STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM
FOR THE DEPARTMENT OF COMMUNITY HEALTH
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IN THE MATTER OF:

Docket No. 2011-8998 HHS
[redacted], Case No. [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge (ALJ) 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], the Appellant's daughter and provider, represented her.

[redacted] of the Department of Community Health, represented the Department of Community Health. [redacted] appeared as a witness on behalf of the Department. [redacted], the Appellant's former worker was also present. [redacted] was present on behalf of the Department.

ISSUE

Did the Department properly authorize Home Help Services (HHS) payments to the Appellant?

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 a [redacted] year old Medicaid beneficiary who had been receiving Home Help Services.

2. The Appellant's medical diagnoses include osteoarthritis, diabetes, hypertension, chronic kidney disease, depression, migraine headaches and neuropathy. The Appellant resides with her [redacted] year old daughter.

3. The Appellant has another daughter who serves as her chore provider, through an agency her mother employs to provide services.

4. The Appellant had a services approval notice sent her in [redacted] notifying her of payment approval of [redacted] per month. The Appellant was not informed of which tasks she had payment approval for. She was, however, specifically notified that if she did not spend the night in her own home she was required to notify her worker of this. (Department Exhibit A)

5. The Appellant appealed the payment approval amount on [redacted].

6. On [redacted], the Department sent an Advance Negative Action Notice terminating the Appellant's payment retroactively; effective [redacted]. The reason provided to her was that she was unavailable for a home visit that had been scheduled for [redacted]. (Department Exhibit A)

7. The evidence submitted by the Department indicates the former worker printed a letter [redacted], scheduling a home call for [redacted] The letter was sent to the Appellant via regular mail. (Department Exhibit A)

8. The evidence further indicates the former worker attempted a home call on [redacted], and no contact was established. (Department Exhibit A)

9. The original hearing date was scheduled for [redacted].

10. The parties went on the record and agreed to adjourn the hearing for 30 days in an effort to settle the matter. This ALJ agreed to the adjournment.

11. The hearing was re-noticed for [redacted]. All parties were present for the hearing.

12. As of the [redacted], hearing, the Appellant had been re-assessed by a new worker and approved for a monthly payment assistance benefit of [redacted].

13. The Appellant's representative indicated she was not satisfied with this because an insufficient amount of time had been allocated for each of the tasks approved.

14. The hearing proceeded given the lack of agreement between the parties. There was no withdrawal on the part of the Appellant.

15. The Appellant had not been provided any of the evidence intended to be used in advance of hearing, however agreed to proceed with the hearing.

16. This ALJ allowed the Department to submit additional pages of documentation establishing the functional ranks, time allocations and medical needs form into the record given the Appellant's agreement to proceed with hearing.

17. The evidence of record establishes the Appellant's doctor certified on a DHS 54A Medical Needs form that the Appellant has a medical need for assistance with laundry, housekeeping and shopping.

18. An in home comprehensive assessment was conducted [redacted], resulting in payment assistance for tasks including housekeeping, laundry, meal preparation, bathing, grooming and shopping. The payment is effective [redacted].

19. The Appellant's chore provider is dissatisfied with the payment assistance authorized for the Appellant, thus she went forward with the hearing.

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.

Program requirements are set forth in Adult Services Manual item 362, below:

> **GENERAL SERVICES REQUIREMENTS** The client must sign an Adult Services Application (DHS-390) to receive ILS. An authorized representative or other person acting for the client may sign the DHS-390 if the client:
>
> • Is incapacitated, **or**
>
> • Has been determined incompetent, **or**
>
> • Has an emergency. A client unable to write may sign with an "X", witnessed by one other person (e.g., relative or department staff). Adult services workers must not sign the services application (DHS-390) for the client. Eligibility must be determined within 45 days of the signature date on the DHS-390.

Note: ASSIST (Automated Social Services Information and Support) requires a disposition within 30 days of the registered request. See ASSIST User Manual (AUM) 150-7/8. The DHS-390 is valid indefinitely unless the case is closed for more than 90 days.

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.

ASM 362, 12-1-2007

Manual Item 363 addresses what a comprehensive assessment consists of, as well as other program procedures.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (DHS-324) is the primary tool for determining need for services. The comprehensive assessment will be completed on all open cases, whether a home help payment will be made or not. ASCAP, the automated workload management system provides the format for the comprehensive assessment and all information will be entered on the computer program.

