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) 373-4147

IN THE MATTER OF:

[redacted]

Docket No. 2013-19967 HHS
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 on [redacted]. [redacted], the Appellant, appeared on his own behalf. [redacted], provider, appeared as a witness for the Appellant. [redacted], represented the Department. [redacted], and [redacted] appeared as witnesses for the Department. The hearing record was left open for the Department to submit additional documentation.

ISSUE

Did the Department properly assess the Appellant's Home Help Services ("HHS") case?

FINDINGS OF FACT

The Administrative Law Judge, based upon the competent, material and substantial evidence on the whole record, finds as material fact:

1. On or about [redacted], the Appellant applied for the HHS program. (Exhibit 2, page 1)

2. On [redacted] an ASW attempted to complete a home visit for the initial assessment of the Appellant's HHS application. The ASW noted she was unable to access the building because there was no answer at the buzzer and the door was locked. (Exhibit 2, page 2)

3. The Appellant was home with his provider waiting for the [redacted] home visit and made several attempts to contact the ASW through [redacted] (Exhibit 1, page 3)

4. On [redacted], the Department determined the Appellant's HHS application was considered withdrawn because there was no contact from the Appellant. (Exhibit 2, pages 1-2)

5. No written denial notice was issued to the Appellant regarding the [redacted] application that was considered withdrawn.

6. On [redacted], the Appellant called the Department regarding his HHS application. The Department treated this call as a new referral for the Appellant for the HHS program. (Exhibit 1, page 12; ASW and Adult Services Supervisor Testimony)

7. On [redacted], the Appellant's doctor provided medical verification of the Appellant's diagnoses and need for assistance. The Appellant has been diagnosed with lower back pain, hyperlipidemia and anxiety. (Exhibit 1, pages 13 and 19)

8. On [redacted], [redacted] went to the Appellant's home and completed an initial assessment for the Appellant's HHS application. The Appellant was present and reported additional diagnoses of closed head injury, urethral divertivulum, 3 herniated discs, arthritis in wrist, paranoid schizophrenia, brain disorder, and post stress disorder. The Appellant stated his [redacted] reside with him and he is in the process of getting custody of them. The Appellant was observed walking with a cane, going up/down stairs, and standing to walk. The Appellant reported not being able to lift over 10 pounds. The Appellant was instructed to call to make an appointment at the Department office with his provider to complete needed documents. (Exhibit 1, page 19)

9. Between [redacted] and [redacted] the Appellant changed providers. (Exhibit 1, page 5)

10. On [redacted], the Appellant went to the Department office but did not have an appointment. An appointment was scheduled. (Exhibit 1, page 19)

11. On [redacted] the Appellant and his new provider went to the Department office. The Appellant had gone to the Department office for the scheduled appointment on [redacted], but the office was closed due to [redacted]. The Appellant and his provider completed paperwork and the Appellant's functional abilities and needs for assistance were discussed with the ASW. It was noted that the Appellant's [redacted] assists with dressing and the provider only assists the Appellant with getting in/out of the tub when he is present. (Exhibit 1, page 18)

12. The ASW determined that the Appellant should be ranked at a level 3 for bathing, dressing, housework, shopping, and laundry. The ASW authorized a total of 15 hours and 3 minutes per month of HHS for assistance with bathing, housework, shopping, and laundry. (Exhibit 1, pages 20-21)

13. On [redacted], the Department sent the Appellant a Services and Payment Approval Notice which informed him that he was approved for HHS with a monthly care cost of [redacted] with a start date o [redacted] (Exhibit 1, pages 15-16)

14. On [redacted], the Appellant's request for hearing was received by the Michigan Administrative Hearing System. (Exhibit 1 pages 3-11)

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.

Adult Services Manual (ASM) 110, 11-1-2011, page 1 of 2 addresses the referral process:

> **REFERRAL INTAKE**
>
> A referral may be received by phone, mail or in person and must be entered on ASCAP upon receipt. The referral source does not have to be the individual in need of the services.
>
> **Registration and Case Disposition Action**
>
> Complete a thorough clearance of the individual in the ASCAP client search and Bridges search.
>
> Complete the **Basic Client** and **Referral Details** tabs of the **Client** module in **ASCAP**.
>
> Supervisor or designee assigns case to the adult services specialist in the **Disposition** module of **ASCAP**.
>
> Documentation
>
> Print introduction letter, the DHS-390, Adult Services Application and the DHS-54A, Medical Needs form and mail to the client. The introduction letter allows the client 21 calendars days to return the documentation to the local office.

