

**STATE OF MICHIGAN  
MICHIGAN ADMINISTRATIVE HEARING SYSTEM  
FOR THE DEPARTMENT OF COMMUNITY HEALTH**

P.O. Box 30763, Lansing, MI 48909  
(877) 833-0870; Fax: (517) 334-9505

IN THE MATTER OF:

Docket No. 2011-22279 HHS  
Case No. [REDACTED]

[REDACTED],  
Appellant

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**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 on [REDACTED]. [REDACTED] appeared on behalf of the Appellant. Her witness was [REDACTED]. [REDACTED], represented the Department. Her witnesses were [REDACTED] and [REDACTED].

**ISSUE**

Did the Department properly establish the start date for Home Help Services payments?

**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] Medicaid beneficiary. (Appellant's Exhibit #1)
- 2) The Appellant alleges disability by way of Down's Syndrome, MR, Bi-polar disorder and self-injurious conduct. He receives psychiatric help, including medication, through the [REDACTED]. (Department's Exhibit A, p. 10)
- 3) The Appellant's witness testified that her brother is aggressive and self-abusive. At age [REDACTED] he is hard to handle and will be graduating from school after this summer – thus increasing the need for assistance at home. (See Testimony and Department's Exhibit A, pp. 10, 11)
- 4) The Appellant's physician certified the need for personal care assistance for the Appellant on or about [REDACTED]. (Department's Exhibit A, p. 10)
- 5) On [REDACTED], the Department sent the Appellant a DHS 1210 Services and Payment Notice advising him that HHS was approved retroactively to [REDACTED], the date that the Appellant's request and medical certification

was initially received. (Department's Exhibit A, pp. 2, 10)

- 6) The request for hearing on the instant appeal was received by the Michigan Administrative Hearings System for the Department of Community Health on [REDACTED]. (Appellant's Exhibit #1)

### **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.

### **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 agency record.
- Follow specialized rules of confidentiality when ILS cases have companion APS cases.

Adult Service Manual (ASM), §363, page 2 of 24, September 1, 2009.

### **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. (Emphasis supplied) ASM *Supra* page 9 of 24.

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The Department witness testified that she further investigated the Appellant's request for services and was able to secure supervisory permission to apply retroactive HHS payment back to ██████████, the date of request and medical certification.

She explained further the limits of the Home Help Services program in that it is not a 24-hour around the clock service, but rather hands-on assistance with assorted ADLs and IADLs. In this case the Appellant receives appropriate assistance with bathing, grooming, dressing, toileting medication, housework, laundry, and shopping and meal preparation – prorated for the number of adults living in the home. The Appellant lives with his parents and an adult sibling.

The Appellant's representative testified that she understands the proration policy, but advises that ██████████ requires [or will require after graduation] a greater number of HHS hours. She was directed to her ██████████ for assistance in securing additional services as she indicated that the Appellant received no other services outside of DHS – yet apparently receives some mental health assistance through the ██████████.

On review, the Appellant's appeal must fail because there was no dispute or evidence that the allotted hours of hands-on assistance were inadequate or improperly assessed. A comprehensive assessment and the application of policy is the responsibility of the ASW. Based on the information presented at hearing I found the proration policy to be correctly applied as was the payment for retroactive HHS based on the date of medical certification.

**DECISION AND ORDER**

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that the Department properly established the start date for the Appellant's HHS based on the date of medical certification.

**IT IS THEREFORE ORDERED** that:

The Department's decision is AFFIRMED.

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Dale Malewska  
Administrative Law Judge  
for Olga Dazzo, Director  
Michigan Department of Community Health

**Docket No. 2011-22279 HHS**  
**Decision and Order**

CC:



Date Mailed: 5/6/2011

**\*\*\* 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.