

**STATE OF MICHIGAN  
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

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IN THE MATTER OF:

██████████

Appellant

\_\_\_\_\_ /

Docket No. 2009-33942 HHS

Case No. ██████████

**DECISION AND ORDER**

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and 42 CFR 431.200 *et seq.*, upon the Appellant's request for a hearing.

After due notice, a hearing was held ██████████. ██████████ represented himself at hearing. ██████████, was also present.

██████████, represented the Department. ██████████ was present as a Department witness. ██████████, was also present on behalf of the Department.

**ISSUE**

Did the Department properly suspend Home Help Services (HHS) payments to the Appellant?

**FINDINGS OF FACT**

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. The Appellant is a Medicaid beneficiary who was participating in the Adult Home Help Services program.
2. The Appellant is married and resides with his spouse, age ██████.
3. The Department suspended payments for the Appellant's HHS case, pending a determination of whether the Appellant's spouse is disabled, per the Appellant's claim she is unable to provide his care.



### **Necessity For Service**

The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Customer choice.
- A complete comprehensive assessment and determination of the customer's need for personal care services.
  
- Verification of the customer's medical need by a Medicaid enrolled medical professional. The customer is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:
  - Physician
  - Nurse Practitioner
  - Occupational Therapist
  - Physical Therapist

The physician is to certify that the customer's need for service is related to an existing medical condition. The physician does not prescribe or authorize personal care services.

If the Medical Needs form has not been returned, the adult services worker should follow-up with the customer and/or medical professional.

### **COMPREHENSIVE ASSESSMENT**

The Adult Services Comprehensive Assessment (DHS-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.

- A face-to-face contact is required with the customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

### **Functional Assessment**

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the customer's ability to perform the following activities:

#### Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring
- Mobility

#### Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping
- Laundry
- Housework

Functional Scale ADL's and IADL's are assessed according to the following five-point scale:

1. Independent  
Performs the activity safely with no human assistance.
2. Verbal Assistance  
Performs the activity with verbal assistance such as reminding, guiding or encouraging.
3. Some Human Assistance  
Performs the activity with some direct physical assistance and/or assistive technology.
4. Much Human Assistance  
Performs the activity with a great deal of human assistance and/or assistive technology.
5. Dependent  
Does not perform the activity even with human assistance and/or assistive technology.

**Note:** HHS payments may only be authorized for needs assessed at the 3 level or greater.

### **Time and Task**

The worker will allocate time for each task assessed a rank of 3 or higher, based on the interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a guide. The RTS can be found in ASCAP under the Payment module, Time and Task screen. When hours exceed the RTS rationale must be provided.

### **IADL Maximum Allowable Hours**

There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- Five hours/month for shopping
- Six hours/month for light housework
- Seven hours/month for laundry
- 25 hours/month for meal preparation.

These are maximums; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements. If there is a need for expanded hours, a request should be submitted to:

\* \* \*

### **Service Plan Development**

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.
- The extent to which the Client does not perform activities essential to the caring for self. The intent of the Home Help program is to assist individuals to function as independently as possible. It is important to work with the recipient and the provider in developing a plan to achieve this goal.
- The kinds and amounts of activities required for the client's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the client to perform the tasks the client does not perform. Authorize HHS only for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.

Note: Unavailable means absence from the home, for employment or other legitimate reasons. Unable means the responsible person has disabilities of his/her own which prevent caregiving. These disabilities must be documented/verified by a medical professional on the DHS-54A.

- Do not authorize HHS payments to a responsible relative or legal dependent of the client.


- The extent to which others in the home are able and available to provide the needed services. Authorize HHS only for the benefit of the client and not for others in the home. If others are living in the home, prorate the IADL's by at least 1/2, more if appropriate.
- The availability of services currently provided free of charge. A written statement by the provider that he is no longer able to furnish the service at no cost is sufficient for payment to be authorized as long as the provider is not a responsible relative of the client.
- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for the same time period).

*Adult Services Manual (ASM) 9-1-2008*

Policy establishes the Department cannot pay for a personal care or chore provider if the beneficiary has a legally responsible relative available and able to provide the care the beneficiary may need. In this case the Department asserts the Appellant's wife is able to provide all of the care the Appellant requires. The lack of any medical corroboration of the claim of disability is cited.

The Appellant and his wife assert she is unable to provide the care needed due to her own disability. When asked to identify the physical disability preventing her from providing care, the Appellant's wife stated she was hospitalized for 19 weeks and in a coma and she has gout. Concerned for her condition, this ALJ inquired when she was released from the hospital. She answered ██████████. No medical documentation or evidence of more recent disabling medical condition was presented. The burden of establishing an inability to provide for the care needs of one's own spouse rests with the Appellant and his wife. Here, there is no evidence upon which this ALJ could find the Appellant's spouse is unable to provide the care needed by the Appellant. The two medical needs forms provided were not returned. No doctor is corroborating the claim of disability.

The worker's determination the Appellant's spouse was able to meet the Appellant's needs is supported by the evidence of record. The worker correctly applied the policy prohibiting payment to a legally responsible relative for tasks she is able to do.

  
Docket No. 2009-33942 HHS  
Decision and Order

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department has properly suspended the Appellant's home help assistance payments.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

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Jennifer Isiogu  
Administrative Law Judge  
for Janet Olszewski, Director  
Michigan Department of Community Health

cc:



Date Mailed: 11/19/2009

**\*\*\* NOTICE \*\*\***

The State Office of Administrative Hearings and Rules may order a rehearing on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. The State Office of Administrative Hearings and Rules will not order a rehearing on the Department's motion where the final decision or rehearing cannot be implemented within 90 days of the filing of the original request. The Appellant may appeal the Decision and Order to Circuit Court within 30 days of the receipt of the Decision and Order or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.