Requirements for the comprehensive assessment include, but are not limited to:

- A comprehensive assessment will be completed on all new cases.
- A face-to-face contact is required with the customer in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the customer's social security card.
- Observe a picture I.D. of the caregiver, if applicable.
- The assessment must be updated as often as necessary, but minimally at the six month review and annual re-determination.
- A release of information must be obtained when requesting documentation from confidential sources and/or sharing information from the department record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the HHS payment.

Conduct a functional assessment to determine the customer's ability to perform the following activities:

Activities of Daily Living (ADL)

- Eating
- Toileting
- Bathing
- Grooming
- Dressing
- Transferring
- Mobility

Instrumental Activities of Daily Living (IADL)

- Taking Medication
- Meal Preparation and Cleanup
- Shopping
- Laundry
- Housework

Functional Scale ADL's and IADL's are assessed according to the following five-point scale:

1. Independent
   Performs the activity safely with no human assistance.

2. Verbal Assistance
   Performs the activity with verbal assistance such as reminding, guiding or encouraging.

3. Some Human Assistance
   Performs the activity with some direct physical assistance and/or assistive technology.

4. Much Human Assistance
   Performs the activity with a great deal of human assistance and/or assistive technology.

5. Dependent
   Does not perform the activity even with human assistance and/or assistive technology.

Note: HHS payments may only be authorized for needs assessed at the 3 level or greater.

Time and Task

The worker will allocate time for each task assessed a rank of 3 or higher, based on the interviews with the client and provider, observation of the client's abilities and use of the reasonable time schedule (RTS) as a guide. The RTS can be found in ASCAP under the Payment module, Time and Task screen. When hours exceed the RTS rationale must be provided.

IADL Maximum Allowable Hours
There are monthly maximum hour limits on all IADLs except medication. The limits are as follows:

- Five hours/month for shopping
- Six hours/month for light housework
- Seven hours/month for laundry
- 25 hours/month for meal preparation.

These are maximums; as always, if the client needs fewer hours, that is what must be authorized. Hours should continue to be prorated in shared living arrangements.

A service plan must be developed for all ILS cases. The service plan is formatted in ASCAP and interacts with the comprehensive assessment. The service plan directs the movement and progress toward goals identified jointly by the client and specialist.

Philosophy
Service planning is person-centered and strength-based.

Areas of concern should be identified as an issue in the comprehensive assessment to properly develop a plan of service.

Participants in the plan should involve not only the client, but also family, significant others, and the caregiver, if applicable.

Involvement of the client's support network is based on the best practice principles of adult services and the mission of the Department of Human Services, which focus on:

- Strengthening families and individuals.
- The role of family in case planning.
- Coordinating with all relevant community-based services, and
- Promoting client independence and self-sufficiency.

Service plans are to be completed on all new cases, updated as often as necessary, but minimally at the six month review and annual reassessment.

Service Plan Development

Address the following factors in the development of the service plan:

- The specific services to be provided, by whom and at what cost.
- The extent to which the Client does not perform activities essential to the caring for self. The intent of the Home Help program is to assist individuals to function as independently as possible. It is important to work with the recipient and the provider in developing a plan to achieve this goal.
- The kinds and amounts of activities required for the client's maintenance and functioning in the living environment.
- The availability or ability of a responsible relative or legal dependent of the client to perform the tasks the client does not perform. Authorize HHS only for those services or times which the responsible relative/legal dependent is unavailable or unable to provide.

Note: Unavailable means absence from the home, for employment or other legitimate reasons. Unable means the responsible person has disabilities of his/her own which prevent caregiving. These disabilities must be documented/verified by a medical professional on the DHS-54A.

- Do not authorize HHS payments to a responsible relative or legal dependent of the client.
- The extent to which others in the home are able and available to provide the needed services. Authorize HHS only for the benefit of the client and not for others in the home. If others are living in the home, prorate the IADL's by at least 1/2, more if appropriate.
- The availability of services currently provided free of charge. A written statement by the provider that he is no longer able to furnish the service at no cost is sufficient for payment to be authorized as long as the provider is not a responsible relative of the client.
- HHS may be authorized when the client is receiving other home care services if the services are not duplicative (same service for the same time period).

Good Practices Service plan development practices will include the use of the following skills:

- **Listen actively** to the client.
- Encourage clients to **explore options** and select the appropriate services and supports.
- Monitor for **congruency** between case assessment and service plan.
- Provide the necessary supports to **assist** clients **in applying for resources**.
- Continually **reassess** case planning.
- Enhance/preserve the client's **quality of life**.
- **Monitor and document** the status of all **referrals** to waiver programs and other community resources **to ensure quality outcomes**.

