STATE OF MICHIGAN
STATE OFFICE OF ADMINISTRATIVE HEARINGS AND RULES
FOR THE DEPARTMENT OF COMMUNITY HEALTH
P.O. Box 30763, Lansing, MI 48909
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

[redacted]

Appellant
_____/

Docket No. 2010-13064HHS
[redacted]

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge 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 [redacted]. [redacted], Social Worker with [redacted], appeared on the Appellant's behalf. [redacted] appeared and testified. [redacted], Appeals Review Officer, represented the Department (DHS). [redacted], Adult Services Worker, appeared as a witness on behalf of the Department.

ISSUE

Did the Department properly deny the Appellant's HHS application due to not having full coverage Medicaid?

FINDINGS OF FACT

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

1. In [redacted], the Department received a Home Help Services Application for the Appellant.

2. The Department checked the Appellant's Medicaid status and discovered she was enrolled in the Adult Medical Plan (AMP) beginning [redacted]. (Exhibit 1, page 12)

3. On [redacted], the Department issued an Adequate Negative Action notice informing the Appellant that her HHS application was denied due to not having full Medicaid status. (Exhibit 1, pages 5 and 9-11)

4. The Appellant requested an administrative hearing contesting the denial of her HHS application on [redacted]. (Exhibit 1, page 6)

CONCLUSIONS OF LAW

The Medical Assistance Program is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

Home Help Services (HHS) are provided to enable functionally limited individuals to live independently and receive care in the least restrictive, preferred settings. These activities must be certified by a physician and may be provided by individuals or by private or public agencies.

ELIGIBILITY CRITERIA

Independent Living Services

The following **nonpayment** related independent living services are available to any person upon request **regardless** of income or resources:

- Counseling.
- Education and training.
- Employment.
- Family planning.
- Health related.
- Homemaking.
- Housing.
- Information and referral.
- Money management.
- Protection (For adults in need of a conservator or a guardian, but who are not in any immediate need for protective service intervention.)

Home Help Services (HHS)

Payment related independent living services are available if the client meets HHS eligibility requirements. Clients who may have a need for HHS should be assisted in applying for Medicaid (MA). Refer the client to an eligibility specialist. Cases pending MA determination may be opened to program 9 (ILS). HHS eligibility requirements include all of the following:

- The client must be eligible for Medicaid.

- Have a scope of coverage of:
  - 1F or 2F,

•• 1D or 1K, (Freedom to Work), **or**
•• 1T (Healthy Kids Expansion).

• The client must have a need for service, based on
•• Client choice, **and**
•• Comprehensive Assessment (DHS-324) indicating a functional limitation of level 3 or greater in an ADL or IADL.

• Medical Needs (DHS-54A) form signed and dated by a medical professional certifying a medical need for personal care services. The medical professional must be an enrolled Medicaid provider and hold one of the following professional licenses:
•• Physician.
•• Nurse practitioner.
•• Occupational therapist.
•• Physical therapist.

Adult Services Manual (ASM) 362, pages 1-2, 12-1-2007
(Exhibit 1, pages 18-19)

The Department has introduced evidence that the Appellant had Adult Medical Program (AMP) coverage beginning [redacted]. (Exhibit 1, page 12) The Department testified that this was the reason the Appellant's Home Help Services (HHS) application was denied, in accordance with the policy outlined above requiring full coverage Medicaid for HHS eligibility. (See *Medicaid Provider Manual, Beneficiary Eligibility,* pages 5-6, October 1, 2009 for an explanation of the scope of coverage codes.)

Medicaid eligibility is a requirement of HHS eligibility. *Adult Services Manual (ASM)* 362, pages 1-2, 12-1-2007 (Exhibit 1, pages 18-19) However, at the time of her HHS application, the Appellant had AMP coverage. The Adult Medical Program (AMP) is also known as Adult Benefit Waiver (ABW). *Bridges Administrative Manual* (BAM) 402, page 21, 1-1-2009. The ABW program provides basic medical care for low income childless adults who do not qualify for Medicaid. *Medicaid Provider Manual, Beneficiary Eligibility,* page 5 January 1, 2010. (Exhibit 1 page 20)

The Appellant's representative disagrees with the denial and testified that she believes the Appellant is eligible for Medicaid. A copy of the Appellant's mihealth card was submitted with the hearing request as evidence of Medicaid eligibility. (Exhibit 1, page 4) However, under Department policy, mihealth cards are issued to each recipient who is eligible for Medicaid or AMP. *Bridges Administrative Manual (BAM) 400*, page 5 10-1-2008. Therefore, the mihealth card in the Appellant's name can not be considered evidence of Medicaid eligibility.

The Appellant's representative testified that the Appellant has applied for disability benefits. However, the testimony indicated that this application was made for Social Security disability benefits, as opposed to filing application for Medicaid based upon disability with the Department of Human Services.

Based upon the available evidence, the Department properly denied the Appellant's HHS application as there was no evidence the Appellant was Medicaid eligible at the time of the application. It is possible that the Appellant's Medicaid status has changed since [redacted] or that it may change in the future. If the Appellant becomes Medicaid eligible, she may wish to re-apply for the HHS program.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly denied the Appellant's HHS application based on the available information.

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED.

_____
Colleen Lack
Administrative Law Judge
for Janet Olszewski, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 2/23/2010

***** 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.