination. If additional information is needed to determine whether or not the individual is disabled or blind according to the Social Security Act, consulting examinations may be required. The reasonable charge for medical examination(s) required to render a decision on disability or blindness shall be paid by the Department of Social Welfare.

The disability determination agent shall forward the decision, and a written explanation (rationale) thereof to the Program Integrity Unit for

transmittal to the appropriate District Office. The District Office shall send a copy of the decision to the applicant. When the disability determination agent denies a claim, the rationale shall explain why the applicant's impairments, when viewed individually and cumulatively, do not prevent her/him from engaging in substantial gainful activity.

M211.4

Those regulations make it clear that disability must be determined by assessing doctor's reports and the applicant's own statements about himself. No assessment can be made without the applicant's statements contained in the Social Report or without access to the applicant's treating sources whose names are reported in the Social Report and who usually require releases to give information about a patient. It must be concluded that the Department legitimately needed the Social Report and medical forms in order to make a determination on the disability issue, and that those forms were in fact essential to making that determination.

Similarly, the Department must assess the value of resources owned by any Medicaid applicant in order to determine eligibility. The regulations provide that "an individual or couple passes the resource test for Medicaid eligibility if the total value of the countable resources of the individual or couple does not exceed the applicable Resource Maximum." M230. The resource maximum for a single non-elderly person is \$2,000. Procedures Manual 2420 C.

Resources are defined in the regulations as "cash, liquid assets or any real or personal property that an individual owns and could convert to cash to be used for his/her support and maintenance." M231. Life insurance policies are considered resources under the regulations as follows:

The following items owned by the applicant individual or couple, or by a responsible relative are not considered resources:

. . .

(11) The value of a life insurance policy(ies) if the total face value(s) of the policy(ies) owned by an individual does not exceed \$1500. If the total face value(s) of all countable policies owned by an individual is over \$1500, the cash surrender value of all countable policies owned by the individual (including the amount under \$1500) shall be counted as a resource. In the case of a couple this does not provide for an average of \$1500 per each member of the couple. The following are not considered countable policies:

- (a) Term insurance.
- (b) Insurance which by its conditions of coverage provides payment only for burial expenses.

Note: Life insurance holdings may be adjusted to a lower face value in order to reduce countable resources to an amount which is below the Resource Maximum. If an adjustment is made, the cash surrender amount received shall be treated as a resource.

Note: If the total face value(s) of the policy(ies) exceeds \$1500, up to \$1500 of the cash surrender value for an individual (and an additional \$1500 for a spouse) may be

excluded for burial and the
remained, if any, counted as a
resource. If the full \$1500 (or
\$3000 if a couple) is excluded
from a life insurance
policy(ies) for burial, no
additional amount may be
excluded under the provisions
(18).

. . .

M234(11)

If an applicant reports that he has a life insurance policy, as the petitioner did herein, it must be evaluated in terms of its cash value in order to determine Medicaid eligibility. The regulations clearly indicate that the information sought by the Department in this case is necessary to make a determination on eligibility.

Furthermore, the Department's regulations specifically require that written documents or records, known as verification, be provided for certain kinds of information:

Verification (Proof)

Verification means proof of an applicant's statements by written records or documents shown to a Department employee, or by statements of another person who adds to or supports the applicant's statements.

Proof of the following is required:

All applicants' and recipients' Social Security numbers. Verification of application for such numbers is an acceptable substitute until such time as the Social Security numbers are received and verified; and

A medical decision, based on professional examination and judgment, on blindness, disability or incapacity; and

All countable income; and

All resources, when the total is within \$200 of the resource maximum.

Proof may also be necessary when the statement form and interview, if one is held, do not give enough clear and consistent information to make a decision on any other eligibility test.

Proof documents sent with the statement of need are returned to the applicant as soon as necessary information is recorded. Proof documents may be brought to the interview if one is held. Added proofs asked for after review of the applicant's statement may be sent or brought to the office.

When an applicant refuses to give necessary proofs, his application may be denied.

M126

Both the petitioner's medical condition and resources (since they were potentially within \$200 of the resource maximum) are required by regulation to be verified by documents or records. The petitioner's statements as to his condition or assets are not sufficient. The Department was well within its rights in requesting written verification of the resources or to request documents which would have given them access to needed medical documentation.

As the final sentence of the above cited regulation states, refusal to give the necessary proofs may result in denial of the application. That penalty is also set forth at M121 which states that "when an applicant fails to do his

part, an application may be denied if a decision cannot be made within the time limit, for example: An applicant fails to give necessary information or proofs asked for or takes longer than expected without explaining the delay; or an applicant fails to have necessary medical examinations asked for."¹

The Board has held in prior cases that the Department's thorough and clear request for information or proofs required by law, coupled with a warning of the consequences, which is then followed by an unexplained failure to take the required action within reasonable time limits is sufficient to imply a refusal to cooperate. See Fair Hearing No. 9480. In this matter, the petitioner received clear requests for required proofs and information on at least three occasions, was warned as many times of the possibility of denial if the proofs and information were not returned and yet still failed to give the required information. At no time did he indicate to the Department that he did not understand what was being asked of him or why it was being requested. Nor did he indicate to the

¹. Departmental regulations allow 90 days to make a decision in Medicaid disability cases. See M122. The Departmental worker originally only gave the petitioner 30 days to get the information in, presumably because it was felt that the other 60 days would be needed to get the medical evidence. However, the Department made it clear at the hearing, that they would have accepted the information and proofs at that time (six months after the application) if the petitioner had produced them.

Department that he was having difficulty obtaining the information. In fact, the petitioner made it quite clear at his hearing that he refused to give the requested information. Given this expressed (or implied) refusal over a period of six months, it must be concluded that the Department acted within its regulations in making a decision to deny the petitioner's application.

The petitioner should be aware that he has a right to reapply for Medicaid but that he will undoubtedly be asked to provide the same information and proofs. While this information is an invasion of the petitioner's privacy, this invasion is necessary to determine eligibility. The regulations do specifically narrow inquiries to information necessary to make determinations and require that the Department respect the privacy of individuals and the confidentiality of the information it receives. See e.g., M105, M124. The petitioner's concerns about his life insurance policy were first raised and answered at the December hearing. However, it should be reiterated that the Department's request for verification of the cash value of the insurance is only the initial step in evaluation of its status as an includible resource. No determination has been made yet whether the insurance will be disqualifying or not. Finally, the petitioner should understand that he does have a right as well to reapply at any time for General Assistance benefits

for medication or other needs.

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