> **Note:** The introduction letter does **not** serve as adequate notification if home help services are denied. The specialist must send the client a DHS-1212A, Adequate Negative Action Notice; see ASM 150, Notification of Eligibility Determination.
>
> *Adult Services Manual (ASM) 110, 11-1-2011,*
> Page 1 of 2

Adult Services Manual (ASM) 150, 11-1-2011, pages 1-4 addresses the notification of eligibility determinations:

> **INTRODUCTION**
>
> Individuals who submit an application (DHS-390) for home help services or adult community placement must be given written notification of approval or denial for services. A written notice must be sent within the 45 day standard of promptness.
>
> Clients with active service cases must be provided written notice of any change in their services (increase, reduction, suspension or termination).
>
> **Written Notification of Disposition**
>
> All notifications are documented under ASCAP contacts when they are generated. This documentation acts as the file copy for the case record. For this purpose, the form letters used are:
> - DHS-1210, Services Approval Notice.
> - DHS-1212A, Adequate Negative Action Notice.
> - DHS-1212, Advance Negative Action Notice.
>
> Each notification letter includes an explanation of the procedures for requesting an administrative hearing.
>
> The adult services specialist **must sign** the bottom of the second page of all notices (DHS-1210, DHS-1212A, DHS-1212) before they are mailed to the client.
>
> **Services Approval Notice (DHS-1210)**
>
> Notification Services Have Been Approved
>
> If independent living services (non-payment services) or adult community placement services are approved, the DHS-1210, Services Approval Notice, is sent indicating what services have been authorized.

If home help services will be authorized, note the amount and the payment effective date. Print and attach a copy of the Time and Task worksheet. The DHS-1210 is completed and generated through the Adult Service Comprehensive Assessment Program (ASCAP).

Notification Services Have Been Increased

The DHS-1210 must also be used when there is an increase in the amount of home help services on an open case. Appropriate notations must be entered in the comment section. A copy of the Time and Task worksheet must be printed and sent with the notice.

Adequate Negative Action Notice (DHS-1212A)

The DHS-1212A, Adequate Negative Action Notice, is used and generated on ASCAP when home help services and adult community placement services cases have been denied. Appropriate notations **must** be entered in the comment section explaining the reason for the denial.

Adequate Negative Action Notices **do not** require a 10 business day notice to the client.

Advance Negative Action Notice (DHS-1212)

The DHS-1212, Advance Negative Action Notice, is used and generated on ASCAP when there is a reduction, suspension or termination of services. Appropriate notations must be entered in the comment section to explain the reason for the negative action.

- Reduced - decrease in payment.
- Suspended - payments stopped but case remains open.
- Terminated - case closure.

***

Negative Actions Not Requiring Ten Day Notice

The following situations **do not** require the ten business day notice on negative actions:

- The department has factual confirmation of the death of the client (negative action notice must be mailed to the guardian or individual acting on the client's behalf) or death of the service provider.

  Note: Cases should remain open until all appropriate payments have been issued.

- The department receives a verbal or written statement from the client, stating they no longer want or require services, or that they want services reduced.

  Note: This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The department receives a verbal or written statement from the client that contains information requiring a negative action. The statement must acknowledge the client is aware the negative action is required **and** they understand the action will occur.

  Example: A home help services client informs the specialist that they are engaged and will be married on a specific date. They also acknowledge that their new spouse will be responsible for meeting their personal care needs and they will no longer qualify for home help services.

  Note: This information must be clearly documented in the general narrative of ASCAP. Written notices must be maintained in the paper case file and documented in the general narrative.

- The client has been admitted to an institution or setting (for example, hospital, nursing home) where the client no longer qualifies for federal financial participation under the Medicaid State Plan for personal care services in the community.

  Note: When a client is admitted to a hospital or nursing home, the facility is reimbursed for the client's care on the day the client is admitted, but not for the day of discharge. The home help provider cannot be reimbursed for the date the client is admitted to the facility but may be paid for the day of discharge.

- The client cannot be located and the department mail directed to the client's last known address has been returned by the post office indicating the forwarding address is unknown.

  Note: In this circumstance, a services payment must be made available if the client is located during the payment period covered by the returned warrant.

- The client has been accepted for services in a new jurisdiction and that fact has been established by the jurisdiction previously providing services.

