



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ORLENE HAWKS
DIRECTOR

[REDACTED], MI [REDACTED]

Date Mailed: April 27, 2022
MOAHR Docket No.: 22-001119
Agency No.: [REDACTED]
Petitioner: [REDACTED]

ADMINISTRATIVE LAW JUDGE: Landis Lain

HEARING DECISION

Following Petitioner's request for a hearing, this matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and 400.37; 7 CFR 273.15 to 273.18; 42 CFR 431.200 to 431.250; 42 CFR 438.400 to 438.424; 45 CFR 99.1 to 99.33; and 45 CFR 205.10; and Mich Admin Code, R 792.11002. After due notice, a telephone hearing was held on April 13, 2022, from Lansing, Michigan. Petitioner is in Long Term Care. The Petitioner was represented by her daughter and Authorized Hearings Representative/Power of Attorney ([REDACTED]). The Department of Health and Human Services (Department) was represented by Lead Worker, Kimberly Reed and Tracy Patterson, Long Term Care Specialist.

Department's Exhibits pages 1-92 were admitted as evidence.

ISSUE

Did the Department properly determine that Petitioner has a divestment penalty?

FINDINGS OF FACT

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

1. 01/18/2022 MDHHS received a DCH-4574 Application for Health Care Coverage Patient of Nursing Facility for [REDACTED] and verifications. Power of Attorney paperwork designating [REDACTED] as Power of Attorney was submitted with the application. In addition to the Power of Attorney paperwork, Authorization/Consent for [REDACTED] to act as an Authorized Representative, signed by [REDACTED], was submitted.
2. On 02/16/2022 MDHHS processed the application and issued a DHS-3503 Verification Checklist requesting proof of how [REDACTED] spent the

\$ [REDACTED] in proceeds from the sale of her home in 2018 and other monies. MDHHS also requested further information on four transactions noted on the bank statement submitted with the application.

3. On 02/18/2022 [REDACTED] submitted verifications on behalf of [REDACTED]. MDHHS received an explanation of all withdrawals over \$300 from [REDACTED]'s bank account since she sold her home. This explanation provided proof Elsa wrote a check to [REDACTED] on 01/04/2021 in the amount of \$ [REDACTED]. \$ [REDACTED] of this was returned to [REDACTED].
4. On 02/22/2022 MDHHS reviewed the expense verifications that had been returned. An email was sent to [REDACTED] requesting further verification of a car given to Petitioner's grandson.
5. On 02/25/2022 MDHHS received additional verifications submitted by [REDACTED]. Proof of the sale of Petitioner's vehicle to her grandson was included as well as a list of Petitioner's monthly expenses and a current bank statement. Proof of a water well repair completed in October 2021 was also submitted. If needed, [REDACTED] offered to obtain estimates for repairs that had not been completed since [REDACTED] was uncertain if Petitioner would be able to return home.
6. On 03/03/2022 MDHHS processed the verifications. A DHS-1606 Health Care Coverage Determination Notice was mailed approving Medicaid with a \$1,012 monthly patient pay amount as of January 2022. The notice also notified [REDACTED] of a divestment penalty that would be imposed from January 1, 2022, through May 6th, 2022.
7. The divestment penalty was implemented because Petitioner gave \$47,000 to her daughter, [REDACTED], for repairs to her home from Petitioner living there.
8. The only completed repair at the time of the application was a well repair in the amount of \$1,583.
9. [REDACTED] returned \$5,000 to [REDACTED]'s account three days after the \$ [REDACTED] check was written. MDHHS determined Petitioner divested \$ [REDACTED] ($47,000 - 5,000 - 1,583 = 40,417$).
10. The \$ [REDACTED] check written to [REDACTED] does not meet the transfers that are not divestment criteria outlined in BEM 405 MA Divestment.
11. On 03/10/2022 MDHHS received a signed DHS-18 Request for Hearing disputing the divestment determination.
12. On March 23, 2022, the Michigan Office of Administrative Hearings and Rules received a Hearing Summary and attached documents.

