State of New Jersey
OFFICE OF ADMINISTRATIVE LAW

FINAL DECISION
OAL DKT. NO. HMA 00490-25
AGENCY DKT. NO. N/A

E.O.
Petitioner,
v.
UNION COUNTY BOARD OF SOCIAL SERVICES,
Respondent.

CONSOLIDATED

E.O.
Petitioner
v.
UNION COUNTY BOARD OF SOCIAL SERVICES
Respondent

OAL DKT. NO. HMA 09494-25
AGENCY DKT. NO. N/A

E.O., represented by **Jake Brand,** JB Elder Planning, **Shelby Neiss**, Esq., Attorney for Plaza Nursing Home (Schwartz, Sladkus, Reich, Greenberg and Atlas) for petitioner.

Steven Hockaday, Esq., for respondent pursuant to N.J.A.C. 1:1-5.4(a)3

Record Closed: August 15, 2025 Decided: December 15, 2025

BEFORE **ANDREW M. BARON**, ALJ

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

Petitioner seeks coverage under the New Jersey Age, MLTSS program. The Division denied the initial application based on failure to timely provide paperwork in a timely manner, specifically failure to adequately explain over 116 separate transactions, most of which were in cash, which it turns out was petitioner's preferred method of deposit and payment. A new application was then filed on May 5, 2025 which is also the subject of this consolidated appeal. That application was also denied. Specifically, the Division initially sought information on 116 different items and subsequently sought additional information on at least eight (80) different items and transactions in order to determine eligibility. Petitioner's designated representative contends they substantially complied with the requests related to both applications, yet what they supplied was deemed insufficient. Throughout this time, it is undisputed that Plaza Health Care, where petitioner had been admitted for several months, was delivering services while waiting on payment of a bill that rose to over $190,000.00.

An appeal was timely filed and transmitted to the Office of Administrative Law on December 17, 2024. That appeal was identified as HMA 00490-25. A second appeal involving the petitioner's second application, under case number HMA 09494-25 was transmitted after July 1, 2025, and consolidated with the first appeal which was already underway.

Shelby Neiss, counsel for Plaza Nursing Home and Rehabilitation Center, where petitioner has resided and received services throughout the proceedings, sought and was granted the right to appear and join the case with proper standing in July 2025 since the facility remained uncompensated by the Division for uninterrupted services it continued to render to E.O. It was determined that counsel had standing to participate on behalf of her client, since at the time of hearing, petitioner's unpaid bill was in excess of $190,000.00

FACTUAL DISCUSSION AND FINDING OF FACTS

Jake Brand and Esther Lanky from J.E. Elder Planning testified for petitioner E.O. Barbara Sandargus, Supervisor, Sandra Arevalo, specialist Brenda Realpe and Heli Perez caseworker, and Modupeola Daramola testified for the Division.

Upon re-certification on April 15, 2024, petitioner was denied eligibility on September 24, 2024, due to failure to provide documents, specifically certain information about multiple transactions from certain bank accounts. The first Request for Information was sent May 3, 2024, which was followed by a second request on August 22, 2024. Though very extensive bank records were requested, each time petitioner's representative was only given ten days to respond. It is undisputed that after being told on more than one occasion that certain records could not be supplied by the bank, which had been taken over by a larger bank, at no time did County representatives offer under their regulatory authority to assist petitioner's designated representatives in obtaining the missing documents.

The second request sought information on 116 transactions, well beyond the 80 requests in the first communication from Division officials.

For reasons unknown, three months went by without anyone from the Division reviewing the packet if information supplied in response to the requests. During the hearing, it was explained that the file had been reassigned without notice to petitioner"s representative, so there was no one for them to communicate with for an extended period of time.

Though the monthly bill for petitioner's stay at the Plaza facility remained unpaid, reaching an extraordinary total of over $190,000, the Division says the long delay in processing was not prejudicial to petitioner as both respective applications were ultimately denied anyway due to non-compliance.

At the time of hearing, petitioner's unpaid bill was well over one hundred ninety thousand dollars, ($190,000), a significant sum while still rendering services to petitioner. **I FIND** this is an arbitrary and capricious denial of approval and violates the covenants and regulatory obligations between nursing homes and agencies responsible for reviewing and ultimately approving legitimate applications for Medicaid coverage.

The Division did not propose any alternate means of satisfying the request or to assist petitioner's designated representative in trying to secure the information.