- The time frame for a services payment, granted for a specific time period, has elapsed. The client was informed, in writing, at the time payments were initiated, that services would automatically terminate at the end of the specified period.

  Example: The DHS-1210 clearly states a begin and end date for the services payments.

Adult Services Manual (ASM) 150, 11-1-2011,
Pages 1-4

Adult Services Manual (ASM) 105, 11-1-11, addresses HHS eligibility requirements:

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.

***

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 forms 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 IADL's 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.

Adult Services Manual (ASM) 105,
11-1-2011, Pages 1-3 of 3

Adult Services Manual (ASM) 120, 5-1-12, addresses the comprehensive assessment:

INTRODUCTION

The DHS-324, Adult Services Comprehensive Assessment is the primary tool for determining need for services. The comprehensive assessment must be completed on **all open independent living services cases**. ASCAP, the automated workload management system, provides the format for the comprehensive assessment and all information must be entered on the computer program.

Requirements

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.
- The assessment may also include an interview with the individual who will be providing home help services.

- A new face-to-face assessment is required if there is a request for an increase in services before payment is authorized.
- A face-to-face assessment is required on all transfer-in cases before a payment is authorized.
- 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.
- Use the DHS-27, Authorization to Release Information, when requesting client information from another agency.
- Use the DHS-1555, Authorization to Release Protected Health Information, if requesting additional medical documentation; see RFF 1555. The form is primarily used for APS cases.
- Follow rules of confidentiality when home help cases have companion APS cases, see SRM 131 Confidentiality.

***

Functional Assessment

The **Functional Assessment** module of the **ASCAP** comprehensive assessment is the basis for service planning and for the home help services 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 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.

Home help payments may only be authorized for needs assessed at the 3 level ranking or greater.

An individual must be assessed with at least one activity of daily living 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 IADL's if the assessment determined a need at a level 3 or greater.

See ASM 121, Functional Assessment Definitions and Ranks for a description of the rankings for activities of daily living and instrumental activities of daily living.

***

Time and Task

The specialist 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.

An assessment of need, at a ranking of 3 or higher, does not automatically guarantee the maximum allotted time allowed by the reasonable time schedule (RTS). **The specialist must assess each task according to the actual time required for its completion.**

Example: A client needs assistance with cutting up food. The specialist would only pay for the time required to cut the food and not the full amount of time allotted under the RTS for eating.

IADL Maximum Allowable Hours

There are monthly maximum hour limits on all instrumental activities of daily living 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

Proration of IADLs

If the client does not require the maximum allowable hours for IADLs, authorize only the amount of time needed for each task. Assessed hours for IADLs (except medications) must be prorated by **one half** in shared living arrangements where other adults reside in the home, as home help services are **only** for the benefit of the client.

Note: This does not include situations where others live in adjoined apartments/flats or in a separate home on shared property and there is no shared, common living area.

In shared living arrangements, where it can be **clearly** documented that IADLs for the eligible client are completed separately from others in the home, hours for IADLs do not need to be prorated.

Example: Client has special dietary needs and meals are prepared separately; client is incontinent of bowel and/or bladder and laundry is completed separately; client's shopping is completed

separately due to special dietary needs and food is purchased from specialty stores; etc.

Adult Services Manual (ASM) 120, 5-1-2012,
Pages 1-4 of 5

Adult Services Manual (ASM) 101, 11-1-11, addresses services not covered by HHS:

Services not Covered by Home Help

Home help services must **not** be approved for the following:

- Supervising, monitoring, reminding, guiding, teaching 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 (such as house cleaning, laundry or shopping).
- Services provided by another resource at the same time (for example, hospitalization, MI-Choice Waiver).
- Transportation - See Bridges Administrative Manual (BAM) 825 for medical transportation policy and procedures.
- Money management such as power of attorney or representative payee.
- Home delivered meals.
- Adult or child day care.
- Recreational activities. (For example, accompanying and/or transporting to the movies, sporting events etc.)

Note: The above list is not all inclusive.

Adult Services Manual (ASM) 101, 11-1-2011,
Pages 3-4 of 4.

Adult Services Manual (ASM) 115, 11-1-11, addresses the start date for payments relative to the medical certification date:

Do **not** authorize home help services prior to the date of the medical professional signature on the DHS-54A.