REVIEWS
ILS cases must be reviewed every six months. A face-to-face contact is required with the client, in the home. If applicable, the interview must also include the caregiver.

Six Month Review
Requirements for the review contact must include:

- A review of the current comprehensive assessment and service plan.
- A reevaluation of the client's Medicaid eligibility, if home help services are being paid.
- Follow-up collateral contacts with significant others to assess their role in the case plan.
- Review of client satisfaction with the delivery of planned services.

Documentation
Case documentation for all reviews should include:

- Update the **"Disposition"** module in ASCAP.
- Generate the CIMS Services Transaction (DHS-5S) from **forms** in **ASCAP**.
- Review of **all** ASCAP modules **and** update information as needed.
- Enter a brief statement of the nature of the contact and who was present in **Contact Details** module of ASCAP.
- Record expanded details of the contact in **General Narrative**, by clicking on **Add to & Go To Narrative** button in **Contacts** module.
- Record summary of progress in service plan by clicking on **Insert New Progress Statement in General Narrative** button, found in any of the **Service Plan** tabs.

Annual Redetermination
Procedures and case documentation for the annual review are the same as the six month review, with the following additions:
Requirements:

• A reevaluation of the client's Medicaid eligibility, if home help services are being paid. • A new medical needs (DHS-54A) certification, if home help services are being paid.

Note: The medical needs form for SSI recipients will **only** be required at the initial opening and is no longer required in the redetermination process. All other Medicaid recipients will need to have a DHS-54A completed at the initial opening and then annually thereafter.

• A face-to-face meeting with the care provider, if applicable. This meeting may take place in the office, if appropriate.

ELIGIBILITY FOR HOME HELP SERVICES

Home help services (HHS) are defined as those which the department is paying for through Title XIX (Medicaid) funds. The client must be eligible for Medicaid in order to receive these services.

Medicaid/Medical Aid(MA)

Verify the client's Medicaid/Medical aid status. The client may be eligible for MA under one of the following:

• All requirements for MA have been met, **or**

• MA deductible obligation has been met. The client must have a scope of coverage of:

- 1F or 2F, **or**
- 1D or 1K (Freedom to Work), **or**
- 1T (Healthy Kids Expansion).

Clients with eligibility status 07 (Income scale 2-Non MA) and scope of coverage 20 or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

An ILS case may be opened (service program 9) to assist the client in becoming MA eligible. However, do **not** authorize HHS payment prior to the MA eligibility date. The payment must be prorated if the eligibility period is less than the full month. To prorate, divide the monthly care cost by the number of days in the month. Then, multiple that daily rate by the number of eligible days.

Note: A change in the scope of coverage by the eligibility specialist (ES) will generate a DHS-5S for cases active to services programs 1, 7, and 9.

Necessity For Service
The adult services worker is responsible for determining the necessity and level of need for HHS based on:

- Client choice.
- A complete comprehensive assessment and determination of the client's need for personal care services.
- Verification of the client's medical need by a Medicaid enrolled medical professional. The client is responsible for obtaining the medical certification of need. The Medicaid provider identification number must be entered on the form by the medical provider. The Medical Needs form must be signed and dated by one of the following medical professionals:
    - •• Physician.
    - •• Nurse practitioner.
    - •• Occupational therapist.
    - •• Physical therapist.

Exception: DCH will accept a DHS-54A completed by a VA physician or the VA medical form in lieu of the medical needs form. The medical professional certifies that the client's need for service is related to an existing medical condition. The medical professional does not prescribe or authorize personal care services. If the medical needs form has not been returned, the adult services worker should follow-up with the client and/or medical professional. If the case is closed and reopened within 90 days with no changes in the client's condition, a new DHS-54A is not necessary. Do **not** authorize HHS prior to the date of the medical professional signature on the DHS-54A.

Payment for Medical Exams:
The Medicaid card is to be used to pay for medical professional charges for examinations or tests to certify the client's need for services and for completing the DHS-54A for MA recipients. Use the Examination Authorization/Invoice for Services (DHS-93) to pay for professional charges for non-MA clients. Payment is limited to the medical procedures and tests necessary to certify the client's need for home help services. See SRM 234, Diagnostic Fee Schedule.

Medical Review Team (MRT)
If the client refuses to see a physician, or the physician refuses to complete a DHS-54A, forward medical and case information to the Medical Review Team (MRT) through the local office medical contact worker and/or the local office's designated person responsible for reviewing medical information. Attach a cover memo explaining the reason a MRT evaluation is needed. The local office designee will forward the packet to the regional Disability Determination Services (DDS) MRT. The MRT will make a determination and return the forms. See L-letter 00-130, June 20, 2000. The MRT may also be used if the client's physician does not certify a need for personal care services, but services appear to be justified.

