STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF: [redacted]

Claimant

Reg. No: 2009-5776
Issue No: 3008; 2014; 2015
Case No:
Load No: [redacted]
Hearing Date:
March 25, 2009
Macomb County DHS

ADMINISTRATIVE LAW JUDGE: Robert J. Chavez

HEARING DECISION

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and MCL 400.37 upon claimant's request for a hearing. After due notice, a hearing was held on March 25, 2009.

ISSUES

(1) Was the claimant's FAP application properly denied for a failure to provide verifications?

(2) Was the claimant's Medicaid eligibility properly determined?

(3) Was the claimant's Medicaid deductible properly determined?

FINDINGS OF FACT

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

(1) Claimant and claimant's wife were receiving Medicaid as caretaker relatives for their daughter, [redacted]

(2) In August, 2008, claimant sent a letter to DHS explaining that [redacted] had moved out of the house and enrolled in college full time.

(3) DHS subsequently reprocessed claimant's Medicaid application and grant.

(4) DHS notified claimant on 10-14-08 that claimant and claimant's wife were no longer eligible to receive Medicaid as a caretaker relative.

(5) Claimant was subsequently re-evaluated for Medicaid disability.

(6) Claimant was approved for Medicaid on the basis of disability on 10-14-08.

(7) Claimant was also informed at this time that his Medicaid deductible would be $841.

(8) Claimant's wife was also re-evaluated for other Medicaid programs.

(9) Claimant's wife was deemed ineligible for other Medicaid programs, though claimant's wife has a recent application in for Medicaid disability that is currently being appealed.

(10) [redacted] moved back into the home sometime during October, 2008.

(11) A new DHS-1171 was sent to the claimant to update their information.

(12) Claimant turned in this application on 11-8-08.

(13) In this application, claimant states that [redacted] was not buying or preparing food with claimant or his wife.

(14) In this application, claimant stated that [redacted] was not applying for food assistance.

(15) On 11-12-08, DHS sent claimant a DHS-3503, Verification Checklist.

(16) This checklist required, among other things, an interview with claimant, claimant's wife, and [redacted], as well as verifications of "all income that you have".

(17) Claimant returned all verifications except one: income verification for [redacted]

(18) On 12-17-08, claimant was given an application denial for failure to return verifications of [redacted] income.

(19) Claimant told DHS through a new DHS-1171 in January that [redacted] had moved out of the house in December; a new FAP application was processed, and claimant was approved for an allotment of $41 per month.

(20) On 10-29-08, claimant requested a hearing regarding the Medicaid eligibility decisions. On 1-26-09, claimant requested a hearing regarding the FAP eligibility decision.

(21) Administrative Hearings subsequently combined these two issues into one hearing; a hearing was conducted on 3-25-09 before Administrative Law Judge Robert J. Chavez that addressed both the cases.

CONCLUSIONS OF LAW

The Food Assistance Program (FAP) (formerly known as the Food Stamp (FS) program) is established by the Food Stamp Act of 1977, as amended, and is implemented by the federal regulations contained in Title 7 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the FAP program pursuant to MCL 400.10, *et seq.*, and MAC R 400.3001-3015. Department policies are found in the Program Administrative Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). The Department of Human Services (DHS or department) administers the MA program pursuant to MCL 400.10, *et seq.*, and MCL 400.105. Department policies are found in the Program Administrative

Manual (PAM), the Program Eligibility Manual (PEM) and the Program Reference Manual (PRM) and Reference Tables (RFT).

When eligibility ends for one Medicaid program, the Department must consider eligibility under all other MA-only categories before terminating benefits under a specific category. In addition, when Group 1 eligibility does not exist but all eligibility factors except income are met for a Group 2 category, deductibles become involved. PEM 135.

A DHS-1171, Assistance Application must be completed when eligibility is re-determined. An application is considered incomplete until it contains enough information to determine eligibility. PAM 115. Eligibility is determined through a claimant's verbal and written statements; however, verification is required to establish the accuracy of a claimant's verbal and written statements. Verification must be obtained when required by policy, or when information regarding an eligibility factor is incomplete, inconsistent, or contradictory. An application that remains incomplete may be denied. PAM 130. All sources of income must be verified. PEM 500.

With regard to group composition, PEM 212 states:

> Parents and their children **under 22 years of age** who live together **must** be in the same group regardless of whether the child has his/her own spouse or child who lives with the group.

The current case involves two separate issues: (1) Whether the claimant's Medicaid was properly transferred from the caretaker relative program to Medicaid disability, and whether the eligibility factors were properly determined when this happened; and (2), whether the claimant's FAP application was properly denied. We shall address the issue of Medicaid first.

Claimant makes several arguments as to why the Department erred when it made changes to claimant's Medicaid eligibility, the first of which involves whether or not the fact that

[redacted] moved back into the house should have prevented the loss of the caretaker relative classification.

Group 2 Caretaker Relative Medicaid is a classification of Medicaid that provides Medicaid to a caretaker relative who is the caretaker or parent of a dependant child. A dependant child is defined, among other things, as a child under the age of 18, or over the age of 18 and still enrolled full time in high school or the equivalent vocational training. PEM 135.

It is undisputed that [redacted] was over the age of 18, a high school graduate, and college bound when claimant's current issues came about. Claimants do not have any other children in the household; therefore, caretaker relative Medicaid would be inappropriate for the circumstances. While the claimant alleges that [redacted] moving out of the house is what triggered the review, the truth is that the review would, or should, have happened upon [redacted] 18th birthday, regardless of her current living situation. The fact that claimant alerted DHS to a living situation that quickly reversed itself is irrelevant; the only relevant fact is that [redacted] turned 18, and was a high school graduate.