CONCLUSIONS OF LAW

The regulations governing the hearing and appeal process for applicants and recipients of public assistance in Michigan are found in the Michigan Administrative Code, MAC R 400.901-400.951. An opportunity for a hearing shall be granted to an applicant who requests a hearing because his or her claim for assistance has been denied. MAC R 400.903(1). Clients have the right to contest a department decision affecting eligibility or benefit levels whenever it is believed that the decision is incorrect. The department will provide an administrative hearing to review the decision and determine the appropriateness of that decision. BAM 600.

Department policies are contained in the Department of Health and Human Services Bridges Administrative Manual (BAM), Department of Health and Human Services Bridges Eligibility Manual (BEM), Department of Health and Human Services Reference Tables Manual (RFT), and Department of Health and Human Services Emergency Relief Manual (ERM).

The Medical Assistance (MA) program is established by Title XIX of the Social Security Act, 42 USC 1396-1396w-5; 42 USC 1315; the Affordable Care Act of 2010, the collective term for the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152; and 42 CFR 430.10-.25. The Department (formerly known as the Department of Human Services) administers the MA program pursuant to 42 CFR 435, MCL 400.10, and MCL 400.105-.112k.

Title XIX of the Social Security Act, commonly referred to as “The Medicaid Act,” provides for medical assistance services to individuals **who lack the financial means to obtain needed health care**. 42 U.S.C. §1396. (Emphasis added)

The Medicaid program is administered by the federal government through the Centers for Medicaid and Medicare Services (CMS) of the Department of Health and Human Services (HHS). The state and federal governments share financial responsibility for Medicaid services. Each state may choose whether or not to participate in the Medicaid program. Once a state chooses to participate, it must operate its Medicaid program in accordance with mandatory federal requirements, imposed both by the Medicaid Act and by implementing federal regulations authorized under the Medicaid Act and promulgated by HHS.

Participating states must provide at least seven categories of medical services to persons determined to be eligible Medicaid recipients. 42 USC §1396a(a)(10)(A), 1396d(a)(1)-(5), (17), (21). One of the seven mandated services is *nursing facility services*. 42 USC §1396d(a)(4)(A).

For medical assistance eligibility, the Department has defined an asset as “any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether or not presently vested with possessory rights.” NDAC 75-02-02.1-01(3).

Under both federal and state law, an asset must be “actually available” to an applicant to be considered a countable asset for determining medical assistance eligibility. Hecker, 527 N.W.2d at 237 (On Petition for Rehearing); Hinschberger v. Griggs County Social Serv., 499 N.W.2d 876, 882 (N.D.1993); 42 U.S.C. § 1396a(a)(17)(B); 1 J. Krauskopf, R. Brown, K. Tokarz, and A. Bogutz, Elderlaw: Advocacy for the Aging § 11.25 (2d ed. 1993). Yet, “actually available” resources “are different from those *in hand*.” Schweiker v. Gray Panthers, 453 U.S. 34, 48, 101 S.Ct. 2633, 2642, 69 L.Ed.2d 460 (1981) (emphasis in original). NDAC 75-02-02.1-25(2) explains: Only such assets as are actually available will be considered. Assets are actually available when at the disposal of an applicant, recipient, or responsible relative; when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible relative has the lawful power to make the asset available, or to cause the asset to be made available. Assets will be reasonably evaluated... See also 45 C.F.R. § 233.20(a)(3)(ii)(D).

As noted in Hecker, if an applicant has a legal ability to obtain an asset, it is considered an “actually available” resource. The actual-availability principle primarily serves “to prevent the States from conjuring fictional sources of income and resources by imputing financial support from persons who have no obligation to furnish it or by overvaluing assets in a manner that attributes non-existent resources to recipients.” Heckler v. Turner, 470 U.S. 184, 200, 105 S.Ct. 1138, 1147, 84 L.Ed.2d 138 (1985).

The focus is on an applicant's actual and practical ability to make an asset available as a matter of fact, not legal fiction. See Schrader v. Idaho Dept. of Health and Welfare, 768 F.2d 1107, 1112 (9th Cir.1985). See also Lewis v. Martin, 397 U.S. 552, 90 S.Ct. 1282, 25 L.Ed.2d 561 (1970) (invalidating California state regulation that presumed contribution of non-AFDC resources by a non-legally responsible and non-adoptive stepfather or common law husband of an AFDC recipient's mother).

