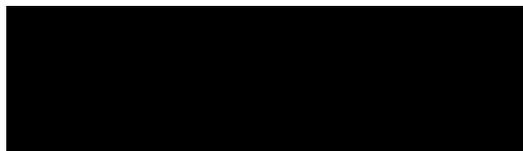


FILED

Oct 06, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 16F-05856

PETITIONER,

Vs.

AGENCY FOR HEALTH
CARE ADMINISTRATION (AHCA)
CIRCUIT: 07 Volusia
UNIT: AHCA

AND

UNITED HEALTHCARE (United)

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 29, 2017 at 1:12 p.m. at the Department of Children and Families Service Center in [REDACTED] Florida.

APPEARANCES

For the Petitioner: [REDACTED], father

For the Respondent: Christian Laos, senior compliance analyst with United

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive six dental crowns through Medicaid. The petitioner holds the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The Agency for Health Care Administration (Agency or AHCA or respondent) administers the Florida Medicaid Program. The Agency contracts with numerous health care maintenance organizations (HMOs) to provide medical services to Medicaid enrollees. United was the contracted HMO in the instant case.

By notice dated August 1, 2016, United informed the petitioner that his request for six dental crowns through Medicaid was denied because the “requested services are not medically necessary.”

The petitioner timely requested a hearing to challenge the denial decision.

The matter was scheduled to be heard on October 21, 2016; February 27, 2017; and June 28, 2017, but was continued on each occasion at the petitioner’s request.

The respondent filed an oral dismissal motion on the record during the hearing, citing lack of jurisdiction due to termination of the petitioner’s Medicaid coverage effective April 30, 2017. A ruling was withheld pending the final order. The respondent’s motion is hereby denied.

The petitioner was present and testified. The petitioner did not submit documentary evidence.

Present as witnesses for the respondent from United: Dr. Brittany Vo, dental consultant and Arlene Carrion, dental account manager. Present as a witness for the

respondent from AHCA: Selwyn Gossett, senior human services program specialist.

The respondent submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 14) was a Florida Medicaid recipient from at least July 1, 2016 – April 30, 2017. The petitioner was enrolled with United HMO during this time period. (Respondent's Exhibit 1)

2. On or about July 27, 2016, the petitioner's treating dentist submitted a request to United for six dental crowns for teeth 6 – 11. The request consisted of four dental x-rays; no additional clinical records were included with the request. (Respondent's Exhibit 1)

3. United denied the request on August 1, 2017. The denial notice reads in pertinent part: "The request is denied for lack of medical necessity. The information submitted by your dentist was insufficient to demonstrate the necessity of the requested item/service. Additional x-rays, periodontal information, and/or pertinent clinical findings can be resubmitted by your dentist." (Respondent's Exhibit 1)

4. The petitioner timely requested a hearing to challenge the denial decision.

5. The petitioner explained that he is experiencing enamel erosion (weakening and loss of tooth enamel). The condition has impacted the color and shape of his teeth. The condition also causes chronic pain. (Testimony of father and petitioner)

6. The petitioner's treating dentist recommended crowns for all his teeth. He decided to request prior service authorization in increments, approximately six teeth at a time, instead of submitting once prior service authorization for all of the petitioner's teeth. He felt there was a better chance of the request being approved if it was submitted in increments. (Testimony of petitioner's father)

7. The petitioner's Medicaid coverage was terminated during the appeals process, effective April 30, 2017, due to household income in excess of Medicaid limitations. The petitioner has been enrolled in another government sponsored health insurance program, Florida KidCare, since June 1, 2017. Florida KidCare is not administered by the respondent, nor under the jurisdictional authority of the Office of Appeal Hearings. The petitioner has not requested prior service authorization for the dental crowns through KidCare because the instant appeal was still pending. He is waiting on a final decision in this matter before contacting KidCare. (Testimony of petitioner's father)

8. The respondent explained that the petitioner's x-rays showed no sign of tooth decay or holes in the teeth. The x-rays showed small chips in the petitioner's teeth which could be addressed by a more conservative and cost effective treatment, dental fillings. Absent clinical evidence to support the request for dental crowns, United concluded that the service was in excess of the petitioner's needs. Medicaid rule prohibits the provision of goods and services in excess of a recipient's needs. (Testimony of Dr. Brittany Vo)

CONCLUSIONS OF LAW

9. By agreement between the AHCA and the Department of Children and Families, AHCA has conveyed jurisdiction to the Office of Appeal Hearings to conduct this hearing pursuant to Section 120.80, Florida Statutes.

10. This is a final order pursuant to Sections 120.569 and 120.57, Florida Statutes.

11. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. In accordance with Fla. Admin. Code R. 65-2.060(1), the burden of proof was assigned to the petitioner.

13. The standard of proof in an administrative hearing is by a preponderance of the evidence (See Fla. Admin. Code R. 65-2.060(1)). The preponderance of the evidence standard requires proof by “the greater weight of the evidence,” (Black’s Law Dictionary at 1201, 7th Ed.).

14. The Florida Medicaid Program is authorized by Chapter 409 Florida Statutes and Fla. Admin. Code Chapter 59G.

15. Fla. Admin. Code R. 59G-1.010(166) explains that medical or allied care, goods, or services furnished or ordered must meet the definition of medically necessary or medical necessity, and defines medical necessity as:

“Medical necessary” or “medical necessity” means that medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;

2. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
3. Be consistent with generally accepted professional medical standards as defined by the Medicaid program and not be experimental or investigational;
4. Be reflective of the level of service that can safely be furnished, for which no equally effective and more conservative or less costly treatment is available statewide; and,
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. . .

....

(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods or services does not, in itself, make such care, goods or services medically necessary, or a medical necessity, or a covered service.

16. As the petitioners are under 21, a broader definition of medically necessary applies to include the EPSDT requirements. Section 409.905, Florida Statutes, Mandatory Medicaid services, defines Medicaid services for children to include:

(2) EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT SERVICES.--The agency shall pay for early and periodic screening and diagnosis of a recipient under age 21 to ascertain physical and mental problems and conditions and provide treatment to correct or ameliorate these problems and conditions. These services include all services determined by the agency to be medically necessary for the treatment, correction, or amelioration of these problems, including personal care, private duty nursing, durable medical equipment, physical therapy, occupational therapy, speech therapy, respiratory therapy, and immunizations.

17. The above citation explains that the respondent must provide treatment and services to Medicaid recipients under 21 years of age, but only to the extent such services are medically necessary. The state is authorized to establish the amount, duration, and scope of such services.

18. The respondent denied the petitioner's request six dental crowns through Medicaid. Dr. Brittany Vo, the only expert witness to appear at the hearing, opined that there was insufficient information to determine that the requested service was medically necessary. X-rays of the petitioner's teeth showed no holes or evidence of decay, only small chips which could be addressed with dental fillings, a more cost effective treatment.

19. The petitioner provided no evidence which contradicted the respondent's conclusions. In the final analysis, the petitioner did not prove by a preponderance of the evidence that it is medically necessary that he receive dental crowns.

20. After carefully reviewing the evidence and controlling legal authorities, the undersigned concludes that the respondent's decision in this matter was correct.

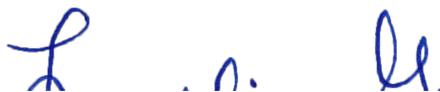
DECISION

The appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the agency. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308-5403. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the agency has no funds to assist in this review.

DONE and ORDERED this 06 day of October, 2017,
in Tallahassee, Florida.



Leslie Green
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
AHCA, Medicaid Fair Hearings Unit
United Health Care Hearings Unit

Sep 27, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-02602

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88999

RESPONDENT.

/

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 13, 2017 at 1:00 p.m. and reconvened on August 10, 2017 at 1:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Brian Meola, Esq., Assistant General Counsel for the Department of Children and Families

STATEMENT OF ISSUE

At issue is whether the petitioner is eligible for Institutional Care Program (ICP) Medicaid coverage for November 2016 through March 2017. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The parties submitted a Joint Motion for Continuance on June 8, 2017. The undersigned granted the continuance request and rescheduled the hearing for July 13, 2017. On July 13, 2017, the parties conducted a pre-hearing conference outside of the undersigned's presence. On record, the parties determined that testimony was needed from the Department of Elder Affairs (DOEA); therefore, the parties agreed to reconvene the hearing. The hearing was reset for August 10, 2017.

The petitioner was not present; however, she was represented by legal counsel. Appearing as a witness for the petitioner was [REDACTED], the petitioner's son and designated authorized representative. The petitioner's husband, [REDACTED] was the petitioner's designated authorized representative (AR) until June 6, 2017 when he passed away.

Appearing as witnesses for the respondent, on August 10, 2017, were Stan Jones, ACCESS Economic Self-Sufficiency Specialist II, Yvette Worlow, Program Operations Administrator with DOEA. Appearing as observers from DOEA were Karen Swindler, Regional Program Supervisor, Susan Pietris, Registered Nurse Specialist, Vicky Sexton, Government Analyst II, Francis Carbon, Deputy General Counsel, and Jeanne Kirk, Senior Attorney.

The petitioner submitted four exhibits, entered as Petitioner's Exhibits "1" through "4". The respondent submitted six exhibits, entered as Respondent's Exhibits "1" through "6". The record remained open until August 21, 2017 for Proposed Orders from both parties. The petitioner's Proposed Order was received on August 17, 2017, which

was entered as Petitioner's Exhibit "5". The respondent did not file a Proposed Order or request a deadline extension. The record closed on August 21, 2017.

FINDINGS OF FACT

1. The petitioner (age 69) was admitted to Life Care Center of Melbourne, a skilled nursing home facility, on August 30, 2016. The petitioner was hospitalized at [REDACTED] [REDACTED], she returned to [REDACTED] [REDACTED] on October 4, 2016. The petitioner had a couple more hospital stays in between until she returned to [REDACTED] on November 28, 2016. The petitioner has not left the facility since November 28, 2016. The petitioner suffers from multiple physical and mental illnesses.
2. On December 22, 2016, the petitioner's husband and AR at that time, submitted an application for ICP Medicaid coverage for the petitioner. On the application, the AR answered "Address where you get your mail (if different from where you live)" and he wrote [REDACTED]. In addition to ongoing ICP Medicaid coverage, the AR requested retroactive ICP Medicaid coverage for the petitioner for November 2016.
3. On December 28, 2016, the respondent mailed the petitioner a Notice of Case Action which requested the petitioner submit the following information by January 9, 2017:



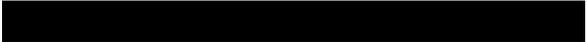
The following is information about your eligibility.

Once you receive your case number you can go to www.myflorida.com/accessflorida to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need the following information by January 09, 2017.

Other - please see comments below

level of care , date of admissions to the nursing facility , financial release forms proof of all life insurance policies
face/cash and loan values for 2016 proof of all gross income for 2016/2017 proof of all medicare supplements
premiums proof of all stocks

4. The respondent mailed the pending notice to the petitioner's home address; the application submitted on December 22, 2016 indicates her mailing address was 
.
5. On January 24, 2017, the respondent issued a Notice of Case Action to the petitioner's mailing address indicating the Medicaid application dated December 22, 2016 was denied; reason: "We did not receive all the information requested to determine eligibility".
6. The AR did not receive the December 28, 2016 pending notice as it was incorrectly sent by the respondent to the home address instead of the mailing address. The petitioner's legal counsel argued that the AR was not aware that the case was pending until the petitioner's legal counsel contacted the respondent on February 20, 2017 and various dates after, following receipt of the January 24, 2017 denial Notice of Case Action.
7. The respondent explained that it had determined all the technical and financial eligibility requirements for the petitioner; however, it could not approve ICP Medicaid for

the petitioner until DOEA/CARES determined if she met the required level of care (LOC).

8. Via interagency agreement, DOEA's Comprehensive Assessment and Review for Long-Term Care Services (CARES) unit must complete a Pre-Admission Screen and Resident Review (PASRR) for nursing home applicants. A registered nurse and/or assessor performs these client assessments. A physician or registered nurse reviews each application to determine the level of care (LOC) that is most appropriate for the applicant. The assessment identifies long-term care needs and establishes the appropriate LOC (medical eligibility for nursing facility care).

9. DOEA/CARES communicates the LOC decision to the Department via the PASRR form. The LOC decision is required before the Department can approve an application for ICP Medicaid.

10. On May 11, 2017, the respondent received confirmation from DOEA/CARES that a PASRR was completed for the petitioner on April 27, 2017 and the LOC effective date was determined as April 27, 2017.

11. On June 5, 2017, the respondent mailed the petitioner a Notice of Case Action approving ICP Medicaid coverage for April 2017, May 2017, June 2017, July 2017, and ongoing. The respondent determined that the petitioner was not eligible for retroactive ICP Medicaid coverage for November 2016 and ICP Medicaid coverage for December 2016, the application month, through March 2017 because the ICP LOC was not effective until April 2017.

12. The Department's witness, Yvette Worlow, explained that the PASRR review process should be initiated before the patient is discharged from the hospital or, at the

latest, as soon as the patient is admitted into the nursing home. The review is initiated by the hospital or nursing home by completing the appropriate section of the PASRR form and submitting the form to DOEA/CARES. When an application is submitted for ICP Medicaid, the respondent must request a level of care determination from DOEA/CARES.

13. The petitioner's medical records show [REDACTED] submitted a PASRR form to DOEA/CARES on August 2016. According to the DOEA/CARES notes, the PASRR originally provided had a screening date of August 30, 2016; however, the PASRR was not signed until October 3, 2016, and no LOC was determined.

14. DOEA/CARES received a PASRR review request on March 2017 from the nursing home facility. DOEA/CARES did not submit the petitioner's PASRR form to the Department until May 11, 2017. This delay caused the Department to deny the petitioner's ICP Medicaid coverage for November 2016 through March 2017.

15. The petitioner's legal counsel disagreed with the respondent's decision. The petitioner's legal counsel asserts that the petitioner met the nursing home LOC effective November 2016 through March 2017 and seeks to have the respondent's decision overturned.

16. The PASRR review process does not include a retroactive component that allows DOEA/CARES to approve level of care for a month prior to the month the PASRR review was requested.

17. Taking into consideration the fact that the respondent delayed many months by not sending the pending notice to the petitioner's reported mailing address, and the fact that

the petitioner's legal counsel made numerous attempts to contact the respondent since February 2017 to indicate no pending notice was issued to the petitioner, the undersigned finds that the respondent delayed the PASRR review process and the determination of the LOC by not issuing the pending notice to the petitioner's correct mailing address.

18. Additionally, as the petitioner's medical records indicate a PASRR was requested on August 2016 and signed on October 2016, the undersigned finds that the PASRR review process was initiated on August 2016 and signed on October 2016.

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

20. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

21. Fla. Admin. Code R. 65A-1.203(9) defines representative: "Authorized/Designated Representative: An individual who has knowledge of the assistance group's circumstances and is authorized to act responsibly on their behalf."

22. [REDACTED] are the petitioner's authorized representatives and acted on her behalf in this case.

23. PASRR requirements can be found under federal and state authorities.

24. Section 409.985, Florida Statutes, addresses the role of DOEA/CARES in the ICP Medicaid Program:

(1) The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) preadmission screening program to ensure that only individuals whose conditions require long-term care services are enrolled in the long-term care managed care program.

(2) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. s. 483.20, relating to preadmission screening and review.

25. Section 409.983, Florida Statutes, addresses Long-term care managed care plan payment and states the following:

...

(4) The initial assessment of an enrollee's level of care shall be made by the Comprehensive Assessment and Review for Long-Term-Care Services (CARES) program, which shall assign the recipient into one of the following levels of care:

(a) Level of care 1 consists of recipients residing in or who must be placed in a nursing home.

26. The Code of Federal Regulations at 42 C.F.R. § 483.122, FFP for NF services states:

a) Basic rule. Except as otherwise may be provided in an alternative disposition plan adopted under section 1919(e)(7)(E) of the Act, FFP is available in State expenditures for NF services provided to a Medicaid eligible individual subject to the requirements of this part only if the individual has been determined—

(1) To need NF care under §483.116(a) or

(2) Not to need NF services but to need specialized services, meets the requirements of §483.118(c)(1), and elects to stay in the NF.

(b) FFP for late reviews. When a preadmission screening has not been performed prior to admission or an annual review is not performed timely, in accordance with §483.114(c), but either is performed at a later date, FFP is available only for services furnished after the screening or review has been performed, subject to the provisions of paragraph (a) of this section.

27. The Code of Federal Regulations at 42 C.F.R. § 483.132, Evaluating the need for NF services and NF level of care (PASARR/NF) states:

- (a) Basic rule. For each applicant for admission to a NF and each NF resident who has MI or IID, the evaluator must assess whether—
- (1) The individual's total needs are such that his or her needs can be met in an appropriate community setting;
 - (2) The individual's total needs are such that they can be met only on an inpatient basis, which may include the option of placement in a home and community-based services waiver program, but for which the inpatient care would be required;
 - (3) If inpatient care is appropriate and desired, the NF is an appropriate institutional setting for meeting those needs in accordance with §483.126; or
 - (4) If the inpatient care is appropriate and desired but the NF is not the appropriate setting for meeting the individual's needs in accordance with §483.126, another setting such as an ICF/IID (including small, community-based facilities), an IMD providing services to individuals aged 65 or older, or a psychiatric hospital is an appropriate institutional setting for meeting those needs.
- (b) Determining appropriate placement. In determining appropriate placement, the evaluator must prioritize the physical and mental needs of the individual being evaluated, taking into account the severity of each condition.
- (c) Data. At a minimum, the data relied on to make a determination must include:
- (1) Evaluation of physical status (for example, diagnoses, date of onset, medical history, and prognosis);
 - (2) Evaluation of mental status (for example, diagnoses, date of onset, medical history, likelihood that the individual may be a danger to himself/herself or others); and
 - (3) Functional assessment (activities of daily living).
- (d) Based on the data compiled in §483.132 and, as appropriate, in §§483.134 and 483.136, the State mental health or intellectual disability authority must determine whether an NF level of services is needed.

28. The PASRR screening is set forth in Fla. Admin. Code R. 59G-1.040, which states, in part:

- (1) Purpose. This rule applies to all Florida Medicaid-certified nursing facilities (NF), regardless of payer source; all providers rendering NF services to Florida Medicaid recipients; and all entities that perform a

function in the Preadmission Screening and Resident Review (PASRR) process as specified in this rule...

(2) Definitions.

...

(f) New Admission – An individual admitted to any NF for the first time, who was not readmitted or admitted as an inter-facility transfer.

(g) Preadmission Screening and Resident Review – Federal requirement mandated by 42 CFR 483.100-483.138.

(h) Readmission – When an NF resident is transferred to a hospital and returns to any NF within 90 calendar days. (emphasis added)

(i) Resident Review (RR) – An evaluation and determination conducted by state-designated authorities when an NF resident experiences a significant change in his or her physical or mental status...

(3) Level I PASRR Screen.

(a) The Agency for Health Care Administration (AHCA), or its designee, performs the Level I PASRR screens for all individuals seeking admission to an NF.

(b) The Agency for Health Care Administration delegates the following entities to perform Level I PASRR screens (collectively referred to as the Level I PASRR screeners):

...

2. Florida Department of Elder Affairs' (DOEA) Comprehensive Assessment and Review for Long-Term Care Services (CARES) program for individuals age 21 years and older. The CARES program may only delegate the Level I PASRR screen responsibility to hospital and NF staff who are licensed clinical social workers, physicians, physician assistants, registered nurses, mental health counselors, psychologists, or persons who hold a Master's Degree in Social Work.

(c) The Level I PASRR screen must be completed by the Level I PASRR screener prior to all new admissions to an NF, and within two business days of the request.

(4) Level II PASRR Evaluation Request.

Upon completion of the Level I PASRR screen, if the individual has a diagnosis of or suspicion of having an SMI, ID, or both:

(a) The Level I PASRR screener must send the individual or their legal representative, as applicable, written notice stating the individual has a diagnosis of, or is suspected of having, an SMI, ID, or both, and is being referred for a Level II PASRR evaluation.

(b) The AHCA-designated Level I PASRR screener must send all of the following documentation for a Level II PASRR evaluation to the Agency for Persons with Disabilities (APD), or the state's contracted vendor, for individuals diagnosed with, or suspected of having, an ID; or, to the state's contracted Level II PASRR evaluator for individuals diagnosed with, or suspected of having, an SMI:

1. Completed Preadmission Screening and Resident Review (PASRR) Level I Screen For Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID) (Level I PASRR Screen), AHCA MedServ Form 004 Part A, March 2017, incorporated by reference and available on AHCA's website at

<http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <https://www.flrules.org/Gateway/reference.asp?No=Ref-07931>.

2. Informed consent, as documented on the Level I PASRR Screen, AHCA MedServ Form 004 Part A, March 2017, or the Preadmission Screening and Resident Review (PASRR) Resident Review (RR) – Evaluation Request For a Significant Change for Serious Mental Illness (SMI) and/or Intellectual Disability or Related Conditions (ID) (Resident Review-Evaluation Request), AHCA MedServ Form 004 Part A1, March 2017, incorporated by reference and available on AHCA's website at <http://ahca.myflorida.com/Medicaid/review/index.shtml>, and at <https://www.flrules.org/Gateway/reference.asp?No=Ref-07932>.

29. Federal law mandates that the CARES Program perform an assessment or review of each individual who requests Medicaid reimbursement for nursing facility placement.

A CARES assessment is also mandatory if any applicant is suspected of having an intellectual disability or serious mental illness. Any person or family member can initiate a CARES assessment by applying for ICP Medicaid benefits. In this case, the petitioner's AR submitted an application for ICP Medicaid benefits for the petitioner on December 22, 2016.

30. The intent of the cited authorities is to ensure that individuals placed into nursing home facilities receive the appropriate level of care. Therefore, prior to establishing ICP Medicaid eligibility, DOEA/CARES staff must complete the PASRR review process and ensure the assessment confirms an applicant's need for nursing home care. In this case, there were two PASRRs completed; one on October 3, 2016 and another one on April 27, 2017. The PASRR completed on April 27, 2017 by DOEA/CARES staff determined that the LOC effective date was April 27, 2017. However, the PASRR

completed on October 3, 2016 was not used to complete and determine the petitioner's LOC.

31. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1440.1302, Who Determines Need for Placement (MSSI) states in relevant part:

The agency or office responsible for determining the need for care depends on the applicant's age and what kind of facility or program is needed. After the eligibility specialist requests a determination, the specialist must receive DOEA CARES Form 603 (Notification of Level of Care) for nursing home placement or the Certification of Enrollment Status for Home and Community Based Services (HCBS) Form (CF-ES 2515) for HCBS waivers from the responsible office to document the specific need in the case record.

Note: The eligibility specialist does not request level of care decisions for HCBS waivers but must receive documentation of decisions from case managers or CARES.

The determination will be obtained from one of the following offices: CARES (Comprehensive Assessment and Review for Long Term Care Services), Department of Elder Affairs:

1. For ICP: determines Level of Care for applicant/recipients over age 21 in nursing facilities, swing beds or hospital based nursing facility beds.

32. The Policy Manual, CFOP 165-22, passage 0640.0400, APPLICATION TIME STANDARDS (MSSI, SFP), addresses when to request a LOC and states in relevant part:

The time standard begins upon receipt of a signed application. Process applications as soon as possible after the assistance group (AG) completes all eligibility requirements. If the household completes all requirements and provides all information, process the application by the 30th day after the application date. Process applications and determine eligibility or ineligibility within 90 calendar days after the date of the application for individuals who claim a disability.

...

Level of Care Determination:

1. Request a level of care determination on ICP cases from the CARES Unit within two days of receipt of the application.

2. The CARES Unit provides the level of care decision within 12 days of receipt of the request. (emphasis added)

Begin counting processing days the day following the date of application.

Evaluate any delay beyond the time standards listed above in the application process to determine applicant or Department delay.

Department delay occurs when application processing exceeds 90 days, and the delay cannot be attributed to the applicant.

0640.0401, Requests for Additional Information/Time Standards (MSSI, SFP) continues:

If the Department needs additional information or verification from the applicant, provide:

1. a written list of items required in order to complete the application process,

...

The verification/information due date is 10 calendar days after the date of the interview or if there is no interview requirement, 10 days after the date the pending notice is generated. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next business day. At the individual's request, extend the due date. Leave the case pending until the 30th day after the date of application to allow the household a chance to provide verifications. Assist applicants with getting missing verifications when needed.

...

Evaluate any delay in submitting information that exceeds the time standard to determine applicant or Department delay.

Apply retroactive Medicaid policy to months prior to the original month of application. (emphasis added)

33. The record clearly demonstrates that the petitioner's nursing home placement was appropriate and she is eligible for ICP Medicaid. The remaining issue is the onset date of her eligibility. The petitioner's legal counsel argued the onset date should be November 1, 2016. The petitioner's legal counsel argued the respondent caused an agency delay by its failure to send the petitioner's pending notice to her mailing address; instead, the respondent mailed the pending notice to her home address. The petitioner was not aware that a LOC determination was needed until her legal counsel

contacted the respondent's witness regarding the application denial. The respondent's legal counsel argued that the onset date should be April 27, 2017, the month the DOEA/CARES unit initiated and completed the PASRR review. The findings show a PASRR review was initiated on August 30, 2016 and signed on October 3, 2016, there was no documentation or testimony provided to explain why a LOC determination was not completed at that time.

34. The petitioner's AR filed an ICP Medicaid application on December 22, 2016 and requested retroactive coverage for November 2016 as well as ICP coverage for December 2016 through March 2017. The findings show the respondent did not properly notify the petitioner that a LOC determination was needed as it mailed the December 28, 2016 pending notice to the wrong address. Furthermore, the respondent did not request a level of care determination from the DOEA/CARES Unit within two days of receipt of the application as required. After careful review of the evidence and controlling legal authorities, the undersigned concludes the respondent's errors caused the delay in obtaining the LOC for the petitioner. The undersigned concludes the petitioner meets the ICP LOC requirements for November 2016 through March 2017; therefore, this matter is hereby remanded to the Department for corrective action.

35. Fla. Admin. Code R. 65-2.066, Final Orders, explains: "(6) In the Final Order the Hearings Officer shall authorize corrective action retroactively to the date the incorrect action was taken." Therefore, the Department is ordered to approve ICP Medicaid benefits for the petitioner for the months of November 2016 through March 2017. Once this corrective action has been completed, the respondent is to issue a new Notice of Case Action to the petitioner's AR notifying of the outcome, including her appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is granted and remanded to the Department to take corrective action as specified in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 27 day of September, 2017,
in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To:



Shane DeBoard, Esq.
Brian Meola, Esq.

Oct 19, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03063

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 HENDRY
UNIT: 88287

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter September 26th, 2017, at 11:41 a.m.

APPEARANCES

For the Petitioner: Petitioner was not present, but was represented by [REDACTED]

For the Respondent: Stefanie Camfield, Esq., District Legal Counsel for the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll him into the Medically Needy (MN) program and delay determining eligibility for the Institutional Care Program (ICP) for the months of October 2016 and ongoing. The petitioner carries the burden of proving his position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The hearing was originally scheduled for June 1st, 2017, at 1:00 p.m. All parties phoned in at the scheduled time, and counsels for both parties jointly requested a continuance. The request was granted and the hearing was rescheduled for July 11th, 2017, at 8:30 a.m.

On July 10th, 2017, the counsel for the respondent requested a continuance, and counsel for the petitioner had no objections. Therefore, the request was granted and the hearing was rescheduled as detailed above.

Appearing as a witness for the petitioner was [REDACTED], financial expert for [REDACTED] for the petitioner.

Appearing as a witness for the respondent was Kane Lamberty, Senior Human Services Program Specialist for the Policy Unit for the Department of Children and Families.

Appearing as observers for the proceeding were Teshia Green, Economic Self-Sufficiency II for the Department of Children and Families, and Brian Meola, Assistant Regional Counsel for the Central Region.

Petitioner's composite 1 was admitted into evidence.

Respondent's exhibits 1 and 2 were admitted into evidence.

The record was held open until the close of business October 6th, 2017, to allow both parties an opportunity to provide proposed final orders and closing statements if they chose to do so. Both parties provided the proposed final orders timely. In addition, to the proposed final order, the petitioner provided a closing statement, a funeral trust, and a Unity Financial Life Delaware Trust Agreement.

By way of a Notice of Case Action dated March 2nd, 2017, the respondent informed the petitioner that his application for Medically Needy dated January 31st, 2017, was approved. On April 6th, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner submitted a paper application for ICP coverage on January 31st, 2017. As part of application process, the respondent is required to explore and verify all factors of eligibility, which include but are not limited to all sources of income and assets.
2. The petitioner requests retroactive ICP coverage for the month of October 2016 through the current month.
3. The respondent issued a NOCA dated February 22nd, 2017, that requested the following information be provided by March 6th, 2017 (See Respondent's Exhibit 1):
 - “1. Please have the nursing home complete the PASSR assessment and submit the Medical Certification (form 3008) and the Informed Consent (form 2040) to DOEA CARES Unit: 2295 Victoria Avenue, Suite 153, Fort Myers, FL 33901.
 2. Please send legal property deion [*sic*] and amount of debt and who it is owed to, for the coastal income property.
 3. Please send up dated bank statement for months requesting retro coverage and bank statements for income trust for every month requesting coverage.
 4. Please send proof of gross pension reported.”
4. On March 2nd, 2017, the respondent issued a NOCA and informed the petitioner that his application for MN dated January 31st, 2017, was approved. The NOCA further informed the petitioner that he was enrolled in a monthly Share of Cost of \$1,901 for the months of January 2017 and ongoing. (See Respondent's Exhibit 1).

5. On October 31st, 2016, the petitioner converted \$100,000 to an equivalent [REDACTED]. According to [REDACTED], witness for the petitioner, the \$100,000 did not change in amount and is drawing four percent interest. The petitioner receives a monthly check for \$333.33 based on the interest that the \$100,000 draws. Both the petitioner and respondent provided, as part of their evidence, a copy of the Subscriber Certificate of Ownership Conditions. The certificate lists the conditions of ownership as follows (See Petitioner's Composite 1 and Respondent's Exhibit 2):

1. Subscription is in the face amount of \$100,000.
2. Subscription ownership is irrevocable upon issuance of this certificate.
3. Subscription ownership is unassignable upon issuance of this certificate.
4. There is no secondary market and subscriber investment is illiquid until Maturity.
5. Subscription provides a monthly income of \$333.33 from the resulting interest rate of 4% per annum.
6. Payment will be made on the 25th day of each month.
7. Payment of interest is irrevocably assigned to: [REDACTED].

6. The respondent contends that it did not have enough information to determine whether the petitioner's asset with [REDACTED] should be included or excluded as an asset in the ICP eligibility review. Therefore, the respondent did not determine ICP eligibility and instead enrolled the petitioner into the MN program. A NOCA regarding the outcome of the ICP coverage was not issued. The respondent asserts that it has reached out to [REDACTED] in attempts to resolve the outstanding issue but was unable to verify the necessary information. Evidence of a NOCA requesting clarification of the asset with [REDACTED] or any additional clarification needed was not provided.

CONCLUSIONS OF LAW

7. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

8. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. Fla. Admin. Code R. 65A-1.204 Rights and Responsibilities states in part:

(1) An individual has the right to apply for assistance, to have eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing information, documentation and verification needed to establish eligibility. If the information, documentation or verification is difficult for the individual to obtain, the Department must provide assistance in obtaining it when requested or when it appears necessary.

10. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process states in relevant part:

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification...the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later...If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension. When the applicant provides all required information or verification, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

11. As stated in the above-cited authorities, the applicant has the responsibility to provide requested information required to determination eligibility. If the applicant has difficulty obtaining the information, the respondent must provide assistance. In this instance there is no indication that the applicant (petitioner) had difficulty in obtaining the information requested by the respondent. The authorities also state that if any time during the application process the applicant must provide additional information, the respondent must provide a written notice and allow ten (10) calendar days from the date of the notice for the applicant to provide the information. As established in the Findings of Fact, the respondent requested information from the petitioner via written notice on February 22nd, 2017, which listed a due date of March 6th, 2017. A second and final NOCA was issued on March 2nd, 2016, indicating that the petitioner had been enrolled in the MN program. The respondent failed to follow its own guidelines and did not allow ten calendar days before taking action on the petitioner's case. The respondent took action after only 8 days. Furthermore, no evidence was provided to indicate that the respondent requested additional information or clarification of the [REDACTED] [REDACTED] asset in writing and provided the petitioner with a ten day time limit to return the information. According to the respondent's testimony, there were still unanswered questions regarding the asset at the time of hearing.

12. The Code of Federal Regulations appearing in 42 C.F.R. Section 435.917 Notice of agency's decision concerning eligibility, benefits, or services states in part:

(a) *Notice of eligibility determinations.* Consistent with §§431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or

suspension of eligibility, or a denial or change in benefits and services. Such notice must—

(1) Be written in plain language;

(2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with §435.905(b), and

(3) If provided in electronic format, comply with §435.918(b).

(b) *Content of eligibility notice—(1) Notice of approved eligibility.* Any notice of an approval of Medicaid eligibility must include, but is not limited to, clear statements containing the following information—

(i) The basis and effective date of eligibility;

(ii) The circumstances under which the individual must report, and procedures for reporting, any changes that may affect the individual's eligibility;

(iii) If applicable, the amount of medical expenses which must be incurred to establish eligibility in accordance with §435.121 or §435.831.

(iv) Basic information on the level of benefits and services available based on the individual's eligibility, including, if applicable—

(A) The differences in coverage available to individuals enrolled in benchmark or benchmark-equivalent coverage or in an Alternative Benefits Plan and coverage available to individuals described in §440.315 of this chapter (relating to exemptions from mandatory enrollment in benchmark or benchmark-equivalent coverage);

(B) A description of any premiums and cost sharing required under Part 447 Subpart A of this chapter;

(C) An explanation of how to receive additional detailed information on benefits and financial responsibilities; and

(D) An explanation of any right to appeal the eligibility status or level of benefits and services approved.

(2) Notice of adverse action including denial, termination or suspension of eligibility or change in benefits or services. Any notice of denial, termination or suspension of Medicaid eligibility or change in benefits or services must be consistent with §431.210 of this chapter.

13. Fla. Admin. Code R. 65A-1.710 SSI-Related Medicaid Coverage Groups states in relevant part:

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. **The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.** *[Emphasis added.]*

14. As stated in the above-stated authorities, the respondent must provide a notice indicating whether or the petitioner's application was approved or denied. The notice must also contain appeal rights among other pertinent information. The Findings of Fact show that the respondent issued a NOCA informing the petitioner that he was enrolled in the MN program. However, the respondent did not provide the petitioner with a notice explaining the outcome of his ICP application as required by the above-stated requirement. In addition, the respondent failed to provide the petitioner with appeal rights pertaining to the ICP application. The above-cited authorities also state that the MN program does not cover nursing facility care or other long-term care services. The evidence shows that the respondent felt it was appropriate to authorize MN coverage since it was unable to determine how to calculate the asset from [REDACTED]

15. In conclusion, the hearing officer cannot make a determination on whether or not the respondent erred in its ICP eligibility determination since eligibility has yet to be determined. No evidence was provided to indicate that the respondent either authorized

or denied the ICP coverage requested by the petitioner. The respondent failed to follow guidelines and did not wait the required ten days when requesting information, did not request additional information or clarification in writing, did not allow the petitioner ample time to provide the additional information, and did not issue the appropriate NOCA with a determination of benefits for the correct program including appeal rights. The respondent chose to place the petitioner into a MN program which he did not request and for which his services will likely not be covered according to the regulations. The placement of the petitioner into MN was not appropriate. The hearing officer does not affirm the respondent's action to enroll the petitioner into MN and fail to issue the proper documentation regarding the outcome of the January 31st, 2017, ICP application. Within ten (10) days of the date of this notice, the respondent must make a determination on the petitioner's ICP application and issue a NOCA that lists the whether the ICP coverage was authorized or denied. The NOCA must also afford the petitioner new appeal rights.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the appeal is granted to the extent described above. This decision is not a guarantee of eligibility. Rather, the respondent is ordered to take corrective action in the appeal as described above.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the

FINAL ORDER (Cont.)

17F-03063

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appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 19 day of October, 2017,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency
Stephanie Camfield, Esq.

Sep 18, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-03257

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88222

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 10:38 a.m. on July 14, 2017.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:
Economic

Stan Jones, ACCESS
Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Home and Community Based Services (HCBS) Medicaid Waiver for March 2017, April 2017 and May 2017, is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on May 10, 2017. On April 24, 2017, the petitioner's AR requested the hearing be rescheduled for June 21, 2017. On June 21, 2017, both parties appeared and agreed to reschedule the hearing, due to missing documents from the AR. The hearing was rescheduled for July 14, 2017.

The petitioner was not present at the hearing. The petitioner's AR did not submit exhibits. The respondent's representative submitted nine exhibits, entered as Respondent Exhibits "1" through "9". The record remained open through end of business day on July 14, 2017, for the respondent's representative to submit additional exhibits. The exhibits were received timely and entered as Respondent Exhibits "10" and "11". The record was closed on July 14, 2017.

FINDINGS OF FACT

1. The petitioner resides at Somerset Assisted Living Facility.
2. On January 13, 2017, the petitioner's daughter completed an HCBS Medicaid Renewal Letter for the petitioner. Which was faxed to the Department on January 18, 2017 from Humana American Elder Care (Respondent Exhibit 3).
3. The Renewal letter lists the petitioner's daughter mailing address, [REDACTED] as the current address. And lists \$1,272 Social Security (SS), \$361.65 pension and \$1,153 Veterans Affairs (VA) benefits as the petitioner's income.
4. The Social Security Administration (SSA) State On-Line Query lists \$1,276 SS for the petitioner (Respondent Exhibit 5, page 22)
5. The petitioner's daughter submitted verification of the petitioner's \$1,153 VA and \$361.65 (\$4,339.80 yearly divided by 12 months) pension income (Respondent

Exhibit 6).

6. The following is the Department's calculation of the petitioner's monthly income:

\$1,276.00	SS
+\$1,153.00	VA
<u>+\$ 361.65</u>	<u>pension</u>
\$2,790.65	Total

7. The HCBS income limit for an individual is \$2,205. The petitioner's \$2,790.65 income is over the HCBS income limit.

8. On February 17, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) notifying her Medicaid benefits would end on February 28, 2017, due to unearned income increased (Respondent Exhibit 4, page 17).

9. The AR asserts that Department only notified Humana American Elder Care that the petitioner's Medicaid would be ending on February 2017. And the petitioner nor her daughter were aware that the petitioner's Medicaid would end on February 2017.

10. The respondent's representative responded that a NOCA, dated February 17, 2017, was also mailed to the petitioner at her daughter's address listed on the Renewal Letter (Respondent Exhibit 11).

11. The AR asserts that the \$1,153.00 VA is incorrect, because it includes Aid & Attendance income.

12. The day of the hearing (July 14, 2017), the AR faxed the Department a letter from the VA, listing \$432 as Aid & Attendance and basic pension of \$721 (Respondent Exhibit 9).

13. The respondent's representative said that the decrease in VA income would still make the petitioner over the \$2,205 income limit. The following is the petitioner's income with the VA decrease:

\$1,276.00	SS
+\$ 721.00	VA
+\$ 361.65	pension
<u>\$2,358.65</u>	Total

14. The AR alleges that the petitioner's daughter was never informed by the Department that an Income Trust was required to be eligible for HCBS.

15. The respondent's representative stated that an Irrevocable Income Trust for the petitioner was established on February 26, 2017 (Respondent Exhibit 10). However, it was not funded until May 30, 2017 (Respondent Exhibit 10, page 11).

16. The respondent's representative said since the Income Trust was funded on May 30, 2017, the petitioner is eligible for HCBS effective June 2017.

17. The AR disagrees that the petitioner is only eligible effective June 2017.

CONCLUSIONS OF LAW

18. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

19. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

20. *Florida Administrative Code* R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, in part states:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...

(e) For HCBS, gross income cannot exceed 300 percent of the SSI federal benefit rate...

(2)(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. § 1396...

(b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:
1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month...

21. A qualified income trust is a legal document that meets criteria in 42 U.S.C. §1396

(p)(d), which in part states "(B) A trust established in a State for the benefit of an individual if—(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust) ..."

22. In accordance with the above authorities, for the petitioner to be eligible for HCBS, her monthly income cannot exceed 300 percent of the SSI federal benefit rate. And an income trust may be established for those that exceed the income standard.

23. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-10 (January 2017) sets the federal benefit rate for an individual at \$735.

24. Policy Manual, Appendix A-9 (January 2017), sets \$2,205 as the HCBS income standard for an individual (300% of \$735 = \$2,205).

25. The evidence submitted establishes that the petitioner's income trust was not funded until May 30, 2017. Therefore, the petitioner was over the \$2,205 HCBS income limit until June 2017.

26. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The undersigned concludes the respondent's action to deny the petitioner HCBS Medicaid Waiver for March 2017, April 2017 and May 2017, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 18 day of September, 2017,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 18, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03258

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 Lake
UNIT: 88999

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:25 a.m. on October 4, 2017.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:
Economic

Stan Jones, ACCESS
Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to terminate the petitioner's Home and Community Based Services (HCBS) Medicaid Waiver, is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on May 12, 2017. On April 24, 2017, the petitioner's AR requested the hearing be rescheduled to June 21, 2017. The petitioner's AR's request was granted and the hearing was rescheduled for June 21, 2017. On June 21, 2017, both parties appeared and requested a continuance. The request was granted and the hearing was rescheduled for July 17, 2017. On July 17, 2017, both parties appeared and again requested a continuance, due to missing documents from the petitioner's AR. The request was granted and the hearing was rescheduled for August 18, 2017. On August 18, 2017, the respondent's representative and the undersigned appeared and waited 15 minutes for the petitioner's AR; the petitioner's AR did not appear. On August 22, 2017, the petitioner's AR requested the hearing be rescheduled, "Due to unforeseen circumstances with another resident." The request was granted and the hearing was rescheduled for September 8, 2017. On September 6, 2017, the undersigned notified both parties the September 8, 2017 hearing was cancelled and rescheduled for September 22, 2017, due to Hurricane Irma. On September 22, 2017, the respondent's representative and the undersigned appeared and waited 15 minutes for the petitioner's AR; the petitioner's AR did not appear. On September 26, 2017, the petitioner's AR requested the hearing be rescheduled, "due to an emergency" with another resident. The request was granted and the hearing was rescheduled for October 4, 2017.

The petitioner was not present at the hearing. The petitioner's AR submitted two exhibits, entered as Petitioner Exhibits "1" and "2". The respondent's representative

submitted four exhibits, entered as Respondent Exhibits "1" through "4". The record was closed on October 4, 2017.

FINDINGS OF FACT

1. The petitioner is a resident at Somerset Assisted Living Facility (Facility).
2. On January 19, 2017, the petitioner's HCBS Medicaid Waiver recertification application was faxed to the Department (Respondent Exhibit 1).
3. On January 23, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) (Respondent Exhibit 2). The NOCA states in part:

We need the following information by February 2, 2017...
We need the following to process your recertification: We need a current statement from your [REDACTED] accounts [REDACTED]...If you need help getting this information, let us know right away.

4. The Department did not receive the petitioner's requested bank statements. And on February 21, 2017, the Department mailed the petitioner a NOCA (Respondent Exhibit 2, page 9), notifying her Medicaid benefits would end on March 31, 2017, "Reason: We did not receive all the information requested to determine eligibility."
5. The petitioner's AR did not dispute that the petitioner's bank statements were not submitted to the Department by the required February 2, 2017 date.
6. On June 20, 2017, the petitioner's AR emailed the Department the petitioner's bank statements. The bank statements are in the petitioner's name and the petitioner's daughter's name (Petitioner Exhibit 1). The bank statements list:

[REDACTED]	[REDACTED]	[REDACTED]
2/8/17 – 3-7/17	\$222.93	\$11,704.81
3/8/17 – 4/7/17	\$235.94	\$14,368.01
4/8/17 – 5/5/17	\$246.94	\$16,917.18
5/6/17 – 6/7/17	\$267.94	\$19,368.24

7. Also included with the bank statements is a "CHECKING/SAVINGS ACCOUNT HISTORY" for [REDACTED] balance on June 12, 2017 and a [REDACTED]".
8. The asset limit for an individual to be eligible for HCBS Medicaid Waiver is \$2,000 (Respondent Exhibit 3).
9. The petitioner's bank account [REDACTED] is over the \$2,000 asset limit. Therefore, the petitioner is not eligible for HCBS Medicaid Waiver.
10. The petitioner's AR stated that in January 2017 or February 2017 the petitioner received "back pay" from the Veteran's Administration (VA), which is the reason for the petitioner's high bank balance.
11. The petitioner's AR claims the money the petitioner received from the VA was to pay the Facility for "back rent".
12. The petitioner's AR alleges that the Facility wrote checks to the Facility from the petitioner's checking account (date(s) were not given); however, the petitioner nor the petitioner's daughter signed the checks. The petitioner's AR said that the checks were not signed because the petitioner was in and out of the hospital between January 2017 and March 2017 and the petitioner's daughter was in Mexico.
13. The petitioner's AR asserts that the above mentioned checks (#12) were converted to seven cashier's checks on June 20, 2017, totaling \$18,550. Which is the \$18,550 bank check or draft "pending" listed in the above "CHECKING/SAVINGS ACCOUNT HISTORY" (#7).
14. The cashier's checks are made out to Jest Operating (Petitioner Exhibit 2). Jest Operating operates under the Somerset Assisted Living Facility name.

15. The respondent's representative stated that the petitioner met the HCBS Medicaid Waiver asset limit on June 20, 2017, when the cashier's checks were created (\$19,358.21 - \$18,500 = \$808.21).

16. The respondent's representative agreed to approve the petitioner HCBS Medicaid Waiver effective June 20, 2017; and mail the petitioner a NOCA authorizing HCBS Medicaid Waiver.

17. The petitioner's AR asserts that the petitioner is eligible for HCBS Medicaid Waiver effective April 2017, because the \$18,550 in the petitioner's bank account did not belong to the petitioner; it is money that belonged to the Facility for "back rent".

18. The respondent's representative stated that the \$18,550 was in the petitioner's bank account until June 20, 2017. Therefore, the petitioner had access to the money and is over the \$2,000 asset limit until June 20, 2017.

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

20. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

21. *Florida Administrative Code* R. 65A-1.712, "SSI-Related Medicaid Resource Eligibility Criteria", in part states:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is

the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions...

(f) For the Home and Community Based Services (HCBS) Waiver Program, an individual cannot have countable resources that exceed \$2,000. If the individual's income falls within the MEDS-AD Demonstration Waiver limit, the individual can have resources up to \$5,000...

22. *Florida Administrative Code R. 65A-1.716, "Income and Resource Criteria"*, in part states, "(5) SSI-Related Program Standards. (a) SSI (42 U.S.C. §§1382 – 1383c) resource Limits: 1. \$2000 per individual..."

23. The above authorities explain the HCBS Medicaid Waiver asset limit for an individual is \$2,000.

24. The evidence submitted establishes that the petitioner was over the \$2,000 asset limit until June 20, 2017.

25. The petitioner's AR argued that the petitioner was under the \$2,000 asset limit, because the \$18,550 in the petitioner's bank account did not belong to the petitioner; it is money that belonged to the Facility for "back rent".

26. *Florida Administrative Code R. 65A-1.303, "Assets"*, in part states:

(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset. (emphasis added)

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. **Assets are considered available to an individual when the individual has unrestricted access to it.** (emphasis added)

27. In accordance with the above authority, all of the money in the petitioner's bank account is counted as an asset towards the petitioner, regardless of the purpose of the money.

28. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The undersigned concludes the respondent's action to terminate the petitioner's HCBS Medicaid Waiver, effective March 31, 2017, is proper.

29. The undersigned also concludes that the petitioner is eligible for HCBS Medicaid Waiver, effective June 20, 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 18 day of October, 2017,

in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 10, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-03683

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 CHARLOTTE
UNIT: 88287

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter October 5th, 2017, at 1:23 p.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se.

For the Respondent: Teshia Green, Senior Worker for the Economic Self-Sufficiency Program.

STATEMENT OF ISSUE

The petitioner is appealing the issue of a medical bill dated February 23rd, 2017, not being considered as meeting her Share of Cost (SOC). On the record, the undersigned the burden of proof to the respondent. However, after further review, the undersigned has determined that the burden belongs to the petitioner. The petitioner must meet her burden by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled for June 29th, 2017, at 1:00 p.m. The hearing officer and the respondent phoned in as scheduled, but the petitioner did not. After the hearing, the petitioner called the Office of Appeal Hearings and explained that she misunderstood the hearing instructions and did not realize that she was supposed to phone in, and requested a reschedule. The hearing was rescheduled for August 14th, 2017, at 11:30 a.m.

On August 14th, 2017, all parties phoned in as scheduled, and the petitioner and the respondent held a brief pre-hearing conference. The petitioner requested a continuance to allow the respondent time to continue to work on her case, and the respondent did not object. Therefore, the hearing was rescheduled for September 14th, 2017, at 11:30 a.m.

On September 14th, 2017, a representative from the Office of Appeal Hearings and the petitioner phoned in as scheduled. However, the hearing officer was unavailable due to a natural disaster. Therefore, the petitioner was advised that the hearing would be rescheduled. The hearing was rescheduled as detailed above.

The petitioner did not provide any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 7 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated April 13th, 2017, the respondent informed the petitioner of the following, "The individual(s) listed below have met their Medically Needy (MN) share of cost (SOC) and are eligible for Medicaid for the

following periods: February 25th, 2017, through February 28th, 2017.” On May 8th, 2017, the petitioner filed a timely request to challenge the respondent’s action.

FINDINGS OF FACT

1. The petitioner has a SOC of \$1,331 that must be met each month before Medicaid can be opened.
2. The petitioner submitted two bills for bill tracking on April 13th, 2017. One bill referenced a date of service on February 23rd, 2017, from [REDACTED] in the amount of \$250. The other bill listed a range of dates from February 25th, 2017, through March 4th, 2017, from [REDACTED] in the amount of \$1,575. (See Respondent’s Exhibit 4).
3. The respondent asserts that both bills were reviewed and tracked. However, the petitioner’s SOC was not met until February 25th, 2017. The bill dated February 23rd, 2017, was not enough to meet the SOC, leaving an outstanding amount of \$1,081. According to the respondent, the Medicaid was authorized from February 25th, 2017, through February 28th, 2017. (See Respondent’s Exhibits 3 and 5).
4. The petitioner asserts that she does not have any additional paid or unpaid medical bills from the month of February 2017. Furthermore, the petitioner testified that she is making three \$10 monthly payments on outstanding medical bills from 2016, but other than that does not have any additional medical expenses.
5. The petitioner contends that she understands how SOC works but feels that it is unfair that the respondent is unwilling to cover the medical expense dated February 23rd, 2017.

CONCLUSIONS OF LAW

6. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

7. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

8. Fla. Admin. Code 65A-1.701 Definitions explains SOC and states in relevant part:

(30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

9. Fla. Admin. Code 65A-1.702 Special Provisions explains when an individual becomes Medicaid eligible and states in relevant part:

(b) Individuals applying for the Medically Needy program become eligible on the date they incurred allowable medical expenses, excluding payments by all third party sources except state or local governments not funded in full by federal funds, equal their share of cost, provided that all other conditions of eligibility are met.

[Emphasis added.] Any bill used in full to meet the individual's share of cost (SOC) shall not be paid by Medicaid.

