



State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION

N.D.,

Petitioner,

v.

**ESSEX COUNTY DIVISION OF FAMILY
ASSISTANCE AND BENEFITS,**

Respondent.

OAL DKT. NO. HMA 00309-25

AGENCY DKT. NO. N/A

N.D.,

Petitioner,

v.

**ESSEX COUNTY DIVISION OF FAMILY
ASSISTANCE AND BENEFITS,**

Respondent.

OAL DKT. NO. HMA 03013-25

AGENCY DKT.NO. N/A

Simon P. Wercberger, Esq., for petitioner N.D. (Law Office of Simon P. Wercberger, L.L.C., attorneys)

Mario Greco, Fair Hearing Liaison, for respondent Essex County Division of Family Assistance and Benefits under N.J.A.C. 1:1-5.4(a)(3)

Record Closed: July 27, 2026

Decided: July 30, 2026

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

STATEMENT OF THE CASE

Petitioner, Estate of N.D., appeals the October 24, 2024, denial of her August 28, 2024, 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. She also appeals the December 20, 2024 denial of her October 30, 2024, Medicaid application. N.D. argues that all available requested information was supplied in a timely manner and that both applications were complete and should have been approved. N.D. further argues that, despite diligent efforts, the sole documents that were not provided (bank records from Chime Bank) were unavailable. Instead of attempting to assist the petitioner or even responding to her request for an extension of time, the respondent simply denied the applications. It further notes that the second application was denied, in part, for failing to supply documents that had never been requested.

The Agency argues that the petitioner never supplied the records in question despite numerous requests for documents and that it had no choice, given strict decision deadlines, to deny the two applications in question before finally approving the third application after the records were supplied.

The scope of the dispute, however, is limited, since N.D.'s subsequent December 31, 2024, application was approved with three months of retroactive benefits being awarded with an effective date of September 1, 2024. If the August 28, 2024, application is approved, N.D. is seeking a pick-up date of August 1, 2024, with an additional three months of retroactive benefits (May, June and July 2024). Alternatively, if the October 30, 2024, application is approved, she is seeking a pick-up date of October 1, 2024, with an additional two months of retroactive benefits (July and August 2024).

PROCEDURAL HISTORY

While the full timeline of events that led to this filing is detailed below, for this specific appeal, the petitioner filed an application for Medicaid on September 30, 2024.

That application was denied by letter dated October 7, 2024. On or about November 27, 2024, petitioner's representative timely requested a fair hearing, and the matter was transmitted to the Office of Administrative Law on or about January 15, 2025, for a hearing as a contested case pursuant to N.J.S.A. 52:14B-1 to -15; N.J.S.A. 52:14F-1 to -13.

In N.D. v. Essex Cnty. Div. of Fam. Assistance & Benefits, OAL DKT. No. HMA 00309-25, an initial conference scheduled for April 22, 2025 was adjourned by the petitioner. The respondent failed to appear for a May 6, 2025, hearing and a conference scheduled for May 29, 2025 was adjourned by the petitioner. Following the June 17, 2025 death of the petitioner, a hearing scheduled for September 3, 2025 was adjourned. While a new hearing was scheduled for November 3, 2025, once the petitioner filed an Order to Show Cause in Superior Court,¹ an Order of Inactivity was entered on October 14, 2025, and a status conference was scheduled for December 15, 2025. (C-1.) That conference was adjourned by the petitioner. A conference was held on January 6, 2026, and on January 12, 2026, a second Order to Show Cause was filed under the same docket number. That OTSC was granted on February 4, 2026, and the DAR was appointed as the administrator of N.D.'s estate for the limited purpose of obtaining Medicaid benefits. (C-2.) A scheduled telephone conference on March 24, 2026, ran into technical difficulties, but the following day, the matters were formally consolidated. (C-3.)

In N.D. v. Essex Cnty. Div. of Fam. Assistance & Benefits, OAL DKT. No. HMA 03013-25, a hearing was scheduled for May 20, 2025, but the respondent failed to appear. The July 1, 2025, and September 4, 2025, hearings were adjourned by the petitioner. The December 15, 2026, hearing was adjourned due to petitioner's counsel's jury duty. Once the January 12, 2026, Order to Show Cause was filed, a January 15, 2026, hearing date was adjourned. The matters were formally consolidated on March 25, 2026, and the consolidated hearing was scheduled to take place on July 8, 2026. However, the respondent failed to appear, and ultimately the parties agreed to proceed to hearing on the papers. The record formally closed on July 27, 2026.