Determining whether an asset is “actually available” for purposes of medical assistance eligibility is largely a fact-specific inquiry depending on the circumstances of each case. See, e.g., Intermountain Health Care v. Bd. of Cty. Com'rs, 107 Idaho 248, 688 P.2d 260, 264 (Ct.App.1984); Radano v. Blum, 89 A.D.2d 858, 453 N.Y.S.2d 38, 39 (1982); Haynes v. Dept. of Human Resources, 121 N.C.App. 513, 470 S.E.2d 56, 58 (1996). Interpretation of the “actually available” requirement must be “reasonable and humane in accordance with its manifest intent and purpose...” Moffett v. Blum, 74 A.D.2d 625, 424 N.Y.S.2d 923, 925 (1980). That an applicant must sue to collect an asset the applicant has a legal entitlement to usually does not mean the asset is actually unavailable. See, e.g., Wagner v. Sheridan County S.S. Bd., 518 N.W.2d 724, 728 (N.D.1994); Frerks v. Shalala, 52 F.3d 412, 414 (2d Cir.1995); Probate of Marcus, 199 Conn. 524, 509 A.2d 1, 5 (1986); Herman v. Ramsey Cty. Community Human Serv., 373 N.W.2d 345, 348 (Minn.Ct.App.1985). See also Ziegler v. Dept. of Health & Rehab. Serv., 601 So.2d 1280, 1284 (Fla.Ct.App.1992) At issue here is the methodology utilized in determining the availability of an individual's “resources” for purposes of evaluating his or her eligibility. SSI recipients, and thus SSI-related “medically needy”

recipients, may not retain resources having a value in excess of \$2,000. 42 U.S.C. § 1382(a)(1)(B).

The regulations governing the determination of eligibility provide that resources mean cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his support and maintenance. If the individual has the right, authority or power to liquidate the property, or his share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse). 20 C.F.R. § 416.1201(a).

After the Medicaid program was enacted, a field of legal counseling arose involving asset protection for future disability. The practice of "Medicaid Estate Planning," whereby "individuals shelter or divest their assets to qualify for Medicaid without first depleting their life savings," is a legal practice that involves utilization of the complex rules of Medicaid eligibility, arguably comparable to the way one uses the Internal Revenue Code to his or her advantage in preparing taxes. See generally *Kristin A. Reich, Note, Long-Term Care Financing Crisis-Recent Federal and State Efforts to Deter Asset Transfers as a Means to Gain Medicaid Eligibility*, 74 N.D. L.Rev. 383 (1998). Serious concern then arose over the widespread divestiture of assets by mostly wealthy individuals so that those persons could become eligible for Medicaid benefits. *Id.*; see also *Rainey v. Guardianship of Mackey*, 773 So.2d 118 (Fla. 4th DCA 2000). As a result, Congress enacted several laws to discourage the transfer of assets for Medicaid qualification purposes. See generally *Laura Herpers Zeman, Estate Planning: Ethical Considerations of Using Medicaid to Plan for Long-Term Medical Care for the Elderly*, 13 *Quinnipiac Prob. L.J.* 187 (1988). Recent attempts by Congress imposed periods of ineligibility for certain Medicaid benefits where the applicant divested himself or herself of assets for less than fair market value. 42 U.S.C. § 1396p(c)(1)(A); 42 U.S.C. § 1396p(c)(1)(B)(i); *Fla. Admin. Code R. 65A-1.712(3)*. More specifically, if a transfer of assets for less than fair market value is found within 36 months of an individual's application for Medicaid, the state must withhold payment for various long-term care services, i.e., payment for nursing home room and board, for a period of time referred to as the penalty period. *Fla. Admin. Code R. 65A-1.712(3)*. Medicaid does not, however, prohibit eligibility altogether. It merely penalizes the asset transfer for a certain period of time. See generally *Omar N. Ahmad, Medicaid Eligibility Rules for the Elderly Long-Term Care Applicant*, 20 *J. Legal Med.* 251 (1999). [*Thompson v. Dep't of Children & Families*, 835 So.2d 357, 359-360 (Fla App, 2003).]

