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]

Docket No. 2011-2181 CMH
Case No. 2240619

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 upon the Appellant's request for a hearing.

After due notice, a hearing was held [redacted]. [redacted] represented the Appellant. The Appellant's [redacted], was present and testified.

[redacted], was present as a witness on behalf of the Department. [redacted], was present on behalf of the Department. [redacted], represented the PIHP on behalf of the Department of Community Health.

ISSUE I

Did CMH properly deny the Appellant's request for an increase in Community Living Services from 20 hours per week to 24 hours per week?

ISSUE II

Did CMH properly deny the Appellant's request for housing assistance services for rent expenses?

ISSUE III

Was the Appellant denied case management and supports coordination services?

FINDINGS OF FACT

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

1. The Appellant is [redacted] Medicaid beneficiary who is developmentally

disabled. She resides alone in the community and is reliant upon supports and services provided through Community Mental Health to maintain her placement in the Community. (uncontested)

2. The Appellant is diagnosed with Autism. She is functionally non-verbal and unable to make her needs and preferences known. She has a seizure disorder. (uncontested)

3. The Appellant is functionally dependent on others for her instrumental activities of daily living and some activities of daily living. (uncontested)

4. The Appellant has a legal guardian. Her [redacted] services as legal guardian. The Appellant has no ability to manage financial affairs. (uncontested)

5. The Appellant participates with Home Help Services (HHS) through the Department of Human Services. She is authorized for 1 hour and 45 minutes per day of HHS. (uncontested)

6. The Appellant is served by Community Mental Health. The services authorized include community living supports, occupational therapy, physical therapy, music therapy, medication management, case management/supports coordination services and housing assistance. She participates in the self determination program. (uncontested)

7. The Appellant has no income other than Food Assistance (food stamps) at this time. The Appellant formerly received SSI benefits through the Social Security Administration. The Appellant's legal guardian is engaged in legal activity to have the SSI benefits restored. (uncontested)

8. The Appellant's rent obligation exceeds the amount of the SSI benefits she formerly received. Should the SSI benefits be restored, they are not expected to be adequate to pay her entire rent obligation. (uncontested)

9. The Appellant has no income that is not provided by her [redacted], thus no resources of her own with which she could meet rental or utility expenses necessitated by her current living arrangement. (uncontested)

10. The Appellant resides alone in an apartment. She formerly had a roommate, however, has resided alone for a period of at least [redacted] years. (uncontested)

11. The Appellant has received housing assistance through Community Mental Health to pay her utility expenses, including her telephone bill. (uncontested)

12. The Appellant has been issued an eviction notice, although no legal proceedings have yet been scheduled, as of the hearing date, to effectuate an actual eviction. (uncontested)

13. The Appellant's most recent IPOS included a request for increased CLS

supports. The level of supports requested is 24 hours per day. (uncontested)

14. The Appellant requested housing assistance equal to money sufficient to pay rental and utility expenses for an indeterminate amount of time. (uncontested)

15. The CMH authorized a continuation of housing assistance for utility and telephone payments for an additional 90 days following the most recent request. (uncontested)

16. The CMH denied the request for housing assistance that would be used to pay the Appellant's rent, asserting policy prohibits use of Medicaid funds to cover room and board expenses unless they are to assist with transitional expenses while securing other resources.

17. The Appellant asserts the request for housing assistance is temporary because she has filed an appeal with the Social Security Administration requesting her SSI benefits be restored and retroactive benefits as well.

18. The Appellant asserts CLS equal to 24 hours per day is necessary to protect her safety, health and well being. She further asserts she cannot maintain her placement in the community without 24 hour per day CLS authorization.

19. The CMH denied the Appellant's request for 24 hours per day of CLS services, although an increase in CLS to 20 hours per day was authorized.

20. The Appellant's immediately preceeding IPOS did not contain an authorization for 24 hour per day CLS.

21. The CMH asserts there has been no denial of case management/supports coordination services and cites the authorization for them in the Appellant's IPOS.