¹ In re: N.D. (ESX-CP-00341-25). The initial OTSC filed under that docket number was denied.

FACTUAL DISCUSSION AND FINDINGS

The following facts are not in dispute, and I therefore **FIND** the following as **FACTS**:

1. On January 23, 2024, petitioner, N.D., was admitted to Columbus Hospital in Newark, New Jersey. Her Pre-Admission Screening ("PAS") approval date was March 18, 2024, ahead of her March 21, 2024 transfer from Columbus and admission to Alaris Health at St. Mary's in Orange, New Jersey. (P-1-20.)
2. On August 28, 2024, per N.J.A.C. 10:60-6.1, she applied for NJ Family Care Aged, Blind, Disabled Medicaid/Managed Long-Term Services and Supports ("MLTSS Medicaid" or "Medicaid") (Application #1). (P-1.)
3. On September 26, 2024, the respondent sent a Request for Information ("RFI") to petitioner on Application #1, requesting extensive documentation. This was to be supplied by October 10, 2024. (P-2.)
4. By letter dated October 24, 2024, Application #1 was denied. (P-5.)
5. On October 30, 2024, petitioner N.D. applied for Medicaid again. (Application #2). (P-11.)
6. On November 26, 2024, the respondent sent an RFI to petitioner on Application #1, requesting extensive documentation. This was to be supplied by December 10, 2024. (P-12.)
7. On November 27, 2024, petitioner appealed the denial of Application #1. (C-4.)
8. On December 20, 2024, the respondent denied Application #2. (P-13.)
9. On December 27, 2024, petitioner appealed the denial of Application #2.
10. On December 31, 2024, N.D. filed a third Medicaid application (Application #3).

11. On January 3, 2025, the Agency sent an RFI to petitioner in response to Application #3, requesting "current November and December bank statements and PNA ledger." (C-5.)
12. Application #3 was approved by letter dated January 28, 2025, with an effective date of December 1, 2024. Retroactive benefits for the months of September, October and November 2025 were also awarded. (R-2.)
13. Unfortunately, N.D. died on June 17, 2025. (C-6.)

APPLICATIONS AT A GLANCE

For easier reference, the below details the history of the petitioner's Medicaid applications and denials.

Application #1

Filed	August 28, 2024
Denied	October 24, 2024

Application #2

Filed	October 30, 2024
Denied	December 20, 2024

Application #3

Filed	December 31, 2024
Approved	January 28, 2025
Retroactive date	September 1, 2024

ISSUES

The issues are rather straightforward and are somewhat similar for both applications.

As for Application #1, the petitioner noted that it had made every effort to obtain the missing information that had been requested from N.D.'s Chime Bank account and

had kept the Agency apprised of its efforts. It had also requested an extension of time to supply that information but only received a denial letter.

Concerning Application #2, the petitioner made a two-pronged argument. First, it noted that it had supplied all of the information requested by the Agency and then followed up repeatedly concerning whether that information had been received and as to the status of the application. Then, after an unexplained denial, it supplied additional information (that had never been requested previously) in an expeditious manner.

The respondent argued that it had given the petitioner ample opportunity to provide the Chime Bank records, including granting the requested extension, before making its decision to deny the application, which is in line with N.J.A.C. 10:71-2.3 and Medicaid Communication 22-04. (C-8.)

Similarly, as to the second application, the Agency argued that the petitioner had failed to supply specific information concerning N.D.'s (purported) PNA and had further failed to provide documentation from her Credit Builders account. Without that information, it is argued that it was unable to make a credible determination as to her eligibility for benefits.

THE APPLICATIONS AND DENIALS

Application #1

As noted above, N.D. first filed for Medicaid on August 28, 2024. (P-1.) In response to that application, the Agency sent a "Request for Information" letter dated September 26, 2024. (P-2.) That letter requested a substantial amount of information and was generally formulaic. Among the information requested were five years of all bank account statements (open and closed). All of this information was to be supplied by October 10, 2024.

Clearly, in anticipation of having to supply this information, N.D.'s DAR contacted Chime, which is an online-only bank.² According to the email exchange between the DAR and Chime, the bank could not release the records to the DAR without a signed Power of Attorney. Alternatively, N.D. could download the documents on her own through Chime's app or call the bank herself. (P-3.) These emails were all sent/received prior to the receipt of the RFI.