Adult Services Manual (ASM) 115,
11-1-2011, Pages 2 of 3

Adult Services Manual (ASM) 140, 11-1-11, addresses payment authorizations:

ADULT SERVICES AUTHORIZED PAYMENTS (ASAP)

The Adult Services Authorized Payments (ASAP) is the Michigan Department of Community Health payment system that processes adult services authorizations. The adult services specialist enters the payment authorizations using the **Payments** module of the **ASCAP** system.

No payment can be made unless the provider has been enrolled in Bridges. Adult foster care, homes for the aged and home help agency providers must also be registered with Vendor Registration; see ASM 136, Agency Providers.

Note: The adult services home page provides a link to the provider enrollment instructions located on the Office of Training and Staff Development web site.

Home help services payments to providers must be:

- Authorized for a specific period of time and payment amount. The task is determined by the comprehensive assessment in ASCAP and will automatically include tasks that are a level three or higher.

- Authorized **only** to the person or agency actually providing the hands-on services.

  Note: An entity acting in the capacity of the client's fiscal intermediary is not considered the provider of home help and **must not** be enrolled as a home help provider; see ASM 135, Home Help Providers.

- Made payable jointly to the client and the provider.

  Exception: Authorizations to home help agency providers are payable to the provider only. There are circumstances where payment authorizations to the provider only are appropriate, for example, client is physically or mentally unable to endorse the warrant. All single party authorizations must be approved by the supervisor.

- Prorate the authorization if the MA eligibility period is less than the full month.

  Example: A client meets his/her MA deductible on the third of every month. ASCAP will process prorated month (s) automatically. To prorate manually, divide the monthly care cost by the number of days in the month. Multiple the daily rate by the number of eligible days. Refer to the ASCAP User Guide for additional instructions on steps for prorating in ASCAP.

- Do **not** authorize payments to a **responsible relative**.
- Do not authorize a home help payment if there is not a MSA-4678 on file with the Michigan Department of Community Health; see ASM 135, Home Help Providers.

Adult Services Manual (ASM) 140,
11-1-2011, Pages 1-2 of 3

In the present case, the Appellant first applied for HHS on or about [redacted] (Exhibit 2, page 1) On [redacted], an ASW attempted to complete a home visit for the initial assessment of the Appellant's HHS application. The ASW noted she was unable to access the building because there was no answer at the buzzer and the door was locked. (Exhibit 2, page 2) The Appellant was home with his provider waiting for the [redacted] home visit and made several attempts to contact the ASW through [redacted] (Exhibit 1, page 3) It is not documented if the ASW assigned to this referral made any attempt to call the Appellant or even send the Appellant a letter after the one attempted home visit. On [redacted] the Department determined the Appellant's HHS application was considered withdrawn because there was no contact from the Appellant. (Exhibit 2, pages 1-2) There is no documentation that any denial notice was issued to the Appellant for this HHS application. The above cited policy requires a written determination be issued, either the DHS-1212A Adequate Negative Action Notice or the DHS-1210, Services Approval Notice. The exceptions listed in the policy apply to issuing 10 business day advance notice of a determination, which would utilize the DHS-1212A, Adequate Negative Action Notice issued when there is a reduction, suspension or termination of an open HHS case. Further, there was no verbal or written statement from the Appellant that he wished to withdraw his HHS application or requiring a negative action. The Department erred by considering this HHS application withdrawn and closing out this HHS referral without issuing a written determination notice.

The Appellant called the Department on [redacted] and spoke to the Adult Services Supervisor to inquire about the status of his HHS application. This call was considered a new referral for HHS for the Appellant. (Exhibit 1, page 12; ASW and Adult Services Supervisor Testimony)

On [redacted] the Appellant's doctor provided medical verification of the Appellant's diagnoses and need for assistance. The Appellant has been diagnosed with lower back pain, hyperlipidemia and anxiety. Based on the ASW's home visit note, it appears that not all of the diagnoses listed on the Appellant's medical certification were entered into the computer system. (Exhibit 1, pages 13 and 19)

On [redacted] went to the Appellant's home and completed an initial assessment for the Appellant's HHS application. The Appellant was present and reported additional diagnoses of closed head injury, urethral divertivulum, 3 herniated discs, arthritis in wrist, paranoid schizophrenia, brain disorder, and post stress disorder. The Appellant stated his [redacted] reside with him and he is in the process of getting custody of them. The Appellant was observed walking with a cane, going

up/down stairs, and standing to walk. The Appellant reported not being able to lift over 10 pounds. The Appellant was instructed to call to make an appointment at the Department office with the provider to complete needed documents. (Exhibit 1, page 19)

