The Delaware Code (31 Del. C. §520) provides for judicial review of hearing decisions. In order to have a review of this decision in Court, a notice of appeal must be filed with the clerk (Prothonotary) of the Superior Court within 30 days of the date of the decision. An appeal may result in a reversal of the decision. Readers are directed to notify the DSS Hearing Office, P.O. Box 906, New Castle, DE 19720 of any formal errors in the text so that corrections can be made.

DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SOCIAL SERVICES

In re: DCIS No. Redacted

Redacted

Appearances: Redacted, pro se, Appellant

Linda Greene, Sr. Social Worker/Case Manager, Division of Social Services

I.

Redacted ("Appellant") opposes a decision by the Division of Social Services ("DSS") to close her Medicaid for Uninsured Adults based upon being over the income limit for a household of two (2).

The Division of Social Services ("DSS") contends that the Appellant is over the income limit for a household of two (2) to qualify for Medicaid for Uninsured Adults.

II.

On April 15, 2011, DSS sent to Appellant a Notice to Close Your Medical Assistance, effective April 30, 2011. (Exhibit 3)

On May 23, 2011, the Appellant filed a request for a fair hearing requesting that benefits continue during the pendency of the case. (Exhibit 2) According to the Fair Hearing Summary dated June 7, 2011, benefits have not continued. (Exhibit 1)

The Appellant was notified by certified letter dated July 5, 2011, that a fair hearing would be held on July 18, 2011. The hearing was conducted on that date in Newark, Delaware.

This is the decision resulting from that hearing.

III.

DSS testified that with a renewal application, the Appellant submitted statements from her public accountant that DSS then used to determine the household's income. DSS testified that these

statements provided income information for March and April 2011, which was then prospectively budgeted to determine the amount the Appellant's household would earn in May 2011. DSS testified that according to the submitted statements, the Appellant's husband was expected to earn $7,737.67 from self-employment in May 2011, and that the Appellant was expected to earn $3,394.50 from self-employment in May 2011. DSS testified that as this income was generated through self-employment, both the Appellant and her husband received a business expense deduction equal to 51% of the income earned. DSS testified that the Appellant therefore received a business expense deduction of $2,422.91 and her husband received a business expense deduction of $4,881.50 ($3,394.50 X 51% = $2,422.91); ($7,737.67 X 51% = $4,881.50).[1] In addition, DSS testified that it utilized the Appellant's submitted 2010 tax return to confirm the amounts of income and expenses.

Pursuant to the Division of Social Services Manual ("DSSM") 16230, countable income is used to determine eligibility for benefits. DSSM 16230 defines countable income as earned or unearned income minus any disregards, if applicable. In this case, both the Appellant and her husband each received an earned income deduction (disregard) of $90.00 because their household's income is considered earned under DSSM 16230. Accordingly, DSS determined that the Appellant's monthly income amounted to $881.59 ($3,394.50 - $2,422.92 business deduction - $90.00 earned income deduction = $881.59). DSS also determined that the Appellant's husband's monthly income amounted to $2,766.17 ($$7,737.67 - $4,881.50 business deduction - $90.00 earned income deduction = $2,766.17). As a result, DSS determined that the Appellant's household's monthly income would be $3,647.76 for the month of May ($881.59 + $2,766.17 = $3,647.76). DSS applied a monthly income limit for a household of two (2) amounting to $1,226.00 and the agency closed the Appellant's medical assistance benefits.

The Appellant testified that while she and her husband did constitute a household of two (2) as their children are all adults, she testified that neither she nor her husband actually received the income anticipated by DSS. The Appellant testified that in April 2011, her household had an income of $2,766.70. The Appellant testified that due to the economic downturn, her and her husband's businesses have not been doing well. The Appellant further testified that she has submitted all business statements to her accountant. However, the Appellant testified that the figures used by DSS in making its determination were correct at the time.

According to DSSM 16230, countable Income is earned or unearned income from which certain disregards (if applicable) have been deducted. DSS is instructed to determine eligibility prospectively based on the best estimate of income and circumstances that will exist in the month for which the eligibility determination is being made.