10. As stated in the above-cited guidelines, an individual enrolled in the MN program does not become Medicaid eligible until the day the SOC is met. As established in the Findings of Fact, the petitioner provided two medical bills. The first bill was dated February 23rd, 2017, in the amount of \$250. The second bill was dated February 25th, 2017, in the amount of \$1,575. According to the petitioner's testimony, these bills are

the only outstanding medical expenses that are not covered by a payment plan. The petitioner had a SOC of \$1,331 in the month of February 2017. Therefore, the medical expense in the amount of \$250 would not have met the SOC, and Medicaid would not have been able to be authorized. The respondent was correct to approve Medicaid from February 25th, 2017 through February 28th, 2017.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 10 day of October, 2017,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 26, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-03742

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 04 Duval
UNIT: 88882

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 1, 2017 at 10:21 a.m.

APPEARANCES

For the Petitioner: [REDACTED].

For the Respondent: Roger Williams, Attorney for the Department of Children and Families (DCF).

ISSUE

At issue is the respondent's action on May 3, 2017 to deny the petitioner's application for Institutional Care Program (ICP) Medicaid on its contention that the petitioner failed to provide verifications necessary to determine eligibility.

The petitioner held the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene on June 22, 2017 at 2:00 p.m.

On June 6, 2017, the petitioner's representative requested a continuance due to a calendar conflict. The Department's representative did not object. The hearing was rescheduled to August 1, 2017 at 10:15 a.m.

Appearing as witnesses for the petitioner were [REDACTED] petitioner's spouse, [REDACTED]

[REDACTED].

Evidence was submitted and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on August 11, 2017 to allow the petitioner and the respondent to submit additional evidence.

The petitioner provided additional evidence on August 9, 2017 and the Department provided additional evidence on August 10, 2017.

The petitioner's representative provided a written response on August 15, 2017 after reviewing the respondent's supplemental evidence. The petitioner's representative pointed out that page 20 was missing from the respondent's supplemental evidence.

The respondent provided a response to the petitioner's statement and explained that page 20 was missing from the 60 page fax that was sent by the petitioner to the Department. The respondent further explained that all of the faxes sent to the Department are scanned into its document scanning system and is received by date and time. The respondent also explained that Department staff do not have the

capability to remove pages from the documents that are faxed and scanned into its document imaging system. The respondent pointed out that pages 3-58 through 3-60 were included in the documents that the petitioner faxed to the Department on April 24, 2017. However, the documents that were included in the petitioner's evidence to show what was faxed to the Department on April 24, 2017, did not include those same pages.

The undersigned did not receive an additional response from the petitioner's representative regarding the Department's written explanation.

The supplemental evidence was received and entered as the Petitioner's Exhibit 2 and the Respondent's Exhibit 3.

The undersigned extended the deadline to allow additional time for both parties to respond to the other party's supplemental evidence. Therefore, the record was closed at 5:00 p.m. on August 17, 2017.

FINDINGS OF FACT

1. On March 30, 2017, the petitioner's representative filed an application for ICP Medicaid on the petitioner's behalf. The petitioner is 91 years of age and has been residing at the [REDACTED]. The petitioner's husband is the community spouse. The petitioner indicated on the application that she is married; however, the petitioner's spouse and his information, such as his date of birth and Social Security number, were not included on the application (*Respondent's Exhibit 2, pages 4 through 9*).

2. The Department mailed to the petitioner's representative, the Notice of Case Action to inform of the requested verifications necessary to determine eligibility for the

ICP Medicaid. The Department contends that its records show that it requested from the petitioner the level of care, nursing home placement date, spouse's Social Security Number and date of birth, last three months' of bank statements, current face and cash values for life insurance policies, property ownership and transfers, financial release for petitioner, Florida identification for the petitioner, Medicare card, and Social Security card (*Respondent's Exhibit 2, pages 10 through 11*). The Running Records Comments (CLRC) also includes notes that states: "Note: Living trust document, proof of all other deposits and origin, bank statements from admit month through 12/16 also required."

3. The Petitioner's Exhibit 1, page 1, includes the Notice of Case Action (Notice), dated April 14, 2017, requesting verifications due by April 24, 2017. The fax number notated on the upper left-hand corner of the Notice was 866-619-5720. The Notice requested the following:

Please Complete and sign the "Financial Information Release" form...
Please send Forms 3008 & 2040 to Dept of Elder Affairs-CARES (Level of Care required-see NH rep). Please provide nursing home placement date, bc/bs premium, last three months statements for all bank accounts owned, life ins current face & cash value for all policies. Spouse's ssn & dob, proof of all property owned and transferred, Power of Attorney if applicable, financial release signed by [REDACTED] or medical incapacity statement is required. Thanks

4. The Department explained that not all of the requested verifications, including the information for the petitioner's spouse, were provided. The Department explained that the petitioner's demographic information was the only information included in its system. The Department explained that the petitioner's spouse's name, date of birth, and Social Security number were not included in its system (*Respondent's Exhibit 2,*

page 14). Therefore, On May 3, 2017, the Department issued to the petitioner the Notice of Case Action to deny the petitioner's application for ICP Medicaid.

5. The petitioner's representative contends that the petitioner is seeking retroactive Medicaid for the months of October 2016 to February 2017. The petitioner's representative believes that pages 35 through 90 included in the Petitioner's Exhibit 1, were faxed to the Department on April 24, 2017; some of the pages were out of numerical order. Page 35 of the exhibit includes a letter from the Edwards Law Firm dated April 24, 2017, which states:

To Whom It May Concern, Please see as follows the documentations requested in order:

Nursing home Placement date

BC/BS Premium

Last Three Statements for all bank accounts owned

Life Insurance current face value and cash value for all policies

Spouse's SSN and DOB

Proof of all property owned and transferred

Power of Attorney

Financial Information Release

Appointment of a Designated Representative

AHCA DOEA Informed Consent Form

6. The Petitioner's Exhibit 1 page 36 includes the Notification of Level of Care. The exhibit's page 37 includes the 2016 rate information for the Blue Cross Blue Shield service benefit plan. The Petitioner's Exhibit 1 also includes one page of the [REDACTED] joint bank statement dated January 25, 2017 (*page 38*); one page of the [REDACTED] joint bank statement dated February 25, 2017 (*page 39*); one page of the [REDACTED] joint bank account dated March 25, 2017 (*page 40*); [REDACTED] bank statement for spouse's account, dated January 31, 2017 (*pages 41 through 43*); [REDACTED] bank statement for spouse's

account, dated February 28, 2017 (*pages 44 through 46*); [REDACTED] bank statement for spouse's account, dated March 31, 2017 (*pages 47 through 49*); statement for the Auto Owner's whole life insurance policy (*page 50*); letter dated April 24, 2017 concerning the [REDACTED] Living Trust for the petitioner set up on April 2, 2009 (*page 51*); petitioner's and spouse's identification cards, their Medicare cards, their Blue Cross and Blue Shield Cards, and their Social Security cards (*page 52*); real estate property records from [REDACTED] (*page 53*); Warranty Deed for the homestead property (*pages 54 through 55*); Power of Attorney (*pages 56 through 86*); receipt in the amount of \$16500 for room and board (*page 87*); financial release signed and dated by spouse on April 24, 2017 (*page 88*); appointment of a designated representative form signed and dated by spouse on April 24, 2017 (*page 89*); and Informed Consent Form signed and dated by spouse on April 24, 2017 (*page 90*). The petitioner's representative was not sure of the fax number where the documents were faxed. The petitioner's representative was to provide, post-hearing, the document showing which number was used to send the fax to the Department.

7. The Department contends that some information was provided on April 24, 2017. The Department contends that proof of the petitioner's spouse's assets, date of birth and Social Security number, were not provided. The Respondent's Exhibit 3 includes the Document Imaging System screen which shows the date verifications were received and scanned into the petitioner's case. On April 24, 2017, the Department's records show that verifications that consisted of 15 pages (Asset Verifications) were scanned in at 4:20 p.m.; three pages (Expense Verifications) were scanned in at 4:20

p.m.; two pages (Medical Documents) were scanned in at 4:20 p.m.; 33 pages (Legal/Court Records) were scanned in at 4:20 p.m.; one page (Medical Records) were scanned in at 4:20 p.m.; two pages (Notices) were scanned in at 4:20 p.m.; two pages (Cover Sheet) were scanned in at 4:20 p.m.; one page (Driver's License/Identification) was scanned in at 4:20 p.m.; and one page (Social Security Number documentation) was scanned in at 4:20 p.m. for a total of 60 pages.

8. The Respondent's Exhibit 3 includes the pages of the fax that was received on April 24, 2017 at 4:20 p.m. Page 3-3 includes the cover sheet dated April 24, 2017 from the [REDACTED]. The cover sheet shows that the documents were being faxed to phone number 866-619-5720 and included a total of 59 pages.

9. The Respondent's Exhibit 3, page 3-4, includes the letter dated April 24, 2017 from the [REDACTED]. The letter lists the documentation included in its fax (**page 35 of the petitioner's documents**); pages 3-5 through 3-6 is the Notice of Case Action dated April 14, 2017 (**not included in the petitioner's documents pages 35 through 90**). Page 3-7 is the Level of Care (**page 36 in the petitioner's documents**); page 3-8 is the 2016 Rate Information for the Blue Cross and Blue Shield Service Benefit Plan (**page 37 in the petitioner's documents**); pages 3-9 through 3-11 are the joint bank statements from [REDACTED] dated January 25, 2017, February 25, 2017, and March 25, 2017 (**pages 38 through 40 in the petitioner's documents**); pages 3-12 through 3-14 is the spouse's bank statement from [REDACTED], dated January 31, 2017 (**pages 41 through 43 in the petitioner's documents**); pages 3-15 through 3-17 is the spouse's bank statement from [REDACTED] dated February 28, 2017 (**pages 44 through 46 in the**

petitioner's documents); pages 3-18 through pages 3-20 includes the spouse's bank statement from [REDACTED] dated March 31, 2017 (***pages 47 through 49 in the petitioner's documents***); page 3-21 includes a letter dated April 24, 2017 concerning the Kennedy Living Trust for the petitioner set up on April 2, 2009 (***page 51 of the petitioner's documents***); page 3-22 is the real estate property records from [REDACTED] [REDACTED] (***pages 53 of the petitioner's documents***); page 3-23 (and the unnumbered page after) includes the Warranty Deed for the homestead property (***pages 54 through 55 of the petitioner's documents***); page 3-24, an unnumbered page, and pages 3-25 through 3-53, includes the Power of Attorney (***pages 56 through 86 of the petitioner's documents***); page 3-54 includes a copy of a receipt in the amount of \$16500 for room and board (***page 87 of the petitioner's documents***); page 3-55 includes the financial release signed and dated by spouse on April 24, 2017 (***page 88 of the petitioner's documents***); page 3-56 includes the appointment of a designated representative form signed and dated by spouse on April 24, 2017 (***page 89 of the petitioner's documents***); page 3-57 includes the Informed Consent Form signed and dated by spouse on April 24, 2017 (***page 90 of the petitioner's documents***); page 3-58 includes an illegible copy of a photo identification card (***not included in the petitioner's documents pages 35 through 90***); page 3-59 includes the Medicare Health Insurance card for the petitioner (***not included in the petitioner's documents pages 35 through 90***); and page 3-60 includes a copy of the petitioner's Social Security card (***not included in the petitioner's documents pages 35-90***). The

pages 50 and 52 from the petitioner's faxed documents, sent on April 24, 2017, are not included in the documents that are a part of the Respondent's Exhibit 3.

10. The Petitioner's Exhibit 2 includes the same information included in pages 35 through 90, with the exception of the cover sheet and the Notice of Case Action dated April 14, 2017.

11. The Department contends that she sent an email to [REDACTED] on May 25, 2017 to inform her that all of the requested verifications were not received, and that the verifications would need to be returned by May 30, 2017 in order for it to reuse the application dated March 30, 2017. The Respondent's Exhibit 3 page 3-61 includes the email sent to the petitioner on May 25, 2017.

12. The petitioner's representative contends that information was also faxed to the Department on May 30, 2017. The Petitioner's Exhibit 2 includes a transmittal report on a 142 page fax sent on May 30, 2017 at 16:06. The spaces next to the destination telephone number and the destination identification are blank. The exhibit also includes the Activity Report, which shows that there were four faxes sent on May 30, 2017. One fax was sent to phone number [REDACTED] at 7:36, 8:20, and 11:55. Another fax of 142 pages was sent to an unknown destination at 16:06.

13. The Department acknowledges that additional information was provided on June 1, 2017 but the information provided was insufficient to approve the petitioner's application for ICP Medicaid. The Department contends that on June 2, 2017, the caseworker communicated with Ms. Neeck and informed her on what was required to approve the petitioner's for ICP Medicaid. The Department contends that [REDACTED]

was informed at that time that a new application would need to be submitted. The Department contends that one week prior to the hearing, ██████████ requested additional information on retroactive policy, as she wanted ICP Medicaid coverage from the date the petitioner went into the nursing home in October 2016. The Department explained the its retroactive policy allows the three months' prior to the application completed on March 30, 2017, which would cover the months of December 2016, January 2017, and February 2017.

14. The petitioner's witness acknowledges speaking with the Department and being informed that the petitioner would need to reapply for ICP Medicaid. The petitioner's witness believes that the Department informed her one week before the hearing that the policy regarding retroactive months of coverage would be applied to the new application when it was filed.

15. It is the Department's contention that the retroactive months of coverage may be applied to any application on file. The Department contends that its records show that the only application on file is the one dated March 30, 2017.

CONCLUSIONS OF LAW

16. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

17. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. The Fla. Admin. Code R. 65-2.060 (1), informs: “The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue...” Because of state rule and federal regulations, the petitioner holds the burden of proof by a preponderance of the evidence.

19. The Fla. Admin. Code R. 65A-1.203(9) defines representative: “Authorized/Designated Representative: An individual who has knowledge of the assistance group’s circumstances and is authorized to act responsibly on their behalf.”

20. The Fla. Admin. Code R. 65A-1.204, Rights and Responsibilities, sets forth:

(1) An individual has the right to apply for assistance, to have eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing information, documentation and verification needed to establish eligibility.

21. The Fla. Admin. Code R. 65A-1.302 Social Security Numbers states:

(1) To be eligible for public assistance, the individual must either provide the social security number (SSN) when known for each person whose needs are included in the assistance group or SFU or, apply for a SSN for each individual who either does not have a number assigned or whose number is unknown. The client’s verbal statement is sufficient to verify this information.

22. The Fla. Admin. Code R. 65A-1.710 SSI-Related Medicaid Coverage Groups states:

(2) Institutional Care Program (ICP). A coverage group for institutionalized aged, blind or disabled individuals (or couples) who would be eligible for cash assistance except for their institutional status and income as provided in 42 C.F.R. §§435.211 and 435.236. Institutional benefits include institutional provider payment or payment of Medicare coinsurance for skilled nursing facility care.

23. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, states in relevant part:

(a) When an institutionalized applicant has a community spouse all countable resources owned solely or jointly by the husband and wife are considered in determining eligibility.

24. The above authority explains resource eligibility for ICP when a married couple is involved. All resources owned solely or jointly are considered in determining eligibility. In this case, the petitioner is institutionalized and has a community spouse. Therefore, the undersigned concludes that the Department was correct to require from the petitioner her spouse's demographic information, including his assets, in order to determine her eligibility for the ICP Medicaid program.

25. The Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process states as follows:

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility.

...

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information...the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an

additional extension The eligibility specialist makes the decision of whether to grant the request for extension. When the applicant provides all required information or verification, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

26. The Department's Program Policy Manual, CFOP 165-22, passage

0640.0400 APPLICATION TIME STANDARDS (MSSI, SFP) states:

The time standard begins upon receipt of a signed application. Process applications as soon as possible after the assistance group (AG) completes all eligibility requirements. If the household completes all requirements and provides all information, process the application by the 30th day after the application date.

27. The Department's Program Policy Manual, CFOP 165-22, passage

0640.0401 Requests for Additional Information/Time Standards (MSSI, SFP) states:

If the Department needs additional information or verification from the applicant, provide:

1. a written list of items required in order to complete the application process,
2. the date the items are due in order to process the application timely, and
3. the consequences for not returning additional information by the due date.

The verification/information due date is 10 calendar days after the date of the interview or if there is no interview requirement, 10 days after the date the pending notice is generated. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next business day. At the individual's request, extend the due date. Leave the case pending until the 30th day after the date of application to allow the household a chance to provide verifications. Assist applicants with getting missing verifications when needed.

1. If the applicant completes the interview, provides all verifications, and meets all eligibility factors, approve the application by the 30th day for Medicaid. If the 30th day falls on a weekend or holiday, approve the application on the business day before the 30th day.

2. If the household does not return the verifications by the 30th day after the date of application, deny the application on the 30th day. If the 30th day falls on a weekend or holiday, deny the application on the next business day after the 30th day.

3. If the household returns the verifications after the 30th day but by the 60th day, approve the application as soon as possible following receipt of the verifications as long as disposal occurs by the 60th day. Do not require a new application.

28. The above authorities explain the application process and time standards.

The Department has 30 days to process an application. The Department is to provide a written request for verifications and allow 10 days. The Department is to deny the application if verifications are not provided. The individual does not need to reapply if all of the requested verifications are provided after the 30th day but by the 60th day. The Department may reuse the original application if all verifications are provided by the 60th day of the original application. In this case, the findings show that the Department provided written notice to the petitioner's representative to request verifications necessary to determine eligibility for the ICP Medicaid program. The findings also show that the petitioner faxed verifications to the Department after the denial action. The petitioner believes all verifications were faxed to the Department on May 30, 2017 (60th day). However, the fax transmittal sheet submitted by the petitioner does not show a fax number where the fax was sent on May 30, 2017. Therefore, undersigned cannot conclude that the petitioner provided all of the necessary verifications by the 60th day (May 30, 2017) of the original application dated March 30, 2017. Therefore, the undersigned concludes that the Department was correct to require a new application, as

all required verifications were not provided by the 60th day in order to reuse the original application of March 30, 2017.

29. The Fla. Admin. Code R. 65A-1.702 Special Provisions states:

(9)(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services...

30. The above authority explains that an individual may be eligible for Medicaid for the three months prior to the date of his or her application. In this case, the petitioner applied for ICP Medicaid on March 30, 2017. Therefore, the undersigned concludes that the petitioner may potentially be eligible for retroactive Medicaid for the months of December 2016, January 2017, and February 2017.

31. The findings show that the petitioner's said documents that were faxed to the Department on April 24, 2017 do not match the documents shown in the Department's business records as being faxed and scanned to her case on April 24, 2017. The findings show that the petitioner's documents that were faxed to the Department and scanned into the petitioner's case on April 24, 2017 included a one page document for a driver's license and a one page document for a Social Security card, which is consistent with the one page document that shows the illegible copy of a photo identification card and the one page document that shows a copy of the petitioner's Social Security card.

32. Based on the above authorities and findings of fact, the undersigned concludes that the petitioner did not meet her burden of proof that the respondent's action to deny her March 30, 2017 application for ICP Medicaid was incorrect. The

undersigned concludes that the Department was correct in its denial of the petitioner's application for ICP Medicaid, dated March 30, 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 26 day of September, 2017,

in Tallahassee, Florida.



Paula Ali
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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FINAL ORDER (Cont.)

17F-03742

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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
David Tucker

FILED

Oct 02, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-03979

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 10 Polk
UNIT: 88582

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 7, 2017 at 10:00 a.m. in , Florida.

APPEARANCES

For Petitioner: 

For Respondent: Marsha Shearer, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's request for retroactive Qualifying Individual 1 (QI1) benefits for the months of January 2017 through March 2017 is correct. At the hearing, no burden of proof was assigned to either party; however, subsequent to the hearing, it was determined the petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

██████████ (“petitioner”) was present and testified. The petitioner did not submit any exhibits at the hearing. The respondent was represented by Marsha Shearer, Economic Self Sufficiency Specialist II, with the Department of Children and Families (“DCF” or “Agency” or “respondent”). Ms. Shearer testified. The respondent submitted six exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” through “6”. One continuance was granted to the petitioner.

The record was left open until August 14, 2017 to allow the respondent to submit additional information. On August 7, 2017, the respondent submitted additional information, which was accepted into evidence and marked as Respondent’s Exhibit “7”. The record closed on August 14, 2017.

FINDINGS OF FACT

1. The petitioner received QI1 benefits through December 31, 2016.
2. On April 11, 2017, the petitioner reapplied for the QI1 benefits and the respondent authorized her QI1 benefits effective April 1, 2017. The petitioner requested retroactive QI1 Medicaid benefits for January 2017 through March 2017.
3. The respondent explained the petitioner’s QI1 benefits could not be authorized as retroactive Medicaid benefits; therefore, the petitioner’s QI1 benefits could not be authorized for the months of January 2017 through March 2017.
4. The respondent explained the petitioner is eligible for QI1 benefits to pay her monthly Medicare Part B premium.

CONCLUSIONS OF LAW

5. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

6. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

7. The Fla. Admin. Code R. 65A-1.702, Medicaid Special Provisions, states in relevant part:

...
(12) Limits of Coverage

...
(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds time limits for those programs.)

8. Pursuant to the above authority, the petitioner is eligible for QI1 benefits to pay her Medicare part B premium.

9. Fla. Admin. Code R. 65A-1.702 further states, in relevant part:

...
(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period) ...

(9) Retroactive Medicaid. Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.

(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The

individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility. However, Qualified Medicare Beneficiaries (QMBs) are not eligible for retroactive Medicaid benefits under the QMB coverage group as indicated in 42 U.S.C. §1396a(e)(8).

10. The Department's Program Policy Manual, CFOP 165-22, passage 0640.0509,

Retroactive Medicaid (MSSI) states:

This policy does not apply to QMB.

Medicaid is available for any one or more of the three calendar months preceding the application month, provided:

1. at least one member of the SFU has received Medicaid reimbursable services during the retroactive period, and
2. the individual meets all factors of eligibility during the month(s) he requests retroactive Medicaid.

The applicant may request retroactive Medicaid at any time, as long as the coverage period is for any one of three months prior to any Medicaid or SSI application.

This retroactive coverage is not affected by:

1. the application's disposition (approval or denial);
2. whether or not the individual was alive at the time of the application; or
3. when the request for assistance or request to add was made.

When the request for retroactive Medicaid for an unpaid bill(s) is for only one member of a SFU, determine Medicaid eligibility for the entire AG.

Determine eligibility for each month there were unpaid medical services provided; do not consider the month the bill was issued. Accept the individual's statement that a member of the SFU has an unpaid bill.

11. Pursuant to the above authority and policy, to be eligible for retroactive Medicaid benefits, an application must be filed for one of the three months preceding that application. In April 2017, the petitioner filed an application for QI1 benefits. The petitioner seeks retroactive QI1 benefits for January 2017 through March 2017. The petitioner is eligible for retroactive QI1 benefits as the only benefit excluded from the retroactive Medicaid policy is QMB. The respondent incorrectly denied the petitioner's

request for retroactive QI1 benefits for the months of January 2017 through March 2017.

12. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner met the burden of proof indicating the respondent incorrectly denied her request for retroactive Qualifying Individual 1 benefits for the months of January 2017 through March 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is GRANTED. The respondent is ORDERED to approve the petitioner Qualifying Individual 1 benefits for the months of January 2017 through March 2017.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 02 day of October, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04150

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88249

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 8, 2017 at 1:34 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Mayra Fuentes, supervisor

STATEMENT OF ISSUE

At issue is the denial of full SSI-Related Medicaid benefits and enrollment in the Medically Needy Program with an estimated share of cost (SOC). The petitioner is seeking a lower SOC. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent presented five exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 5. The petitioner did not present any exhibits. A continuance was granted to the petitioner from a prior scheduled hearing.

FINDINGS OF FACT

1. On May 12, 2017, the petitioner (age 62) submitted an application for SSI-Related Medicaid benefits and Food Assistance benefits. She is the only household member. She reported monthly medical expenses for prescription drugs of \$60 and doctor's visits of \$180. She receives monthly Social Security Disability Income (SSDI) of \$933 and a monthly annuity of \$700. She is not receiving Medicare benefits. The respondent reviewed the petitioner's application and determined eligibility for Medicaid benefits. The Department initially approved Medicaid benefits only counting the petitioner's SSDI of \$933. Her monthly income was compared to the income limits for SSI-Related Medicaid benefits. She was found ineligible for full SSI-Related Medicaid benefits as her income was more than the income limit to qualify for the Program. The maximum income limit to be eligible for full SSI-Related Medicaid benefits is \$885. The respondent proceeded to determine SOC in the Medically Needy Program (Respondent's Exhibit 2).
2. The petitioner's SOC was determined as follows. The respondent subtracted a \$20 unearned income disregard from her SSDI of \$933 resulting to \$913. The Medically Needy Income level (MNIL) of \$180 for a household size of one was then subtracted, resulting in \$733 as the petitioner's SOC (Respondent's Exhibit 4).

3. On May 18, 2017, the respondent sent the petitioner a Notice of Case Action informing her that her application for the Medically Needy program was approved and her SOC was \$733.
4. On May 25, 2017, the petitioner requested a hearing to challenge the respondent's action.
5. Upon review, the respondent realized that it did not count the petitioner's monthly annuity when it initially determined her SOC. The respondent updated the petitioner's case and included her annuity resulting in a new SOC. The respondent determined the new SOC by adding the petitioner's SSDI to her annuity, resulting to her total monthly income of \$1,633. A \$20 unearned income disregard and the MNIL of \$180 was subtracted from her monthly income, resulting to \$1,433 as her ongoing SOC (Respondent's Exhibit 4).
6. On July 17, 2017, the respondent mailed the petitioner a new Notice of Case Action, informing of the new SOC (Respondent's Exhibit 4).
7. The petitioner asserted that she cannot afford such a high SOC of \$1,433 when her income is only \$1,633.

CONCLUSION OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. The respondent determined the petitioner's Medicaid benefits under the SSI Related Program.

11. Fla. Admin. Code R. 65A-1.701, Definitions, states in part:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

12. The above authority explains that the MEDS-AD (full Medicaid for an aged or disabled person) has an income limit of 88% of the federal poverty level.

13. The Department's Program Policy Manual CFOP 165-22 (Policy Manual) at Appendix A-9, lists the MEDS-AD income limit as \$885 for an individual effective April 2017. The undersigned concludes the respondent's action to deny full Medicaid benefits is a correct action, as the petitioner's income exceeds the income limit for those benefits. The undersigned further concludes Medically Needy eligibility must be explored for the petitioner.

The Medically Needy share of cost will now be addressed:

14. Fla. Admin. Code R. 65A-1.701 (30) defines Share of Cost (SOC) as, "the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month."

15. Fla. Admin. Code R. 65A-1.710 (5), SSI-Related Medicaid coverage Groups states. "Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C.

§§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources.”

16. The above authority explains the Medically Needy Program is a coverage group for aged, blind or disabled individuals who do not qualify for full Medicaid.

17. Fla. Admin. Code R. 65A-1.702 (13) Determining Share of Cost (SOC) states, “The SOC is determined by deducting the Medically Needy income level from the individual’s or family’s income.”

18. Federal Regulations at 20 C.F.R. § 416.1124 (c) (12), Unearned Income we do not count, states in part, “The first \$20 of any unearned income in a month...”

19. Income budgeting is set forth in Fla. Admin. Code R. 65A-1.713. It states:

(1) Income limits. An individual’s income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...

(4) (c) Medically Needy. The amount by which the individual’s countable income exceeds the Medically Needy income level, called the “share of cost”, shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:

1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

20. Fla. Admin. Code R. 65A-1.716 (2), Income and Resource Criteria, sets forth the Medically Needy Income Level for one person at \$180.

21. The Policy Manual at passage 2440.0102, Medically Needy Income Limits (MSSI) states:

When the assistance group has met the technical eligibility criteria and the asset limits, it is enrolled. There is no income limit for enrollment. The assistance group is income eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which his income exceeds the MNIL. Once medical bills are equal to this surplus income, referred to as share of cost, the assistance group is eligible.

The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's income exceeds the income limits for another full Medicaid Program.

22. The above states the SOC is determined by subtracting a \$20 unearned disregard and the Medically Needy Income Limit (MNIL) from the petitioner's income.

The undersigned concludes the respondent correctly determined the SOC (\$1,633-\$20-\$180= \$1,433). Eligibility for a lower SOC is not found.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal for full Medicaid benefit is denied and enrollment in the Medically Needy Program with a \$1,433 SOC is correct. The respondent's action is upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 07 day of September, 2017,

in Tallahassee, Florida.



Christiana Gopaul-Narine
Hearing Officer
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Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-04246

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 30, 2017, at 2:32 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

For the Respondent: Stacy Ann Mills, DCF supervisor.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action denying full Medicaid benefits for her 14-year-old child and enrollment in the Medically Needy Program with an estimated share of cost (SOC). The respondent carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Ashley Brunelle, Hearing Officer with the Office of Appeal Hearings, was present as an observer without any objection.

During the hearing, the petitioner did not submit any exhibits for the undersigned to consider. The respondent submitted a set of documents which was accepted and marked as Respondent's Composite Exhibit 1.

The record was left open through September 1, 2017 for respondent to submit additional information and extended through September 15, 2017 for petitioner to provide any evidence for consideration. Just before the end of business day, petitioner called the office to say that she would no longer provide any evidence and that the undersigned can make a decision based on the testimony she provided at today's hearing. Respondent's evidence was timely received and marked as Respondent's Composite Exhibit 2. The record was closed on September 1, 2017.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Prior to the action under appeal, petitioner's 14-year-old daughter had been receiving Medicaid Program benefits. She last received full Medicaid benefits in February 2017.
2. On April 10, 2017, petitioner submitted a web application to the Department to continue her daughter's Medicaid benefits. The petitioner's household consists of herself and her two daughters 19 and 14 years old.

3. Petitioner is employed and averaged \$252.77 per the [REDACTED] [REDACTED] (SWICA). She receives \$1,703 in Social Security disability benefits monthly. She is Medicare eligible and is responsible for her Part B premium. The 14-year-old daughter receives \$851, see respondent's Composite Exhibit 1, pages 26-28.

4. Petitioner was seeking full Medicaid for her household. Petitioner is a tax filer and her daughters are her tax dependents. To begin the budgeting process, the Department determined added petitioner's earned to her unearned income equals $(\$252.77 + \$1,703) \$1,955.77$ as countable monthly income. This amount is considered as modified adjusted gross income (MAGI) for the household. To determine Medicaid eligibility for the child, the household's MAGI of \$1,955.77 was compared to the income limit for the child based on her age group in a household size of two (\$1,800).

5. As the income exceeded the maximum limit for children ages 6 through 18, the 14-year-old child was found ineligible for full Medicaid. As the 14-year-old child was determined ineligible for full Medicaid, the respondent enrolled her in the Medically Needy (MN) Program.

6. To determine the child's estimated SOC the Medically Needy Income Level (MNIL) of \$387 (for a standard filing unit size two) was subtracted from \$1,955.77, followed by the \$1,424.90 medical insurance premium from the MAGI, resulting to the child's final estimated SOC of \$143. The 19-year old was also enrolled in the MN Program with a higher SOC.

7. On April 12, 2017 and May 24, 2017, the Department sent petitioner a Notice of Case Action informing her that her children were enrolled in the Medically Needy (MN)

Program. On May 30, 2017, petitioner timely requested an appeal challenging the Department's action. Petitioner is only challenging eligibility for her 14 year-old.

8. The respondent explained that the 14 year-old child is not eligible for full Medicaid because the household income exceeds the Family-Related Medicaid income limit for the household size. The child was enrolled in the Medically Needy Program because she failed to meet the income guideline for Family-Related Medicaid and that the SOC was directly related to the household's gross income.

9. Petitioner did not dispute the incomes used by the department. She argued that there has been no changes in her household income and that she was making the same money while her daughter was on full Medicaid. Respondent explained that only petitioner's Social Security was included in the prior budget. The record was left open for respondent to submit additional evidence. On September 1, 2017, the undersigned received additional information from respondent. Petitioner's Composite Exhibit 2 indicates that only \$1,703 was counted in the budget.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

Full Medicaid will now be addressed

12. Fla. Admin. Code R. 65-1.707 Family-Related Medicaid Income and Resource Criteria states in pertinent part: “(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages...”

13. The above cited authority explains Family-Related Medicaid eligibility is based on income, earned or unearned, received within the household. In accordance with the above cited authority, the petitioner’s earned income must be included in the Medicaid budget calculations.

14. Fla. Admin. Code R. 65-1.716 Income and Resource Criteria explains: “(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size...”

15. The Family-Related Medicaid income criteria is set forth in 42 C.F.R § 435.603 - Application of modified gross income (MAGI). It states:

(a) Basis, scope, and implementation. (1) This section implements section 1902(e)(14) of the Act.

(2) Effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

(d) Household income—(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household...

(1) Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer,

the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons whom such individual expects to claim as a tax dependent...

(5) For purposes of paragraph (f)(1) of this section, if, consistent with the procedures adopted by the State in accordance with §435.956(f) of this part, a taxpayer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the taxpayer is determined in accordance with paragraph (f)(3) of this section.

16. Federal regulations at 42 C.F.R. § 435.603 Application of modified gross income

(MAGI) (d) defines Household Income. It states:

(1) General rule. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household.

(2) Income of children and tax dependents. (i) The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.

(ii) The MAGI-based income of a tax dependent described in paragraph (f)(2)(i) of this section who is not expected to be required to file a tax return under section 6012(a)(1) of the Code for the taxable year in which eligibility for Medicaid is being determined is not included in the household income of the taxpayer whether or not such tax dependent files a tax return.

(3) In the case of individuals described in paragraph (f)(2)(i) of this section, household income may, at State option, also include actually available cash support, exceeding nominal amounts, provided by the person claiming such individual as a tax dependent.

(4) Effective January 1, 2014, in determining the eligibility of an individual using MAGI-based income, a state must subtract an amount equivalent to 5 percentage points of the Federal poverty level for the applicable family size only to determine the eligibility of an individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

17. The Policy Manual at 2630.0108 Budget Computation (MFAM), states:

Financial eligibility for Family-Related Medicaid is determined using the household's Modified Adjusted Gross income (MAGI). The MAGI is the household's adjusted gross income as calculated by the Internal Revenue Service plus any foreign earned income and interest income exempt from tax.

In computing the assistance group's eligibility, the general formula is:

Step 1 - (Gross Unearned + Gross Earned) = (Total Gross Income).

Step 2 - Deduct any allowable income tax deductions (lines 23-35 from 1040). Deduct any allowable deductions for financial aid or self-employment to obtain the Modified Adjusted Gross Income.

Step 3 - Deduct the appropriate standard disregard. This will give the countable net income.

Step 4 - Compare the total countable net income to the coverage group's income standard.

If less than or equal to the income standard* for the program category, STOP, the individual is eligible. If greater than the income standard for the program category, continue to Step 5.

Step 5 - Apply a MAGI deduction (5% of the FPL based on SFU size).

If the 5% disregard would make the individual eligible, include the disregard. Otherwise the individual is ineligible for Medicaid.

Individuals determined ineligible for Medicaid will be enrolled in Medically Needy and referred, as appropriate, to Florida KidCare and/or the Federally Facilitated Marketplace (FFM).

18. The Policy Manual at 2230.0400 Standard Filing Unit (MFAM) states:

For tax filers, the Standard Filing Unit (SFU) is the tax filing group for the tax year in which eligibility is being determined. Eligibility is determined by each individual using the tax filing group's income. Individuals cannot receive Medicaid benefits under more than one coverage group, but can have their income included in more than one SFU.

For individuals who neither file a federal tax return nor are claimed as a tax dependent (non-filers), the Standard Filing Unit consists of the individual and, if living with the individual, their spouse, their natural, adopted, and step children under age 19, or 19 and 20 if in school full-time.

19. In accordance with the above controlling authorities, the Medicaid household group is the petitioner and her 14-year-old child (two members). The findings show the Department determined the petitioner's eligibility with a household size of two to

determine Medicaid eligibility for the 14-year-old child. The undersigned concludes the Department correctly determined the petitioner's household size as two for Medicaid eligibility purposes.

20. The Family-Related Medicaid income standard appears in the Department's Program Policy Manual CFOP 165-22 at Appendix A-7. Effective April 2016, the income limit for is \$1,776 for a 14-year-old child in a family size of two and the MNIL was \$387. Effective April 2017, the income limit for is \$1,800 for a 14-year-old child in a family size of two, and the MNIL was \$387.

21. The undersigned reviewed the budget and could not find a more favorable outcome. The undersigned concludes that the petitioner's daughter is ineligible for full Medicaid. The undersigned further concludes Medically Needy eligibility must be explored for the child.

22. Fla. Admin. Code 65A-1.701 "Definitions" defines share of cost (SOC) as, "Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month".

23. Fla. Admin. Code 65A-1.702 "Special Provisions" states in part:

(10) Enrollment. The enrollment period under the Medically Needy program begins with the month the individual satisfies the non-financial and resource eligibility criteria, but not earlier than the third month prior to the month of application.

(13) Determining Share of Cost (SOC). The SOC is determined by deducting the Medically Needy income level from the individual's or family's income.

24. The Policy Manual at passage 2630.0500 Share of Cost (MFAM) states:

The Share of Cost (SOC) refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.

Eligibility must be determined for Medically Needy any time the assistance group meets all technical factors but the income exceeds the appropriate income limit for Medicaid.

To calculate the share of cost, compare the countable net income to the Medically Needy Income Level based on the size of the standard filing unit. The difference is the assistance group's share of cost.

25. To determine the child's SOC the respondent subtracted the Medically Needy Income Level of \$387 for a standard filing unit size of two from the household MAGI of \$1,955.77, resulting to the daughter's estimated SOC of \$1,568. It was further reduced by the \$1,424.90 medical insurance premium, resulting in the final remaining SOC of \$143.

26. The hearing officer reviewed the SOC calculation done by the Department and could not find a more favorable outcome.

27. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner full Medicaid under the Family-Related Medicaid coverage group and her enrollment in the Medically Needy Program with a SOC is correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 20 day of September, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
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Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Sep 20, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04275

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 MARION
UNIT: 88991

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter August 22nd, 2017, at 1:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED], representative for the petitioner.

For the Respondent: Stan Jones, Economic Self-Sufficiency Specialist II for the Department of Children and Families.

STATEMENT OF ISSUE

[REDACTED] is appealing the respondent's action to deny the petitioner Institutional Care Program (ICP) Medicaid for the months of March 2016 through November 2016. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The petitioner was not present for the hearing. However, she was represented by

[REDACTED].

Appearing as a witness for [REDACTED] was [REDACTED], [REDACTED]

[REDACTED]

The hearing was originally scheduled for July 25th, 2017, at 1:00 p.m. All parties phoned in as scheduled and briefly went on the record. After going on the record, it was determined that [REDACTED] had not received the respondent's evidence and did not wish to continue without having seen the documents. Therefore, the hearing ceased and was rescheduled for July 31st, 2017, at 1:00 p.m.

On July 31st, 2017, [REDACTED] called the Office of Appeal Hearings prior to the scheduled hearing time and reported that [REDACTED] was unable to attend due to an unforeseen absence. Therefore, the hearing was rescheduled as detailed above.

Petitioner's Exhibits 1 through 4 were admitted into evidence.

Respondent's Exhibits 1 through 5 were admitted into evidence.

By way of a Notice of Case Action (NOCA) dated March 17th, 2017, the respondent informed the petitioner that her application for Medicaid dated February 14th, 2017, was denied. The reasons listed were, "No household members are eligible for the program," and "We did not receive all the information requested to determine eligibility." On May 31st, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. [REDACTED] submitted an online application for ICP Medicaid on the petitioner's behalf on February 14th, 2017. (See Respondent's Exhibit 1). According to the respondent, there was a previous ICP application submitted in June 2016. A copy of the June 2016 application was not provided as evidence.
2. The petitioner passed away on November 18th, 2016. Prior to her passing, the petitioner received \$1,831.22 in monthly Veteran's Administration (VA) benefits. (See Petitioner's Exhibit 3).
3. [REDACTED] is requesting retroactive ICP coverage beginning March 2016 through November 2016. The respondent contends that the application dated February 14th, 2017, secures retroactive ICP coverage for the month of November 2016. The respondent also asserts that in normal circumstances, if the June 2016 application had been authorized, it would have secured coverage for the months of March 2016 through October 2016. However, since the application was denied, no retroactive coverage can be considered.
4. [REDACTED] testified that her office, Medicaid Done Right, was unable to obtain the petitioner's Veteran's Administration (VA) award letter. Therefore, both applications were denied even though a previous application had been approved without the information. [REDACTED] asserts that she required assistance to gather the requested information. However, the respondent did not provide assistance and both applications were denied. According to [REDACTED] she was able to obtain the VA information in July 2017 and provided it to the respondent. At that time, the respondent requested proof of bank statements for the retroactive months. [REDACTED]

██████████ contends these items were not previously requested, and she has no way of obtaining them. The bank account owned by the petitioner closed upon her passing.

5. The respondent testified that it was unable to assist ██████████ with obtaining the VA award letter. The respondent provided as part of its evidence, the ACCESS Program TRANSMITTAL NO.: I-11-07-0006 which states in part:

“Discontinue use of Form CF-ES 2262, *Request for Veteran’s Information*, until further notice...When verification of VA payments is necessary, customers must be pended to provide the information through their award letters or other documentation they have received from the VA...”

6. The respondent asserts that even though it now has the VA award letter, the bank statements from March 2016 through November 2016 are still needed to determine eligibility. The respondent cited policy from the ACCESS Florida Program Policy Manual, CFOP 165.22, passage 2040.0812.02 Requirements for Retroactive Coverage (MSSI) (See Respondent’s Exhibit 3):

3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the program for which the individual applied.

4. A determination of eligibility must be made for each of the month(s) in the period.

7. ██████████ provided the following ██████████ statements ending in account number 1440 as part of the petitioner’s evidence (See Petitioner’s Exhibit 2):

Statement Period	November 18 th , 2015 through December 16 th , 2015
Statement Period	November 17 th , 2015 through January 19 th , 2016
Statement Period	January 20 th , 2016 through February 16 th , 2016
Statement Period	February 17 th , 2016 through March 18 th , 2016
Statement Period	March 19 th , 2016 through April 18 th , 2016

8. According to the respondent, no retroactive coverage has been authorized despite bank statements for two of the requested months being provided. The

respondent provided, as part of its evidence, a NOCA dated February 17th, 2017, that requested several items of the petitioner. One of the items was,

“Proof of all bank statements with bank name on all ages provide the last three months beginning from 11/2016 to present date.”

According to [REDACTED], the petitioner’s bank account was closed at the time of the NOCA. Therefore, she was unable to provide the requested statements. The respondent asserts that the only documents required to determine retroactive Medicaid eligibility are the petitioner’s bank statements. All other information has been provided.

CONCLUSIONS OF LAW

9. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

10. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. The Code of Federal Regulation appearing at 42 C.F.R. 435.952 Use of information and requests of additional information from individuals states in relevant part:

(a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under §435.940 through §435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.

(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency in accordance with §435.948, §435.949 or §435.956 of this subpart, the agency must determine or renew eligibility based on such information.

(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with §435.948, §435.949 or §435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible *[Emphasis added]*, as provided in the verification plan described in §435.945(j) with information provided by or on behalf of the individual.

(1) Income information obtained through an electronic data match shall be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above or at or below the applicable income standard or other relevant income threshold.

(2) If information provided by or on behalf of an individual is not reasonably compatible with information obtained through an electronic data match, the agency must seek additional information from the individual, including—

(i) A statement which reasonably explains the discrepancy; or

(ii) Other information (which may include documentation), provided that documentation from the individual is permitted only to the extent electronic data are not available and establishing a data match would not be effective, considering such factors as the administrative costs associated with establishing and using the data match compared with the administrative costs associated with relying on paper documentation, and the impact on program integrity in terms of the potential for ineligible individuals to be approved as well as for eligible individuals to be denied coverage;

12. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process states in relevant part:

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. **If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.** *[Emphasis added.]*

13. As stated in the above-cited authorities, the respondent must not request additional information from the petitioner unless it cannot be obtained electronically or the electronic verification is not compatible with what has been provided. The respondent did not provide any evidence or testimony to show that the Asset Verification System (AVS) was utilized to determine the petitioner's bank account balances. According to the department's AVS Guide, AVS is an electronic verification system used for the purpose of verifying the financial assets of applicants and recipients receiving SSI-Medicaid. The AVS Guide also states that the AVS alert cannot be requested until all other requested information has been provided by the applicant. The Finding of Facts establish that [REDACTED] was able to obtain the petitioner's VA award letter. However, the petitioner's bank account is closed. Therefore, that particular asset information could not be secured. The above-cited authorities also state that the respondent must provide assistance in obtaining information when it is requested or when it appears necessary.

14. Fla. Admin. Code R. 65A-1.702 Special Provisions states in relevant part:

(9) Retroactive Medicaid. **Retroactive Medicaid is based on an approved, denied, or pending application for ongoing Medicaid benefits.** *[Emphasis Added]*

(a) Retroactive Medicaid eligibility is effective no later than the third month prior to the month of application for ongoing Medicaid if the individual would have been eligible for Medicaid at the time of application for Medicaid covered services. A request for retroactive Medicaid can be made for a deceased individual by a designated representative or caretaker relative filing an application for Medicaid assistance. The individual or his or her representative has up to 12 months after the date of application for ongoing Medicaid to request retroactive Medicaid eligibility.

15. The above-cited authority states that retroactive Medicaid can be determined on an approved, denied, or pending application. As established in the Findings of Fact, the respondent did not consider retroactive Medicaid coverage on the June 2016 application because the application was denied.

16. After review of the evidence, testimony, and guidelines, the hearing officer does not affirm respondent's action to deny the petitioner's applications for ICP Medicaid and retroactive Medicaid without first assisting [REDACTED] in obtaining the necessary verifications. While it is correct that the respondent can no longer communicate with the VA to verify benefits, [REDACTED] provided the VA award letter during the hearing review process. In addition, respondent acknowledged that it received the petitioner's bank statement for April 2016 which was one of the months [REDACTED] requested retroactive Medicaid coverage. The hearing officer notes that the respondent also acknowledged receipt of the petitioner's evidence which included a copy of the bank statement for March 2016. [REDACTED] requested retroactive Medicaid for March 2016, as well. Therefore, the based on the respondent's testimony, it has everything required to review retroactive eligibility for March 2016 and April 2016. As established in the Findings of Fact, the only information lacking to determine eligibility for the months of May 2016 through November 2016 were the petitioner's bank statements. The respondent has all other documentation necessary and can request the AVS alert. In normal circumstances, the AVS request would not be completed until after the bank statements are provided. However, since the petitioner is deceased and the bank account is closed, it is unlikely that these documents can be obtained. Therefore, an AVS alert is necessary.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, the appeal is granted to the extent described above. This decision is not a guarantee of eligibility. Rather, the respondent is ordered to take corrective action as described above.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 20 day of September, 2017,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Oct 16, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 17F-04478
APPEAL NO. 17F-04947

PETITIONER,

Vs.

CASE NO.

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88265

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened two administrative hearings in the above-referenced matter on July 19, 2017 at 10:50 a.m. in Florida; and on August 17, 2017 at 2:05 p.m. in Florida.

APPEARANCES

For Petitioner: , pro se

For Respondent: Bruce Tunsil, Supervisor
Teshia Green, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issues are whether the respondent's action to deny the petitioner's Supplemental Nutrition Assistance Program (SNAP) benefits for the months of March 2017 through June 2017; to determine the petitioner eligible for SNAP benefits in the amount of \$71 for July 2017 and \$152 for August 2017; to terminate the petitioner's

SNAP benefits for September 2017 and ongoing; to terminate the petitioner and her husband's Qualified Medicare Beneficiary (QMB) benefits for March 2017 and ongoing; to deny the petitioner and her husband's application for Qualified Individual 1 (Q11) benefits effective April 2017 and ongoing; to deny the petitioner and her husband's application for full SSI-Related Medicaid benefits and instead enroll them in the SSI-Related Medically Needy (MN) Program with a monthly Share of Cost (SOC) amount for March 2017 and ongoing; and to deny the petitioner's son application for full Medicaid benefits for July 2017 and ongoing are correct.

For the denial of the petitioner's SNAP benefits for the months of March 2017 through June 2017, the petitioner carries the burden of proof by a preponderance of the evidence. For the determination of the petitioner's SNAP benefit amounts for July 2017 and August 2017, the petitioner carries the burden of proof by a preponderance of the evidence. For the termination of the petitioner's SNAP benefits for September 2017 and ongoing, the respondent carries the burden of proof by a preponderance of the evidence.

For the denial of full SSI-Related Medicaid benefits and the enrollment of the petitioner and the husband's in the SSI-Related MN program, the petitioner carries the burden of proof by a preponderance of the evidence. For the denial of the petitioner's son's full Medicaid benefits, the petitioner carries the burden of proof by a preponderance of the evidence.

For the termination of the petitioner's QMB benefits, the respondent carries the burden of proof by a preponderance of the evidence. For the denial of the petitioner

and her husband's Q11 benefits, the petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present and testified at both hearings. At both hearings, the petitioner presented a witness who testified: [REDACTED], petitioner's husband. On July 19, 2017, the petitioner submitted no exhibits at the hearing. On August 17, 2017, the petitioner submitted two exhibits at the hearing, which were marked and entered as Petitioner's Exhibits "1" – "2". On July 19, 2017, the respondent was represented by Bruce Tunsil, Supervisor, with the Department of Children and Families (hereafter "DCF", "Respondent" or "Agency"). On August 17, 2017, the respondent was represented by Teshia Green, the Economic Self-Sufficiency Specialist II, with DCF. On July 19, 2017, the respondent submitted no exhibits at the hearing. On August 17, 2017, the respondent submitted seven exhibits at the hearing, which were marked and entered as Respondent's Exhibits "1" – "7". Joseph Mayberry observed both the July 2017 and August 2017 hearings.

The record was left opened until September 18, 2017 to allow both parties to exchange and review additional information. From on or about August 18, 2017 to September 18, 2017, the petitioner submitted additional information that was marked and entered as Petitioner's Exhibits "3" – "15". On September 18, 2017, the respondent submitted additional information that was marked and entered as Respondent's Exhibits "8" – "17". The record closed on September 18, 2017. The petitioner submitted

additional information after September 18, 2017 that will not be considered in the Final Order as the record was closed.

FINDINGS OF FACT

1. On January 17, 2017, the respondent mailed the petitioner a Notice of Eligibility Review indicating her last month to receive SNAP benefits was February 2017 and she had to reapply by February 15, 2017 to ensure she did not receive a break in her SNAP benefits.
2. On February 14, 2017, the petitioner completed a recertification application for SNAP, SSI-Related Medicaid, and Medicare Savings Plan (MSP) benefits. The application listed the petitioner and her husband as the only household members; and the petitioner and her husband's Social Security benefits and the husband's self-employment income as the only sources of income for the household.
3. On February 21, 2017, the respondent mailed petitioner a Notice of Case Action requesting the petitioner complete a phone interview on or before March 2, 2017 with the respondent. The notice also requested the petitioner submit the following information: "For self employment, write a letter stating how much you have earned in the last 4 weeks, hours worked in the month, and what are the business expenses, if any".
4. On February 27, 2017, the petitioner conducted a phone interview with the respondent. During the interview, she reported her and her husband lived in the household; her and her husband had Social Security income; her husband had self-

employment income; her mortgage was \$1,000 per month; and electric expense was \$175 per month.