In *Gillmore* the Illinois Supreme Court recognized this same history, noting that over the years (and particularly in 1993), Congress enacted certain measures to prevent persons who were not actually "needy" from making themselves eligible for Medicaid: In 1993, Congress sought to combat the rapidly increasing costs of Medicaid by enacting statutory provisions to ensure that persons who could pay for their own care did not receive assistance. Congress mandated that, in determining Medicaid eligibility, a state must "look-back" into a three- or five-year period, depending on the asset, before a person applied for assistance to determine if the person made any transfers solely to become eligible for Medicaid. See 42 U.S.C. § 1396p(c)(1)(B) (2000). If the person disposed of assets for less than fair market value during the look-back period, the person is ineligible for medical assistance for a statutory penalty

period based on the value of the assets transferred. See 42 U.S.C. § 1396p(c)(1)(A) (2000). [*Gillmore*, 218 Ill 2d at 306 (emphasis added).]

See, also, *ES v. Div. of Med. Assistance and Health Servs.*, 412 NJ Super 340, 344; 990 A.2d 701 (2010) (Noting that the purpose of this close scrutiny while “looking back” is “to determine if [the asset transfers] were made for the sole purpose of Medicaid qualification.”).

This statutory “look-back” period, noted in *Gillmore* and *Thompson* and contained within 42 USC 1396p(c)(1), requires a state to “look-back” a number of years (in this case five) from the date of an asset transfer to determine if the applicant made the transfer solely to become eligible for Medicaid, which can be established if the transfer was made for less than fair market value. See 42 USC 1396p(c)(1); DHS Program Eligibility Manual (PEM) 405, pp 1, 4; see also *Gillmore*, 218 Ill 2d at 306.

“Less than fair market value means the compensation received in return for a resource was worth less than the fair market value of the resource.” BEM 405, p 5.

A transfer for less than fair market value during the “look-back” period is referred to as a “divestment,” and unless falling under one of several exclusions, subjects the applicant to a penalty period during which payment of long-term care benefits is suspended. See, generally BEM 405, pp 1, 5-9. “Congress's imposition of a penalty for the disposal of assets or income for less than fair market value during the look-back period is intended to maximize the resources for Medicaid for those truly in need.” *ES*, 412 NJ Super at 344. See also *Mackey v Department of Human Services*, Michigan Court of Appeals, Docket No. 288966, decided September 7, 2010.

Pertinent Department policy states:

Assets must be considered in determining eligibility or SSI related categories. Assets mean cash, any other personal property and real property. (BEM, Item 400 Page 1). Countable assets cannot exceed the applicable asset limit. Not all assets are counted. Some assets are counted for one program but not for another program. (BEM Item 400, Page 1).

The department is to consider both of the following to determine whether and how much of an asset is countable: An asset is countable if it meets the availability test and is not excluded. The department is to consider the assets of each person in the asset group. (BEM, Item 400, Page 1).

Asset eligibility exists when the asset groups countable assets are less than or equal to the applicable asset limit at least one day during the month being tested. (BEM, Item 400, Page 4). An application does not authorize MA for future months if the person has excess assets on the processing date.

The SSI related MA asset limit for SSI related MA categories that are not Medicare savings program or QDWI is \$2000.00 for an asset group for one person and \$3000.00 for an asset group of 2 people. BEM, Item 400 Page 5.

An asset must be available to be counted. Available means that someone in the asset group has the legal right to use or dispose of the asset. BEM, Item 400, Page 6. The department is to assume an asset is available unless the evidence shows that it is not available.

In the instant case, Petitioner had a homestead which was excluded from countable assets in accordance with Department policy. The home stead was sold for \$ [REDACTED] and Petitioner received proceeds from the sale in the amount of \$ [REDACTED].

BEM, Item 405, states:

Divestment results in a penalty period in MA, **not** ineligibility. Divestment is a type of transfer of a resource and not an amount of resources transferred.

Divestment means a transfer of a resource (see RESOURCE DEFINED below and in glossary) by a client or his spouse that are all of the following:

- Is within a specified time; see LOOK-BACK PERIOD in this item.
- Is a transfer for LESS THAN FAIR MARKET VALUE;
- Is not listed below under TRANSFERS THAT ARE NOT DIVESTMENT

See Annuity Not Actuarially Sound and Joint Owners and Transfers below and BEM 401 about special transactions considered transfers for less than fair market value.

