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

IN THE MATTER OF:

Reg. No: 2010-50412
Issue No: 2006
Case No:
Hearing Date:
January 4, 2011
Livingston County DHS

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, an in-person hearing was held on January 4, 2011. Claimant is in long-term care. Claimant's son , is guardian and conservator of claimant and appeared on her behalf. Claimant was represented at the hearing by

ISSUE

Did the Department of Human Services (the department) properly cancel claimant's Medical Assistance (MA) benefits?

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 was a Medical Assistance benefit recipient and is in long-term care.

(2) On April 16, 2010, a Quality Assurance reviewer reviewed claimant's assistance application DHS 1171, which was received February 19, 2008, and a bank statement received September 8, 2008.

(3) The Q reviewer called the office and requested proof of claimant's assets from her son

(4) Verifications were due by April 27, 2010.

(5) On April 26, 2010, the department received claimant's birth certificate and a quit claim deed.

(6) On April 30, 2010, a telephone interview was held with , claimant's son.

(7) It was determined that there was a trust which had not been disclosed to the department as well as bank account information which had not been disclosed to the department from

(8) Claimant's son indicated that he could not get the information since it was now called he had no Power of Attorney.

(9) The Quality Assurance reviewer requested case closure.

(10) On May 7, 2010, a copy of the trust was received in the department. In Article I section 1.1, the trust is named the Trust Agreement. On page 3 of the trust it is indicated that assets are described in schedule A attached. Schedule A was attached to the Trust documents.

(11) On May 12, 2010, a telephone conversation was held with claimant's son informing him that the bank account information in schedule A of the Trust document were not received.

(12) Claimant's son stated that he was not sure if there was a schedule A.

(13) The department requested claimant's son to get verification from the person who set up the trust and from the successor trustee.

(14) The information was also discussed regarding the monthly automatic deduction of $

(15) Claimant's son indicated that he did not understand what the deduction was and that the bank would not give him information because he was not the Power of Attorney.

(16) On May 13, 2010, a statement was received in the department from they indicating that they were unable to located a schedule A for the claimant's Trust.

(17) On May 24, 2010, the department caseworker spoke to claimant's son explaining that verification from the successor Trustee regarding the

schedule A was still needed and that he had needed to provide a copy of the [redacted] statement dated August 15, 2008.

(18) The Medicaid case was pending to close effective June 5, 2010.

(19) On May 25, 2010, a fax was received from the successor Trustee indicating that he was unaware of the existence of a schedule A.

(20) On May 27, 2010, the reviewer was unable to complete the Medicaid review as information needed to determine Medicaid asset eligibility or divestment penalties was not received.

(21) On May 24, 2010, the department caseworker sent claimant notice that her application for continued Medical Assistance benefits was scheduled to be cancelled on June 5, 2010, for failure to provide verification information.

(22) On June 29, 2010, claimant's representative filed a request for a hearing to contest the department's negative action.

CONCLUSIONS OF LAW

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his or her claim for assistance has been denied. MAC R 400.903(1). Clients have the right to contest a department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. The department will provide an administrative hearing to review the decision and determine the appropriateness of that decision. BAM 600.

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).

In the instant case, claimant's representative argues that claimant's case should have been reconsidered and they should have been given the opportunity for reconsideration.

Department policy at BAM, Item 320, p. 4, indicates that upon receipt of a DHS-1599 indicating completion of an audit, local offices have 7 work days to respond to results they believe to be incorrect. This begins the formal process known as the re-consideration process. The local office designee must complete the steps of the re-

consideration process. In the instant case, the local office did not perform any re-consideration because it did not have any evidence that a mistake had been made.

Assets must be considered in determining eligibility for SSI related medical assistance categories. Assets mean cash, any other personal property and real property. Real property is land and objects affixed to the land such as buildings, trees, and fences. Personal property is any item subject to ownership that is not real property (BEM, Item 400, p. 1). An asset eligibility limit for SSI related Medical Assistance that is not Medicare Savings Program or QDWI is $2000 for an asset group of 1 or $3000 for an asset group of 2 persons, BEM, Item 400, p. 5. An asset must be available to be countable. Available means that someone in the asset group has the legal right to use or dispose of the asset. The department is to assume an asset is available unless evidence shows that it is not available. An asset remains available during periods in which a guardian or conservator is being sought. This includes situations such as:

- A person's guardian dies and a new guardian has not been appointed yet.
- A court decides a person is a guardian but has not appointed one yet.
- A person is unconscious and his family asked the court to appoint a guardian. BEM, Item 400, p. 6.

