



State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

OAL DKT. NO. HMA 06887-26

AGENCY DKT. NO. N/A

J.M.,

Petitioner,

v.

**HUDSON COUNTY DEPARTMENT
OF FAMILY SERVICES,**

Respondent.

Eliyahu Pekier, Esq, for petitioner (Law Office of Simon P. Werchberger,
attorneys)

Osvaldo Vagni, Human Services Specialist Four, Fair Hearing Liaison, for
respondent under N.J.A.C. 1:1-5.4(a)(3)

Record Closed: August 3, 2026

Decided: August 18, 2026

BEFORE **NANCI G. STOKES**, ALJ:

STATEMENT OF THE CASE

J.M. unsuccessfully sought current Merrill Edge retirement account statements, which he last provided to Hudson County (Hudson) in 2022. Thus, Hudson could not verify his 2025 Medicaid eligibility after three requests seeking petitioner's financial information. Is the denial supported? Yes. A county welfare agency (CWA) must provide reasonable time to supply eligibility proofs, but if no exceptional circumstances exist, the

CWA must deny the application. N.J.A.C. 10:71-2.2, 2.3; 42 C.F.R. 935.952.

PROCEDURAL HISTORY

On March 6, 2026, Hudson denied the petitioner's Medicaid application, determining that he failed to supply necessary financial eligibility verifications.

On March 23, 2026, petitioner's designated authorized representative (DAR), Rikki Hirsch, of Future Care Consultants, appealed the denial.

On April 30, 2026, the Division of Medical Assistance and Health Services (DMAHS) transmitted the case to the Office of Administrative Law (OAL) as a contested case under the Administrative Procedure Act, N.J.S.A. 52:14B-1 to-15, and the act establishing the OAL, N.J.S.A. 52:14F-1 to-13, for a hearing under the Uniform Administrative Procedure Rules, N.J.A.C. 1:1-1.1 to -21.6.

I conducted the hearing on July 7, 2026. The parties requested to submit written closing arguments.

On July 21, 2026, I received the petitioner's submission. I gave Hudson until August 3, 2026, to reply. However, Hudson presented no additional submission. Notably, both parties supply annotated regulatory provisions, which this tribunal considers as courtesy copies rather than evidence.

Still, I kept the record open to allow the petitioner to supply digital copies of recorded conversations relied upon as evidence. On August 7, 2026, I received the USB, and I closed the record.

DISCUSSION AND FINDINGS OF FACT

Based upon the testimony provided and my assessment of its credibility, together with the documents submitted and my evaluation of their sufficiency, I **FIND** the following as **FACT**:

On June 24, 2025, J.M., a nursing home resident, electronically applied for Medicaid Managed Long-Term Care Services and Supports (MLTSS) program, following an earlier Medicaid denial on July 29, 2024, for his failure to supply Merrill Edge retirement account statements. (R-2, R-8.)

J.M. was a Medicaid recipient through the COVID-19 pandemic, when CWAs could neither terminate Medicaid recipients nor had the ability to perform eligibility redeterminations. The June 24, 2025, application did not specify that J.M. needed nursing home-level care, was disabled, or identify that he had a designated authorized representative (DAR). (R-2.) Many application answers reflected “not given,” e.g., were unanswered. Under the section requiring the applicant to identify financial accounts that may contain resources, the application listed only a PNA account with a balance of \$0.01. Id. In other words, he failed to identify several financial accounts known to him, including the Merrill Edge account.

Undeniably, Hudson did not commence processing J.M.’s application for several months. On December 16, 2025, Ms. Dailey, the Hudson caseworker assigned to process J.M.’s 2025 application, sent a Request for Information (RFI) seeking income information, resource information from the past five years, whether J.M. received Supplemental Security Income, and his living arrangements, such as a nursing facility or residence. (R-3.) The letter advised J.M. that he had until December 30, 2025, to provide the requested materials. He supplied none. However, Hudson learned that J.M. had a DAR.

On December 30, 2025, Ms. Dailey sent the same Request for Information (RFI) to Rikki Hirsch, the current DAR. The letter advised J.M. and Ms. Hirsch that they had until January 13, 2026, to provide the requested information. Id.