5. On March 14, 2017, the respondent mailed the petitioner a Notice of Case Action indicating her SNAP application dated February 14, 2017 was denied for March 2017 and April 2017 as “we did not receive all the information requested to determine eligibility”. The notice also indicated the petitioner’s MN application dated February 14, 2017 was approved effective February 2017 with an estimated SOC amount of \$1,711 per month. The notice further indicated the petitioner’s Qualifying Individual 1 application dated February 14, 2017 was denied for April 2017 as “Your household’s income is too high to qualify for this program”.

6. On July 17, 2017, the petitioner submitted an online change reporting her son had moved into the household; and her husband had incurred \$925 per month in self-employment expenses (business meals away \$25; contract labor \$500; business telephone cost \$150; and business transportation of \$250). The online change also reported the son not disabled. The respondent added the petitioner’s son to her SNAP standard filing unit (SFU) effective July 2017 as she reported her son moved into the household in July 2017.

7. On July 19, 2017, the respondent determined the petitioner eligible for SNAP benefits effective July 17, 2017.

8. On July 20, 2017, the respondent mailed the petitioner a Notice of Case Action indicating her SNAP application dated July 17, 2017 was approved and she was eligible to receive \$71 in SNAP benefits for July 2017 and \$153 per month in SNAP benefits for

August 2017 through December 31, 2017. The respondent explained that the SNAP benefits approved on July 19, 2017 were approved in error.

9. On August 9, 2017, the respondent determined the petitioner's Qualified Medicare Beneficiary (QMB) ended because her and her husband's Social Security incomes were more than the MSP income limits.

10. On August 11, 2017, the petitioner completed an application for the additional benefits of Temporary Cash Assistance (TCA), SNAP; SSI-Related Medicaid; and Medicare Savings Plan (MSP) benefits. TCA benefits are not an issue under appeal. The application listed the petitioner, her husband, and her adult son as the only household members; all family members purchase and prepare their foods together; the petitioner and her husband's Social Security benefits and the husband's self-employment income as the only sources of income for the household.

11. On August 31, 2017, the respondent mailed the petitioner a Notice of Case Action indicating her SNAP would end effective September 2017 as "Your household's income is too high to qualify for this program. The notice also indicated the petitioner's MN application dated August 11, 2017 was approved effective July 2017 with an estimated SOC amount of \$2,703 per month. The notice further indicated the petitioner's Qualifying Individual 1 application dated August 11, 2017 was denied for May 2017 and ongoing as "Your household's income is too high to qualify for this program".

12. The petitioner's husband receives \$1,230 (gross) per month in Social Security benefits. He pays for Medicare part A and B premiums. The state of Florida last paid his Medicare part B premium in April 2017. The petitioner receives \$952 (gross) per

month in Social Security benefits. She pays for Medicare part A and B premiums. The state of Florida last paid her Medicare part B premium in April 2017.

13. The petitioner pays \$1,000 per month for mortgage and pays \$175 per month for electric.

14. The respondent calculated the petitioner's ongoing medical expenses in her SNAP budgets as \$26.24 per month for expenses related to a service animal; \$54 per month for prescription co-pays; \$65 per month for physician visits; \$45 per month for medical testing; and \$268 per month for Medicare part B premiums.

15. The petitioner incurred one-time medical expenses for the following dates and amounts: July 24, 2017 \$24.94; July 25, 2017 \$3.40; August 6, 2017 \$252.90; August 9, 2017 \$205; and August 31, 2017 and September 1, 2017 combined to \$85.67. The petitioner's one-time medical expenses totaled \$571.91. The petitioner verified her July 2017; August 6, 2017; and August 9, 2017 one-time medical expenses, which totaled \$486.24 in August 2017. The petitioner verified her August 31, 2017 and September 1, 2017 one-time medical expenses, which totaled \$85.67, in September 2017.

16. The petitioner paid and or incurred one-time dental expenses for the following dates and amounts: July 6, 2017 (incurred) \$292.90; July 6, 2017 (paid) \$742.90; and July 12, 2017 (paid) \$261 with no remaining balance. The petitioner verified her one-time dental expense in August 2017.

17. The petitioner's husband incurred one-time medical expenses for the following dates and amounts: July 24, 2017 \$50; and August 1, 2017 \$155.43. The husband's medical expenses totaled \$205.43. The petitioner verified her husband's one-time medical expenses in September 2017.

18. On June 12, 2017, the petitioner's dog, Buddy, became certified as a "USA Service Dog". On July 17, 2017, the petitioner paid \$113.01 for Buddy's veterinary bill. The petitioner verified her one-time service animal expense in August 2017.

19. For March 2017 through August 2017, the respondent utilized the petitioner's 2015 tax return when determining the husband's gross and net self-employment income as well as his self-employment expenses. For September 2017 and ongoing, the respondent utilized the petitioner's 2016 tax return when determining the husband's gross and net self-employment income as well as his self-employment expenses.

20. The petitioner's 2015 tax return indicates the husband's yearly business income as \$58,628. The 2015 tax return indicates the husband's yearly business expenses as follows:

- Advertising: \$850 per year
- Insurance: \$1,197 per year
- Car, Truck Vehicle Equipment Expense: \$11,593 per year
- Legal and Professional Services: \$6,254 per year
- Contract Labor: \$615 per year

The 2015 tax return indicates the husband's yearly "other business expenses" as \$1,440 per yearly for Highlander Insurance; \$590 per year for Power; \$74 per year as Trash; and \$1,929 for Communications.

21. The petitioner's 2015 tax return indicates the petitioner's yearly business income as \$952. The 2015 tax return indicates the petitioner's yearly business expenses as follows:

- Advertising: \$429 per year
- Insurance: \$1,197 per year
- Car, Truck Vehicle Equipment Expense: \$4,155 per year
- Legal and Professional Services: \$171 per year

The 2015 tax return indicates the petitioner's yearly "other business expenses" as \$2,910 for Explorer; \$750 for Explorer Insurance; \$352 for [REDACTED]; and \$1,321 for Communications.

22. The petitioner's 2016 tax return indicates the husband's yearly business income as \$34,215. The 2016 tax return indicates the husband's yearly business expenses as follows:

Advertising: \$625 per year
Insurance: \$1,081 per year
Car, Truck Vehicle Equipment Expense: \$12,174 per year
Legal and Professional Services: \$150 per year
Contract Labor: \$560 per year

The 2016 tax return indicates the husband's yearly "other business expenses" as \$1,239 for Highlander Insurance; \$455 for Power; \$74 for Trash; \$760 for half of the year Explorer Insurance; and \$1,559 for Communications.

23. The petitioner's 2016 tax return indicates the petitioner's yearly business income as -\$210. The 2016 tax return did not indicate the petitioner's incurred any yearly business expenses.

24. Subsequent to the hearing, the respondent determined the husband's monthly gross self-employment income as \$4,885.67 for the March 2017 through August 2017 SNAP budgets.

25. Subsequent to the hearing, the respondent determined the husband's monthly gross self-employment income as \$2,851.25 for the September 2017 and ongoing SNAP budgets.

26. Subsequent to the hearing, the respondent determined the following self-employment expenses for the March 2017 through August 2017 SNAP budgets:

Advertising: \$850 per year or \$70.83 per month
Office Expenses: \$2,207 per year or \$183.92 per month
Rent/Lease Vehicles, Machines and Equipment: \$339 per year or \$28.25 per month
Supplies: \$21,194 per year or \$1,766.17 per month
Taxes and Licenses: \$427 per year or \$35.58 per month
Insurance: \$1,197 per year or \$99.75 per month
Car, Truck Vehicle Equipment Expense: \$11,593 per year or \$966.08 per month
Contract Labor: \$615 per year or \$51.25 per month
Legal and Professional Services: \$6,254 per year or \$521.17 per month
Repairs and Maintenance: \$435 per year or \$36.25 per month

27. Subsequent to the hearing, the respondent determined the following self-employment expenses for September 2017 and ongoing SNAP budgets:

Advertising: \$625 per year or \$52.08 per month
Office Expenses: \$1,152 per year or \$96 per month
Rent/Lease Vehicles, Machines and Equipment: \$162 per year or \$13.50 per month
Supplies: \$8,796 per year or \$7 per month
Taxes and Licenses: \$427 per year or \$35.58 per month
Insurance: \$1,081 per year or \$90.08 per month
Car, Truck Vehicle Equipment Expense: \$12,174 per year or \$1,014.50 per month
Contract Labor: \$560 per year or \$46.67 per month
Legal and Professional Services: \$6,254 per year or \$521.17 per month
Repairs and Maintenance: \$435 per year or \$36.25 per month

28. Subsequent to the hearing, the respondent determined the husband's yearly self-employment expenses for March 2017 through August 2017 as \$45,111 or \$3,759.25 per month. The respondent determined the husband's yearly net self-employment income as \$13,517 (\$58,628 - \$45,111) or as \$1,126.42 per month (\$4,885.67 - \$3,759.25).

29. Subsequent to the hearing, the respondent determined the husband's yearly self-employment expenses for September 2017 and ongoing as \$24,765 or \$2,063.75 per

month. The respondent determined the husband's yearly net self-employment income as \$9,450 (\$34,215 - \$24,765) or as \$787.50 per month (\$2,851.25 - \$2,063.75).

30. The respondent determined the petitioner over the SNAP net income limit for March 2017 through June 2017 as follows:

Expenses/Income Dollar	Amount
Self-Employment income	\$1177.67
<u>Unearned Income (SSA benefits)</u>	<u>+\$2182.67</u>
Total Household Income	\$3359.67
<u>Earned income deduction</u>	<u>-\$ 235.53</u>
<u>Standard deduction for a household of 2&3</u>	<u>-\$ 157.00</u>
<u>Excess Medical Expenses</u>	<u>-\$ 423.24</u>
Adjusted income after deductions	\$2543.90
Total Medical Expenses	\$ 458.24
<u>Medical Deduction</u>	<u>-\$ 35.00</u>
Excess Medical Expense	\$ 270.00
Rent/shelter	\$1000.00
<u>Standard utility allowance</u>	<u>+\$ 338.00</u>
Total rent/utility costs	\$1338.00
<u>Shelter standard (50% adjusted income)</u>	<u>-\$1271.95</u>
Excess shelter deduction	\$ 66.05
Adjusted income	\$2543.90
<u>Excess Shelter Deduction</u>	<u>-\$ 66.05</u>
Adjusted income after shelter deduction	\$2477.85

31. For March 2017 through June 2017, the respondent compared the petitioner's adjusted net income of \$2,477.85 to \$1,335.00 or the net income limit for a household of two. For March 2017 through June 2017, the respondent determined the petitioner was not eligible for SNAP benefits as her net monthly income exceeded the SNAP net income limit.

32. The respondent determined the petitioner over the SNAP net income limit effective August 2017 and ongoing as follows:

Expenses/Income Dollar	Amount
Self-Employment income	\$ 834.17
<u>Unearned Income (SSA benefits)</u>	<u>+\$2182.67</u>
Total Household Income	\$3016.17
<u>Earned income deduction</u>	<u>-\$ 166.83</u>
<u>Standard deduction for a household of 2&3</u>	<u>-\$ 157.00</u>
<u>Excess Medical Expenses</u>	<u>-\$ 423.24</u>
Adjusted income after deductions	\$2269.10
Total Medical Expenses	\$ 458.24
<u>Medical Deduction</u>	<u>-\$ 35.00</u>
Excess Medical Expense	\$ 270.00
Rent/shelter	\$1000.00
<u>Standard utility allowance</u>	<u>+\$ 338.00</u>
Total rent/utility costs	\$1338.00
<u>Shelter standard (50% adjusted income)</u>	<u>-\$1134.55</u>
Excess shelter deduction	\$ 203.45
Adjusted income	\$2269.10
<u>Excess Shelter Deduction</u>	<u>-\$ 203.45</u>
Adjusted income after shelter deduction	\$2065.65

33. For August 2017 and ongoing, the respondent compared the petitioner's adjusted net income of \$2,065.65 to \$1,680.00 or the net income limit for a household of three.

For August 2017 and ongoing, the respondent determined the petitioner was not eligible for SNAP benefits as her net monthly income exceeded the SNAP net income limit.

34. The respondent determined the petitioner and her husband's monthly SOC amount effective August 2017 and ongoing as \$2,037.00:

\$2182.00	petitioner's and husband's Social Security income
-\$20.00	unearned income disregard
\$2162.00	petitioner's countable unearned income
\$834.17	husband's self-employment income

<u>-\$65.00</u>	<u>earned income disregard</u>
<u>-\$384.58</u>	<u>½ remaining disregard</u>
\$384.58	petitioner's total countable earned income
\$384.58	petitioner's total countable earned income
<u>+\$2162.00</u>	<u>petitioner's countable unearned income</u>
\$2546.59	petitioner's total countable income
<u>-\$241.00</u>	<u>medically needy income level for household size of two</u>
\$2305.59	share of cost
<u>-\$268.00</u>	<u>medical insurance premium</u>
\$2037.00	remaining share of cost

35. The respondent determined the petitioner and her husband's monthly SOC amount for March 2017 through July 2017 as \$2,209.00:

\$2182.00	petitioner's and husband's Social Security income
<u>-\$20.00</u>	<u>unearned income disregard</u>
\$2162.00	petitioner's countable unearned income
\$1177.67	husband's self-employment income
<u>-\$65.00</u>	<u>earned income disregard</u>
<u>-\$556.33</u>	<u>½ remaining disregard</u>
\$556.33	petitioner's total countable earned income
\$556.33	petitioner's total countable earned income
<u>+\$2162.00</u>	<u>petitioner's countable unearned income</u>
\$2718.34	petitioner's total countable income
<u>-\$241.00</u>	<u>medically needy income level for household size of two</u>
\$2477.34	share of cost
<u>-\$268.00</u>	<u>medical insurance premium</u>
\$2,209.00	remaining share of cost

36. The respondent determined the petitioner and her husband are not eligible for full SSI-Related Medicaid benefits as they are over the income limit for full SSI-Related Medicaid benefits.

37. The petitioner requested Medicaid benefits as she cannot afford to pay for her and her husband's medical expenses as well as the household's expenses. She and her husband cannot afford to pay for some of the medical expenses and often cannot pay their prescription copays or pay for their durable medical equipment regularly.

38. The respondent determined the petitioner's adult son is not eligible for Medicaid benefits as he is not over the age of 65; is not under the age of 21; is not considered disabled by SSA; and does not have any children under the age of 18 living in with him.

39. The respondent determined the petitioner and her husband were over the Q11 income standard for a household of two effective August 2017 and ongoing as follows:

\$2182.00	petitioner's and husband's Social Security income
-\$20.00	unearned income disregard
\$2162.00	petitioner's countable unearned income
\$834.17	husband's self-employment income
-\$65.00	earned income disregard
<u>-\$384.58</u>	<u>½ remaining disregard</u>
\$384.58	petitioner's total countable earned income
\$384.58	petitioner's total countable earned income
<u>+\$2162.00</u>	<u>petitioner's countable unearned income</u>
\$2546.59	petitioner's total countable income

40. For August 2017 and ongoing, the respondent compared the petitioner's total countable income of \$2,546.59 to \$1,827.00 or the net income standard for a household of two. For August 2017 and ongoing, the respondent determined the petitioner and her husband were not eligible for Q11 benefits as their net monthly income exceeded the Q11 income standard.

41. The respondent determined the petitioner and her husband were over the Q11 income standard for a household of two for March 2017 and July 2017 as follows:

\$2182.00	petitioner's and husband's Social Security income
-\$20.00	unearned income disregard
\$2162.00	petitioner's countable unearned income
\$1177.67	husband's self-employment income
-\$65.00	earned income disregard
<u>-\$556.33</u>	<u>½ remaining disregard</u>
\$556.33	petitioner's total countable earned income
\$556.33	petitioner's total countable earned income
<u>+\$2162.00</u>	<u>petitioner's countable unearned income</u>
\$2718.34	petitioner's total countable income

42. For March 2017 through July 2017, the respondent compared the petitioner's total countable income of \$2,546.59 to \$1,827 or the net income standard for a household of two. For March 2017 through July 2017, the respondent determined the petitioner and her husband were not eligible for QI1 benefits as their net monthly income exceeded the QI1 income standard.

43. The petitioner did not agree with respondent's termination of her and her husband's QMB benefits as she reported no changes in their income. Since she reported no changes in income she argued her benefits should not have changed.

CONCLUSIONS OF LAW

44. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

45. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

Whether the petitioner's SNAP benefits for March 2017 and ongoing were correctly calculated.

46. Federal Regulations at 7 C.F.R. § 273.9 defines income and states, in part:

(1) Earned income shall include: (i) All wages and salaries of an employee.

(ii) The gross income from a self-employment enterprise, including the total gain from the sale of any capital goods or equipment related to the business, excluding the costs of doing business as provided in paragraph (c) of this section. Ownership of rental property shall be considered a self-employment enterprise; however, income derived from the rental property shall be considered earned income only if a member of the household is actively engaged in the management of the property at least an average of 20 hours a week. Payments from a roomer or boarder, except foster care boarders, shall also be considered self-employment income...

(2) Unearned income shall include, but not be limited to. . .

(i) Annuities; pensions; retirement, veteran's, or disability benefits; worker's or unemployment compensation including any amounts deducted to repay claims for intentional program violations as provided in §272.12; old-age, survivors, or social security benefits; strike benefits; foster care payments for children or adults who are considered members of the household; gross income minus the cost of doing business derived from rental property in which a household member is not actively engaged in the management of the property at least 20 hours a week.

47. Pursuant to the above authority, the petitioner and her husband's self-employment income as well as their Social Security income must be included in the determination of her household's monthly SNAP benefit amount. In this instance, the petitioner's self-employment income shall not be considered in the determination of her SNAP benefits.

48. The Code of Federal Regulations at 7 C.F.R. § 273.11 sets forth the calculation of self-employment income:

(a) Self-employment income. The State agency must calculate a household's self-employment income as follows...

(2) Determining monthly income from self-employment. (i) For the period of time over which self-employment income is determined, the State agency must add all gross self-employment income (either actual or anticipated, as provided in paragraph (a)(1)(i) of this section) and capital gains (according to paragraph (a)(3) of this section), exclude the costs of producing the self-employment income (as determined in paragraph (a)(4) of this section), and divide the remaining amount of self-employment income by the number of months over which the income will be averaged. This amount is the monthly net self-employment income. The monthly net self-employment income must be added to any other earned income received by the household to determine total monthly earned income. . .

(b) Allowable costs of producing self-employment income. (1) Allowable costs of producing self-employment income include, but are not limited to, the identifiable costs of labor; stock; raw material; seed and fertilizer; payments on the principal of the purchase price of income-producing real estate and capital assets, equipment, machinery, and other durable goods; interest paid to purchase income-producing property; insurance premiums; and taxes paid on income-producing property.

(2) In determining net self-employment income, the following items are not allowable costs of doing business:

(i) Net losses from previous periods;

(ii) Federal, State, and local income taxes, money set aside for retirement purposes, and other work-related personal expenses (such as transportation to and from work), as these expenses are accounted for by the 20 percent earned income deduction specified in § 273.9(d)(2);

(iii) Depreciation...(emphasis added)

49. Department's Program Policy Manual (Policy Manual), 165-22, passage

1810.0302 Allowable Costs of Self Employment Income (FS) states:

The assistance group is required to keep a record of the expenses incurred in the production of self-employment income.

Examples of allowable costs of producing self-employment income are:

1. identifiable costs of labor (salaries, employer's share of Social Security, **insurance**, etc.);
2. stock, raw materials, seed and fertilizer, and feed for livestock;
3. rent and cost of building maintenance;
4. business telephone costs;
5. costs of operating a motor vehicle when required in connection with the operation of the business;

6. the principal and **interest paid on loans** to purchase income producing real estate and capital assets, equipment, machinery, and other durable goods;
7. insurance premiums and taxes paid on income producing property;
8. cost of meals and equipment for children for whom child care is provided in the home; and
9. travel and lodging, **but not meals**, away from home. (emphasis added)

50. The Department's Program Policy Manual, 165-22, passage 1810.0303

Costs not Allowed (FS) states, in part:

The following expenses are not allowed as a cost of producing self-employment income:

1. net losses from previous periods,
2. federal, state and local income taxes, money set aside for retirement purposes and other work related personal expenses (such as transportation to and from work) for any SFU member, as these expenses are accounted for by the 20% earned income adjustment, and
3. depreciation. . .

51. Pursuant to the above authority and policies, some of petitioner's self-employment expenses may be included in the calculation of her husband's net self-employment income. However, the respondent should not have included any taxes in husband's self-employment expenses. For March 2017 through August 2017, the respondent determined the husband's yearly self-employment expenses as \$45,111 or monthly as \$3,759.25. The undersigned determines the husband's yearly self-employment expenses as \$44,684 per year (\$45,111 - \$427 (yearly cost of taxes)) or \$3,723.67 per month (\$3,759.25 - \$35.58 (monthly cost of taxes)).

52. For September 2017 and ongoing, the respondent determined the husband's yearly self-employment expenses as \$24,765 or monthly as \$2,063. The undersigned determines the husband's yearly self-employment expenses as \$24,338 per year

(\$24,765 - \$427 (yearly cost of taxes)) or \$2,027.42 per month (\$2,063 - \$35.58 (monthly cost of taxes)).

53. The Policy Manual, 165-22, passage 2610.0402.05 Determining Net Self-Employment Income (FS) states, in part:

To determine net income from self-employment:

Step 1 - Add all gross self-employment income, including capital gains.

Step 2 - Subtract from the gross self-employment income the cost of producing the self-employment income (allowable business expenses). Refer to Chapter 1800.

Step 3 - Divide the above amount by the number of months over which the income will be averaged. . .

54. Pursuant to the above policy, the respondent subtracts petitioner's gross self-employment income from his allowable business expenses then divides the amount by the number of months the income will be averaged. The undersigned determines for March 2017 through August 2017, the husband's yearly net self-employment income as \$13,944 (\$58,628 - \$44,684) and his monthly net self-employment income as \$1,162 (\$13,944 divided by 12).

55. The undersigned determines for September 2017 and ongoing, the husband's yearly net self-employment income as \$9,877 (\$34,215 - \$24,338) and his monthly net self-employment income as \$823.08 (\$9,877 divided by 12).

56. Federal Regulations at 7 C.F.R. § 273.9 defines deductions and states, in part:

(d) Income deductions. Deductions shall be allowed only for the following household expenses...

(1) Standard deduction—(i) 48 States, District of Columbia, Alaska, Hawaii, and the Virgin Islands. Effective October 1, 2002, in the 48 States and the District of Columbia, Alaska, Hawaii, and the Virgin Islands, the standard deduction for household sizes one through six shall be equal to 8.31 percent of the monthly net income eligibility standard for each

household size established under paragraph (a)(2) of this section rounded up to the nearest whole dollar...

(2) Earned income deduction. Twenty percent of gross earned income as defined in paragraph (b)(1) of this section. Earnings excluded in paragraph (c) of this section shall not be included in gross earned income for purposes of computing the earned income deduction, except that the State agency must count any earnings used to pay child support that were excluded from the household's income in accordance with the child support exclusion in paragraph (c)(17) of this section...

(3) Excess medical deduction. That portion of medical expenses in excess of \$35 per month, excluding special diets, incurred by any household member who is elderly or disabled as defined in §271.2. Spouses or other persons receiving benefits as a dependent of the SSI or disability and blindness recipient are not eligible to receive this deduction but persons receiving emergency SSI benefits based on presumptive eligibility are eligible for this deduction. Allowable medical costs are:

(i) Medical and dental care including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by State law or other qualified health professional.

(ii) Hospitalization or outpatient treatment, nursing care, and nursing home care including payments by the household for an individual who was a household member immediately prior to entering a hospital or nursing home provided by a facility recognized by the State.

(iii) Prescription drugs, when prescribed by a licensed practitioner authorized under State law, and other over-the-counter medication (including insulin), when approved by a licensed practitioner or other qualified health professional.

(A) Medical supplies and equipment. Costs of medical supplies, sick-room equipment (including rental) or other prescribed equipment are deductible;

(B) Exclusions. The cost of any Schedule I controlled substance under The Controlled Substances Act, 21 U.S.C. 801 et seq., and any expenses associated with its use, are not deductible.

(iv) Health and hospitalization insurance policy premiums. The costs of health and accident policies such as those payable in lump sum settlements for death or dismemberment or income maintenance policies such as those that continue mortgage or loan payments while the beneficiary is disabled are not deductible;

(v) Medicare premiums related to coverage under Title XVIII of the Social Security Act; any cost-sharing or spend down expenses incurred by Medicaid recipients;

(vii) Securing and maintaining a seeing eye or hearing dog including the cost of dog food and veterinarian bills. . .

(6) Shelter costs...

(ii) Excess shelter deduction. Monthly shelter expenses in excess of 50 percent of the household's income after all other deductions in paragraphs (d) (1) through (d)(5) of this section have been allowed...If the household does not contain an elderly or disabled member, as defined in § 271.2 of this chapter, the shelter deduction cannot exceed the maximum shelter deduction limit established for the area.

(A) Continuing charges for the shelter occupied by the household, including rent, mortgage, condo and association fees, or other continuing charges leading to the ownership of the shelter such as loan repayments for the purchase of a mobile home, including interest on such payments...

(iii) Standard utility allowances. (A) With FNS approval, a State agency may develop the following standard utility allowances (standards) to be used in place of actual costs in determining a household's excess shelter deduction: an individual standard for each type of utility expense; a standard utility allowance for all utilities that includes heating or cooling costs (HCSUA)...

57. Pursuant to the above authority, the petitioner's shelter costs, utilities, medical expenses an earned income deduction, and a standard deduction must be included in the determination of her household's monthly SNAP benefit amount.

58. The respondent determined the petitioner's ongoing medical expenses as their Part B Premiums, expenses related to a service dog, and prescription copays.

59. The Department's Program Policy Manual, 165-22, passage 2410.0360

One-Time Medical Expense (FS) states, in part:

For prospective budgeting and beginning months, one-time medical expenses might, in some instances, be anticipated.

If anticipated and verified prior to certification, the assistance group (AG) is eligible for the medical disregard and has the option of deducting the full amount, less reimbursements, in the month billed or due, or averaging the amount due over the certification period.

If the AG reports that a one-time medical expense is anticipated during the upcoming certification period but fails to verify prior to certification, the expense is allowable during the month in which it was verified.

Sometimes averaging brings the total to less than \$35 per month. When this happens, the total medical expenses (less \$35) can be added in the budget for the first available month not posted and removed the next month.

If an AG which is not currently eligible (that is, initially applying or applying after the certification period has expired) makes application and reports a one-time medical expense, only the currently existing balance due at the time the expense is reported can be considered. This amount is allowable in the month in which the expense is verified.

If an unanticipated one-time medical expense is reported, the expense is allowable in the certification period in which it is verified.

60. Pursuant to the above policy, one-time medical expenses can be included in the petitioner's SNAP budgets. The evidence indicates that in August 2017 and September 2017, the petitioner submitted verification of various one-time medical expenses for her and her husband. The petitioner incurred \$723.53 in one-time medical expenses and the husband incurred \$205.43 in one-time medical expenses. The petitioner paid \$1,003.90 in one-time dental expenses.

61. The Department's Memorandum Dated March 12, 2002 titled Allowable Medical Expenses states "The assistance group can also voluntarily report medical expenses that come due during the certification period and have them taken into consideration in determining its monthly medical deduction for the remainder of the certification period". The respondent had determined the petitioner's SNAP certification period as July 2017 through December 2017.

62. The petitioner verified \$1,603.05 in one-time medical expenses in August 2017. The respondent divides \$1,603.05 by the number of months left in the certification period or in this instance five months. The monthly medical expense amount is \$320.61 or $\$1,603.05 \div 5 = \320.61 .

63. The petitioner verified \$291.10 in one-time medical expenses in September 2017. The respondent divides \$291.10 by the number of months left in the certification period or in this instance four months. The monthly medical expense amount is \$72.76 or $\$291.10 \div 4 = \72.76 .

64. The respondent determined the petitioner's ongoing medical expenses as \$458.24 for March 2017 and ongoing. Since the petitioner verified some one-time medical expenses in August 2017, her medical expenses for August 2017 should be \$642.61 ($\$268 + \$54 + \320.61). Since the petitioner verified some one-time medical expenses in September 2017, her medical expenses for September 2017 and ongoing should be \$715.37 ($\$268 + \$54 + \$320.61 + \72.76).

65. The Policy Manual, CFOP 165-22, Appendix A-1, sets forth the following Eligibility Standards for Food Assistance benefits for March 2017 through September 2017:

(1) \$511 maximum benefit amount for a household of three; (2) \$1,335 maximum net income limit for a household of two and \$1,680 for a household of three (3) \$338.00 standard utility allowance; (4) \$157.00 standard deduction for a household size of two and three; and (5) uncapped shelter deduction for AGs with elderly or disabled members.

66. The Policy Manual, CFOP 165-22, Appendix A-1, sets forth the following Eligibility Standards for Food Assistance benefits effective October 2017 and ongoing:

(1) \$504 maximum benefit amount for a household of three; (2) \$1,702 maximum net income limit for a household of three; (3) \$347.00 standard utility allowance; (4) \$160.00 standard deduction for a household size of two and three; and (5) uncapped shelter deduction for AGs with elderly or disabled members.

67. Pursuant to the various aforementioned authorities and policies, for the months of March 2017 through July 2017, the respondent incorrectly calculated the husband's self-employment income, but correctly calculated the shelter expense, utility expense, and all deductions allowed in the determination of FA benefits.

68. For August 2017, the respondent incorrectly calculated the self-employment income and monthly medical expenses, but correctly calculated the shelter expense, utility expense, and all deductions allowed in the determination of FA benefits.

69. The Policy Manual, 165-22, passage 2610.0106.02 Minimum Benefit (FS) states:

Initial month: Issue no benefits less than \$10. Recurring months: 1. Issue a minimum of eight percent of the maximum benefit for a one-person assistance group to one or two person assistance groups who are eligible. 2. Issue a benefit less than the minimum benefit to eligible assistance groups of three or more. \$1, \$3, or \$5 benefits will round to \$2, \$4, or \$6.

70. The undersigned concludes that the petitioner is eligible for \$12 for September 2017 as follows:

Expenses/Income Dollar	Amount
Self-Employment Income	\$ 823.08
<u>Unearned Income</u>	<u>+\$2182.00</u>
Total Household Income	\$3005.08
<u>Earned income deduction</u>	<u>-\$ 164.62</u>
<u>Standard deduction for a household of three</u>	<u>-\$ 157.00</u>
<u>Excess Medical Expenses</u>	<u>-\$ 680.37</u>
Adjusted income after deductions	\$2003.09
Total Medical Expenses	\$715.37
<u>Medical Deduction</u>	<u>-\$ 35.00</u>
Excess Medical Expense	\$ 680.37

Rent/shelter	\$1000.00
<u>Standard utility allowance</u>	<u>+\$ 338.00</u>
Total rent/utility costs	\$1338.00
<u>Shelter standard (50% adjusted income)</u>	<u>-\$1001.55</u>
Excess shelter deduction	\$ 336.45
Adjusted income	\$2003.09
<u>Excess Shelter Deduction</u>	<u>-\$ 336.45</u>
Adjusted income after shelter deduction	\$1666.64

71. The undersigned took 30% of \$1,666.64 to calculate the FA benefit reduction of \$500. The benefit reduction of \$500 was then subtracted from \$511 (the maximum FA benefit amount for a household of three) to arrive at \$11. Since the benefit amount is under the minimum SNAP amount of \$16, the \$11 is rounded to \$12.

72. The undersigned concludes that the petitioner is eligible for \$481 for October 2017 and ongoing as follows:

Expenses/Income Dollar	Amount
Self-Employment Income	\$ 823.08
<u>Unearned Income</u>	<u>+\$2182.00</u>
Total Household Income	\$3005.08
<u>Earned income deduction</u>	<u>-\$ 164.62</u>
<u>Standard deduction for a household of three</u>	<u>-\$ 160.00</u>
<u>Excess Medical Expenses</u>	<u>-\$ 680.37</u>
Adjusted income after deductions	\$2000.09
Total Medical Expenses	\$715.37
<u>Medical Deduction</u>	<u>-\$ 35.00</u>
Excess Medical Expense	\$ 680.37
Rent/shelter	\$1000.00
<u>Standard utility allowance</u>	<u>+\$ 347.00</u>
Total rent/utility costs	\$1347.00
<u>Shelter standard (50% adjusted income)</u>	<u>-\$1000.05</u>
Excess shelter deduction	\$ 346.95
Adjusted income	\$2000.09

<u>Excess Shelter Deduction</u>	<u>-\$ 346.95</u>
Adjusted income after shelter deduction	\$1653.14

73. The undersigned took 30% of \$1,653.14 to calculate the FA benefit reduction of \$496. The benefit reduction of \$496 was then subtracted from \$504 (the maximum FA benefit amount for a household of three) to arrive at \$8.00.

74. The petitioner's self-employment income was not considered for SNAP benefits for September 2017 through December 2017 as she did not earn any money during 2016.

75. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof indicating the respondent incorrectly denied her Supplemental Nutrition Assistance Program benefits for March 2017 through June 2017. The undersigned concludes the petitioner did not meet the burden of proof indicating the respondent incorrectly determine her eligible for Supplemental Nutrition Assistance Program benefits of \$71 for July 2017 and \$152 for August 2017.

76. The undersigned concludes the respondent did not meet the burden of proof indicating the petitioner's Supplemental Nutrition Assistance Program benefits were correctly terminated for September 2017 through December 2017.

77. The respondent is ordered to approve the petitioner Supplemental Nutrition Assistance Program benefits in the amount of \$12 for September 2017 and \$8 per month for October 2017 through December 2017.

As whether the petitioner and her husband were correctly enrolled in a SSI-Related MN Medicaid instead of full SSI-Related Medicaid benefits

78. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, defines the criteria to receive SSI-Related Medicaid benefits and states, in part:

The Department covers all mandatory coverage groups and the following optional coverage groups:

(1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

...

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

79. Pursuant to the above authority, the petitioner and her husband are eligible for the SSI-Related Medicaid programs as they are considered disabled.

80. The Code of Federal Regulations at 20 C.F.R. § 416.1121 defines earned income as:

Earned income may be in cash or in kind. We may include more of your earned income than you actually receive. We include more than you actually receive if amounts are withheld from earned income because of a garnishment or to pay a debt or other legal obligation, or to make any other payments. Earned income consists of the following types of payments. . .

Net earnings from self-employment. Net earnings from self-employment are your gross income from any trade or business that you operate, less allowable deductions for that trade or business. Net earnings also include your share of profit or loss in any partnership to which you belong. For taxable years beginning before January 1, 2001, net earnings from self-employment under the SSI program are the same net earnings that we would count under the social security retirement insurance program and that you would report on your Federal income tax return. (See §404.1080 of this chapter.) For taxable years beginning on or after January 1, 2001, net earnings from self-employment under the SSI program will also include the earnings of statutory employees. In addition, for SSI purposes only, we consider statutory employees to be self-employed individuals. Statutory employees are agent or commission drivers, certain full-time life insurance salespersons, home workers, and traveling or city salespersons. (See §404.1008 of this chapter for a more detailed

description of these types of employees).

81. Pursuant to the above authority, the petitioner's and her husband's self-employment incomes are considered included income in the determination of their eligibility for MSP Medicaid benefits.

82. The Code of Federal Regulations at 20 C.F.R. § 416.1121 defines unearned income as:

Some types of unearned income are—(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits...

83. Pursuant to the above authority, the petitioner and her husband's Social Security incomes are considered included income in the determination of her eligibility for MSP Medicaid benefits.

84. The petitioner and her husband's self-employment incomes should be considered in the determination of their MSP Medicaid Benefits; however, in this instance, the undersigned shall not consider their self-employment incomes, but only consider their Social Security incomes.

85. Fla. Admin. Code R. 65A-1.713 (1)(a), SSI-Related Medicaid Income Eligibility Criteria established income limits and states, in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan.

The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

86. Effective January 2017 through June 2017, the Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for a couple for MEDS-AD as \$1,174.

87. Effective July 2017 and ongoing, the Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for a couple for MEDS-AD as \$1,191.

88. Pursuant to the above authority and policies, the petitioner's and her husband's monthly Social Security incomes (\$2,182 or \$1,230 + \$952) exceeds the Medicaid income standard for them to receive full SSI-Related Medicaid benefits.

89. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof indicating her and her husband were incorrectly denied full SSI-Related Medicaid benefits. Furthermore, the petitioner and her husband were correctly enrolled in a MN SSI-Related Medicaid Program with a monthly SOC effective March 2017 and ongoing.

As whether the respondent correctly determined the petitioner's son ineligible for full Medicaid benefits

90. Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility Criteria, in part states:

If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI...

91. According to the above authority, to be eligible for Family-Related Medicaid benefits, the petitioner's son must have a minor child under age 18 living in the

household with him. Since the petitioner's son does not have a minor child under age 18 living in the household; therefore, he does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

92. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

For an individual less than 65 years of age to receive Medicaid benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R.

§ 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy...

93. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, the petitioner's son must be determined disabled as he is under the age of 65. Since the petitioner's son is under the age of 65 and has not been determined disabled by SSA, he does not meet the technical requirement to be eligible for SSI-Related Medicaid benefits.

94. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof in establishing her son's application for Medicaid benefits was terminated incorrectly by the respondent effective July 2017 and ongoing.

Whether the respondent correctly determined the petitioner and her husband are

ineligible for the MSP programs that pays for their Medicare part B premium

95. The Fla. Admin. Code R. 65A-1.702, Medicaid Special Provisions, states in relevant part:

(12) Limits of Coverage

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium...

(d) Part B Medicare Only Beneficiary(QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)

96. The Code of Federal Regulations at 20 C.F.R. § 416.1121 defines earned income as:

Earned income may be in cash or in kind. We may include more of your earned income than you actually receive. We include more than you actually receive if amounts are withheld from earned income because of a garnishment or to pay a debt or other legal obligation, or to make any other payments. Earned income consists of the following types of payments. . .

Net earnings from self-employment. Net earnings from self-employment are your gross income from any trade or business that you operate, less allowable deductions for that trade or business. Net earnings also include your share of profit or loss in any partnership to which you belong. For taxable years beginning before January 1, 2001, net earnings from self-employment under the SSI program are the same net earnings that we would count under the social security retirement insurance program and that you would report on your Federal income tax return. (See §404.1080 of this chapter.) For taxable years beginning on or after January 1, 2001, net earnings from self-employment under the SSI program will also include the earnings of statutory employees. In addition, for SSI purposes only, we consider statutory employees to be self-employed individuals. Statutory employees are agent or commission drivers, certain full-time life insurance salespersons, home workers, and traveling or city salespersons. (See §404.1008 of this chapter for a more detailed description of these types of employees).

97. Pursuant to the above authority, the petitioner and her husband's self-employment incomes are considered included income in the determination of her eligibility for MSP Medicaid benefits.

98. The Code of Federal Regulations at 20 C.F.R. § 416.1121 defines unearned income as:

Some types of unearned income are—(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits...

99. Pursuant to the above authority, the petitioner and her husband's Social Security incomes are considered included income in the determination of her eligibility for MSP Medicaid benefits.

100. The petitioner and her husband's self-employment incomes should be considered in the determination of their MSP Medicaid Benefits; however, in this instance, the undersigned shall not consider their self-employment incomes, but only consider their Social Security incomes.

101. The Fla. Admin. Code R. 65A-1.713 further addresses the SSI-Related Medicaid Income Eligibility Criteria as follows:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

...

(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

102. The Code of Federal Regulations at 20 C.F.R. 416.1124(c)(12) sets forth income that is not counted in this program and states, "The first \$20 of any unearned income in a month other than...income based on need."

103. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for the month of January 2017 through June 2017 as follows: the Income Standard for QMB as \$1,339; the Income Standard for SLMB as \$1,606; and the Income Standard for QI1 as \$1,808.

104. The Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Limits for a household size of two for the month of July 2017 and ongoing as follows: the Income Standard for QMB as \$1,354; the Income Standard for SLMB as \$1,624; and the Income Standard for QI1 as \$1,827.

105. Pursuant to the above authorities and polices, the petitioner and her husband's Social Security incomes minus the first \$20 of their unearned income exceeds the income limit for the QMB, SLMB, and QI1 Programs; therefore, the respondent correctly terminated the petitioner and her husband's QMB Medicaid benefits effective March 2017 and correctly denied their QI1 Medicaid benefits effective April 2017 and ongoing.

106. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met the burden of proof indicating the petitioner and her husband's QMB benefits were correctly terminated effective March 2017 and ongoing. Furthermore, the undersigned concludes the petitioner did not meet the burden of proof

in establishing the respondent incorrectly denied her and her husband's QI1 benefits effective April 2017 and ongoing.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Supplemental Nutrition Assistance Program and Medicaid appeals are partially GRANTED and partially DENIED as follows:

The appeal concerning the petitioner's Supplemental Nutrition Assistance Program benefits for March 2017 through August 2017 is DENIED. The appeal concerning the petitioner's Supplemental Nutrition Assistance Program benefits for August 2017 through December 2017 is GRANTED. The respondent is ORDERED to approve the petitioner Supplemental Nutrition Assistance Program benefits in the amount of \$12 for September 2017 and \$8 per month for October 2017 through December 2017.

The appeal concerning the petitioner and her husband's application for full SSI-Related Medicaid benefits effective March 2017 and ongoing is DENIED.

The appeals concerning the petitioner and her husband's application for Qualified Medicare Benefits effective March 2017 and ongoing and application for Qualified Individual 1 effective April 2107 and ongoing are DENIED.

The appeal concerning the petitioner son's application for full Medicaid benefits effective July 2017 is DENIED.

ANY FOOD STAMP BENEFITS DUE APPELLANT PURSUANT TO THIS ORDER MUST BE AVAILABLE WITHIN (10) TEN DAYS OF THIS DECISION OR

**WITHIN (60) SIXTY DAYS OF THE REQUEST FOR THE HEARING. ANY BENEFITS
DUE WILL BE OFFSET BY PRIOR UNPAID OVERISSUANCES**

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 16 day of October, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Sep 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04509

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 Hillsborough
UNIT: 883DT

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on July 27, 2017 at 2:53 p.m.

APPEARANCES

For Petitioner: [REDACTED]

For Respondent: Teshia Green, Economic Self Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's action to deny the petitioner's application for SSI-Related Medicaid benefits is correct. The burden of proof is assigned to the petitioner by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present and testified. The petitioner was represented by [REDACTED], his Power of Attorney. The petitioner submitted one exhibit, which was accepted into evidence and marked as Petitioner's Exhibit "1". The respondent was

represented by Teshia Green, Economic Self Sufficiency Specialist II, with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). The respondent provided one witness who testified: Consevilla Martinez, Operations Services Manager with the Department of Health Division of Disability Determination (hereafter “DDD”). The respondent submitted two exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” and “2”.

FINDINGS OF FACT

1. On March 18, 2017, the petitioner applied for Supplemental Security Income (SSI) benefits from the Social Security Administration (SSA). To the date of the hearing, the petitioner’s SSI application had not been approved or denied by SSA. (Respondent’s Exhibit 1)

2. On March 20, 2017, the petitioner submitted an application for Food Assistance (FA) and Medicaid benefits. FA benefits are not an issue under appeal. The application listed the petitioner as the only household member; as 41 years old; and as claiming to be disabled. (Respondent’s Exhibit 1)

3. The petitioner’s alleged diagnoses were [REDACTED]

[REDACTED] (Respondent’s testimony) The petitioner’s listing impairments DDD stated on the Medical Evaluation were 3.02, 4.02, 12.04, and 12.06. (Respondent’s Exhibit 1)

4. The petitioner’s medications include [REDACTED] unknown high blood pressure medicine, [REDACTED]. The petitioner took both [REDACTED] and [REDACTED] as the psychiatrist believed some of the petitioner’s shaking issues were related to [REDACTED]. The petitioner’s shaking issues have decreased since taking [REDACTED]

except for when he was anxious or hot. If Latuda were to be successful, the petitioner would no longer be prescribed [REDACTED] (Petitioner's testimony)

5. The petitioner suffered from tremors where he would shake from head to toe and the shaking could last a few minutes, a few hours, or several days. The tremors were believed to be part of his [REDACTED]. During an episode, the petitioner shook so severely he was unable to hold a glass of milk without the milk spilling on him. After suffering an episode, the petitioner would stutter and slur his words. (Petitioner's testimony)

6. On April 17, 2017, the respondent submitted both the Disability Determination and Transmittal form and a packet of medical information to DDD to determine if the petitioner met the criteria to be considered disabled. (Respondent's testimony)

7. The respondent explained DDD is responsible for determining the petitioner's disability eligibility by requesting and reviewing copies of his medical records. DDD also spoke with the petitioner concerning his ability to complete his Activities of Daily Living (ADL). (Respondent's testimony)

8. On February 10, 2017, the Florida Department of Corrections completed a Summary of Outpatient Services on the petitioner. The period of the Summary is from June 28, 2016 through March 9, 2017. It listed the petitioner's diagnosis as Unspecified [REDACTED]; the petitioner's treatment was for mood swings; and the petitioner's failure to take a prescription while incarcerated. (Petitioner's Exhibit 1)

9. The petitioner was hospitalized many times in 2017. He was first hospitalized in March 2017 and his last hospitalization was in July 2017. The petitioner was hospitalized on March 10, 2017 for gastritis; on March 27, 2017 for neck and back pain;

on May 22, 2017 for lithium toxicity; on July 1, 2017 for bronchitis; on July 10, 2017 for severe abdominal pain and constipation; on July 11, 2017 for a possible seizure; and on July 18, 2017 for an unspecified mental disorder. (Petitioner's Exhibit 1)

10. On July 19, 2017, an assessment was completed on the petitioner by [REDACTED] that indicated he was discharged from treatment within forty-eight hours. The petitioner reported to the doctor that he was less [REDACTED] [REDACTED] while in treatment; had the ability to verbalize his thoughts and feelings more openly; and was showing better coping skills dealing with his mental illness. (Petitioner's Exhibit 1)

11. The respondent explained the petitioner's medical records indicated he could ambulate without assistance despite suffering tremors; was alert and able to follow commands; and was able to complete personal care activities without any assistance. Furthermore, the medical records indicated the petitioner was never hospitalized due to asthma; suffered from a bout of pneumonia; had a regular heartbeat, heart rhythm, no heart murmur; and showed no edema in his extremities. (Respondent's testimony)

12. [REDACTED] from DDD determined the petitioner exhibited a moderate degree of limitation in interacting with others and with concentration, persistence, and pace; and exhibited a mild degree of limitation in the ability to adapt or manage himself. (Respondent's Exhibit 2 and Respondent's testimony)

13. DDD determined the petitioner could understand, retain, and complete complex instructions; could consistently and usefully perform familiar tasks on a sustained basis with minimal or normal supervision; and could adjust to the mental demands of most new task settings. (Respondent's Exhibit 2 and Respondent's testimony)

14. DDD completed a five-step analysis to determine if the petitioner is disabled. DDD concluded the petitioner meets Step 1 as he is not employed. DDD concluded the petitioner's impairments are severe; therefore, he meets Step 2. In regards to Step 3, the petitioner's impairments do not meet or equal a listing impairment. DDD went on to Step 4, which determined if the petitioner was able to perform past relevant work. As the petitioner has no work history, he could not perform past relevant work; therefore, he meets Step 4. DDD determined the petitioner could perform other work and determined the petitioner not disabled as he did not meet Step 5. (Respondent's Exhibit 2 and Respondent's testimony)

15. DDD determined, based on the assessment of the petitioner, he was able to complete light Residual Functional Capacity (RFC) or able to complete light work. The respondent also determined the petitioner could frequently lift ten pounds; occasionally carry twenty pounds; was able to walk and stand six to eight hours per day; was able to sit for six to eight hours per day; and had an unlimited ability to push and pull objects. However, the petitioner was restricted to climbing stairs, ladders, ropes, etc. and had environmental limitations where he was to avoid moderate exposure to humidity, dust, and other environmental issues. (Respondent's testimony)

16. Based on documentation and the assessment of the petitioner, DDD determined the petitioner could perform an unskilled work activity even though he had no prior work history. DDD believed the petitioner could perform work as a sorter, key cutter, and paper cutter. (Respondent's testimony)

17. The petitioner disagreed with DDD's determination of the types of employment he could hold as he became easily confused and would have to ask a person to repeat

what was said several times until he understood the conversation. His Power of Attorney accompanied him on appointments so she was able to advocate for him. The petitioner cannot shave his head with a razor as one time while shaving his head he cut himself so much he required eight to ten Band-Aids. (Petitioner's testimony)

18. On June 8, 2017, the respondent denied the petitioner's application for SSI-Related Medicaid benefits as DDD determined he was not disabled. (Respondent's testimony)

19. On June 9, 2017, the respondent mailed the petitioner a Notice of Case Action indicating his March 20, 2017 Medicaid application was denied as "You or a member of your household do not meet the disability requirement. No household members are eligible for this program". (Respondent's Exhibit 1)

20. On June 12, 2017, DDD returned the Disability Determination and Transmittal form to the respondent with the denial code of N32. N32 means "Non-pay-Capacity for substantial gainful activity – other work, no visual impairment". (Respondent's testimony) Handwritten on the DDD transmittal is "PRTC & MRFC by Dr. Thomas Clark Ph.D.". (Respondent's Exhibit 1) The respondent did not submit either the "PRTC or MRFC" into evidence.

21. The petitioner requested Medicaid benefits as he and his aunt are unable to pay for his physician visits, medications, and various treatments that are required to treat his ongoing medical conditions. (Petitioner's testimony)

CONCLUSIONS OF LAW

22. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

23. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

24. Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility

Criteria, in part states:

If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI...

25. According to the above authority, to be eligible for Family-Related Medicaid benefits, the petitioner must have a minor child under age 18 living in the household with him. Since the petitioner does not have a minor child under age 18 living in the household, he does not meet the technical requirement to be eligible for Family-Related Medicaid benefits.

26. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for SSI-Related Medicaid Coverage Groups. The MEDS-AD Demonstration Waiver is a coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

For an individual less than 65 years of age to receive Medicaid benefits, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R.

§ 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental

impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see § 416.960(b)) or any other substantial gainful work that exists in the national economy...

27. Pursuant to the above authority, to be eligible for SSI-Related Medicaid, the petitioner must be determined disabled as he is under the age of 65. Since the petitioner is under the age of 65 and has not been determined disabled by SSA, DDD is to conduct an independent review to determine if the petitioner meets the criteria of disability.

28. Federal Regulations at 20 C.F.R. § 404.1520 address the disability evaluation and states:

(a) (4) The five-step sequential evaluation process. The sequential evaluation process is a series of five "steps" that we follow in a set order. See paragraph (h) of this section for an exception to this rule. If we can find that you are disabled or not disabled at a step, we make our determination or decision and we do not go on to the next step. If we cannot find that you are disabled or not disabled at a step, we go on to the next step. Before we go from step three to step four, we assess your residual functional capacity. (See paragraph (e) of this section.) We use this residual functional capacity assessment at both step four and step five when we evaluate your claim at these steps. These are the five steps we follow:

(i) At the first step, we consider your work activity, if any. If you are doing substantial gainful activity, we will find that you are not disabled. (See paragraph (b) of this section.)

(ii) At the second step, we consider the medical severity of your impairment(s). If you do not have a severe medically determinable physical or mental impairment that meets the duration requirement in § 404.1509, or a combination of impairments that is severe and meets the duration requirement, we will find that you are not disabled. (See paragraph (c) of this section.)

