State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 09175-24
AGENCY DKT. NO. N/A

B.M.,
Petitioner,
v.
ESSEX COUNTY DIVISION OF FAMILY ASSISTANCE AND BENEFITS,
Respondent.

Michael Heinemann, Esq., for petitioner

Rebecca Colon-Smith, Fair Hearing Liaison, and **Renee Williams**, Family Service Supervisor, for respondent, pursuant to N.J.A.C. 1:1-5.4(a)(3)

Record Closed: August 18, 2025 Decided: September 4, 2025

BEFORE **MATTHEW G. MILLER**, ALJ:

STATEMENT OF THE CASE

Generally, petitioner, B.M., appeals the November 14, 2023 denial of her September 21, 2023 application for Medicaid benefits by the Essex County Division of Family Assistance and Benefits ("respondent" or "Agency") for failure to provide information in violation of N.J.A.C. 10:71-2.3.

More specifically, B.M. argues that rather than denying her September 21, 2023 application, the Agency should have approved it with a penalty.

The Agency argued that the application was properly denied and that with the approval of her February 5, 2024 application retroactive to February 1, 2024, and the approval of three months of Pre-Eligibility Medical Expenses ("PEME"), B.M. obtained the benefits to which she was entitled.

It must be emphasized that the sole issue to be decided here is whether the September 21, 2023 application was properly denied or whether it should have been approved with a penalty. The amount of any potential penalty would be calculated by the Agency and any disagreement concerning that amount would potentially be the subject of a separate appeal/fair hearing request.

PROCEDURAL HISTORY

The record shows that B.M. submitted an initial application for Managed Long-Term Services and Supports ("MLTSS") Medicaid on September 21, 2023. In reply, the Agency sent her a Request for Information ("RFI") letter dated October 12, 2023. The application was then denied by letter dated November 2, 2023 for failure to supply requested information. The application was reconsidered by the Agency and was again denied by letter dated November 14, 2023.

B.M. submitted a second application on February 5, 2024 and that was approved (retroactive to February 1, 2024) by letter dated May 20, 2024. Petitioner was also granted PEME for the months of November and December 2024 and January 2025.

On November 21, 2023, petitioner timely requested a fair hearing as well as continuing benefits and the matter was transmitted to the Office of Administrative Law (OAL) on or about February 15, 2024, for a hearing as a contested case pursuant to N.J.S.A. 52:14B-1 to -15 and N.J.S.A. 52:14F-1 to -23. However, the petitioner failed to appear for a scheduled June 11, 2024 hearing and the matter was dismissed.

Notwithstanding that non-appearance, the matter was retransmitted to the OAL on or about July 9, 2024. An initial conference in this matter took place on December 12, 2024, but the scheduled hearing was adjourned at the request of the parties so that they could explore the possibility of resolving the case. Following a conference on January 7, 2025, respondent failed to appear for a February 25, 2025 hearing. The matter was then rescheduled for March 25, 2025. At that time, a hearing was held, and the record was held open for post-hearing submissions. The hearing recommenced on July 16, 2025 for additional testimony and the record officially closed on August 18, 2025.

TIMELINE, FACTUAL DISCUSSION, AND FINDINGS

It should be noted that many of the facts of this case are undisputed and the testimony was therefore limited. Given the uncontested nature of same as well as the evidence submitted by the parties, I **FIND** the following as **FACTS**:

1. On April 3, 2023, petitioner, B.M., an eighty-six-year-old female, was admitted to St. Vincent's Nursing Home in Cedar Grove, New Jersey.
2. On September 21, 2023, B.M. applied for MLTSS Medicaid.
3. On October 12, 2023, the Agency sent an RFI[1] letter to B.M. (P-C), requesting information about the sale of her home and about a life insurance policy with First Allmerica. Information was also requested about a $57,000 transfer that occurred on August 28, 2023. The letter requested information about the following items by no later than October 26, 2023:
    a. An updated LTC-2[2] form "that includes a pickup date."
    b. "Your 57K statements" from September 2018 through September 2023.
    c. "Residential ledger from 9/2018 through 09/2023."

[1] Request for Information .
[2] Notification From Long-Term Care Facility Admission or Termination of a Medicaid Beneficiary form.

d. PNA statement from 9/2018 through 09/2023.

e. Information about Check # 1007 ($57,400) that was cashed by L.L. on August 28, 2023. "Who is [L.L.] and why was the money sent? Send a detailed letter of explanation."

f. Information about Check # 7135 ($121,810.25) that was cashed by L.L. on January 2, 2020. "Who is [L.L.] and why was the money sent? Send a detailed letter of explanation."

g. Information about Check # 7133 ($57,000) that was cashed by A.B.[3] on December 31, 2019. "Who is [A.B.] and why was the money sent? Send a detailed letter of explanation."