Notably, the DAR form attached to the fair hearing request identifying Ms. Hirsch as J.M.'s DAR is dated March 26, 2026. Still, she assisted J.M. with the June 24, 2025, application. Ms. Hirsch works for Future Care Consultants, a commercial entity that assists individuals, such as J.M., in obtaining Medicaid benefits, which helped J.M. in the past.

On January 13, 2026, Ms. Hirsch reached out to a Hudson Medicaid supervisor, not Ms. Dailey, to advise her that the RFI sought five years of bank statements, but that the patient had prior Medicaid coverage through earlier applications. (P-1.) Thus, she asked Hudson whether it could link the cases so that the current application could be treated as a redetermination, requiring less documentation, like only 2025 materials necessary to reassess his continued eligibility. The supervisor advised she was adding Ms. Dailey's supervisor to the email, who could respond to the request. Id.

Hudson must verify all sources of income and resources under the Medicaid program to assess financial eligibility. To this end, Hudson reviewed prior application materials to ascertain that the petitioner had numerous accounts. In connection with the June 24, 2025, application, the Merrill Edge account did not show up on AVES, an electronic database that Hudson can use to verify certain information, like Social Security income.

On January 16, 2026, Ms. Dailey's supervisor asked Ms. Hirsch to confirm that the J.M. owned two Valley National Bank accounts. In addition, she advised that the 2024 Medicaid renewal asked for the statements for the Merrill Edge account number ending in 6580. Id.

On January 19, 2026, Ms. Hirsch provided the 2025 Valley National Bank statements. She further advised that although they requested the Merrill Edge statements, they had yet to get a response.

On January 22, 2026, Ms. Dailey's supervisor acknowledged receipt of the Valley National Bank statements. In other words, Hudson allowed the petitioner to submit current statements rather than the extent of documentation it initially requested. She also asked whether Ms. Hirsch needed an extension to obtain the Merrill Edge

statements as the verifications were due on January 13, 2026. Ms. Hirsch responded that she did. Id.

Thus, Hudson's February 2, 2026, RFI sought Merrill Edge statements from January 1, 2023, through December 31, 2025, due on February 16, 2026. If J.M. closed the account, Hudson requested documentation supporting such closure and an explanation of what was done with the funds in the account. As of the last 2022 Merrill Edge statement Hudson had in its file, the account had \$7.25. Still, Hudson needed to verify what had occurred to the account since the last statements it received. Hudson gave the petitioner an extension until February 16, 2026, to provide the materials.

On February 16, 2026, Ms. Hirsch emailed Hudson regarding the Merrill Edge statements. Per Ms. Hirsch, Merrill Edge confirmed that it received the request and that it would send the statements, but she did not have them yet. However, none of the recorded calls to Merrill Edge confirmed that it had received such a request. (P-16, P-17, P-18, and P-19). Still, Ms. Hirsch requested Hudson provide an extension until the next day to get the statements.

Hudson granted the extension, plus a few days.

On March 3, 2026, Hudson emailed Ms. Hirsch and again requested the statements. Hudson advised Ms. Hirsch that the case would be denied on March 6, 2026.

On March 6, 2026, Ms. Hirsch emailed Hudson to provide an update on her efforts. She advised Hudson that she contacted Merrill Edge by telephone herself and with the patient to obtain the bank statements.

J.M. executed a durable Power of Attorney (POA) to an individual other than Ms. Hirsch that was in effect during the June 24, 2025, application process.

Undeniably, Ms. Hirsch contacted Merrill Edge by telephone on February 12, February 17, February 18, and March 17, 2026, attempting to obtain the necessary

Merrill Edge statements. (P-16, P-17, P-18, and P-19). J.M. was not on three of the calls made by Ms. Hirsch: P-16, P-17, or P-18.

J.M.'s designated POA was also not on these calls. In P-19, Merrill Edge attempted to have J.M. verify his identity on the phone, but he could not receive a verification code through his phone or provide his driver's license number. Indeed, J.M. no longer has a driver's license or cell phone since he resides in the facility. He was also unable to recall certain information, like his account number.

Ms. Hirsch also sent a release to Merrill Edge from J.M. to obtain the records, but no Merrill Edge representative confirmed that it was sufficient or received on the recorded calls. In P-16, Ms. Hirsch advised Merrill Edge that she submitted the POA form to them, but she was not J.M.'s POA. During that call, the Merrill Edge representative recommended that the POA go to a branch office with the executed POA document to get the statements.

