



**STATE OF WISCONSIN  
Division of Hearings and Appeals**

---

In the Matter of

[REDACTED]  
[REDACTED]  
c/o [REDACTED]  
[REDACTED]  
[REDACTED]

DECISION

MGE/151127

---

**PRELIMINARY RECITALS**

Pursuant to a petition filed August 1, 2013, under Wis. Stat. § 49.45(5), and Wis. Admin. Code § HA 3.03(1), to review a decision by the Chippewa County Department of Human Services in regard to Medical Assistance, a hearing was held on November 19, 2013, at Chippewa Falls, Wisconsin. Hearings scheduled for September 17, 2013 and October 22, 2013, were rescheduled at the petitioner's request. The record was left open for 14 days at the petitioner's request.

The issue for determination is whether the county agency correctly denied the petitioner's application for medical assistance because his wife did not sign his application and he failed to provide adequate verification of his financial information.

There appeared at that time and place the following persons:

**PARTIES IN INTEREST:**

Petitioner:

[REDACTED]  
[REDACTED]  
c/o [REDACTED]  
[REDACTED]  
[REDACTED]

Petitioner's Representative:

Attorney Gregory P. Dowling  
PO Box 65  
Bloomer, WI 54724-0065

Respondent:

Department of Health Services  
1 West Wilson Street, Room 651  
Madison, Wisconsin 53703

By: Kelly Goettl

Chippewa County Department of Human Services  
711 N. Bridge Street  
Chippewa Falls, WI 54729-1877

ADMINISTRATIVE LAW JUDGE:

Michael D. O'Brien  
Division of Hearings and Appeals

### FINDINGS OF FACT

1. The petitioner (CARES # [REDACTED]) was a resident of a nursing home in Chippewa County. He died on September 3, 2013.
2. The petitioner applied for medical assistance on March 29, 2013. The county agency denied that application on July 1, 2013. The petitioner appealed that denial on August 1, 2013.
3. The petitioner and his spouse had less than \$52,000 but more than \$2,000 in countable assets from December 1, 2012, until he died.
4. The 2012 1099-R provided by the petitioner adequately verifies his pension income.

### DISCUSSION

The petitioner filed at least six applications for institutional medical assistance in 2012 and 2013. Each was denied on a different date. The petitioner seeks to have this matter determined under an application the agency received on March 29, 2013. Agencies must inform applicants of their right to appeal in writing. Wis. Admin. Code, § HA 3.04. The county agency contends that it denied the March 29, 2013, application in April, but the only evidence I have of a written denial of that application was one that occurred on July 1, 2013. Applicants must appeal any denial within 45 days or the Division of Hearings and Appeals loses jurisdiction to consider them. Wis. Admin. Code § HA 3.05(3). The petitioner appealed that denial on August 1, 2013. Therefore, he filed a timely appeal of the April 29, 2013 application. This means that his eligibility will be based upon the March 29, 2013, application.

Generally, a person cannot be eligible for medical assistance if his assets exceed \$2,000. Wis. Admin. Code, § DHS 103.06(1)(a); Wis. Stat. § 49.47(4)(b)3g. However, the medical assistance program contains special spousal impoverishment provisions that increase this limit so that a person does not fall into poverty when her spouse becomes institutionalized. *See* Wis. Stat. § 49.455 and 42 U.S.C. § 13964-5. Generally, the spousal impoverishment provisions allow persons with under \$100,00 in countable assets to transfer \$50,000 of those assets to the community spouse. Wis. Stat. § 49.455(6)(b); *Medical Eligibility Handbook*, § 18.4.3. Because the spouse considered institutionalized may retain an additional \$2,000, the couple can have a total of \$52,000 and still have one of them eligible for benefits.

Neither party disputes that the petitioner and his spouse had less than \$52,000 in assets, However, the agency contends that the higher spousal impoverishment limit does not apply because the petitioner's wife did not sign the April 2013, application. She did sign the March 29, 2013. Medical assistance policy found at *Medicaid Eligibility Handbook*, § 2.5.3, requires "the signatures of both the institutionalized person and the community spouse or of another authorized person." That policy goes on to state that if the "community spouse's signature is missing, test the institutionalized person's eligibility as if s/he were unmarried." *See also* Wis. Admin. Code, § DHS 102.01(7).

The agency contends that the April 2013 application was the one being considered because it was more recent. I disagree because the March 2013 application had not yet been denied. Furthermore, even if the agency was acting on the April 2013 application, it should have recognized from the previous application that the petitioner sought spousal impoverishment benefits—and it is clear from the way that it processed that the application that it did. The county sent a request for verification to the petitioner on May 8, 2013, that sought evidence concerning both the petitioner and his spouse's financial information, which would be unnecessary if it was testing the petitioner's eligibility as if he were unmarried. Rather than warn the petitioner that a signature was missing—an omission that the petitioner's representative indicates occurred because the online application was not user-friendly—the agency gathered the information as if it were processing a spousal impoverishment application and then denied it because the petitioner's assets exceeded the \$2,000 limit for a single person. During this process, the petitioner's spouse cooperated and

provided all of the information requested of her. For these reasons, I find that the agency cannot deny the petitioner's request for benefits on the grounds that his spouse did not sign the application.