Between [redacted] and [redacted] the Appellant changed providers. (Exhibit 1, page 5) On [redacted] the Appellant went to the Department office but did not have an appointment. An appointment was scheduled. (Exhibit 1, page 19) On [redacted] the Appellant and his new provider went to the Department office. The Appellant had gone to the Department office for the scheduled appointment on [redacted] but the office was closed due to [redacted] The Appellant and his provider completed paperwork and the Appellant's functional abilities and needs for assistance were discussed with the ASW. It was noted that the [redacted] assists with dressing and the provider only assists the Appellant with getting in/out of the tub when he is present. (Exhibit 1, page 18) Clearly the scheduling of an appointment at the Department office on a day the office was closed was an error, but the required interview and paperwork were completed the next day, [redacted]

The ASW determined that the Appellant ranked at a level 3 for bathing, dressing, housework, shopping, and laundry. The ASW authorized a total of 15 hours and 3 minutes per month of HHS for assistance with bathing, housework, shopping, and laundry. (Exhibit 1, pages 20-21) On [redacted] the Department sent the Appellant a Services and Payment Approval Notice which informed him that he was approved for HHS with a monthly care cost of [redacted] with a start date of [redacted] (Exhibit 1, pages 15-16)

The Appellant testified he told the ASW he needed assistance with additional activities including grooming, meal preparation and taking medications. However, regarding medications, the Appellant indicated he needs reminders. (Appellant Testimony) The Appellant's HHS provider testified he assists the Appellant three days per week, including medications, cooking, bathing, laundry, carrying groceries, and going with to appointments. While the Appellant's [redacted] provide some help with socks and shoes, the provider helps the Appellant with this when he is there. (Provider Testimony)

Reminders to ensure the Appellant takes his medications are very important. However, the HHS policy is clear that HHS payments can not be authorized for this type of assistance. Similarly, the policy does not allow for HHS payments for medical transportation or accompanying to appointments. The ASW credibly testified that the Appellant did not indicate he needed assistance with meal preparation during the assessment, rather he reported cooking for [redacted] (ASW Testimony) Further, meal preparation is being completed the four days per week the Appellant's HHS provider is not there. The ASW also documented that it was reported the [redacted] is the one who assists with putting on shoes and socks. (Exhibit 1, pages 18 and 21) The policy only allows for HHS payments to be authorized for medically necessary services completed by an enrolled HHS provider. There was sufficient evidence to support the ASW's determination not to authorize HHS hours for meal preparation and dressing based on the information available to the ASW.

The Appellant disagrees with how his HHS case was handled and how long it took for payments to start. The Appellant explained that this affected scheduling a surgery because he did not have a plan for help at home. Also, the Appellant has not seen eye to eye with the ASW who completed the intake assessment for the second referral. (Exhibit 1, pages 3-11; Appellant Testimony) However, this ALJ does not have any authority over the professionalism of an ASW or which ASW is assigned to the Appellant's HHS case. Further, it is noted that a new ASW has already been assigned to the Appellant's ongoing HHS case. (Exhibit 1, page 14)

While it is clear that the Department made several errors in processing the Appellant's HHS applications, the determination to start services with the effective date of [redacted] must be upheld. As noted above the Department clearly erred by closing the Appellant's first HHS application as withdrawn with no verbal or written statement from the Appellant that he wanted to withdraw this application and by failing to issuing written notice of the denial. Accordingly, HHS payments could have been considered back to the date of the medical certification, [redacted] if it could be established that an enrolled HHS provider was providing the authorized services during that time. However, the Appellant changed providers just prior to the [redacted] meeting at the Department office. The prior provider did not complete an interview with the ASW or the required paperwork. Accordingly there was never a determination as to whether she met the minimum criteria to be a HHS provider and she was never enrolled as a HHS provider for the Appellant. (See Adult Services Manual (ASM) 135, 11-1-2011, Pages 1-7) This ALJ does not have equitable authority and can not order any remedy for the errors with the first HHS application being closed out without written notice and HHS payments for the second referral not beginning until the Appellant's new, enrolled HHS provider started on [redacted]

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, finds that while several errors were made, the resulting HHS authorization was appropriate based on the available information.

IT IS THEREFORE ORDERED THAT:

The Department's decision is AFFIRMED.

/S/
Colleen Lack
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

cc: [redacted]

Date Mailed: _____03/14/13_____

***** 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.