In P-17, the representative told Ms. Hirsch that J.M. would need to be on the call to provide verification information or that J.M. could have his POA call. Merrill Edge was unable to discuss the account with Ms. Hirsch for obvious security reasons, and these attempts were unsuccessful. Notably, each call's recorded message to callers awaiting to speak to a representative advised that individuals could obtain statements online. Yet, petitioner supplies no evidence that his POA, as opposed to Ms. Hirsch, attempted to obtain the statements on his behalf. Undeniably, the DAR did not submit the Merrill Edge statements before the denial.

In her March 6, 2026, email to Hudson, Ms. Hirsch also explained the steps she intended to follow to get the statements: obtain a Social Security card for J.M., go to the Department of Motor Vehicles with the patient to obtain a government-issued identification (ID), supply the ID to Merrill Edge, and then call Merrill Edge with the patient after submitting the ID. Ms. Hirsch expected the process to take three to six months. (P-1.) Although Ms. Hirsch testified that the patient's health was deteriorating and that he could not assist with obtaining the statements, this is inaccurate according to her email about her intended next steps with the patient and his call participation,

albeit unsuccessful. Ms. Hirsch does not refer to employing the POA as Merrill Edge suggested. She asked Hudson for advice on how to proceed.

Hudson advised that it had no further resources to suggest. Still, Hudson was responsive and clear about what remained missing.

Ms. Hirsch indicated she would file a fair hearing request to subpoena the documents in the absence of the requested additional extension. She did not ask Hudson to subpoena the records. Regardless, caseworkers are not attorneys, and such practice is not typical in application processing.

Ms. Hirsch was uninvolved in the 2024 application. Still, she acknowledges that J.M.'s file contains Merrill Edge statements from February to April 2024 that she believes were sent to Hudson with the prior application. Yet, Hudson denied the 2024 application because it did not receive those materials following its May 20, 2024, request. Still, Ms. Hirsch had 2024 account statements she could have supplied to J.M. to utilize during the call to Merrill Edge to assist him in verifying account information.

Hudson's file contains Merrill Edge statements from 2017 to 2022, utilized with an earlier Medicaid application that Hudson approved. In other words, J.M. and Future Care obtained these statements previously. Still, Ms. Hirsch does not know how Future Care obtained the prior statements. While the denial in 2024 is not before this tribunal, the case history demonstrates that the need for Merrill Edge statements was well-known before the June 24, 2025, application, whether the same individual from Future Care assisted with the 2024 or 2025 application.

Upon filing a fair hearing request and receiving an OAL docket number for the contested case, counsel for petitioner and the DAR sent a subpoena for the Merrill Edge statements on June 4, 2026. (P-3.) On June 16, 2026, Merrill Lynch supplied the statements. The statements reflect a \$7.25 balance. (P-5.)

J.M. submitted a new application with those materials. Hudson was still processing that application at the time of the hearing. Thus, this fair hearing seeks to reinstate the June 24, 2025, application to obtain Medicaid approval retroactively.

LEGAL DISCUSSION AND CONCLUSIONS OF LAW

Congress created the Medicaid program under Title XIX of the Social Security Act. 42 U.S.C. §§1396 to 1396w. The federal government funds the programs that the states administer. Once the state joins the program, it must comply with the Medicaid statute and federal regulations. Harris v. McRae, 448 U.S. 297, 300 (1980). New Jersey participates in Medicaid through the New Jersey Medical Assistance and Health Services Act (Act). N.J.S.A. 30:4D-1 to -19.5.

The Commissioner of the Department of Human Services (DHS) promulgated regulations implementing New Jersey's Medicaid programs to explain each program's scope and procedures, including income and resource eligibility standards. See, e.g., N.J.A.C. 10:71-1.1 to -9.5 (Medicaid Only); N.J.A.C. 10:72-1.1 to -9.8 (Special Medicaid Programs); E.S. v. Div. of Med. Assistance and Health Servs., 412 N.J. Super. 340, 347 (App. Div. 2010).

The Act established DMAHS within the DHS to perform the administrative functions concerning Medicaid program participation. Bergen Pines County Hosp. v. New Jersey Dep't of Human Serv., 96 N.J. 456, 465 (1984); see also N.J.S.A. 30:4D-4, -5.

