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

Docket No. 2012-24636 HHS

[redacted] Case No. [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 [redacted] The Appellant was represented by her provider, [redacted]. [redacted] represented the Department. [redacted] and [redacted], appeared as witnesses 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 [redacted] Medicaid beneficiary who has been receiving Home Help Services.

2. The Appellant is wheelchair bound and suffers right-sided arm and hand paralysis following a stroke.

3. The Appellant requires assistance with transferring, toileting, eating, mobility, bathing, grooming, dressing, laundry, shopping, medication administration and meal preparation.

4. The ASW is a new worker who completed a home call in conjunction with a review on [redacted] It was his first meeting with the Appellant.

5. The ASW spoke with the Appellant and her provider about the tasks of eating, laundry and shopping at the home call.

6. The ASW made adjustments to the time authorized for the provider to complete the tasks required by the Appellant as a result of his evaluation in [redacted]

7. The ASW sent notice of reduction in payment authorization [redacted] with an effective date of [redacted] The payment was reduced from $924.21 to $768.27 per month.

8. The ASW reduced the time authorized for eating to 10 minutes per day. Time for laundry was reduced to 4 hours, 18 minutes per month. Time for shopping was reduced to hours 9 minutes per month.

9. The Appellant requires food to be cut up for her. She is able to feed herself after her food is cut.

10. The Appellant is not fully continent of bowel and bladder. She requires her bed linens to be changed each morning.

11. The Appellant generates a large amount of laundry due to her medical problems.

12. The Appellant toilets on a portable commode several times a day when her provider is in the home.

13. The Appellant requires assistance to get out of her wheelchair onto and off the portable commode several times per day.

14. The Appellant contested the reductions in home help authorizations by requesting a hearing.

15. On [redacted] the Appellant's Request for Hearing was received.

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. The Adult Services Manual (ASM) sets forth eligibility criteria, program mission and goals. The current, updated policy states:

ELIGIBILITY CRITERIA

GENERAL

Home help services are available if the client meets all eligibility requirements. An independent living services case may be opened to supportive services to assist the client in applying for Medicaid.

Home help services payments cannot be authorized prior to establishing Medicaid eligibility and a face-to-face assessment completed with the client. Once MA eligibility has been established, the case service methodology **must** be changed to case management.

Requirements

Home help eligibility requirements include **all** of the following:

- Medicaid eligibility.
- Certification of medical need.
- Need for service, based on a complete comprehensive assessment (DHS-324) indicating a functional limitation of level 3 or greater for activities of daily living (ADL).
- Appropriate Level of Care (LOC) status.

Medicaid/Medical Aid (MA)

The client may be eligible for MA under one of the following:

- All requirements for Medicaid have been met.
- MA deductible obligation has been met.

The client must have a scope of coverage of either:

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

Clients with a scope of coverage 20, 2C or 2B are **not** eligible for Medicaid until they have met their MA deductible obligation.

Note: A change in the scope of coverage in Bridges will generate a system tickler in ASCAP for active services cases.

Medicaid Personal Care Option

Clients in need of home help personal care services may become eligible for MA under the Medicaid personal care option.

Discuss this option with the client and coordinate implementation with the eligibility specialist.

Conditions of eligibility:

- The client meets all Medicaid eligibility factors except income.
- An independent living services case is open.
- The client is eligible for home help services.
- The cost of personal care services is **more** than the MA excess income amount.

If **all** the above conditions have been satisfied, the client has met MA deductible requirements. The adult services specialist can apply the personal care option in ASCAP. The deductible amount is entered on the **MA History** tab of the Bridges **Eligibility** module in ASCAP.

Use the DHS-1210, Services Approval Notice to notify the client of home help services approval when MA eligibility is met through this option. The notice must inform the client that the home help payment will be affected by the deductible amount, and that the client is responsible for paying the provider the MA deductible amount each month.

Do **not** close a case eligible for MA based on this policy option if the client does not pay the provider. It has already been ensured that MA funds will not be used to pay the client's deductible liability. The payment for these expenses is the responsibility of the client.

Changes in the client's deductible amount will generate a system tickler from Bridges.

MA eligibility under this option **cannot** continue if the cost of personal care becomes **equal to or less than** the MA excess income amount.

Note: See Bridges Eligibility Manual (BEM) 545, Exhibit II, regarding the Medicaid Personal Care Option.

Medical Need Certification

Medical needs are certified utilizing the DHS-54A, Medical Needs form and must be completed by a Medicaid enrolled medical professional. A completed DHS-54A or veterans administration medical form are acceptable for individual treated by a VA physician; see ASM 115, Adult Services Requirements.