I note that an argument can be made that the rule requiring a signature cannot be applied strictly to online applications; if the rule is read literally, almost all applications filed online are invalid because § DHS 102.01.(7) requires that (with a limited exception) the "application shall be signed in the presence of an agency representative." Obviously an online will not be signed in the presence of an agency representative.

Medicaid rules require recipients to verify relevant information, including income and assets. Wis. Admin. Code, § DHS 102.03(3)(a) and (h). The petitioner's application was denied in part because he allegedly failed to verify all of the evidence required of him. On May 8, 2013, the agency sent the petitioner a five-page list of verifications. The only piece of verification at issue is whether the petitioner responded properly to the following portion of the request directed toward his pension income: "**OTHER PENSION/RETIREMENT:** Type of income received; Amount received per month." The petitioner provide his 2012 1099-R statement showing that his pension paid him \$1,320 that year. The agency considered this inadequate because it did not provide a monthly amount or prove what he received in 2013.

According to Wis. Admin. Code, § DHS 102.03(1):

An application for MA shall be denied when the applicant or recipient is able to produce required verifications but refuses or fails to do so....If the applicant or recipient is not able to produce verifications, or requires assistance to do so, the agency may not deny assistance but shall proceed immediately to verify the data elements

Agencies must allow at least 30 days from the date of application or 10 days from the date of the request, whichever is later, to verify the information. *Medicaid Eligibility Handbook*, § 20.7.1.1. *see also* Wis. Admin. Code § DHS 102.03(1). Medical assistance policy instructs when to approve or deny an application:

Begin or continue benefits when:

1. The member provides requested verification within the specified time limits and is otherwise eligible.
2. Requested verification is mandatory, but the member does not have the power to produce the verification and s/he is otherwise eligible

*Medicaid Eligibility Handbook*, § 20.8.1.

Deny or reduce benefits when all of the following are true:

1. The member has the power to produce the verification.
2. The time allowed to produce the verification has passed.
3. The member has been given adequate notice of the verification required.
4. You need the requested verification to determine current eligibility. Do not deny current eligibility because a member does not verify some past circumstance not affecting current eligibility

*Medicaid Eligibility Handbook*, § 20.8.3.

Workers are instructed not to "over-verify" information or "exclusively require a particular type of verification when various types are possible. *Medicaid Eligibility Handbook*, § 20.2.

Nothing in the agency's request required any specific form of documentation, and it would probably have been improper if it had. The agency's worker testified that the petitioner should have included bank statements to show that he continued to receive the same amount, but his son testified that the petitioner cashed the \$110 he received each month, so bank statements would not have shown anything. Verification is not meant to be a minefield, and those seeking benefits are not required to prove the validity of the various pieces of information needed for their eligibility beyond a reasonable doubt. Verification is meant to ensure that workers can be reasonably sure that the information on the application is correct. The petitioner's 2012 1099-R was an adequate response to the agency's request. The annual figure could be divided by 12 to get the monthly figure, and it is unlikely that the pension of a 99-year-old man will vary much from year to year. There is no evidence that the petitioner was hiding anything or trying to mislead the agency: he submitted over 60 of pages of documents in response to the agency's request for verification. Therefore, the agency cannot deny his application because of inadequate verification.

The remaining question is when the petitioner's eligibility should begin. Medical assistance eligibility can be made retroactive to "the first day of the month 3 months prior to the month of application." Wis. Admin. Code § DHS 103.08(1). Because the petitioner applied in March 2013, his benefits can begin on December 1, 2013. Because the documentation indicates that there has been no significant change in the petitioner and his spouse's financial situation since then, I will order the agency to find him eligible retroactive to that date.

### **CONCLUSIONS OF LAW**

1. The petitioner's appeal is timely.
2. The petitioner adequately verified all information needed to determine his eligibility.
3. The petitioner is eligible for the spousal impoverishment provisions of the medical assistance program.
4. The petitioner has met all of the conditions to be eligible for institutional medical assistance since December 1, 2012.

**THEREFORE, it is**

**ORDERED**

That this matter is remanded to the county agency with instructions that within 10 days of the date of this decision it find the petitioner eligible for institutional medical assistance retroactive to December 1, 2012.

### **REQUEST FOR A REHEARING**

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

**APPEAL TO COURT**

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Room 651, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Madison,  
Wisconsin, this 30th day of December, 2013

---

\sMichael D. O'Brien  
Administrative Law Judge  
Division of Hearings and Appeals



**State of Wisconsin\DIVISION OF HEARINGS AND APPEALS**

Brian Hayes, Administrator  
Suite 201  
5005 University Avenue  
Madison, WI 53705-5400

Telephone: (608) 266-3096  
FAX: (608) 264-9885  
email: [DHAmail@wisconsin.gov](mailto:DHAmail@wisconsin.gov)  
Internet: <http://dha.state.wi.us>

The preceding decision was sent to the following parties on December 30, 2013.

Chippewa County Department of Human Services  
Division of Health Care Access and Accountability  
[gdownling@bloomer.net](mailto:gdownling@bloomer.net)