During the penalty period, MA will **not** pay the client's cost for:

- LTC services.
- Home and community-based services.
- Home Help.
- Home Health. BEM, Item 405, page 1

Resource means all the client's and his spouse's assets and income. It includes all assets and all income, even countable and/or excluded assets, the individual or spouse receive. It also includes all assets and income that the individual (or their spouse) were entitled to but did **not** receive because of action by one of the following:

- The client or spouse.
- A person (including a court or administrative body) with legal authority to act in place of or on behalf of the client or the client's spouse.
- Any person (including a court or administrative body) acting at the direction or upon the request of the client or his spouse. BEM, Item 405, page 2

Transferring a resource means giving up all or partial ownership in (or rights to) a resource. Not all transfers are divestment. Examples of transfers include:

- Selling an asset for fair market value (not divestment).
- Giving an asset away (divestment).
- Refusing an inheritance (divestment).
- Payments from a **MEDICAID TRUST** that are **not** to, or for the benefit of, the person or his spouse; see BEM 401 (divestment).
- Putting assets or income in a trust; see BEM 401.
- Giving up the **right** to receive income such as having pension payments made to someone else (divestment).
- Giving away a lump sum or accumulated benefit (divestment).
- Buying an annuity that is **not** actuarially sound (divestment).
- Giving away a vehicle (divestment).
- Putting assets or income into a Limited Liability Company (LLC)BEM, item 405, page 2

Department policy states that it is **not** divestment to transfer a homestead to the client's:

- Spouse; see Transfers Involving Spouse above.
- Blind or disabled child; see Transfers Involving Child above.
- Child under age 21.
- Child age 21 or over who:
 - Lived in the homestead for at least two years immediately before the client's admission to LTC or BEM 106 waiver approval, **and**
 - Provided care that would otherwise have required LTC or BEM 106 waiver services, as documented by a physician's (M.D. or D.O.) statement. BEM Item 405, page 8.

Policy also states that the uncompensated value of a divested resource is

- The resource's cash or equity value.
- Minus any compensation received.
- The uncompensated value of a promissory note, loan, or mortgage is the outstanding balance due on the "Baseline Date" BEM, Item 405, page 12.

The first step in determining the period of time that transfers can be evaluated for divestment is determining the baseline date; see baseline date in this item. Once the baseline date is established, you determine the look-back period. The look back period is 60 months prior to the baseline date. Transfers that occur on or after a client's baseline date must be considered for divestment. In addition, transfers that occurred within the 60-month look-back period must be considered for divestment. BEM 405 page 5

A person's baseline date is the first date that the client was eligible for Medicaid and one of the following:

- In LTC.
- APPROVED FOR THE WAIVER; see BEM 106.
- Eligible for Home Health services.
- Eligible for Home Help services

A client's baseline date does not change even if one of the following happens:

- The client leaves LTC.
- The client is no longer APPROVED FOR THE WAIVER; see BEM 106.
- The client no longer needs Home Help.
- The client no longer needs Home Health. BEM 405, page 6

Personal Care Contract means a contract/agreement that provides health care monitoring, medical treatment, securing hospitalization, visitation, entertainment, travel/transportation, financial management, shopping, home help or other assistance with activities of daily living.

Home Care Contract means a contract/agreement which pays for expenses such as home/cottage/care repairs, property maintenance, property taxes, homeowner's insurance, heat and utilities for the homestead or other real property of the client.

Home Care and Personal Care contracts/agreements may be between relatives or non-relatives. A relative is anyone related to the client by blood, marriage or adoption.

Note: When relatives provide assistance or services they are presumed to do so for love and affection and compensation for past assistance or services shall create a rebuttable presumption of a transfer for less than fair market value. Fair market value of the services may be determined by consultation with area businesses which provide such services.

Contracts/agreements that include the provision of companionship are prohibited. BEM 405 page 7 (Emphasis Added)

All Personal Care and Home Care contracts/agreements, regardless of whether between a client and a relative or a client and a non-relative, must be considered and evaluated for divestment.