Multiple emails between the DAR and the Agency were also supplied. (P-4.) The first one of true substance was seen by the DAR on October 10 and included multiple records and noted the following to be "pending":

- a. Statements for Chime account ending in (4) from 7/2020 to 8/31/2021.
- b. Statement for Chime account ending in (6) from 8/1/2022–10/31/2022 and 8/2/2024–8/31/24.

It was requested that the Agency extend the deadline for the provision of these documents until October 24, 2024.

Later that day (October 10), the DAR emailed the Agency again, this time attaching the missing statements from the "6" account. However, she was having difficulty obtaining the missing statements from the "4" account. In the email, she referenced the September 4 and 5, 2024, emails and then the following:

We called chime bank on 9/20/24 with (N.D.) and asked for the saving account statements to be sent to (her) however the rep stated that there is some breach on her account, it has to be fixed and we can call back at a later date.

We called the bank with the client again on 10/10 however the rep said the same thing; there is a breach on the account!!! The error was never fixed!

² <https://www.chime.com/> (last accessed July 8, 2026).

We are continuing to try to reach a supervisor at chime to get this error fixed so they can send (N.D.) the missing saving account statements.

Please can you give an extension?

While the Agency denied the application on October 24, 2024, the DAR was apparently unaware of the same and sent two emails to respondent on October 28, 2024. The first asked if the extension had been granted and advised that they were "still working on getting" the remaining account "4" statements, with the second email simply clarifying a scrivener's error as to the dates of the missing statements.

Application #2

The second application was submitted on October 30, 2024. (P-11.) In response to that application, the Agency sent a "Request for Information" letter dated November 26, 2024. (P-12.) Again, that letter requested a substantial amount of information and was generally formulaic. However, this specific information was requested:

PNA and payment ledger for the past 3 months

Current bank/financial statements for the months of
September–November 2024

This information was to be supplied by December 10, 2024. On December 3, 2024, the DAR emailed the Chime statements specifically as requested and further advised that "(t)here is no PNA account and no account ledger as we have not received any payment for (N.D.)." (P-14.) This email was followed by emails on December 5, 6 and 10, 2024 asking the respondent to confirm receipt of the statements. The statements were then resent in a separate December 10, 2024, email.

These emails were followed by emails on December 11, 13, 17, 18 and 26, 2024, all of which asked for confirmation of receipt of the statements and when the application would be approved. However, the case had been denied by letter dated December 20,

2024. After receiving that letter, the DAR, via a December 30, 2024, email, asked the Agency to “clarify” the denial, noting that all requested documents had been supplied.

Respondent’s representative finally responded on December 31, 2024:

My apologies in the delay in responding. When reviewing the case at the time of the denial the requested documentation was not in the case file. I do see the attached Chime accounts requested for September and October. However, I do not see the PNA and Payment ledger. Please submit and I will reevaluate for eligibility. I hope this helps.

The DAR replied to the email later that morning, reiterating that there was no PNA account. That email confirmed the existence of an RFMS account,³ reflecting the Social Security deposit for the month. The DAR followed up with January 3, 7, 8, 9 and 10, 2025 emails.

The Agency finally responded on January 10, 2025, advising that the “new” application (referring to the December 31, 2024, application) was waiting to be assigned to a worker. The DAR, apparently unaware of the new application, replied that same morning, questioning why the October 30, 2024 application had not been approved. The Agency replied, stating that it was being sent to another worker to determine whether the case should be reopened. Emails from the DAR on January 13 and 14, 2025, followed.

There was then a call between the DAR and the caseworker, confirming that the October 30, 2024, application was being reviewed to see if it would be reopened. The worker, in a January 14, 2025, email, then requested additional information concerning where N.D.’s Social Security income was being deposited prior to December 2024, since it was not in her Chime account. The email also requested information from Credit Builders.

³ <https://www.nationaldatacare.com/products/resident-fund-management-service/> (last accessed July 29, 2026).

In a reply the next day, the DAR noted that, first, a Social Security deposit had been made on October 29, 2024, into the Chime account. Second, this was the first time that this issue had been raised. Then, on January 16, 2025, the DAR confirmed that the September Social Security deposit had been deposited in the Chime account and attached the Credit Builder statements for September through December 2024. The DAR followed up later that day and in a subsequent January 16, 2025 email, attached additional Credit Builders statements from January through August, 2024.