22. The Appellant's guardian requested a formal, administrative hearing [redacted]

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 Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State

> governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> 42 CFR 430.10

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) Medicaid Managed Specialty Services waiver. [redacted] (CMH) contracts with the Michigan Department of Community Health to provide specialty mental health services. Services are provided by CMH pursuant to its contract obligations with the Department and in accordance with the federal waiver.

In performing the terms of its contract with the Department, the PIHP must apply Medicaid funds only to those services deemed medically necessary or appropriate. The Department's policy regarding medical necessity provides as follows:

> **2.5 MEDICAL NECESSITY CRITERIA**
>
> The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; and
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; and
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning; and
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; and
- Made within federal and state standards for timeliness; and
- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; and
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; and
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; and
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

Deny services that are:

- deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- experimental or investigational in nature; or
- for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

> A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

The Medicaid Provider Manual specifies what supports and services are available for persons such as the Appellant. It states in pertinent part:

> **SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)**
> PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.
>
> **17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES**
> The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation
The individual uses community services and participates in community activities in the same manner as the typical community citizen.

Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with mental retardation).

Independence
"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning.

For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.

Productivity
Engaged in activities that result in or lead to maintenance of or increased self sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.

For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services,

individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.

17.3.B. COMMUNITY LIVING SUPPORTS

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:
  - meal preparation
  - laundry
  - routine, seasonal, and heavy household care and maintenance
  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - shopping for food and other necessities of daily living

  CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:
  - money management
  - non-medical care (not requiring nurse or physician intervention)
  - socialization and relationship building
  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
  - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
  - attendance at medical appointments
  - acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS **assistance** with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these

activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Medicaid Provider Manual
Mental Health/Substance Abuse
Version Date: January 1, 2010, Pages 97-101
Michigan Department of Community Health

ISSUE I

In this case, it is undisputed that CLS services are medically necessary for the Appellant. Her [redacted] asserts she must have 24 hours per day of CLS authorized or she would not be able to maintain residence in the least restrictive placement in the community. The uncontested facts are that she is residing in the same apartment this year as last year. Last year she lived there without a roommate and without 24hours per day of CLS authorization. She participates in the Self Determination program. It is not known exactly how she used the budget given to pay staff for the services authorized, however, it is known and undisputed the 20 hours of CLS she was authorized after the last IPOS represents an increase in CLS hours. There is no showing in the evidentiary record that her health and safety needs were not met during that time period. While it is asserted they would not be met during this authorization period without 24hours per day of CLS authorization, the Appellant's [redacted] did not present evidence of what had changed about the Appellant or her circumstances since the last IPOS that would require an increase in the CLS beyond that given. This ALJ did consider the argument put forth by the Appellant's [redacted] and is concerned for the Appellant's safety, health and well being. Given that the Appellant has been residing in her apartment alone for at least 2 IPOS authorization periods without the 24 hours CLS currently requested, this ALJ could not find justification for an increase beyond the 20 hours authorized without more evidence of what has changed for the Appellant that requires a larger increase. The CMH presented evidence the goals of the (CLS) service are reasonably met with the current authorization. This ALJ finds the Appellant has not met her burden of proof on this issue and that the increase to 20hours per day of CLS is sufficient to reasonably meet the goals stated in the Appellant's IPOS.

ISSUE II

The assertion that the Appellant was denied case management/supports coordination services because they were ineffective at addressing her housing "crisis" is a recipient rights issue. The IPOS authorizes and provides for case management/supports coordination services. Their alleged lack of effectiveness is not a proper subject for a Medicaid Fair Hearing.

ISSUE III

Housing Assistance is also available as a service and is addressed in the Medicaid Provider Manual chapter covering Additional (B3) Services available for beneficiaries of Mental Health and Substance Abuse Services.

17.3.G. HOUSING ASSISTANCE

Housing assistance is assistance with short-term, interim, or one-time-only expenses for beneficiaries transitioning from restrictive settings and homelessness into more independent, integrated living arrangements while in the process of securing other benefits (e.g., SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that will become available to assume these obligations and provide needed assistance.