4. Petitioner, through her prior representative, replied to the request by letter dated October 20, 2023. (P-B.) Included with the letter was the following:

a. Updated LTC-2 with a requested pickup date of September 1, 2023.

b. Clarification that the 57K referenced in the Agency's letter was a cash transfer.

c. Residential ledger from B.M.'s current admission.

d. PNA[4] statement.

5. The letter also stated the following about the three checks:

a. 8/28/2023 Check #1007 to L.L. – to a disabled daughter, please see the disability verification attached. Being that this [is] an allowable transfer, no further documentation should be necessary.

b. 1/2/2020 Check #7135 to L.L. $121,810.25 – to a disabled daughter, please see verification statement attached. Being that this [is] an allowable transfer, no further documentation should be necessary.

c. 12/31/2019 Check #7133 A.B. $57K – to a disabled daughter, please see verification attached. Being that this [is] an allowable transfer, no further documentation should be necessary.

[3] a/k/a A.U.
[4] Personal Needs Account

[P-B.]

6. In reply to that October 20, 2023 submission from B.M., on November 14, 2023, respondent forwarded another denial letter, claiming (without specificity) that she had again failed to supply the requested information. (P-E.)

7. In the interim between the October 20 submission and the November 14 denial, there was an email exchange between the parties (P-E):

   a. November 3, 2023 email from petitioner to respondent attaching the PAS[5] request and advising that "50K withdrawal was transferred to disabled daughter, as previously provided."

   b. November 7, 2023 email from petitioner to respondent advising that she was "quite surprised" to have received a denial and asking directly, "what else is needed to complete this case?"

   c. November 14, 2023 email from Ms. Colon-Smith to petitioner advising that following the receipt of the October 20 documentation, the application was reconsidered and that the denial was standing. When a new application is filed, it must include the following:

      i. Daughters' dates of birth

      ii. SSA verification of the daughters' disabilities

      iii. Verification of the bank accounts where the funds were deposited or "you can take the penalty."

   d. November 16, 2023 email from petitioner's representative to Ms. Colon-Smith advising that the daughters' dates of birth had been

[5] Pre-Admission Screening

supplied initially, as had the SSA verifications, "and should not have resulted in denials." As for the bank account information, the representative asked, "wouldn't you have sent a penalty letter and not denied the application?"

e. Petitioner appealed the denial via facsimile on November 21, 2023.

f. November 28, 2023 email from petitioner to respondent asking if the denial had been rescinded. That email was forwarded to Ms. Williams, who responded thusly:

> In order for the agency to move forward with the case, the requested documents are needed to assist the agency with determining eligibility.
>
> The award letters, that you submitted does not tell the agency that the daughters are disabled, it just shows that they are receiving social security benefits.
>
> We need the letters from Social Security or their DOB and Social Security #s to electronically verify if the daughters have been determined disabled by the SSA office. If the information can not be determined we will still need the letters from SSA office.
>
> The denial has not been rescinded, however a penalty can be given if eligibility has been determined, the money has not been returned and found to be gifted. Also, submit all other documents needed.
>
> At this point, you will have to submit a new application, however we can use the documents that were previously submitted.

g. On November 29, 2023, petitioner replied to Ms. Williams' email, clarifying that she had provided Social Security benefits letters with verification of the birthdates "being that they are under 65 and would not be eligible otherwise." She also confirmed that the daughters' Social Security numbers had been supplied, which could be used to determine what benefits they were receiving.

h. Follow-up emails were sent by petitioner on November 30, December 5 and December 7, 2023, asking for a response to the November 29, 2023 emails. Another subsequent email was sent, but the date is unclear.

8. The denial was never rescinded and as noted, an appeal of the denial was filed on November 21, 2023.

ISSUE

The Agency has taken the position that per N.J.A.C. 10:71-2.3 et seq., petitioner failed to provide the requested information so that it was unable to make an informed decision as to B.M.'s Medicaid eligibility. Therefore, its denials of the September 21, 2023 application were appropriate.

PETITIONER'S ARGUMENT:

Petitioner argues that she has proven that all of the requested information was timely and that the Agency had more than sufficient information to determine that B.M. was eligible for benefits and that, at the very least, the application should have been approved with a penalty, rather than denied.

