Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: July 2, 2025
Docket No.: 25-014624
Case No.: [redacted]
Petitioner: [redacted]

[redacted]
MI [redacted]

This is an important legal document. Please have someone translate the document.

هذه وثيقة قانونية مهمة. يرجى أن يكون هناك شخص ما يترجم المستند.

এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

Este es un documento legal importante. Por favor, que alguien traduzca el documento.

这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

Date Mailed: July 2, 2025
Docket No.: 25-014624
Case No.: [redacted]
Petitioner: [redacted]

DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on June 4, 2025. [redacted] Petitioner's legal guardian, appeared on Petitioner's behalf. [redacted] testified as a witness for Petitioner. Heather Woods, Customer Service Specialist, appeared and testified on behalf of Respondent Southwest Michigan Behavioral Health (Respondent). Jarrett Cupp, Chief Compliance Officer at Pivotal, and Jeremy Franklin, Clinical Quality Specialist at Respondent, also testified as witnesses for Respondent/

During the hearing, the following exhibits were admitted into evidence without objection:

Petitioner's Exhibit #1: Request for Hearing, pages 1-5

Petitioner's Exhibit #2: Psychological Report, pages 1-10

Respondent's Exhibit A: Hearing Summary and Evidence Packet, pages 1-25

ISSUE

Did Respondent properly decide to deny reauthorization of Petitioner's community living supports (CLS) and personal care services in a licensed specialized residential setting?

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 a [redacted] Medicaid beneficiary who has been diagnosed with schizophrenia and an unspecified intellectual disability. (Exhibit #2, pages 4, 11; Exhibit A, page 18).

2. Due to his diagnoses and need for assistance, Petitioner has been approved for services through Pivotal, a Community Mental Health Service Provider (CMHSP) associated with Respondent, a Prepaid Inpatient Health Plan (PIHP). (Testimony of Respondent's representative).

3. As part of those services, Petitioner has been approved for CLS and personal care services at a licensed specialized residential setting. (Exhibit A, pages 7, 16-17; Testimony of Respondent's representative).

4. On November 6, 2024, the Probate Court for the County of Branch appointed a full legal guardian for Petitioner. (Exhibit #1, page 5).

5. As part of the process of determining whether Petitioner required a legal guardian, Petitioner had been referred for an evaluation by a psychologist. (Exhibit #2, page 5; Testimony of Psychologist).

6. On September 25, 2024, Petitioner was assessed by [redacted], [redacted] (Exhibit #2, page 4).

7. Petitioner was assessed solely for the purpose of determining whether he required a guardian. (Testimony of Psychologist).

8. In the Psychologist's Report subsequently issued by [redacted] on October 7, 2024, [redacted] wrote in part:

> **Overall clinical impressions in regard to reasons for referral:**
> [Petitioner] is a schizophrenic, emotionally immature, and intellectually limited individual who will demonstrate distorted and delusional thinking as well as outbursts of anger. He lacks the capacity for independent living and will require the appointment of a full Guardian.
>
> * * *

Discussion:

[Petitioner] demonstrates an intellectual ability within the borderline intellectual range (Full Scale IQ equals 71; 3rd percentile). He appears to have problems with mathematical reasoning, but also appears to have some deficits in the areas of verbal comprehension and memory. His current program manager's response to the BRIEF-A suggests significant problems with initiating thought, memory, and monitoring tasks. She believes that he has some problems with self-monitoring. During his clinical interview and overall interaction with this examiner, [Petitioner] demonstrated some distorted and disjointed thinking . . .

Having determined that [Petitioner] is in need of guardianship, the issue becomes whether this is due to neurological issues or is more indicative of neurodevelopmental issues. [Petitioner's] profile would suggest his issues are neurodevelopmental in nature . . .

* * *

[Petitioner's] response to the sensorium portion of the evaluation suggests a dependent individual with limited levels of insight. He reports some visual hallucinatory experiences. He reports suicide attempts 12 years prior to this evaluation. He demonstrates poor abstract reasoning and common judgment.

In conclusion, [Petitioner's] overall profile suggests a developmentally disabled individual who lacks the capacity or judgment to make his own judgment. He will require the appointment of a full Guardian. His developmental disability is attributable to a mental and physical impairment manifesting before he was [redacted] and likely to continue indefinitely. His deficits result in substantial functional limitations in self-care, learning, self-direction, capacity for independent living, and economic self-sufficiency.

Exhibit #2, pages 5, 10-11

9. On February 20, 2025, Petitioner was assessed by staff at Pivotal. (Exhibit A, page 10).

10. During that assessment, it was noted that Petitioner goes out in the community about once a week by himself and does not have any problems while out; despite prompting by staff, he rarely brushes his teeth and only showers about once a week; he is independent in bathing, grooming, dressing and eating; and he still presents with behaviors that require close monitoring. (Exhibit A, pages 10, 15-16).

11. On February 21, 2025, Pivotal staff also performed a Level of Care Utilization System (LOCUS) assessment with Petitioner. (Exhibit A, pages 18-19).

12. In that LOCUS assessment, Petitioner scored at a Level 3, which is defined as "high intensity community-based services". (Exhibit A, page 15).

13. Petitioner had previously scored at a Level 5 at the time he was approved for CLS and personal care services in a licensed specialized residential setting. (Exhibit A, page 15).

14. On March 14, 2025, in response to a request for the reauthorization of services, Pivotal sent Petitioner's guardian a Letter of Adverse Benefit Determination stating that Petitioner's request for specialized residential services had been partially denied. (Exhibit A, pages 4-6).