Expanded Home Help Services (EHHS)
EHHS may be authorized if **all** of the following criteria are met:

- The client is eligible for HHS.
- The client has functional limitations so severe that the care cost cannot be met safely within the monthly maximum payment.
- The local office director/supervisory designee has approved the payment (EHHS $550-$1299.99) **or** the Department of Community Health (DCH) has approved the payment (EHHS $1300 or over). All EHHS requests for approval must contain:
- Medical documentation of need, e.g., DHS-54A, **and**
- An updated DHS-324 **and** written plan of care which indicates:
  •• How EHHS will meet the client's care needs **and**
  •• How the payment amount was determined.

Note: See adult services home page for Expanded Home Help Services Procedure Guideline under Training Materials/Job Aids, developed by the Department of Community Health. **Service Animal** Payment for maintenance costs of a service animal may be authorized if **all** of the following conditions are met:

- The client is eligible for HHS.
- The client is certified as disabled due to a specific condition such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury.

- The service animal is certified as professionally trained by a recognized agency to meet specific needs of the client.
- The HHS plan documents that the service animal will be used primarily to meet specific client personal care needs.

Service animal maintenance may be authorized for a client in an alternative care setting (AFC or HA). Authorize payment for maintenance costs of a service animal if the client meets **all** eligibility criteria.

COORDINATION OF HHS WITH OTHER SERVICES
Coordinate available home care services with HHS in developing a services plan to address the full range of client needs. Do **not** authorize HHS if another resource is providing the same service at the same time.

Supported Independent Living Programs (SIP)
Clients in supported independent living program homes (SIP) may be eligible for HHS payments. See L-Letter 97-278.

Services not Covered by Home Help Services
Do **not** authorize HHS payment for the following:

- Supervising, monitoring, reminding, guiding or encouraging (functional assessment rank 2);
- Services provided for the benefit of others;
- Services for which a responsible relative is able and available to provide;
- Services provided free of charge;
- Services provided by another resource at the same time;
- Transportation - See Program Administrative Manual (PAM) 825 for medical transportation policy and procedures.
- Money management, e.g., power of attorney, representative payee;
- Medical services;
- Home delivered meals;
- Adult day care.

> **Note:** If it appears the client's primary need is for adult foster care (AFC) or foster care is being provided without a license, the case should be referred to the local AFC licensing consultant.
>
> ASM 363, 9-1-2008

Adult Services Manual (ASM 362) 12-1-2007, page 4 of 5 addresses the issue of termination of HHS payments:

> **TERMINATION OF HHS PAYMENTS**
>
> Suspend and/or terminate payments for HHS in **any** of the following circumstances:
>
> • The client fails to meet any of the eligibility requirements.
> • The client no longer wishes to receive HHS.
> • The client's provider fails to meet qualification criteria.
>
> When HHS are terminated or reduced for any reason, send a DHS- 1212 to the client advising of the negative action and explaining the reason. **Continue the payment during the negative action period.** Following the negative action period, complete a payment authorization on ASCAP to terminate payments.
>
> **If the client requests a hearing before the effective date of the negative action, continue the payment until a hearing decision has been made.** If the hearing decision upholds the negative action, complete the payment authorization on ASCAP to terminate payments effective the date of the original negative action.
>
> See Program Administrative Manual (PAM) 600 regarding interim benefits pending hearings and Services Requirements Manual (SRM) 181, Recoupment regarding following upheld hearing decisions.

Additionally, the Code of Federal Regulations, Chapter 42 addresses the Appellant's rights with respect to Advance Negative Notice of an agency action:

> **§ 431.211 Advance notice.**
> The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.

> **§ 431.213 Exceptions from advance notice.**
> The agency may mail a notice not later than the date of action if—
> (a) The agency has factual information confirming the death of a recipient;
> (b) The agency receives a clear written statement signed by a recipient that—
> (1) He no longer wishes services; or
> (2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;
> (c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;
> (d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);
> (e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth;
> (f) A change in the level of medical care is prescribed by the recipient's physician;
> (g) The notice involves an adverse determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act; or (h) The date of action will occur in less than 10 days, in accordance with § 483.12(a)(5)(ii), which provides exceptions to the 30 days notice requirements of § 483.12(a)(5)(i)