Specifically, the petitioner acknowledges that there is a sixty-month look-back period from the date the institutionalized individual applies for Medicaid to determine if that patient has disposed of assets at less than fair market value. N.J.A.C. 10:71-4.10(a)(2). If such transfers have been made during that period, the applicant may (with certain exceptions) be subject to a period of ineligibility, also known as "the penalty period." N.J.A.C. 10:71-4.10(b)(9)(iv).

While the petitioner argues that the transfers were exempt from any potential penalty per N.J.A.C. 10:71-4.10(e) et seq., that issue is not yet cognizable since the Agency has not made a formal determination on that issue.

TESTIMONY

FOR RESPONDENT:

Rebecca Colon-Smith, Family Service Worker, appeared for respondent. She testified that B.M. first applied for Medicaid on September 21, 2023. The case was originally denied because she failed to provide the details of the $57,000 transfer, information regarding the child's alleged disability, information concerning B.M.'s PNA, and a letter of explanation for the transfer. The Agency then received additional documentation, but since there was information still missing: a) a letter from Social Security stating that the one daughter was disabled; b) a letter stating what account the money was transferred to; c) a letter explaining the transfer out; d) date of birth for one of the daughters.

Ms. Colon-Smith explained that B.M.'s account had $106,000 in August 2023, then it went down to $928 and then she was over-resource in October and November 2023, "so they were trying to figure out where did that money go?" The Agency asked B.M.'s representative for that information "and that's where the second application came in," and the representative asked for more time.

Ms. Colon-Smith reiterated that they asked the question about the transfers in conjunction with the initial application and during the reconsideration process, and they never received an answer "or received any information ever." They knew who received the money, but not where it went (the type of account it went to).

Ultimately, Ms. Colon-Smith was able to electronically confirm A.B.'s disability information, but was unable to do so concerning L.L. More specifically, the Agency was unable to confirm her disability and at what age she was deemed disabled, with neither Social Security nor B.M.'s representative being able to provide that information. They went to B.M. and asked her representative to provide them with a letter from Social Security stating what her disability was and what year and at what age she was deemed disabled.

She also testified that Renee Williams, her supervisor, had been in contact with B.M.'s representatives for that information, including Form E-79.[6]

Renee Williams, Family Service Supervisor, appeared for respondent. She testified that the PAS is to determine whether the applicant is clinically eligible for MLTSS Medicaid. B.M.'s PAS was dismissed in July 2023, but she was unsure why, since that is handled by the State nurses. She testified that the Agency cannot deny just on the PAS but cannot approve MLTSS without an approved PAS. The Agency only deals with the income and resources aspects of the application.

She testified that the Agency's first contact with the case was that September 21, 2023 application. Personally, her first contact was as a supervisor, evaluating the case worker's work. She testified that an RFI letter was sent out to B.M. on October 12, 2023. According to the case notes, the Agency was looking for information concerning the $57,000 case transfer and the PNA.

She testified that there was a denial of the application on November 2, 2023, but that denial was reconsidered on November 14, 2023. Information had been requested to demonstrate that the child(ren) receiving the monetary transfers was/were disabled "in order to exempt the income that was given to her" and to determine exactly where that money went (i.e., a trust, an annuity, etc.). However, she testified that they had all the information on one of B.M.'s daughters, but not the other one. The Agency attempted to look up information on that daughter electronically, but they were "unable to determine her disability," and they asked for that information from B.M. so that they "could determine whether this was a legal transfer or not."

Ms. Williams further testified that ultimately, B.M.'s February 5, 2024 application was approved with an effective date of February 1, 2024. Three months of PEME were also approved (November and December 2023 and January 2024).

[6] Notice of Verification (C-2.)

Ms. Williams reiterated Ms. Colon-Smith's testimony that in August 2023, B.M. had $106,000 in the bank, and then in September 2023, the balance was down to $928. The Agency was told that the money had been transferred to her two disabled daughters. B.M.'s representative was able to supply information showing that one of the children was disabled, but the Agency was never provided with the information confirming that the second child was disabled. Finally, on the third application, the Agency was able to determine where the money ended up and that application was approved.

LEGAL ANALYSIS AND CONCLUSION

Perhaps the most concise description of the Medicaid program and how it works in New Jersey is as follows:

> The Medicaid program is a creature of federal law but is implemented at the state level. It provides coverage for medical care to individuals who cannot afford to obtain it on their own. See 42 U.S.C § 1396, et seq. The program is designed to provide benefits to persons "whose income and resources are insufficient to meet the cost of necessary medical services." 42 U.S.C. § 1396-1. State participation is voluntary; however, states that participate in the Medicaid program must comply with the federal statutory and regulatory framework governing Medicaid. Sabree v. Richman, 367 F.3d 180, 182 (3d Cir. 2004). New Jersey has authorized participation in the Medicaid program through its Medical Assistance and Health Services Act, N.J.S.A. 30:4D-1, et seq. The state's Medicaid program is administered by the DMAHS . . . .
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> [Galletta v. Velez, 2014 U.S. Dist. LEXIS 75248 at *17 (D.N.J. June 3, 2014).]

