STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
ADMINISTRATIVE HEARINGS FOR THE
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF:

Reg. No: 2010-44796
Issue No: 2006
Case No:
Load No:
Hearing Date:
October 14, 2010
Genesee County DHS (5)

ADMINISTRATIVE LAW JUDGE: Landis Y. Lain

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 telephone hearing was held on October 14, 2010. Claimant is deceased. Claimant was represented at the hearing by

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance and retroactive Medical Assistance based upon it's determination that claimant failed to provide verification information in a timely manner?

FINDINGS OF FACT

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

(1) filed an application for Medical Assistance and retroactive Medical Assistance for February and March 2008.

(2) The authorized representative and the client were both mailed verification checklists on May 8, 2008.

(3) On May 16, 2008, claimant passed away.

(4) On July 21, 2008, the department approved claimant for Medical Assistance in error for the month of his death.

(5) On July 21, 2008, the department sent client an 1150 application eligibility notice denying Medical Assistance due to failure to provide asset verification.

(6) An initial hearing request received October 20, 2008, was filed by

(7) A hearing was held on December 8, 2009.

(8) On January 14, 2010, Administrative Law Judge Carmen G. Fahie, decided that there was no evidence in the file that submitted the asset verifications required to determine Medical Assistance eligibility, but the department failed to send a denial notice for the Medical Assistance program to as required by policy. Therefore, the department had not established that it was acting in compliance with department policy by determining that claimant was eligible for MA benefits when they failed to send the MA denial notice. Administrative Law Judge Fahie, ordered the department to send the appropriate denial notice denying MA for the March 28, 2008, application, with retroactive benefits to February 2008, because of failure to provide asset verification.

(9) On January 21, 2010, the department sent an application eligibility notice and an Administrative Hearing Order certification.

(10) Judge Carmen G. Fahie's hearing Decision and Order is herein incorporated in its' entirety.

(11) The fact on the record indicates that did not provide asset or income verification before December 23, 2008.

CONCLUSIONS OF LAW

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 (BAM), the Program Eligibility Manual (BEM) and the Program Reference Manual (PRM).

Cooperation, Verification, and Eligibility Determination (Rev. 01-01-08)

DEPARTMENT POLICY

All Programs

Clients have rights and responsibi lities as specified in this item.

The local office must do **all** of the following:

- Determine eligibility.
- Calculate the level of benefits.
- Protect client rights. BAM, Item 105, p. 1.

CLIENT OR AUT HORIZED RE PRESENTATIVE RESPONSIBILITIES

Responsibility to Cooperate

All Programs

Clients must cooperate with the lo cal offic e in determining initial and ongoing eligibi lity. This includes completion of the necessary forms. BAM, Item 105, p. 5.

Client Cooperation

The client is responsible fo r providing evidence needed to prove disability or blindness. However, you must assist the client when they need your help to obtain it. Such help includes the following:

- Scheduling medical exam appointments
- Paying for medical evidence and medical transportation
- See BAM 815 and 825 for deta ils. BEM, Item 260, p. 4.

A client who refuses or fails to submit to an exam necessary to determine disabilit y or blindness **cannot** be deter mined disabled or blind and you may deny or close the case. BEM, Item 260, p. 4.

All Programs

Clients must completely and truthfully ans wer all questions on forms and in interviews. BAM, Item 105, p. 5.

The client might be unable to answer a question about himself or another person whose circumstances must be known. Allow the client at least 10 days (or other timeframe

specified in policy) to obtain the needed information. BAM, Item 105, p. 5.

FAP Only

Do **not** deny eligibility due to failure to cooperate with a verification request by a person **outside** the group. In applying this policy, a person is considered a group member if residing with the group and is disqualified. BAM, Item 105, p. 5.

Refusal to Cooperate Penalties

All Programs

Clients who are able but refuse to provide necessary information or take a required action are subject to penalties. BAM, Item 105, p. 5.

Responsibility to Report Changes

All Programs

This section applies to all groups **except** most FAP groups with earnings.

Clients must report changes in circumstances that potentially affect eligibility or benefit amount. Changes must be reported **within 10 days**:

- after the client is aware of them, or
- the start date of employment. BAM, Item 105, p. 7.

Income reporting requirements are limited to the following:

- Earned income

  - Starting or stopping employment
  - Changing employers
  - Change in rate of pay
  - Change in work hours of more than 5 hours per week that is expected to continue for more than one month

- Unearned income

.. Starting or stopping a source of unearned income
.. Change in gross monthly income of more than $50 since the last reported change. BAM, Item 105, p. 7.

See BAM 220 for processing reported changes.

Other reporting requirements include, but are **not** limited to, changes in:

. Persons in the home
. Marital status
. Address and shelter cost changes that result from the move
. Vehicles
. Assets
. Child support expenses paid
. Health or hospital coverage and premiums
. Day care needs or providers. BAM, Item 105, pp. 7-8.

For TLFA only, the client must report to the specialist any month the work requirement is not fulfilled.

Explain reporting requirements to all clients at application, redetermination and when discussing changes in circumstances. BAM, 105, p. 8.