Following a January 20, 2025, follow-up, a second January 20 email attached Credit Builders statements from June through December 2023. Later that day, the balance of the 2022 and 2023 Credit Builders statements was forwarded (as well as the December 2021 statement).

On January 21, 2025, the DAR acknowledged receipt of a January 3, 2025, RFI concerning the December 31, 2024, application but again requested reconsideration of the October 30, 2025, application.

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 implemented at the state level, which 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.

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).

N.S. v. Div. of Med. Assistance & Health Servs., 2019 N.J. Super. Unpub. LEXIS 1499 (App. Div. July 3, 2019).]

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. N.J.A.C. 10:71-4.2 (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.

The duties of the agency are also delineated in N.J.A.C. 10:71-2.2(d) and the applicant is also obliged to:

1. Complete, with assistance from the CWA if needed, any forms required by the CWA as a part of the application process;
2. Assist the CWA in securing evidence that corroborates his or her statements; and
3. Report promptly any change affecting his or her circumstances.

[N.J.A.C. 10:71-2.2(e)]

As noted in Galletta, "when seeking an eligibility decision, applicants must provide the county agencies with documentation and evidence related to their resources." Id. at 18.

It should also be noted that in the realm of Medicaid, there must "be strict adherence to law and complete conformity with administrative policies. Requirements other than those established by law or regulations shall not be imposed on any person as a condition of receiving medical assistance." N.J.A.C. 10:71-1.6(a)(4).

Finally, N.J.A.C. 10:71-2.3 imposes time restrictions on the Agency concerning the disposition of the application. This Code provision reads in relevant part:

- (a) The maximum period of time normally essential to process an application for the aged is 45 days; for the disabled or blind, 90 days.

- (c) It is recognized that there will be exceptional cases where the proper processing of an application cannot be completed within the 45/90-day period. Where substantially reliable evidence of eligibility is still lacking at the end of the designated period, the application may be continued in pending status. In each such case, the CWA shall be prepared to demonstrate that the delay resulted from one of the following:
1. Circumstances wholly within the applicant's control;
 2. A determination to afford the applicant, whose proof of eligibility has been inconclusive, a further opportunity to develop additional evidence of eligibility before final action on his or her application;
 3. An administrative or other emergency that could not reasonably. . . have been avoided; or
 4. Circumstances wholly outside the control of both the applicant and CWA.
- (d) When the complete processing of an application is delayed beyond 45 days for the aged or 90 days for the blind or disabled, written notification shall be sent to the applicant on or before the expiration of such period, setting forth the specific reasons for delay.

(emphasis added.)⁴

With the above as background, we must add Medicaid Communication 22-04 (May 3, 2022) into the mix. The key language there is:

If an applicant/beneficiary fails to provide the requested information, fails to respond to the EDA while under a good faith extension, or fails to respond to EDA outreach, a denial/termination letter with the applicable citation must be sent.

⁴ See also, Medicaid Communication 10-09.

- For denial letters when the individual failed to provide requested information (new applicants only) no further documentation will be accepted by the Agency and the individual will be provided with information to reapply. Verifications from the previous application shall be utilized in the new application where appropriate.

So, let's review the application timelines noted above and compare them to the law and see where we end up.

Application #1 is actually rather straightforward, with petitioner's primary problem being the inability to obtain some of the documentation from Chime Bank in a timely manner. The RFI had requested specific Chime statements to be supplied by no later than October 10, 2024. That day, the petitioner supplied most of those statements, except for a few from Account "4." The petitioner had already documented the difficulties she was having in obtaining those statements in prior emails and on that October 10 deadline day, she requested a two-week extension.

While the Agency did not specifically acknowledge that request, in effect, it granted that extension, since the denial letter was not dated until October 24. Key here is the fact that in the interim, there was no communication from the petitioner. In fact, it was not until October 28, 2024 that the petitioner communicated with the Agency and even then, it was only to advise that it had yet to receive the requested statements. Further, that email did not provide any timeline as to when they would be supplied or, alternatively, that they could not be obtained.

