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:

Docket No. 2014-12457 CMH

[redacted] [redacted] [redacted]

Appellant
_____/

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge, pursuant to MCL 400.9 and 42 CFR 431.200 *et seq*., and upon a request for a hearing filed on behalf of Appellant.

After due notice, a hearing was held on [redacted] Appellant's legal guardian and sister, appeared and testified on Appellant's behalf. Appellant and [redacted], a caregiver at Appellant's Adult Foster Care (AFC) home, also testified on Appellant's behalf. [redacted] represented Respondent [redacted] Supports Coordinator; [redacted], Clinical Director; and [redacted] Supports Coordinator Supervisor; from [redacted] also testified for Respondent.

ISSUE

Did the CMH properly deny Appellant's request for services at a sheltered workshop?

FINDINGS OF FACT

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

1. Appellant is a[redacted] year-old Medicaid beneficiary who has been diagnosed with severe mental retardation; Down's syndrome; hypothyroid; osteoporosis; and gastroesophageal reflux disease. (Respondent's Exhibit A, page 1; Respondent's Exhibit D, page 1).

2. Appellant's sister is her plenary legal guardian. (Petitioner's Exhibit 1, pages 2-3).

3. Appellant previously lived in an AFC home in [redacted]. (Respondent's Exhibit A, pages 1-3).

4. At that time, she received services through [redacted], including Community Living Supports (CLS). (Testimony of [redacted]; Testimony of [redacted]

5. By [redacted] 1[redacted] Appellant and her guardian planned to have Appellant move to a new AFC home in [redacted]. (Testimony of Appellant's representative).

6. [redacted] would remain the County of Financial Responsibility (COFR) and would continue to pay for services after the move, but it would also subcontract with [redacted]") and have that entity provide direct services. (Testimony of [redacted]).

7. On [redacted] Appellant and her guardian held a planning meeting with [redacted]. (Respondent's Exhibit A, pages 1-5).

8. During that meeting, it was noted that, in the next few weeks, [redacted] would make a referral to a workshop near Appellant's new AFC home, but that any approval was pending. (Respondent's Exhibit A, page 2).

9. Appellant subsequently moved into her new AFC home. (Testimony of Appellant's representative).

10. [redacted] was willing to continue to authorize CLS following the move, but [redacted] has had difficulty locating a provider for Appellant and no such services have been received. (Testimony of [redacted]).

11. [redacted] did make a referral and request to have Appellant go to a sheltered workshop near her AFC home. (Testimony of Appellant's representative).

12. According to Appellant's representative, Appellant wanted to go to that workshop after learning that other residents of the AFC home go there and seem to like it. (Testimony of Appellant's representative).

13. Appellant's representative had no other specific knowledge of the workshop at the time and she is unaware of what information [redacted] submitted along with the request. (Testimony of Appellant's representative).

14. According to [redacted] provided little information along with the request and [redacted] has no real knowledge of the requested services, other than that they would be provided at a sheltered workshop. (Testimony of [redacted]

15. [redacted] has sought further information from [redacted] regarding the nature of the sheltered program and what specific services it offers without success. (Testimony of [redacted]).

16. Given the information it did have regarding the sheltered workshop, [redacted] determined that the request should be denied as it would not support the goals or purposes of CLS. (Testimony of [redacted]).

17. On [redacted] the Michigan Administrative Hearing System (MAHS) received a request for hearing with respect to that denial. (Petitioner's Exhibit 1, pages 1-3).

18. That request also provided that Appellant "desire[s] to socialize with others by attending a sheltered workshop." (Petitioner's Exhibit 1, page 1).

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.

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.
>
> *42 CFR 430.0*

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to

> determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.
>
> *42 CFR 430.10*

Moreover, Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection(s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915(c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS) the Department of Community Health (MDCH) operates a section 1915(b) and 1915(c) Medicaid Managed Specialty Services and Support program waiver.

Among the services that can be provided by the CMH are Community Living Supports (CLS) and skill-building assistance. With respect to those services, the applicable version of the Medicaid Provider Manual (MPM) provides:

> **17.3.B. COMMUNITY LIVING SUPPORTS**
>
> Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).
>
> Coverage includes:
>
> - Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
>
> - meal preparation
>
> - laundry

- routine, seasonal, and heavy household care and maintenance

- activities of daily living (e.g., bathing, eating, dressing, personal hygiene)

- shopping for food and other necessities of daily living

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the DHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the DHS assessment.

- Staff assistance, support and/or training with activities such as:

  - money management

  - non-medical care (not requiring nurse or physician intervention)

  - socialization and relationship building

  - transportation from the beneficiary's residence to community activities, among community activities,

and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

- attendance at medical appointments

- acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through DHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a DHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.

* * *

17.3.K. SKILL-BUILDING ASSISTANCE

Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for sheltered work services provided by Michigan Rehabilitation Services (MRS).
Information must be updated when the beneficiary's MRS eligibility conditions change.

Coverage includes:

- Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and

adaptive skills; and supports services incidental to the provision of that assistance, including:

- Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.

- When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).

Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment, but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce, or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

  Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if

applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Services that would otherwise be available to the beneficiary.

MPM, October 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 114-115, 127-128

However, while the above services are covered by Medicaid, Medicaid beneficiaries are still only entitled to medically necessary covered services for which they are eligible and the services must be provided in the appropriate scope, duration, and intensity to reasonably achieve the purpose of the covered service. *See* 42 CFR 440.230.