Additional criteria for housing assistance:

- The beneficiary must have in his individual plan of services a goal of independent living, and either live in a home/apartment that he/she owns, rents, or leases; or be in the process of transitioning to such a setting; and
- Documentation of the beneficiary's control (i.e., beneficiary-signed lease, rental agreement, deed) of his living arrangement in the individual plan of service; and
- Documentation of efforts (e.g., the person is on a waiting list) under way to secure other benefits, such as SSI or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available they will assume these obligations and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to owning or leasing/renting a dwelling
- Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings and homelessness
- Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his own or other community resources
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.

Coverage excludes:

- Funding for on-going housing costs
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits

- Home maintenance that is of general utility or cosmetic value and is considered to be a standard housing obligation of the beneficiary

Replacement or repair of appliances should follow the general rules under assistive technology. Repairs to the home must be in compliance with all local codes and be performed by the appropriate contractor (refer to the general rules of the Environmental Modifications subsection of this chapter). Replacement or repair of appliances, and repairs to the home or apartment do not need a prescription or order from a physician.

Version Mental Health/Substance Abuse
Date: January 1, 2011 Pages 111-112

The Appellant asserts she has a temporary need for housing assistance that is a covered benefit for persons in her circumstance. She is appealing the termination of her SSI benefits, thus expects to have her funding restored. She further asserts the request is for temporary assistance because after her SSI is restored she will use it to pay her rent. The Appellant asserts the following provision of the relevant policy specifically addresses her circumstance:

Coverage includes:…

Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his own or other community resources

The CMH asserts rent is a room and board expense that is not payable with Medicaid funds. It further asserted the need is not really temporary due to the termination of SSI benefits. While it is stipulated the SSI termination is under appeal, there is no end date known or reasonable evidence she is likely to prevail. Furthermore, even if issued, the SSI funds are insufficient to meet the entire rent obligation without a roommate, thus it could not be fairly said she has a reasonable expectation of meeting her own living expenses even if her benefits were to be restored. For these reasons the CMH asserts it is not appropriate or supported by policy to provide housing assistance for the rent obligation owed by the Appellant.

The Appellant's [redacted] ties the lack of roommate for sharing expenses to the aforementioned issue of case management/supports coordination services being denied as lacking suitability to the Appellant's condition. Again, services suited to condition is a recipient rights issue. Additionally, this ALJ sees this line of argument as an attempt to shift responsibility for appropriate housing arrangements from the legal guardian to the CMH. The Appellant's legal [redacted] is responsible for making decisions on behalf of the Appellant because she is unable to do it for herself. How to obtain, maintain and use her public benefits is among them. Where to live is also among them. This does not mean the guardian selects a living arrangement and then informs the CMH of what it will cost to keep the Appellant there. A legal guardian is

charged with the responsibility to make appropriate decisions on behalf of the Appellant such that she does not lose her public benefits or lack an appropriate residence. That is true in this case. The Appellant's guardian has a responsibility to address the issues faced by the Appellant, her charge. The CMH authorizes services suitable to her condition and that are medically necessary, however, the legal obligation of appropriate decision making on behalf of the Appellant is not assumed by the CMH when it provides services. The services provided by the CMH are not a substitute for a legal guardian. It is improper to attempt to shift responsibility for a "housing crisis" to the CMH because it won't authorize Medicaid funds for room and board expenses such as rent.

Based upon the credible evidence of record, the Appellant's current IPOS has sufficient authorization of housing assistance, CLS and case management/supports coordination services to meet the Appellant's medically necessary needs, therefore the Appellant's requested relief is denied.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the authorization of 20 hours per day of Community Living Supports are sufficient in amount, scope and duration to reasonably achieve the goals as stated in the person centered plan. The ALJ further finds the denial of housing assistance to meet the rent obligation of the Appellant is not supported by Medicaid Policy and was appropriately denied.

IT IS THEREFORE ORDERED that:

The CMH's decisions are AFFIRMED.

Jennifer Isiogu
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 1/13/2011

***** 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.