Necessity For Service

The adult services specialist is responsible for determining the necessity and level of need for home help services based on:

- Client choice.
- A completed DHS-324, Adult Services Comprehensive Assessment. An individual must be assessed with at least one activity of daily living (ADL) in order to be eligible to receive home help services.

Note: If the assessment determines a need for an ADL at a level 3 or greater but these services are not paid for by the department, the individual would be eligible to receive IADL services.

Example: Ms. Smith is assessed at a level 4 for bathing however she refuses to receive assistance. Ms. Smith would be eligible to receive assistance with IADLs if the assessment determines a need at a level 3 or greater.

- Verification of the client's medical need by a Medicaid enrolled medical professional via the DHS-54A. The client is responsible for obtaining the medical certification of need; see ASM 115, Adult Services Requirements.

Appropriate Level of Care Status

Verify client's level of care to avoid duplication of services. The level of care will determine if the client is enrolled in other programs. The level of care information can be found in ASCAP under the **Bridges Search** or **Bridges Eligibility**

module, **MA History** tab; see ASM 125 Coordination With Other Services for a list of level of care codes.

Adult Services Manual 105
effective November 1, 2011

ASM 115 ADULT SERVICES REQUIREMENTS

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.

Veteran's Administration (VA)

The Michigan Department of Community Health (MDCH) will accept a DHS-54A completed by a Veteran's Administration physician or the VA medical form in lieu of the medical needs form.

COMPREHENSIVE ASSESSMENT (DHS-324)

Conduct a face-to-face interview with the client in their home to assess the personal care needs. Complete the DHS-324, Adult Services Comprehensive Assessment which is generated from the Adult Services Comprehensive

Assessment Program (ASCAP); see ASM 120, Adult Services Comprehensive Assessment.

SERVICE PLAN

Develop a service plan with the client and/or the client's representative. Determine the method of service delivery and any use of home help services with other types of services to meet the assessed needs of the client. The ILS service plan is developed whenever an issue is identified in the comprehensive assessment; see ASM 130, Service Plan.

CONTACTS

The specialist must, at a minimum, have a face-to-face interview with the client, prior to case opening, then every six months in the client's home, at review and redetermination.

An initial face-to-face interview must be completed with the home help provider in the client's home or local DHS office. A face-to-face or phone contact must be made with the provider at the next review or redetermination to verify services are being furnished.

Note: If contact is made by phone, the provider must offer identifying information such as date of birth and the last four digits of their social security number. A face-to-face interview in the client's home or local DHS office must take place at the next review or redetermination.

ADULT SERVICES REQUIREMENTS § 115

The ASM provides the following instruction to the worker in implementing the policy:

PERSON CENTERED PLANNING

The adult services specialist views each client as an individual with specific and unique circumstances, and will approach case planning holistically, from a person-centered, strength-based perspective.

Person-centered, strength-based case planning focuses on the following:

- Client as **decision-maker** in determining needs and case planning.

- Client **strengths and successes,** rather than problems.

- Client as their **own best resource.**

- Client **empowerment.**

- The adult services specialist's role includes **being an advocate** for the client. **As advocate, the specialist will:**

  - Assist the client to become a self-advocate.

  - Assist the client in securing necessary resources.

  - Inform the client of options and educate him/her on how to make the best possible use of available resources.

  - Promote services for clients in the least restrictive environment. Participate in community forums, town meetings, hearings, etc. for the purpose of information gathering and sharing.

  - Ensure that community programming balances client choice with safety and security.

  - Advocate for protection of the frail, disabled and elderly.

  - Promote employment counseling and training services for developmentally disabled persons to ensure **inclusion** in the range of career opportunities available in the community.

PARTNERSHIPS

Work cooperatively with other agencies to ensure effective coordination of services; see ASM 125, Coordination With Other Services.

Previous policy included different eligibility criteria. It was initially changed with an Interim Policy Bulletin issued and a effective October 1, 2011.

Adult Services Manual (ASM)
11-1-2012

Adult Services Manual (ASM 363, 9-1-08), pages 2-5 of 24 addresses the issues of assessment and service plan development: policy is unchanged as regards how to complete the comprehensive assessment and functional assessment although the results of the assessment may require different actions, after the [redacted] policy change.

COMPREHENSIVE ASSESSMENT

The Adult Services Comprehensive Assessment (FIA-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 work load 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 client in his/her place of residence.
- An interview must be conducted with the caregiver, if applicable.
- Observe a copy of the client'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 redetermination.
- 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 client'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
- Light Housework

Functional Scale ADLs and IADLs are assessed acc ording 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 activ ity with a great deal of human assistance and/or assistive technology.
5. Dependent
   Does not perform the activity even with hum an 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 alloc ate time for each task assessed a rank of 3 or higher, based on inte rviews with the client and provider, observation of the clie nt's abilities and use of the reasonable time schedule (RTS) as a guide. The RT S can be found in **ASCAP** under the **Payment** module, Time and Task screen. When hours exc eed the RT S rationale must be provided.