County welfare agencies (CWA), such as Hudson, assist [DMAHS] in processing applications for Medicaid and determining whether applicants have met the income and resource eligibility standards." Cleary v. Waldman, 959 F. Supp. 222, 229 (D.N.J.1997), aff'd, 167 F.3d 801 (3d Cir.), cert. denied, 528 U.S. 870 (1999). Significantly, an applicant bears the burden of establishing eligibility for Medicaid benefits. D.M. v.

Monmouth Cnty. Bd. of Soc. Servs., HMA 6394-06, Initial Decision (April 24, 2007), adopted, Dir. (June 11, 2007), <https://njlaw.rutgers.edu//OAL>.

Hudson must verify all eligibility factors. See Medication Communication No. 22-04; N.J.A.C. 10:71-1.6. Notably, N.J.A.C. 10:71-4.1(d)(3) requires a CWA to verify the value of resources through “appropriate and credible sources.”

Still, an applicant is the primary source of information and must cooperate with the CWA in securing evidence to corroborate their statements. N.J.A.C. 10:71-1.6(2). Further, a CWA must seek verification of questionable information provided by an applicant, N.J.A.C. 10:71-2.2 and -2.3, and permit the applicant to comply. Indeed, the CWA and applicants have responsibilities during the application or redetermination process. Id. A CWA can verify resources or other eligibility information from collateral investigation to clarify or supplement essential information. N.J.A.C. 10:71-2.10. To that end, petitioner cites to a CWA director’s ability to subpoena records to assess eligibility under N.J.S.A. 44:7-20 and suggests Hudson should have done so. Yet, this is not common practice, and case processing representatives are not lawyers.

Importantly, J.M.’s POA also could obtain his financial statements under her authority. N.J.S.A. 46:2B-11(e). Although Ms. Hirsch undeniably attempted to assist J.M. in this process in good faith, Ms. Hirsch is not J.M.’s POA. Further, Merrill Edge suggested the POA make attempts to obtain the records, but there is insufficient evidence to suggest that she did so.

DMAHS issues Medicaid Communications to guide CWAs processing Medicaid cases. Medicaid Communication No. 22-04, updating Medicaid Communication No. 10-09, addresses case processing timeframes and verifications. (R-7.)

Under Medicaid Communication No. 22-04 and 42 CFR 435.952 (c)(2), if verification results in a discrepancy, insufficient information, or an error, the CWA will send a Request for Information (RFI) letter. The RFI letter will allow the applicant fourteen days to respond. Ibid. Undeniably, the submitted June 2025 application lacked significant information regarding J.M.’s living situation, need for nursing home-

level care, finances, and the existence of a DAR. Thus, Hudson sent an RFI seeking considerable information already known to J.M. and Future Care Consultants.

If the CWA receives no response, it will deny the application for failure to provide information under 42 CFR 435.952 (c)(2). Here, Hudson later learned of a DAR and sent a second RFI even though it did not receive the requested information in the first RFI. Hudson gave Ms. Hirsch a multiple-day extension when she stated she needed “one day.” Before denying the case after a third RFI deadline with an extension that came and went, Hudson again followed up on the missing verifications. Hudson still allowed more time, but received a subsequent lengthy extension request, which it could not grant. See N.J.A.C. 10:71-2.3(c) (permitting an extension of time to issue an eligibility determination when the applicant did not produce information due to exceptional “[c]ircumstances wholly beyond the control of both the applicant and the [CWA]”). Yet, at best, an extension is permissible, not required. Ibid.; S.D. v. Division of Med. Assistance & Health Servs. and Bergen County Bd. of Social Services, 2013 N.J. Super. Unpub. LEXIS 393 (February 22, 2013).

Under Medicaid Communication No. 22-04, the CWA may send an additional RFI letter if the applicant's response to the first RFI prompts the need for further outreach, as Hudson did here. Here, I **CONCLUDE** that Hudson provided several extensions and diligently followed up on its verification requests. In essence, the petitioner suggests Hudson should have given more time or done more. However, the need for Merrill Edge statements was not a novel one. Future Care obtained the statements in the past. J.M. had a POA, and no evidence suggests that the POA made attempts to obtain the missing statements.

The petitioner relies upon several cases to support his position in this case. However, each Medicaid application and its processing challenges are specific to the individual applying for benefits.