While given N.D.'s status as a "disabled" applicant, there was a ninety-day case processing limit, which is not a minimum processing time, but rather a maximum. In essence, the Agency granted the petitioner's extension request and then denied the application when it didn't hear anything by the extended date. As it turns out, those statements were not forwarded until December 10, 2024, forty-seven days after the extended deadline and after the October 30, 2024 submission date of Application #2.

Was the Agency quick on the trigger in denying the application? Perhaps, but I **CONCLUDE** that it was not an unreasonable decision. While the decision to extend was not specifically communicated to the petitioner, the Agency extended the due date exactly as requested by her in the October 10, 2024 email. It was also key that the petitioner did not communicate with the Agency until after that deadline had passed.

While I appreciate that the extension had not been communicated, the petitioner knew that she had requested a specific date but still went eighteen days before attempting to confirm the same and/or provide an update. Even then, it did not provide any substantive update but merely advised that it was still attempting to obtain the statements in question. It would have been a more difficult issue if the Agency had refused a timely subsequent extension request, but that didn't happen.

The cases supplied by petitioner in support of its position, at least as to this application, are not persuasive. Only one of them is an Appellate Division case, but even then, the facts are substantially different. For example, in A.G. v. Essex Cnty., 2025 N.J. Agen. LEXIS 376 (July 9, 2025), on a very tight timeframe over the holidays, the DAR supplied a detailed explanation as to his efforts to obtain the requested information and requested an extension of time. Although it was not communicated to the DAR, Essex had effectively granted a ten-day extension and didn't issue the denial letter until fourteen days past the deadline. The sole missing documents were then supplied about two months later in conjunction with a subsequent application. The primary difference here is that the DAR requested an extension to a specific date, October 24, 2024. Effectively, that request was granted. There was also no mystery in what information was missing: the statements from Chime account "4".

While it would have been preferable if the Agency had communicated that it had granted N.D.'s specific extension request, the DAR received what she asked for. When it became apparent that those records would not be received by the new self-imposed deadline, the DAR did not reach out before that new "deadline" date.

I acknowledge that at the time of the denial, only fifty-seven days had passed since the application, which is well within the “normal” ninety-day processing deadline. However, an extension is “permissible,” not mandatory. S.D. v. Div. of Med. Assistance & Health Servs., 2013 N.J. Super. Unpub. LEXIS 393 at *14 (App. Div. 2013). And here, the one extension that was requested for Application #1 was granted.

The other case cited by petitioner is less favorable. In E.M. v. Middlesex, 2023 N.J. Agen. LEXIS 949 (Dec. 8, 2023), while the Agency’s denial was reversed, the DAR had provided updates before the initial RFI deadline and requested a short extension. Then, prior to the expiration of the extension, the DAR provided a very specific update and requested another short extension, which was denied without explanation, only thirty-five days into the application process. DMAHS was incredulous in adopting the initial decision. E.M. v. Middlesex, 2024 N.J. Agen. LEXIS 58 at *5 (Jan. 22, 2024).

As for the October 30, 2024, application (#2), however, it’s a different story. There, it is unquestioned that an RFI dated November 26, 2024, was sent to the DAR requesting two items:

- a. PNA and payment ledger for the past 3 months.
- b. Current bank/financial statements for the months of September–November 2024.

That documentation was to be supplied by December 10, 2024. The petitioner responded via email on December 3, 2024, attaching the Chime statements and advising that there was no PNA account and no account ledger. (P-14.) Significantly, the DAR then followed up at least four times (including resending the statements), confirming receipt. There were then four more emails sent prior to the December 20, 2024, denial letter. None of those **NINE** emails were ever responded to (nor was a December 26 email).

It was not until December 31 that the Agency replied. Even then, while acknowledging the receipt of the bank statements, the reply ignored the email assertion

that there was no PNA or PNA account statement, but only a Resident Fund Management Service account, which reflected the deposit of her Social Security payment. The DAR then followed up with five more emails through January 10, 2025.

There was then a colloquy of emails before, on January 14, 2025, the Agency, for the first time, requested the Credit Builders statements, all of which were supplied by January 20, 2025.

At no point after the December 3, 2024 RFI reply until the December 20, 2024 denial letter did the Agency communicate with the DAR either confirming receipt of the documents in question or advising that there were any additional documents that it needed to make a decision on the application. This despite FOUR additional emails sent prior to the expiration of the RFI deadline and FOUR MORE emails sent prior to the denial letter.