Pursuant to DSSM 16230.1.1, DSS is only permitted to utilize gross income, and not net income (after expenses), for purposes of eligibility. As this benefit is based solely on income, there are no deductions made for medical or other expenses and a person's medical condition is not taken into consideration when determining eligibility.

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[1] I note that these calculations are incorrect, but were in the Appellant's favor. For her own business deduction, $2,422.91 is actually 71% of $3,394.50 For her husband's business deduction, $4,881.50 is actually 63% of $7,737.67.

DSSM 16230.1.2 identifies that a self-employment standard deduction is used to calculate self-employment income. The self-employment standard deduction is considered the cost to produce income. The self-employment standard deduction is a percentage that is determined annually and announced in the Cost-of-Living Adjustment (COLA) Administrative Notice each October. To calculate self-employment income, use the gross proceeds and subtract the self- employment standard deduction. The result is the amount included in the individual's gross income. Standard earned income deductions are then applied to the individual's gross income.

To receive the self-employment standard deduction, the individual must provide verification that costs are incurred to produce the self-employment income. Verification can include, but is not limited to, tax records, ledgers, business records, receipts, check receipts, and business statements. The individual does not have to verify all business costs to receive the standard deduction. If the individual does not claim or verify any costs to produce the self-employment income, the self-employment standard deduction will not be applied.

When the application of the standard deduction results in a finding of ineligibility, the applicant or recipient will be given an opportunity to show that actual self-employment expenses exceed the standard deduction. If the actual expenses exceed the standard deduction, they will be used to determine net income from self-employment.

Administrative Notice A-19-2008 identifies that the business deduction for self-employment income was increased to 51% effective October 1, 2007. A review of the administrative notices rendered from 2009 through 2011 reveal that no subsequent increase was made.

DSSM 16250 identifies that in order to be eligible for medical assistance, Uninsured adults must have family income at or below 100% of poverty.

Administrative Notice A-05-2011 identifies that 100% of the federal poverty level for a household of two (2) is equal to $1,226.00.

Based upon the information provided, DSS correctly determined that the Appellant's total monthly countable income is over the income limit for a household of two (2). While the Appellant may now take home less than what was budgeted, the Appellant testified that the amounts used at the time were correct. Moreover, DSS was correct in prospectively budgeting the Appellant's household income in accordance with DSSM 16230. As a result, the Appellant was properly sent a Notice to Close Your Medical Assistance, effective April 30, 2011. I conclude that substantial evidence supports DSS' decision to close the Appellant's medical assistance benefits. The Appellant is encouraged to re-apply for medical assistance benefits as her income has subsequently decreased.

Further, because the Appellant filed her request for a fair hearing after the effective date of the closure of her medical assistance benefits, her medical assistance benefits were correctly not continued at their prior level through the pendency of this case. According to DSSM 5308, only if the recipient requests a hearing within the timely notice period, assistance will not be suspended, reduced, discontinued, or terminated (but is subject to recovery by the agency if its action is sustained on appeal) until a decision is reached after a fair hearing, unless the recipient specifically requests reduction or discontinuance, or if a listed exception applies. In this instance, the Appellant's request for a fair hearing was submitted after April 30, 2011, the effective date of her medical assistance benefit closure. As a result, DSS correctly did not continue benefits during the pendency of this proceeding.

IV.

For these reasons, the April 15, 2011 decision of the Division of Social Services to close the Appellant's medical assistance benefits effective April 30, 2011 is AFFIRMED.

Date: August 4, 2011

MICHAEL L. STEINBERG, J.D.
HEARING OFFICER

THE FOREGOING IS THE FINAL DECISION OF THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

August 4, 2011
POSTED

cc: Redacted
Linda Greene, DSS

EXHIBITS FILED IN OR FOR THE PROCEEDING

EXHIBIT #1 – Copy of DSS Fair Hearing Summary dated June 7, 2011, consisting of two (2) pages.

EXHIBIT #2 – Copy of the Appellant's request for a fair hearing date-stamped May 23, 2011, consisting of one (1) page.

EXHIBIT #3 – Copy of the Notice to Close Your Medical Assistance, dated April 15, 2011, consisting of five (5) pages.