The role of counties in the administration of Medicaid cases is as follows:

> Local county welfare agencies evaluate Medicaid eligibility. N.J.S.A. 30:4D-7a; N.J.A.C. 10:71-1.5, 2.2(c). An applicant must establish "eligibility . . . in relation to each legal requirement to provide a valid basis for granting or denying medical assistance." N.J.A.C. 10:71-3.1. "The CWA exercises direct responsibility in the application process to . .

> . [a]ssist the applicants in exploring their eligibility for assistance." N.J.A.C. 10:71-2.2(c)(3). Similarly, an applicant shall "[a]ssist the CWA in securing evidence that corroborates his or her statements." N.J.A.C. 10:71-2.2(e)(2). The CWA "review[s] . . . the application for completeness, consistency, and reasonableness." N.J.A.C. 10:71-2.9.
>
> "[T]o be financially eligible [for benefits], the applicant must meet both income and resource standards." Brown, 448 N.J. Super. at 257 (citing N.J.A.C. 10:71-3.15). Specifically, "[t]he regulations governing an individual's eligibility for Medicaid reimbursement of nursing home costs provide that in order for an individual to participate in the Medicaid Only Program, the value of that individual's resources may not exceed $2,000." H.K. v. State, 184 N.J. 367, 380, 877 A.2d 1218 (2005) (footnote omitted) (citing N.J.A.C. 10:71-4.5(c)). To determine eligibility, the agency evaluates the available assets both of the "institutionalized spouse" and the "community spouse" during a five-year "look back" period. N.J.A.C. 10:71-4.8; N.J.A.C. 10:71-4.10(b)(9); see also 42 U.S.C. § 1396r-5(c)(1)(A).
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> [N.S. v. Div. of Med. Assist. & Health Servs., 2019 N.J. Super. Unpub. LEXIS 1499 (App. Div. July 3, 2019).]

For MLTSS applicants, there is a limited prohibition against the transfer of assets that is codified in N.J.A.C. 10:71-4.10(a)(2), which reads in pertinent part;

> (a) The provisions of this section shall apply . . . only to persons who are receiving an institutional level of services . . . . An individual shall be ineligible for institutional level services through the Medicaid program if he or she . . . has disposed of assets at less than fair market value at any time during or after the 60-month period immediately before:
>
> 1. In the case of an individual who is already eligible for Medicaid benefits, the date the individual becomes an institutionalized individual; or
>
> **2. In the case of an individual not already eligible for Medicaid benefits, the date the individual applies for Medicaid as an institutionalized individual.**
>
> [emphasis added.]

If, as here, there is evidence of such asset transfers, the applicant would be subject

to a period of ineligibility, which is then transformed into a monetary period. Per N.J.A.C. 10:71-4.10(b)(9)(iv):

> 9. The look-back period shall be 60 months.
>
> . . . .
>
> iv. Penalties of ineligibility shall be assessed for transfers which take place during or after the look-back period. Periods of ineligibility cannot be imposed for resource transfers which take place prior to the look-back period.

Further, per N.J.A.C. 10:71-4.10(m),

> For the purposes of this subchapter, the penalty period shall be the period of time during which payment for long-term care level services is denied. An institutionalized individual who is ineligible for payment of long-term care services as a result of an asset transfer shall be precluded from eligibility, but shall be entitled to ancillary services if otherwise eligible.
>
> 1. In accordance with 42 U.S.C. § 1396p(c)(1)(E), the penalty period for asset transfer shall be the number of months equal to the total, cumulative uncompensated value of all assets transferred by the individual, on or after the look-back date, divided by the average monthly cost of nursing home services in the State of New Jersey adjusted annually in accordance with the change in the Consumer Price Index-All Urban Consumers, rounded up to the nearest dollar. The annual adjustment to the average cost of nursing home services in New Jersey shall be published as a notice of administrative change in the New Jersey Register. As of November 2009, the average monthly cost is $ 7,282. The penalty period shall begin with the date of the resource transfer. As of November 2009, the current daily divisor is $ 239.41. A penalty shall be calculated for partial months of ineligibility. There shall be no limit on the length of the penalty period.
>
> i. For the purpose of determining a penalty period, the transfer of real property shall be considered to have occurred the date the title is recorded or registered with the appropriate office.
>
> ii. When calculating the penalty period, all of the whole

> months are calculated first, using the monthly average in (m)1 above; then remaining days are calculated using the daily divisor. The resulting figures will provide the length of the penalty period in months and days.