15. Specifically, the requested services would be approved for 3 months as Petitioner transitioned to a lower level of care. (Exhibit A, page 4).

16. With respect to the reason for the decision, the Letter of Adverse Benefit Determination stated in part:

> The clinical documentation provided does not establish medical necessity.
>
> Your request for specialized residential services, which includes community living supports (CLS) and personal care services was reviewed by Jarrett Cupp, MA, LPC, CHC on 3/14/25 and partially approved. You are being authorized for three months of CLS and personal care to transition to a lower level of care, such as a CLS/ Semi Independent Living (SIL) home, or your own apartment with CLS supports and

> intensive community services, such as assertive community treatment (ACT).
>
> When making this decision, your most recent assessment, LOCUS, treatment plan and past six months of progress notes were reviewed . . . Per your assessment, “He ([Petitioner]) does not require help with bathing, grooming, dressing or eating. He just chooses not to bath or brush his teeth after prompting was present and actively engaged during annual assessment.” As you don’t require personal care assistance, you do not meet the criteria for placement in a specialized residential home because both CLS and personal care services are not needed at the same time. The prompting that you get from staff to preform [sic] your activities of daily living (ADLs) can be provided to you under Community Living Supports; which is outlined in the Medicaid provider manual. Your water consumption was noted as well; please note that CLS services can also assist “with preserving the health and safety of the beneficiary in order that they may reside or be supported

Exhibit A, page 5

17. On March 26, 2025, Petitioner’s guardian filed an Internal Appeal with respect to that decision. (Exhibit A, page 7).

18. On April 15, 2025, Pivotal sent a Letter of Appeal Denial stating that it had not approved Petitioner’s appeal. (Exhibit A, pages 7-8).

19. With respect to the reason for that decision, the Letter of Appeal Denial stated in part:

> Your appeal was not approved for the services(s)/item(s) listed above because:
>
> On April 11, 2025, a review was done by Clinical Director, Nichole Fraizer, LMSW. She agrees with the partial denial of Community Living Support per diem and Personal Care per diem services. By continuing to build on your current skills and actively participating in your care plan, you will be prepared to transition to a less restrictive environment. A partial denial of

> services provides an opportunity to find a placement that better aligns with your current needs.
>
> *Exhibit A, page 7*

20. On April 24, 2025, MOAHR received the request for hearing filed on Petitioner's behalf in this matter with respect to that decision. (Exhibit #1, pages 1-5).

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.
>
> *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

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…

42 USC 1396n(b)

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, while Petitioner has been receiving CLS and personal care services through Respondent in a licensed specialized residential setting, Respondent has denied the reauthorization of such services and to transition Petitioner to a lower level of care.

With respect to the location and medical necessity of services through Respondent, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **2.3 LOCATION OF SERVICE**
>
> 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.

* * *

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, January 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 10, 13-15

Moreover, with respect to personal care in licensed specialized settings and CLS specifically, the applicable version of the MPM also states:

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care

setting or in a Child Caring Institution (CCI) if 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. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

“Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks themself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.

- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.

- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

* * *

17.4.A. COMMUNITY LIVING SUPPORTS (CLS)

NOTE: This service is a State Plan EPSDT service when

delivered to children birth-21 years.

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary'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 activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary'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 from MDHHS. CLS may be used for those activities

while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist them 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.

- CLS staff providing 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 beneficiary in order that they 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 Medicaid FFS 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 CLS.

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 services when the beneficiary's need for this assistance has been officially determined to exceed the 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.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary'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 beneficiary. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.

Here, Respondent partially denied Petitioner's request for reauthorization of CLS and personal care services in a licensed specialized residential setting pursuant to the above policies and on the basis that the requested setting is not medically necessary for Petitioner.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred in denying his request. Moreover, the undersigned ALJ is limited to reviewing the Respondent's decision in light of the information it had at the time it made the decision.

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

It is undisputed in this case that Petitioner has significant care needs, but Respondent's exhibit and witness credibly explained how those needs could be met at a lower, less restrictive level of care, such as a CLS or Semi-Independent Living (SIL) home following a transition period. Petitioner can still receive monitoring and personal care, in addition to other intensive services, outside of a licensed setting and none of Petitioner's needs appear to rise to the level of a more restrictive residential placement.

Moreover, while Petitioner's representative/guardian disputes that decision, she failed to show any error. Petitioner's appeal relies solely on the report and testimony of [redacted], but neither the report nor the testimony contradicts Respondent's findings or determination.
[redacted] credibly described Petitioner's needs, in addition to recommending that Petitioner stay in an Adult Foster Care (AFC) home, but he did not describe any needs not addressed by Respondent; he only evaluated Petitioner for the purposes of determining whether Petitioner needed a guardian; and he expressly disclaimed any knowledge of the differences between the levels of care at issue in this case. The mere fact that Petitioner requires a guardian does not mean that he needs services at a licensed specialized residential setting.

To the extent Petitioner's circumstances change following the transition to a lower level of care, or his representative has additional or updated information to provide, then Petitioner's representative can always request services at a licensed specialized residential setting again in the future. With respect to the decision at issue in this case however, Respondent's decision must be affirmed given the available information and applicable policies.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent properly denied Petitioner's request for reauthorization of services at a licensed specialized residential setting.

IT IS THEREFORE ORDERED that:

Respondent's decision is **AFFIRMED**.

Steven Kibit

SK/sj

Error! Unknown document property name.
Administrative Law Judge

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

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