[redacted]
[redacted], MI [redacted]

Date Mailed: May 12, 2020
MOAHR Docket No.: 20-000238
Agency No.: [redacted]
Petitioner: [redacted]

ADMINISTRATIVE LAW JUDGE: Corey Arendt

DECISION AND ORDER

This matter is before the undersigned Administrative Law Judge pursuant to MCL 400.9 and upon the Appellant's request for a hearing.

After due notice, a hearing was held on May 7, 2020. [redacted], Attorney, appeared on behalf of the Petitioner. Mrs. [redacted], Petitioner's Mother and Legal Guardian, appeared as a witness for Petitioner. Shawn Dilts, Access & Utilization Manager, appeared on behalf of Respondent (Department).

Exhibits:

Petitioner:
A. December 5, 2019 PCP Meeting
B. December 9, 2019 Adverse Benefit Determination
C. January 14, 2020 Appeal Denial Notice

Respondent:
1. Hearing Summery

ISSUE

Did the Department properly suspend Petitioner's Community Living Supports Services?[1]

[1] On review, this is a borderline hearable issue. Although 42 CFR 438.400 allows for hearings where there is a suspension of benefits, this does not appear to be a true suspension of benefits as all parties agree the Petitioner should continue receiving the services. And the adverse benefit determination indicates that the "suspension" is the sole result of the provider "Umbrellex not having the staffing to provide CLS service. This does not mean the Petitioner is no longer eligible for the benefits or is no longer approved for the benefits or that a different provider cannot provide the services in question. It is not uncommon to have a lapse in coverage while other providers are found. This does not necessarily mean there is a suspension. Similarly, albeit slightly different, when there is under utilization and benefits are not being exhausted, you would not call it a suspension of the unused allocation.

FINDINGS OF FACT

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

1. Petitioner is Medicaid beneficiary born [redacted] who resides with his family. Petitioner receives and continues to receive natural supports from his family. (Exhibit 1, pp 9, 22.)

2. Prior to December 9, 2019, Petitioner was approved for 132 hours a month of CLS services. Of the approved allocation, CSI provided 102 hours a month during the week while Umbrellex provided 30 hours a month every other weekend. (Exhibit B; Exhibit 1, p 3.)

3. On approximately November 23, 2019 or November 24, 2019, Petitioner's Guardian contacted Department and requested CSI provide all of Petitioner's CLS hours and chose to discontinue services with Umbrellex. At this time, Petitioner was having communication issues with Umbrellex. (Exhibit A, p 7.)

4. On November 27, 2019, Department staff contacted Umbrellex and confirmed Petitioner's Guardian's choice to terminate services with Umbrellex. (Exhibit A, p 8.)

5. On December 5, 2019, a PCP Meeting took place. Petitioner's mom, stepdad and CLS providers participated in the meeting. At the time of the meeting, it was recommended Petitioner continue to receive an average of 29 hours a week of CLS services in his home and community to develop independent skills and monitor health and safety. (Exhibit 1, p 9.)

6. The December 5, 2019 PCP meeting recommended Petitioner primarily receive CLS staffing hours in the following day/time intervals:

    - Tuesday 10 am to 3 pm.
    - Wednesday 10 am to 3 pm.
    - Saturday 10 am to 4 pm.
    - Sunday 9 am to 2 pm and 4 pm to 8 pm. (Exhibit 1, p 10.)

7. At the time of the PCP meeting, Petitioner's family understood that currently staffing was only available every other weekend as the current provider was at capacity and that CLS would remain at every other weekend until provider had available staff. (Exhibit 1, pp 9-10.)

8. During the PCP meeting, Petitioner's Guardian requested that Umbrellex continue to provide staffing as there was a lack of staffing available from other providers. (Exhibit 1, p 15.)

9. On December 6, 2019, Umbrellex reported that they were unable to provide staffing to Petitioner as the former staffing had already been reassigned to serve other individuals. (Exhibit 1, p 15.)