Even then, as evidenced by the Agency's December 31 email, petitioner's submission received, at best a cursory review (i.e., "you didn't send the PNA info that you already advised us doesn't exist.") Only after the January 10 Agency reply did it start asking for the Credit Builders account information and refuse to reopen the October 30, 2024, application, despite the DAR having complied with any request it had propounded and repeatedly asking if there was anything else that was needed.

Was Essex quick to deny Application #1? Yes, but at least that was a justifiable denial. The denial of Application #2 was, I **FIND**, clearly arbitrary, capricious and unreasonable. The Agency's failure to communicate with the petitioner is simply unacceptable and its failure to reopen the case within the ninety-day review period is similarly unacceptable. "Just re-apply" or "You've already re-applied" just aren't adequate responses when a petitioner is seeking benefits to which she is entitled.

This sentiment was recognized in J.P. v. Div. of Med. Assistance, 2024 N.J. Agen. LEXIS 779 (Sept. 23, 2024). There, amongst other issues, the Agency "failed to

communicate to the Petitioner that their response to the second RFI was insufficient, or that additional documentation was needed prior to denying their application. . .” Id. at *4.

In consideration of the Petitioner's prompt responses to all of Atlantic County's prior RFIs, the ALJ found that the Petitioner would have promptly responded to any notice by the Atlantic County of a deficiency and worked with the Agency to provide the information in a timely fashion. Ibid. As such, the ALJ concluded that Atlantic County's denial was unreasonable according to N.J.A.C. 10:71-2.3(a). . .

[Ibid.]

Similarly, in M.L. v. Div. of Med. Assistance & Health Servs., 2025 N.J. Super. Unpub. LEXIS 407 (App. Div. 2025), a decision involving this respondent, the Appellate Division emphasized that the Agency's job is not to play “gotcha,” but rather to assist the applicant:

N.J.A.C. 10:71-2.2(c)(1) to (5), requires a caseworker to: “[i]nform the applicants about the purpose and eligibility requirements for Medicaid Only, inform them of their rights and responsibilities under its provisions and inform applicants of their right to a fair hearing; [r]eceive applications; [a]ssist . . . applicants in exploring their eligibility for assistance; [m]ake known to . . . applicants the appropriate resources and services both within the agency and the community, and, if necessary, assist in their use; and [a]ssure the prompt and accurate submission of eligibility data to the Medicaid status files for eligible persons and prompt notification to ineligible persons of the reason(s) for their ineligibility.”

State agencies must “turn square corners” with the public they serve in carrying out their statutory responsibilities. W.V. Pangborne & Co. v. N.J. Dep't of Transp., 116 N.J. 543, 561-62 (1989), 562 A.2d 222.

In M.L., the petitioner timely replied to an RFI by supplying the requested bank statements. Then, with no further communication, the Agency denied the pending application. The Court noted that it was the worker's duty:

. . . to review the pending application and notify petitioner concerning what, if any, additional information was required to make an eligibility determination. The record shows Lewis failed to do so. Instead, she denied the March 31 application, and only then informed petitioner his application was deficient. It follows that DMAHS' final administrative decision adopting DFAB's improper denial of the March 31 application was arbitrary, capricious and unreasonable.

[Id. at *10.]

In M.L., the caseworker, after receiving the requested documents, determined that, based on those documents, additional information (concerning three withdrawals from the account in question) was needed to determine the petitioner's eligibility. However, as noted, the caseworker never advised the applicant of this and simply denied the application, leading to the above analysis and a reversal of the denial.

Essentially, the Court held that an Agency, under normal circumstances, can't deny an application because of a failure to supply information that the petitioner either didn't know they needed to supply or didn't realize they hadn't supplied. Unfortunately, that is what happened with N.D.'s second application.

As I have written before, Medicaid case workers, particularly in Essex County, can often be overwhelmed with their workload. However, when faced with situations where the petitioner is responsive and is obviously doing their best to successfully push an application through, the office has to do better and simply cannot default to the mantra of "just re-apply."

Having fully considered the substantial documentary evidence supplied by the parties, their arguments and the law, I **FIND** that the petitioner has proven by a preponderance of the credible evidence that the Agency's decision to deny (and continue to deny) the October 30, 2024, Medicaid application (Application #2) was arbitrary, capricious and unreasonable. I therefore **CONCLUDE** that the Agency's denial of the petitioner's October 30, 2024, application should be **REVERSED**.