IADL Maximum Allowable Hours

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

- 5 hours/month for shopping
- 6 hours/month for light housework
- 7 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.

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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 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 IADLs 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 same time period).

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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.

Adult Services Manual (ASM) 363, 9-1-2008,
Pages 2-15 of 24

The Department of Human Services issued Interim Policy Bulletin ASB 2011-001 with an effective date of October 1, 2011. This Interim Policy limits HHS eligibility for Medicaid beneficiaries with a medical need for assistance with one or more ADL at a ranking of 3 or higher. Interim Policy Bulletin ASB 2011-001 provides in pertinent part:

> **Home Help Eligibility Criteria**
>
> To qualify for home help services, an individual must require assistance with at least one activity of daily living (ADL) assessed at a level 3 or greater. The change in policy must be applied to any new cases opened on or after October 1, 2011, and to all ongoing cases as of October 1, 2011.
>
> **Comprehensive Assessment Required Before Closure**
>
> Clients currently receiving home help services must be assessed at the next face-to-face contact in the client's home to determine continued eligibility. If the adult services specialist has a face-to-face contact in the client's home prior to the next scheduled review/redetermination, an assessment of need must take place at that time.
>
> **Example:**
> A face-to-face review was completed in August 2011; the next scheduled review will be in February 2012. The specialist meets with the client in his/her home for a provider interview in December 2011. Previous assessments indicate the client only needing assistance with instrumental activities of daily living (IADL). A new comprehensive assessment must be completed on this client.
>
> If the assessment determines a need for an ADL at level 3 or greater but these services are **not** paid for by the department, or the client refuses to receive assistance, the client would **continue** to be eligible to receive IADL services.
>
> If the client is receiving only IADLs and does **not** require assistance with at least one ADL, the client no longer meets eligibility for home help services and the case must close after negative action notice is provided.

Each month, beginning with October, 2011, clients with reviews due who only receive IADL services must take priority.

Negative Action Notice

The adult services specialist must provide a DHS-1212, Advance Negative Action notice, if the assessment determines the client is no longer eligible to receive home help services. The effective date of the negative action is ten business days after the date the notice is mailed to the client.

The reason for termination of services should state the following:

> *New policy, effective October 1, 2011, by the Department of Community Health/Department of Human Services requires the need for hands-on services of at least one activity of daily living (ADL). The most recent assessment conducted at your last review did not identify a need for an ADL. Therefore, you are no longer eligible for home help services*.

Right to Appeal

Clients have the right to request a hearing if they disagree with the assessment. If the client requests a hearing within ten business days, do not proceed with the negative action until after the result of the hearing.

Explain to the client that if the department is upheld, recoupment must take place back to the negative action date if payments continue. Provide the client with an option of continuing payment or suspending payment until after the hearing decision is rendered.

If the client requests a hearing after the 10-day notice and case closure has occurred, do not reopen the case pending the hearing decision. If the department's action is reversed, the case will need to be reopened and payment re-established back to the effective date of the negative action. If the department's action is upheld, no further action is required.

Reason: Implementation of new polic y pursuant to requirements under Public Act 63 of 2011.

Online Manual Pages

Online manual pages will be updated with the Nov ember 2011 policy release.

INTERIM POLICY BULLETIN INDEPENDENT LIVING SERVICES (ILS) ELIGIBILITY CRITERIA
ASB 2011-001 10-1-2011

Advance Notice

The [redacted] Advance Negative Ac tion Notice indicates that the Department intends to make the reductions t o the Appe llant's case effective [redacted] 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, ex cept as permitted under §§ 431.213 and 431.214 of this subpart.

§ 431.213 Exceptions from advance notice.

The agenc y 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 inf ormation that requires termi nation or reduction of services and indic ates that he understands that this must be the result of supply ing that information;
(c) The recipient has been admitted to an institution where he is i neligible under the plan for further services;
(d) The recipient's w hereabouts are unknown and the post office returns agency m ail directed to him indicat ing 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 wit h regard to the preadmission screening requirements of secti on 1919(e) (7) of the Act; or
(h) The date of action wil l occur in less than 10 days, in accordance wit h § 483.12(a)(5)(ii), which provides exc eptions to the 30 days notice requirements of § 483.12(a)(5)(i)

§ 431.214 Notice in cases of probable fraud.

