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. 2012-35528 HHS

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 . The Appellant represented herself. Home Help Services Inc., represented the Appellant. Appeals Review Officer, represented the Department. , Adult Services Worker ("ASW"), and Sharonda Campbell, Adult Services Supervisor, 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 -year-old Medicaid beneficiary who applied for Home Help Services.

2. The Appellant has been diagnosed with multiple medical conditions which include pulmonary embolism, deep vein thrombosis, asthma, right shoulder sprain, high cholesterol and vitamin D deficiency. (DHS-54A page 13 and15 of Department exhibit A)

3. On the ASW went to the Appellant's home and completed an in-home initial assessment. The Appellant reported breathing problems, need for assistance with some of the Instrumental Activities of Daily Living (IADLs) and the need for some assistance with the Activities of Daily Living of bathing, dressing and grooming.

4. The Medical certification from the doctor certified a medical need for assistance with bathing, dressing, grooming and all the listed Instrumental Activities of Daily Living.

5. The DHS-54A was initially completed by the doctor and signed

6. The ASW followed up with the doctor's office following her in-home assessment. She sent the doctor a fax request to "provide further documentation why this patient is unable to bathe, groom and dress herself and why she is unable to clean, cook, do laundry and grocery shop. What disability physically prevents her from these tasks?"

7. The doctor's office sent back the DHS-54A with an added explanation in box K, stating "pt recently had a blood clot in her lung. She has chest pain, sob and gets sob with exertion. She is on blood thinners for months"

8. Following the in-home assessment and follow up from the doctor, the ASW ranked the Appellant as a level 1 for all ADLs. She ranked the Appellant a 3 for housework, laundry and shopping. She ranked a 1 for meal preparation. (uncontested)

9. The ASW did not authorize any payment assistance for the Appellant because she determined she was independent with her Activities of Daily Living and she had teenagers in the home that could provide the assistance with the Instrumental Activities of Daily Living the Appellant required. (testimony from the ASW at hearing)

10. On , the Department sent the Appellant an Adequate Action Notice which informed her that her HHS application was denied based on the policy which requires a ranking of 3 or higher for ADLs.

11. The Appellant requires some hands on assistance with bathing, dressing, housework, shopping, laundry, and meal preparation. (Appellant Testimony)

12. On , 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 October 1, 2011 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 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 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 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 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:

- 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 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 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 policy pursuant to requirements under Public Act 63 of 2011.

Online Manual Pages

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

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

In this case the Appellant applied at the time the October 1, 2011 Interim Policy Bulletin came into effect. Her doctor certified her medical need [redacted], thus establishing a need for Instrumental Activities of Daily Living only would not qualify for payment assistance under this program due to the new policy. The Interim Policy Bulletin was incorporated into the new policy which was published [redacted] although it states it became effective [redacted]. New policy is effective upon publication, thus the Interim Policy Bulletin is effective for purposes of this case. It had been published and established the new eligibility criteria prior to case determination.

The ASW went to the Appellant's home [redacted] to complete the initial comprehensive assessment. She interviewed the Appellant. Her narrative notes prepared after her assessment are entered into evidence. She was told at the assessment (by the Appellant) that she requires assistance getting into and out of the

bathtub. She informed the ASW she has a cane, had her Achilles tendon repaired, however, had a lot of pain still in that foot. She informed the worker she requires assistance getting her pants on. She informed the worker she is unable to complete laundry, shopping and housework due to restrictions she has with her foot. She said she can make a sandwich or toast as far as food preparation went. The worker noted "there are no physically disabling conditions requiring home help services on her current 54)." The worker had the Appellant sign a release so she could obtain additional information from the doctor. The narrative notes also contain the worker's observation that she saw the Appellant ambulate within her bedroom apartment without use of her cane and she made noises and gestures indicating she was in pain. The worker noted there are steps leading up to the Appellant's apartment and that she was able to use them to get to her apartment. She noted the Appellant gets reminders for medication. The Appellant informed the worker after showering and eating breakfast she usually returns to bed to rest. She stated the restrictions she has are due to foot pain. (narrative notes from ASW)

After the in-home assessment the worker sent a fax request to the doctor to provide additional **documentation** about the Appellant's reasons for needing assistance. She did not ask the doctor about the Appellant's Achilles tendon, if there had been a surgery or a successful resolution to the surgery. She testified she did not speak with the doctor or call the office. It is noted she did not ask for additional information, rather, she required additional documentation.

The doctor's office sent back the DHS-54A with a written explanation indicating the Appellant had a pulmonary embolism and deep vein thrombosis. She has chest pain and is short of breath upon exertion. Furthermore, the doctor indicated the Appellant is taking blood thinners.

Upon review of the documentation in evidence, this ALJ notes the DHS-54A contains one diagnosis this ALJ is unable to read. It is not noted by the worker, either as having been identified or that she is also unable to read it. Furthermore, it is indicated by the worker that she was told by the Appellant that she had asthma but that it was not noted on the 54. This is inaccurate. The asthma diagnosis appears on the 54 dated October 21, 2011, right after "PE". The diagnosis that is not known to this ALJ appears right after asthma. The worker also entered notes indicating the Appellant is able to make a sandwich or light meal, use the microwave but could not stand long enough to prepare a full meal. She thereafter ranked the Appellant a 1 for meal preparation.