(iii) At the third step, we also consider the medical severity of your impairment(s). If you have an impairment(s) that meets or equals one of our listings in appendix 1 of this subpart and meets the duration requirement, we will find that you are disabled. (See paragraph (d) of this section.)

(iv) At the fourth step, we consider our assessment of your residual functional capacity and your past relevant work. If you can still do your past relevant work, we will find that you are not disabled. See paragraphs (f) and (h) of this section and § 404.1560(b).

(v) At the fifth and last step, we consider our assessment of your residual functional capacity and your age, education, and work experience to see if you can make an adjustment to other work. If you can make an adjustment to other work, we will find that you are not disabled. If you cannot make an adjustment to other work, we will find that you are disabled. See paragraphs (g) and (h) of this section and § 404.1560(c).

29. Pursuant to the above authority, Step 1 of the sequential analysis for disability is to determine if the individual is engaging in substantial gainful activity. Since the petitioner is not working, he meets Step 1.

30. Pursuant to the above authority, Step 2 is to determine if the individual has an impairment or a combination of impairments that are “severe”. Since DDD concluded the petitioner’s mental impairments are severe, he meets Step 2.

31. Pursuant to the above authority, Step 3 is to determine whether or not the individual’s impairments meet or equal a listed impairment. DDD determined the petitioner’s listed impairments as [REDACTED].

32. Appendix 1 to Subpart P of Part 404 – Listing of Impairments indicates the types of body systems that are considered severe enough to prevent an individual from completing any gainful activity. Appendix 1 was utilized to determine if the petitioner’s impairments meet or equal a listed impairment.

33. The petitioner’s first listing was [REDACTED] due to all causes but [REDACTED]. For the petitioner’s impairment to meet this listing, the petitioner must submit medical records to indicate he exhibited respiratory complications, which required three hospitalizations within a twelve-month period. The

petitioner submitted medical records to indicate he was hospitalized one time for bronchitis; therefore, his impairment does not meet or equal the listed impairment of chronic respiratory disorders.

34. The second listing was [REDACTED]. For the petitioner's impairment to meet this listing, he must submit medical records to indicate he exhibited signs of pulmonary or systemic congestion or limited cardiac output; his impairment severely limited his Activities of Daily Living (ADL); and he had three or more episodes of chronic heart failure within a twelve-month period. The petitioner did not submit any medical records to support his impairment meets or equals the listed impairment of chronic heart failure.

35. The third and four listings were 12.04 or [REDACTED]
[REDACTED]. For the petitioner's impairments to meet these listings, he must submit medical records and other documentation to indicate his mental disorders result in an "extreme limitation" in his ability to learn, recall, and use information; to perform work activities; to interact with others; to focus and stay on task with his work activities; to regulate emotions; to control his behavior, and to maintain his well-being in a work setting.

36. "Extreme limitation" means the inability to function independently, appropriately, effectively, and on a sustained basis in each of the aforementioned areas. The medical records and other documentation do not indicate the petitioner's mental disorders result in an "extreme limitation" in the aforementioned areas.

37. The petitioner's mental disorders must also be medically documented to have lasted for a period of over two years. The medical documentation submitted does not indicate the petitioner has suffered from his mental disorders for over two years.

38. The petitioner did not submit any medical records or other documentation to support his impairments meet or equal the listed impairments of bipolar and related disorders and anxiety or obsessive-compulsive disorders.

39. Since the petitioner's impairments do not meet or equal the listed impairments, he does not meet Step 3.

40. Pursuant to the above authority, Step 4 determines if an individual can perform past relevant work. Since the petitioner has no work history, he meets Step 4.

41. Pursuant to the above authority, Step 5 determines if an individual has the ability to adjust and to perform any work in the national economy. DDD reviews medical records and other documentation to determine if the petitioner has any limitations from performing work.

42. After reviewing all of the documentation, DDD determined the petitioner is capable of performing light RFC or light work. The petitioner can be employed as a sorter, key cutter, and paper cutter. While the petitioner may have severe medical impairments, the evidence does not show these impairments preclude him from performing the aforementioned jobs; therefore, the petitioner does not meet Step 5. For this reason, DDD has correctly determined the petitioner not to be disabled as he did not meet Step 5 of the five-step sequential evaluation process.

43. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner has not met his burden of proof to indicate the respondent incorrectly denied his March 20, 2017 application for SSI-Related Medicaid benefits.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Medicaid appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 13 day of September, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 07, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04520

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88778

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned hearing officer convened an administrative hearing in the above-referenced matter on July 10, 2017 at 10:37 a.m. All parties appeared by telephone from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Stephanie Gurley, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of June 12, 2017 denying ongoing coverage in the Qualified Individual 1 (QI1) program at his most recent recertification. During the hearing, the burden of proof was assigned to the petitioner. Upon review, the burden of proof is assigned to the respondent by the preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or respondent) administers eligibility for the Medicaid Program for the state of Florida. The Department presented evidence which was marked and accepted as Respondent's Exhibits "1" through "10" respectively. The petitioner did not present any evidence for the undersigned to consider. The record was closed on July 10, 2017.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. The petitioner is 67 years old and is the sole member of the assistance group, see Respondent's Exhibit 3.
2. On June 7, 2017, the petitioner applied for the Medicare Savings Plan (MSP) for himself, see Respondent's Exhibit 1. No income was reported on this application.
3. On this application the earned income section of the application was prepopulated by a system generated update from the Federal Data Sharing Hum (FDSH), see Respondent's Exhibits 2 & 3.
4. The petitioner asserted that he provided paystubs to the Department. The Department used wage information provided by The Work Number, see Respondent's Exhibit 7 & Petitioner testimony. .
5. The Department verified the petitioner's receipt of Social Security Disability (SSDI) via the Social Security On-Line Query (SOLQ), see Respondent's Exhibit 10.

6. On June 12, 2017, the Department issued a Notice of Case Action (NOCA) to the petitioner informing him that his request for MSP was denied as he was over income for the program, see Respondent's Exhibit 4.

7. The Department closed the MSP benefits effective June 2017, see Respondent's Exhibit 4.

8. The petitioner's gross monthly SSDI benefits are \$1,060, see Respondent's Exhibit 10.

9. The petitioner is paid weekly and his gross paychecks for the last two weeks in May and the first two weeks in June were used to determine the June 2017 budget, see Respondent's Exhibit 7. They are as follows:

June 9, 2017	\$414.50
June 2, 2017	\$346.55
May 26, 2017	\$489.24
May 19, 2017	<u>\$489.24</u>
	\$1,739.53

10. The gross monthly income limit for the MSP, specifically the Qualified Individual 1 Program is \$1,357, see Respondent's Exhibit 9.

11. The petitioner's countable income is calculated using the following formula. The gross unearned income of the petitioner is \$1,060 in SSDI benefits. The petitioner is eligible for a \$20 standard deduction of his gross unearned income ($\$1,060 - \$20 = \$1,040$). The petitioner's gross earned income is \$1,739.53. The petitioner is eligible for a \$65 earned income disregard which is subtracted from the gross earnings ($\$1,739.53 - \$65 = \$1,674.53$). The petitioner is eligible to have $\frac{1}{2}$ of that balance disregarded ($\$1,674.53 / 2 = \837.27). The remaining balance of \$837.27 is the countable

earned income. The countable unearned income of \$1,040 + the countable earned income of \$837.27=\$1,877.27 in total countable income.

\$1,040.00
+\$ 837.27
\$1,877.27

12. The Department incorrectly calculated the petitioner's income using the net SSDI amount. Even so, his income is over the program limits, see Respondent's Exhibit 6.

13. There are three programs which pay the Medicare premium: Qualified Medicare Beneficiaries (QMB), Special Low Income Beneficiaries (SLMB), and Qualifying Individuals 1 (QI1). QMB has an income limit for individuals of \$1,005. SLMB, has an income limit for individuals of \$1,206. QI1 has an income limit for individuals of \$1,357.

The petitioner's countable income of \$1,877.27 exceeds each of the limits. The Department explained this is why the QI1 benefit was terminated for the petitioner.

14. Even if both the net SSDI of \$680 and the countable net earned income of \$837.27 were used in the budget calculations, the petitioner's income would still exceed the limit for the program.

\$680.00
\$837.27
\$1,517.27

15. The petitioner appealed this action on June 12, 2017, as he states he is barely making it and his earnings are lower now. He believes that he is eligible for the Medicare Savings Program.

CONCLUSIONS OF LAW

16. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

17. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. Fla. Admin. Code R. 65A-1.713 (1) (j), SSI-Related Medicaid Income Eligibility Criteria, sets forth the income limits for recipients of SSI-Related Medicaid and states in pertinent parts.

An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:"

...

(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level.

...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

19. In this instant case, the petitioner's total countable income is \$1,877.27 and is over the one-person income limit for QMB, SLMB and QI1.

20. The Department's Program Policy Manual CFOP 165-22 at 2040.0819, Qualifying Individuals 1 (QI1) (MSSI) states that:

To qualify as a Qualifying Individuals 1 beneficiary, an individual must meet all the following eligibility criteria:

1. Be enrolled in Medicare Part A;
2. **Have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level; (emphasis mine)**
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9);
4. Be a U.S. citizen or qualified noncitizen;
5. Take necessary steps to access any other benefits to which they may be entitled; and
6. Does not qualify for Medicaid under any other Medicaid coverage group, except Medically Needy.

21. The above policy states that an individual must meet all of the eligibility criteria to be approved for QI1 program benefits.

22. Determined on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the Department's action to deny the petitioner QI1 benefits is correct. The undersigned cannot find a more favorable outcome for the petitioner.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is DENIED and the Department's actions are upheld.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
17F-04520
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DONE and ORDERED this 07 day of September, 2017,
in Tallahassee, Florida.



Ursula Lett-Robinson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Sep 07, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04571

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 66032

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 5, 2017 at 1:00 p.m.

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: Sylma Dekony, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

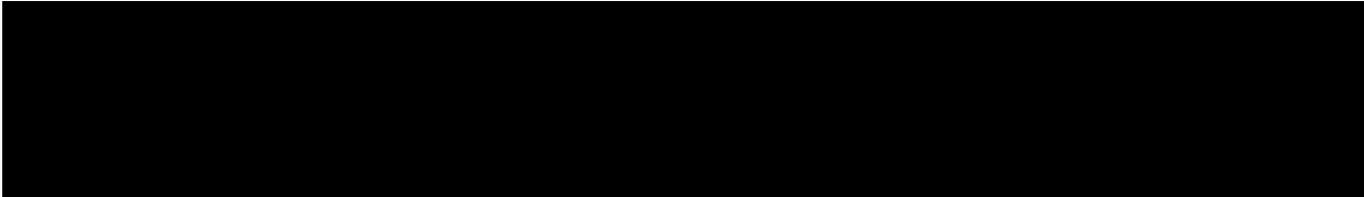
The petitioner is appealing the respondent's action to deny her application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits. The respondent submitted four exhibits, which were entered into evidence as Respondent's Exhibits "1" through "4".

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner's husband was receiving Medicare Savings Plan (MSP) under the Special Low-Income Medicare Beneficiary (SLMB) Program and Medically Needy (MN) Program with a share of cost (SOC).
2. On February 13, 2017, the petitioner (61) filed an application through the Federally Facilitated Marketplace¹. The application was for Adult-Related (SSI) Medicaid benefits for herself. On the application, the petitioner reported that she is not age 65 or older and does not have any minor children.
3. She reported on her application the household's sources of income were her husband's Social Security Income, his pension and other sources of \$333.33 per month.
4. The respondent reviewed the application and notated the following:



5. The Department utilized the State of Florida Social Security Administration (SSA) State On-Line Query to verify information from the SSA. The information on the Query screen comes directly from SSA and indicated that the petitioner was denied disability benefits through SSA on February 24, 2015 with a denial code N-04. Code N-04 means; "Non-Pay-Recipient's non-excluded resources exceed Title XVI limitations."

¹ The Marketplace offers a single application that determines eligibility for multiple health care programs, including private Qualified Health Plans, Medicaid, or Florida Kid Care. The application is sent to the Department of Children and Families for eligibility determination.

FINAL ORDER (Cont.)

17F-04571

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6. On February 16, 2017, the respondent mailed the petitioner a pending notice giving her a deadline of February 17, 2017 to contact the office to complete a telephone interview and to provide the following information within ten (10) days:

Dear [REDACTED]

The following is information about your eligibility.

Once you receive your case number you can go to www.myflorida.com/accessflorida to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need to have a phone interview with you to determine your eligibility or to continue your benefits. Please call (863) 589 - 0217 on or before February 17, 2017 between the hours of 8:00 A.M and 3:00 P.M for your phone interview.

To finish your application we need the following information no later than ten days from the date of your interview.

*Proof of loans, contributions, or gifts used to pay your expenses this month or a statement from anyone paying your household's bill

Please Complete and sign the "Financial Information Release" form

Proof of income and assets for each month you are requesting retroactive Medicaid

Other - please see comments below

5Juana, Since you are claiming to be disabled, You must either return the DDD Questionnaire mailed out separately or call for DDD phone interview, It is IMPORTANT that when you call for your interview that you have available the name, address, and phone number of your medical providers (doctors and hospitals), including name and any treatments and procedures received and the date received. Sign and date the Authorization to Disclose. The Financial Information Release mailed with this notice must be signed by you and your spouse, if married, your designated representative, or legal guardian. Note: you must also apply for benefits with the Social Security Administration and provide proof of application before Medicaid can be approved and diligently pursue to conclusion any benefits you may be entitled to. (YOU DO NOT NEED TO CALL FOR DDD INTERVIEW IF YOU RETURN THE QUESTIONNAIRE/FORMS REQUIRED) also pended for all assets/ and Juana's other sources of income

7. On March 7, 2017, the petitioner submitted the Division of Disability Determination (DDD) questionnaire form to the respondent (Respondent Exhibit 3, page 46). By submitting the DDD questionnaire form, the petitioner was no longer required to complete a DDD interview. No additional pending notice was issued to the petitioner.

8. DDD is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner's application was referred to DDD on March 7, 2017.

9. On March 24, 2017, the petitioner contacted the Department to find out the status of her case. The Department representative explained the case was still pending DDD's decision. The petitioner explained she had a hard time understanding the notices sent to her. It is unknown why the Department representative did not remind the petitioner

additional pending information was needed based on the February 16, 2017 pending notice.

10. On April 13, 2017, a favorable disability determination was rendered by DDD finding the petitioner disabled beginning November 1, 2016.

11. On April 14, 2017, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application due to “We did not receive all the information requested to determine eligibility”. The respondent explained that the petitioner did not submit proof of “income from other sources” and did not apply for other benefits (SSA) for which she may have been eligible.

12. The petitioner explained she does not have any sources of income and believes the \$333.00 other income was added by mistake.

13. The respondent explained partial information was provided by the petitioner. The respondent did not send the petitioner a new notice to inform her that there was missing information. The respondent explained that since the application is now over thirty days old, the petitioner must reapply.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to § 409.285, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under § 409.285, Fla. Stat.

15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

16. Fla. Admin. Code R. 65A-1.205 addresses the eligibility determination and verification processes and states in relevant part:

(1)(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility. If the Department schedules a telephonic appointment, it is the Department's responsibility to be available to answer the applicant's phone call at the appointed time. If the information, documentation or verification is difficult for the applicant to obtain, the eligibility specialist must provide assistance in obtaining it when requested or when it appears necessary.

...

(b) Time standards for processing applications...

All days counted after the date of application are calendar days. Applicant delay days do not count in determining compliance with the time standard. The Department uses information provided on the Screening for Expedited Medicaid Appointments form, CF-ES 2930, 04/2007, incorporated by reference, to expedite processing of Medicaid disability-related applications.

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview... If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension...

(d) In accordance with 42 C.F.R. § 435.911, unusual circumstances that might affect the timely processing of Medicaid applications include applicant delay, physician delay and emergency delay as defined below. Unusual circumstances are non-agency processing delays, and the calendar time passing during such delay(s) does not count as part of the 90-day time standard for determining the timeliness of Medicaid eligibility decisions based on disability...

17. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at passage number 0640.0400, APPLICATION TIME STANDARDS (MSSI, SFP), states in part:

The time standard begins upon receipt of a signed application. Process applications as soon as possible after the assistance group (AG) completes all eligibility requirements. If the household completes all requirements and provides all information, process the application by the 30th day after the application date. **Process applications and determine eligibility or ineligibility within 90 calendar days after the date of the application for individuals who claim a disability.** (Emphasis added)

18. The Policy Manual CFOP 165-22, at passage number 0640.0401, Requests for Additional Information/Time Standards (MSSI, SFP), states in part:

If the Department needs additional information or verification from the applicant, provide:

1. a written list of items required in order to complete the application process,
2. the date the items are due in order to process the application timely, and
3. the consequences for not returning additional information by the due date.

The verification/information due date is 10 calendar days after the date of the interview or if there is no interview requirement, 10 days after the date the pending notice is generated. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next business day. At the individual's request, extend the due date. Leave the case pending until the 30th day after the date of application to allow the household a chance to provide verifications. Assist applicants with getting missing verifications when needed.

1. If the applicant completes the interview, provides all verifications, and meets all eligibility factors, approve the application by the 30th day for Medicaid. If the 30th day falls on a weekend or holiday, approve the application on the business day before the 30th day.
2. If the household does not return the verifications by the 30th day after the date of application, deny the application on the 30th day. If the 30th day falls on a weekend or holiday, deny the application on the next business day after the 30th day.

19. According to the authority cited above, the responsibility of obtaining verification/information falls on the petitioner; however, the respondent has an obligation to provide the petitioner assistance in obtaining the required verification or extend the due date if necessary. The petitioner testified she had a difficult time understanding the notices issued to her by the Department. The petitioner explained she does not receive any income for herself and could not explain why on the application it was noted she received \$333.00 as other income. In this case, the petitioner submitted the DDD questionnaire form; therefore, no interview was conducted to seek clarification from the petitioner. The respondent did not send her another pending notice to inform her of the missing verification. The findings show the petitioner contacted the Department on March 24, 2017 regarding the status of her case; however, the Department representative did not explain to the petitioner that pending information was still needed to complete her Medicaid application.

20. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner met her burden of proof in establishing that the respondent incorrectly denied her February 13, 2017 application for ongoing Adult-Related (SSI) Medicaid benefits and for the retroactive coverage months (November 2016, December 2016 and January 2017). Therefore, the undersigned hereby remands this matter to the Department to obtain the necessary information and complete the eligibility determination process for the petitioner's Adult-Related (SSI) Medicaid benefits. The Department is to preserve the petitioner's original application date of February 13, 2017 and determine her eligibility for Adult-Related (SSI) Medicaid benefits from that date as

well as retroactive Medicaid coverage. Once an eligibility determination is made, the respondent is to issue a new notice to the petitioner including her appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted and remanded to the Department to take corrective action as specified in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 07 day of September, 2017,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Sep 06, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04581

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88701

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on July 24, 2017 at 3:42 p.m.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Hillary Campbell, Economic Self-Sufficiency Specialist
II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her recertification application for Medicare Saving Plan (MSP)/Qualifying Individual 1 (QI1) benefits. At the hearing, the burden of proof was assigned to the petitioner, but after careful consideration the burden of proof was reassigned to the respondent by a preponderance of evidence.

PRELIMINARY STATEMENT

At the hearing, the respondent presented eight exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 8. The petitioner presented two exhibits which were accepted into evidence and marked as Respondent's Composite Exhibit 1 and Respondent's Exhibit 2.

FINDINGS OF FACT

Based on the documentary and oral evidence presented at the hearing, and on the entire record of this proceeding, the following Findings of Fact are made:

1. The petitioner was approved for MSP/QI1 in a prior certification. In that certification, the respondent did not count all of the petitioner's income, as a result her monthly household income was below the maximum income standard of \$1,325 (in 2016) to be eligible for QI1. The respondent approved her for QI1 benefits in error.
2. QI1 is a Medicaid program that pays for Medicare Part B premium. To be eligible for QI1, applicants cannot exceed the QI1 income standard.
3. On May 30, 2017, the petitioner submitted a recertification application for Food Assistance (FA), Medicaid and MSP.
4. The respondent reviewed the petitioner's application and determined she was ineligible for MSP benefits. The respondent determined the petitioner's monthly countable income by adding her Social Security Disability Income (SSDI) of \$1,263 to her Social Security Widow's benefits of \$482, resulting in her total unearned income of \$1,745. A \$20 unearned income disregard was subtracted resulting in \$1,725 as her countable income. Her countable income exceeded the income standards for QI1 of \$1,341 effective January 2017 and \$1,357 effective July 2017.

5. On June 1, 2017, the respondent mailed a Notice of Case Action to the petitioner, informing her that her recertification application dated May 30, 2017, was denied. The reason given for the denial was that her household's income was too high to qualify for the program.

6. On June 13, 2017, the petitioner requested a hearing to challenge the respondent's action.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under section 409.285, Florida Statutes.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. Federal regulation at 20 C.F.R. § 416.1121 define different types of unearned income as follows:

(a) *Annuities, pensions, and other periodic payments.* This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, veterans benefits, worker's compensation, railroad retirement annuities and unemployment insurance benefits.

...

(e) *Death benefits.* We count payments you get which were occasioned by the death of another person...

10. The above cited authorities states that Social Security payments are to be included as unearned income.

11. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at passage 1840.0900 addresses BENEFITS (MSSI, SFP) and defines unearned income

as:

1. Social Security payments;
2. private benefit income such as annuities, pensions, retirement, or disability (other than SSA);
3. veterans payments;
4. Agent Orange benefits;
5. workers' compensation;
6. railroad retirement;
7. unemployment benefits;
8. striker support;
9. severance pay; or
10. death benefits.

12. Income limits for Medicare Savings Plan benefits are set forth in the Fla. Admin.

Code R. 65A-1.713. It states:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(b) For QMB, income must be less than or equal to the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but less than 120 percent of the federal poverty level....

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid.

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100, et seq...

(4) Income Budgeting Methodologies. To determine eligibility SSI budgeting methodologies are applied except where expressly prohibited by 42 U.S.C. §1396, or another less restrictive option is elected by the state under 42 U.S.C. §1396a(r)(2)...

13. The above authority explains in order to be eligible for Q11, "income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level."

14. The Policy Manual at Appendix A-9 sets forth the income limit for Q11 for an individual effective January 1, 2017 as \$1,341 and effective July 1, 2017 as \$1,357.

15. The Code of Federal Regulations at 20 C.F.R. § 416.1124 (c) (12), establishes a \$20 disregard for "the first \$20 of any unearned income in a month". The respondent deducted \$20 from petitioner's income to arrive at \$1,725 as her countable income.

16. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent followed the rules when it denied the petitioner Q11 benefits. It is also concluded that the petitioner is ineligible for the MSP/Q11 as her total income is over the income limit for all of the MSP programs.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and respondent's action affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
17F-04581
PAGE -6

DONE and ORDERED this 06 day of September, 2017,
in Tallahassee, Florida.

Christiana Gopaul-Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To:


Office of Economic Self Sufficiency

Sep 19, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04634

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88778

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 8, 2017, at 10:04 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner:

[REDACTED]

For the Respondent:

Pamela Wesley, DCF supervisor.

STATEMENT OF ISSUE

At issue is the respondent's action to terminate full Medicaid for petitioner's household for failing to submit an application for recertification. The burden of proof was assigned to the respondent by a preponderance of evidence.

PRELIMINARY STATEMENT

On June 15, 2017 the petitioner requested an appeal challenging the termination of Medicaid benefits for her household.

The petitioner submit six (6) exhibits which were accepted into evidence and marked as Petitioner's Exhibits 1 through 6. The respondent submitted three (3) exhibits which were accepted into evidence and marked as Respondent's Exhibits 1 through 3.

The record was left open through August 10, 2017 for the respondent to submit additional information and extended through August 17, 2017 for the petitioner to submit a rebuttal statement and any additional evidence. The respondent's evidence was timely received and marked as Respondent's Exhibit 4. The petitioner's information was timely received and marked as Petitioner's Exhibits 7 through 12. The record was closed on August 17, 2017.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Prior to the action under appeal petitioner's household has been receiving Medicaid benefits under the Family-Related Medicaid coverage group.
2. Petitioner and her three minor children currently receive Social Security benefits. She receives \$1,501 and the children receive \$250 each. Her husband is gainfully employed and is paid biweekly. Petitioner's household incurred some medical expenses over time, see Petitioner's Exhibits 1 through 5.

3. On April 15, 2015, petitioner applied for and was approved for Medicaid benefit for her household. No Notice of Case Action on the above action was provided to the undersigned. Petitioner has been receiving benefit continuously until June 30, 2017.

4. On March 21, 2016, the respondent sent a Notice of Eligibility Review to the petitioner informing her that it's time to review her case to find out if she is still eligible for benefits. The notice was sent to [REDACTED]

The notice informed the petitioner that she can complete the review online and provided her with the website www.myflorida.com/accessflorida to do so. The notice informed the petitioner that if she did not complete a review by April 5, 2016, her Medicaid benefits would end. No application was received from the petitioner.

5. On May 16, 2016, the respondent sent a Notice of Eligibility Review to the petitioner informing her that it's time to review her case to find out if she is still eligible for benefits. The notice was sent to [REDACTED]

The notice informed the petitioner that she can complete the review online and provided her with the website www.myflorida.com/accessflorida to do so. The notice informed the petitioner that if she did not complete a review by May 31, 2016, her Medicaid benefits would end. No application was received from the petitioner.

6. On June 6, 2017, the respondent worked on a mass change report on overdue cases and petitioner's case was closed. On June 7, 2017, the respondent sent the petitioner a Notice of Case Action informing her that her Medicaid benefits would end effective June 30, 2017 because the Medicaid for this period has ended. The notice was sent to [REDACTED] see Respondent's Exhibit 1.

7. The respondent explained that Medicaid benefits for the petitioner's household was terminated because she failed to submit the necessary application to continue her benefits. She explained Medicaid benefits are usually approved for a year and that petitioner failed to respond to two notices sent to her reminding her to reapply. She explained that Medicaid should have been closed since May 2016 and that petitioner has received an extra year of Medicaid coverage.

8. Petitioner is seeking continued Medicaid benefits for her family and asserting as follows: That she only received the termination notice informing her that her Medicaid benefits would end on June 30, 2017. Since receiving that notice, she has tried to access a number of medical services so they can be covered before the benefits are terminated.

9. The petitioner alleges she did not receive the notices informing her to submit an application to continue her Medicaid benefits. The petitioner did not report any mailing issues. The respondent has no record of the notices being returned. All notices were sent to [REDACTED]. The undersigned finds that the two notices at issued were received by the petitioner.

10. During the hearing, the petitioner explained that her family needs Medicaid. That she did not know she had to be re-evaluated every year. That she has tried to submit an application in the past and was unsuccessful. That her child (E M-O) must have Medicaid to continue receiving his WIC benefit. That continuous Medicaid should have been explored prior to her case being closed. That the Department's representative did not attend to her needs and that she was misinformed throughout the process.

Petitioner's brought up allegations of non-cooperation and mistreatments against the

respondent. The representative apologized for any misunderstanding and explained that the case was correctly closed and that the Medicaid could not be continued without petitioner submitting an application.

11. While the action under appeal is being considered, the petitioner completed a new application on August 8, 2017, see Petitioner's Exhibit 6. As of the day of the hearing, no determination has been made yet on this most recent application.

12. The record was left open through August 17, 2017 for the petitioner to provide additional information, including a list of notices received from the respondent from her April 15, 2015 application date to present. The documents indicate that prior to the June 15, 2017 hearing request date, the petitioner last applied for benefits on April 14, 2015. She received two notices dated June 7, 2017 between January 1, 2017 and August 8, 2017. The search for notices was not extended to include notices sent in 2016, see Petitioner's Exhibits 7 through 12.

13. In a post-hearing statement, petitioner explained that she received a notice from the Department on August 14, 2017 informing her that she, her husband and her their adult child have been approved for the Medically Needy benefits. Petitioner believes that her case was inappropriately closed and that her Medicaid should continue until the appropriate evaluation and period has been fulfilled, see Petitioner's Exhibit 7.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

Addressing the Notices of Eligibility Review not received.

16. The petitioner argued that she did not received the notices dated March 21, 2016 and May 16, 2016 respectively. Petitioner was to provide a list of notices received from the Department from the April 14, 2015 application to the present. Instead, petitioner limited her search to notices received effective January 1, 2017 forward.

17. The petitioner did not report any mailing issues. The respondent has no record of the notices being returned. Petitioner acknowledged receipt of the termination notice sent to her on June 6, 2017. All notices were sent to [REDACTED]

[REDACTED]. Where mail has been properly addressed, stamped, and mailed pursuant to normal office procedure, there is a presumption that the addressee received the mail. See (Brown v. Giffen Industries, Inc., 281 So. 2d 897 (Fla. 1973)).

The undersigned concluded that the two notices at issued were received by the petitioner.

Addressing the termination of the Medicaid coverage.

18. The Department determines Medicaid eligibility based on the household circumstances. When the household consists of parents and children, Medicaid eligibility is determined under Family-Related Medicaid policy.

19. Fla. Admin. Code R. 65-1.707 Family-Related Medicaid Income and Resource Criteria states in pertinent part: “(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements

as follows (a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages...”

20. Fla. Admin. Code R. 65-1.716 Income and Resource Criteria explains: “(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size...”

21. The above cited authorities explain Family-Related Medicaid eligibility is based on income, earned or unearned, received within the household. The petitioner’s household was determined eligible for full Medicaid benefits based on the April 14, 2015 application and has been receiving continued coverage until it was terminated on June 30, 2017.

22. Federal regulation at 42 C.F.R § 435.916 addresses Period renewal of Medicaid eligibility and states in part

(a) Renewal of individuals whose Medicaid eligibility is based on modified adjusted gross income methods (MAGI). (1) Except as provided in paragraph (d) of this section, the eligibility of Medicaid beneficiaries whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months. (emphasis added)

23. The Department’s Program Policy Manual, CFOP 165-22, Passage number 0830.0100 ELIGIBILITY REVIEWS (MFAM) and states in part:

An eligibility review reestablishes eligibility on all factors, resolves discrepancies and ensures correct benefits. If there are multiple AGs in the case, use the earliest review date of any AG in the case to review all AGs.

An eligibility review for Medicaid is defined as an application, or any time all applicable items addressed in the interim contact letter are evaluated. If it becomes necessary to close TCA or food stamps, evaluate the Medicaid portion of the case separately to determine if closure is appropriate. If the eligibility determination was completed within the last 12 months, do not close the Medicaid AGs, but close the other programs as

appropriate. Keep the Medicaid AGs open, and schedule the eligibility review 12 months from the month Medicaid eligibility was last determined. For applications assign a 12-month review period from the month of disposition, unless eligibility does not begin until a future month. At review assign a 12-month review period from the month following disposition. For Medically Needy cases, evaluate the individual for reenrollment prior to the expiration of the current enrollment period.

24. Fla. Admin. Code R. 65-1.702 Special Provisions states in the pertinent part:

(4) Ex Parte Process.

(a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage...

(b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights.

25. In this instant case, petitioner applied on April 14, 2015 and has been receiving Medicaid ever since until it was closed on June 30, 2017. The respondent explained that an ex-parte was not done because the petitioner had already received an extra year of Medicaid eligibility. The undersigned concludes that petitioner is not eligible for continued Medicaid under the Family-Related Medicaid Program without an application for recertification. The undersigned recognizes the petitioner's concerns about her family's medical needs; however, the controlling legal authorities do not allow for a more favorable outcome.

26. Based on the evidence and testimony presented, the above-cited rules and regulations, the hearing officer concludes that the respondent's action to close Medicaid benefits for the petitioner's household under the Family-Related Medicaid coverage group is correct. The respondent has met its burden.

27. At the hearing the petitioner's brought up allegations of non-cooperation and mistreatments against the respondent. The undersigned only has jurisdiction over issues as described in Fla. Admin. Code R. 65-2.056 Basis of Hearings, which in pertinent part states:

The Hearing shall include consideration of:

(1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

(2) Agency's decision regarding eligibility for Financial Assistance, Social Services, Medical Assistance or Food Stamp Program Benefits in both initial and subsequent determination, the amount of Financial or Medical Assistance or a change in payments.

(3) The Hearing Officer must determine whether the department's decision on eligibility or procedural compliance was correct at the time the decision was made.

28. The hearing officer has no jurisdiction over customer service issues. The petitioner may contact the Southeast Region's Client Relations office at 1 954-375-3338 to discuss the issues raised regarding customer service if she wishes to.

29. Petitioner was approved Medically Needy benefit based on her August 8, 2017 application. Post hearing, the petitioner expressed dissatisfaction with the Medically Needy benefits she was approved for from her recent application. She may exercise her right to appeal the Department's most recent action if she chooses.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 19 day of September , 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 14, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04668

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 88222

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:03 p.m. on July 14, 2017.

APPEARANCES

For the Petitioner: [REDACTED], the petitioner's wife

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) calculation of the petitioner's Institutional Care Program (ICP) Medicaid patient responsibility, is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing. The petitioner's wife submitted one exhibit, entered as Petitioner Exhibit "1". The respondent's representative

submitted seven exhibits, entered as Respondent Exhibits “1” through “7”. The record remained open until July 18, 2017, for the respondent’s representative to submit additional exhibits. The exhibits were received timely and entered as Respondent Exhibits “8” and “9”. The record was closed on July 18, 2017.

FINDINGS OF FACT

1. The petitioner is a resident at [REDACTED]. The petitioner’s wife lives in her home. The petitioner is referred to as the institutional spouse and the petitioner’s wife is referred to as the community spouse, for ICP purposes.
2. On March 27, 2017, an ICP recertification application for the petitioner was received (Respondent Exhibit 1). The application lists income from a pension and veteran’s benefits for the petitioner, amounts were not listed. Expenses listed include \$700 rent and utilities for the petitioner’s wife.
3. The ICP patient responsibility is determined by first calculating the maintenance needs allowance for the community spouse.
4. Based on verification the Department had available, it calculated the following patient responsibility (Respondent Exhibit 4). MMMIA is the Minimum Monthly Maintenance Income Allowance.

<i>Maintenance Needs Allowance</i>	
\$1,038.00	shelter costs (\$700 rent + \$338 SUA)
<u>-\$ 601.00</u>	<u>30% of MMMIA (30% X \$2,003)</u>
\$ 437.00	excess shelter costs
<u>+\$2,003.00</u>	<u>MMMIA</u>
\$2,440.00	total
<u>-\$ 688.00</u>	<u>community spouse income</u>
\$1,752.00	community spouse income allowance

Patient Responsibility

\$4,891.14	petitioner's income
-\$ 105.00	personal needs allowance
-\$1,752.00	community spouse income allowance
-\$ 100.00	insurance premium
<u>\$2,934.14</u>	<u>patient responsibility</u>

5. On April 26, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA), notifying he has a \$2,934.14 patient responsibility to the nursing facility, effective April 2017 (Respondent Exhibit 2, page 26).

6. The petitioner's wife said in addition to the \$700 rent, she pays \$135 home owner's insurance, \$45 condo maintenance and \$598 medical insurance premium for six months.

7. The respondent's representative accepted the petitioner's wife's changes and changed the shelter costs to include \$700 rent, \$135 home owner's insurance, \$45 condo maintenance and \$338 standard utility allowance (SUA), which totals \$1,218 shelter costs. The insurance premium was also changed to \$99.67 (\$598/6).

8. The following is the recalculation of the patient responsibility to include the above changes:

<i>Maintenance Needs Allowance</i>	
\$1,218.00	shelter costs
-\$ 601.00	30% of MMMIA (30% X \$2,003)
<u>\$ 617.00</u>	<u>excess shelter costs</u>
<u>+\$2,003.00</u>	<u>MMMIA</u>
\$2,620.00	total
-\$ 688.00	community spouse income
<u>\$1,932.00</u>	<u>community spouse income allowance</u>

Patient Responsibility

\$4,891.24	petitioner's income
-\$ 105.00	personal needs allowance
-\$1,932.00	community spouse income allowance
-\$ 99.67	insurance premium
<u>\$2,754.47</u>	patient responsibility

9. On July 18, 2017, the Department mailed the petitioner a NOCA, notifying he had a \$2,754.47 patient responsibility to the nursing facility for May 2017 (Respondent Exhibit 9).

10. During the hearing, the respondent's representative recalculated the petitioner's income with new verification submitted by the petitioner's wife:

\$1,542.16	NY pension - \$896.25 + \$645.91(Petitioner Exhibit 1)
\$ 109.00	NY Medicare credit (Petitioner Exhibit 1)
\$ 333.08	FL pension (Respondent Exhibit 5, page 40)
\$1,072.00	Veterans Affairs (VA) pension (Respondent Exhibit 5, page 42)
\$1,839.00	SSRI (Respondent Exhibit 5, page 44)
<u>\$4,895.24</u>	total

11. The petitioner's wife disagreed with the petitioner's monthly income. She said the following amounts are the correct amounts, because that is what is being deposited into her bank account:

\$1,389.48	NY pension
\$ 333.08	FL pension
\$1,025.00	VA
\$1,710.30	SSRI
<u>\$4,457.86</u>	total

12. The respondent's representative explained that the Department uses gross income not net income in its calculations.

13. The following is the calculation of the patient responsibility using the \$4,895.24 income (Respondent Exhibit 8):

<i>Maintenance Needs Allowance</i>	
\$1,218.00	shelter costs
<u>-\$ 601.00</u>	<u>30% of MMMIA (30% X \$2,003)</u>
\$ 617.00	excess shelter costs
<u>+\$2,003.00</u>	<u>MMMIA</u>
\$2,620.00	total
<u>-\$ 688.00</u>	<u>community spouse income</u>
\$1,932.00	community spouse income allowance

<i>Patient Responsibility</i>	
\$4,895.24	petitioner's income
<u>-\$ 105.00</u>	<u>personal needs allowance</u>
<u>-\$1,932.00</u>	<u>community spouse income allowance</u>
<u>-\$ 99.67</u>	<u>insurance premium</u>
\$2,758.57	patient responsibility

14. On July 18, 2017, the Department mailed the petitioner a NOCA, notifying he had a \$2,758.57 patient responsibility to the nursing facility for June 2017 (Respondent Exhibit 9).

15. The MMMIA changed from \$2,003 to \$2,030 effective July 2017. The following is the patient responsibility calculation for July 2017 and ongoing (Respondent Exhibit 8):

<i>Maintenance Needs Allowance</i>	
\$1,218.00	shelter costs
<u>-\$ 609.00</u>	<u>30% of MMMIA (30% X \$2,030)</u>
\$ 609.00	excess shelter costs
<u>+\$2,030.00</u>	<u>MMMIA</u>
\$2,639.00	total
<u>-\$ 688.00</u>	<u>community spouse income</u>
\$1,951.00	community spouse income allowance

<i>Patient Responsibility</i>	
\$4,895.24	petitioner's income
<u>-\$ 105.00</u>	<u>personal needs allowance</u>
<u>-\$1,951.00</u>	<u>community spouse income allowance</u>
<u>-\$ 99.67</u>	<u>Insurance premium</u>
\$2,739.57	patient responsibility

16. On July 18, 2017, the Department mailed the petitioner two NOCAs, notifying he had a \$2,739.57 patient responsibility to the nursing facility for July 2017 and August 2017 (Respondent Exhibit 9).

17. The petitioner's wife alleges that "On the computer there is something called The Financial Protection for spouses of patients in a Nursing Home and on Medicaid". Which "states that a wife of a patient in a Nursing Home should not be deprived of her money and so on and so forth."

18. The Hearing Officer offered to leave the record open for the petitioner's wife to submit said document. The petitioner's wife said she does not have access to a computer and that her neighbor told her about the document.

CONCLUSIONS OF LAW

19. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

20. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

21. *Florida Administrative Code* R. 65A-1.716 sets forth the Program standards and the calculation of the community spouse income allowance, and states in part:

- (5) (c) Spousal Impoverishment Standards...
2. State's Minimum Monthly Maintenance Income Allowance (MMMIA). The minimum monthly income allowance the department recognizes for a community spouse is equal to 150 percent of the federal poverty level for a family of two.
3. Excess Shelter Expense Standard. The community spouse's shelter expenses must exceed 30 percent of the MMMIA to be considered excess

shelter expenses to be included in the maximum income allowance: MMIA × 30% = Excess Shelter Expense Standard. This standard changes July 1 of each year.

22. *Florida Administrative Code R. 65A-1.7141, SSI-Related Medicaid Post-Eligibility*

Treatment of Income, states in part:

(1) For institutional care services and Hospice, the following deductions are applied to the individual's income to determine patient responsibility in the following order:

(a) A Personal Needs Allowance (PNA) of \$105. Individuals residing in medical institutions and intermediate care facilities shall have \$105 of their monthly income protected for their personal need allowance...

(f) The community spouse's excess shelter and utility expenses. The amount by which the sum of the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a homeowner's association, condominium or cooperative, required maintenance charge, for the community spouse's principal residence and utility expense exceeds thirty percent of the amount of the Minimum Monthly Maintenance Needs Allowance (MMMNA) is allowed. The utility expense is based on the current Food Assistance Program's standard utility allowance as referenced in subsection 65A-1.603(2) F.A.C...

23. The Department's Program Policy Manual, CFOP 165-22, Appendix A-9, sets forth the Personal Needs Allowance at \$105, MMMIA at \$2,003 (April 1, 2017) and \$2,030 (July 1, 2017). Appendix A-1, lists \$338 as the standard utility allowance.

24. The above cited authorities set forth the rules and budgeting methodology for determining how much income the institutional spouse pays the nursing facility and the spousal allowance in the ICP.

25. The evidence submitted establishes that the Department included the petitioner's income, his wife's income and allowable deductions in the community spouse income allowance and patient responsibility computations.

26. The petitioner's wife argued that the Department's calculation of the petitioner's income was incorrect because they are not using the amounts being deposited into her bank account.

27. *Florida Administrative Code* R. 65A-1.713 "SSI-Related Medicaid Income Eligibility Criteria" in part states "(1) (d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions..."

28. In accordance with the above authority, the Department used the petitioner's gross income in the patient responsibility calculation.

29. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof. The undersigned concludes the Department's calculation of the petitioner's ICP Medicaid patient responsibility is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 14 day of September, 2017,

in Tallahassee, Florida.

D. M. D. +

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 14, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families



PETITIONER,

APPEAL NO. 17F-04695

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88991

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on July 27, 2017 at 8:30 a.m.

APPEARANCES

For the petitioner: [REDACTED], Tech Medicaid Specialist, from Geriatric Management LLC, authorized designated representative for the petitioner

For the respondent: Stan Jones, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's request for retroactive Institutional Care Program (ICP) Medicaid coverage for the months of January 2016 through August 2016. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner's representative did not submit any exhibits. The respondent submitted three exhibits, which were entered as Respondent's Exhibits "1" through "3". The record was held open until close of business on August 4, 2017 for submission of additional evidence from the parties. On July 27, 2017, additional evidence was received from the respondent, which was entered as Respondent's Exhibit "4". No documents were submitted by the petitioner. The record closed on August 4, 2017.

FINDINGS OF FACT

1. On April 20, 2017, an ICP Medicaid application was submitted for the petitioner. The petitioner (63) was residing at [REDACTED], Florida. The petitioner passed away on April 18, 2017.
2. On May 20, 2017, the respondent issued a Notice of Case Action informing the petitioner that his ICP Medicaid application was approved for retroactive coverage from September 2016 through April 2017 and ongoing. The case closed on June 2017.
3. The petitioner's authorized representative (AR) is requesting retroactive ICP Medicaid coverage from January 2016 through August 2016.
4. The AR submitted the following ICP Medicaid applications for the petitioner to the respondent: April 19, 2016, May 24, 2016, June 30, 2016, October 18, 2016, November 17, 2016 and April 20, 2017. No Notice of Case Action was submitted to describe the action taken by the respondent on the petitioner's April 19, 2016 application, which would include retroactive coverage beginning January 2016.
5. The respondent explained that as part of the application process, the Department received a Data Exchange Asset Verification (DEAV) report; the respondent requested

verification of the unreported asset through the Asset Verification System (AVS)¹.

According to AVS, the petitioner had a checking account with a balance of \$84,082.71 from ██████ bank. The respondent requested spend down verification from the AR.

6. The respondent explained that, on February 28, 2017, the AR provided evidence of the balances in the petitioner's checking account at ██████ bank. The petitioner had the following balances in his checking account: \$30,488.11 for the month of January 2016; \$23,250.57 for the month of February 2016; \$15,152.39 for the month of March 2016; \$14,756.01 for the month of April 2016; \$12,012.24 for the month of May 2016; \$11,864.29 for the month of June 2016; \$9,646.39 for the month of July 2016 and \$7,173.79 for the month of August 2016.

7. No documents were provided to the respondent by the AR regarding a spend down on the petitioner's checking account beginning January 2016. The respondent determined that the petitioner was not eligible for ICP Medicaid coverage prior to the month of September 2016 due to the balances in his checking account exceeding the \$2,000.00 ICP asset limit for an individual.

8. The respondent determined that the petitioner was eligible for ICP Medicaid beginning September 2016, as the balance in his checking account was under the \$2,000.00 asset limit. On May 20, 2017, the respondent issued a notice to the AR notifying the petitioner was approved for ICP Medicaid coverage beginning September 2016.

¹ The DEAV screen provides Asset data and the AVS is used to request financial records for individuals applying for the Adult-Related Medicaid Program.

9. The petitioner's AR did not dispute the facts regarding the balance of the petitioner's checking account exceeding the \$2,000.00 asset limit during the months in question.

The AR alleged that the petitioner was incapacitated and without the consent of the petitioner, family members had obtained a bank card for the petitioner's checking account and withdrew money from the account through an automated teller machine (ATM). The petitioner's AR alleged the family members who withdrew the petitioner's money live in Tennessee; the AR contacted the Adult Protective Services for allegations of elderly abuse/exploitation.

10. No evidence or reports were provided to support the alleged exploitation or to verify the petitioner's family members stole money from his checking account.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

12. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. The Code of Federal Regulations at 20 C.F.R. § 416.1201, Resources, general states:

(a) Resources; defined. For purposes of this subpart L, 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 or her support and maintenance.

(1) If the individual has the right, authority or power to liquidate the property or his or her 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).

...

(b) Liquid resources. Liquid resources are cash or other property which can be converted to cash within 20 days, excluding certain nonwork days as explained in §416.120(d). Examples of resources that are ordinarily liquid are stocks, bonds, mutual fund shares, promissory notes, mortgages, life insurance policies, financial institution accounts (including savings, checking, and time deposits, also known as certificates of deposit) and similar items...

14. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility

Criteria, states:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C..."

(2) Exclusions...

(d) The individual, and their spouse, may designate up to \$2,500 each of their resources for burial funds for any month, including the three months prior to the month of application. The designated funds may be excluded regardless of whether the exclusion is needed to allow eligibility. The \$2,500 is not reduced by the value of excluded life insurance policies or irrevocable burial contracts. The funds may be commingled in the retroactive period.

15. The Fla. Admin. Code R. 65A-1.716 sets forth, "(5) SSI-Related Program Standards. (a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits: 1. \$2000 per individual."

16. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 1640.0205, Asset Limits (MSSI, SFP) states in relevant part:

Total countable assets for an individual or a couple must not exceed the following limits:

...

3. For ICP, PACE, all HCBS Waivers and Hospice, the asset limit is \$2,000 for an individual (\$3,000 for eligible couple) or \$5,000 if the individual's income is within the MEDS-AD limit (\$6,000 for eligible couple).

17. The Fla. Admin. Code R. 65A-1.303 addresses assets and in part states:

...

(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. **Assets are considered available to an individual when the individual has unrestricted access to it.** (emphasis added) Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

18. According to the above authorities, in order to qualify for ICP Medicaid, an individual must own no more than \$2,000 in countable assets. The findings show that the petitioner had a checking account at [REDACTED] bank with a balance over the asset limit for the months at issue, which were not spent down to under the asset limit for an individual until September 2016. No evidence was presented to establish that the value of this asset was equal to or less than \$2,000 during the review period in question.

19. The petitioner's AR claimed the asset ([REDACTED] bank checking account) was unavailable to the petitioner due to circumstances beyond his control and that without the consent of the petitioner, his family members withdrew money from the petitioner's bank account. However, no evidence was presented to verify the petitioner had restricted or no access to the account at issue.

20. After careful review of the evidence and controlling legal authorities, the undersigned concludes the respondent correctly denied the petitioner's request for

retroactive ICP Medicaid coverage for the period of January 2016 through August 2016 on the basis of being over the asset limit.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 14 day of September, 2017,
in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

FILED

Sep 15, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04730

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 88222

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:10 p.m. on July 19, 2017.

APPEARANCES

For the Petitioner: [REDACTED], Authorized Representative (AR) and
[REDACTED], Administrator

For the Respondent: Stan Jones, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Institutional Care Program (ICP) Medicaid for November 2016, December 2016 and January 2017, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present at the hearing. [REDACTED] Rehab., Business Office Manager, appeared as a witness. The petitioner's AR did not submit exhibits. The respondent's representative submitted six exhibits, entered as Respondent Exhibits "1" through "6". The record was closed on July 19, 2017.

FINDINGS OF FACT

1. The petitioner was admitted to [REDACTED] in August 2016. The petitioner is incapacitated and did not have a guardian when she was admitted. The court assigned the petitioner a guardian on June 14, 2017.
2. On February 13, 2017, the petitioner's AR submitted an ICP application for the petitioner (Respondent Exhibit 2). The AR made a comment on the application that states in part, "The bank account will show a balance of over \$8,000. However, the family wrote [REDACTED] a check to cover her expenses at the facility."
3. On February 15, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) requesting bank statements and verification of the \$8,000 paid to Plantation Bay (among other items), due by February 27, 2017 (Respondent Exhibit 3).
4. The bank statements provided are dated October 31, 2016, balance of \$7,243.11 and November 30, 2016, balance of \$7,933.17 (Respondent Exhibit 4).
5. The ICP asset limit for an individual is \$2,000. The petitioner's bank statements show the petitioner was over the ICP asset limit.
6. The petitioner's AR agrees that the petitioner was over the \$2,000 asset limit until February 2017.

7. On March 6, 2017, the Department mailed the petitioner a NOCA, notifying her February 13, 2017 application was approved, effective February 2017 (Respondent Exhibit 3, page 14).

8. The petitioner's AR argued that due to the petitioner being legally incapacitated, she was unable to deplete her bank account to meet the \$2,000 ICP asset limit, until a guardian was court appointed. The petitioner's AR testified that the petitioner is not and has not been in a coma.

9. The respondent's representative stated that although the petitioner is incapacitated, the money in the petitioner's bank was still available to her.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

11. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

12. *Florida Administrative Code* R. 65A-1.712 and 65A-1.716 address SSI-Related Medicaid asset criteria and in part state:

65A-1.712

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C....

65A-1.716

(5) SSI-Related Program Standards.