I further **CONCLUDE** that, given the stipulation that retroactive benefits for September 2024 have already been granted to N.D. (and paid to the nursing home), the Agency is only responsible for the payment of retroactive benefits for July 2024 and August 2024.

ORDER

Based on the foregoing, it is hereby **ORDERED** that respondent's denial of petitioner's August 28, 2024, application for Medicaid benefits be and is hereby **AFFIRMED**.

It is further **ORDERED** that respondent's denial of petitioner's October 30, 2024, application for Medicaid benefits be and is hereby **REVERSED**.

It is further **ORDERED** that the petitioner's October 30, 2024, application for Medicaid benefits be **APPROVED** by respondent.

It is further **ORDERED** that the parties cooperate in as expeditious a manner as possible to determine the appropriate retroactive payments to the subject facility for July 2024 and August 2024, to which this award is limited.

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.

July 30, 2026

DATE



MATTHEW G. MILLER, ALJ

Date Received at Agency:

July 30, 2026

Date Mailed to Parties:

July 30, 2026

MGM/sej

APPENDIX

EXHIBITS

Court:

- C-1 Order of Inactivity (October 14, 2025)
- C-2 Order in In re: N.D. (ESX-CP-0341-2025) (February 4, 2026)
- C-3 Consolidation Order (March 25, 2026)
- C-4 Appeal (November 27, 2024)
- C-5 RFI (January 3, 2025)
- C-6 Death Announcement (June 17, 2025)
- C-7 Medicaid Communication 10-09 (November 24, 2010)
- C-8 Medicaid Communication 22-04 (May 3, 2022)

For petitioner:

- P-A Brief
- P-1 Medicaid application (August 28, 2024)
 - P-1-20 LTC-2 (May 7, 2024)
 - P-1-21 Medicare eligibility document
- P-2 RFI (September 26, 2024)
- P-3 Email chain between Chime Bank and N.D.'s DAR (September 4–6, 2024)
- P-4 Email chain between respondent and N.D.'s DAR (August 27–October 28, 2024)
- P-5 Denial letter (October 24, 2024)
- P-6 E.M. v. Middlesex Cnty. Bd. of Social Servs., OAL Dkt. No. HMA 05068-23, Initial Decision (Dec. 8, 2023).

- P-7 E.M. v. Middlesex Cnty. Bd. of Social Servs., OAL Dkt. No. HMA 05068-23, Final Decision (Jan. 22, 2024).
- P-8 M.L. v. Essex Cnty. Div. of Fam. Assistance & Bens., 2025 N.J. Super. Unpub. 407 LEXIS (App. Div., Mar. 18, 2025).
- P-9 G.T. v. Ocean Cnty. Bd. of Social Servs. and N.T. v. Ocean Cnty. Bd. of Social Servs., 2025 N.J. Agen. LEXIS 203 (Apr. 8, 2025).
- P-10 A.R. v. Monmouth Cnty. Bd. of Social Servs., 2025 N.J. Agen. LEXIS 68 (Feb. 11, 2025).
- P-11 Medicaid application (October 30, 2024)
- P-12 Request for Information letter (November 26, 2024)
- P-13 Denial letter (December 20, 2024)
- P-14 Email chain between petitioner and respondent (December 3, 2024–January 21, 2025)
- P-15 J.P. v. Div. of Med. Assistance and Health Servs., 2024 N.J. Agen. LEXIS 779 (Sept. 23, 2024).
- P-16 A.G. v. Essex Cnty. Div. of Fam. Assistance and Benefits, OAL Dkt. No. HMA 04972-25, Initial Decision (July 9, 2025).

For respondent:

- R-1 Fair Hearing Packet #1
- R-1-1 Fair Hearing Summary Report (April 17, 2025)
- R-1-2 Hearing Notice (HMA 00309-2025) (April 22, 2025)
- R-1-3 DMAHS Referral Packet (HMA 00309-2025)
- R-1-5 Same as P-13
- R-1-7 Appeal (January 28, 2025)
- R-1-8 Completed DAR form (May 2, 2024)
- R-1-21 Agency case notes (October 21, 2024–January 21, 2025)

OAL DKT. NOS. HMA 00309-25 and HMA 03013-25

R-2 Approval letter (January 28, 2025)

R-3 PR-1 (January 28, 2025)