

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

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IN THE MATTER OF:

Docket No. 2013-19944 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 on ██████████ the Appellant, appeared on his own behalf. ██████████ Appeals Review Officer, represented the Department. ██████████, Adult Services Worker ("ASW"), and ██████████ Adult Services Supervisor, appeared as witnesses for the Department.

**ISSUE**

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

**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 ██████████ the Department received a referral for the Appellant for the HHS program. (Exhibit 1, page 6)
2. On ██████████ the Department sent the Appellant a DHS-54A Medical Needs form. (Exhibit 1, page 6)
3. Policy requires the Appellant to return the Medical Needs form within ██████████ days. (Adult Services Manual (ASM) 110, 11-1-2011, Page 1 of 2)
4. On ██████████, the Department received a DHS-54A Medical Needs form completed by the Appellant's physician. (Exhibit 1, page 5)

5. On [REDACTED], the Department sent an Adequate Action Notice to the Appellant stating the HHS referral was denied because the Medical Needs form was never returned back therefore eligibility could not be determined. (Exhibit 1, pages 6-7)
6. On or about [REDACTED] the Department received another referral for the Appellant for the HHS program. (Exhibit 1, page 10)
7. On [REDACTED] the Department sent an Adequate Action Notice to the Appellant stating the HHS referral was denied because no needs for assistance with Activities of Daily Living (“ADLs”) were indicated on the Medical Needs form or in the discussion with the potential provider. (Exhibit 1, pages 8-9)
8. On [REDACTED] the Appellant’s Request for Hearing was received by the Michigan Administrative Hearing System. (Exhibit 1, page 4)

### **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.

[REDACTED]

Adult Services Manual (ASM) 115, 11-1-2011, page 1 of 3 addresses 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.

*Adult Services Manual (ASM) 115, 11-1-2011,*  
Page 1 of 3

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 calendar 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*

On or about ██████████ the Department received a referral for the Appellant for the HHS program. (Exhibit 1, page 6) The ASW testified the Department sent the Appellant an Independent Living Services (ILS) introduction letter, DHS-390 Adult Services Application and DHS-54A Medical Needs form. The introduction letter would have indicated these forms were due back within █ days. (ASW Testimony; Adult Services Manual (ASM) 110, 11-1-2011, Page 1 of 2) However, the Department's screen print of the case contacts only documents that on ██████████ the Department sent the Appellant a DHS-54A Medical Needs form. (Exhibit 1, page 6) The ASW testified as far as she knew the DHS-54A Medical Needs form was not returned. (ASW Testimony) On ██████████ the Department sent an Adequate Action Notice to the Appellant stating the HHS referral was denied because the Medical Needs form was never returned back therefore eligibility could not be determined. (Exhibit 1, pages 6-7)

However, the evidence contains a DHS-54A Medical needs form from the Appellant's physician with a date stamp from the local Department office documenting they received it on [REDACTED] (Exhibit 1, page 5) It is also noted that this would have been the [REDACTED] day from when the Department printed the [REDACTED] Medical Needs form. Accordingly, the Department's determination to deny the Appellant's [REDACTED] HHS referral because the DHS-54A Medical Needs form was not returned cannot be upheld.

Normally, the Department would be ordered to reprocess the Appellant's [REDACTED] HHS referral. However, in this case, the Department has already processed a subsequent HHS referral for the Appellant utilizing the DHS-54A Medical Needs form they received [REDACTED]. Therefore, there is no need to order reprocessing of the [REDACTED] referral.

[REDACTED]  
Adult Services Manual (ASM) 101, 11-1-11, addresses HHS payments:

### **Payment Services Home Help**

Home help services are non-specialized personal care service activities provided under the independent living services program to persons who meet eligibility requirements.

Home help services are provided to enable individuals with functional limitation(s), resulting from a medical or physical disability or cognitive impairment to live independently and receive care in the least restrictive, preferred settings.

*Adult Services Manual (ASM) 101,  
11-1-2011, Page 1of 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.

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### **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, 5-1-2012), pages 1-4 of 5 addresses the adult services 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 will 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.

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## **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 IADLs 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.

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### **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 adjoining 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 1-5 of 5*

Certain services are not covered by HHS. ASM 101 provides a listing of the 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.

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- 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.


On or about ██████████ the Department received another referral for the Appellant for the HHS program. (Exhibit 1, page 10) The Department explained that the ██████████ HHS referral for the Appellant was assigned to a different ASW, who is now retired. That ASW noted that a discussion with the Appellant's proposed HHS provider did not indicate that the Appellant had a need for assistance with any ADLs. (Exhibit 1, pages 9-10) This is consistent with the DHS-54A Medical Needs form completed by the Appellant's physician, which appears to only certify a medical need for assistance with the IADLs of taking medications, meal preparation, shopping, laundry and housework. (Exhibit 1, page 5)

The Appellant's testimony further indicated his niece was not helping him with ADLs like bathing toileting, and eating. Rather, the Appellant's niece assisted with activities like cooking, taking the Appellant to doctor's appointments, and getting prescriptions. (Appellant Testimony)

The evidence was not sufficient to establish that the Appellant had a need for hands on assistance, functional ranking 3 or greater, with at least one ADL. The retired ASW's brief notes, the DHS 54A Medical Needs form, and the Appellant's testimony did indicate a medical need for assistance with any ADLs. A HHS case cannot be opened when the only medically necessary needs for hands on assistance are with IADLs like cooking and shopping/errands. Further, medical transportation is not covered under the HHS program. Based on the available information, the Appellant did not require hands on assistance, functional ranking 3 or greater, with at least one ADL. Accordingly, the denial of the Appellant's HHS application must 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 denied the Appellant's first HHS referral, but utilized the DHS-54A Medical Needs form in processing the subsequent HHS referral and correctly denied HHS for the Appellant because there was no need for hands on assistance with any ADLs.

  
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**IT IS THEREFORE ORDERED THAT:**


The Department's decision to deny HHS for the Appellant is **AFFIRMED**.

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

Date Signed: 

Date Mailed: 

CL/db

cc: 

**\*\*\* 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.