This ALJ will address the issues in this case chronologically. From what this ALJ could ascertain from the computer record printouts of the sequence of events, a medical doctor certified the Appellant's medical needs back in [redacted]. There was an assessment conducted [redacted] and disagreement between the original worker and the Appellant and/or her daughter about what the Appellant required assistance with. The worker telephoned the doctor's office to clarify and obtain their direct input about what services the Appellant would need. She learned directly from the doctor's office that only housekeeping and shopping were required, thus that is all she approved payment assistance for. She approved it effective, at least partially, in [redacted] An approval notice was not generated or mailed until [redacted]. The Appellant's daughter requested a formal administrative hearing after receiving the payment approval notice, in [redacted]. It did not bear the Appellant's signature so it was returned by the legal secretary for this ALJ with a request for signature. The hearing request was thereafter returned bearing the signature of the Appellant on [redacted] Meanwhile, on [redacted] the Department printed a letter scheduling a home call with the Appellant for [redacted]. The Worker attempted to have face to

face contact on [redacted], however, the Appellant was not home. The Department thereafter printed an Advance Negative Action Notice [redacted]. The Notice informed the Appellant her payment was terminated effective [redacted] This is not advance notice. It does not comport with Department policy, state or Federal law. The Appellant's rights under the Code of Federal Regulations have been violated by this procedure followed by the Department, apparently at the behest of the supervisor. This must be remedied. The earliest the termination notice could be effective is 10 days after it is mailed.

This ALJ cannot support termination of the payment simply because the Appellant was not at her residence for the one home call attempted by the worker. In this case, it is undisputed the home call notice was not printed until [redacted]. This is a Monday. It is quite possible it was not placed into the mail delivery system until either quite late on Monday or the next day, Tuesday, [redacted]. This only leaves one business day left for the letter to make it to the Appellant's home, assuming she is in her home. This is an inadequate amount of notice to schedule a home call. Being absent from your home one time is also an inadequate basis for termination from the program. The policy does not support termination of benefits for missing a single scheduled home call. Certainly in circumstances such as this where it is entirely possible the Notice was not received prior to the attempted home call, it is not a sound basis to find the Appellant is not qualified for services any longer. The Department improperly terminated the Home Help Services of this Appellant effective [redacted] This must be remedied.

The Appellant was re-assessed [redacted]. The newly assigned worker approved services beyond what the Appellant's doctor had recommended on the DHS 54. At hearing the Appellant raised the issue that insufficient time was allotted for each of the tasks she aided her mother with. The worker testified about how she conducted the assessment. She conducted a reasonable assessment of the Appellant's needs and approved adequate time for each task the Appellant was ranked a 3 or above. She appropriately pro-rated the Instrumental Activities of Daily Living because the Appellant resides with her [redacted] year old daughter. Whether the daughter actually participates in housekeeping, shopping, laundry and meal preparation is immaterial to whether it is appropriate to pro-rate payment for these tasks. She is expected to participate by the DHS policy and it is a personal matter between the Appellant and her daughter if her daughter elects not to do her share around the house. The Appellant's daughter's irresponsible decisions do not obligate the Department to approve a higher payment on behalf of the Appellant. Furthermore, there is still controversy about how the DHS 54 had more tasks circled as necessary for assistance than the doctor's office originally indicated. Frankly, the longer the Appellant's daughter talked at hearing, the less credible she became. Given the inconsistency between the DHS 54 as sent over by the doctor's office and what the worker received, a referral to program integrity or the fraud division may be called for. It is not within this ALJ's purview to order any such action.

At hearing [redacted], the Appellant's representative pursued only arguments pertaining to the current payment. The Department sought to drop the earlier dispute,

however it had been properly raised prior to the adjournment. It was not legally withdrawn by the Appellant when she agreed to the adjournment. It is unfair to penalize her for agreeing to an adjournment only to have her earlier claim disregarded at decision time by this ALJ. This ALJ finds it is legally necessary to address the earlier claim as it was never withdrawn and only put aside upon the Department's request for adjournment.

After consideration of the evidence of record, this ALJ finds the comprehensive assessment completed by the worker in [redacted] is more than adequate to address the Appellant's needs.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department's determination of the Appellant's Home Help Services payment is adequate to meet her needs. However, the Department improperly terminated benefits without good cause. The Department must reinstate the original payment of [redacted] effective [redacted], until the new payment approval was effective, [redacted].

IT IS THEREFORE ORDERED that:

The Department's decision is AFFIRMED in part and REVERSED in part.

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

cc: [redacted]

Date Mailed: 6/3/2011

***** NOTICE *****

The Michigan Administrative Hearing System 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 Michigan Administrative Hearing System 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.