(a) SSI (42 U.S.C. §§ 1382 – 1383c) Resource Limits:

1. \$2000 per individual.
13. The above authorities explain the resource (asset) limit is \$2,000 for an individual to be eligible for ICP Medicaid.
14. Both parties agreed that the petitioner was over the \$2,000 asset limit to be eligible for ICP benefits until February 2017.
15. The petitioner's AR argued that although the money was in the petitioner's bank account, she was unable to access the money due to being legally incapacitated.
16. 20 C.F.R. § 416.1210 addresses asset exclusions and in part states:

In determining the resources of an individual (and spouse, if any), the following items shall be excluded:

- (a) The home...
- (b) Household goods and personal effects...
- (c) An automobile...
- (d) Property of a trade or business...
- (e) Nonbusiness property...
- (f) Resources of a blind or disabled individual...
- (g) Stock in regional or village corporations...
- (h) Life insurance...
- (i) Restricted allotted Indian lands...
- (j) Payments or benefits provided under a Federal statute other than title XVI of the Social Security Act where exclusion is required by such statute;
- (k) Disaster relief assistance...
- (l) Burial spaces...
- (m) Title XVI or title II retroactive payments as provided in §416.1233;
- (n) Housing assistance...
- (o) Refunds of Federal income taxes and advances made by an employer...
- (p) Payments received as compensation for expenses incurred or losses suffered as a result of a crime...
- (q) Relocation assistance from a State or local government...
- (r) Dedicated financial institution accounts...
- (s) Gifts to children under age 18 with life-threatening conditions...
- (t) Restitution of title II, title VIII or title XVI benefits because of misuse by certain representative payees...
- (u) Any portion of a grant, scholarship, fellowship, or gift used or set aside for paying tuition, fees, or other necessary educational expenses...
- (v) Payment of a refundable child tax credit...

(w) Any annuity paid by a State...

17. Additionally, 20 C.F.R. § 416.1218 "Exclusion of the automobile" explains that one automobile can be excluded as an asset.

18. The above authorities define which income and assets may be excluded in the ICP eligibility determination; none of which apply to the petitioner.

19. *Florida Administrative Code* R 65A-1.712 further explains exclusions and in part states:

(2) Exclusions. The Department follows SSI policy prescribed in 20 C.F.R. § 416.1210 and 20 C.F.R. § 416.1218 in determining resource exclusions, with the exceptions in paragraphs (a) through (g) below, in accordance with 42 U.S.C. § 1396a(r)(2).

(a) Resources of a comatose applicant (or recipient) are excluded when there is no known legal guardian or other individual who can access and expend the resource(s). (emphasis added)

(b) The value of a life estate interest in real property is excluded.

(c) The cash surrender value of life insurance...

(d) The individual, and their spouse, may designate up to \$2,500 each of their resources for burial funds for any month...

(e) One automobile is excluded, regardless of value.

(f) Property that is essential to the individual's self-support...

(g) An individual who is a beneficiary under a qualified state Long-Term Care Insurance Partnership Policy...

20. The above authority explains seven asset exclusions. One of the exclusions listed is for comatose applicants "when there is no known legal guardian or other individual who can access and expend the resource(s)".

21. The petitioner's AR testified that the petitioner is not comatose; therefore, the above exclusion(s) do not apply to the petitioner.

22. The evidence submitted establishes that the petitioner was over the \$2,000 ICP asset limit in November 2016, December 2016 and January 2017.

23. In careful review of the cited authorities and evidence, the undersigned concludes the petitioner did not meet the burden of proof. The undersigned concludes the Department's action to deny the petitioner ICP Medicaid for November 2016, December 2016 and January 2017, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 15 day of September, 2017,
in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Sep 14, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04779

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 05 MARION
UNIT: 66292

RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter July 31st, 2017, at 2:34 p.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sylma Dekony, Economic Self-Sufficiency Specialist II for the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her SSI-Related Medicaid application. The petitioner carries the burden of proving her position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The petitioner did not present any documents for the hearing officer's consideration.

During the hearing, respondent's exhibits 1 through 6 were admitted into evidence.

The hearing officer allowed until the close of business August 7th, 2017, for the respondent to submit additional information to the petitioner. The respondent provided the same information to the Office of Appeal Hearings during the proceeding. However, the hearing officer had not received the information and made note that it would be marked into evidence once received. After the proceeding, the documents were marked into evidence as Respondent's exhibit 7. The hearing officer then allowed until the close of business August 17th, 2017, for the petitioner to respond to the information in writing if she chose to do so. The petitioner did not respond within the allotted timeframe. Therefore, the record was closed.

By way of a Notice of Case Action (NOCA) dated February 23rd, 2017, the respondent informed the petitioner that her application for Medically Needy dated January 23rd, 2017, was denied because she did not complete an interview necessary to determine eligibility for the program. On April 4th, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner applied for health insurance through the Federally Facilitated Marketplace (FFM) while awaiting a decision on a disability application from the Social Security Administration (SSA). The respondent received an application for disability Medicaid dated January 23rd, 2017. (See Respondent's Exhibit 5). According to the respondent, the application was to add additional benefits to an existing case and was forwarded from the FFM. As part of the application process, the respondent is required to explore and, if deemed necessary, verify certain factors of eligibility which includes technical eligibility requirements.

2. According to an entry in the respondent's business records (CLRC) dated January 27th, 2017, the application was pended for a disability interview and proof that the petitioner applied for benefits through SSA. A second entry dated February 6th, 2017, indicates that the petitioner did not wish to apply for Medicaid. The petitioner only wanted to renew her Food Assistance (FA) benefits. A third CLRC dated February 14th, 2017, lists the interview notes from the petitioner's FA interview. (See Respondent's Exhibit 3). A portion of the interview states the following:

"Does not want to apply for medical at this time just wants to renew FA...she does not want to apply for medical."

3. The petitioner contends that she did not want the respondent to complete an independent disability determination in January 2017 because she was awaiting a decision from SSA. The petitioner asserts that the application dated January 23rd, 2017, is a false application since she did not intend to apply for Medicaid. The petitioner was attempting to apply for health insurance and was unaware that the application would be forwarded to the respondent for processing. According to the petitioner, SSA approved disability benefits on June 30th, 2017, and she is requesting that the respondent authorize Medicaid coverage now that disability has been established. However, the petitioner testified that she has not applied for Medicaid since the January 23rd, 2017, application was forwarded from the FFM.

4. The respondent contends that the application dated January 23rd, 2017, can be used for retroactive Medicaid coverage but not ongoing coverage since it was denied. However, the respondent explained that other technical criteria may be required to be met before Medicaid could be approved retroactively.

5. The respondent was unaware that the petitioner was approved for disability benefits until the hearing was in progress. During the hearing, the respondent verified the petitioner Social Security benefits through the State Online Query (SOLQ) and provided a screen print as evidence. According to SOLQ, the petitioner is receiving \$903 a month in Social Security Disability (SSD) payments with a disability begin date of October 1st, 2016. (See Respondent's Exhibit 6). The respondent testified that it had previously checked SOLQ and there were no SSD benefits authorized. The respondent provided a screen print of SOLQ from an earlier date as evidence. (See Respondent's Exhibit 2).

CONCLUSIONS OF LAW

6. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under 409.285, Fla. Stat.

7. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

8. Fla. Admin. Code R. 65A-1.203 Administrative Definitions states in relevant part:

Except as otherwise provided within, the following definitions apply to this chapter.

(3) Application: The ACCESS Florida Application, CF-ES 2337, 11/2011, incorporated by reference in Rule 65A-1.205, F.A.C., or an ACCESS Florida Web Application, CF-ES 2353, 09/2011, incorporated by reference in Rule 65A-1.205, F.A.C. An application must include at least the individual's name, address and signature to initiate the application process.

(4) Date of Application: The date the Department receives an application. If a web or facsimile application is received after business hours, the next business day following receipt is the date of application. Applications may be submitted in person, by the postal system, facsimile or electronically.

9. As stated in the above-cited authority, an application is valid if it contains the individual's name, address and signature. The authority also states that applications may be submitted electronically. The hearing officer finds that the application dated January 23rd, 2017, was a valid application, and the respondent was correct to initiate eligibility determination on the application.

10. Fla. Admin. Code R. 65A-1.205 Eligibility Determination Process states in relevant part:

(a) The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility.

(a) A complete eligibility review is the process of reviewing all factors related to continued eligibility of the assistance group.

11. According to the above-cited authority, the respondent must determine eligibility initially at application and if the applicant is determined eligible, have the eligibility reviewed periodically thereafter. In this instance, the petitioner did not wish to have her eligibility determined since she was awaiting a decision from SSA. Therefore, the application dated January 23rd, 2017, was denied.

12. Fla. Admin. Code R. 65A-1.702 Special Provisions states in relevant part:

(2) Date of Eligibility. The date eligibility for Medicaid begins. This was formerly called the date of entitlement. The date of eligibility includes the three months immediately preceding the month of application (called the retroactive period). Eligibility for Medicaid begins the first day of a month if an individual was eligible any time during the month...

13. According to the above-cited authority, Medicaid coverage begins the first day of a month the applicant becomes eligible. The application also preserves the ability for the respondent to determine retroactive Medicaid coverage for the three months immediately preceding the month of application. Eligibility was not established for the application dated January 23rd, 2017. Therefore, ongoing Medicaid coverage cannot be established from that application. However, the application can be used for retroactive Medicaid coverage if the petitioner meets all other technical requirements.

14. In conclusion, the hearing officer reviewed the regulations and guidelines and has determined that the respondent correctly denied the January 23rd, 2017, application. As established in the Findings of Fact, the petitioner has not applied for Medicaid since the FFM forwarded the application in January 2017. If the petitioner wishes to pursue ongoing Medicaid coverage, she is required to submit a new application and meet all technical factors. The hearing officer affirms the respondent's action.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no

FINAL ORDER (Cont.)
17F-04779
PAGE -7

funds to assist in this review.

DONE and ORDERED this 14 day of September, 2017,
in Tallahassee, Florida.



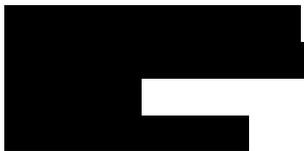
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 23, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 17F-04826

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 DADE
UNIT: 88690

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 24th, 2017, at 1:00 p.m.

APPEARANCES

For the Petitioner: [REDACTED] pro se.

For the Respondent: Paula Henao, Operations and Management Consultant for the ESS Program.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action denying her Disability Medicaid application dated March 9th, 2017. The petitioner carries the burden of proof by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The hearing was originally scheduled for August 2nd, 2017. However, the respondent requested a continuance, which was granted, and the hearing was rescheduled and completed as described above.

The petitioner did not submit any documents to be considered.

Respondent's exhibits 1 through 8 were admitted into evidence.

By way of Notice of Case Action (NOCA) dated April 11th, 2017, the respondent informed the petitioner that it had denied her Disability Medicaid application due to not receiving all information requested to determine eligibility. However, the respondent obtained medical records for the petitioner on the 60th day of application, and forwarded it to the Division of Disability Determination (DDD) on May 10th, 2017 for a disability decision. On May 23rd, 2017, the respondent received an unfavorable disability decision from DDD for the petitioner, and the respondent subsequently denied the petitioner's application. On June 27th, 2017, the petitioner filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. On March 9th, the petitioner submitted an application for public assistance benefits, with comments, "this application is for a DDD for Elizabeth Prado, the disability report will follow." (Respondent's Exhibit 1, page 5.)

2. On the application, the petitioner listed her 23-year-old son and 18-year-old daughter. The petitioner also stated that her son is receiving Supplemental Security Income (SSI.) No

other sources of income were listed including employment income for other members.

(Respondent's Exhibit 1, pages 9 and 10.)

3. On the application, the petitioner answered "no" to the question "disability established," and "yes" to the question appeal denied in last year. For the question "health condition changed since denial," the petitioner answered "no." (Respondent's Exhibit 1, page 8.)

4. The petitioner used to receive Medicaid benefits, but once her youngest child turned 18 years old in October 2016, she lost her eligibility. The petitioner described her disabling conditions as neurological and psychological and stated that she gets panic attacks, and feels depressed.

5. On November 30th, 2015, the petitioner applied for disability through the Social Security Administration (SSA.) On April 4th, 2016, the SSA denied the petitioner's disability application with a denial code N35 (Non-pay-Impairment is severe at time of adjudication but not expected to last twelve months, no visual impairment.) (Respondent's Exhibit 4, page 34.)

6. The petitioner has appealed the SSA denial as of October 13th, 2016. (Respondent's Exhibit 4, page 34.)

7. On May 23rd, 2017, the respondent electronically sent the petitioner's medical records to DDD for a determination of disability for the petitioner. (Respondent's Exhibit 4, page 36.)

8. The Division of Disability Determination did not make an independent disability decision on the petitioner's disability claim. Instead, it adopted the Social Security

Administration's decision since it was made within the past year, and denied the petitioner's application based on that decision.

9. The respondent denied the petitioner's application for Medicaid based on her not meeting the disability criteria. The respondent stated that the petitioner would not be eligible based on her age as she is not sixty-five, and has no children under eighteen.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to section 409.285 of the Florida Statutes. This order is the final administrative decision of the Department of Children and Families under section 409.285 of the Florida Statutes.

11. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

12. Florida Administrative Code, Section 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual to receive Medicaid who are less than 65 years of age, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905.

The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s)

that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...

13. The Code of Federal Regulations Title 42, Section 435.541, Determinations of

Disability, states in relevant part:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c) (3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

...

14. The above authority explains that the SSA determination is binding on the Department. Federal regulation prohibits the respondent from making an independent determination of disability if SSA has already made a disability determination within the time limits set for in section 435.912 on the same issues presented in the Medicaid application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA.

15. In accordance with the above authority, the respondent denied Petitioner's March 9th, 2017, Medicaid Disability application, due to adopting the SSA denial decision. If the petitioner wishes to challenge SSA's denial, she may do so by utilizing SSA's appeal process.

16. After reviewing the totality of the evidence and controlling legal authorities, the undersigned concludes that the petitioner did not meet the burden of proof to indicate that the respondent incorrectly denied her application for Medicaid based on Disability. The petitioner has no children under eighteen, is not aged sixty-five years, and was not found to be disabled

according to the definition of Social Security Administration. Therefore, the undersigned concludes that the respondent's action to deny the petitioner's application for Disability Medicaid was proper.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of October, 2017,
in Tallahassee, Florida.



Sajan George
Hearing Officer
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1317 Winewood Boulevard
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Sep 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04872

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88694

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 2, 2017, at approximately 9:43 a.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED] aughter and designated representative

For the Respondent: Teshia Green, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of June 2, 2017 ending the petitioner's Medicaid benefits effective June 30, 2017. The burden of proof was assigned to the petitioner at hearing; however, after further review, it is assigned to the respondent.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "11".

The record was left open for additional information. Additional information was received from the respondent, admitted into evidence and marked as Respondent's Exhibits "12" through "16".

The information received from the petitioner was admitted into evidence and marked as Petitioner's Exhibits "1" and "2". The record was closed August 2, 2017.

FINDINGS OF FACT

1. Both parties agree that a lump sum of a sizeable amount was received by the petitioner from the Veteran's Administration (VA) in February 2016. An account was created for this and according to instructions from the VA and action later taken by the Social Security Administration (SSA), the on-going unearned income from both agencies was later assigned to be direct-deposited into this new account.
2. On May 8, 2017, the petitioner submitted an application to the respondent for redetermination of HCBS-related Medicaid benefits (Home and Community Based Services) (Respondent's Exhibit 2).
3. On May 30, 2017, the petitioner submitted an application to the respondent for redetermination of ICP-related Medicaid (Institutional Care Program), HCBS, and Medicare Savings Program (MSP) benefits (Respondent's Exhibit 2).
4. On June 1, 2017 the respondent denied the above-referenced applications.

5. On June 2, 2017, the respondent mailed a notice of case action (NOCA) to the petitioner informing her that her Medicaid benefits would end on June 30, 2017, giving the reason that her “assets were too high for this program” (Respondent’s Exhibit 3).

6. On June 19, 2017, the petitioner submitted an application to the respondent for redetermination of ICP and HCBS related Medicaid benefits (Respondent’s Exhibit 2).

7. On July 20, 2017, by NOCA, the respondent informed the petitioner that her request for HCBS services were denied because no household members meet the requirements of the program and household assets were too high for the program (Respondent’s Exhibit 3).

8. On June 21, 2017, by NOCA, the respondent requested information from the petitioner requesting the last three months of bank statements, verification of income from the source, verification of any and all assets transferred in the last 60 months, and a signed 2613, Financial Release form (Respondent’s Exhibit 3).

9. The asset limit of \$5,000 for the SSI-Related Medically Needy program was exceeded by \$15, 421.26 (Respondent’s Exhibit 4).

10. The petitioner’s asset balances for the following months were as follows:

MONTH AMOU	NT	SOURCE
JUNE 2016	\$22,776.82	DATA EXCHANGE
JULY 2016	\$18,464.44	DATA EXCHANGE
AUGUST 2016	\$20,781.75	DATA EXCHANGE
SEPTEMBER 2016	\$20,761.56	DATA EXCHANGE
OCTOBER 2016	\$21,369.48	DATA EXCHANGE
NOVEMBER 2016	\$20,001.89	DATA EXCHANGE

DECEMBER 2016	\$17,137.35	DATA EXCHANGE
JANUARY 2017	\$18,788.25	DATA EXCHANGE
FEBRUARY 2017	\$18,036.02	DATA EXCHANGE
MARCH 2017	\$19,042.40	DATA EXCHANGE
APRIL 2017	\$20,307.83	DATA EXCHANGE
MAY 2017	\$19,619.25	DATA EXCHANGE
MARCH 2017	\$19,042.40	BANK STATEMENT
APRIL 2017	\$20,307.83	BANK STATEMENT
MAY 2017	\$19,619.25	BANK STATEMENT

The ownership or the value of the asset was not in question. The petitioner's concern was the inclusion of VA income. The petitioner considered the lump sum received from the VA as income. The respondent explained how the ongoing VA payments were being treated in the budget pointing out that per policy the amount identified as Aid and Attendance was excluded in the consideration of monthly VA income. The respondent also explained, and later provided policy-manual material, that a lump-sum payment is considered as income in the month of receipt and that in the month after the month of receipt the amount of the lump sum that remains in a bank account would then be considered as asset. The respondent submitted a data exchange inquiry and bank statements as documentation of the asset in question (Respondent's Exhibits 5 and 6).

11. The petitioner's gross income consists of \$1,366 in Social Security (SS) Title II benefits and \$1,149 in benefits from the Department of Veterans Affairs (VA). The VA benefits are identified as consisting of a \$719 Death Pension Amount and a \$430 Aid and Attendance Amount (Respondent's Exhibits 7 and 8).

12. The petitioner questioned the respondent's action to terminate the benefits based in part upon advice from CSB, LICSW of the VA Office of Survivors Assistance, as follows:

According to the Centers for Medicare and Medicaid Services (CMS) and the Internal Revenue Service (IRS): "The IRS has provided guidance on how VA benefits should be considered when calculating income. As noted in IRS Publication 17, states should not count any veterans benefits paid under any law, regulation or administrative practice administered by the Department of Veterans Affairs in their income calculations. CMS agrees that VA benefits are not part of the Modified Adjusted Gross Income (MAGI) calculation." If you were denied due to VA benefits income, you should contact your state Medicaid Agency ... (Petitioner's Exhibit 1).

13. A CMS publication titled "Medicaid and CHIP FAQs: Eligibility Policy," originally released May 2012 and August 2013, was provided by the petitioner as support of their claims, stating in pertinent part (Petitioner's Exhibit 2):

Q10: What are some examples of income that is not considered taxable, and therefore excluded from MAGI:

A10: Supplement Security Income (SSI), Temporary Assistance to Needy Families (TANF), Veterans' disability, Workers' Compensation, child support, federal tax credits, and cash assistance are common types of income that are not taxable.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

15. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

16. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

17. Federal Regulations at 20 § 416.1121, Types of unearned income, states in pertinent part:

Some types of unearned income are—
Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits, **veterans benefits**, worker's compensation, railroad retirement annuities and unemployment insurance benefits. [Emphasis added.]

18. Based on the above cited authority, veteran's benefits are considered unearned income.

19. Fla. Admin. Code R. § 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in pertinent part:

(2) Included and Excluded Income. **For all SSI-related coverage groups the department follows the SSI policy** specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., **including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions**, to determine what counts as income and what is excluded as income ... [Emphasis added.]

20. The Department's Program Policy Manual (Policy Manual) CFOP 165-22.

Passage 1840.0906, Veterans Benefits and Payments (MSSI, SFP), states in pertinent part:

Veterans' compensation and pensions are based primarily on service in the armed forces and may also be made to the veterans' dependents or survivors. These payments, including stipend payments for participation in a study of Vietnam era veterans' psychological problems (P.L. 99-576) and monthly payments to veterans of the Vietnam era as a result of exposure to Agent Orange (P.L. 102-4) are counted as unearned income.

The following are excluded as income:

1. Reductions in basic pay while in active duty service or selected reserve service to provide for future basic educational assistance (P.L. 99-576).
2. Payments to a natural child of a Vietnam veteran born with spina bifida, except spina bifida occulta, as a result of the exposure of one or both parents to Agent Orange (P.L. 104-204).

3. Payments to a natural child of a woman Vietnam veteran born with one or more birth defects resulting in permanent physical or mental disability (P.L. 106-419).

4. Aid and attendance, a housebound allowance and unreimbursed medical expenses for MSSI and HCDA. [Emphasis added.]

21. The Policy Manual, Passage 1840.0906.02, Veterans Payments-Pensions (MSSI, SFP), states in pertinent part:

VA pensions are included as unearned income, excluding the amount of aid and attendance, housebound allowance, and unreimbursed medical expenses. Except in OSS, refer to passage 1840.0906.10 for OSS information. VA pensions generally are based on need and, therefore, do not receive the \$20 general exclusion. Pensions are paid to veterans based on a combination of services and age (65 or older), or a non-service connected disability. Pensions are paid to a widow, widower, or child of a veteran because of the non-service connected death of a veteran. [Emphasis added.]

22. Based on the three above cited authorities, income from the Veterans Administration is and is not counted as unearned income. VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions are not counted in the eligibility determination budget. VA pensions are included as income. The hearing officer concludes that the respondent correctly disregarded VA Aid and Attendance income and correctly included the VA pension in the eligibility determination.

23. Federal Regulations at 20 § 416.1201, Resources; general, states in pertinent part:

(3) Except for cash reimbursement of medical or social services expenses already paid for by the individual, cash received for medical or social services that is not income under §416.1103 (a) or (b), or a retroactive cash payment which is income that is excluded from deeming under §416.1161(a)(16), is not a resource for the calendar month following the month of its receipt. However, cash retained until the first moment of the

second calendar month following its receipt is a resource at that time.

24. The Policy Manual, Passage1840.0906.08, VA Lump Sum Payments (MSSI, SFP), states in pertinent part: "Lump sum payments, minus A&A, housebound, and UME, are **included as unearned income in the month received**. Any balance, including A&A, housebound, and UME, left **as of the next month is counted as an asset**." [Emphasis added.]

25. Based on the above two cited authorities, a distinction is made between income and resources (also called assets). Income, even income that is not counted in the month of receipt, is counted as a resource, a liquid asset in this instant case, when allowed to remain in an account in the month after the month of receipt. The hearing officer concludes that the respondent acted correctly when counting VA income, retained in the petitioner's bank account into the following month, as an asset/resource and comparing the total accumulated resource amount against the resource limit.

26. Therefore, hearing officer concludes that the respondent has met the burden of proof.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay

FINAL ORDER (Cont.)

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the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 14 day of September, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Sep 14, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04912

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88261

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 3, 2017 at approximately 8:21 a.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED], *pro se*

For the Respondent: Roneige Alnord, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of June 29, 2017 denying SSI-Related Medicaid eligibility. The burden of proof was originally assigned to the petitioner at hearing; however, after further review, it is assigned to the respondent by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted a packet of information that was admitted into evidence and marked as Petitioner's Exhibit "1".

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "9". During the course of the hearing, additional screen prints were requested. The respondent submitted them by the end of the same day. They were admitted into evidence and marked as Respondent's Exhibits "10" and "11," and the record was closed.

FINDINGS OF FACT

1. The petitioner applied with the Social Security Administration (SSA) for Supplemental Security Income (SSI) on June 29, 2015. This application was denied September 3, 2015 with denial code 31, [REDACTED]. [REDACTED]. The petitioner appealed this decision on February 18, 2016. The decision is currently still under appeal. A hearing is scheduled with the SSA for September 25, 2017. The petitioner has retained counsel for the SSA hearing. Petitioner's counsel is aware of her current medical conditions (Respondent's Exhibits 4, 5 and 8).
2. Beginning November 1, 2015 and through May 31, 2017, the petitioner, a single female, without dependents in the home, now age 56, who has not been determined disabled, yet had been labeled as an eligible adult in an SSI-Related Medicaid coverage group and a recipient of Medicaid benefits (Respondent's Exhibit 10).
3. On June 15, 2017, after her Medicaid coverage had been terminated, the petitioner submitted an application to the respondent for Medicaid. The petitioner's

Medicaid had been terminated after the respondent realized that the petitioner did not meet the eligibility requirements (she had not been determined disabled) for the Medicaid benefits she had been approved for in error (Respondent's Exhibit 3).

4. On June 23, 2017, the respondent forward a request for a disability determination to the Division of Disability Determination. It was returned June 28, 2017 denied with reason code N32, "non-pay – capacity for substantial gainful activity – other work, no visual impairment." In the remarks section is recorded: "Hankerson 12/15 same allegations, hearing pending 9/25/17" (Respondent's Exhibits 5 and 8).

5. On June 29, 2017, the respondent mailed a notice of case action (NOCA) informing the petitioner that the June 15, 2017 SSI-Related Medicaid application was denied as she did "not meet the disability requirement" and that "no household members are eligible for this program" (Respondent's Exhibit 6).

6. The petitioner questions why her Medicaid coverage was stopped after being covered for more than two years and why she is no longer eligible. She states she has chronic medical issues and must have regular medical care. These issues include

[REDACTED]

[REDACTED]. The petitioner stated

that her initial disability determination with the SSA was based on her have [REDACTED]

[REDACTED] and that the other issues were discovered after she received Medicaid

coverage. The petitioner reported that her lawyer, representing her before the SSA, is aware of her current conditions. The Disability Determination and Transmittal lists two

diagnoses considered primarily in the determination, [REDACTED] and a

degenerative disorder of the back. The petitioner has been continuously employed during this period.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
8. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
9. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.
10. Federal Medicaid Regulations at 42 C.F.R. §435.541 “Determinations of disability” states in part:
 - (a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
 - (1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
 - (2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.
 - (b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—
 - (i) **An SSA disability determination is binding on an agency until the determination is changed by SSA.**
 - (ii) If the SSA determination is changed, the new determination is also binding on the agency.
 - (2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of

ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section. (c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

[Emphasis added.]

11. The Department's Program Policy Manual, CFOP 165-22, Passage 1440.1205, Exceptions to State Determination of Disability (MSSI, SFP), states in part: "The state does not make a disability determination under the following conditions...5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA)."

12. The findings show that the petitioner applied with the SSA and was denied as she was found not disabled. The denial date was September 3, 2015. The petitioner received Medicaid benefits from November 1, 2015 through May 31, 2017. Upon review in June 2017, the respondent recognized that the petitioner had not been determined disabled and terminated Medicaid coverage. During this entire period, the petitioner was gainfully employed.

13. The undersigned concludes that all of the petitioner's potentially disabling conditions have been reviewed by the SSA. The undersigned concludes there are no new disabling conditions not known by the SSA.

14. The above cited authorities state that the respondent must accept the decision made by the SSA for the length of the time it is in appeal with the SSA or *until SSA changes that decision*. In this instant case, the original SSA denial was appealed February 18, 2016 and has remained in an active appeal status.

15. The undersigned concludes that the respondent correctly adopted the federal SSA disability decision rather than make a duplicate independent decision on the petitioner's disability request.

16. Fla. Admin. Code 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R. Part 435, subparts E and F (2007) (incorporated by reference) ... (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905 (2007) (incorporated by reference).

17. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (by either the Department or SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs. Because petitioner is under age 65 and has not yet been determined disabled by SSA, she does not meet the technical criteria to be eligible for SSI-Related Medicaid; therefore, the respondent correctly denied the request for Medicaid at issue.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
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DONE and ORDERED this 14 day of September, 2017,
in Tallahassee, Florida.



Gregory Watson
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Sep 15, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04956

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 21, 2017 at 9:45 a.m.

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: Stan Jones, ACCESS, Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny her applications for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit any exhibits. The respondent submitted five exhibits which were entered into evidence as Respondent's Exhibits "1" through "5". The record was held open until close of business on August 31, 2017 for submission of additional evidence from the parties. On August 22, 2017, the petitioner submitted evidence which was entered as Petitioner's Exhibit "1". On August 22, 2017, additional evidence was received from the respondent, which was entered as Respondent's Exhibit "6". The record closed on August 31, 2017.

FINDINGS OF FACT

1. The petitioner (age 42) filed an application for Medicaid disability on June 6, 2017. On the application, she reported that she was disabled. The petitioner is not age 65 or older and does not have any minor children.
2. The petitioner applied for disability with Social Security Administration (SSA) on September 2011 and May 2017. The petitioner reported her disabling conditions to SSA. The petitioner was denied disability benefits through SSA with a denial code N-32. Code N-32 means "Non-Pay-Capacity for substantial gainful activity- other work, no visual impairment." The petitioner's attorney (Law Offices of Rotstein & Shiffman) filed a reconsideration with SSA. The SSA appeal remains pending.
3. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner's application was referred to DDD on June 12, 2017.
4. DDD did not conduct an independent review; instead, it denied the petitioner's

disability claim by adopting the SSA denial decision on May 2017. DDD has access to SSA information. The Disability Determination and Transmittal returned from DDD lists the petitioner's primary diagnosis as affective (mental disorder) and her secondary diagnosis as anxiety.

5. On June 20, 2017, the respondent mailed the petitioner a Notice of Case Action denying her Medicaid application; due to not meeting the disability requirement.

6. On June 20, 2017, the petitioner applied again for Medicaid disability. The petitioner alleged a new condition, degenerative arthritis. The petitioner's application was referred again to DDD on June 22, 2017. On June 27, 2017, DDD denied the petitioner's Disability Medicaid and issued to the respondent an Interoffice Memorandum citing "A determination was made in the last 90 days. The claimant should apply for a hearing."

7. The medical documents that was forward to DDD were documents already forward from the first application submitted on June 6, 2017. The documents consisted of the following: an emergency room visit at [REDACTED] on June 12, 2017 for migraines, and on June 16, 2017 hip/back pain. She was treated and referred to an orthopedic specialist; the note also indicated she may return to work on June 20, 2017.

8. The respondent submitted medical records from the petitioner. On August 15, 2017, the petitioner had an MRI completed for the lumber spine. According to the report, the petitioner has sustained a car accident (petitioner testified car accident occurred on March 2016). The findings show; [REDACTED]

[REDACTED] The petitioner did not provide any evidence of what medical conditions were considered by SSA.

9. The petitioner has an SSA hearing scheduled on November 2017. The record was held open to provide the opportunity to submit additional medical records to validate her new conditions. The petitioner submitted a complete medical treatment and medications and work background questionnaire to SSA on August 20, 2017. No evidence was submitted to show that SSA refused to consider her new allegation.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

11. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

12. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R.

§ 416.905, "Basic definition of disability for adults". The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...

13. The Code of Federal Regulations at 42 C.F.R. § 435.541 addresses

determinations of disability and states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) **An SSA disability determination is binding on an agency until the determination is changed by SSA.** [emphasis added]

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) **The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.** [emphasis added]

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist:

...

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid....

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) **Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—**

(A) **Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations;** [emphasis added] and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

14. The Department of Children and Families published Transmittal No.: I-03-05-0025

on May 23, 2013, regarding "Disability Reminders," it states in part:

The purpose of this memorandum is to remind staff of certain procedures that must be taken for applications in which a state disability decision is required.

...

Adoption of Social Security Disability Decision

Most Social Security disability decisions must be adopted by the state. A favorable decision is always adopted. To help staff determine when to adopt an unfavorable SSA disability decision, the following guidelines must be followed:

1. **If the SSA disability denial was made within a year of the Medicaid application with DCF, the state MUST adopt the SSA decision and deny Medicaid, even if the client claims a worsened condition.**

(emphasis added)

The only two exceptions to the above rule are listed below.

The state must conduct an independent disability determination if the individual provides evidence that they have a condition that SSA did not consider. The eligibility specialist must request a copy of the SSA denial letter because it contains an explanation of all the conditions considered and the reasons for the denial.

The state must conduct an independent disability determination if SSA refuses to reconsider an individual's disability or worsened condition. (emphasis added) This situation may occur when an individual does not meet other factors of eligibility for SSI and does not have enough quarters for SSDI. Under those circumstances, SSA would have no reason to reconsider an individual's disability.

2. If the SSA disability denial was made over a year prior to the application for Medicaid with DCF, the state must conduct an independent disability determination unless the client's case is still under appeal with SSA based on the same condition.

Again, it may be necessary to obtain a copy of the SSA denial letter in order for staff to determine whether or not the client has a condition that is different than that which is under appeal.

Adoption of Previous DDD Decision

There has been some confusion among staff regarding the DDD decision itself. The following should address the most common misunderstandings.

1. If an individual reapplies for Medicaid within 90 days of a disability denial from DDD, the eligibility specialist: must not submit a new disability packet unless the client has a condition that DDD has not already considered, and must advise the applicant that the DDD decision must be adopted (emphasis added) and of the client's right to a fair hearing if they disagree with the DDD decision.

15. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. In this case, the petitioner's SSI applications were denied in September 2011 and May 2017 by SSA. The petitioner applied for Adult-Related Medicaid on June 6, 2017 and the application was denied by adopting the SSA's decision from less than a year from that time. The petitioner submitted another application on June 20, 2017; on this application, she alleged to have a new condition; [REDACTED]. The evidence shows that the respondent forward medical documentation to DDD when the petitioner submitted her application on June 6, 2017. The information was accessible for DDD to review during the June 6, 2017 and June 20, 2017 applications. On June 27, 2017, DDD forward to the respondent an interoffice memorandum indicating a determination was made in the last 90 days (June 20, 2017 application).

16. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid disability application. The respondent is bound by the federal agency's decision unless

there is evidence of a new disabling condition not reviewed by SSA. The petitioner reported all her disabling conditions to SSA. On August 20, 2017, the petitioner submitted a recent medical treatment and medications and work background questionnaire. There is no evidence that SSA refused to consider any new allegations.

17. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial. The respondent's action to deny the petitioner's Adult-Related (SSI) Medicaid applications dated June 6, 2017 and June 20, 2017 was correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 15 day of September, 2017,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255

FINAL ORDER (Cont.)

17F-04956

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1317 Winewood Boulevard

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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 26, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-04979

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 8:21 a.m. on August 14, 2017.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Sylma Dekony, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Medicare Savings Plan (MSP), Qualified Medicare Beneficiary (QMB), is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner did not submit exhibits. The respondent's representative submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record

remained open until end of business day on August 14, 2017, for the respondent's representative to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "9". The record was closed on August 14, 2017.

FINDINGS OF FACT

1. Prior to the action under appeal, the petitioner received MSP QMB.
2. On March 27, 2017, the petitioner submitted a public assistance web application (Respondent Exhibit 3). Household members listed include the petitioner and his wife. Income listed is Social Security (SS) for the petitioner and from the petitioner's wife employment at [REDACTED] MSP for the petitioner is the only benefit at issue.
3. The MSP has three types of Buy-In Programs; QMB, Special Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual 1 (QI1). Buy-In Programs, if eligible, pay for the Medicare premium.
4. The Social Security Administration (SSA) State On-Line Query lists \$1,023 SS for the petitioner (Respondent Exhibit 9).
5. Employment verification report, printed July 31, 2017, from The Work Number, a third party source of employment verification, lists the petitioner's wife's employment at TeleTech; "original hire date" August 16, 2013, "most recent start date" September 2, 2016, and "employment status" active. And lists the following paychecks received by the petitioner's wife in March 2017(Respondent Exhibit 5):

\$ 953.16	March 10, 2017
<u>\$ 959.66</u>	<u>March 24, 2017</u>
\$1,912.82	Total

6. The petitioner's wife's \$1,912.82 income is more than the half of the \$368 individual federal benefit rate (FBR). Therefore, a portion (referred to as deemed) of her income is counted in the petitioner's MSP eligibility.

7. The following is the Department's calculation of the petitioner's MSP determination (Respondent Exhibit 6):

\$1,023.00	petitioner's SS
-\$ 20.00	unearned income disregard
<hr/>	
\$1,003.00	total unearned income
\$1,912.82	petitioner's wife's earned income
-\$ 65.00	earned income disregard
<hr/>	
\$1,847.82	total earned income
\$ 923.91	½ of petitioner's wife's earned income (\$1,847.82/2)
+\$1,003.00	petitioner's unearned income
<hr/>	
\$1,926.91	countable household income.

8. For the petitioner to be eligible for the MSP, the petitioner's countable household income cannot exceed the following MSP income limits:

\$1,827 QI1
\$1,624 SLMB
\$1,354 QMB

9. The petitioner's \$1,926.91 countable household income exceeds all of the above MSP income limits.

10. On April 4, 2017, the Department mailed the petitioner a Notice of Case Action, notifying QI1 was denied (Respondent Exhibit 2), "Reason: Your household's income is too high to qualify for this program."

11. The petitioner did not dispute his wife's employment at [REDACTED]. He disagrees with the income amount the Department determined for his wife. He asserts that his

wife's employment is "seasonal". The petitioner believes the Department needs to base her income on the 2016 tax return he provided (Respondent Exhibit 4).

12. The respondent's representative said the reason the petitioner was eligible last year for the MSP was because his wife received less income. And the Department uses "prospective budgeting" in their income determination; which means they use the last four weeks prior to the application date to determine future income.

13. The respondent's representative explained if the petitioner's wife's income changes, the petitioner must report the change and the Department will recalculate his MSP eligibility.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

15. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

16. *Florida Administrative Code* R. 65A-1.702, Special Provisions, explains the MSP and in part states:

(12) Limits of Coverage.

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...

(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.) ...

17. *Florida Administrative Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility*

Criteria, in part states:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...

(b) For QMB, income must be less than or equal to the federal poverty level...

(g) For SLMB, income must be greater than 100 percent of the federal poverty level but equal to or less than 120 percent of the federal poverty level...

(j) For a Qualified Individual 1 (QI1), income must be greater than 120 percent of the federal poverty level, but equal to or less than 135 percent of the federal poverty level. QI1 is eligible only for payment of the Part B Medicare premium through Medicaid...

18. *The Department's Program Policy Manual (Policy Manual), CFOP 165-22,*

Appendix A-9 (April 2017), sets forth the following:

Couple income limits

\$1,827 QI1

\$1,624 SLMB

\$1,354 QMB

\$65 + one-half earned income disregard

\$735 indiv idual FBR

\$368 ineligible spouse deeming, one-half FBR

19. *20 C.F.R. § 416.1110, What is earned income, in part states, "(a) Wages—(1)*

Wages paid in cash—general. Wages are what you receive (before any deductions) for working as someone else's employee..."

20. *Policy Manual, CFOP, passage 2440.0201, Prospective Budgeting (MSSI, SFP),*

states:

Prospective budgeting is a method by which eligibility and benefit levels are based on the assistance group's composition and income circumstances as they exist in the month for which benefits are being calculated. This can be either a past, current or future month. When budgeting prospectively for a future month, the estimated anticipated income and circumstances may be based on what occurred in prior months if those months are considered representative of the assistance group's continued situation. Prospective budgeting may also be based on the amount the individual can anticipate to receive. All assistance groups are subject to prospective budgeting.

21. In accordance with the above Policy Manual, the Department used the petitioner's wife's four weeks earned income, prior to March 27, 2017, the date of application, in the petitioner's MSP eligibility determination.

22. 20 C.F. R. § 416.1112 explains, "(c) Other earned income we do not count. We do not count as earned income—(5) \$65 of earned income in a month..."

23. 20 C.F.R. § 416.1121 states, "Some types of unearned income are—(a) Annuities, pensions, and other periodic payments. This unearned income is usually related to prior work or service. It includes, for example, private pensions, social security benefits, disability benefits..."

24. 20 C.F.R. § 416.1124 explains, "(c) Other unearned income we do not count. We do not count as unearned income—(12) The first \$20 of any unearned income in a month..."

25. 20 C.R.F. § 416.1163, How we deem income to you from your ineligible spouse, in part states:

If you have an ineligible spouse who lives in the same household, we apply the deeming rules to your ineligible spouse's income in the following order.

(a) Determining your ineligible spouse's income. We first determine much earned and unearned income your ineligible spouse has...

(d)(2)(i) Combining the remainder of your spouse's unearned income with your own unearned income and the remainder of your spouse's earned income with your earned income...

(g) Examples. These examples show how we deem income from an ineligible spouse to an eligible individual in cases which do not involve any of the exceptions...

Example 3. In September 1986, [REDACTED], a disabled individual, lives with his ineligible spouse, [REDACTED], who earns \$201 per month. [REDACTED] receives a pension (unearned income) of \$100 a month. Since [REDACTED] income is greater than \$168, which is the difference between the September Federal benefit rate for an eligible couple and the September Federal benefit rate for an eligible individual, we deem all of her income to be available to both Mr. and [REDACTED] and compute the combined countable income for the couple. We apply the \$20 general income exclusion to [REDACTED] \$100 unearned income, leaving \$80. Then we apply the earned income exclusion (\$65 plus one-half of the remainder) to [REDACTED] ...

26. In accordance with the above authorities, the Department included the petitioner's \$1,023 SS unearned income minus the \$20 unearned income disregard. And his wife's \$1,912.82 earned income minus the \$65 earned income disregard, plus one-half of the remainder earned income (\$923.91) to arrive at \$1,926.91 countable household income.

27. The evidence submitted establishes the petitioner and his wife's deemed income exceed the income limit of all three MSP benefits (#18).

28. In careful review of the cited authorities and evidence, the undersigned concludes the Department met its burden of proof. The undersigned concludes the Department's action to deny the petitioner MSP benefits, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 26 day of September, 2017,

in Tallahassee, Florida.

P. Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-04999

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88249

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 16, 2017, at 1:00 p.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Mary Triplett, economic self-sufficiency supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action denying Petitioner's Medicaid benefits through the Department's SSI-Related Medicaid Program on the basis that he does not meet the disability criteria is correct. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

Ashley Brunelle, Hearing Officer with the Office of Appeal Hearings, was present as an observer without any objection.

Petitioner's sister, [REDACTED] appeared as a witness on his behalf.

During the hearing, Petitioner did not submit any exhibits for the undersigned to consider. Respondent submitted four (4) exhibits which were marked as Respondent's Exhibits "1" through "4" respectively.

The record was left open through end of business day for Respondent to provide additional information and extended through September 1, 2017 for Petitioner to provide information related to the Social Security Disability issue. Respondent's evidence was timely received and marked as Respondent's Exhibits 5 through 7. Petitioner did not provide any additional information, nor did he contact the hearing officer for additional time. The record was closed on September 1, 2017.

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the final hearing and on the entire proceeding, the following Findings of Fact are made:

1. On June 22, 2016, Petitioner applied for Supplemental Security Income (SSI) with the Social Security Administration (SSA) alleging he is disabled.
2. On August 17, 2016, SSA denied Petitioner's application on the contention that the he has the "capacity for substantial gainful activity-(SGA) other work, no visual impairment" (N 32).

3. On December 27, 2016, Petitioner requested an appeal challenging the SSA's decision, see Respondent's Exhibit 6. Petitioner has retained legal representation to assist with his appeal. A hearing date is still pending.

4. Petitioner is 35 years old. He does not meet the aged criteria for SSI-Related Medicaid benefits. He has no minor children residing with him and does meet the technical requirement for the Family-Related Medicaid category. Petitioner is not blind. Disability must be established as part of his Medicaid eligibility determination.

5. Petitioner is not currently employed. He last worked in 2015, when he was terminated for failure to follow work instructions. Petitioner suffers from the following medical conditions: [REDACTED], see Respondent's Exhibit 3.

6. The Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible, an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility. Once a disability review is completed, the case file is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

7. On March 22, 2017, Petitioner applied for Medicaid benefits for himself through the Department's Family-Related and SSI-Related Medicaid Programs. He was interviewed on April 11, 2017, but no disability reviewed was initiated.

8. On April 24, 2017, Respondent sent Petitioner a Notice of Case Action informing him that his Medicaid benefits were denied because he did not meet the disability requirement, see Respondent's Exhibit 1.

9. On June 9, 2017, information obtained from Petitioner was forwarded to DDD for review. DDD received Petitioner's disability package from the Department for a disability review. The DDD has access to Social Security information. Case notes from the DDD Transmittal indicate Petitioner's medical conditions to be [REDACTED] and [REDACTED]. DDD determined these medical conditions were already known and considered by SSA and will be addressed in the course of his appeal before an administrative law judge (ALJ).

10. On June 16, 2017, DDD denied Petitioner's claim of disability by adopting the 2016 SSA denial citing "same/related allegations, hearing pending". The denial reason code was N 32-(other work, no visual impairment). DDD did not make an independent determination, see Respondent's Exhibit 3 & 4.

11. On June 19, 2017, Respondent sent Petitioner a Notice of Case Action denying his application for SSI-Related Medicaid due to not meeting the disability criteria, see Respondent's Exhibit 5. On July 3, 2017, Petitioner timely requested a hearing to challenge the respondent's action.

12. Respondent explained that it denied Petitioner's SSI-Related Medicaid application because SSA has determined that he was not disabled and DDD has adopted the decision. She explained that the SSA decision is binding and must be accepted by the Department as final. She further explained that once DDD determined that Petitioner is not disabled, the Department has to deny his Medicaid for not meeting the technical requirement for the SSI-Related Medicaid Program for persons under age 65.

13. Petitioner's representative asserts as follows: That he has psychological issues and cannot relate to his environment. That he was diagnosed with [REDACTED] and has trouble concentrating. That he cannot keep a regular job due to his anti-social nature resulting from his [REDACTED] and [REDACTED]. That this medications to control his behavior has caused him to gain weight, leading to [REDACTED] and [REDACTED]). That Petitioner's mother has been using her Social Security benefits to assist him with his medications. The representative believes that Petitioner should be found disabled with his medical conditions and approved for Medicaid benefits to get the necessary treatment. Petitioner did not provide any evidence of what medical conditions were considered by SSA.

CONCLUSIONS OF LAW

14. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

15. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

16. Fla. Admin. Code R 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. Individuals less than 65 years of age must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states in relevant part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted

or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy.

17. The Code of Federal Regulations at 42 C.F.R. § 435.540(a) sets forth the definition and determination of disability and states, “the agency must use the same definition of disability as used under SSI...”

18. Federal Regulations at 42 C.F.R. § 435.541 “Determination of Disability,” states:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.911 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash recipient and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with

SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

19. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage 1440.1204 "Blindness/Disability Determinations (MSSI, SFP) states:

...If SSA has denied disability within the past year and the decision is under appeal with SSA, do not consider the case as pending. Use the decision SSA has already rendered. The SSA denial stands while the case is pending appeal (emphasis added)

20. The Policy Manual at passage 1440.1205 Exceptions to State Determination of Disability (MSSI, SFP) states:

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).
3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.
4. When an individual is no longer eligible for SSI solely due to institutionalization.
5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).

The eligibility specialist must explore eligibility for Medicaid for the individual based on other coverage criteria, e.g., family-related coverage prior to exploring eligibility for disability-related Medicaid.

21. According to the above-cited authorities, an SSA decision made within 12 months of the Medicaid application that is under appeal is controlling and binding on the State Agency unless the applicant reports a disabling condition not previously reviewed by SSA. Additionally, they direct worsening and deteriorating of conditions to the SSA. In this instant case, SSA has determined that Petitioner's conditions were not severe enough to prevent him from engaging in substantially gainful activities. DDD received Petitioner's disability packet and concluded that it contained the "same/related allegations" already considered by SSA. On June 16, 2017, DDD adopted the SSA decision and alerted the Department that Petitioner was not disabled.

22. The evidence shows Petitioner was denied for SSA disability in October 2016. Petitioner did not provide verification of any new condition not previously considered by

SSA. The SSA case is presently under appeal at the ALJ level. Under these circumstances, the controlling authorities preclude the Department from rendering an independent disability determination. Pursuant to the above cited authorities, the SSA determination remains binding on the Department. The hearing officer concludes that the Department's action to deny Petitioner's Medicaid request under the SSI-Related Medicaid coverage group is correct.

23. The hearing officer explored all other Medicaid groups. The only other Medicaid group was Family-Related Medicaid Program benefits. Petitioner has no minor children residing with him. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. Petitioner does not meet the criteria for Family-Related Medicaid Program benefits. It is concluded, Respondent's action to deny Petitioner's application for Medicaid Program benefits was within the rules of the Program.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied. The Department's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Agency Clerk, Office of Legal Services, Bldg. 2, Rm. 204, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 13 day of October, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
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Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 02, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05000

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 66292

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 21, 2017 at 10:45 a.m.

APPEARANCES

For the petitioner: [REDACTED]

For the respondent: Susan Martin, ACCESS, Operations Management
Consultant

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his application for Adult-Related (SSI) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The undersigned secured a full record of the matter. However, as the merits of the case were being developed, the petitioner concluded any further discussion. He

explained that he no longer wished to discuss the matter and would wait to receive the Final Order. The petitioner disconnected the call. The undersigned noted the petitioner's statement on the record.

The petitioner submitted one exhibit, which was accepted into evidence and entered after the hearing as Petitioner's Exhibit "1". The respondent submitted four exhibits, which were accepted into evidence and entered as Respondent's Exhibits "1" through "4".

FINDINGS OF FACT

1. The petitioner (55) filed an application for Medicaid disability on June 26, 2017. On the application, he reported that he was disabled. The petitioner is not age 65 or older and does not have any minor children.
2. The petitioner applied for disability with the Social Security Administration (SSA) on March 26, 2016. The petitioner was denied disability benefits through SSA with a denial code N-31 on April 29, 2016. Code N-31 means "Non-Pay-Capacity for substantial gainful activity-customary past work, no visual impairment". The petitioner filed a reconsideration with SSA on October 11, 2016.
3. The Division of Disability Determination (DDD) is responsible for making State disability determinations on behalf of the respondent when an applicant applies for Medicaid on the basis of disability. The petitioner's June 26, 2017 application was not referred to DDD.
4. Prior to the application received on June 26, 2017, the petitioner submitted an application on February 22, 2017. That application was referred to DDD on March 23, 2017. DDD did not conduct an independent review; instead, it denied the petitioner's

disability claim by adopting the SSA denial decision and forwarded its decision to the respondent on March 27, 2017. DDD has access to SSA information. The Disability Determination and Transmittal returned from DDD lists the petitioner's primary diagnosis as back D/O.

5. The respondent explained a DDD determination was made in the last 90 days (March 27, 2017); therefore, no further review was conducted. Additionally, no new medical condition was reported on the June 26, 2017 application.

6. On June 28, 2017, the respondent mailed the petitioner a Notice of Case Action denying his Medicaid application; due to not meeting the disability requirement.

7. The petitioner does not agree with the Department's denial. He does not understand why he does not qualify for Medicaid disability. The petitioner explained he has been declared to be disabled by an Orthopedic doctor who he alleged is a former SSA medical examiner. The petitioner was receiving Medicaid benefits in New Jersey. He needs Medicaid benefits to get the necessary treatments to help him with his medical conditions.

8. The respondent explained that the Medicaid Program is federal but each state must abide by its own set of rules and criteria when administering the Program.

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. Fla. Admin. Code R. 65A-1.710 et seq., sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he or she must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905, "Basic definition of disability for adults". The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy...

12. The Code of Federal Regulations at 42 C.F.R. § 435.541 addresses determinations of disability and states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations.

(1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) **An SSA disability determination is binding on an agency until the determination is changed by SSA.** [emphasis added]

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) **The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of**

the determination, except in cases specified in paragraph (c)(4) of this section. [emphasis added]

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of following circumstances exist:

...

