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. 2012-18495 HHS

[redacted] [redacted]

Appellant

_____/

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 and testified. [redacted] represented the Appellant and testified. [redacted] Appeals Review Officer, represented the Department. [redacted], Adult Services Worker, testified for the Department.

ISSUE

Did the Department properly deny the Appellant's Home Help Services (HHS) application?

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 Medicaid beneficiary who resides alone in his Farmington Hills, Michigan home.

2. The Appellant has been diagnosed with severe bi- lateral vision loss in both eyes. He is legally blind. The Appellant undergoes dialysis three times per week.

3. On [redacted], the Appellant was discharged from a nursing facility to his home. While in his home the Appellant received Home Health services.

4. On [redacted], the Appellant's Home Health nurse initiated contact with HHS services and attempted to assist the Appellant with the filing of an application for Home Help Services.

5. Subsequently the Appellant's Adult Services Worker forwarded the Appellant a HHS application and a DHS-54A with instructions to return

both completed forms to a designated address.

6. On [redacted], the Appellant's Adult Services Worker, [redacted] reviewed the Appellant's case file and found that the Appellant had failed to provide a completed HHS application and a completed Medical Needs form.

7. On [redacted] sent the Appellant a Negative Action Notice in which she indicated that the Appellant's application for HHS was denied because the Appellant failed to provide the required documents.

8. Subsequently, the Appellant submitted a second HHS application with the required paperwork, the Appellant was approved for HHS, and a case was opened.

9. Also subsequent to the [redacted], denial the Appellant was placed on a spend down, did not meet his spend down and his Medicaid coverage was terminated by the Department of Human Services.

10. On [redacted], the Michigan Administrative Hearing System received the Appellant's request for 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 Social Welfare Act, 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.

Department of Human Services HHS policy at Adult Services Manual (ASM 363, 9-1-08), pages 2-5 of 24 now ASM 115, pp 1-3 provides the requirements for HHS applications.

> **APPLICATION FOR SERVICES (DHS-390)**
> The client must complete and sign a DHS 390, Adult Services Application to receive independent living services. An authorized representative or other person acting for the client may sign the DHS-390 if the client either:
> - Is incapacitated.
> - Has a court-appointed guardian.

A client unable to write may sign with an X, witnessed by one other person (for example, relative or department staff). The adult services specialist **must not** sign the DHS-390 on behalf of the client.

The DHS-390 remains valid unless the case record is closed for more than 90 days.

MEDICAL NEEDS FORM (DHS-54A)

The DHS-54A, Medical Needs form must be 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 (M.D. or D.O.).
- Nurse practitioner.
- Occupational therapist
- Physical therapist.

Note: A physician assistant (PA) is not an enrolled Medicaid provider and **cannot** sign the DHS-54A.

The medical needs form is only required at the initial opening for SSI recipients and disabled adult children (DAC). All other Medicaid recipients must have a DHS-54A completed at the initial opening and annually thereafter.

The client is responsible for obtaining the medical certification of need but the form must be completed by the medical professional and not the client. The National Provider Identifier (NPI) number must be entered on the form by the medical provider and the medical professional must indicate whether they are a Medicaid enrolled provider.

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**. Needed services are determined by the comprehensive assessment conducted by the adult services specialist. If the medical needs form has not been returned, the adult services specialist should follow-up with the client and/or medical professional.

Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A. The medical needs form does not serve as the application for services. If the signature date on the DHS-54 is **before** the

> date on the DHS-390, payment for home help services must begin on the date of the application.
>
> **Example:** The local office adult services unit receives a DHS-54A signed on 1/18/2011 but a referral for home help was never made. The adult services staff enters a referral on ASCAP and mails an application to the client. The application is returned to the office with a signature date of 2/16/2011. Payment cannot begin until 2/16/2011, or later, if the provider was not working during this time period. 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.
>
> ASM 115, pp. 1-3

The following facts are not disputed. On or about [redacted], the Appellant's Home Health nurse requested information and paperwork for HHS. In response, [redacted], the Appellant's Adult Services Worker sent the Appellant a HHS application and a DHS-54A Medical Needs form with instructions to return the completed forms. Subsequently, neither the Appellant nor his Home Health nurse submitted the completed forms. The Appellant is legally blind, is unable to read and resides in his home alone. On [redacted], [redacted] issued an Adequate Action Notice which informed the Appellant that his application for HHS was denied because the Appellant failed to submit a completed HHS application and DHS-54A. [redacted] a personal friend and the Appellant's authorized hearing representative, went to the Appellant's home and found that the Appellant had not opened and was unable to read approximately two months of mail. Included in the unopened mail were the blank HHS application and DHS-54A and the [redacted], denial notice. [redacted] then initiated a second HHS application and obtained a completed DHS-54A for the Appellant. Subsequently, the Appellant was assessed for HHS and a case was opened. The issue in this appeal is only the [redacted], decision to deny the Appellant's request for HHS.

The Appellant's representative, [redacted], testified that the Appellant is blind and undergoes dialysis three times per week. [redacted] testified that the Appellant does not open and read his mail and did not open and read his mail for several months. [redacted] testified that she initiated his appeal because she wants to make sure that the Appellant was approved for HHS [redacted] testified that she submitted this appeal before she was informed that the Appellant had been approved for HHS and she did not withdraw her appeal because the Appellant is currently not receiving HHS because DHS has terminated the Appellant's Medicaid coverage. [redacted] testified that the Appellant was placed on a spend down, his Medicaid was terminated and he is still not receiving HHS.

DHS HHS policy provides that an HHS case may not be opened until the applicant provides a completed HHS application and completed DHS-54A. [redacted] testified

that the Appellant provided neither so she was unable to open the Appellant's HHS case. Neither the Appellant nor Ms. Bagley disputed the fact that as of [redacted], the Appellant had not provided the paperwork required to open the Appellant's HHS case. Therefore the Department properly denied the Appellant HHS services on [redacted]

Because this appeal is limited to issues related to the Department's [redacted] negative action I have no jurisdiction regarding the Appellant's second HHS application. In addition, issues related to the Appellant's Medicaid eligibility are also not within my jurisdiction. The Appellant would have appeal rights for changes made to the Appellant's Medicaid eligibility and may pursue those rights through a timely hearing request with the responsible DHS local office.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department properly denied the Appellant's application for Home Help Services.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

Martin D. Snider
Administrative Law Judge
for Olga Dazzo, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: 3-6-12

***** 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 March 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.