However, the Department was required to evaluate claimant and claimant's wife for other Medicaid programs. Claimant argues that the Department erred when claimant's wife was cut-off of Medicaid completely. Claimant alleges that claimant's wife still should have been classified as a caretaker relative because she provides claimant needed care with regard to his disability.

Unfortunately, the caretaker relative Medicaid program only applies to caretakers of dependant children, and not to other types of caretaker relatives. There is no dispute that DHS did attempt to classify claimant's wife under a different Medicaid program; however, there was no Medicaid program under which claimant's wife could be found eligible. For instance, claimant's wife was evaluated under the disability standards by the Medical Review Team and

denied; that issue is under appeal in a different case. Therefore, the Department did not err when it cut off claimant's wife's Medicaid.

With regard to claimant's Medicaid deductible, the State of Michigan has set guidelines for income, which determine if an MA group is eligible. Net income (countable income minus allowable income deductions) must be at or below a certain income limit for Group 1 eligibility to exist. PEM 105. For a household size of 2, this limit is $1167. RFT 242. For Group 2, eligibility is possible even when net income exceeds the income limit. This is because incurred medical expenses are used when determining eligibility for FIP-related and SSI-related Group 2 categories. PEM 105. Income eligibility exists for the calendar month tested when:

- There is no excess income, **or**
- Allowable medical expenses equal or exceed the excess income (under the Deductible Guidelines). PEM 545.

Income eligibility exists when net income does **not** exceed the Group 2 needs in PEM 544. PEM 166. The protected income level is a set allowance for non-medical need items such as shelter, food and incidental expenses. RFT 240 lists the Group 2 MA protected income levels based on shelter area and fiscal group size. PEM 544. An eligible Medical Assistance group (Group 2 MA) has income the same as or less than the "protected income level" as set forth in RFT 240. An individual or MA group whose income is in excess of the monthly protected income level is ineligible to receive MA. However, a MA group may become eligible for assistance under the deductible program. The deductible program is a process, which allows a client with excess income to be eligible for MA, if sufficient allowable medical expenses are incurred. Each calendar month is a separate deductible period. The fiscal group's monthly excess income is called the deductible amount. Meeting a deductible means reporting and verifying allowable medical expenses that equal or exceed the deductible amount for the

calendar month. The MA group must report expenses by the last day of the third month following the month it wants medical coverage. PEM 545; 42 CFR 435.831.

In the budget, claimant was found ineligible for Group 1 MA by virtue of an unearned income of $1,499, for a net income of $1,479, which is $312 above the threshold to maintain Group 1 eligibility.

The Administrative Law Judge has reviewed this corrected budget and found one error.

The Department's budget used a gross income of $1,499, stemming from claimant's gross RSDI income. However, Department Exhibit 7, the SOLQ, used to verify this income, shows a gross RSDI income of $1,599—in other words, the Department erred when it included a gross income that was too low. This was error. Claimant has confirmed that his income was indeed $1,599, and the Department should rerun the budget with the corrected gross income amount, though this will unfortunately most likely result in claimant's Medicaid deductible increasing further.

The second issue is whether or not the Department erred when it denied claimant's FAP application when claimant did not provide verifications regarding [redacted] income.

As stated above, verification is required to determine eligibility; however, there are limits to what the Department can request. A request for verification must be reasonable, and relevant to the need to determine eligibility. The license to request verifications of assets and income is not a license for the Department to request any document it wants. The need for verification stops once the Department has the information it requires to determine eligibility, unless further verification is required by policy. Furthermore, the Department does not need to request verifications if it already has this information.

Claimant did not apply for FAP benefits for [redacted] Nor did claimant state that she would be preparing food with the claimant and his wife. Under normal circumstances, [redacted] would have been considered a separate group; while the Department would have been within its rights to inquire and verify the separate households, income verification would not have been required of [redacted].

However, this was a not a normal circumstance; the circumstances the claimant found himself in were specifically an exception to the normal separate household rule. Specifically speaking, PEM 122 states that any child under the age of 22 living in the parental household is considered a group member, regardless of the circumstances. Therefore, as long as [redacted] was in the household, she was a member of the group, and thus, verification was required.

The Department alleges that it never received the verification of income they required; claimant alleges that it was sent, but was unable to provide proof that it arrived. The burden of proof is upon the claimant to provide proof that any verifications were turned in; claimant has not met this burden. Therefore, the undersigned must find that the verifications were not turned in. As the Department needed these verifications in order to determine eligibility, and the Department did not have these verifications, the Department was unable to determine eligibility. An application remains incomplete until the Department is able to determine eligibility, and PAM 130 states that an incomplete application such as this may be denied. Therefore, the Department was correct when it denied claimant's FAP application.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, decides that:

(1) The Department's decision to deny claimant's FAP application was correct.

(2) The Department was incorrect in its Medicaid income eligibility determination with regard to claimant.

(3) The Department's decision to cut off claimant's wife's Medicaid was correct.

Accordingly, the Department's decision in the above-stated matter is, hereby, AFFIRMED in part, and REVERSED in part.

The Department is ORDERED to re-determine claimant's Medicaid eligibility using claimant's correct gross income, following all proscribed procedures in the Program Eligibility Manual.

/s/
Robert J. Chavez
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: April 9, 2009

Date Mailed: April 9, 2009

**NOTICE:** Administrative Hearings may order a rehearing or reconsideration on either its own motion or at the request of a party within 30 days of the mailing date of this Decision and Order. Administrative Hearings will not order a rehearing or reconsideration on the Department's motion where the final decision cannot be implemented within 60 days of the filing of the original request.

The Claimant 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 date of the rehearing decision.

RJC/cv

cc: [redacted]