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid....

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; [emphasis added] and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

13. The Department of Children and Families published Transmittal No.: I-03-05-0025, on May 23, 2013, regarding "Disability Reminders," it states in part:

The purpose of this memorandum is to remind staff of certain procedures that must be taken for applications in which a state disability decision is required.

...

Adoption of Social Security Disability Decision

Most Social Security disability decisions must be adopted by the state. A favorable decision is always adopted. To help staff determine when to adopt an unfavorable SSA disability decision, the following guidelines must be followed:

1. If the SSA disability denial was made within a year of the Medicaid application with DCF, the state MUST adopt the SSA decision and deny Medicaid, even if the client claims a worsened condition.

The only two exceptions to the above rule are listed below.

The state must conduct an independent disability determination if the individual provides evidence that they have a condition that SSA did not consider. The eligibility specialist must request a copy of the SSA denial letter because it contains an explanation of all the conditions considered and the reasons for the denial.

The state must conduct an independent disability determination if SSA refuses to reconsider an individual's disability or worsened condition. This situation may occur when an individual does not meet other factors of eligibility for SSI and does not have enough quarters for SSDI. Under those circumstances, SSA would have no reason to reconsider an individual's disability.

2. If the SSA disability denial was made over a year prior to the application for Medicaid with DCF, the state must conduct an independent disability determination unless the client's case is still under appeal with SSA based on the same condition.

Again, it may be necessary to obtain a copy of the SSA denial letter in order for staff to determine whether or not the client has a condition that is different than that which is under appeal.

Adoption of Previous DDD Decision

There has been some confusion among staff regarding the DDD decision itself. The following should address the most common misunderstandings.

1. If an individual reapplies for Medicaid within 90 days of a disability denial from DDD, the eligibility specialist: must not submit a new disability packet **unless the client has a condition that DDD has not already considered**, (emphasis added) and must advise the applicant that the DDD decision must be adopted and of the client's right to a fair hearing if they disagree with the DDD decision.

14. The above federal regulation explains that the respondent may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid disability application. The respondent is bound by the federal agency's decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner reported all his disabling conditions to SSA. SSA denied the petitioner's disability claim on April 29, 2016 because it determined he was not disabled under its rules. The

petitioner appealed SSA's decision on October 11, 2016 and that appeal remains pending. The petitioner did not testify to any new or worsening condition.

15. In careful review of the evidence and controlling legal authorities, the undersigned concludes that the respondent followed rule in adopting the SSA disability denial. The respondent's action to deny the petitioner's June 26, 2017 Adult-Related (SSI) Medicaid application was correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 02 day of October, 2017,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 20, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05026

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 88328

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 12:55 p.m. on August 22, 2017, at the Department of Children and Families in [REDACTED] FL.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Susan Martin, ACCESS
Operations Management Consultant

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Medicaid disability, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was scheduled to convene telephonically on August 14, 2017. On July 25, 2017, the petitioner requested that the hearing be in person. The petitioner's request was granted and the hearing was rescheduled to convene in person on August 22, 2017.

Appearing as witnesses for the petitioner were, [REDACTED], the petitioner's mother and [REDACTED], the petitioner's husband. The petitioner submitted one exhibit, entered as Petitioner Exhibit "1". The respondent's representative submitted nine exhibits, entered as Respondent Exhibits "1" through "9". The record remained open until August 29, 2017, for the petitioner to submit the Social Security Administration (SSA) denial letter. The petitioner's SSA denial letter was not received. The record was closed on August 29, 2017.

FINDINGS OF FACT

1. On February 16, 2017, the petitioner (age 28) submitted a recertification Food Assistance application. The petitioner was also adding SSI-Related Medicaid and Cash (Respondent Exhibit 3, page14). The Department did not process the SSI-Related Medicaid portion of the application.
2. On July 5, 2017, the petitioner requested a hearing. The Department generated an application, dated July 5, 2017, to add SSI-Related Medicaid since it erred by not processing the petitioner's February 16, 2017 for SSI-Related Medicaid (Respondent Exhibit 3).

3. The petitioner described her disabilities as [REDACTED]
[REDACTED]
[REDACTED] h.

4. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older, or considered blind/disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD).

5. DDD is responsible for determining Medicaid disability on behalf of the Department.

6. The petitioner last applied with the SSA in December 2015. The SSA denied the petitioner in December 2016. The petitioner appealed the SSA denial decision. On June 12, 2017, the SSA upheld the denial decision (Respondent Exhibit 6).

7. The record remained open until August 29, 2017, for the petitioner to submit the June 12, 2017, SSA denial.

8. The petitioner did not submit the June 2017 SSA denial.

9. On August 9, 2017, the Department sent DDD the petitioner's documents for disability review. February 16, 2017, was used as the application date on the Disability Determination and Transmittal sent to DDD.

10. On August 15, 2017, DDD denied the petitioner Medicaid disability due to adopting the June 12, 2017, SSA denial decision (Respondent Exhibit 5).

11. On August 17, 2017, the Department mailed the petitioner a Notice of Case Action (Respondent Exhibit 2), notifying she was denied Medicaid disability, "Reason: You or a member(s) of your household do not meet the disability requirement."

12. The petitioner stated that she does not have new or worsening medical conditions, and that she will reapply for disability through the SSA.

CONCLUSIONS OF LAW

13. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

14. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

15. 42 C.F.R. § 435.541, Determinations of Disability in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section-

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and-

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and-

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

16. The above authority explains that the SSA determination is binding on the Department.

17. In accordance with the above authority, the Department adopted the June 12, 2017, SSA denial decision and also denied the petitioner's Medicaid disability.

18. In careful review of the cited authority and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the Department's action to deny the petitioner Medicaid disability, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
17F-05026
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DONE and ORDERED this 20 day of September, 2017,
in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Sep 27, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

PETITIONER,

APPEAL NOs. 17F-05087
17F-05088
17F-05089

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 CHARLOTTE
UNIT: 88287

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter August 8th, 2017, at 1:14 p.m.

APPEARANCES

For the Petitioner: [REDACTED] pro se.

For the Respondent: Lorry Beauvais, Economic Self-Sufficiency Specialist II for the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the issue of her Share of Cost (SOC) through the Medically Needy (MN) program not showing on the providers' networks. Therefore, the providers do not consider there to be active coverage. The respondent carries the burden of proof in the appeal and must meet its burden by a preponderance of the evidence.

PRELIMINARY STATEMENT

Appeal number 17F-05088 is a companion appeal to appeal number 17F-05087 for Food Assistance (FA) and appeal number 17F-05089 for Special Low-Income Medicare Part B Medicaid (SLMB). On the record, the petitioner stated that the only issue under appeal is the MN issue relating to appeal number 17F-05088. Therefore, appeal numbers 17F-05087 and 17F-05089 were invalidated.

The petitioner did not provide any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 7 were admitted into evidence.

At the beginning of the hearing it was determined that the petitioner had not received the respondent's evidence but chose to move forward with the proceeding without having reviewed it. Therefore, the hearing officer held the record open until the close of business August 24th, 2017, for the petitioner to receive and review the respondent's evidence. The timeframe also allowed the petitioner an opportunity to respond to the evidence in writing if she chose to do so. The petitioner did not respond within the allotted timeframe, and the record was closed.

On August 25th, 2017, the hearing officer received evidence from the petitioner. The information was reviewed. However, since the documents were received after the record closed, it was not considered.

By way of a Notice of Case Action (NOCA) dated June 23rd, 2017, the respondent informed the petitioner that her MN was reviewed and she was eligible for continued Medicaid coverage. On July 3rd, 2017, the petitioner filed a timely request to challenge the respondent's action.

FINDINGS OF FACT

1. The petitioner submitted an online application to recertify her FA, SLMB, and MN benefits on May 23rd, 2017. (See Respondent's Exhibit 1). FA and SLMB are not issues for this appeal.
2. On June 23rd, 2017, the respondent issued a NOCA to the petitioner informing her that she was eligible for continued Medicaid coverage in the Medically Needy program. (See Respondent's Exhibit 2).
3. The petitioner contends that she was hospitalized at the end of May 2017 and the dates of hospitalization may have overlapped into June 2017. The petitioner further states that she has started to receive bills from a kidney doctor who treated her while she was admitted to the hospital. The petitioner spoke with the physician's office regarding the bills and advised them that she has Medicaid with a SOC. However, according to the petitioner, the physician's office was unable to locate the SOC information in their system and did not consider the coverage to be active. Therefore, they were unwilling to submit the outstanding bills for May 2017 to the Department of Children and Families (DCF) for bill tracking.
4. The petitioner testified that she contacted DCF on multiple occasions to inquire as to why the coverage was not showing as active in the physician's system. The petitioner asserts that the reason provided was that the coverage will not show as active until the SOC is met and Medicaid is open. The petitioner does not believe this is correct since she has Medicaid and has never had this problem before. According to the petitioner, the physician's office will not be able to send the bills for collection of payment to be paid if coverage has not been established.

5. According to the respondent, the petitioner's SOC for May 2017 was \$841. However, the SOC has not been met. There is still \$763.73 left that needs to be incurred before Medicaid can be opened for that month. The respondent explained this is why the Medicaid coverage is not showing in the provider's system. The respondent contends that it has only received one bill for bill tracking, and it is from [REDACTED]

[REDACTED] The bill was tracked using the following dates of service and amounts due:

5/28/2017	\$41.33
5/29/2017	\$21.26
5/30/2017	\$14.68

The petitioner did not dispute that the bill from [REDACTED] was the only bill she has received thus far.

6. The respondent explained to the petitioner that in order to meet the SOC, either she or the provider needs to provide copies of the bills to DCF for bill tracking. The petitioner inquired if this was a new policy and stated she has never had to provide the bills previously.

CONCLUSIONS OF LAW

7. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

8. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. Fla. Admin. Code 65A-1.701 Definitions explains SOC and states in relevant part:

(30) Share of Cost (SOC): SOC represents the amount of recognized medical expenses that a Medically Needy enrolled individual or family must incur each month before becoming eligible to receive Medicaid benefits for medical expenses incurred during the remainder of the month.

10. The above-cited authority explains SOC and states that an individual is not eligible for Medicaid benefits until the SOC is met each month. Therefore, active Medicaid benefits would not show in a physician's system until the SOC has been met. As stated in the Findings of Fact, both the petitioner and the respondent made mention that the petitioner had been told that the SOC needs to be met each month before Medicaid can be opened, and then it will appear as active for the providers. The respondent was correct in its statements to the petitioner.

11. The ACCESS Florida Policy Manual CFOP 165-22 passage 2640.0508, Proof of Medical Expenses, states in part:

The following are verification requirements for allowable medical expenses to be counted toward share of cost.

For Medicare premiums the individual's statement may be accepted (including coinsurance charges).

For other health insurance premiums proof is needed of the amount and frequency of the premium. Acceptable evidence is the insurance policy, canceled check, receipt, pay stub or verbal verification from the agent.

For paid medical services bills (includes coinsurance payments) proof is needed of the date of the payment, amount of payment and an estimate of third party liability/TPP, if applicable. Acceptable evidence is the paid bill, receipt, canceled check, written statement from doctor or verbal verification from the provider. (For TPP, verbal verification is not acceptable.)

12. The above-cited authority states that aside from Medicare premiums, proof of outstanding medical expenses is required in order to complete bill tracking. Therefore, if the provider or physician is unwilling to submit the bills to DCF, the responsibility falls to the petitioner.

13. The hearing officer has reviewed the evidence, testimony, and regulations and has determined that the respondent did not err in the bill tracking process or in its explanation of how SOC works. The respondent received one bill for May 2017 and appropriately tracked the bill. The petitioner's SOC was not met; therefore, Medicaid coverage was not established. In regards to future bill tracking, if the provider is unwilling to submit an itemized bill to DCF, the petitioner is ultimately responsible for providing the information.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 27 day of September, 2017,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

FINAL ORDER (Cont.)

17F-05088

PAGE -7

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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 06, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05091

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 Hillsborough
UNIT: 88262

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on August 24, 2017 at 9:02 a.m.

APPEARANCES

For Petitioner: [REDACTED] pro se

For Respondent: Paul Regan, Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner's full SSI-Related Medicaid benefits and enroll him in the Medically Needy (MN) program with a monthly share of cost (SOC) amount effective July 2017 and ongoing is correct. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present and testified. The petitioner submitted no exhibits at the hearing. The respondent was represented by Paul Regan, Supervisor, with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). The respondent submitted seven exhibits at the hearing, which were marked and entered as Respondent’s Exhibits “1” – “7”.

FINDINGS OF FACT

1. The petitioner’s full SSI-Related Medicaid benefits were terminated effective June 30, 2017. (Respondent’s testimony)
2. On May 15, 2017, the petitioner completed a recertification application for SSI-Related Medicaid benefits. The application listed the petitioner as the only household member and his Social Security income of \$960 per month as the only source of income for the household. (Respondent’s Exhibit 1)
3. On May 22, 2017, the respondent approved the petitioner’s May 15, 2017 application and determined the petitioner’s Medicaid certification period would not be extended beyond October 2017. (Respondent’s Exhibit 3)
4. The petitioner’s Social Security Disability Insurance (SSDI) amount is \$961 (gross) per month. (Respondent Exhibit 5) The petitioner does not receive Medicare Part A and B. (Petitioner’s testimony) The petitioner’s SSDI gross amount is \$961 per month; however, his net amount is \$936 per month. Social Security Administration (SSA) is recouping \$25 per month due to an overpayment caused by the petitioner’s family receiving his SSDI benefits while he was incarcerated.

5. The respondent determined the petitioner's MN estimated SOC amount as \$761 effective July 2017 and ongoing as follows: (Respondent's Exhibit 6)

\$ 961.00	petitioner's SSDI income
<u>-\$ 20.00</u>	<u>unearned income disregard</u>
\$ 941.00	total countable unearned income

\$ 941.00	total countable income
<u>-\$ 180.00</u>	<u>MNIL for a household of one</u>
\$ 761.00	estimated share of cost

6. On May 23, 2017, the respondent mailed the petitioner a Notice of Case Action indicating his MN application dated May 15, 2017 was approved with an estimated monthly SOC amount of \$761 effective July 2017 and ongoing. The notice did not include the effective date the petitioner's full SSI-Related Medicaid benefits were terminated. (Respondent's Exhibit 4)

7. The respondent determined the petitioner was not eligible for full SSI-Related Medicaid benefits as he is over the income limit for full SSI-Related Medicaid benefits for a household of one. The respondent explained the petitioner's rent could not be utilized in the determination of his monthly SOC amount; however, certain medical expenses, such as the cost of health insurance premiums, can be utilized in the determination of his monthly SOC amount. (Respondent's testimony)

8. The petitioner does not agree with the respondent's determination that he is not eligible for full SSI-Related Medicaid benefits as he is not able to pay for all of his medical expenses as well as all of his household expenses. Furthermore, the petitioner no longer receives transportation assistance because he is not eligible for full SSI-Related Medicaid benefits. (Petitioner's testimony)

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

10. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, defines the criteria to receive SSI-Related Medicaid benefits and states, in part:

The Department covers all mandatory coverage groups and the following optional coverage groups:

(1) MEDS-AD Demonstration Waiver. A coverage group for aged and disabled individuals (or couples), as provided in 42 U.S.C. § 1396a(m).

...

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

12. Pursuant to the above authority, the petitioner is eligible for the SSI-Related Medicaid programs as he is considered disabled.

13. Fla. Admin. Code R. 65A-1.713 (2), SSI-Related Medicaid Income Eligibility Criteria, defines the types of included and excluded income and states, in part:

(2) Included and Excluded Income. For all SSI-related coverage groups the department follows the SSI policy specified in 20 C.F.R. 416.1100 (2007) (incorporated by reference) et seq., including exclusionary policies regarding Veterans Administration benefits such as VA Aid and Attendance, unreimbursed Medical Expenses, and reduced VA Improved pensions, to determine what counts as income and what is excluded as income with the following exceptions:

(a) In-kind support and maintenance is not considered in determining income eligibility.

(b) Exclude total of irregular or infrequent earned income if it does not exceed \$30 per calendar quarter.

(c) Exclude total of irregular or infrequent unearned income if it does not exceed \$60 per calendar quarter.

(d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS.

(e) Interest and dividends on countable assets are excluded, except when determining patient responsibility for ICP, HCBS and other institutional programs.

14. Pursuant to the above authority, the petitioner's SSDI income is considered included income in the determination of his SSI-Related Medicaid benefits.

15. Fla. Admin. Code R. 65A-1.713 (1)(a), SSI-Related Medicaid Income Eligibility Criteria, establishes income limits and states, in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan.

The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

16. Effective January 2017 through March 2017, the Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for an individual for MEDS-AD as \$874.

17. Effective April 2017 and ongoing, the Policy Manual, CFOP 165-22, Appendix A-9, lists the SSI-Related Income Standard for an individual for MEDS-AD as \$885.

18. The Policy Manual, CFOP 165-22, passage 2440.0372, Overpayments - Included as Unearned Income (MSSI, SFP) states:

Unearned income includes amounts withheld by other benefit programs to recover overpayments. This policy applies to income received by a recipient as well as by a person whose income is subject to deeming. An

exception to this general policy applies when another program's overpayment occurred while the individual was receiving benefits from an SSI-Related Program and the overpayment was budgeted as unearned income at that time. In this situation, do not include as unearned income the amount being withheld to recover overpayment. This prevents the same income from being counted twice, as it was already counted when the overpayment was received and therefore should not be counted again.

19. Pursuant to the above authorities and policies, the petitioner's monthly SSDI income (either the gross amount of \$961 or the net amount of \$936) exceeds the Medicaid income standard for him to receive full SSI-Related Medicaid benefits.

20. Federal Regulations at 42 C.F.R. § 435.917 address notice of the respondent's decisions concerning eligibility, benefits, or services and states, in part:

(a) Notice of eligibility determinations. Consistent with §§431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice must—

(1) Be written in plain language;

(2) Be accessible to persons who are limited English proficient and individuals with disabilities, consistent with §435.905(b), and

(3) If provided in electronic format, comply with §435.918(b).

(b) Content of eligibility notice—...

(2) Notice of adverse action including denial, termination or suspension of eligibility or change in benefits or services. Any notice of denial, termination or suspension of Medicaid eligibility or change in benefits or services must be consistent with §431.210 of this chapter.

21. The Policy Manual, CFOP 165-22, passage 3440.0100, Written Notice Requirement (MSSI, SFP) states:

The individual must be informed in writing of all DCF decisions affecting eligibility, appointment times, or any request for information. All requests for information from the individual must be given in writing and must specify the date on which the information must be returned. Except in situations indicated in passages 3440.0102 through 3440.0106, written notice must be given or mailed at least 10 days prior to the effective month of the action if action is being taken to terminate or reduce benefits

(adverse action). In addition, the individual must be notified in writing when data exchange from a federal source indicates a discrepancy between the information provided and information contained in FLORIDA or the case record. The individual must be provided an opportunity to dispute the findings.

22. Pursuant to the above authority and policy, the respondent is required to provide individuals written notification that is at least ten days prior to the effective month of the adverse action. Although the respondent erred by not providing the petitioner written and ten-day advance notification of the termination of his full SSI-Related Medicaid benefits, the findings show his total countable monthly income exceeds the income limit for full SSI-Related Medicaid benefits. Therefore, the respondent correctly enrolled the petitioner in the MN Program with a monthly SOC amount effective July 1, 2017.

23. In careful review of the cited authorities and evidence, the undersigned concludes the respondent met its burden of proof in establishing the petitioner's full SSI-Related Medicaid benefits were correctly terminated and he was correctly enrolled in the SSI-Related Medically Needy Program with a monthly share of cost amount effective July 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's appeal is DENIED.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 06 day of October, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

FILED

Oct 06, 2017

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05155

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 13 Hillsborough
UNIT: 883DT

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing by phone in the above-referenced matter on August 25, 2017 at 2:14 p.m.

APPEARANCES

For Petitioner: [REDACTED], pro se

For Respondent: Paul Regan, Supervisor

STATEMENT OF ISSUE

At issue is whether the respondent's action to terminate the petitioner's daughter's full Medicaid benefits and enroll her in the Medically Needy (MN) Program with a share of cost (SOC) effective July 2017 and ongoing is correct. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was present and testified. The petitioner submitted two exhibits, which were accepted into evidence and marked as Petitioner's Exhibits "1" – "2". The

respondent was represented by Paul Regan, Supervisor with the Department of Children and Families (hereafter “DCF”, “Respondent” or “Agency”). The respondent submitted five exhibits, which were accepted into evidence and marked as Respondent’s Exhibits “1” through “5”.

FINDINGS OF FACT

1. The petitioner’s daughter received Presumptively Eligible Newborn (PEN) Medicaid coverage from June 2016 through May 31, 2017. (Respondent’s testimony)
The household consists of the petitioner, his wife, and their daughter. (Petitioner’s testimony)
2. On May 16, 2017, the respondent completed an ex-parte of the child’s Medicaid benefits. The child’s PEN Medicaid coverage was terminated effective May 31, 2017 and her “MMC” Medicaid benefits were authorized effective June 1, 2017. The Medicaid certification period was also extended to June 30, 2017. The respondent did not know the reason why the child was eligible for MMC Medicaid benefits and why the certification period was extended to June 30, 2017. (Respondent’s testimony)
3. On May 17, 2017, the respondent mailed the petitioner a Notice of Case Action indicating his daughter’s Medicaid application dated May 16, 2017 was approved. The notice also indicated the child was eligible for Medicaid benefits effective June 2017 and ongoing. (Petitioner’s Exhibit 2)
4. On June 14, 2017, the respondent completed a second ex-parte of the child’s Medicaid benefits. The child’s “MMC” Medicaid benefits were terminated effective June 30, 2017 and she was enrolled in Family-Related Medically Needy (MN) Medicaid benefits with a monthly Share of Cost (SOC) effective July 1, 2017. The respondent did

not know the reason why the child's MMC Medicaid benefits were terminated and why she was enrolled in a Family-Related MN Medicaid benefits. (Respondent's testimony)

5. On June 15, 2017, the respondent mailed the petitioner a Notice of Case Action indicating his daughter's Medicaid benefits would end effective June 30, 2017. The notice also indicated the petitioner's daughter's Family-Related MN Medicaid application dated June 14, 2017 was approved and she was enrolled in the MN Medicaid program with an estimated SOC of \$3,764 per month effective July 2017 and ongoing. (Petitioner's Exhibit 2)

6. The petitioner believed his daughter's Medicaid benefits were terminated in error and he requested her Medicaid benefits be restored for one more year. (Petitioner's testimony)

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. The Fla. Admin. Code R. 65A-1.703, Family-Related Medicaid Coverage Groups, states in part:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection

of this rule.

(a) Children under the age of 21 living with a specified relative who meet the eligibility criteria of Title XIX of the Social Security Act. Included in this coverage group are children who are under age 21 in intact families, provided that the children are living with both parents, unless a parent is temporarily absent from the home.

10. Pursuant to the above authority, since the petitioner's daughter is under the age of twenty-one and lives in same household as her parents, she is eligible for Medicaid benefits under the Family-Related Medicaid Program.

11. The Fla. Admin. Code R. 65A-1.702(4), Special Provisions states:

(4) Ex Parte Process.

(a) When a recipient's eligibility for Medicaid ends under one or more coverage groups, the department must determine their eligibility for medical assistance under any other Medicaid coverage group(s) before terminating Medicaid coverage. Both family-related Medicaid and SSI-related Medicaid eligibility are determined based on available information. If additional information is required to make an ex parte determination, it can be requested from the recipient, or, for SSI-related Medicaid eligibility, from the recipient or from the Social Security Administration.

(b) All individuals who lose Medicaid eligibility under one or more coverage groups will continue to receive Medicaid until the ex parte redetermination process is completed. If the department determines that the individual is not eligible for Medicaid, the individual will be sent a notice to this effect which includes appeal rights. The individual may appeal the decision and, if requested by the individual within 10 days of the decision being appealed, Medicaid benefits will be continued pending resolution of the appeal.

12. Pursuant to the above authority, the respondent must determine individuals' eligibility for medical assistance under any other Medicaid coverage group before terminating their Medicaid benefits. On May 16, 2017, the respondent completed an ex-parte determination and determined the petitioner's daughter was eligible for full Family-Related Medicaid benefits effective June 1, 2017. On June 14, 2017, the respondent completed a second ex-parte determination and determined the petitioner's daughter was eligible for Family-Related MN Medicaid benefits with a monthly SOC amount.

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, passage 0830.0800 Continuous Medicaid (MFAM) states, in part:

After Medicaid eligibility has been established, children who become ineligible for Medicaid for any reason may remain on Medicaid for up to twelve months from the last application, eligibility review or addition to Medicaid coverage. Children up to age 5 receive a minimum of twelve months of continuous Medicaid coverage. Children age five up to 19 receive a minimum of six months of continuous Medicaid coverage. If it is later discovered that the child was not eligible at the point eligibility was determined, continuous Medicaid does not apply. An ex parte review must be completed to explore eligibility in other categories...

Months of Medicaid received since the most recent application or eligibility review count toward the six or twelve months of continuous Medicaid eligibility. Count the first month of eligibility as month one if the last action is an application. If the last action is an eligibility review, count as month one the month following the date the eligibility review was completed. Retroactive Medicaid does not count as a month of continuous Medicaid coverage.

14. Pursuant to the above policy, a child under the age of five is eligible for Medicaid benefits for twelve months from the last application, eligibility review, or addition to Medicaid coverage.

15. The Policy Manual, CFOP 165-22, passage 4600 defines an Eligibility Review as "a review of some or all factors of eligibility at specific intervals." The ex-parte process determines individuals' eligibility for one or more Medicaid coverage groups when they lose eligibility for Medicaid benefits. In May 2017, the respondent determined the petitioner's daughter was eligible for full Family-Related Medicaid benefits when her PEN Medicaid coverage ended. The evidence submitted does not indicate the petitioner's daughter was not eligible for Medicaid benefits during the May 2017 ex-parte determination; therefore, the child is eligible for Full Family-Related Medicaid benefits effective June 1, 2017.

16. In careful review of the cited authorities and evidence, the undersigned concludes the respondent did not meet its burden of proof in establishing the petitioner's daughter was correctly terminated from full Medicaid benefits and correctly enrolled in the Family-Related Medically Needy Program with a monthly share of cost amount.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the petitioner's Medicaid appeal is GRANTED. The respondent is ORDERED to approve full Family-Related Medicaid benefits for the petitioner's daughter effective July 1, 2017.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 06 day of October, 2017,

in Tallahassee, Florida.

Mary Jane Stafford

Mary Jane Stafford
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 24, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05188

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 17 Broward
UNIT: 88651

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 27, 2017, at 10:43 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED] Manager of Operations with [REDACTED] represented Petitioner

For the Respondent: [REDACTED], economic self-sufficiency supervisor

STATEMENT OF ISSUE

At issue is whether Respondent's action denying petitioner's Medicaid benefits through the Emergency Medicaid for aliens (EMA) Program on the basis that he was not authenticated is correct. Petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

On July 13, 2017 Petitioner's representative requested an appeal challenging his Medicaid denial.

Ashley Brunelle, Hearing Officer with the Office of Appeal Hearings, was present as an observer without any objection.

During the hearing, Petitioner submit one exhibit which was accepted into evidence and marked as Petitioner's Composite Exhibit 1. Respondent's exhibit was marked as Respondent's Composite Exhibit 1.

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the final hearing and on the entire proceeding, the following Findings of Fact are made:

- 1 On March 27, 2017, Petitioner, age 78, was hospitalized at [REDACTED]. He remained there until May 5, 2017, see Petitioner's Composite Exhibit 1.
2. On March 31, 2017, an application for EMA benefits was submitted to Respondent on behalf of Petitioner by a representative. On that application, Petitioner was reported to be homeless with a mailing address listed as [REDACTED]. Also included on the application is the representative's address: [REDACTED]. The application was processed without the representative's address included. Respondent determined that no interview was required.
3. On April 6, 2017, a Notice of Case Action was sent to Petitioner notifying him that his application for Medicaid Program benefits was denied citing, "No household

members are eligible for this program.” The notice was sent to [REDACTED]

[REDACTED]. No notice was sent to the representative.

4. On April 27, 2017, the representative sent an inquiry to Respondent requesting an update on the application. Respondent documented in its case record that Petitioner still needed to be authenticated.

5 On June 22, 2017 Petitioner’s case was reopened from its closed status. As part of the application process, the respondent is required to establish, explore, and verify all factors of eligibility. The applicant’s cooperation in securing such verification(s) is requested if deemed necessary.

6. On June 23, 2017, Respondent determined that a verbal authentication was necessary. A Notice of Case Action was sent to Petitioner requesting pending information. The notice requests (in full and verbatim) the following:

We need the following by July 3, 2017

*Proof of INS status

*proof of your identification (example: driver’s license)

Other- please see comments below

The department is committed to protecting your identity. Therefore we must have a face-to face meeting with [REDACTED]

7. The notice was sent to [REDACTED]. No notice was sent to the representative. Petitioner did not report to the location and no pending information was received.

8. On June 26, 2017, the representative sent an inquiry to Respondent requesting an update on the application. Respondent documented in its case record that the case was pending.

9. On July 6, 2017, Respondent sent a Notice of Case Action to Petitioner informing him that his Medicaid application was denied citing, "We did not receive all the information necessary to determine eligibility." The notice was sent to [REDACTED]. No notice was sent to the representative, see Respondent's Composite Exhibit 1.

10. Respondent acknowledged that the case was improperly denied originally, but was reopened and processed correctly to issue a formal denial. She asserts as follows: That Petitioner was not authenticated by the system and that a manual authentication process was necessary. That identification and authentication are two different things. That petitioner was identified, but needed to be authenticated before his Medicaid could be approved. That once Petitioner failed to report for his face-to-face interview, his Medicaid was denied. Respondent acknowledged that no notices were sent to the petitioner's representative; however, she maintains that Petitioner has the ultimate responsibility to submit all requested information.

11. Representative argued he never received any notices from respondent. That as the Petitioner's representative, he should have received all notices associated with the case. That once Petitioner was "identified" he did not have to be "authenticated". That he had only become aware of the denial after checking Petitioner's online account for notices. He is seeking EMA coverage from March 31, 2017 through May 5, 2017 to

cover Petitioner's medical bills for those days. Respondent recognized the designated representative as being qualified to act on Petitioner's behalf.

CONCLUSIONS OF LAW

12. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

13 This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

14. The Fla. Admin. Code R. 65A-1.203(9) defines representative:

“Authorized/Designated Representative: An individual who has knowledge of the assistance group's circumstances and is authorized to act responsibly on their behalf.”

15. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22 at passage:0640.0109 addresses Designated Representatives (MSSI) and states:

A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An applicant must authorize a designated representative in writing prior to eligibility determination or anytime during the review period. The applicant does not have to be functionally or legally incompetent to have a designated representative...

16. Petitioner's representative can act on his behalf for the application, including interviews. The representative assumes the same rights and responsibilities as the applicant, including the responsibility of furnishing information, documentation and verification needed.

17. Respondent was aware that the petitioner had a representative when it reopened the case and sent a pending notice on June 23, 2017. The representative was not added to the case. The evidence did not demonstrate that Respondent excluded Petitioner's representative on the basis that he provided insufficient or inaccurate information concerning Petitioner's circumstances. It is concluded that Respondent should have sent Petitioner's representative all case notices. Without the notices, Petitioner's representative did not know to submit information he was required to in assuming the responsibility to provide information on behalf of the petitioner related to the March 31, 2017 application.

18. The Fla. Admin. Code R. 65A-1.204, Rights and Responsibilities, sets forth:

(1) An individual has the right to apply for assistance, to have eligibility determined, and if found eligible, to receive benefits. The applicant for or recipient of public assistance must assume the responsibility of furnishing information, documentation and verification needed to establish eligibility.

19. Fla. Admin. Code Rule 65A-1.025, Eligibility Determination Process, 1(a) states as follows:

The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility.

20. The Fla. Admin. Code R 65A-1.205, Eligibility Determination Process, sets forth the time frame for an applicant to provide additional information:

(1)(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, or that a member of the assistance group must comply with Child Support Enforcement or register for employment services, the eligibility specialist must give the applicant

written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later...

21. As Respondent did not send Petitioner's representative copies of the notices, it is concluded that Respondent incorrectly denied Petitioner's application for EMA benefits. The case is remanded to Respondent to send Petitioner's representative a notice which lists the required verification, and give 10 days to provide the required verification.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Respondent's denial of Petitioner's March 31, 2017 application for EMA was incorrect. The case is remanded to Respondent to send Petitioner's representative a notice which lists ALL the required information, and allow 10 days to provide the required verification. The remand does not insure Petitioner is eligible for Medicaid Program benefits, but it will give Petitioner's representative the opportunity to provide the necessary documentation protecting the March 31, 2017 application. Once Petitioner's representative is properly noticed, eligibility is redetermined, and a decision is made; a new notice should be issued informing him of the outcome and said notice shall include appeal rights.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
17F-05188
PAGE -8

DONE and ORDERED this 24 day of October, 2017,
in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 12, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05230

PETITIONER,

Vs.

CASE [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Seminole
UNIT: 55207

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter at 2:45 p.m. on September 19, 2017. The hearing was in-person at [REDACTED]

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Marsha Shearer, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner Medicaid disability, is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The hearing was originally scheduled to convene by telephone on August 28, 2017. On August 28, 2017, the parties appeared, the petitioner's father requested that the hearing convene in-person. The request was granted and the hearing was rescheduled and convened in-person on September 19, 2017.

The petitioner was present at the hearing and provided testimony. The petitioner did not submit exhibits. The respondent's representative submitted seven exhibits, entered as Respondent Exhibits "1" through "7". The record remained open through end of business day on September 20, 2017, for the respondent's representative to submit an additional exhibit. The exhibit was received timely and entered as Respondent Exhibit "8". The record was closed on September 20, 2017.

FINDINGS OF FACT

1. On April 17, 2017, the petitioner (age 32) submitted a Food Assistance and Family Medicaid application for himself (Respondent Exhibit 8). Medicaid is the only issue.
2. The petitioner's father described the petitioner's disabilities as [REDACTED]
[REDACTED]
3. To be eligible for Family-Related Medicaid, the petitioner must have minor children.
4. The petitioner does not have children; therefore, he is not eligible for Family-Related Medicaid.
5. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older; or considered blind/disabled by the Social Security Administration (SSA) and/or the Division of Disability Determination (DDD).
6. The DDD determines Medicaid disability eligibility on behalf of the Department.

7. On June 8, 2017, the Department forwarded the petitioner's medical documents to the DDD, for a disability review (Respondent Exhibit 4).
8. The SSA denied the petitioner disability on July 6, 2017 (Respondent Exhibit 5). The petitioner is currently appealing the SSA denial decision.
9. On July 6, 2017, the DDD denied the petitioner disability, due to adopting the SSA denial decision (Respondent Exhibit 4).
10. On July 11, 2017, the Department mailed the petitioner a Notice of Case Action, denying Medicaid, due to not meeting the disability requirement (Respondent Exhibit 3).
11. The petitioner does not have new medical conditions that the SSA is not aware of. The petitioner's father stated that the petitioner's disabilities are not worsening, and are not getting any better.

CONCLUSIONS OF LAW

12. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
13. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.
14. Medicaid eligibility is based on Federal Regulations. There are two categories of Medicaid that the Department determines eligibility for; (1) Family-Related Medicaid for parents and children, and pregnant women, and (2) SSI-Related Medicaid for disabled individuals and adults 65 or older.

15. *Florida Administrative Code R. 65A-1.703, Family-Related Medicaid Coverage*

Groups, in part states:

(1) The department provides mandatory Medicaid coverage for individuals, families and children described in Section 409.903, F.S., Section 1931 of the Social Security Act and other relevant provisions of Title XIX of the Social Security Act. The optional family-related Title XIX and Title XXI coverage groups served by the department are stated in each subsection of this rule...

16. In accordance with the above authority, the petitioner must have minor children to be eligible for Family-Related Medicaid.

17. The petitioner does not have children; therefore, he is not eligible for Family-Related Medicaid.

18. *Florida Administrative Code R. 65A-1.711, SSI-Related Medicaid Non-Financial Eligibility Criteria, in part states, “(1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 20 C.F.R. § 416.905...”*

19. Title 20 of the Code of Federal Regulations Section 416.905, Basic definition of disability for adults, in part states:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy. If your severe impairment(s) does not meet or medically equal a listing in appendix 1 to subpart P of part 404 of this chapter, we will assess your residual functional capacity as provided in §§416.920(e) and 416.945. (See §416.920(g)(2) and 416.962 for an exception to this rule.) We will use this residual functional capacity assessment to determine if you can do your past relevant work. If we find that you cannot do your past relevant work, we will use the same residual functional capacity assessment and your vocational factors of age, education, and work

experience to determine if you can do other work. (See §416.920(h) for an exception to this rule.) ...

20. In accordance with the above authorities, the petitioner must be age 65 or older or considered disabled to be eligible for SSI-Related Medicaid.

21. Title 42 of the Code of Federal Regulations § 435.541, Determinations of disability, in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and—
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

22. The above authority explains that the SSA determination is binding on the Department.

23. The evidence submitted establishes that the SSA denied the petitioner disability on July 6, 2017. The petitioner is currently appealing the SSA denial decision.

24. The petitioner does not have new medical conditions that the SSA is not aware of. And his disabilities are not worsening, and are not getting any better.

25. In accordance with the above authority (#21), the Department adopted the SSA July 6, 2017 denial decision and also denied the petitioner's Medicaid disability.

26. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the Department's action to deny the petitioner Medicaid disability is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 12 day of October, 2017,

in Tallahassee, Florida.

Priscilla Peterson

Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency
[REDACTED]

Oct 16, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05251

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Orange
UNIT: 88991

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter on August 22, 2017 at 8:30 a.m.

APPEARANCES

For the petitioner: [REDACTED] the petitioner's daughter and designated representative

For the respondent: Stan Jones, ACCESS Economic Self-Sufficiency Specialist

II

STATEMENT OF ISSUE

At issue is the respondent's action to deny the petitioner's application for Institutional Care Program (ICP) Medicaid benefits. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner was not present. Appearing as a witness for the petitioner was [REDACTED], the petitioner's son-in-law. The petitioner's representative presented one exhibit, which was entered into evidence as Petitioner's Exhibit "1". The respondent presented four exhibits, which were entered into evidence as Respondent's Exhibits "1" through "4". The record was held open until close of business on September 1, 2017 for submission of additional evidence from the respondent. Additional evidence was received from the respondent on August 23, 2017 and entered into evidence as Respondent's Exhibit "5". The record closed on September 1, 2017.

FINDINGS OF FACT

1. The petitioner (age 87) has been a resident at [REDACTED] facility since January 31, 2017.
2. On April 27, 2017, the petitioner submitted an application for ICP Medicaid benefits and retroactive coverage for January 2017, February 2017 and March 2017. The petitioner reported on her application her sources of income were Social Security of \$556.00, civil service annuity of \$2,611.26 and Veterans Administration (VA) benefits of \$769.00. The petitioner reported her assets were her checking account at [REDACTED], life insurance, a burial plot and her home.
3. On April 28, 2017, the respondent mailed the petitioner a Notice of Case Action (NOCA) which requested the petitioner submit the following information by May 8, 2017:

FINAL ORDER (Cont.)

17F-05251

PAGE - 3

April 28, 2017

Case: [REDACTED]

Phone: (866) 762 - 2237

Fax : (866) 886 - 4342

ACCESS Number: [REDACTED]

Dear [REDACTED]

The following is information about your eligibility.

Once you receive your case number you can go to www.myflorida.com/accessflorida to activate your My ACCESS Account. You will be able to get case status information. You will also be able to print a temporary Medicaid card if you are eligible for Medicaid.

We need the following information by May 08, 2017.

Other - please see comments below

The following information is needed to complete this application: 1-2017 to current bank statements (with bank name on all pages) for the following accounts: Checking [REDACTED] Provide proof from the bank of the income trust account & all deposits made for Wells Fargo 5114 1-2017 to 4-2017 with all months transactions of deposits. (Correct funding amount for all months)

4. On May 31, 2017, the respondent issued a NOCA to the petitioner indicating her Medicaid application dated April 27, 2017 was denied; reason: "We did not receive all the information requested to determine eligibility".
5. On June 23, 2017, the petitioner submitted to the respondent her Social Security Income award letter that indicates she receives \$663.00 per month, documentation of her civil service annuity of \$3,133.00 and bank statements.
6. On June 26, 2017, the respondent received the petitioner's Qualified Income Trust (QIT). The QIT was executed by the power of attorney (petitioner's representative) for the petitioner on January 31, 2017. According to the trust agreement, funding began on January 31, 2017. The petitioner is funding \$1,800.00 a month in the QIT.
7. On August 15, 2017, a pre-hearing conference was completed with the petitioner's daughter. During the pre-hearing conference, the respondent realized the petitioner was receiving VA benefits.

8. Prior to the hearing, on August 20, 2017, the petitioner's representative submitted to the undersigned and the respondent the petitioner's VA award letter that indicates her pension amount is \$337.00 and her Aid & Attendance amount is \$432.00. The respondent realized it had not included the VA benefits in the petitioner's income calculation. The total income amount was \$4,565.00; however, the respondent removed the \$432.00 Aid & Attendance amount as excluded income. The respondent determined the petitioner's monthly countable income was \$4,133.00. The petitioner is funding \$1,800.00 of her income into the QIT account leaving \$2,333.00 as her monthly countable income ($\$4,133.00 - \$1,800.00 = \$2,333.00$).

9. The respondent explained, after further review, it determined the petitioner is over the \$2,205.00 ICP income limit to be eligible for ICP Medicaid.

10. The petitioner's representative objected to the respondent including the VA's Aid & Attendance income in the calculations of the ICP Medicaid budget. The respondent explained the Aid & Attendance amount (\$432.00) was excluded from the ICP Medicaid calculations. The respondent determined the petitioner was not eligible for ICP Medicaid because her countable income of \$2,333.00 ($\$4,133.00 - \$1,800.00$) exceeded the \$2,205.00 ICP income limit.

CONCLUSIONS OF LAW

11. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to section 409.285 of the Florida Statutes. This order is the final administrative decision of the Department of Children and Families under section 409.285 of the Florida Statutes.

12. This hearing was held as a de novo proceeding pursuant to Florida Administrative Code Rule 65-2.056.

13. The Florida Administrative Code R. 65A-1.713, "SSI-Related Medicaid Income Eligibility Criteria", in part states:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows...

(d) For ICP, gross income cannot exceed 300 percent of the SSI federal benefit rate after consideration of allowable deductions set forth in subsection 65A-1.713(2), F.A.C. Individuals with income over this limit may qualify for institutional care services by establishing an income trust which meets criteria set forth in subsection 65A-1.702(15), F.A.C...

(2) (d) Income placed into a qualified income trust is not considered when determining if an individual meets the income standard for ICP, institutional Hospice program or HCBS...

(4) (b) For institutional care, hospice, and HCBS waiver programs the department applies the following methodology in determining eligibility:
1. To determine if the individual meets the income eligibility standard the client's total gross income, excluding income placed in qualified income trusts, is counted in the month received. The total gross income must be less than the institutional care income standard for the individual to be eligible for that month...

14. The above authority explains that gross income cannot exceed 300% of the SSI federal benefit rate to be eligible for ICP benefits and, an income trust may be established for those that exceed the income standard.

15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Appendix A-10 sets the federal benefit rate for an individual at \$735 (300% of \$735 = \$2,205).

16. Policy Manual, Appendix A-9, sets \$2,205 as the ICP income standard for an individual.

17. The Policy Manual, CFOP 165-22, passage 1840.0110, Income Trusts (MSSI) states:

The following policy applies only to the Institutionalized Care Program (ICP), institutionalized MEDS-AD, institutionalized Hospice, Home and Community Based Services (HCBS) and PACE. It does not apply to Community Hospice.

To qualify, an individual's gross income cannot exceed 300 percent of the SSI federal benefit rate (refer to Appendix A-9 for the current income standard). If an individual has income above the ICP income limit, they may become eligible for institutional care or HCBS if they set up and fund a qualified income trust. A trust is considered a qualified income trust if:

1. it is established on or after 10/01/93 for the benefit of the individual;
2. it is irrevocable;
3. it is composed only of the individual's income (Social Security, pensions, or other income sources); and
4. the trust stipulates the state will receive the balance in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on their behalf.

The eligibility specialist must forward all income trusts to their Region or Circuit Program Office for review and submission to the Circuit Legal Counsel for a decision on whether the trust meets the criteria to be a qualified income trust. Refer to Appendix A-22.1, Guidance for Reviewing Income Trusts, for instructions on processing income trust cases...

18. The findings establish that the petitioner's income exceeded the \$2,205 ICP income limit. The findings also show the QIT was executed by the petitioner's representative and funded on January 31, 2017 with \$1,800.00 per month. However, the petitioner remained over the \$2,205.00 ICP income limit.

19. The Policy Manual, CFOP 165-22, passage 1840.0906.02, Veterans Payments-Pensions (MSSI, SFP) states:

VA pensions are included as unearned income, excluding the amount of aid and attendance, housebound allowance, and unreimbursed medical expenses. Except in OSS, refer to passage 1840.0906.10 for OSS information. VA pensions generally are based on need and, therefore, do not receive the \$20 general exclusion.

20. The respondent determined the petitioner's total income as \$4,133.00, \$1,800.00 of the petitioner income was funded in the QIT; therefore, it is excluded. The petitioner's countable income of \$2,333.00 (\$4,133.00-\$1,800.00) exceeds the ICP income limit of \$2,205.00 for an individual.

21. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the respondent's action to deny the petitioner ICP Medicaid benefits, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 16 day of October, 2017,

in Tallahassee, Florida.



Cassandra Perez
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

FILED

Sep 27, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-05267

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 09 Osceola
UNIT: 55511

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 1:04 p.m. on August 28, 2017.

APPEARANCES

For the Petitioner: [REDACTED] pro se

For the Respondent: Sylma Dekony, ACCESS
Economic Self-Sufficiency Specialist II

STATEMENT OF ISSUE

At issue is whether the respondent's (Department) action to deny the petitioner full Medicaid and instead approve Medically Needy (MN) with a \$834 share of cost (SOC), is proper. The respondent carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

Ashley Brunelle, Hearing Officer, appeared as an observer. The petitioner did not submit exhibits. The respondent's representative submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record was closed on August 28, 2017.

FINDINGS OF FACT

1. On January 27, 2017, the petitioner submitted a web application for SSI-Related Medicaid (Respondent Exhibit 3).
2. On February 3, 2017, the Department mailed the petitioner a Notice of Case Action (NOCA) approving full Medicaid (Respondent Exhibit 2, page 11).
3. On April 4, 2017, the Department was notified that the petitioner started receiving \$1,034 in Social Security Disability Income (SSDI) (Respondent Exhibit 7, page 26).
4. To be eligible for full Medicaid, the petitioner's household income cannot exceed the \$885 Medicaid income limit.
5. The next available Medicaid is the MN with a SOC. The following is the Department's calculation of the petitioner's SOC (Respondent Exhibit 5, page 22):

\$1,034	SSDI (Respondent Exhibit 5)	.
-\$ 20	unearned income disregard	
-\$ 180	medically needy income limit (MNIL)	
<u>\$ 834</u>	<u>SOC</u>	

6. On April 5, 2017, the Department mailed the petitioner a NOCA, notifying she was enrolled in MN with a \$834 SOC (Respondent Exhibit 2, page 7).
7. On July 20, 2017, the Department mailed the petitioner another NOCA, notifying her MN was reviewed and she continued to be eligible for MN (Respondent Exhibit 2).
8. The petitioner argued that she cannot afford to pay \$834 monthly for MN.

9. The respondent's representative explained that she is not required to pay \$834 monthly. She explained that the \$834 SOC is the amount of incurred medical expenses required. And verification of the incurred medical expenses must be submitted to the Department before full Medicaid coverage can be approved.

10. The respondent's representative gave an example; if the petitioner goes to the hospital and her bill is \$900, she submits the bill to the Department for bill tracking. Since the \$900 bill is more than the petitioner's \$834 SOC, the bill will be paid and the petitioner will have full Medicaid for the duration of the month.

11. The petitioner stated the MN with the \$834 SOC is "not helpful and is detrimental".

CONCLUSIONS OF LAW

12. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

13. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

14. The *Florida Administrative Code* R.65A-1.713, SSI-Related Medicaid Income Eligibility Criteria, states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level...

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost", shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service... To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months...

15. The above authority explains to be eligible for full SSI-Related Medicaid, income cannot exceed 88 percent of the federal poverty level (FPL). And MN provides coverage for individuals who do not qualify for full Medicaid, due to income.

16. The Department's Program Policy Manual, CFOP 165-22, appendix A-9, identifies \$885 as 88 percent of the FPL for an individual.

17. The petitioner's \$1,034 SSDI exceeds the \$885 income limit for full Medicaid.

18. 20 C.F.R. § 416.1124 explains unearned income not counted and states in part "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

19. The *Florida Administrative Code* R. 65A-1.716 sets forth the MNIL at \$180 for a family size of one.

20. In accordance with the above authorities, the Department deducted \$20 and \$180 from the petitioner's \$1,034 SSDI to arrive at a \$834 SOC.

21. In careful review of the cited authorities and evidence, the undersigned concludes that the respondent met the burden of proof. The undersigned concludes the

respondent's action to deny the petitioner full Medicaid and instead approve the petitioner MN with a \$834 SOC, is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 27 day of September, 2017,
in Tallahassee, Florida.



Priscilla Peterson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Oct 03, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05282

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 11 Dade
UNIT: 66709

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 28, 2017 at 11:30 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Sonya Ceason, Operations & Management Consultant

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to enroll her in the Medically Needy program with an assigned share of cost. The petitioner bears the burden of proving the respondent's action was incorrect. The standard of proof at a Fair Hearing is a preponderance of the evidence.

PRELIMINARY STATEMENT

Petitioner's Composite Exhibit 1 was admitted into evidence, consisting of information

describing household and insurance expenses.

Respondent's Composite Exhibit 1 was admitted into evidence, consisting of the petitioner's application for benefits, notice of case action, and applicable policy provisions.

By way of a Notice of Case Action dated July 20th, 2017, the respondent informed the petitioner that she would be enrolled in the Medically Needy program with an estimated share of cost (SOC) of \$3,281 effective July, 2017. The petitioner thereafter filed a timely appeal to challenge the respondent's action.

FINDINGS OF FACT

1. On July 17th, 2017, the petitioner submitted an application for family Medicaid for herself and her twelve (12) year-old child.

2. On the application, the petitioner listed her employment information, child support information, and assets. Her monthly gross income from employment was listed as \$3,668.60. The petitioner also listed her monthly child care expenses.

3. The petitioner submitted into evidence a composite exhibit which shows her other expenses, such as housing, utilities, real estate taxes, transportation, auto insurance, and health insurance. She expressed difficulty in meeting her SOC after those obligations. The petitioner contends that those expenses should entitle her to full Medicaid instead of enrollment in the Medically Needy program. The petitioner's child is currently enrolled in the Florida KidCare program.

4. The respondent processed the petitioner's application using the monthly gross earned income of \$3,668.60. After a Medically Needy Income Level (MNIL) deduction of \$387

for a Standard Filing Unit (SFU) of two (the petitioner and her child), the petitioner was enrolled in the Medically Needy program with an estimated SOC of \$3,281.

