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: 2010-9660
Issue No: 2006
Case No: [redacted]
Load No:
Hearing Date:
June 9, 2010
Calhoun 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, a telephone hearing was held on June 9, 2010. Claimant is in [redacted] and was represented at the hearing by [redacted].

ISSUE

Did the Department of Human Services (the department) properly deny claimant's application for Medical Assistance (MA) 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) On June 30, 2009, claimant's representative filed an application for Medical Assistance benefits. Claimant is [redacted]

(2) On July 23, 2009, the department caseworker sent claimant a 3503 verification checklist with the information due to be returned to the department on August 3, 2009.

(3) Verification information was returned to the department with the exception of the railroad income and the pension information.

(4) On August 14, 2009, the department caseworker sent claimant notice that her application was denied based upon failure to provide verification information.

(5) On November 16, 2009, the claimant's representative filed a request for a hearing to contest the department's negative action.

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

In the instant case, the claimant's representative stated that she talked to the department caseworker before she received notice of the denial. Claimant is in a Nursing Home. The department caseworker stated that on the record that the request for a hearing was beyond the 90 days as there are two date stamps on the request for a hearing, one for November 20, 2009 and one for November 16, 2009, which is more than 90 days from the time the denial notice was mailed.

DEPARTMENT POLICY

All Programs

Clients have rights and responsibilities as specified in this item.

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

- Determine eligibility.
- Calculate the level of benefits.
- Protect client rights. PAM, 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. PAM, 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 PAM 815 and 825 for details. PEM, 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. PEM, Item 260, p. 4.

All Programs

Clients must completely and truthfully answer all questions on forms and in interviews. PAM, 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. PAM, 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. PAM, 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. PAM, 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. PAM, 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. PAM, Item 105, p. 7.

See PAM 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. PAM, 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. PAM, 105, p. 8.

Verifications

All Programs

Clients must take actions within their ability to obtain verifications. DHS staff must assist when necessary. See PAM 130 and PEM 702. PAM, 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. PEM 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. PAM, Item 130, p. 1.

Verification is usually required at application/redetermination **and** for a reported change affecting eligibility or benefit level. PAM, 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. PAM, 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. PAM, Item 130, p. 2.

The client must obtain required verification, but you must assist if they need and request help. PAM, 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. PAM, 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. PAM, 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. PAM, Item 130, p. 4.

MA Only

Send a negative action notice when:

- the client indicates refusal to provide a verification, **or**
- the time period given has elapsed. PAM, Item 130, p. 4.

Only **adequate** notice is required for an application denial. **Timely** notice is required to reduce or terminate benefits.

Exception: At redetermination, **FAP** clients have until the last day of the redetermination month **or** 10 days, whichever is later, to provide verification. See PAM 210. PAM, Item 130, p. 4.

TMAP

See PEM 647 regarding timeliness standards for TMA-Plus determinations. PAM, Item 130, p. 5.

Discrepancies

All Programs

Before determining eligibility, give the client a reasonable opportunity to resolve any discrepancy between his statements and information from another source. PAM, Item 130, p. 5.

In the instant case, the claimant's representative provided documentation that she mailed out bank statements and pension verification to the department on August 3, 2009, and on August 10, 2009, she contacted the department caseworker to notify her that she had sent the bank statements and pension and would forward the railroad pension as soon as it was received. An August 13, 2009, note indicates that the claimant's representative received the railroad retirement pension verification and mailed it to the caseworker.

On August 17, 2009, the representative stated that she called and left a message letting the caseworker know that she had mailed the railroad retirement pension and then on August 30, 2009, she reapplied for Medical Assistance benefits with a retroactive application.

This Administrative Law Judge finds that claimant is in [redacted] Her representative did provide a majority of the verification information and should have been given at least one extension of time before the case was closed pursuant to BAM, Item 130, which indicates that the claimant shall be allowed 10 calendar days to provide verification. Verifications are considered timely if received by the date they are due. If the client cannot provide the verification despite a reasonable effort, the department is to extend the time limit up to 3 times. In the instant case, the department did not extend the time limit up to 3 times and therefore cancelled the case without following department policy.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that the department has not 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 failure to provide verification information in a timely manner. The department did not follow department policy because it did not provide at least 1 extension of time to provide the verification information.

Accordingly, the department's decision is REVERSED. The department is ORDERED to reinstate the June 30, 2009, application for Medical Assistance benefits. The department shall allow 30 days for the claimant's representative to provide adequate verification information and once that verification information has been provided, the department shall assess claimant's eligibility for Medical Assistance benefits. If claimant is otherwise eligible, the department shall

open an on-going Medical Assistance case for claimant from the June 30, 2009, application date. If claimant has also filed a retroactive Medical Assistance application with the June 30, 2009, application, the department shall also make an assessment of claimant's eligibility for retroactive Medical Assistance in this case.

/s/

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

Date Signed: June 28, 2010

Date Mailed: June 29, 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: [redacted]