See generally, E.S. v. Div. of Med. Assist. & Health Servs., 412 N.J. Super. 340 (App. Div. 2010).

However, if it can be shown that the asset transfer was either not made for the purposes of Medicaid eligibility, or for some other valid/exempt reason (here, the transfer of assets to a disabled child), no penalty would apply. N.J.A.C. 10:71-4.10(e) reads, in relevant part:

> (e) The application of a transfer penalty as set forth in this section shall not apply when:
>
> 1. The assets were transferred to a trust established for the sole benefit of an individual under 65 years of age who is disabled as defined by the Social Security Administration;
>
> . . . .
>
> 5. The assets were transferred from the individual or individual's spouse to the individual's child who is blind or permanently and totally disabled.
>
> i. In the event that the child does not have a determination from the Social Security Administration of blindness or disability, the blindness or disability will be evaluated by the Disability Review Unit of the Division of Medical Assistance and Health Services in accordance with the provisions of N.J.A.C. 10:71-3.13; or
>
> 6. A satisfactory showing is made to the State that:
>
> i. The individual intended to dispose of the assets at either fair market value or for other valuable consideration;

> ii. The assets were transferred exclusively for a purpose other than to qualify for medical assistance; or

Per N.J.A.C. 10:71-4.10(j), the burden of proof in demonstrating that the asset transfer was exempt from penalty is on the applicant;

> (j) Any applicant or beneficiary may rebut the presumption that assets were transferred to establish Medicaid eligibility by presenting convincing evidence that the assets were transferred exclusively (that is, solely) for some other purpose. The applicant shall be assisted in obtaining information when necessary. However, the burden of proof shall rest with the applicant. When the applicant expresses the desire to rebut the presumption that he or she transferred assets to establish Medicaid eligibility, the procedures below shall be followed.
>
> 1. The applicant's statement concerning the circumstances of the transfer shall be included in the case record. The statement shall include, but need not be limited to, the following:
>
> j. The applicant's stated purpose for transferring the asset;
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> ii. The applicant's attempt to dispose of the asset at fair market value;
>
> iii. The applicant's reasons for accepting less than the fair market value for the asset;
>
> iv. The applicant's means of and plans for, supporting himself or herself after the transfer; and
>
> v. The applicant's relationship, if any, to the person(s) to whom the asset was transferred.
>
> 2. The applicant shall be asked to submit any pertinent evidence (for example, legal documents, realtor agreements, and relevant correspondence) with regard to the transfer.
>
> 3. Statements shall be taken from other individuals, if such statements are material to the decision. The statement shall indicate if such individual has or had a relationship with the applicant and the extent of the

> relationship (that is, related by blood or marriage, friendship).

At first glance, what looked like the key to this case was N.J.A.C. 10:71-4.10(f), which reads as follows:

> In determining whether an asset was transferred for the sole benefit of a spouse, child or disabled individual as defined in N.J.A.C. 10:71-4.10(b)8, the transfer shall be accomplished via a written instrument of transfer, such as a trust document, which legally binds the parties to a specific course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. Moreover, the written instrument shall state that the State of New Jersey shall be the first remaining beneficiary. A transfer without such a document shall not be considered to have been made for the sole benefit of the spouse, child or disabled individual.

However, as will be seen below, nothing involving Medicaid is simple.

It should also be noted that the Medicaid definition of an "asset" is a broad one. Per N.J.A.C 10:71-4.10(b)(3) and (4), "[a]ssets shall include all income and resources of the individual . . . ." Further, "[r]esources, for the purpose of asset transfer, shall include all resources . . . ."

So, to track the facts to the law;

1. B.M. made multiple asset transfers during the look-back period.
2. Those transfers were made to her daughters.
3. It is alleged that those daughters were both disabled.

Given these three undisputed facts, the Agency has to determine three things;

a. How old are the daughters?

b. Were one or both of the daughters disabled?

If the answer to those questions are "under sixty-five" and "yes" respectively, then;

c. Were the asset transfers properly documented?

Here, the Agency has now clarified its position that it was able to determine that:

a. Both daughters were under the age of sixty-five.
b. A.B. was disabled.

However, the Agency maintains that it was unable to determine:

a. If L.L. was disabled.
b. Where the transferred assets were deposited.

Given the facts and circumstances, it makes sense to address the "transferred assets" aspect of this case first. As a reminder, it is the Agency's position that because it was unable to determine that L.L. was disabled, and it was unclear where the transferred assets had been deposited, it correctly denied the application rather than approving it with a penalty.