5. The respondent presented into evidence the “Family Related Medicaid Income Limit” chart which shows that for a family size of two, the maximum income limit for a parent to qualify for Medicaid is \$241 a month. Once the parent fails the \$241 threshold, the only applicable deduction available is a MNIL of \$387, which the petitioner was afforded. No other expenses such as shelter or utilities (except allowable medical expenses) are allowed in the Medically Needy budget calculation.

CONCLUSIONS OF LAW

6. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 120.80, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

7. This hearing was held as a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

8. Fla. Admin. Code R. 65A-1.707 and 65A-1.716 list the Family-Related Medicaid Income and Resource Criteria. These authorities set forth full Medicaid coverage groups available for the household member.

9. Fla. Admin. Code R. 65A-1.707 Family-Related Medicaid Income and Resource Criteria states in part:

(1) Family-related Medicaid income is based on the definitions of income, resources (assets), verification and documentation requirements as follows.

(a) Income. Income is earned or non-earned cash received at periodic intervals from any source such as wages, self-employment, benefits, contributions, rental property, etc. Cash is money or its equivalent, such as a check, money order or other negotiable instrument. Total gross income includes earned and non-earned income from all sources.... For Medically Needy coverage groups, the amount by which the gross income exceeds the applicable payment standard income level is a share of cost as defined in Rule 65A-1.701, F.A.C. For the CNS criteria, refer to subsection 65A-1.716(1), F.A.C. For the payment standard income levels, refer to subsection 65A-1.716(2), F.A.C.

10. Fla. Admin. Code R. 65A-1.716 Income and Resource Criteria continues:

(2) Medicaid income and payment eligibility standards and Medically Needy income levels are by family size as follows:

Family Size	Income Level
1	\$180
2	\$241 [emphasis added]
3	\$303 ...

11. The authorities cited set forth the income limits for full Medicaid. The undersigned concludes the petitioner's total monthly gross countable income of \$3,668.60 exceeds the income standard for a household size of two (\$241). Therefore, the petitioner is not eligible for full Medicaid.

12. Federal Regulation 42 C.F.R. § 435.831, Income eligibility, explains:

The agency must determine income eligibility of medically needy individuals in accordance with this section.

(b) Determining countable income. The agency must deduct the following amounts from income to determine the individual's countable income.

(1) For individuals under age 21 and caretaker relatives, the agency must deduct amounts that would be deducted in determining eligibility under the State's AFDC plan.

(c) Eligibility based on countable income. If countable income determined under paragraph (b) of this section is equal to or less than the applicable income standard under §435.814, the individual or family is eligible for Medicaid...

13. The above authority explains the Medically Needy program provides coverage for individuals who do not qualify for full Medicaid due to income.

14. The ACCESS Florida Program Policy Manual Appendix A-7, Family-Related Medicaid Income Limits chart sets forth a \$387 MNIL for a household size of two.

15. The respondent subtracted the \$387 MNIL from the gross earned income of \$3,668.60 to arrive at the \$3281 share of cost for the petitioner.

16. The ACCESS Florida Program Manual at 2030.1400, Medically Needy Coverage (MFAM) sets forth:

The Medical Needy Program coverage is for individuals who meet the technical requirements of the above coverage groups but whose income exceeds the income limit. If the household's income is great than the income limit, the exceeding amount is determined as the share of cost. The individual is enrolled but is not eligible until the share of cost is met. Medically Needy provides month-to-month coverage when individuals have incurred medical bills that meet their share of cost.

17. A review of the rules and regulations did not find any exception to this formula. Based on a review of the evidence in its totality, the hearing officer concludes that the respondent's action to enroll the petitioner in a Medicaid Medically Needy Program and determine a share of cost of \$3,281 was within the rules of the program.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied, and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 03 day of October, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished to: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 13, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NOS. 17F-05437
17F-06007

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88262

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 3, 2107 at approximately 2:20 p.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED] *pro se*

For the Respondent: Roneige Alnord, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department’s action of July 6, 2017 enrolling him in the Medically Needy (MN) Program with a remaining share of cost (SOC) of \$803. He thinks his remaining SOC is high. Also of concern was the petitioner’s desire to use his SNAP (Supplemental Nutrition Assistance Program, formerly known as the Food Assistance Program) benefits to purchase pre-prepared food at the site where he is

receiving chemo-therapy. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted information that was admitted into evidence and marked as Petitioner's Exhibit "1".

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "10".

FINDINGS OF FACT

1. The petitioner requested that he be allowed to use his SNAP benefit to purchase pre-prepared meals where he receives his chemo-therapy.
2. On June 15, 2017, the petitioner submitted an application to the respondent for SNAP and Medicaid benefits. The household consists of himself and his wife. Total gross income for the household is \$1,064.33 (Respondent's Exhibits 1 and 2).
3. On July 31, 2017, the respondent mailed a Notice of Case Action (NOCA) informing the petitioner that his SNAP benefits for the period of September 2017 through June 2018 would be \$140; that beginning June 2017 he would be enrolled in the MN Program with a SOC of \$803; and that he remained eligible for continued coverage in the Qualified Medicare Beneficiary (QMB) Program (Respondent's Exhibit 6).
4. The MN budget, as prepared by the respondent is as follows (Respondent's Exhibit 7):

\$235.33	Husband's Retirement
+ \$515.00	Husband's Social Security
+ <u>\$314.00</u>	Wife's Social Security

\$1,064.33	Total Unearned Income
- 20.00	Unearned Income Disregard
<u>\$1,044.33</u>	Countable Unearned Income
0.00	Earned Income/Earned Income Disregards
<u>\$1,044.33</u>	Total Countable Income
- 241.00	Medically Needy Income Level (MNIL)
\$803.00	Share of Cost (SOC)
- 0.00	Medical Insurance Premium
<u>- 0.00</u>	Recurring Medical Expense
\$803.00	Remaining SOC

5. The petitioner has not reported to the respondent any unreimbursed medical expenses or medical health insurance premiums other than those already counted in his SNAP budget. The respondent includes \$37 in medical expenses in the SNAP budget.

CONCLUSIONS OF LAW

6. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

7. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

8. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

SNAP

9. Section 409.285(1), Florida Statutes, Opportunity for hearing and appeal, states in part:

If an application for public assistance is not acted upon within a reasonable time after the filing of the application, or is denied in whole or in part, or if an assistance payment is modified or canceled, the applicant or recipient may appeal the decision to the Department of Children and Families in the manner and form prescribed by the department.

10. Furthermore, Fla. Admin. Code, Section 65-2.056, Basis of Hearings, states:

The Hearing shall include consideration of:

(1) Any Agency action, or failure to act with reasonable promptness, on a claim of Financial Assistance, Social Services, Medical Assistance, or Food Stamp Program Benefits, which includes delay in reaching a decision on eligibility or in making a payment, refusal to consider a request for or undue delay in making an adjustment in payment, and discontinuance, termination or reduction of such assistance.

11. As the petitioner's issue is not one as described in the above cited authorities, the undersigned concludes that he does not have jurisdiction. How SNAP benefits may be used is determined by the federal government, and is outside the parameters of the undersigned's authority. Without jurisdiction, the undersigned does not have the authority to make a decision concerning this matter; therefore, the SNAP issue is withdrawn as the hearing officer lacks jurisdiction.

MEDICIAD/MEDICALLY NEEDY

12. The Fla. Admin. Code R. 65A-1.701, Definitions, states in part:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

13. The above authority explains that to be eligible for full Medicaid, the applicant in most cases cannot be a Medicare recipient. The undersigned concludes that the petitioner is therefore not eligible for full Medicaid.

14. The Fla. Admin. Code R. 65A-1.713, SSI-Related Medicaid Income Eligibility Criteria states in part:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses...

(4)(c) Medically Needy. The amount by which the individual's countable income exceeds the Medically Needy income level, called the "share of cost," shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs. If countable income exceeds the Medically Needy income level the department shall deduct allowable medical expenses in chronological order, by day of service. Countable income is determined in accordance with subsection 65A-1.713(2), F.A.C. To be deducted the expenses must be unpaid, or if paid, must have been paid in the month for which eligibility is being determined or incurred and paid during the three previous calendar months to the month for which eligibility is being determined but no earlier than the three retroactive application months. The paid expense may not have been previously deducted from countable income during a period of eligibility. Medical expenses reimbursed by a state or local government not funded in full by federal funds, excluding Medicaid program payments, are allowable deductions. Any other expenses reimbursable by a third party are not allowable deductions. Examples of recognized medical expenses include:

1. Allowable health insurance costs such as medical premiums, other health insurance premiums, deductibles and co-insurance charges; and,
2. Allowable medical services such as the cost of public transportation to obtain allowable medical services; medical services provided or prescribed by a recognized member of the medical community; and personal care services in the home prescribed by a recognized member of the medical community.

15. The above authority explains that Medically Needy provides coverage for individuals who do not qualify for full Medicaid. It also explains the inclusion of medical expenses.

16. Federal Regulations at 20 C.F.R. § 416.1124 explain unearned income not counted and states in part "(c) Other unearned income we do not count... (12) The first \$20.00 of any unearned income in a month..."

17. The Fla. Admin. Code R. 65A-1.716 sets forth the MNIL at \$241 for a family size of two.

18. In accordance with the authorities, respondent deducted \$20 unearned income and \$241 MNIL from \$1,044, petitioner's household income, to arrive at \$803 SOC, and as there are no health insurance premiums or unreimbursed medical expenses budgeted, a remaining SOC of \$803.

19. After careful review of the budgets and the cited authorities and testimony, the undersigned recognizes an inconsistency. There are medical expenses included in the determination of SNAP eligibility that are not also included in the budget determining the petitioner's SOC. The unreimbursed medical expenses used in the SNAP budget may also be applied in the MN budget potentially lowering the petitioner's remaining SOC. The undersigned concludes that the petitioner has met his burden to prove a lower remaining SOC should be determined.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The respondent is ordered to review the case for unreimbursed medical expenses that may be used to lessen the petitioner's remaining SOC. Once a decision is reached, the respondent shall notify the petitioner by NOCA which shall include hearing rights.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the

appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 13 day of October, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 27, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGSOffice of Appeal Hearings
Dept. of Children and Families

APPEAL NO. 17F-05487

PETITIONER,

Vs.

CASE NO. FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 18 Brevard
UNIT: 66292RESPONDENT.

FINAL ORDER

Pursuant to notice, the undersigned telephonically convened an administrative hearing in the above-referenced matter at 2:13 p.m. on September 1, 2017.

APPEARANCES

For the Petitioner:

For the Respondent:
EconomicSylma Dekony, ACCESS
Self-Sufficiency Specialist II**STATEMENT OF ISSUE**

At issue is whether the respondent's (Department) action to deny the petitioner Medicaid disability is proper. The petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

The petitioner submitted one exhibit, entered as Petitioner Exhibit "1". The respondent submitted eight exhibits, entered as Respondent Exhibits "1" through "8". The record was closed on September 1, 2017.

FINDINGS OF FACT

1. On June 23, 2017, the petitioner (age 54) submitted a web application for Food Assistance and SSI-Related Medicaid disability for herself (Respondent Exhibit 3). Medicaid is the only issue.
2. To be eligible for SSI-Related Medicaid, the petitioner must be age 65 or older or considered blind/disabled by the Social Security Administration (SSA) or the Division of Disability Determination (DDD).
3. DDD determines Medicaid disability eligibility for the Department.
4. The last time the petitioner applied for disability through the SSA was on August 31, 2015. The SSA denied the petitioner disability on October 20, 2015 (Respondent Exhibit 6). The petitioner is appealing the SSA denial decision through an attorney. A hearing date of December 17, 2017 has been scheduled for the appeal.
5. On July 7, 2017, the Department forwarded the petitioner's medical documents to DDD. On July 13, 2017, the DDD denied the petitioner disability due to adopting the SSA denial decision (Respondent Exhibit 5).
6. The petitioner alleges [REDACTED] as new medical conditions that the SSA is unaware of.
7. The petitioner stated that her attorney will present her new medical conditions to the SSA during the December 17 2017 appeal.
8. On July 14, 2017, the Department mailed the petitioner a Notice of Case Action (Respondent Exhibit 2), notifying her June 23, 2017 Medicaid application was denied, "Reason: You or a member(s) of your household do not meet the disability requirement."

CONCLUSIONS OF LAW

9. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

10. This proceeding is a de novo proceeding pursuant to *Florida Administrative Code* R. 65-2.056.

11. C.F.R. 42 § 435.541, Determinations of disability, in part states:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability...

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in § 435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided under § 435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c) (3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c) (4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist...

(4) The individual applies for Medicaid as a non-cash recipient, whether or not the State has a section 1634 agreement with SSA. and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act. and—

(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or

(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility...

12. The above authority explains that the SSA determination is binding on the Department.

13. In accordance with the above authority, the Department adopted the SSA denial decision and also denied the petitioner's Medicaid disability.

14. The petitioner alleges new disabling conditions different from that considered by SSA in making its denial determination.

15. The findings establish that the petitioner has appealed the SSA denial decision and has a hearing date of December 17, 2017. And the petitioner's attorney will present the petitioner's new medical conditions documents to the SSA at the December 17, 2017 hearing.

16. In careful review of the cited authority and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes that the Department's action to deny the petitioner Medicaid disability is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 27 day of September, 2017,

in Tallahassee, Florida.

Priscilla Peterson

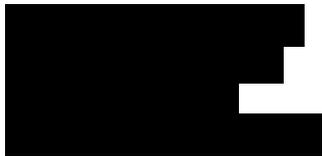
Priscilla Peterson
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 13, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families



APPEAL NO. 17F-05497

PETITIONER,

Vs.

CASE 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88268

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August 30, 2017 at approximately 10:52 a.m. CDT.

APPEARANCES

For the Petitioner: Ken Denman, designated representative

For the Respondent: Teshia Green, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 11, 2017 denying the petitioner's Medicaid application for being over the asset limit. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a packet of information that was admitted into evidence and marked as Petitioner's Exhibit "1". The record remained open for more information from the respondent. The petitioner also submitted additional evidence which duplicated evidence already admitted by the respondent. These second copies of documents were not admitted into evidence.

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "5". The record was to remain open for further submissions from the respondent until September 8, 2017. Because of hurricane Irma, these were received September 19, 2017, and were admitted into evidence and marked as Respondent's Exhibits "6" through "12". The record was closed September 19, 2017.

FINDINGS OF FACT

1. On April 28, 2017, the petitioner submitted an application for SSI-Related Medicaid by way of Division of Disability Determination (DDD) (Respondent's Exhibit 2).
2. DDD determined the petitioner met disability requirements and notified the respondent on May 8, 2017 (Respondent's Exhibit 1).
3. On May 10, 2017, the respondent received a response from the automated asset inquiry system showing liquid assets amounting to \$5,374.09 for the months of February through May 2017 (Respondent's Exhibit 7).
4. On May 11, 2017, the respondent mailed a notice of case action (NOCA) informing the petitioner that the April 28, 2017 application was denied. The reason cited

for the denial was “the value of your assets is too high for this program” (Respondent’s Exhibit 3).

5. A subsequent application, June 6, 2017, for Medicaid was approved effective June 2017, as documentation was received showing the funds were withdrawn May 1, 2017. This hearing is concerned specifically with the two denied months of April and May 2017.

6. On May 15, 2107, the petitioner’s son submitted a hand written communication to the respondent stating that the \$5,000 in his father’s checking account was his and his alone, that the funds were withdrawn on May 1, 2017 and the account closed. He also mentioned that he and his father have the same name, and that their birthdays are on the same day of the year, hinting but not directly saying that the funds may have accidentally been deposited in the wrong account.

7. The respondent reasoned that the information received was insufficient to rebut the ownership and availability of the asset because no written statement was received from the petitioner himself. The only communication concerning the asset issue was received from the petitioner’s son and the petitioner’s designated representative.

8. The account in question is not a joint account with the petitioner and his son. The only name that appears on this account is the petitioner’s; however, the petitioner’s son, in writing, states that he removed the funds from the account on May 1, 2017 and submitted documentation of the account being closed. The respondent’s automated asset response screen print shows the balance of the account as of June 2017 as zero. (Respondent’s Exhibits 7 and 8).

9. There are two accounts with the same name; [REDACTED] the petitioner's account; and [REDACTED] is the petitioner's son's account; however, the petitioner's representative made no argument that this was a banking clerical error that was later rectified by the petitioner's son (Respondent's Exhibit 8).

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

11. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

12. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility Criteria, sets forth: "(1) Resource Limits. **If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month.** [Emphasis added]

The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C..."

14. The Fla. Admin. Code R. 65A-1.716 sets forth:

(3) The resource limits for the Medically Needy program are as follows:

Monthly
Family Asset
Size Level
1 \$5,000

15. The above cited authority explains that the appropriate income level is \$5,000 and states that if the amount of resources falls below that level at any time during the

month the individual is eligible on the factor of resources for that month; therefore, in this instant case, the petitioner is over the asset level and ineligible for MN in the month of April 2017. For the month of May 2017, the respondent has shown that the petitioner's asset value fell below the limit during the month; therefore, the petitioner is eligible for MN in the month of May 2017 on the factor of resources.

16. The Fla. Admin. Code R. 65A-1.303 Assets states:

Specific policies concerning assets vary by program and are found in federal statutes and regulations and Florida Statutes.

Any individual who has the legal ability to dispose of an interest in an asset owns the asset.

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

17. The above cited authority explains the availability of assets. The undersigned concludes that the asset, being funds in a bank account with the petitioner's name on it, is available to him and should be considered a countable asset.

18. The Department's Program Policy Manual, passage 1640.0302.04 Proof Needed to Rebut Ownership (MSSI, SFP) explains the rebuttal process and states:

When an individual has unrestricted access to the funds in a joint account but does not consider himself an owner of part or all of the account funds, you must advise the individual that:

1. the funds are presumed to be his; and
2. he may rebut the presumption of ownership by presenting proof the funds belong to someone else.

To rebut the presumption of ownership, the individual must provide the following information:

First, the individual must provide a written statement and corroborating evidence from the financial institution(s) and other sources to substantiate:

1. any claims about ownership of the funds or interest from the funds;
2. the reasons for establishing the joint account;
3. whose funds were deposited into the account;
4. who made withdrawals from the account; and
5. information on how withdrawals were spent.

Second, the individual must provide a written statement from the joint owner(s) explaining their understanding of the ownership of the account(s); that is, claims of ownership, why the account was set up, who deposited funds, withdrew funds and used the account.

...

If there is no third party or the individual is unable to provide all bank verification, you must make a rebuttal determination based on the evidence submitted. Enter an explanation on CLRC why no written corroborating statement was obtained from the joint owner.

To successfully rebut ownership of a joint account, the evidence must clearly support that the individual is not a joint owner of the funds.

19. The above cited authority explains the steps and requirements of the rebuttal process. The respondent denied MN eligibility for April and May 2017 based on their interpretation of this authority.

20. The rule states the individual must provide a written statement and corroborating evidence. The individual, by way of his designated representative, supplied only a written statement from the petitioner's son as to the ownership of the \$5,000, who states that the funds were his alone and that the funds were deposited into the petitioner's account and on May 1, 2017, withdrawn by the son

21. After careful consideration of the cited authorities, evidence and testimony, the undersigned concludes that the petitioner has not met his burden, in part. The denial of enrollment of the petitioner in the MN Program for the month of April 2017 is affirmed;

however, the designated representative did prove that the petitioner's assets fell below the asset limit in the month of May 2017. According to the above cited authority, if asset value falls below the asset limit for one day of the month, then the applicant is Medicaid eligible based on assets for the entire month; therefore, the undersigned concludes that respondent's action to deny MN enrollment for May 2017 to be in error.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is partially denied and granted. The petitioner is determined Medically Needy ineligible for April 2017. The respondent is ordered to enroll the petitioner in the Medically Needy Program for the month May 2017 as explained in the Conclusions of Law unless May 2017 is determined to be a penalty month because of the transfer of assets. Either way, once accomplished, the respondent must send a notice of case action explaining the action taken and containing appeal rights.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
17F-05497
PAGE -8

DONE and ORDERED this 13 day of October, 2017,
in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Sep 22, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 17F-05498

PETITIONER,

Vs.

CASE NO. 

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 PINELLAS
UNIT: 88261

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on August at approximately 1:08 p.m. CDT.

APPEARANCES

For the Petitioner:  designated representative

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action denying Medicaid for the petitioner for the month of May 2017. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "9". During the course of the hearing, the respondent emailed the petitioner and hearing officer an additional page of information which was admitted into evidence and marked as Respondent's Exhibit "10".

Tanya Cavaleri, Outreach office manager, appeared as a witness.

Romaine Wright, revenue specialist II with the Department of Revenue, appeared as a witness.

Teresa Bowman, revenue administrator II with the Department of Revenue, appeared as a witness.

FINDINGS OF FACT

1. On May 17, 2017, the respondent received an application for Family-Related Medicaid for the petitioner. This application was denied June 8, 2017 for the stated reason that the petitioner was subject to a Child Support Enforcement (CSE) sanction. This sanction was put into place March 14, 2014.
2. On June 5, 2017, the authorized representative submitted an application on behalf of the petitioner requesting Family-Related Medicaid. The household consisted of the petitioner and her three-year-old child. This application was approved effective June 1, 2017, as the respondent had received notification from CSE that the petitioner had cooperated effective June 1, 2017. The retro-month of May 2017 was not addressed in the notice; however, the respondent testified that the petitioner was not

eligible for Medicaid for May 2017, as the effective date of the sanction lift was June 1, 2017 (Respondent's Exhibits 3, 4 and 5).

3. On May 31, 2017 after 4:00 p.m. local time, TC, acting as a designated representative for the petitioner, visited the [REDACTED] She spoke with RW, revenue specialist II, to whom she submitted completed copies of the Department of Revenue's designated representative form, a power of attorney, and an absent-parent information form.

4. RW testified that the absent-parent information form was sufficient to meet the cooperation requirement for the petitioner and told TC that the sanction would be lifted with an effective date of May 31, 2017.

5. CSE's computer system was updated with information concerning the new information beginning June 1, 2017. The data exchange notifying the respondent to lift the sanction imposed in March 2014 was received by the respondent on June 6, 2017. The sanction removal date in the data exchange was June 1, 2017 (Respondent's Exhibit 10).

CONCLUSIONS OF LAW

6. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

7. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

8. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. Fla. Admin. Code R. 65A-1.705(7)(c) Family-Related Medicaid General Eligibility

Criteria, in part states:

If assistance is requested for the parent of a deprived child, the parent and any deprived children who have no income must be included in the SFU. Any deprived siblings who have income, or any other related fully deprived children, are optional members of the SFU. If the parent is married and the spouse lives in the home, income must be deemed from the spouse to the parent. For the parent to be eligible, there must be at least one child under age 18, with or without income, in the SFU, or who would be in the SFU if not receiving SSI...

10. According to the above authority, to be eligible for Family-Related Medicaid benefits, the petitioner must have a minor child under age 18 living in the household with her. Since the petitioner has a minor child under age 18 living in the household, she meets one of the technical requirements to be eligible for Family-Related Medicaid benefits.

11. Section 409.2572, Florida Statutes, Cooperation, states in part:

(1) An applicant for, or recipient of, public assistance for a dependent child shall cooperate in good faith with the department or a program attorney...

(2) Noncooperation, or failure to cooperate in good faith...

(3) The Title IV-D staff of the department shall be responsible for determining and reporting to the staff of the Department of Children and Family Services acts of noncooperation by applicants or recipients of public assistance. Any person who applies for or is receiving public assistance for, or who has the care, custody, or control of, a dependent child and who without good cause fails or refuses to cooperate with the department, a program attorney, or a prosecuting attorney in the course of administering this chapter shall be sanctioned by the Department of Children and Family Services pursuant to chapter 414 and is ineligible to receive public assistance until such time as the department determines cooperation has been satisfactory.

(4) Except as provided for in s. 414.32, the Title IV-D agency shall determine whether an applicant for or recipient of public assistance for a dependent child has good cause for failing to cooperate with the Title IV-D agency as required by this section...

12. Federal Regulations at 42 C.F.R. § 435.610 define the assignment of rights to benefits and states, in part:

(a) As a condition of eligibility, the agency must require legally able applicants and recipients to...

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902 (1)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and...

13. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, Passage 1430.1711, Ending Sanction (MFAM), it states in pertinent part, "The effective date of adding the sanctioned individual in retroactive to the first day of the month of compliance."

14. Pursuant to the above authorities, in order for the petitioner to receive Medicaid benefits for herself, she must cooperate with CSE in establishing support except when she claims good cause exists or is pregnant. The findings show that she cooperated with CSE on May 31, 2017 and this cooperation resulted in CSE requesting that her sanction be lifted. The Findings show that the correct effective date for the lifting of the sanction is May 1, 2017, as it is the first day of the month in which the petitioner cooperated.

15. After carefully reviewing the evidence, testimony and controlling legal authorities, the undersigned concludes that the denial of Medicaid for the month of May 2017 due to a CSE sanction was incorrect. Therefore, the respondent's action to deny Medicaid effective May 2017 is reversed. The appeal is remanded to the respondent to open

Medicaid eligibility for the month of May 2017 and remove the CSE sanction at issue effective May 2017.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The respondent's action to not remove an imposed child support sanction against the petitioner's Medicaid for the month of May 2017 is reversed. The respondent is to take corrective action and reinstate the Medicaid benefits effective May 1, 2017.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
17F-05498
PAGE -7

DONE and ORDERED this 22 day of September, 2017,
in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 23, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-05522

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 08 Levy
UNIT: 88328

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on August 29, 2017 at 10:13 a.m.

APPEARANCES

For the Petitioner: [REDACTED], pro se

For the Respondent: Stephanie Ross, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Whether the petitioner is eligible to receive full coverage SSI-Relative Medicaid. The petitioner holds the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The Department of Children and Families (Department or DCF or respondent) determines eligibility for both the Family-Related and SSI-Related Medicaid Programs.

By notice dated July 31, 2017, the Department informed the petitioner that she was enrolled in the Medically Needy Program with a \$1,104 estimated share of cost.

The petitioner timely requested a hearing to challenge the decision. The petitioner seeks full coverage Medicaid, without a share of cost.

There were no additional witnesses for the petitioner. The petitioner did not submit documentary evidence.

There were no additional witnesses for the Department. The Department submitted documentary evidence which was admitted into the record as Respondent's Composite Exhibit 1.

The record was held open until the close of business on the day of the hearing for the submission of additional evidence. The Department timely submitted evidence which admitted as Respondent's Exhibit 2. The record was closed on August 29, 2017.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following findings of fact are made:

1. The petitioner (age 64) filed an application for SSI-Related Medicaid with the Department on June 29, 2017. The petitioner is a single person household. Her sole source of income is Social Security disability (SSDI) benefits, \$1,304 monthly. (Respondent's Composite Exhibit 1)

2. The Department concluded that the petitioner's countable income exceeded the limit for full coverage SSI-Related Medicaid and enrolled her in the Medically Needy

Program with a \$1,104 monthly estimated share of cost. (Respondent's Composite Exhibit 1)

3. The petitioner requested a hearing on July 31, 2017.

4. The petitioner explained that she recently move to Florida from the state of Ohio, where, with the some income and household size, she was eligible for full coverage Medicaid. The petitioner questioned why she was not eligible for the same Medicaid benefit in Florida. (Petitioner testimony)

5. The petitioner explained that after paying rent and other living expenses, she could not afford to pay or incur \$1,104 monthly out of pocket medical expenses. The petitioner believes she should be eligible for full coverage Medicaid. (Petitioner testimony)

6. The Department explained that Medicaid is a state and Federal medical assistance program. Some states have expanded benefits for single adults; Florida is not one of those states. (Respondent testimony)

7. The Department explained its eligibility determination. The Department's Program Policy Manual at Appendix A-9 shows the income limit for full coverage SSI-Related Medicaid for an individual is \$885. The petitioner's \$1,304 monthly SSDI income exceeds program limitations. Accordingly, the Department enrolled petitioner in the Medically Needy Program with an estimated share of cost. The Department explained its calculations as follows: \$1304 SSDI minus \$20 standard disregard and \$180 Medically Needy Income Level (MNIL), leaving the share of cost at \$1104. (Respondent Composite Exhibit 1)

CONCLUSIONS OF LAW

8. Pursuant to Section 409.285, Florida Statutes, the Department of Children and Families' Office of Appeal Hearings has jurisdiction over this proceeding.

9. This order is the final administrative decision of the Department of Children and Families pursuant to Section 409.285(2), Florida Statutes.

10. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

11. In accordance with Fla. Admin. Code R. 65-2.060 (1), the burden of proof was assigned to the petitioner as she is seeking a higher level of benefits. The standard of proof to be met for fair hearings is by a preponderance of the evidence.

12. Fla. Admin. Code R. 65A-1.710, SSI-Related Medicaid Coverage Groups, states in part:

(5) Medically Needy Program. A Medicaid coverage group, as allowed by 42 U.S.C. §§ 1396a and 1396d, for aged, blind or disabled individuals (or couples) who do not qualify for categorical assistance due to their level of income or resources. The program does not cover nursing facility care, intermediate care for the developmentally disabled services, or other long-term care services.

13. The above authority explains that the Medically Needy Program is for certain individuals who do not qualify for full coverage Medicaid due to the level of their income or resources. The Department's Program Policy Manual, 165-22, Appendix A-9 defines the income limit for full Medicaid for an aged or disabled individual at \$885. The petitioner's monthly income of \$1,304 exceeds that limit. The Department's determination that the petitioner was not eligible for full coverage Medicaid was correct.

14. Federal Regulations at 20 C.F.R. § 416.1124, Unearned income we do not count, states in part:

(a) *General.* While we must know the source and amount of all of your unearned income for SSI, we do not count...the \$20 general exclusion described in paragraph (c)(12).

15. The above regulations explains there is a \$20 general exclusion applied in the SSI-Related Medicaid programs.

16. Fla. Admin. Code R. 65A-1.716, Income and Resource Criteria, defines the Medically Needy Income Levels (MNIL) at \$180 for an individual.

17. The undersigned concludes that the Department applied the applicable deductions, \$20 general exclusion and \$180 MNIL, and correctly enrolled the petitioner in the Medically Needy Program with a \$1,104 share of cost. The Department's determination in this matter was correct.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 23 day of October, 2017,
in Tallahassee, Florida.



Leslie Green
Hearing Officer
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Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency

Oct 06, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05563

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 20 LEE
UNIT: 88284

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter August 29th, 2017, at 2:40 p.m.

APPEARANCES

For the Petitioner: [REDACTED].

For the Respondent: Ed Poutre, Senior Worker for the Department of Children and Families.

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to terminate her full Medicaid coverage and enroll her in the Medically Needy (MN) program. The respondent carries the burden of proving its position by a preponderance of the evidence in this appeal.

PRELIMINARY STATEMENT

The petitioner did not provide any documents for the hearing officer's consideration.

Respondent's exhibits 1 through 8 were admitted into evidence.

By way of a NOCA dated July 18th, 2017, the respondent notified the petitioner that “Your application for Medically Needy dated July 13th, 2017 is approved. On August 1st, 2017, the petitioner filed a timely request to challenge the respondent’s action.

FINDINGS OF FACT

1. The petitioner submitted an online application to add Temporary Cash Assistance (TCA) to her open Food Assistance (FA) and Medicaid case on July 13th, 2017. (See Respondent’s Exhibit 2). FA and TCA are not issues for this appeal. As part of the application process, the respondent is required to explore and verify all factors of eligibility, which include but are not limited to all sources of income and allowable expenses.
2. By way of a NOCA dated July 18th, 2017, the respondent notified the petitioner that “Your application for Medically Needy dated July 13th, 2017 is approved. You are enrolled with an estimated share of cost for the month listed below.” The petitioner was enrolled for the MN program with an estimated SOC of \$923 a month beginning August 2017. (See Respondent’s Exhibit 3 pg. 64).
3. The petitioner is a single-person household, and was 60 years of age at the time of application.
4. The petitioner is disabled and receives a combination of Social Security Disability (SSD) and Widow’s benefits totaling \$1,123 per month. (See Respondent’s Exhibit 4 pg. 74). The respondent considered the same amount when determining eligibility. According to the respondent, during the last certification, the petitioner was only receiving SSD in the amount of \$818 per month. However, the petitioner now receives

an additional amount of \$305 in Widow's benefits each month which put her over the income limit for full Medicaid. The respondent provided, as part of its evidence, a copy of the SSI-Related Programs Financial Eligibility Standards: January 2017 chart which shows that in order to receive full Medicaid, the petitioner's income must fall below 88 percent of the federal poverty limit for an individual. (See Respondent's Exhibit 7 pg. 82) According to the Financial Eligibility Standards: April 2017 chart, 88 percent of the poverty level is \$885 a month. The petitioner acknowledged that the SSD and Widow's benefits amount used by the respondent were correct.

5. The respondent calculated the petitioner's countable income for the MN program as follows:

\$1,123.00	Total unearned income	
- \$ 20.00	<u>Unearned income disregard</u>	
\$1,103.00	Countable unearned income	
Total countable income:		\$1,103.00
<u>-Medically Needy Income Limit (MNIL)</u>		<u>\$ 180.00</u>
Remaining SOC		\$ 923.00

6. The petitioner asserts that she does not receive Medicare and has no other insurance or out of pocket medical expenses. Prior to being on MN, the petitioner had full Medicaid coverage which paid for all of her medical costs.

7. During the hearing, the petitioner requested that the Medicaid coverage be reinstated until she becomes eligible for Medicare B. The respondent agreed to provide full Medicaid throughout the duration of the hearing process.

CONCLUSIONS OF LAW

8. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to

Section 120.80, Fla. Stat. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Fla. Stat.

9. This hearing was held as a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. Fla. Admin Code 65-2.060, Evidence states:

(1) The burden of proof, except where otherwise required by statutes, is on the party asserting the affirmative of an issue. The burden is upon the Department when the Department takes action which would reduce or terminate the benefits or payments being received by the recipient. The burden is upon the petitioner if an application for benefits or payments is denied. The party having the burden shall establish his/her position, by a preponderance of evidence, to the satisfaction of the hearing officer.

11. Fla. Admin. Code R. 65A-1.701, Definitions, states in part:

(20) MEDS-AD Demonstration Waiver: Medicaid coverage group for aged or disabled individuals who meet all SSI-related Medicaid non-financial eligibility criteria, whose resources do not exceed the limit in the Medically Needy Program, whose income is at or below 88 percent of the federal poverty level and are not receiving Medicare or if receiving Medicare are also eligible for Medicaid covered institutional care services, hospice services or home and community based services.

12. Fla. Admin. Code R. 65A-1.713 defines the income limits for SSI - Related Medicaid programs:

(1) Income limits. An individual's income must be within limits established by federal or state law and the Medicaid State Plan. The income limits are as follows:

(a) For MEDS-AD Demonstration Waiver, income cannot exceed 88 percent of the federal poverty level after application of exclusions specified in subsection 65A-1.713(2), F.A.C.

...

(h) For Medically Needy, income must be less than or equal to the Medically Needy income standard after deduction of allowable medical expenses.

13. The ACCESS Florida Program Manual at 2640.0500, Share of Cost (MSSI) sets forth:

The eligibility specialist must determine eligibility for Medically Needy any time the assistance group's assets and/or income exceeds the appropriate categorical asset/income limits. The eligibility specialist determines whether the assistance group's assets are within the Medically Needy asset limits and whether the assistance group members meet the technical factors. If the Medically Needy asset limit is met and the assistance group meets all technical factors, the eligibility specialist determines the amount of countable income and computes a budget using the MNIL which is the same for both family and SSI-Related Medicaid coverage groups (refer to Appendix A-7).

If income is equal to or less than the MNIL, there is no share of cost and the individual is eligible. Medicaid is authorized for individuals who are eligible without a share of cost.

14. The Code of Federal Regulations 20 C.F.R. Section 416.1124 defines unearned income that is not counted in SSI – Related Medicaid programs:

(C)(12) The first \$20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another (see Section 416.1131) and income based on need. Income based on need is a benefit that uses financial need as measured by your income as a factor to determine your eligibility.

15. Fla. Admin. Code R. 65A-1.713 sets forth the Income Budgeting Methodologies for the Medically Needy Program:

(C) Medically Needy. The amount by which the individual's countable income excess the Medically Needy income level, called the "share of cost," shall be considered available for payment of medical care and services. The department computes available income for each month eligibility is requested to determine the amount of excess countable income available to meet medical costs.

16. The above controlling authority explains that the full coverage Medicaid coverage group (MEDS-AD Demonstration Waiver) in the SSI-related Programs is for individuals whose income is below the federal poverty level and are not receiving Medicare, or if

receiving Medicare are eligible for Medicaid covered institutional care services (ICP), hospice services, or community based services. The findings show that the petitioner's income is above 88% of the federal poverty level. Therefore, she is no longer eligible for Medicaid. The undersigned concludes that the respondent was correct in its action to terminate full Medicaid and enroll the petitioner in the MN program.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied. The respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 06 day of October, 2017,

in Tallahassee, Florida.



Kimberly Vargo
Hearing Officer
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FINAL ORDER (Cont.)

17F-05563

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Copies Furnished [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 25, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05604

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 07 Volusia
UNIT: 88882

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on September 19, 2017, at 10:00 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the petitioner: [REDACTED] Esq.

For the respondent: Jane Almy-Loewinger, DCF Legal Counsel.

STATEMENT OF ISSUE

At issue is whether Respondent's action (or the Department) denying Petitioner's June 12, 2017 application for Institutional Care Program (ICP) Medicaid benefits is correct. Petitioner carries the burden of proof by a preponderance of the evidence.

PRELIMINARY STATEMENT

By a Notice of Case Action dated July 13, 2017, Respondent notified petitioner that his June 12, 2017 application for ICP was denied because it did not receive all the information necessary to determine eligibility. On August 3, 2017, Petitioner timely requested an appeal challenging Respondent's action.

Appearing as witnesses for Petitioner were his daughter and POA, [REDACTED] (DH), his grand-daughter, [REDACTED] and [REDACTED] firm legal assistant [REDACTED]. Viola Dickinson, economic self-sufficiency specialist II with the Special Services Unit, appeared as a witness for Respondent.

During the hearing, Petitioner submitted 14 exhibits which were entered into evidence and marked as Petitioner's Exhibits 1 through 14. Respondent submitted a composite exhibit which was marked as Respondent's Composite 1. The record was held open through September 22, 2017 for Respondent to submit additional information and extended through September 27, 2017 for Petitioner to respond. Respondent's evidence was timely received and marked as Petitioner's Composite Exhibit 2. On September 27, 2017 Counsel for Petitioner filed a statement with the Office of Appeal Hearings objecting to its consideration since he was not provided with a copy. Respondent's Counsel did not respond. The undersigned sustained Petitioner's objection and deleted Respondent's Composite Exhibit 2 from the record. This document will not be relied on in rendering the final decision. The record was closed on September 27, 2017.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. On June 12, 2017, DH submitted an application for ICP Medicaid Program benefits Respondent on behalf of Petitioner. On that application, Petitioner was reported to be residing at [REDACTED] located at [REDACTED] [REDACTED] DH resides in [REDACTED] and used her sister's address: [REDACTED] [REDACTED] as Petitioner's mailing address.
2. Applications are good for 60 days and up to four different addresses can be entered in a case file.
3. In the "Comments After E-Signature" box on the application, DH indicated she signed the application. She also indicated that Petitioner had [REDACTED] [REDACTED] as his attorney, see Respondent's Composite Exhibit 1, pages 8 & 9. The attorney's contact was not entered in the case record.
4. As part of the application process, the respondent is required to establish, explore, and verify all factors of eligibility. The applicant's or his representative's cooperation in securing such verification(s) is requested if deemed necessary.
5. On June 14, 2017, Respondent determined that additional verifications were needed to make an eligibility determination. A Notice of Case Action was sent to Petitioner requesting pending information. The notice requests (in full and verbatim) the following:

We need the following by June 26, 2017

Please Complete and sign the “Financial Information Release” form
Proof of income and assets for each month you are requesting retroactive
Medicaid

Proof of out-of-pocket medical expenses if you are receiving disability
benefits or are over the age of 60.

Oher –please see comments below

Please provide the following information: 1) Signed financial release (sic) signed
by the client or POA/Guardian, if the POA/Guardian signs the form provide a
copy of the court document 2) last 3 months of bank statements for any & all
accounts with names & account numbers on the statements 3) Copy of
Facesheet 4) Proof of a QIT account being properly set up and funded 5) proof of
your current monthly retirement income 6)properly fill out & fax the 3008 & 2040
to CARES 7) Medical bills incurred no earlier than 3 months prior to this
application including nursing home bills.

6. The notice goes on to provide information on the various available means to
submit the requested verifications. The notice instructs the recipient to advise the
respondent in the event that help is needed in securing this information. The notice also
states that if the requested information is not provided, eligibility cannot be determined
and the application will be denied or benefits ended.

7. The notice was sent to [REDACTED]

[REDACTED] A separate notice addressed to [REDACTED] was sent to [REDACTED]

[REDACTED] see Petitioner’s Exhibits 6 & 7. No pending notice was
addressed to DH. No notice was sent to the attorney. Respondent did not receive the
pending information by the due date. The case was processed and denied.

8. On July 13, 2017, Respondent sent a Notice of Case Action to Petitioner
informing him that his Medicaid application was denied because “We did not receive all
the information necessary to determine eligibility.” The notice was sent to [REDACTED]

[REDACTED] A separate notice
addressed to [REDACTED] see

Respondent's Composite Exhibit, pages 1-4. No notice was addressed to DH. No notice was sent to the attorney.

9. On July 19, 2017, Petitioner's legal representative faxed the following documents to DCF Adult Medicaid Services:

1. Appointment of a Designated Representative
2. Property Power of attorney of [REDACTED] and
3. Copy of last page of the Medicaid application with 'additional information note regarding [REDACTED] as POA, see Petitioner's Exhibit 9.

10. On August 10, 2017, Petitioner's legal representative faxed the following documents to DCF Adult Medicaid Services:

1. Appointment of a Designated Representative
2. Property Power of attorney of [REDACTED] and
3. Copy of last page of the Medicaid application with 'additional information note regarding [REDACTED] as POA.

11. On August 14, 2017, Petitioner's legal representative faxed the following documents to AHCA-CARES:

- a. Form 3008 Medical Certification for Medicaid Long term care,
- b. Form 2040 Informed Consent Form,
- c. Form 004 Level 1 Screen,
- d. Notification of Level of Care, and
- e. Copy of the "Notice of Case Action" requesting these enclosures.

12. On August 29, 2017, Petitioner's attorney faxed a "new" Level of Care received from [REDACTED] to DCF, see Petitioner's Exhibit 11.

13. Case notes from Respondent's Running Record Comments indicate that on July 17, 2017 Respondent was contacted by a non-authorized representative, but no information was released on the case. They also indicate that on August 9, 2017, a representative from a law firm called to inquire about forms 3008 & 2040, see Respondent's Composite Exhibit 1, page 15.

14. At the hearing, the POA asserted as follows: That she has been managing Petitioner's finances since her mother's passing. That she used her sister's address as Petitioner's mailing address because Petitioner previously resided there. That her sister has never told her about any notices received from Respondent and that she failed to forward them to her. The grand-daughter testified that she has helped Petitioner establish the Qualified Income Trust (QIT) and is currently making payments on Petitioner's vehicle and the related expenses.

15. Respondent's witness acknowledged the omission of petitioner's attorney from the case record, but explained that the "comments" section is not routinely reviewed when applications are being processed. She also could not confirm that any notices were addressed to the POA. She asserted as follows: That she had no obligation to inform Petitioner of any missing documents after a case is denied. That she could only use the 60-day rule to reopen the case only if all the necessary information was received within that time. That some documents were received after the 60-day period expired.

16. Petitioner's representative argued he never received any notices from Respondent. That as the Petitioner's legal representative, all notices associated with the case should have been sent to him. That Respondent maliciously denied

Petitioner's ICP Medicaid without a valid reason. That he had only become aware of the denial after checking Petitioner's online account for notices. That the 60-day rule should not be applied in this case since respondent has wasted the first 30 days when it failed to send notices to him. The assistant testified that she had had several contacts with Respondent and was never explained what was really needed to get this case approved.

17. Petitioner's representative was advised to submit a new application, but he has not completed one as of the date of this appeal. He is seeking ICP Medicaid eligibility beginning with March 2017 (retro months included), based on the June 12, 2017 application.

CONCLUSIONS OF LAW

18. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

19. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

20. The Fla. Admin. Code R. 65A-1.203(9) defines representative:

"Authorized/Designated Representative: An individual who has knowledge of the assistance group's circumstances and is authorized to act responsibly on their behalf."

21. The Department's Program Policy Manual (The Policy Manual), CFOP 165-22, passage: 0640.0109 addresses Designated Representatives (MSSI) and states:

An applicant/recipient, their spouse, legal guardian, Power of Attorney, or a responsible member of the assistance group may appoint an individual or organization to act responsibly on their behalf in assisting with the application and redetermination of eligibility and other ongoing communication with the Department.

A designated representative may be appointed or self-designated to act on behalf of the household. If the individual does not select a specific person as designated representative, determine if the self-designated representative is the most appropriate person to fulfill this responsibility. An applicant must authorize a designated representative in writing prior to eligibility determination or anytime during the review period. The applicant does not have to be functionally or legally incompetent to have a designated representative...(emphasis added)

22. Petitioner's POA or representative can act on his behalf for the application, including interviews. The representative assumes the same rights and responsibilities as the applicant, including the responsibility of furnishing information, documentation and verification needed.

23. In this instant case, DH appointed a legal representative to help with the ICP Medicaid application process. Respondent did not review the "comments" section on the June 12, 2017 application and the representative was not added to the case. The evidence did not demonstrate that Respondent excluded Petitioner's representative on the basis that he provided insufficient or inaccurate information concerning Petitioner's circumstances. It is concluded that Respondent should have sent Petitioner's representative all case notices. Without the notices, Petitioner's representative did not know to submit information he was required to in assuming the responsibility to provide information on behalf of the petitioner related to the June 12, 2017 application.

24. The Fla. Admin. Code R. 65A-1.204, Rights and Responsibilities, sets forth:

(1) An individual has the right to apply for assistance, to have eligibility determined, and if found eligible, to receive benefits. The applicant for or

recipient of public assistance must assume the responsibility of furnishing information, documentation and verification needed to establish eligibility. If the information, documentation or verification is difficult for the individual to obtain, the Department must provide assistance in obtaining it when requested or when it appears necessary.

25. The Fla. Admin. Code Rule 65A-1.025, Eligibility Determination Process, 1(a)

states as follows:

The Department must determine an applicant's eligibility initially at application and if the applicant is determined eligible, at periodic intervals thereafter. It is the applicant's responsibility to keep appointments with the eligibility specialist and furnish information, documentation and verification needed to establish eligibility.

26. Fla. Admin. Code R. 65A-1.205, Eligibility Determination Process, further

addresses the verification process in part and states:

(1)(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information...the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension. When the applicant provides all required information or verification, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

(5) The Department can substantiate, verify or document information provided by the applicant/recipient as part of each determination of eligibility. For any program, when there is a question about the validity of the information provided, the Department will ask for additional documentation or verification as required. The term verification is used

generically to represent this process.

(a) Substantiation establishes accuracy of information by obtaining consistent, supporting information from the individual.

(b) Verification confirms the accuracy of information through a source(s) other than the individual. The Department can secure verification electronically, telephonically, in writing, or by personal contact.

(c) Documentation establishes the accuracy of information by obtaining and including in the case record an official document, official paper or a photocopy of such document or paper or electronic source that supports the statement(s) made by the individual.

27. As Respondent did not send Petitioner's representative copies of the notices, it is concluded that Respondent incorrectly denied Petitioner's application for the ICP Medicaid benefits. The case is remanded to Respondent to reopen and add Petitioner's representative to the case. Once the case is reopened, all information submitted by Petitioner should be evaluated making sure all items listed on the original pending letter were provided. If any items are missing, a new pending notice which lists the required verification should be issued allowing 10 days to provide the verification.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, Respondent's denial of Petitioner's June 12, 2017 application for ICP was incorrect. The case is remanded to Respondent with order to implement the corrective steps mentioned above. The remand does not insure Petitioner is eligible for the ICP Medicaid Program benefits, but it will give Petitioner's representative the opportunity to provide any necessary verification protecting the June 12, 2017 application. Once Petitioner's representative is properly noticed, and a decision is made; a new Notice of Case Action should be issued informing him of the outcome and said notice shall include appeal rights.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 25 day of October, 2017,

in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED] Petitioner
Office of Economic Self Sufficiency
Jane Almy-Loewinger, Esq.

FILED

Oct 25, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]
[REDACTED]
[REDACTED]

APPEAL NO. 17F-05633

PETITIONER,

Vs.

CASE NO [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88272

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on September 5, 2017 at approximately 3:13 p.m. CDT.

APPEARANCES

For the Petitioner: [REDACTED] *pro se*
[REDACTED], father
[REDACTED] mother

For the Respondent: Ed Poutre, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action of May 5, 2017 denying Medicaid. The petitioner carries the burden of proof by the preponderance of evidence.

PRELIMINARY STATEMENT

The petitioner submitted a packet of information that was admitted into evidence and marked as Petitioner's Exhibits "1" through "4".

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "9".

FINDINGS OF FACT

1. On February 17, 2017, the petitioner submitted an application for Medicaid to the respondent.
2. The petitioner is a single, 46-year-old male living as a household of one.
3. On March 28, 2017, the Division of Disability Determination (DDD) returned its decision to the respondent which stated that the petitioner did not meet the disability requirement with code N32, "Non-Pay, Capacity for substantial gainful activity, other work, no visual impairment" (Respondent's Exhibits 1 and 6).
4. By notice of case action (NOCA) mailed March 30, 2017, the petitioner was informed that the February 17, 2017 application was denied. The reasons given were "You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program" (Respondent's Exhibit 3).
5. On April 5, 2017, the petitioner submitted an application for Medicaid to the respondent.
6. By notice of case action (NOCA) mailed April 21, 2017, the petitioner was informed that the April 5, 2017 was denied. The reasons given were "You or a member(s) of your household do not meet the disability requirement" (Respondent's Exhibit 3).

7. On April 21, 2017, the petitioner submitted an application for Medicaid to the respondent. On this application, the petitioner stated:

I am unable to work because of my condition. I was diagnosed with [REDACTED]. I had a total [REDACTED] in 2010. Now I have the same issue [REDACTED]. I am in desperate need of another [REDACTED]. I am bed ridden and walk with a crutch (Respondent's Exhibit 2).

8. The application was processed and sent to DDD for review. On April 19, 2017, DDD responded stating that a determination was made in the last 90 days and that the claimant should apply for a hearing (Respondent's Exhibit 1).

9. By notice of case action (NOCA) mailed May 5, 2017, the petitioner was informed that the April 21, 2017 was denied. The reasons given were "You or a member(s) of your household do not meet the disability requirement. No household members are eligible for this program" (Respondent's Exhibit 3).

10. On June 1, 2017, the petitioner applied with the Social Security Administration (SSA) for Supplemental Security Income (SSI) Title XVI benefits. The SSA denied this application on June 30, 2017 with the denial code N32 (Respondent's Exhibit 4).