The Division contends that the efforts petitioner's designated representative took to obtain the required verifications were insufficient. **I FIND** that under the circumstances, with all the information that was already supplied and legitimate explanations as to why further information could not be supplied, the denials as to both applications were arbitrary and capricious and must therefore be **REVERSED.**

Curiously, while the Division acknowledges receipt of significant documents from petitioner' bank, it questions the authenticity of the communications received from the bank such as emails, and signed letters. Thus, having received certain bank statements that led to further questions about a voluminous amount of transactions, it is unclear when a financial services institution writes and represents that "no such or further records exist" the Division has any genuine basis to question that type of statement. **I FIND** petitioner's preferred method of financial transactions was primarily through cash, and this does not constitute a method used to avoid Medicaid scrutiny or expedite their eligibility date, nor did they attempt to "hide money."

Further, according to petitioner's agent/attorney-in-fact, J.B Elder Planning, E.O. petitioner, was unable to cooperate with her agent due to her medical and mental health conditions, so if the petitioner themselves is not available or unable to assist, and the financial institution itself can't provide further explanation, does that mean the applicant remains ineligible?

The answer here, especially when the designated representative has substantially complied, and the Division itself has delayed for at least three months process, **I FIND** is

no, continuing to deny petitioner's eligibility after multiple good faith efforts and substantial compliance is arbitrary and capricious and therefore for the reasons set forth herein, should be **REVERSED.**

I FIND that petitioner's agent substantially complied with the requested information in connection with both the first and second applications.

I FIND petitioner's agent's testimony credible that each of these accounts and transactions were not intended to avoid Medicaid scrutiny, but instead were part of an overall pattern of paying for things in cash without a receipt generated for each transaction. Due to a multitude of medical conditions requiring a stay in an institutional facility, petitioner was unable to assist the designated representative in filling the gaps of unexplained transactions, many of which were apparently done in cash. **I FURTHER FIND** that once the Division was advised that petitioner's agent had exhausted all of their remedies to try to secure the remaining information, and that the Division had the authority to extend the time to provide the information, and/or had the authority to assist petitioner's but failed to do so, resulting in a second denial. **I FIND** under the circumstances of this case, the failure of the Division to either extend the time and/or assist petitioner's agent in securing the remaining information is also sufficient grounds to **REVERSE** the denial of both applications.

Finally, in view of the significant information which petitioner's agent did provide, **I FIND** petitioner's agent substantially complied with the request for information and the fact that with documented proof of income of the accounts in question, a **REVERSAL** of the Division's denial of eligibility is warranted.

LEGAL ANALYSIS AND CONCLUSION

In this matter, the only dispute is whether the Division correctly determined that petitioner was not eligible for benefits due to failure to complete paperwork. Such a determination is governed by N.J.A.C. 10:71-2.2, Denial of Eligibility due to Non-Cooperation, and N.J.A.C. 10:71-2.3 Subsequent Refusal to Comply. Both provisions address situations where applicants refuse to comply with Division requests for

information. However, it is important to observe here that the same provisions also allow under certain circumstances for the Division to extend the time to provide requested documents that are difficult to obtain and also permit the agency to assist a petitioner in securing those documents when an applicant is unable or does not know how to secure such information.

This, however, is not a refusal case, and **I CONCLUDE,** not only did petitioner's representative not refuse to comply, but **I CONCLUDE just the opposite,** they substantially complied. Petitioner's designated representative, which specializes in assisting families seeking Medicaid coverage is a credible witness, testified that she substantially complied with the Division's requests, but despite numerous good faith attempts to substantially comply, were rejected by the Division. She further testified that even if she wanted to, she could not get help from the petitioner as their medical condition prevented securing their signature on an affidavit. and there was no way she could successfully communicate or explain or ask for her help. All of this was explained to the Division. At no time did the Division offer to extend the time to secure the outstanding documents, nor did they offer to assist her in securing documents, which under circumstances like these, they are permitted to do. In fact, it appears the Division also refused to accept letters of explanation from petitioner's bank regarding the limitations on what could be provided.

N.J.A.C 10:71-2.2 authorizes a county board of social services to establish a cutoff date for submission, and while a county board has discretion to extend a deadline for submission, it is nonetheless entitled to determine when sufficient time has passed, and make a determination based on the information that was supplied, whether it is complete or not. See: N.V. v. DMAHS and Gloucester Cty. Bd. of Social Services, OAL DKT. No. HMA 01201 16, 2016 N.J. AGEN. LEXIS, 140 (Initial Decision March 17, 2016), see also: M.B. v. Ocean County Board of Social Services, OAL DKT. No. HMA 14682-15. N.J. AGEN.LEXIS 758 Initial Decision (December 22, 2015).