10. On December 9, 2019, Department sent Petitioner a Notice of Adverse Benefit Determination. The notice indicated Petitioner's CLS services were being suspended December 20, 2019 as a result of the Department not having the provider capacity to provide services that Provider Umbrellex had reassigned staff and can no longer provide CLS services. (Exhibit 1, pp 19-21.)

11. On December 17, 2019, Department received from Petitioner, an internal appeal. (Exhibit C.)

12. On December 19, 2019, Petitioner's Guardian requested Petitioner's CLS benefits be restored to full schedule despite the Provider being at capacity. (Exhibit 1, p 23.)

13. On December 20, 2019, Petitioner's Guardian spoke with staff at Department. During the conversation, CLS allocation was discussed. At the conclusion of the conversation, Petitioner's Guardian demanded that a new provider be found so that she would not have to wait to have services. (Exhibit 1, p 25.)

14. On December 23, 2019, Petitioner's Guardian spoke with staff at the Department. Petitioner's Guardian indicated it better not take 6 months to find another staffing solution for the hours in the PCP that CSI does not cover, or she will get Michigan Protection and Advocacy involved. (Exhibit 1, p 26.)

15. In December 2019, Department contacted out-of-network providers to inquire about providing CLS to Petitioner. The providers contacted indicated they were unable to provide services. (Testimony.)

16. On January 9, 2020, Petitioner's Guardian spoke with staff at Department. Department staff indicated that all providers were at capacity but that an option remains for self determination if there is a friend or church member that could work with Petitioner. Petitioner's Guardian indicated she was not interested in self-determination. (Exhibit 1, p 27.)

17. On January 14, 2020, Department sent Petitioner a Notice of Appeal. The notice indicted Petitioner's appeal had been thoroughly considered and was denied. The notice specifically stated:

> …It was determined that Umbrellex voluntarily discontinued providing CLS services. It was also apparent that SHW (Department) staff tried to triage any problems and attempted to help maintain Umbrellex in his home which was

> unsuccessful. It is also evident that SHW staff tried to recruit another provider to fulfill the needed CLS. However, all other providers are not taking new referrals due to maximum capacity. SHW staff have discussed the option of Self-Determination with Donald's (Petitioner) guardian, which she declined.
>
> It is apparent that Mr. Grantham needs additional CLS hours. This is not being challenged. SHW has been diligently working to find an alternative provider and has offered Self-Determination. Therefore, another option for fulfilling these hours has been offered and [illegible]. Until, SHW can secure another provider to accept Donald's CLS hours, there is no option other than suspending this service. (Exhibit C.)

18. On January 22, 2020, the Michigan Office of Administrative Hearings and Rules, received from Petitioner, a request for hearing.

19. On February 25, 2020, Department staff spoke with CLS provider CSI regarding the availability to increase hours. CSI indicated there was no available staff to take additional hours. (Exhibit 1, p 28.)

20. The Department serves a rural population. Petitioner resides within that population. (Testimony.)

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) 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.[2]
>
> 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.[3]

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…[4]

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 Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, Petitioner has been receiving CLS through Respondent. With respect to services, the applicable version of the Medicaid Provider Manual (MPM) provides in part:

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[2] 42 CFR 430.0.
[3] 42 CFR 430.10.
[4] 42 USC 1396n(b).

17.3.B. COMMUNITY LIVING SUPPORTS [CHANGE MADE 7/1/19]

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

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 services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or 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 (MDHHS). CLS may be used for those activities while the beneficiary awaits determination by MDHHS 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 MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS 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 MDHHS 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 MDHHS 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 children and youth (revised 7/1/19) 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.[5]

[5] Medicaid Provider Manual (MPM), Behavioral Health and Intellectual and Developmental Disability Supports and Services, October 1, 2019, pp 131-132.

While CLS is a covered service, Medicaid beneficiaries are still only entitled to medically necessary Medicaid covered services.[6] Regarding medical necessity, the MPM also 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;

[6] *See* 42 CFR 440.230.

- 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.[7]

Moreover, in addition to medical necessity, the MPM also identifies other criteria for B3 supports and services such as CLS:

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

[7] MPM, Behavioral and Intellectual and Developmental Disability Supports and Services, October 1, 2019, pp 14-15.