For example, in J.L. v. DMAHS and the Middlesex Cnty. Board of Social Svcs., 2022 N.J. Super. Unpub. LEXIS 2636, the Appellate Division reversed DMAHS's Final Decision that found the petitioner ineligible for Medicaid given the failure to present

timely verifications. (P-11 at *1). In J.L., the caseworker requested bank statements, which the petitioner partially provided. The caseworker advised it would subpoena the records. Still, it did not do so and failed to advise the DAR that it never received the missing statements before denying the application so that the DAR could continue its own efforts. Id. at *3-5. In other words, the denial under those circumstances was unreasonable. Id. at *12-13.

Unlike J.L., Hudson advised J.M. of the continuing need for additional materials and extended the deadlines for their receipt. Hudson never said it would subpoena the records and then failed to do so. Phone conversations with the financial institution, attempted mostly after the extended due date for the statements, indicated that the POA would need to assist J.M., given his inability to verify certain security information, but that did not occur. Indeed, there is also no indication that the POA contacted Merrill Edge to get the statements under her authority or attempted to go to a bank branch as suggested, which she could have. Further, Future Care could not explain how it received prior statements for the account in the past. Instead, it seeks to blame Hudson for not sending its own subpoena, despite Hudson's being unfamiliar with that process, and giving J.M. reasonable extensions. Indeed, the primary responsibility to obtain eligibility materials remains with the applicant.

In another case, E.O. v Union Cnty. Board of Social Services, HMA 00490-25 and HMA 09494-25 (Consolidated), Initial Decision (December 15, 2025), the ALJ highlighted that the county welfare agency inappropriately questioned items, such as letters from financial institutions that reported no account records existed, did not assist the applicant's representative, or extend timelines to submit verifications. Further, the representative provided a "legitimate" explanation as to why it could not supply additional documentation. Thus, the ALJ concluded that reversal of the county's determination was appropriate. Yet, Hudson did not act similarly here; the case is not binding in this case, and Future Care's failure to involve J.M.'s POA, despite recommendations to do so, is distinct from the situation in E.O. In other words, the cases cited do not support the relief the petitioner seeks in this case.

Given this discussion, I **CONCLUDE** that J.M.'s failure to provide timely verifications for his June 24, 2025, Medicaid application made him ineligible, that no exceptional circumstances exist to support another lengthy extension, and that his appeal should be **DISMISSED**.

ORDER

Given my findings of fact and conclusions of law, I **ORDER** that J.M. is ineligible for Medicaid through his June 24, 2025, Medicaid application because he failed to supply necessary verifications in a timely manner, presents no exceptional circumstances to support another extension, and that his appeal is hereby **DISMISSED**.

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.



August 18, 2026

DATE

NANCI G. STOKES, ALJ

Date Filed with Agency:

August 18, 2026

Date Sent to Parties:

August 18, 2026

ljb

APPENDIX

WITNESSES

For Petitioner:

Rikki Hirsch, Future Care Consultants

For Respondents:

Khalilah Dailey, Human Services Specialist Two

EXHIBITS

For Petitioner:

- P-1 Emails
- P-2 Emails
- P-3 Subpoena to Merrill
- P-4 Cover page to response from subpoena
- P-5 Response to subpoena

- P-6 N.J.A.C. 10:71-2.2¹
- P-7 42 CFR 435.908
- P-8 N.J.A.C. 10:71-1.6
- P-9 N.J.A.C. 10:71-2.10
- P-10 N.J.S.A. 44:7-20
- P-11 J.L. v DMAHS
- P-12 E.O. v Union
- P-13 I.L. v DMAHS
- P-14 G.T. v Ocean and N.T. v Ocean
- P-15 Emails
- P-16 February 12, 2026, call recording
- P-17 February 17, 2026, call recording
- P-18 February 18, 2026, call recording
- P-19 March 17, 2026, call recording
- P-20 Call log

For Respondent:

- R-1 Case Summary
- R-2 June 24, 2025, Medicaid application
- R-3 Requests for Information
- R-4 Denial letter dated March 6, 2026
- R-5 42 CFR 435.932
- R-6 Medication Communication 22-04
- R-7 Request for Information, May 20, 2024
- R-8 Denial letter dated July 29, 2024

¹ Many of parties' exhibits include annotated regulations and statutes. This tribunal considers them courtesy copies rather than evidence.