Unmentioned by the parties is the case of A.D. v. Division of Medical Assistance & Health Services, 2009 N.J. AGEN LEXIS 1044 (Nov. 18, 2009), adopted, Comm'r, 2009 N.J. AGEN LEXIS 1128 (Dec. 24, 2009), a comprehensive decision which discusses the documentation requirements codified in N.J.A.C. 10:71-4.10(b)(8). Without block quoting the decision, the ALJ determined that the case of Sorber v. Velez, 2009 U.S. Dist. LEXIS 98799 (D.N.J. Oct. 23, 2009) (order granting preliminary injunction) had made it clear that N.J.A.C. 10:71-4.10(b)(8)'s requirements were contrary to the dictates and meaning of 42 U.S.C. § 1396p(c)(2)(B)(iii), which "clearly exempts outright transfers of resources to blind or disabled children," "regardless of whether the transferor makes special any arrangements to ensure that the transfer is for the child's sole benefit." Id. at *6–7.

In adopting the Initial Decision, the Commissioner noted that "DMAHS has altered

its policy on this issue permanently and has advised the counties that going forward, they should apply 42 U.S.C.A. § 1396p(c)(2)(B)(iii) to permit transfers directly to the disabled or blind child as well as to a sole benefit trust for those individuals, as transfers exempt from penalty for the Medicaid applicant." A.D., 2009 N.J. AGEN LEXIS 1128, at *2.

In addition to Sorber, which was admittedly non-precedential, the ALJ performed a detailed analysis of the law and history of both the Federal and State asset transfer laws. She then concluded,

> In sum, the DMAHS has promulgated its rules in accordance with Federal Medicaid law as it has changed throughout the past forty years and has indirectly inferred, in its own summaries and responses for those rules, that the New Jersey rules on transfer penalties allow direct transfers of assets to disabled children and do not require that such transfers be executed through a trust. The language in N.J.A.C. 10:71-4.7 and -4.10 that the DMAHS seeks now to interpret as requiring assets transferred to disabled children only be transferred in trust has been contradictorily interpreted by the DMAHS in the past to support petitioner's argument.
>
> [A.D., 2009 N.J. AGEN LEXIS 1044, at *31–32.]

There was a clear indication of the "new" DMAHS interpretation of N.J.A.C. 10:71-4.10(b)(8) in M.C. v. Division of Medical Assistance & Health Services, 2014 N.J. AGEN LEXIS 1001 (Mar. 1, 2014). There, an MLTSS applicant wrote her disabled son a check for over $400,000. The ALJ determined that the transfer was permissible and should not result in a penalty. The Agency reluctantly agreed;

> I concur that based on the information supplied Petitioner's son was considered disabled at the time the funds were transferred. While I understand Union County's position that it makes little sense to permit unfettered transfers to a disabled child as there is nothing to stop that child from transferring the funds back to the parent or even to the other non-disabled children. Here, Petitioner's 2011 will which was submitted in the motion to substitute her daughter, as executor, shows that Petitioner intended both of her children to be heirs under her will. In order to qualify for Medicaid, Petitioner transferred $430,183.52 directly to her son who had already been found disabled when the will was drafted. As

> the transfer was not to a trust for the son's sole benefit, there is no impediment for him to transfer 1/2 of that amount to his sister so as to effectuate Petitioner's testamentary intent while having Medicaid pay for Petitioner's care. However, absent a change in the federal law, the assets transferred to her disabled son are exempt from penalty.
>
> [Id. at *2–3.]

This issue was again addressed in M.S. v. Middlesex County Board of Social Services, 2024 N.J. AGEN LEXIS 658 (July 26, 2024), adopted, 2024 N.J. AGEN LEXIS 1101 (Oct. 17, 2024). Both the ALJ and the Commissioner determined that the imposition of a transfer penalty on an asset transfer (in this case, a house) was improper, reversing the agency's denial, which was based on the "sole benefit" language that had been so comprehensively addressed by the ALJ in A.D. See also J.B. v. Union Cnty. Bd. of Soc. Servs., 2023 N.J. AGEN LEXIS 481 (July 6, 2023), adopted, 2023 N.J. AGEN LEXIS 773 (Oct. 4, 2023).