Verifications

All Programs

Clients must take actions within their ability to obtain verifications. DHS staff must assist when necessary. See BAM 130 and BEM 702. BAM, Item 105, p. 8.

LOCAL OFFICE RESPONSIBILITIES

All Programs

Ensure client rights described in this item are honored and that client responsibilities are explained in understandable terms. Clients are to be treated with dignity and respect by all DHS employees. BAM, Item 105, p. 8.

VERIFICATION AND COLLATERAL CONTACTS

DEPARTMENT POLICY

All Programs

Verification means documentation or other evidence to establish the accuracy of the client's verbal or written statements.

Obtain verification when:

- required by policy. BEM items specify which factors and under what circumstances verification is required.
- required as a local office option. The requirement **must** be applied the same for every client. Local requirements may **not** be imposed for MA, TMA-Plus or AMP without prior approval from central office.
- information regarding an eligibility factor is unclear, inconsistent, incomplete or contradictory. The questionable information might be from the client or a third party. BAM, Item 130, p. 1.

Verification is usually required at application/redetermination **and** for a reported change affecting eligibility or benefit level. BAM, Item 130, p. 1.

Verification is **not** required:

- when the client is clearly ineligible, or
- for excluded income and assets **unless** needed to establish the exclusion. BAM, Item 130, p. 1.

Obtaining Verification

All Programs

Tell the client what verification is required, how to obtain it, and the due date (see "**Timeliness Standards**" in this item). Use the DHS-3503, Verification Checklist, or for MA redeterminations, the DHS-1175, MA Determination Notice, to request verification. BAM, Item 130, p. 2.

The client must obtain required verification, but you must assist if they need and request help. BAM, Item 130, p. 2.

If neither the client nor you can obtain verification despite a reasonable effort, use the best available information. If **no** evidence is available, use your best judgment.

Exception: Alien information, blindness, disability, incapacity, incapability to declare one's residence and, for FIP only, pregnancy must be verified. Citizenship and identity must be verified for clients claiming U.S. citizenship for applicants and recipients of FIP, SDA and MA. BAM, Item 130, p. 3.

Timeliness Standards

All Programs (except TMAP)

Allow the client 10 calendar days (**or** other time limit specified in policy) to provide the verification you request. If the client cannot provide the verification despite a reasonable effort, extend the time limit at least once. BAM, Item 130, p. 4.

Send a negative action notice when:

- the client indicates refusal to provide a verification,

or

- the time period given has elapsed and the client has not made a reasonable effort to provide it. BAM, Item 130, p. 4.

In the instant case, the original facts of the case indicate that asset verification was not provided to the department by July 21, 2008. Department policy dictates that a client should be allowed 10 calendar days to provide verification. If the client could not provide the verification despite a reasonable effort, the department was required to extend the time limit up to three times. The original verification checklist was sent May 8, 2208, and the claimant was given 28 days in which to provide verification (document 1, p. 1). [redacted] alleges that they faxed the checklist complete to the department on June 4, 2008, with a request for assistance if there was not enough to process the application. The request for an extension of time was sent June 4, 2008. However, claimant passed away effective May 16, 2008. [redacted] at that point, was no longer the authorized representative for claimant because the claimant was deceased. The [redacted] then ordered a personal representative to represent the deceased client on October 1, 2009. Therefore, [redacted] did not have authorization to represent the clients on the original application eligibility notice date of July 21, 2008. In addition, the original determination that claimant could not provide verification information in a timely manner should stand because claimant's

representative did not provide any proof of asset information until December 23, 2008, based upon the record at hand.

Michigan Compiled Laws section 700.3203 indicates that for either formal or informal proceedings, subject to subsection 2, persons who are not disqualified have prior priority for an appointment as a personal representative in the following order:

A. the person with priority as determined by a probate will including a person nominated by a power to infer a new will

B. the decedents surviving spouse, if the spouse is a devisee of the decedent

C. other devisees, other decedents

D. the decedent surviving spouse

E. other heirs of the decedent

F. after 42 days after the decedent's death, the nominee of creditor if the court finds the nominee suitable.

In the instant case, was never appointed as the personal representative of the claimant in this case, and could not have represented him on the date of the original denial notice. Therefore, the department has established by the necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it denied claimant's application for Medical Assistance and retroactive Medical Assistance benefits, based upon its' determination that claimant failed to provide verification information in a timely manner.

Michigan compiled laws section 700.5510 states that a patient advocate designation is revoked by the patient's death.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that the department has established by the necessary evidence and preponderance of the evidence that it was acting in compliance with department policy when it denied claimant's Medical Assistance application and retroactive Medical Assistance benefits application based upon this determination that claimant failed to provide verification information in a timely manner.

Accordingly, the department's decision is AFFIRMED.

Additionally, the hearing request is HEREBY DISMISSED because client was deceased and the authorization to represent ended on May 16, 2008, with client's death.

/s/
Landis Y. Lain
Administrative Law Judge
for Ismael Ahmed, Director
Department of Human Services

Date Signed: November 22, 2010

Date Mailed: November 23, 2010

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 90 days of the filing of the original request.

The Claimant may appeal the Decision and Order to Circuit Court within 30 days of the mailing 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.

LYL/alc

cc: