State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

INITIAL DECISION
OAL DKT. NO. HMA 20112-20

Medicaid Only
Excess Income Appeal
N.J.A.C. 10:71-5

T.K.

Petitioner,

v.

Division of Medical Assistance and Health Services

Respondent.

For petitioner: T.K., petitioner, pro se

For respondent: Tamara Luciano, Program Support Specialist, for respondent pursuant to N.J.A.C. 1:1-5.4(a)(2)

BEFORE: Bindi Merchant, ALJ

STATEMENT OF THE CASE

Respondent denied petitioner's Medicaid Only application due to excess income under N.J.A.C. 10:71-5.6.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

I.

☑ I **FIND** that petitioner or petitioner's representative is **AUTHORIZED** to pursue this appeal; therefore, I **CONCLUDE** that petitioner has **STANDING** to pursue this appeal.

☐ I **FIND** that petitioner or petitioner's representative is **NOT AUTHORIZED** to pursue this appeal; therefore, I **CONCLUDE** that petitioner has **NO STANDING** to pursue this appeal.

II.

I **FIND** that petitioner's:

(1) Earned income is $ 0 (N.J.A.C. 10:71-5.2, -5.4)

(2) Unearned income is $ 3297.41 (N.J.A.C. 10:71-5.2, -5.4)

(3) Income exclusions total $ 0 (N.J.A.C. 10:71-5.3)

(4) Countable income totals $ 3297.41 (N.J.A.C. 10:71-5.4(b))

(5) The applicable income eligibility standard is $ 1800 (N.J.A.C. 10:71-5.6)

III.

☑ I **CONCLUDE** that petitioner is over the applicable income limit and is therefore income **INELIGIBLE** for Medicaid Only benefits under N.J.A.C. 10:71-5.6.

☐ I **CONCLUDE** that petitioner is not over the applicable income limit and is therefore income **ELIGIBLE** for Medicaid Only benefits as of _____ (*fill in date of eligibility*) under N.J.A.C. 10:71-5.6.

ADDITIONAL FINDINGS OF FACT/CONCLUSIONS OF LAW

Petitioner acknowledge that she receives $761 in weekly unemployment benefits.
$761 x 4.333 = $3,297.41 (MAGI)

The program limit for 2025 is $1800.

Petitioner argues that that her unemployment benefits only cover her essential living expenses, including rent, utilities, food, and other basic needs.

Petitioner does not meet the income requirements necessary to receive NJ FamilyCare, therefore, the benefits were properly terminated.

ORDER

I **ORDER** that:

☐ Petitioner's appeal is **DISMISSED** because petitioner has **NO STANDING**.

☑ Petitioner is income **INELIGIBLE** for Medicaid Only benefits under N.J.A.C. 10:71-5.6.

☐ Petitioner is income **ELIGIBLE** for Medicaid Only benefits as of _____ under N.J.A.C. 10:71-5.6.

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.

June 17, 2026
DATE

/s/ Bindi Merchant
Bindi Merchant , ALJ

Date Record Closed: 06/17/2026

Date Filed with Agency: 06/17/2026

Date Sent to Parties: _____

APPENDIX

Witnesses

For Petitioner:

None

For Respondent:

None

Exhibits

For Petitioner:

None

For Respondent:

R-1 NJ FamilyCare Renewal Application
R-2 Application Received Letter
R-3 Eligibility Outcome Letter
R-4 Fair Hearing Request
R-5 Fair Hearing Acknowledgment Letter