The Commissioner found that the transfer was indeed to the disabled daughter, ruling:

> As the Sorber court ruled, the "solely for the benefit" clause under federal law applies only to the transfers made to a trust, and 42 U.S.C. § 1396p(c)(2)(B)(iii) had the effect of exempting any transfer of resources made directly to an applicant's blind and disabled child, regardless of whether the transferor makes any special arrangements to ensure that the transfer is for the child's sole benefit. Here, Petitioner's transfer of a portion of their home to their disabled daughter is allowed under N.J.A.C. 10:71-4.10(e) and 42 U.S.C. § 1396p(c)(2)(B)(iii), and therefore, Middlesex County should not impose the transfer penalty of $161,760.93.
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> [M.S., 2024 N.J. AGEN LEXIS 1101, at *5.]

There is no question that it is the duty of the Agency to "verify the existence or nonexistence" of the applicant's assets per N.J.A.C. 10:71-4.2(b)(3):

> The [CWA] shall verify the existence or nonexistence of any cash, savings or checking accounts, time or demand deposits,

> stocks, bonds, notes receivable or any other financial instrument or interest. Verification shall be accomplished through contact with financial institutions, such as banks, credit unions, brokerage firms and savings and loan associations. Minimally, the [CWA] shall contact those financial institutions in close proximity to the residence of the applicant or the applicant's relatives and those institutions which currently provide or previously provided services to the applicant.
>
> (c). Documentation of verification: Any verification which occurs in connection with the determination or evaluation of resources shall be fully documented in the case record.

As was noted in Ms. Colon-Smith's November 14, 2023 email, the Agency felt that the following information was necessary in order to be approved with a "new application":

> 1. Daughters' date of birth.
>
> 2. Verification of both daughters' disability from the Social Security Administration.
>
> 3. Verification of where the transferred funds were deposited.
>
> [P-E.]

So, where does that leave us? Well, four distinct facts are clear. First, that at the time of B.M.'s September 2023 application, she was not over-resource. Second, it really doesn't matter where the money transferred to a disabled child ends up, unless it's in a bank account to which B.M. has access. Since she is under an affirmative obligation to disclose her accounts and since there is no evidence of any such account, the transfer cannot be questioned. "Where did the money end up?" is simply not a legitimate question to be answered by the applicant once it is received by the disabled child.

Third, the birth dates of both daughters were timely provided (driver's license for A.U. and birth certificate for L.L.). (P-D2 and P-D4.) Fourth and finally, A.B.'s disability exemption eligibility per N.J.A.C. 10:71-4.10(e) has been confirmed.

Given those four facts, that leaves only the verification of L.L.'s disability as a

factual dispute. Per the case notes, the Agency was unable to determine the details of the disabilities, since the only document provided was a Form SSA-1099, "which does not show disability date or state individuals are disabled." The Agency representatives testified that because the Agency could not verify the disability, "a penalty could not be determined."

However, that statement does not make sense. The penalty could be determined by simply disallowing the transfer exemptions and applying that penalty to the entire amount. Or, given the Agency's concession that it had all of the required information concerning A.B., the transfer of assets to her could have been permitted and the penalty assessed to L.L.'s asset transfers only.

In analyzing the facts and procedural machinations of this case, there is still much that is unclear and one conclusion that is crystal clear.

First, the timeline of events is still muddled. There is no question that the application that was ultimately denied and is the subject of this hearing was the one filed on September 21, 2023.

The details of the second application, however, are unclear. Petitioner did not provide any information about that application and the Agency's case notes concerning same are unclear and the workers' testimony did not shed significant light on it. It appears to have been filed on November 30, 2023 (but the case notes say 2024, which does not make any sense given the ultimate approval date). That application was denied for failure to provide information, with a note that "the rep states that she is still working on getting all" (the rest of the note is cut off).

It was the third application, filed on February 5, 2024, that was ultimately approved, as it was "submitted with the missing documents and approved with PEME/RETRO request back to November 2023." What those missing documents were was not specified and I was not provided with that application or any details concerning it.

But it is the seeming lack of information about the September 2023 application that is the most striking. As noted, there was testimony concerning that proof of disability was provided for A.B. and no one seems to contest the information concerning where the money that was transferred ended up. Confusing the situation even more was the petitioner's argument that the application should have been approved with a penalty and the Agency's email that seemingly confirms that. While I understand that position, it is still a little mysterious as to why that was the argument as opposed to that "the application should have been approved without a penalty."

Notwithstanding that and considering the entirety of the law, facts, evidence and argument, I specifically **FIND** that the following has been demonstrated to be true by a preponderance of the credible evidence:

1. That both A.B. and L.L. are B.M.'s daughters.
2. That both A.B. and L.L. are under the age of sixty-five.
3. That A.B. is disabled as defined by the Social Security Administration.
4. That all of the asset transfers in question were made to accounts over which B.M. had no control.
5. That at the time of the September 21, 2023 application, B.M. was income, resource and medically eligible for MLTSS Medicaid.
6. That the Agency was in possession of all of this information prior to its reconsideration denial.
7. That at the very least, it appears that the $57,000 transfer made to A.B. via check dated December 31, 2019, is exempt from any N.J.A.C. 10:71-4.10 et seq. transfer penalty.