Personal Care and Home Care contracts/agreements shall be considered a transfer for less than fair market value unless the agreement meets all of the following:

- The services must be performed after a written legal contract/agreement has been executed between the client and the provider. The contract/agreement must be dated, and the signatures must be notarized. The services are not paid for until the services have been provided (there can be no prospective payment for future expenses or services); and
- At the time the services are received, the client cannot be residing in a nursing facility, adult foster care home (licensed or unlicensed), institution for mental diseases, inpatient hospital, intermediate care facility for individuals with intellectual disabilities or be eligible for home and community-based waiver, home health or home help; and
- At the time services are received, the services must have been recommended in writing and signed by the client's physician as necessary to prevent the transfer of the client to a residential care or nursing facility. Such services cannot include the provision of companionship; and
- The contract/agreement must be signed by the client or legally authorized representative, such as an agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative cannot be the provider or beneficiary of the contract/agreement.
- MDHHS will verify the contract/agreement by reviewing the written instrument between the client and the provider which must show the type, frequency and duration of such services being provided to the client and the amount of consideration (money or property) being received by the provider, or in accordance with a service plan approved by MDHHS.

Assets transferred in exchange for a contract/agreement for personal services/assistance or expenses of real property/homestead provided by another person after the date of application are considered available and countable assets. BEM 405 page 8

The uncompensated value of a divested resource is

- The resource's cash or equity value.
- Minus any compensation received.
- The uncompensated value of a promissory note, loan, or mortgage is the outstanding balance due on the date of application. BEM 045 page 15

In this case, Petitioner's Representative testified that the monies were given to her because she cared for Petitioner for several years and her mother wanted to make certain to pay her back for her care.

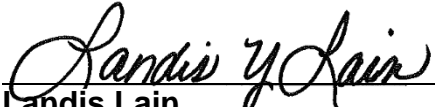
This Administrative Law Judge finds that the department policy is explicit. It states that all the transferred resources must be returned, or fair market value must be paid for the resources, or full compensation paid for the resources, before the necessity for either cancellation or recalculation of the divestment period can be triggered. There is not an arm's length transaction when misconduct involves transactions between relatives. Policy dictates that an arm's length transaction is one between two parties who are not related and who are assumed to have roughly the same bargaining power. By definition, a transaction between two relatives is not an arm length transaction. (Bridges Policy Glossary (BPG)), page 25.

Petitioner's' representative's statements on the record are not sufficient to rebut the department's determination that divestment occurred. The department's determination that Petitioner's penalty period must remain correct under the circumstances. The Department acted in accordance with Department policy when it determined that Petitioner divested funds for less than fair market value. The department has established by the necessary competent, substantial and material evidence on the record that it was acting accordance with department policy when it calculated and instituted the divestment penalty under the circumstances.

DECISION AND ORDER

Accordingly, the Department's decision is **AFFIRMED**.

LL/ml



Landis Lain
Administrative Law Judge

NOTICE OF APPEAL: A party may appeal this Order in circuit court within 30 days of the receipt date. A copy of the circuit court appeal must be filed with the Michigan Office of Administrative Hearings and Rules (MOAHR).

A party may request a rehearing or reconsideration of this Order if the request is received by MOAHR within 30 days of the date the Order was issued. The party requesting a rehearing or reconsideration must provide the specific reasons for the request. MOAHR will not review any response to a request for rehearing/reconsideration.

A written request may be mailed or faxed to MOAHR. If submitted by fax, the written request must be faxed to (517) 763-0155; Attention: MOAHR Rehearing/Reconsideration Request.

If submitted by mail, the written request must be addressed as follows:

Michigan Office of Administrative Hearings and Rules
Reconsideration/Rehearing Request
P.O. Box 30639
Lansing, Michigan 48909-8139

Electronic Mail Recipients:

MDHHS-Montcalm-Hearings
BSC3
C. Geroge
EQAD
MOAHR

First Class Mail Recipient, Petitioner:

[REDACTED]
[REDACTED], MI [REDACTED]

First Class Mail Recipient, AHR:

[REDACTED]
[REDACTED], MI [REDACTED]