With respect to medical necessity, the MPM provides:

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or

- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or

- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
- that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
- that are experimental or investigational in nature; or
- for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

MPM, October 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 12-14

In addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS and skill-building assistance:

SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3S)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual's needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual's needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

* * *

17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary's eligibility for specialty services and supports as defined in this Chapter; and
- The service(s) having been identified during person-centered planning; and
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter; and
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary's plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP's documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual's needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDCH encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental

> health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.
>
> Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.
>
> *MPM, October 1, 2013 version*
> *Mental Health/Substance Abuse Chapter, pages 111-112*

Moreover, regarding the location of such services, the MPM states:

> **2.3 LOCATION OF SERVICE [CHANGE MADE 10/1/13]**
>
> Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.
>
> Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.
>
> For beneficiaries residing in nursing facilities, only the following clinic services may be provided:
>
> - Nursing facility mental health monitoring;
> - Psychiatric evaluation;

- Psychological testing, and other assessments;
- Treatment planning;
- Individual therapy, including behavioral services;
- Crisis intervention; and
- Services provided at enrolled day program sites.

Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services delivered in Institutions of Mental Disease (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or **(revised 10/1/13)** it is for the purpose of transitioning a child out of an institutional setting (CCI). The following mental health services initiated by the PIHP (the case needs to be open to the CMHSP/PIHP) may be provided within the designated timeframes:

- Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI. This should occur up to 60 days prior to the anticipated discharge from a CCI.
- Wraparound planning or case management. This should occur up to 60 days prior to discharge from a CCI.

Medicaid does cover services provided to children with developmental disabilities in a CCI that exclusively serves children with developmental disabilities, and has an enforced policy of prohibiting staff use of seclusion and restraint. Medicaid does not cover services provided to

persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

2.3.A. DAY PROGRAM SITES

The PIHP may organize a set of state plan, HSW or additional/B3 services at a day program site, but the site and the set of services must be approved by MDCH. Some services (e.g., inpatient or respite) may not be provided at a day program site. (Refer to individual program descriptions in this chapter for more information on those limitations.)

Mental health and developmental disabilities day program sites are defined as places other than the beneficiary's/family's home, nursing facility, or a specialized residential setting where an array of mental health or developmental disability services and supports are provided:

- To assist the beneficiary in achieving goals of independence, integrated employment and/or community inclusion, as specified in his individual plan of services.

- Through a predetermined schedule, typically in-group modalities.

- By staff under the immediate and on-site supervision of a professional possessing at least a bachelor's degree in a human service field, and at least two years work experience providing services to beneficiaries with serious mental illness and developmental disabilities.

Medicaid providers wishing to provide mental health and/or developmental disability services and supports at a day program site must obtain approval of the day program site by the MDCH. (Refer to the Directory Appendix for contact information.) MDCH approval will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Existence of an individual beneficiary schedule of state plan, HSW, and additional/B3 services and supports with amount, duration and scope identified.
- The beneficiary's services and supports must be based upon the desired outcomes and/or goals of the individual defined through a person-centered planning process.
- Direct therapy services must be delivered by professional staff, or aides under the supervision of professional staff, who are licensed, certified, or registered to provide health-related services within the scope of practice for the discipline.
- If an aide under professional supervision delivers direct therapy services, that supervision must be documented in the beneficiary's clinical record.

Approval of new program sites will be contingent upon submission of acceptable enrollment information to MDCH by the PIHP, and upon a site visit by MDCH.

MPM, October 1, 2013 version
Mental Health/Substance Abuse Chapter, pages 9-11

Here, Appellant requested services through [redacted] at a sheltered workshop near her AFC home and her request was denied.

As a preliminary matter, this Administrative Law Judge would note that a sheltered workshop is not an expressly covered Medicaid service and this Administrative Law Judge only has jurisdiction to hear matters related to a denial, reduction, termination, or suspension of a Medicaid covered service. *See* the Code of Federal Regulations: 42 CFR 431.200 *et seq.* and 42 CFR 438.400 *et seq.* Nevertheless, as acknowledged by NEMCMHA, the denial at issue in this case is also essentially a denial of CLS, as such services were requested and could be provided at the workshop if appropriate, and

Respondent does not challenge the undersigned Administrative Law Judge's jurisdiction to hear this matter.

With respect to the issue in this matter, Appellant bears the burden of proving by a preponderance of the evidence that [redacted] erred in denying her request. Moreover, this Administrative Law Judge is limited to reviewing the [redacted] decision in light of the information available at the time.

Here, given the lack of information submitted to [redacted] with respect to the nature of and services provided at the sheltered workshop, Appellant has failed to meet her burden of proof and the denial must be affirmed. As noted by Respondent's representative and witnesses, it is not clear how a "sheltered" workshop would promote goals of community inclusion and participation, independence, and/or productivity, or if services there would be provided in the least restrictive, most integrated setting. Moreover, [redacted] credibly testified that [redacted] has sought further information from [redacted] regarding the nature of the sheltered program and what specific services it offers, but no such information has been received. Without such information, neither CLS nor skill-building assistance at the sheltered workshop would be appropriate.

To the extent Appellant, her guardian or [redacted], are able to provide additional information to [redacted] regarding the sheltered workshop in the future, they are free to do so and re-request services through [redacted] at the workshop. With respect to the decision at issue in this case, however, the denial of services must be affirmed given the information available at the time.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that [redacted] properly denied the request for services at a sheltered workshop.

IT IS THEREFORE ORDERED that:

The CMH's decision is **AFFIRMED**.

Steven Kibit

Steven J. Kibit
Administrative Law Judge
for James K. Haveman, Director
Michigan Department of Community Health

Date Signed: [redacted]

Date Mailed: [redacted]

SK/db

cc: [redacted]

***** 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.