That leaves me to answer the base question as to whether the September 21, 2023 application was properly denied. The answer to that question is "no." Based upon the evidence supplied to and in the possession of the Agency at the time of the denial, I **CONCLUDE** that this application should have been approved with the consideration of a potential penalty. While, as noted above, it is relatively clear that the $57,000 transfer to

A.B. was permissible, admittedly that is *dicta* and it will ultimately be up to the Agency to determine the amount of the transfer penalty, if any, that should be applied.

In conclusion, it is unclear why the case was denied. In fact, Ms. Colon-Smith had it correct, to some degree, in her November 14, 2023 email (P-E.) Even though the petitioner disputed the Agency's contentions concerning the daughters' dates of birth and disabilities as well as the banking information, Ms. Colon-Smith gave them the option to supply that information, "OR you can take the penalty."

In fact, two days later, on November 16, 2023, petitioner's representative sent a very succinct, logical reply to that email;

> The information listed in 1 & 2 were provided initially and should not have resulted in denials. Regarding #3, wouldn't you have sent a penalty letter and not denied the application?
>
> [P-E.]

This is consistent with the general tenor of the case law, including M.T. v. Division of Medical Assistance, 2025 N.J. Super. Unpub. LEXIS 1571 (Aug. 18, 2025). While not directly on point, the Appellate Division seemingly had no quarrel with the ALJ's Initial Decision that the assessment of a transfer penalty was the appropriate result (rather than a denial) when there was a factual question concerning the Chase Bank Account. Id. at *11. While the Agency's Final Decision reversing the ALJ's decision was itself reversed and remanded for a factual determination concerning those bank accounts, there was nary an inference that the ALJ's determination was incorrect. Id. at *18.

Based upon the evidence, I **CONCLUDE** that the Agency's decision to flat deny petitioner's September 21, 2023 MLTSS application was arbitrary, capricious and unreasonable and I **ORDER** that it be and is hereby **REVERSED**.

I further **CONCLUDE** that given the evidence supplied by the parties (all of which was in respondent's possession in a timely manner), there is no need for B.M.'s September 21, 2023 application to be reconsidered, but rather I **ORDER** that it be hereby

deemed **APPROVED**. I further **ORDER** that the Agency calculate any potential transfer penalty that may be applicable and transmit that decision to petitioner's representative as soon as is practically possible.

I **FILE** this Initial Decision with the **ASSISTANT COMMISSIONER OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES**. This recommended decision is deemed adopted as the final agency decision under 42 U.S.C. § 1396a(e)(14)(A) and N.J.S.A. 52:14B-10(f). The **ASSISTANT COMMISSIONER OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES** cannot reject or modify this decision.

If you disagree with this decision, you have the right to seek judicial review under New Jersey Court Rule 2:2-3 by the Appellate Division, Superior Court of New Jersey, Richard J. Hughes Complex, PO Box 006, Trenton, New Jersey 08625. A request for judicial review must be made within 45 days from the date you receive this decision. If you have any questions about an appeal to the Appellate Division, you may call (609) 815-2950.

September 4, 2025
DATE

MATTHEW G. MILLER, ALJ

Date Filed with Agency: September 4, 2025

Date Sent to Parties: September 4, 2025

sej

APPENDIX

WITNESSES

For Petitioner:

None

For Respondent:

Rebecca Colon-Smith

Renee Williams

EXHIBITS

Court:

C-1 Exemplar LTC-2 Form

C-2 Exemplar E-79 Form

For Petitioner:

P-A1 $121,810.25 cashed check payable to L.L. (December 31, 2019)

P-A2 $57,000 cashed check payable to A.B. (December 31, 2019)

P-A3 $57,000 cashed check payable to L.L. (August 28, 2023)

P-B Cover letter from Senior Planning Services to Respondent (October 20, 2023)

P-C RFI letter from respondent to B.M. (October 12, 2023)

P-D1 A.U. Social Security Benefit Statement (2022)

P-D2 A.U. New Jersey Driver's License

P-D3 L.L. Social Security Benefit Statement (2020)

P-D4 L.L. Birth Certificate

P-E Email chain between petitioner and respondent (November 7, 2023 – December 7, 2023)

For Respondent:

R-A Fair Hearing Summary Reports

R-B Case Notes

R-C Same as P-C

R-D Respondent Timeline