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

IN THE MATTER OF:

[redacted]

Reg. No: 2010-42777
Issue No: 2006
Case No: [redacted]
Load No: [redacted]
Hearing Date:
October 21, 2010
Ingham 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 October 21, 2010. Claimant personally appeared and testified. Claimant was represented at the hearing by [redacted]

ISSUE

Did the Department of Human Services (the department) properly deny claimant's retroactive Medical Assistance application 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 November 11, 2008, claimant filed an application for Medical Assistance benefits and also stated that he had unpaid medical expenses for the 3 months prior.

(2) Eligibility factors were looked at and verifications were requested and received. On January 13, 2009, a budget was run in Legacy LOA2 for Medical Assistance and Family Independence Program related eligibility based on the fact that there was a minor child in the home.

(3) Along with the eligibility notice on January 13, 2009, the worker also sent a 3503 verification checklist with a retroactive Medicaid application to the

customer explaining what needed to be returned to the department to look at the prior 3 months eligibility.

(4) The information was to be returned to the department. The retroactive Medicaid application was never returned and neither was the verification information.

(5) On January 13, 2009, the department caseworker sent claimant notice that the November 2008, application was denied and that claimant had a spend-down which stated that claimant was denied for Medical Assistance benefits because they were not over age 65 or disabled and only met the standards for Medical Assistance based upon being a caretaker relative with a spend-down.

(6) No notice was sent to claimant denying him Medicaid for the retroactive Medical Assistance benefits because there was no retroactive Medical Assistance benefit application ever filed with the department.

(7) On April 22, 2010, [redacted] filed a request for a hearing to contest the fact that the department did not provide claimant with retroactive Medical Assistance benefits for the months prior to November 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

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. 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 d eny 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 obtai n the needed inf ormation. BAM, Item 105, p. 5.

FAP Only

Do **not** deny eligibilit y 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 refu se to pr ovide nec essary information or take a required act ion 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 repor ted change. BAM , Item 105, p. 7.

See BAM 220 for processing reported changes.

Other reporting require ments 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 Check list, 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.

A request for Assistance may be made in person, by mail, telephone or an application may be obtained on the internet. The requestor has the right to receive the appropriate application form. BAM, Item 110, p. 1.

When a person asks for an application, the local office must provide the client with an application. In the instant case, the caseworker sent claimant a retroactive Medical Assistance application along with a verification checklist which he never returned to the department. BAM, Item 105, indicates that the client must provide the minimum information for filing which is an application of filing form, which must contain the name of the applicant, the birth date of the applicant, the address of the application, and signature of the applicant/authorized representative. An application filing form with the minimum information must be registered in BRIDGES using the receipt date as the application date even if it does not contain enough information needed to determine eligibility. In the instant case, there was no retroactive Medical Assistance application ever filed with the department. The department did send the client a retroactive Medical Assistance application to be completed but it was never completed or sent back to the department. [redacted] provided this Administrative Law Judge with a copy of a retroactive Medical Assistance application which alleges to have been filled out on August 8, 2008, but it was never filed with the department and there is no record of such application ever having been filed with the department. It should be noted that at the time claimant filed the original application, [redacted] sent the claimant a letter stating that [redacted] was unable to represent claimant and if he wished to reapply for August 2008, Medicaid coverage he should do so on or before the last business day of November 2008. It was received by Ingham County DH on September 11, 2008.

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 determined that claimant failed to provide a retroactive Medical Assistance application. Therefore, the department could not consider claimant for retroactive Medical Assistance benefits because he never filed an application for the retroactive months.

DECISION AND ORDER

The Administrative Law Judge, based upon the above findings of fact and conclusions of law, finds that the department has appropriately determined that claimant did not file a retroactive Medical Assistance application. Therefore, no retroactive Medical Assistance application was ever registered or processed.

Accordingly, the department's decision is AFFIRMED.

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

Date Signed: November 18, 2010

Date Mailed: November 19, 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]