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. NOTE: Certain services found in this section are State
Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.

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 ensure 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.

Community Inclusion and Participation	The individual uses community services and participates in community activities in the same manner as the typical

	community citizen. Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary's use of, and participation in, community activities are expected to be integrated with that of the typical citizen's (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).
Independence	"Freedom from another's influence, control and determination." (Webster's New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning. For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when

	to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.
Productivity	Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness. For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.

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. MDHHS 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 . . .

17.3.B. COMMUNITY LIVING SUPPORTS [CHANGE MADE 7/1/19]

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 eyars.

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.).[8]

42 CFR 440.230(b)

* * *

In this case, the Petitioner is requesting the Department be compelled to provide a CLS provider at a time when the in-network and out-of-network providers are at capacity.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Department erred in suspending Petitioner's weekend CLS services. Moreover, the undersigned Administrative Law Judge is limited to reviewing the Department's decision in light of the information it had at the time the decision was made.

Given the record and applicable policies in this case, the undersigned Administrative Law Judge finds that Petitioner has failed to meet his burden of proof and that the Department's decision must therefore be affirmed.

There is no disagreement as to whether or not Petitioner qualifies and is eligible to receive the CLS services in question. Rather, the issue is, does the Department have to provide the missing hours when there are no providers available either in-network or out-of-network? Without a doubt, the Department is required to provide the B3 services if they are medically necessary and if the Department has the documented capacity to reasonably and equitably serve other Medicaid beneficiaries. And while the Petitioner cites 42 CFR 440.230(b) as requiring the Department to provide services in the amount, duration, and scope to reasonably achieve its purpose, that same section indicates agencies may place appropriate limits on a service based on such criteria as medical

[8] MPM, Behavioral Health and Intellectual and Developmental Disability Supports and Services, October 1, 2019, pp 129-130, 132

necessity **or on utilization control procedures**.[9] Moreover, B3 services as discussed above are not intended to meet all of the individuals needs and preferences.

The record indicates, the Department has reached out to their in-network providers and the out-of-network providers in Petitioner's service area and discovered that all of the providers in the service area are currently at capacity. The Department indicated they have continued to reach out to see if and when staff may become available. Additionally, the Department has indicated they reached out to see if Petitioner would like to participate in self-determination and select their own providers. The Petitioner did decline, and although there is no requirement that Petitioner opt into self-determination, it is one more indicium of the Department attempting to find an available provider.

It is also worth noting that the hours in question happen to fall solely on the weekend. The record is barren of any discussion regarding the Petitioner and the Department rearranging the proposed CLS service periods and whether or not that might alleviate the issue. Furthermore, there is also the question of whether not, given the availability of services, the Petitioner might be best served by receiving the services in a specialized residential setting as this might be the best venue given the lack of available providers in the Petitioner's service area. Additionally, the Petitioner lives with natural supports. There does not appear to be much discussion regarding whether or not the natural supports could provide some of the services and possibly receive temporary respite in lieu of the CLS support.

Consequently, I find the Petitioner has failed to meet his burden and that the Department's decision should be affirmed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Department properly suspended Petitioner's CLS services.

IT IS THEREFORE ORDERED that

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

CA/sb

Corey Arendt
Administrative Law Judge
for Robert Gordon, Director
Department of Health and Human Services

[9] 42 CFR 440.230(d).

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 30763
Lansing, Michigan 48909-8139

DHHS Department Rep.

Craig Hause - 78
Shiawassee County CMH
1555 Industrial Drive
Owosso, MI
48867

DHHS -Dept Contact

Belinda Hawks
320 S. Walnut St.
5th Floor
Lansing, MI
48913

Petitioner

[redacted], MI

Authorized Hearing Rep.

[redacted], MI

Authorized Hearing Rep.

Simon Zagata
Michigan Protection & Advocacy Service, Inc.
4095 Legacy Parkway, Suite 500
Lansing, MI
48911