In the instant case, claimant is in long term care and is alleged to have Alzheimer's and to be incompetent at all times relevant to this hearing. In the instant case, claimant's son is not an authorized hearing representative for claimant. In addition, the attorney was also not an authorized representative for claimant on the date that the request for a hearing was filed. The request for a hearing was filed on June 29, 2010. Claimant did not become the guardian/conservator for claimant until July 6, 2010. Therefore, claimant's son did not have standing to represent claimant before July 6, 2010, and could not have authorized an attorney representative for her before that date.

For the Medicaid only, a widow or widower may act as a representative on the Medicaid Plan without probate court authorization. Claimant's son cannot provide a probate court order or court issued letter of authority demanding him or another person as a guardian or conservator prior to July 6, 2010. Department policy dictates that an authorized representative is a person who applies for assistance on behalf of a client or otherwise acts on his or her behalf. BAM, Item 110, p. 7.

An authorized representative is not the same as an authorized hearings representative. The authorized representative assumes all the responsibilities of the client and may file an application on claimant's behalf but an authorized hearing representative is the person who stands in for or represents the client in the hearings process and has the legal right to do so. This right comes from one of the following sources:

- Written authorization, signed by the client, giving the person authority to act on the client in the hearings process.

- Court appointment as the guardian or conservator.
- The representative status as a legal parent of a minor child.
- The repres entative status of an attorney at law for the client, and for Medical Assistance purposes only.
- The representative status as the c lients s pouse or the deceas ed client's widow or widower, only when no one else has the authority to represent the client's interest in the heari ng proce ss. The authorized hearing representative has no right to a hearing but rather exercises the client's rights. Someone who assist s but not stand in or represents the client in the hearings process need not be an autho rized hearing representative. Stands in for, means the authorized hearing representative does whatever the client could do if the client were that representative (BPG Glossary, p. 4).

In the instant case, claimant's son was neither an authorized representative, nor an authorized hearing representative of claimant. Therefore, based upon the facts that the entire process took place in 2010 before claimant's s on receiv ed guardianship and conservatorship over claimant, the hearing request must be DISMISED.

Even assuming that claimant's s on was available to be the authoriz ed representative or authorized hearing representat ive for claimant, this Administrative Law Judge determines that the Trust document was not received by the department until July 15, 2010. The date stamp on the Tr ust indicates that the Trust document was received at the [redacted] Therefore, the document was not received before the [redacted] notice date or even before the [redacted] date of hearing request.

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 AUTHORIZED REPRESENTATIVE RESPONSIBILITIES

Responsibility to Cooperate

All Programs

Clients must cooperate with the local office in determining initial and ongoing eligibility. This includes completion of the necessary forms. BAM, Item 105, p. 5.

Client Cooperation

The client is responsible for 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 details. BEM, Item 260, p. 4.

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

All Programs

Clients must completely and truthfully answer 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 require d verification, but you must assist if they need and request help. BAM, Item 130, p. 2.

If neither the client nor you ca n obtain verification despite a reasonable effort, use the best available inf ormation. If **no** evidence is available, use your best judgment.

Exception: Alien inf ormation, blindness, disability, incapacity, incapabilit y to dec lare one's residence and, for FIP only, pregnancy must be ve rified. Citizens hip and identity must be verified for clie nts 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 t he verific ation des pite 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 elaps ed and the client has not made a reasonable effort to provide it. BAM, Item 130, p. 4.

MA Only

Send a negative action notice when:

. the client indicates refusal to provide a verification, **or**
. the time period giv en has elapsed. BAM, Item 130, p. 4.

This Administrative Law Judge finds t hat the department has established by t he necessary competent, material and substantial evidence on the record that it was acting in compliance with department policy when it determined that claimant's s on faile d to provide verification information in a timely manner. Claimant's son failed to provide the

Trust document and the LaSalle Bank account information in a timely manner and was not authorized to represent the claimant until July 6, 2010.

DECISION AND ORDER

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

Accordingly, the department's decision is AFFIRMED. This Administrative Law Judge also finds that this hearing request is hereby DISMISSED because neither claimant's son or [redacted] had standing/or legal authorization to represent claimant on any date which is relevant to this Medical Assistance application.

/s/
Landis Y. Lain
Administrative Law Judge
for Maura D. Corrigan, Director
Department of Human Services

Date Signed: March 28, 2011

Date Mailed: March 28, 2011

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

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