The agenc y may shorten the period of advance notic e to 5 days before the date of action if—
(a) The agenc y has facts indicating that acti on should be taken because of probable fraud by the recipient; and
(b) The facts have been verified, if possible, through secondary sources.

In this case the Department completed a ho me call [redacted] The Department has updated its policy. It does state it is effective November 1 2011, however, was not yet published, therefore not in effect. The practical result does not impact this case as the pertinent policy changes are not material for the Appellant's circumstances.

The Department did send a notice info rming the Appellant that her payment authorization would be reduced. The Department is requir ed to send Adv ance Notic e when it makes a reduction for a recipi ent. This was not done and c onstitutes Department error. At hearing, the ASW testified the reduc tion was made effective in [redacted] despite t he documentation prepar ed by the Department hearing representative for the purpose of preparing him for hearing a nd specifically identifying the effective date and showing t he payment authorization history. While t he worker eventually conceded to this ALJ the payment s were reduced as indic ated in the documentation actually in evidence, much mi staken testimony was taken prior to this concession. As a result, the assertions from the ASW regarding this cas e are not considered fully reliable.

The Appellant and her represent ative provided fully credible testimony establishing the Appellant has higher needs than recogniz ed at her assessment by this worker. The reduction for eating identifie d by the worker is, howev er, appropriate given th e Appellant's ability to feed herself once her food is cut and served to her. The Appellant and her representative agree t he Appellant is able t o eat once her food is cut and

served to her. The representative stated she does feed the Appellant on occasion while she is in bed. The worker authorized 10 minutes a day for eating, based upon the assessment where he learned she is able to feed herself once her food is cut. This reduction is sustained.

The authorization for laundry is not found sufficient to accomplish the task for this client. She is incontinent every night. She testified credibly to this at hearing. This is not a new medical condition as evidenced by the testimony from both the Appellant and her provider at hearing. While the worker testified "this is the first I have heard of it," this testimony does not establish either that it is not true or that it is new. This ALJ found the specific testimony from the Appellant and her provider was credible and reliable. As a result of the incontinence, the Appellant requires laundry to be done more often than a person who has no continence issues. It is undisputed she is fully dependent for laundry services. Her authorization should be raised to at least the maximum standard (7 hours) in policy given her dependence and medical circumstances. Policy supports and requires the worker to determine what is appropriate for each client on an individual basis. The Appellant's individual circumstances justify an increase in laundry time.

The Appellant does participate in toileting during the day time as evidenced by the credible testimony at hearing. There is an authorization of 26 minutes a day for toileting. The credible testimony from her provider at hearing is that she must be assisted out of the wheelchair and onto the portable commode several times a day for toileting. She must be assisted to clean up. The portable commode must be emptied and cleaned each time. The time provided for all this to occur is 15 minutes. This was not refuted by the Department. It is reasonable to find the Appellant requires 60 minutes a day for toileting in this case given that she must have full assistance with the transfer, is using a portable commode that requires emptying and cleaning and must also have assistance to wash each time she uses it. The time authorized for toileting must be adjusted to 60 minutes per day, 7 days per week, based upon the credible, testimony from the Appellant and her provider. The Department did not refute the Appellant's account of the amount of time it takes to toilet with a differing account. The reasonable time and task is a guide and can be adjusted both upwards and downwards, depending on the need of each client. Here it is appropriate to recognize the Appellant's needs and adjust the time authorized.

The time for shopping was authorized at only 2 hours and 9 minutes per month. The worker provided testimony he had authorized over 4 hours per month for this task, again, despite having documentation that clearly indicates he authorized less. This documentation was prepared on his behalf and sent to him prior to hearing for preparation yet he failed to provide accurate testimony concerning his own actions. He did agree the Appellant is fully dependent on others to shop on her behalf and that she is residing alone. There is no basis in evidence to authorize any less than the maximum allowed by policy (5 hours per month) to accomplish this task on behalf of the dependant client.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that the Department improperly determined that the proper authorization for home help services on behalf of the Appellant at the most recent assessment.

IT IS THEREFORE ORDERED THAT:

The Department's decision is PAR TIALLY AFFIRMED AND PARTI ALLY REVERSED. The Appellant's t ime for shopping, lau ndry, and t oileting shall be adjusted consistent with this decision. The authorization for eating is affirmed and shall r emain at 10 minutes per day until the c ircumstances change. The adjustments ordered herein are to be made retroactive to December 1, 2011.

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

cc: [redacted]

Date Mailed: _____

***** 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 O rder. The Michi gan Administrative Hearing System will not order a re hearing 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 o f the Decision and Ord er or, if a timely request for rehearing was made, within 30 days of the receipt of the rehearing decision.