The agency is charged with requiring the applicant to complete forms and secure evidence that corroborates the statement of applicants and to report any changes that impact an applicant's financial situation. Normally the process is supposed to be

completed in forty-five (45) days. However, the agency has discretion to extend the time to respond, as well as assist a petitioner who is having trouble securing the necessary documents. Due to high volume, and an extensive backlog, the agency has now limited its time to wait after sending out one written request. If it does not hear back in ten days or a petitioner fails to ask for more time, the matter is closed.

In this case, due to staffing changes and assignments, it took the agency several months to finalize processing the respective applications, yet throughout all that time never attempted to work with petitioner's designated representative, who has extensive experience in this field, to devise an alternate method of satisfying the initial request for over 116 documents which it turned out could never be supplied according to petitioner's bank. The agency says this was not prejudicial to petitioner. **I CONCLUDE** just the opposite, as Plaza was forced to continue to render services for the three extra months in which the application sat without activity, and further, there was no communication during that time regarding the need or advice by the Division on compliance.

As a further indication of the arbitrariness of the denial, the Division then challenged the signature and the information provided on the bank's own letterhead.

In this case, under the circumstances described, **I CONCLUDE** that the Division should have given petitioner's representatives additional time to secure the requested information, and **I FURTHER CONCLUDE** that since petitioner's representatives were unable to get petitioner's cooperation due to petitioner's medical condition, such as having petitioner sign an affidavit, they substantially complied in supplying the requested documents. **I ALSO CONCLUDE** that the Division never questioned whether the services were medically necessary, so both these cases were solely decided on the basis of financial eligibility.

Given the detailed explanations provided by petitioner's designated representative and petitioner's bank, **I FURTHER CONCLUDE** that despite some missing information which it turns out could never be provided, petitioner did not conduct over 116 cash transactions to avoid Medicaid scrutiny, it was just their way of handling financial transactions.

Here, petitioner, through their designated representative JB Elder Planning, indicated that they substantially complied with the Division requests, which included over 116 items which both the representative and petitioner's bank indicated were impossible to comply with, meanwhile as months went by and petitioner's two applications languished due to a change in assignment and staffing, petitioner accumulated a nursing home bill of over $190,000.00 while continuing to provide petitioner with uninterrupted services. **I CONCLUDE** this is completely unacceptable and violates the unofficial covenant between facilities of this kind which are a last resort for residents and their families and the Divisions responsible for processing and approving Medicaid applications.

The Division did not offer to give them more time to secure the additional documents, nor did the Division offer to assist petitioner in finding alternate ways to secure the bank documents. I must **CONCLUDE** that the denial of benefits in both cases was **arbitrary and capricious** and should be **REVERSED**.

ORDER

Based on the foregoing it is hereby **ORDERED** that the decision of the agency to deny petitioner's application for benefits in case number **HMA 00490-25** is hereby **REVERSED,** and the decision is **HMA 09494-25** is also **REVERSED.**

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.

December 15, 2025
DATE

ANDREW M. BARON, ALJ

Date Record Closed: December 15, 2025 [1]

Date Filed with Agency: December 15, 2025

Date Sent to Parties: December 15, 2025

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APPENDIX

Witnesses (as to both appeals)

For Petitioner:

Esther Lankry

Jake Brand

For Respondent:

Modupeola Daramola

Barbara Sandargus

Sandra Arevalo

Brenda Realpe

Heli Pelaez

Exhibits (applicable to both appeals)

Petitioner

P-1 Plaza bill dated 6/11/25

P-2 Spouse letter explaining cash

P-3 Spouse letter 5/8/24 explaining cash transfer

P-3 Duplicate marking 8/29/24 JB Planning list of deposits

P-4 9/13/24 Letter from Matthew Seiger VP of Bank Operations Union County Savings Bank

P-5 Email re: bank follow up

P-6 5/22/24 Bank email confirming Christmas Club cash deposits

P-7 JB Planning Summary of 20 additional documents

P-8 Atty letter of 4/9/24 $8500.00 auto settlement

P-8 (duplicate number) Santander Bank confirmation of withdrawals and deposits

P-9 Tax return

P-10 Wells Fargo July 24 bank statement and misc. other bank records

Respondent

R-1 Division Package (List of 116 document requests)

R-2 (F) Summary of misc. bank statements

R-3 (A) 4/15/24 JB letter

R-4 (B) Request for information

R-5 (C) 5/16/24 Request for more documents

R-6 8/22/24 Division notice

R-7 (E) 9/15/24 Acknowledgment of 20 additional documents provided