Summary of Department Testimony

The ASW assigned the functional rank 1 (independent) for the Activities of Daily Living following receipt of the explanation of medical need from the doctor. When asked at hearing why she scored the Appellant independent with all the Activities of Daily Living despite having been informed by the Appellant she required assistance getting her pants on, getting in and out of the bathtub and having the doctor certify **and explain** why the assistance was necessary, the worker stated dressing and bathing do not require exertion, therefore she found no need for assistance. The worker did rank the

Appellant 3 for some Instrumental Activities of Daily Living but said that because the Appellant has teenagers in the home, she could not authorize payment assistance for those tasks. She was asked if she had sought to learn whether the teenagers were available and able to provide the assistance required by the Appellant. She stated no, she had not.

Summary of Appellant's testimony

At hearing the Appellant stated her teenagers are both special education students with learning disabilities. She said they are unable to assist her with what she needs done. She said they both receive SSI checks due to their status as learning disabled. She said her adult son helps her in and out of the bathtub. When asked why her daughter did not, she said she is gone to school all day and did not want to wait for her to return from school or get up early enough to have her do that. She was asked to explain what assistance she requires getting her pants on. She said her son puts them on her feet and gets them up to where she can grab them and pull them the rest of the way up. She did not say she required further assistance dressing. She was asked how long this took. She answered 5 to 10 minutes. She stated she has a torn rotator cuff.

Analysis

Two DHS-54A Medical needs forms were obtained from the same physician for the Appellant's application, both signed . The second submission added an explanation of reasons the medical certification of need was made. This is given controlling weight by this ALJ. This ALJ is mindful that policy explicitly states that a **physician does not prescribe or authorize payment assistance**. However, in this case the worker's determinations are not supported by sound reasoning and relevant observations, thus the physician's certification and explanation are given controlling weight.

In light of the policy that specifically states the worker must determine the need and assign the functional rank, yet the functional rank is contested by the Appellant, this ALJ had to determine whether the functional ranks assigned were supported by the evidence of record. This ALJ must find the conclusions reached by the ASW in this instance are not supported by the evidence of record. The evidence supports a conclusion the worker did not give consideration to the Appellant's statements of need, despite corroboration from the physician. As concerns dressing, the Appellant informed the worker she needs some assistance getting pants on. There were no relevant observations brought into evidence indicating the Appellant is able to get her pants on without physical assistance. The ability to ambulate within a bedroom apartment does not persuade this ALJ the Appellant has not accurately represented she needs a little assistance with her pants. She has a shoulder problem, as well as limitations with exertion. She testified her son puts them on and gets them up to where she can reach them and finish pulling them up. This is not refuted with material evidence. It is found credible, thus the Appellant should have been assigned a functional rank of for dressing

The worker noted the Appellant is unable to stand long enough to make a full meal for herself. Despite this determination, the worker assigned a functional rank of 1 for meal preparation. At hearing this ALJ provided opportunity for the worker to recognize the error and either correct or explain her determination. She testified the Appellant is "able to get food into her stomach", also that "we are not talking about thanksgiving dinner" and she could reheat food. She did not acknowledge the Appellant would be relying on another to prepare the food she is able to reheat. Her testimony that the Appellant can get food into her stomach does not take into account the needs identified in the policy. The functional ranks and definitions state explicitly that a person who is able to make simple meals and reheat food is ranked a 3. The worker had ranked a 1, despite her admission that the Appellant is unable to stand long enough to make a full meal. The failure to identify the fact that the Appellant was improperly ranked a 1 rather than a 3 where the written policy clearly instructs the appropriate rank is a 3 for the circumstances faced by the Appellant illustrates the worker's error.

The fact of surgical repair of the Appellant's Achilles tendon is in evidence. The worker's notes indicate she wanted corroboration of this assertion from the Appellant. It was produced in time for the hearing. It may have been reflected in the original 54, however, it is not known because one of the diagnosis is not clear. In any event, the Appellant asserted she has restrictions due to the less than satisfactory result of this surgery. She is noted to move with pain by the worker. Her claim of requiring assistance getting in and out of the bathtub is found credible. The observation that she walked inside of her apartment without using her cane while the worker was present is not a basis to conclude she does not require help getting in and out a bathtub safely. Furthermore, there is no evidence the worker observed or asked the Appellant if she managed the 8 stairs leading to her apartment without assistance. At hearing the Appellant testified she has the assistance of her daughter to manage the stairs, is short of breath and has to rest before and after using them. Furthermore, she testified she goes out to the doctor's office but not much more than that.

Finally, the determination the Appellant's teenagers can perform the instrumental activities of daily living was not based upon adequate information about the Appellant's specific circumstances. The worker did not seek relevant information to make this determination, she assumed it true. It is contested by the Appellant and refuted by her testimony that her two teenagers are both specially educated due to learning disabilities and receive SSI checks based upon their status. More information needs to be obtained about their abilities in light of this evidence.

Prior to October 1, 2011, the Appellant would have been eligible for HHS even if all she needed was assistance with IADLs at a functional ranking of level 3 or greater. After October 1, 2011, an individual must be ranked as a functional level 3 or greater with at least one ADL to be eligible for HHS. There was sufficient credible evidence presented establishing that the Appellant has needed and received hands on assistance with both ADLs and IADLs since her application. The evidence does not support the ASW's determinations to rank the Appellant as independent for all activities of daily living and deny the HHS application. Accordingly, the denial of her HHS application cannot be upheld.

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 Appellant is ineligible for HHS and denied the Appellant's HHS application.

IT IS THEREFORE ORDERED THAT:

> The Department's decision is REVERSED. The Appellant's rankings for bathing, dressing, housework, shopping, laundry, and meal preparation shall be adjusted to a level 3 and the application processed retroactively and consistent with this functional rank for those activities.

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

cc:

Date Mailed: 6-5-12

***** 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.