11. The petitioner provided a letter from [REDACTED] [REDACTED] that was faxed to the offices of U.S. Senator Bill Nelson, stating in part:

[REDACTED] has been a patient of mine since 03/20/17. He was diagnosed with [REDACTED]. [REDACTED] is having significant pain and is unable to perform activities of daily living without severe pain and difficulty. His x-rays show [REDACTED]. [REDACTED]. The only solution for this condition is to have [REDACTED]. Without having insurance [REDACTED] will not be able to afford this much needed surgery. If [REDACTED] does not have this surgery his condition is only going to

worsen...His prognosis is good if he has the surgery. He should be able to return to work and normal daily activities once the procedure is performed (Petitioner's Exhibit 1).

12. The petitioner provided a report from his medical records created by [REDACTED] supporting the statements made in the letter (Petitioner's Exhibit 2).
13. Also provided by the petitioner were two transmittals prepared by the Florida Department of Health for the SSA to use in its disability determination. The first is a third-party contact list. The second is a supplemental pain questionnaire explaining the petitioner's physical limitations caused by his condition along with copies of x-rays taken on March 20, 2017.
14. Both parties agreed on the record that all of the medical evidence presented for this hearing has been reviewed by the SSA and was in the packet of information sent to the DDD.

CONCLUSIONS OF LAW

15. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.
16. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.
17. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

18. Fla. Admin. Code R. 65A-1.710 sets forth the rules of eligibility for elderly and disabled individuals with income less than the Federal Poverty Level. For an individual less than 65 years of age to receive Medicaid, he must meet the disability criteria of Title XVI of the Social Security Act appearing in 20 C.F.R. § 416.905. The regulation states, in part:

(a) The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy...

19. The findings show the petitioner is a 46-year-old single male requesting assistance as a household of one. The Family-Related Medicaid Program benefit rules are set forth in the Fla. Admin. Code R. 65A-1.705, Family-Related Medicaid General Eligibility Criteria. The rules set forth that to be eligible for that Medicaid Program, a dependent child must be living in the home. The petitioner does not meet the criteria for Family-Related Medicaid Program benefits. In this case, before Medicaid eligibility can be determined, the petitioner must meet the federal definition of disabled.

20. Federal Medicaid Regulations at 42 C.F.R. § 435.541, "Determinations of disability" states in part:

(a) *Determinations made by SSA.* The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.
(1) If the agency has an agreement with the Social Security Administration (SSA) under section 1634 of the Act, the agency may not make a determination of disability when the only application is filed with SSA.
(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A

determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) *Effect of SSA determinations.* (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) *Determinations made by the Medicaid agency.* The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; or

(ii) Alleges more than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated since that SSA determination and alleges a new period of disability which meets the durational requirements of the Act, and has not applied to SSA for a determination with respect to these allegations.

(iii) Alleges less than 12 months after the most recent SSA determination denying disability that his or her condition has changed or deteriorated

since that SSA determination, alleges a new period of disability which meets the durational requirements of the Act, and—
(A) Has applied to SSA for reconsideration or reopening of its disability decision and SSA refused to consider the new allegations; and/or
(B) He or she no longer meets the nondisability requirements for SSI but may meet the State's nondisability requirements for Medicaid eligibility.

21. The findings show that the petitioner applied for disability benefits from the SSA and was denied as he was found not disabled.

22. The finding show that the same condition was considered by SSA and DDD, and there is no new condition not considered by SSA. SSA and DDD separately arrived at the same conclusion using the same denial code, N32. DDD's N32 decision was made March 28, 2017 and SSA's decision was made June 30, 2017.

23. As stated in the above controlling authority, "An SSA disability determination is binding on tan agency until the determination is changed by SSA." In accordance with the controlling authority, the undersigned concludes that the respondent correctly denied the Medicaid as the SSA had determined the petitioner as not disabled.

24. Fla. Admin. Code 65A-1.711 "SSI-Related Medicaid Non-Financial Eligibility Criteria" states in part:

To qualify for Medicaid an individual must meet the general and categorical requirements in 42 C.F.R Part 435, subparts E and F (2007) (incorporated by reference) ... (1) For MEDS-AD Demonstration Waiver, the individual must be age 65 or older, or disabled as defined in 29 C.F.R. § 416.905 (2007) (incorporated by reference).

25. According to the above controlling Medicaid authority, an individual must be age 65 or older, or disabled (as determined by either the respondent via DDD or SSA), to meet the technical criteria for Medicaid in the SSI-Related Medicaid Programs.

Because the petitioner is under age 65 and has not been determined disabled by the

SSA, he does not meet the technical criteria to be eligible for SSI-Related Medicaid. Until the petitioner meets the federal disability criteria (while under age 65) Medicaid cannot be approved. Therefore, the respondent correctly denied the request for Medicaid at this time.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 25 day of October, 2017,
in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To [REDACTED] PETITIONER
OFFICE OF ECONOMIC SELF SUFFICIENCY

FILED

Oct 26, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS



APPEAL NO. 17F-05689

PETITIONER,
Vs.

Case No. 

FLORIDA DEPARTMENT OF
CHILDREN AND FAMILIES
CIRCUIT: 06 Pinellas
UNIT: 88345

RESPONDENT.
_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on September 25, 2017, at 9:30 a.m.

APPEARANCES

For the Petitioner: Ken Denman, Authorized Representative

For the Respondent: Lorry Beauvais, ESS Specialist

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his application for Medicaid. The petitioner bears the burden of proof in this matter.

PRELIMINARY STATEMENT

The respondent's evidence packet, consisting of 48 pages, was entered into evidence as composite Exhibit 1. This packet consisted of the following documents: Hearing Summary, Application, Work Item Details, Medicaid Application, Notices of Case Action, Document Imaging History, Verification of SSA application, Department Policy, and Running Record Comments.

The petitioner did not submit any documents as evidence for the hearing.

FINDINGS OF FACT

1. The petitioner, who is forty-eight (48) years of age, submitted an application to the respondent for Medicaid eligibility on May 15, 2017. In the application, the petitioner claimed he was disabled, but had not yet been determined disabled by either the Social Security Administration (SSA) or the State of Florida.

2. On May 18, 2017, the respondent sent the petitioner (through his authorized representative), a Notice of Case Action which requested further information to process his Medicaid application. The requested documents included proof of income, proof of identification, and verification of current status of his social security disability claim. The notice also requested a phone interview with the applicant.

3. On June 15, 2017, the respondent sent the petitioner a Notice of Case Action stating his Medicaid application had been denied since the respondent had not received the previously requested information/documents. This notice was sent directly to the petitioner, not to his authorized representative. The notice also stated the following:

For applications, if you completed the interview (if required) by the 30th day after the application date, you do not need to give us a new application if you give us all the verification we asked for within 60 days from the day you originally turned in your application. If you do not give us all the verification we asked for within 60 days from the day you originally turned in your application, you will have to complete a new application.

4. Thereafter, the respondent did receive the requested documents from the petitioner on July 18, 2017.

5. The respondent's representative stated the petitioner must submit a new Medicaid application at this time since the requested documents were not submitted within 60 days of the application date. The documents were submitted on July 18, 2017, which was 4 days after the 60th day following the May 15, 2017 application date.

6. The petitioner's representative stated a new application has not been submitted because that would delay the petitioner's Medicaid benefits. He is seeking retroactive Medicaid coverage. He also stated the petitioner is homeless although he does have a mailing address and he has difficulty understanding the contents of any mail he does receive. The petitioner's representative stated the respondent should process the application since the documents were submitted within 90 days of the application. He also pointed out the Policy Transmittal included in the respondent's evidence packet (p. 43), which addresses the 60-day requirement, states it does not apply to disability reviews.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Fla.

Stat § 409.285. This order is the final administrative decision of the Department of Children and Families under Fla. Stat. § 409.285.

8. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

9. The respondent's position is that the petitioner must submit a new Medicaid application since the requested documents were not submitted within 60 days of his application date.

10. The petitioner's position is that he should not be required to submit a new application since he submitted the requested documents within 90 days of his application date. The petitioner's representative cited Section 0640.0400 (entitled "Application Time Standards") of the respondent's Program Policy Manual as support for this position, which states the following:

The time standard begins upon receipt of a signed application.

Process applications as soon as possible after the assistance group (AG) completes all eligibility requirements. If the household completes all requirements and provides all information, process the application by the 30th day after the application date. Process applications and determine eligibility or ineligibility within 90 calendar days after the date of the application for individuals who claim a disability.

11. Section 0640.0401 of the Program Policy Manual, entitled "Requests for Additional Information/Time Standards", states the following

If the Department needs additional information or verification from the applicant, provide:

1. a written list of items required in order to complete the application process,
 2. the date the items are due in order to process the application timely,
- and

3. the consequences for not returning additional information by the due date.

The verification/information due date is 10 calendar days after the date of the interview or if there is no interview requirement, 10 days after the date the pending notice is generated. In cases where medical information is required, the return due date is 30 calendar days from date of request. If the due date falls on a holiday or weekend, the deadline for the requested information is the next business day. At the individual's request, extend the due date. Leave the case pending until the 30th day after the date of application to allow the household a chance to provide verifications. Assist applicants with getting missing verifications when needed.

1. If the applicant completes the interview, provides all verifications, and meets all eligibility factors, approve the application by the 30th day for Medicaid. If the 30th day falls on a weekend or holiday, approve the application on the business day before the 30th day.

2. If the household does not return the verifications by the 30th day after the date of application, deny the application on the 30th day. If the 30th day falls on a weekend or holiday, deny the application on the next business day after the 30th day.

3. If the household returns the verifications after the 30th day but by the 60th day, approve the application as soon as possible following receipt of the verifications as long as disposal occurs by the 60th day. Do not require a new application.

12. In addition, Fla. Admin Code. R. 65A-1.205 address application processing and states the following:

(c) If the eligibility specialist determines during the interview or at any time during the application process that the applicant must provide additional information or verification, ... the eligibility specialist must give the applicant written notice to provide the requested information or to comply, allowing ten calendar days from request or the interview, whichever is later. For all programs, verifications are due ten calendar days from the date of written request or the interview, or 60 days from the date of application, whichever is later. In cases where the applicant must provide medical information, the return due date is 30 calendar days following the written request or the interview, or 60 days from the date of application, whichever is later. If the due date falls on a holiday or weekend, the deadline is the next working day. If the applicant does not provide required

verifications or information by the deadline date the application will be denied, unless the applicant requests an extension or there are extenuating circumstances justifying an additional extension. The eligibility specialist makes the decision of whether to grant the request for extension. When the applicant provides all required information or verification, the eligibility specialist determines eligibility for the public assistance programs. If the eligibility criteria are met, benefits are authorized.

13. Based on the foregoing provisions, the petitioner was required to submit the requested documents within 60 days of his application date. Since he did not, the respondent correctly required him to submit a new application. Section 0640.0400 requires the Department to determine eligibility within 90 days for an applicant who claims a disability, but this section does not allow a 90-day period for submission of requested documents. Section 0640.0401 imposes the 60-day requirement for submission of requested documents, even for disability related applications.

14. Although the respondent sent the June 15, 2017 denial notice directly to the petitioner rather than his authorized representative, the May 18, 2017 notice requesting the additional documents was sent directly to the authorized representative. Therefore, adequate notice was provided that the respondent was seeking the additional information.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, this appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of

FINAL ORDER (Cont.)

17F-05689

PAGE - 7

Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 26 day of October, 2017,

in Tallahassee, Florida.



Rafael Centurion
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies furnished to: [REDACTED], Petitioner
Office of Economic Self Sufficiency

FILED

Sep 28, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17F-05757
17F-06243

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 19 St. Lucie
UNIT: 88510

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 31, 2017, at 8:48 a.m. All parties appeared telephonically from different locations.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Stephanie Gurley, economic self-sufficiency specialist II.

STATEMENT OF ISSUE

At issue is whether the respondent (or the Department) issued the correct amount of Food Assistance Program benefits (FAP), also known as Supplemental Nutrition Assistance Program (SNAP) to the petitioner effective with the July 10, 2017 application.

Additionally, whether the Department is correct denying petitioner's Medicare Savings Program (MSP) or Buy-In benefits. The petitioner carries the burden of proof by the preponderance of evidence for both Programs.

PRELIMINARY STATEMENT

By Notice of Case Action (NOCA) dated July 26, 2017, the Department informed the petitioner that his Food Assistance benefits would decrease from \$54 to \$16 effective September 2017. Petitioner's MSP was also denied due to excess assets. On August 9, 2017, the petitioner timely requested an appeal challenging the Department's actions.

The petitioner did not submit any exhibits. The respondent submitted nine (9) exhibits which were accepted and marked as Respondent's Exhibits "1" through "9". During the hearing, the respondent acknowledged that petitioner did not receive the excess medical deduction for his Medicare Part B premium and that petitioner would be eligible for \$79 in SNAP benefits once the correction is made. The petitioner agreed with the most recent development pending verification. The record was left open through September 1, 2017 for the respondent to provide additional information. The evidence was timely received as marked as Respondent's Exhibit 10. The evidence indicates that petitioner was approved for \$79 effective July 2017. The record was closed on September 1, 2017.

The SNAP benefits level issue has become moot; therefore, the SNAP-related Appeal Number 17F-05757 will be dismissed as such. Only the MSP issue will be addressed in this order.

FINDINGS OF FACT

Based on the oral and documentary evidence presented at the final hearing and on the entire record of this proceeding, the following Findings of Fact are made:

1. Prior to the action under appeal, the petitioner has been receiving \$54 in Food Assistance. His Veteran Administration (VA) benefit was not included in the budget.
2. On July 10, 2017, the petitioner submitted an application requesting FAP and MSP or Buy-in assistance with Medicare Part B premiums. The petitioner is 53 years old [REDACTED] and became eligible for Medicare benefits effective June 2017. On that application, the petitioner reported the following assets: (savings account) \$21,430.34; (stocks/bonds) \$23,852.51; (IRA) \$4,695.45 and (checking (s) \$409.44, \$252.20 and \$2.81 respectively, see Respondent's Exhibit 1.
3. Petitioner receives \$1,017.04 in Social Security disability benefits and \$133.57 in VA benefits.
4. The MSP benefits umbrella includes Qualified Medicare Beneficiary (QMB), Special Low-Income Medicare Beneficiary (SLMB) and Qualified Income 1 (QI 1). Petitioner's income was within the income limit for Buy-In under the SLMB coverage group.
5. The asset limit for an individual to be eligible for MSP benefits is \$7,390 effective July 2017. The application was processed and it was determined that the petitioner's assets exceeded the limit for the Program.
6. On July 26, 2017, the Department sent a NOCA to the petitioner informing him of its action. On August 9, 2017, the petitioner requested an appeal to challenge the Department's action.

7. The respondent's representative explained that petitioner's Buy-In Program was denied for the SLMB coverage because of assets information reported on his application. The petitioner did not dispute the facts reported by the respondent. He acknowledged having balances over the limit, but explained that it's not new money. During the hearing, petitioner reported the following assets: \$1,300 (savings), \$30,000 (stocks /bonds), \$4,000 (IRA) and \$200 (checking). Petitioner maintains that the monies were in his accounts for his future needs and therefore should not be used against him. The petitioner believes that his assets should not be relevant in determining his eligibility for any Buy-In Program.

CONCLUSIONS OF LAW

8. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

9. This proceeding is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

10. Fla. Admin. Code R. 65A-1.702, Special Provisions explains MSP and in part states:

(12) Limits of Coverage.

(a) Qualified Medicare Beneficiary (QMB). Under QMB coverage, individuals are entitled only to Medicare cost-sharing benefits, including payment of Medicare premiums.

(b) Special Low-Income Medicare Beneficiary (SLMB). Under SLMB coverage, individuals are entitled only to payment of the Part B Medicare premium. If eligible, AHCA shall pay the premium for up to three months retroactive to the month of application...

(d) Part B Medicare Only Beneficiary (QI1). Under QI1 coverage, individuals are only entitled to payment of their Medicare Part B premium. (This is coverage for individuals who would be eligible for QMB or SLMB coverage except their income exceeds limits for those programs.)...

11. The Fla. Admin. Code R. 65A-1.712, SSI-Related Medicaid Resource Eligibility

Criteria, sets forth:

(1) Resource Limits. If an individual's total resources are equal to or below the prescribed resource limits at any time during the month the individual is eligible on the factor of resources for that month. The resource limit is the SSI limit specified in Rule 65A-1.716, F.A.C., with the following exceptions:

(d) For Special Low Income Medicare Beneficiary (SLMB), an individual cannot have resources exceeding three times the SSI resource limit with increases based on the Consumer Price Index.

12. The Fla. Admin. Code R. 65A-1.303, Assets, sets forth:

(2) Any individual who has the legal ability to dispose of an interest in an asset owns the asset.

(3) Once the individual's ownership interest of an asset(s) is established, the availability of that asset must be determined. Asset(s) determined not to be available are not considered in determining eligibility. Assets are considered available to an individual when the individual has unrestricted access to it. Accessibility depends on the legal structure of the account or property. An asset is countable, if the asset is available to a representative possessing the legal ability to make the asset available for another's support or maintenance, even though the representative chooses not to do so. Assets not available due to legal restrictions are not considered in determining total available assets unless the legal restrictions were caused or requested by the individual or another acting at their request or on their behalf.

13. The eligibility standards for SSI-Related Program appear in the Department's Program Policy Manual (The Policy Manual), CFOP 165-22, at Appendix A-9. Effective July 2017, the resource limit for a one-person assistance group applying for Medicaid/Medicare Buy in Program is \$7,390.

14. At the time of the application, the petitioner's assets exceeded the \$7,390 assets limit for him to be eligible for MSP. By his own admission, assets in excess of the \$7,390 limit still exist to date. The petitioner acknowledged having bank accounts linked to him with balances higher than the established asset limit. A review of the rules did not find any exceptions to meeting the asset limit. It is concluded that the respondent's action to deny the petitioner's application for MSP benefits was within the rules of the Program, as petitioner's assets exceed the resource limit for the Program the petitioner is seeking.

15. In careful review of the cited authorities and evidence, the undersigned concludes that the petitioner did not meet the burden of proof. The undersigned concludes the Department's action to deny the petitioner's MSP/Buy-In is proper.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is denied.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)
17F-05757 & 17F-06243
PAGE -7

DONE and ORDERED this 28 day of September, 2017,
in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

Oct 30, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-05891

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 06 Pasco
UNIT: 88345

D - DDD - Disability

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing telephonically in the above-referenced matter on October 17, 2017 at approximately 2:56 p.m. EDT.

APPEARANCES

For the Petitioner: [REDACTED] *pro se*

For the Respondent: Roneige Alnord, economic self-sufficiency specialist II

STATEMENT OF ISSUE

Petitioner is appealing the Department's action closing her Medicaid coverage effective June 30, 2017. At the hearing, the burden of proof was assigned to the petitioner; however, after further consideration, the burden is hereby assigned to the respondent by the preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted a packet of information that was admitted into evidence and marked as Respondent's Exhibits "1" through "10". The record was left open for the respondent to submit additional evidence. This was received on October 18, 2017, admitted into evidence and marked as Respondent's Exhibits "11" through "13". The record was closed October 18, 2017.

The hearing was originally scheduled for September 13, 2017. The petitioner called into the hearing conference call; however, the respondent was not available because of complications caused by hurricane Irma. The hearing was rescheduled as above.

FINDINGS OF FACT

1. On September 17, 2015, the petitioner submitted an application to the Social Security Administration (SSA) for disability benefits. The application was denied on December 11, 2015 with code N30, "NoPay-Slight Impairment" (Respondent's Exhibit 12).
2. The petitioner appealed the SSA denial on February 24, 2016. The petitioner reported that this appeal remains unresolved and is currently active.
3. The petitioner began receiving Medicaid coverage under category code MM S January 1, 2016. An Administrative Fair Hearing was requested on June 28, 2016. The petitioner believed that the hearing, which was held August 25, 2016, was her SSA hearing and not a Department of Children and Families hearing. The Fair Hearing was dismissed as non-jurisdictional with the understanding that the petitioner would

“continue to receive Medicaid benefits from the respondent pending the outcome of her SSA appeal (Appeal 16F-04924).”

4. The case narrative, June 28, 2016, states that the petitioner’s Medicaid coverage will end June 30, 2016 because she did not meet the disability requirement (Respondent’s Exhibit 13).

5. The case narrative, June 29, 2016, shows that due to a Fair Hearing request the petitioner’s MM S Medicaid coverage was reopened per her request and that she stated her understanding that were she to lose the hearing she will need to repay Medicaid benefits that she may use in the interim (Respondent’s Exhibit 13).

6. Effective June 30, 2017, the petitioner’s Medicaid coverage, category code MM S, was terminated by the respondent for not meeting the disability requirement (Respondent’s Exhibit 8).

7. On June 15, 2017, after having been advised by the respondent to reapply, she had been notified that her Medicaid coverage would be ending, the petitioner submitted an application for Medicaid coverage (Respondent’s Exhibits 3 and 4).

8. On July 10, 2017, the respondent forwarded a disability determination request to the Division of Disability Determination (DDD). The determination was returned to the respondent July 15, 2017 and marked as received on July 17, 2017. The DDD determined that the petitioner was not disabled. The primary diagnoses considered were 1) [REDACTED]. The denial was coded N32, “NoPay-Other SGA” (Substantial Gainful Activity) (Respondent’s Exhibits 11 and 12).

9. The petitioner believes that her on-going Medicaid eligibility should not have been terminated in June 2017 as she was told she would receive Medicaid benefits at least until a disability determination was finalized by the SSA.

CONCLUSIONS OF LAW

10. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes.

11. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

12. This proceeding is a *de novo* proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. Federal Regulations at 20 C.F.R § 416.996, Continued disability or blindness benefits pending appeal of a medical cessation determination, states:

(1) Benefits may be continued under this section only if the determination that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling is made after October 1984.

(2) Continued benefits under this section will stop effective with the earlier of: (i) The month before the month in which an administrative law judge's hearing decision finds that your physical or mental impairment(s) has ceased, has never existed, or is no longer disabling or the month before the month of a new administrative law judge decision (or final action is taken by the Appeals Council on the administrative law judge's recommended decision) if your case was sent back to an administrative law judge for further action; or (ii) the month before the month in which no timely request for reconsideration or administrative law judge hearing is pending after notification of our initial or reconsideration cessation determination. These benefits may be stopped or adjusted because of certain events (such as, change in income or resources or your living arrangements) which may occur while you are receiving these continued benefits, in accordance with §416.1336(b).

14. The Department's Transmittal No. P02-01-0001, Continued Medicaid During Social Security Appeal, states in pertinent part:

Correct Processing: Staff are correct to terminate existing Medicaid coverage if the individual fails to provide requested verification of a timely SSA appeal within 10 days of the request. Such action ensures that individuals who have no intention of filing an appeal with SSA will have Medicaid benefits terminated as quickly as possible.

However, if the individual later provides proof that a timely appeal was filed with SSA, staff must reinstate Medicaid benefits until the appeals process is resolved through SSA, or the individual otherwise becomes ineligible for Medicaid.

Staff must not lose sight of the state's own fair hearing process when processing a case involving an SSA denial. If an individual fails to provide proof of a timely SSA appeal and Medicaid is terminated, the individual has the right to request a fair hearing with the state and have benefits reinstated if the request is submitted within ten days of the denial notice. Of course, only those individuals who were already receiving Medicaid may have their benefits reinstated during the fair hearing process.

15. The Department's Program Policy Manual, CFOP 165.22, passage 1440.1206, Change in Disability Determination by SSA (MSSI, SFP), states in part, "Should the individual file a timely appeal with SSA, Medicaid benefits must be continued, pending a final decision by SSA."

16. The above cited authority explains the parameters and requirements for continued receipt of Medicaid benefits while awaiting a disability determination from the SSA. As the petitioner was a Medicaid recipient at the time, the undersigned concludes that these requirements were met at the June 2016 continuance of Medicaid coverage.

17. The undersigned concludes that to later deny ongoing eligibility because of failure to meet the disability requirement, after being given the assurance of ongoing Medicaid coverage while awaiting such a determination of disability by the SSA, contradicts the stated intent of the respondent and was incorrect.

18. After careful consideration of the cited authority, evidence and testimony, the undersigned concludes that the respondent has not met its burden. The respondent is ordered to approve the petitioner's MM S category Medicaid coverage beginning July 1, 2017 ongoing. The petitioner's eligibility is not to be reconsidered by the respondent on the element of disability criteria until the SSA makes its determination; after which the respondent must take appropriate action. Per the authority cited above, if other factors merit reconsideration of eligibility, the respondent may do so, notifying the petitioner of such by notice of case action containing appeal rights.

DECISION

Based upon the foregoing Findings of Fact and Conclusions of Law, the appeal is granted. The respondent is ordered to approve Medicaid coverage as explained in the Conclusions of Law.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

FINAL ORDER (Cont.)

17F-05891

PAGE -7

DONE and ORDERED this 30 day of October, 2017,

in Tallahassee, Florida.



Gregory Watson
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
Fax: 850-487-0662
Email: Appeal.Hearings@myflfamilies.com

Copies Furnished To: [REDACTED], PETITIONER
OFFICE OF ECONOMIC SELF SUFFICIENCY

Oct 30, 2017

Office of Appeal Hearings
Dept. of Children and Families

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17F-06088

PETITIONER,

Vs.

CASE NO. [REDACTED]

FLORIDA DEPARTMENT
OF CHILDREN AND FAMILIES
CIRCUIT: 15 PALM BEACH
UNIT: 88621

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened a telephonic administrative hearing in the above-referenced matter on October 10, 2017 at 8:34 a.m.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: Mary Triplett, Supervisor

STATEMENT OF ISSUE

The petitioner is appealing the respondent's action to deny his August 28, 2017, application for disability-related Medicaid. The petitioner carries the burden of proof by a preponderance of evidence.

PRELIMINARY STATEMENT

The respondent submitted six exhibits which were entered into evidence and marked as Respondent's Exhibits 1 through 6. The petitioner did not provide any

exhibits at the hearing. The record was held open until October 24, 2017 for the respondent to provide a computer screen showing when the petitioner applied for disability with Social Security Administration (SSA) and for the petitioner to provide the denial letter from the SSA and recent medical records. The petitioner provided two exhibits, medical records and a SSA denial which were accepted, entered into evidence and marked as Petitioner's Composite Exhibits 1 and 2. The respondent did not provide the DESO screen. The record was closed on October 24, 2017.

Also present for the petitioner was William Walter, Patient Advocate, Delray Medical Center.

FINDINGS OF FACT

1. The petitioner is 32 years old. As he is not yet 65 years, he does not meet the aged criteria to qualify for SSI-Related Medicaid. He has no minor children and does meet the technical requirement for the Family-Related Medicaid category. The petitioner did not allege blindness. Disability must be established to determine Medicaid eligibility.
2. On June 9, 2017, the petitioner applied for Medicaid benefits through the Department's SSI-Related Medicaid Program. He is the only household member. He reported that he was disabled (Respondent's Exhibit 2).
3. The Florida Department of Children and Families (Department or DCF) determines eligibility for SSI-Related Medicaid programs. To be eligible an individual must be blind, disabled, or 65 years or older. The Division of Disability Determinations (DDD) conducts disability reviews regarding Medicaid eligibility. Once a disability

review is completed, the claim is returned to DCF for a final determination of eligibility and effectuation of any benefits due.

4. On June 28, 2017, a disability review was initiated and a disability packet was mailed to Office of Disability Determinations (DDD) for an independent disability determination.

5. On August 9, 2017, the disability packet was denied by DDD, with the reason code N32 (Capacity for substantial gainful activity (SGA) - other work no visual impairment). The DDD adopted a denial of disability made by SSA (Respondent's Exhibit 5).

6. On August 25, 2017, the respondent denied the petitioner's disability application by adopting the SSA denial decision.

7. On September 19, 2017, the petitioner applied for disability benefits through SSA and his application was denied. In September 2017, the petitioner appealed the SSA decision and that appeal is currently pending. SSA reviewed the petitioner's impairments of [REDACTED]

8. On August 28, 2017, the respondent issued a Notice of Case Action informing the petitioner that his Medicaid application dated June 9, 2017 was denied. The reason cited for the denial was, "You or a member of your household do not meet the disability requirement".

9. On August 24, 2017, the petitioner requested a hearing to challenge the respondent's decision.

10. The petitioner did not claim a new condition; he claims a worsening of his medical conditions since the SSA denial. He alleged that he has become more

depressed and he is hearing voices more frequently causing him to become suicidal. He had a recent attempt of suicide and was admitted to [REDACTED]. The petitioner alleges he cannot function or perform any type of work as a result of major depression. He also alleged physical disability due to a recent injury to his throat.

CONCLUSIONS OF LAW

11. The Department of Children and Families Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 409.285, Florida Statutes. This order is the final administrative decision of the Department of Children and Families under Section 409.285, Florida Statutes.

12. This hearing is a de novo proceeding pursuant to Fla. Admin. Code R. 65-2.056.

13. The Code of Federal Regulations at 42 C.F.R. § 435.541, Determinations of disability states in part:

(a) Determinations made by SSA. The following rules and those under paragraph (b) of this section apply where an individual has applied for Medicaid on the basis of disability.

(2) The agency may not make an independent determination of disability if SSA has made a disability determination within the time limits set forth in §435.912 on the same issues presented in the Medicaid application. A determination of eligibility for SSI payments based on disability that is made by SSA automatically confers Medicaid eligibility, as provided for under §435.909.

(b) Effect of SSA determinations. (1) Except in the circumstances specified in paragraph (c)(3) of this section—

(i) An SSA disability determination is binding on an agency until the determination is changed by SSA.

(ii) If the SSA determination is changed, the new determination is also binding on the agency.

(2) The agency must refer to SSA all applicants who allege new information or evidence affecting previous SSA determinations of ineligibility based upon disability for reconsideration or reopening of the determination, except in cases specified in paragraph (c)(4) of this section.

(c) Determinations made by the Medicaid agency. The agency must make a determination of disability in accordance with the requirements of this section if any of the following circumstances exist:

(1) The individual applies for Medicaid as a non-cash beneficiary and has not applied to SSA for SSI cash benefits, whether or not a State has a section 1634 agreement with SSA; or an individual applies for Medicaid and has applied to SSA for SSI benefits and is found ineligible for SSI for a reason other than disability.

(2) The individual applies both to SSA for SSI and to the State Medicaid agency for Medicaid, the State agency has a section 1634 agreement with SSA, and SSA has not made an SSI disability determination within 90 days from the date of the individual's application for Medicaid.

(3) The individual applies to SSA for SSI and to the State Medicaid agency for Medicaid, the State does not have a section 1634 agreement with SSA, and either the State uses more restrictive criteria than SSI for determining Medicaid eligibility under its section 1902(f) option or, in the case of a State that uses SSI criteria, SSA has not made an SSI disability determination in time for the State to comply with the Medicaid time limit for making a prompt determination on an individual's application for Medicaid.

(4) The individual applies for Medicaid as a non-cash beneficiary, whether or not the State has a section 1634 agreement with SSA, and—

(i) Alleges a disabling condition different from, or in addition to, that considered by SSA in making its determination; ...

14. According to the regulations above, the Department is bound by the SSA decision unless there is evidence of a new disabling condition not reviewed by SSA. The petitioner claims a worsening of his known medical conditions.

15. The Department's Program Policy Manual (Policy Manual), CFOP 165-22, at passage 1440.1205 and addresses Exceptions to State Determination of Disability (MSSI, SFP) and states

The state does not make a disability determination under the following conditions:

1. When an individual only applies to SSA (no application is filed with DCF and no SSI denial or ex parte is involved).
2. When an individual receives Title II disability or SSI benefits based on their own disability (not dependent or early retirement benefits).

3. When an earlier favorable federal or state determination of blindness/disability is still in effect and no unfavorable decision has been rendered by SSA.

4. When an individual is no longer eligible for SSI solely due to institutionalization.

5. When the applicant is appealing an earlier decision from SSA and claims no new disabling condition (condition not previously considered by SSA).

6. When the individual files an application within 12 months after the last unfavorable disability determination by SSA, and the individual alleges no new disabling condition or claims a deterioration of an existing condition previously considered by SSA. Refer the individual to SSA for disability reconsideration or appeal (Only request a disability decision from DDD if:

a. SSA refuses (or has already refused) to reconsider the unfavorable disability decision, or

b. the applicant no longer meets SSI non-disability criteria such as income or assets. **(emphasis added)**)

16. The above authorities explain that if SSA has denied disability within the past year, or if the denial is under appeal, the SSA decision is to be adopted. On September 19, 2017, SSA denied the petitioner's application for disability benefits. In September 2017, the petitioner requested an appeal to challenge the SSA decision and that appeal is currently pending. Worsening of conditions or deterioration of conditions reviewed by SSA are referred back to SSA for reconsideration.

17. The hearing officer concludes that the petitioner must complete the appeal process with SSA, and that the respondent is bound by SSA's decision unless an exception as described above is met. The Department must not complete an independent review for disability as the petitioner met no exception.

DECISION

Based on the foregoing Findings of Fact and Conclusions of Law, this appeal is denied and the respondent's action is affirmed.

NOTICE OF RIGHT TO APPEAL

This decision is final and binding on the part of the Department. If the petitioner disagrees with this decision, the petitioner may seek a judicial review. To begin the judicial review, the petitioner must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm. 255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The petitioner must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The petitioner is responsible for any financial obligations incurred as the Department has no funds to assist in this review.

DONE and ORDERED this 30 day of October, 2017,

in Tallahassee, Florida.

C. G. Narine

Christiana Gopaul-Narine
Hearing Officer
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Office: 850-488-1429
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Copies Furnished To: [REDACTED], Petitioner
Office of Economic Self Sufficiency

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00047

PETITIONER,

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on October 18, 2017, at 10:00 a.m. in [REDACTED], Florida.

APPEARANCES

For the Petitioner: [REDACTED]

For the Respondent: [REDACTED]

ISSUE

At issue is whether or not the nursing facility's action to transfer and discharge Petitioner is an appropriate action based on the federal regulations at 42 C. F. R. § 483.15. The burden of proof is by clear and convincing evidence and is assigned to Respondent.

PRELIMINARY STATEMENT

By Nursing Home Transfer and Discharge Notice dated May 12, 2017, Respondent notified Petitioner he was to be discharged from the facility effective June 11, 2017, due to non-payment of bill for services. The Nursing Home Transfer and Discharge Notice indicates the discharge location as: [REDACTED], [REDACTED]

On May 19, 2017, Petitioner timely requested a hearing to challenge Respondent's action. The hearing was continued twice at Petitioner's request.

Appearing as a witness for Petitioner was his wife/ Power of Attorney (POA)/Healthcare surrogate, [REDACTED]. Appearing as witnesses for Respondent were: Steven Furman, Nursing Home Administrator and Tejdeed Singh, Business Office Manager. No representative from the Agency for Health Care Administration (AHCA) was present. However, at the request of the undersigned, AHCA conducted an unannounced visit of the facility on May 25, 2017. On May 31, 2017, it sent a letter to the undersigned stating that violations were found.

The record was left open through October 25, 2017 for Petitioner to submit additional evidence to the undersigned for consideration. The wife was to provide verification of any notices related to any prior ICP Medicaid applications. Post hearing, the evidence was received and marked as Petitioner's Exhibit 1. The record was closed on October 26, 2017.

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the hearing and on the entire proceeding, the following Findings of Fact are made:

1. Petitioner has been a resident of the respondent's nursing facility since September 19, 2016. Petitioner was initially admitted for skilled services through his managed care Medicare provider, [REDACTED]
2. Petitioner's wife is his healthcare surrogate and is responsible to make all decisions related to his medical care. She is also responsible for his finances and responsible to pay his bills.
3. On September 29, 2016, Petitioner's wife entered into an agreement with the facility consenting to Petitioner' receiving services there. She was the only outside party who signed the "Admission Agreement between Patient and Center" document, see Respondent's Exhibit 4.
4. On October 5, 2016, the facility notified the wife that Petitioner's skilled services would end on October 13, 2016. A "Notice of Medicare Non-coverage" was completed to reflect that. The notice explained that the Medicare provider had determined that Medicare probably will not pay for Petitioner's current services after the effective date indicated.
5. A separate notice was issued on October 17, 2016 indicating that Petitioner's skilled services would end on October 19, 2016. The notice explained that petitioner would have to pay for any services received after that date. The notice explained that the Medicare provider has determined that Medicare probably will not pay for Petitioner's current services after the effective date indicated. The wife

appealed the decision through KEPRO, the Quality Improvement Organization (QIO) for



6. On October 19, 2016, after reviewing Petitioner's medical record, the KEPRO physician concluded that the decision of the Medicare Advantage plan to terminate Petitioner's skilled services were correct, see Respondent's Exhibit 5.

7. Effective October 20, 2016. Petitioner attained private pay status for skilled services received at the facility. Respondent had been issuing billing statements to the wife for room & board and other services since he attained that status. For a while, the facility did not receive full payment for their services. Petitioner's niece made partial payments to the facility in April 2017 and May 2017, see Respondent's Exhibit 1.

8. Case notes in Respondent's business record indicate several attempts were made by the business office to contact Petitioner's wife with regards to the money owed to the facility. The notes also indicate that a discharge notice issued on October 28, 2016 was rescinded by the facility after learning Petitioner's funds were tied up in litigation and that a court date was set for February 2017. A separate discharge notice issued in January 2017 was eventually cancelled when Petitioner's wife expressed her unwillingness to take Petitioner home for safety reasons. The notes further indicate that Petitioner's niece (ID) agreed to take him home, but the wife opposed that arrangement, see Respondent's Exhibit 3.

9. The facility's billing representative testified as follows: That she had tried working with the wife and her attorney in exploring possible ways to resolve the issue. That the facility did not apply for Institutional Care Program (ICP) Medicaid on behalf of Petitioner because initial assessment shows his assets exceed the ICP asset limit. That

Petitioner's ICP case file was referred to Complete Elder Solutions, an agency specializing in assessing whether a particular applicant is more likely to be approved for benefits. The agency concluded that Petitioner would not be eligible for ICP due to excess assets. She contends that the facility's requests for payments were mainly ignored and not acknowledged by the wife.

10. When Petitioner's wife failed to pay his bills, Respondent issued a Discharge Notice to him on May 12, 2017. The notice explained that it intended to discharge him from the facility effective June 11, 2017, due to nonpayment of the bill for services.

11. Respondent's attorney argued that the facility has used its resources to provide much needed services to the resident and deserves to be paid. Petitioner's attorney did not dispute the balance owed to the facility. He argued that, by virtue of a settlement agreement, Petitioner's brother and business partner was to pay all valid and outstanding invoices due to the facility, but he has failed to do so. He further argued that Petitioner's funds are tied up in a pending litigation; therefore, not available to the wife. He maintains that the wife cannot afford to pay the facility until the court case is finalized. He argued the discharge is incorrect. The wife testified that Petitioner's "family" has agreed to pay for his bills, but failed to follow through on it.

She explained that the home is in foreclosure; therefore, she cannot take her husband there.

12. As of the date of the hearing, the facility had not received any monthly payments from the wife for services provided to Petitioner. There is no pending ICP Medicaid application on file for Petitioner. No payment arrangements have been made between the wife and the facility after notification of the charges.

13. Petitioner remains in the facility pending the hearing decision. The outstanding balance owed to the nursing facility as of the date of the hearing was \$115,846.97, see Respondent's Exhibit 1.

14. The record was left open for the wife to provide verification that any prior ICP Medicaid applications. Post hearing, the undersigned received a Notice of Case Action addressed to [REDACTED]

[REDACTED] The notice, dated May 2, 2016, indicates a Medicaid application he submitted on April 29, 2016 was denied because the value of his assets was too high for the program, see Petitioner's Exhibit 1.

CONCLUSIONS OF LAW

15. The jurisdiction to conduct this hearing is conveyed to the Department of Children and Families by Federal Regulations appearing at 42 C.F.R. § 431.200. The Department of Children and Families, Office of Appeal Hearings has jurisdiction over the subject matter of this proceeding and the parties, pursuant to s. 400.0255(15), Fla. Stat.

16. Federal Regulations appearing 42 C.F.R. § 483.15 addresses Transfer and discharge and sets forth the reasons a facility may involuntarily discharge a resident as follows:

(c) *Transfer and discharge*—(1) *Facility requirements*—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- (D) The health of individuals in the facility would otherwise be endangered;
- (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or**
- (F) The facility ceases to operate. (emphasis added)

17. In this instant case, no pending ICP Medicaid application exists. Petitioner attained private pay status effective October 20, 2016 and has accrued a large amount of unpaid bills for services received at the facility. Petitioner's attorney argued that the wife does not access to the funds due to pending litigation involving Petitioner's brother, and is unable to meet her financial obligation. The wife testified that Petitioner's "family" has agreed to pay for his bills, but failed to follow through.

18. Based on the evidence and testimony presented, Respondent has established that the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident. The undersigned took notice of wife's concerns, but could not find any provision within the regulation to reverse the discharge. Respondent has met its burden.

19. Establishing that the reason for a discharge is lawful is just one-step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently

preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

20. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, Petitioner's appeal is denied, as the facility's action to discharge Petitioner is correct and in accordance with Federal Regulations. The facility may proceed with the discharge as discussed in the Conclusions of Law, in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 31 day of October, 2017,
in Tallahassee, Florida.



Roosevelt Reveil
Hearing Officer
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Copies Furnished To:



Sep 27, 2017

STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

Office of Appeal Hearings
Dept. of Children and Families

[REDACTED]

APPEAL NO. 17N-00060

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, the undersigned convened an administrative hearing in the above-referenced matter on August 14, 2017 at 2:20 p.m. in [REDACTED], Florida.

APPEARANCES

For the Petitioner: [REDACTED], daughter

For the Respondent: [REDACTED]

STATEMENT OF ISSUE

Petitioner is appealing the Respondent's action to proceed with discharging her from the facility by Nursing Home Transfer and Discharge Notice issued on July 10, 2017. The respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

[REDACTED], ombudsman, appeared as a witness for the petitioner. [REDACTED]
[REDACTED] Business Office Manager, [REDACTED],
Regional Vice President, [REDACTED] appeared as witnesses for the facility.

Ursula Lett-Robinson, hearing officer, and Stephanie Twomey, hearing officer, appeared as observers with no objection from the petitioner.

AHCA was not present for this hearing.

The respondent submitted evidence prior to the hearing which was entered as Respondent's Exhibit 1.

The petitioner submitted evidence at hearing which was entered as Petitioner's Exhibit 1.

The respondent submitted the first page of the Nursing Home Transfer and Discharge Notice prior to the hearing. The complete notice was submitted by the facility at hearing. The Nursing Home Transfer and Discharge notice was admitted as Administrative Exhibit 1.

The record closed on August 14, 2017.

FINDINGS OF FACT

1. The petitioner is a resident of [REDACTED] since at least November 2016.
2. The petitioner was approved for Institutional Care Program (ICP) Medicaid with a current patient responsibility of \$1,838. The amount has changed since the original approval in 2016 due to Social Security and state retirement increases.
3. The respondent presented multiple Notices of Case Action regarding the petitioner's ICP Medicaid case. (Respondent's Exhibit 1, pages 5 through 7)
4. The petitioner has income from Social Security of \$1,212 per month. She also has Florida State Retirement income of \$814 per month.

5. The facility began working with the petitioner's daughter in January 2017 to resolve this matter. The facility presented Billing Notes from January 17, 2017 through July 12, 2017 documenting all efforts to work with the petitioner's family to resolve the past due balance. (Respondent's Exhibit 1, pages 3 & 4)

6. The respondent presented copies of the bills issued to the petitioner's daughter on March 20, 2017, May 22, 2017 and June 13, 2017 regarding the petitioner's account with the facility. Each bill shows the amount owed increasing. The respondent explained this is because they are not receiving full payment each month. (Respondent's Exhibit 1, pages 8 through 10)

7. The petitioner's income is being deposited into a bank account jointly owned with her husband.

8. The petitioner's husband has been using his income to pay his current household bills.

9. The petitioner's daughter explained her parents were the victims of financial exploitation in 2014 and 2015, which caused her parents to incur great debt.

10. The petitioner's husband worked with a credit counseling agency to consolidate many bills which were past due. The credit counseling agency drafts the monthly payment from the account when the petitioner's income is deposited.

11. The petitioner's husband holds power of attorney for the petitioner as of July 2017. The petitioner's daughter, [REDACTED], is secondary. (Petitioner's Exhibit 1, pages 4 through 10)

12. The petitioner's daughter has been trying to assist with having a reverse mortgage approved to help with paying the past due amount at the facility. The reverse

mortgage had not been approved as of the hearing. The daughter explained part of the problem is the mortgage company now wants her mother to complete a debt management class, which her mother will not retain information presented due to her [REDACTED] and [REDACTED] diagnoses. (Petitioner's Exhibit 1, pages 1 through 3)

13. The respondent has applied for the petitioner's Social Security income to be redirected to the facility. This was not approved as of the hearing.

14. The petitioner's daughter stated the environment at this facility was a caring environment. The family is pleased with the care her mother receives. The petitioner's daughter expressed her concern of how the family would not be able to provide the quality care her mother is receiving in the facility.

15. The petitioner's daughter stated she had tried to personally take on the payment of the patient responsibility so that her mother's income could continue to assist her father in paying all of the household bills, but found that was not a feasible solution due to her own household expenses.

16. The petitioner's daughter further stated she understands the situation they are in now with the bill not being paid.

CONCLUSIONS OF LAW

17. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

18. Federal Regulations appearing 42 C.F.R. § 483.15 sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;

(D) The health of individuals in the facility would otherwise be endangered;

(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

19. Based on the evidence presented, the nursing facility has established that the reason for discharge is non-payment of the petitioner's patient responsibility. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

20. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which

includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

21. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

22. The undersigned concludes the facility has given the petitioner reasonable and appropriate notice to pay for the petitioner's stay at the facility. Based on the findings and cited authorities, the undersigned concludes that the facility's action to discharge the petitioner is in accordance with federal regulations.

DECISION

Based upon the foregoing Findings of Fact and Conclusion of Law, the petitioner's appeal is denied. The facility's action to discharge the petitioner is in accordance with federal regulations. The respondent may proceed with the discharge as described in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

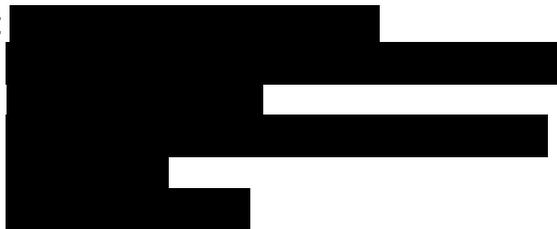
DONE and ORDERED this 27 day of September, 2017,

in Tallahassee, Florida.

Melissa Roedel

Melissa Roedel
Hearing Officer
Building 5, Room 255
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Copies Furnished To:



STATE OF FLORIDA
DEPARTMENT OF CHILDREN AND FAMILIES
OFFICE OF APPEAL HEARINGS

[REDACTED]

APPEAL NO. 17N-00082

PETITIONER,

Vs.

[REDACTED]

RESPONDENT.

_____ /

FINAL ORDER

Pursuant to notice, a hearing in the above-referenced matter convened on September 20, 2017 at 1:35 p.m. at the [REDACTED] located in [REDACTED], Florida.

APPEARANCES

For the Petitioner: The petitioner was not present and was represented by [REDACTED], niece and general guardian to the petitioner.

For the Respondent: [REDACTED], Executive Director for the facility.

ISSUE

At issue is the facility's intent to discharge petitioner due to non-payment of a bill for services; a Nursing Home Transfer and Discharge Notice was issued on August 14, 2017 with an effective date of September 13, 2017.

The respondent carries the burden of proof by clear and convincing evidence.

PRELIMINARY STATEMENT

By notice dated August 14, 2017, the respondent informed the petitioner that the facility was seeking to discharge/transfer her due to nonpayment. On August 16, 2017, the petitioner timely requested a hearing to challenge the discharge/transfer.

Appearing as witnesses for the respondent were [REDACTED], Social Services Director and [REDACTED], Business Office Manager.

Evidence was received and entered as the Petitioner's Exhibit 1 and the Respondent's Exhibits 1 through 2.

The record was held open until 5:00 p.m. on September 21, 2017 to allow the respondent to submit additional evidence. Evidence was submitted and entered as the Respondent's Exhibit 3.

The record was closed at 5:00 p.m. on September 21, 2017.

FINDINGS OF FACT

1. The petitioner, age 76, has been a private pay resident at the facility since June 2016.

2. The respondent contends that an attorney in [REDACTED] was appointed as the financial guardian of the petitioner's estate in May 2017. The respondent contends that the petitioner's attorney is withholding the petitioner's Social Security income. The petitioner's representative explained that another niece was appointed as the financial guardian and was handling the petitioner's business account with the facility prior to the current appointment.

3. The respondent contends that it has been sending the billing statements, by email, to the petitioner's attorney and guardian of the estate since May 2017 (*Respondent's Exhibit 3*). The respondent's records show that the petitioner's balance as of the date of the hearing is \$55000.

4. The petitioner's representative contends that she filed a motion with the court in [REDACTED] to request modification from general guardianship to guardianship of the estate; she received a court date of September 22, 2017.

5. The petitioner's representative explained that the attorney filed a motion to dismiss the hearing set for September 22, 2017. The petitioner's representative argues that she does not have access to any of the petitioner's funds. The petitioner's representative argues that she does not have the medical training or the funds to provide care to the petitioner if discharged to her home.

6. The petitioner's representative argues that the petitioner's attorney refuses to apply for Medicaid for the petitioner. However, the petitioner's representative believes that the petitioner does not qualify for Medicaid due to her assets, as she owns two homes.

CONCLUSIONS OF LAW

7. The Department of Children and Families, Office of Appeal Hearings, has jurisdiction over the subject matter of this proceeding and the parties, pursuant to Section 400.0255(15), Florida Statutes. In accordance with said authority, this order is the final administrative decision of the Department of Children and Families.

8. Federal Regulations appearing 42 C.F.R. § 483.15, sets forth the reasons a facility may involuntarily discharge a resident as follows: Admission, transfer and discharge rights.

(c) Transfer and discharge—(1) Facility requirements—(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

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9. Establishing that the reason for a discharge is lawful is just one step in the discharge process. The nursing home must also provide discharge planning, which includes identifying an appropriate transfer or discharge location and sufficiently preparing the affected resident for a safe and orderly transfer or discharge from the facility. The hearing officer in this case cannot and has not considered either of these issues. The hearing officer has considered only whether the discharge is for a lawful reason.

10. Based on the evidence presented, the nursing facility has established that the petitioner has failed, after reasonable and appropriate notice to pay for a stay at the facility. This is one of the six reasons provided in federal regulation (42 C.F.R. § 483.15) for which a nursing facility may involuntarily discharge a resident.

11. Any discharge by the nursing facility must comply with all applicable federal regulations, Florida Statutes, and Agency for Health Care Administration requirements. Should the resident have concerns about the appropriateness of the discharge location or the discharge planning process, the resident may contact the Agency for Health Care Administration's health care facility complaint line at (888) 419-3456.

DECISION

This appeal is denied, as the facility's action to discharge the petitioner is in accordance with Federal Regulations. The respondent may proceed with the discharge, as describe in the Conclusions of Law and in accordance with applicable Agency for Health Care Administration requirements.

NOTICE OF RIGHT TO APPEAL

The decision of the hearing officer is final. Any aggrieved party may appeal the decision to the district court of appeals in the appellate district where the facility is located. Review procedures shall be in accordance with the Florida Rules of Appellate Procedure. To begin the judicial review, the party must file one copy of a "Notice of Appeal" with the Office of Appeal Hearings, Bldg. 5, Rm.255, 1317 Winewood Blvd., Tallahassee, FL 32399-0700. The party must also file another copy of the "Notice of Appeal" with the appropriate District Court of Appeal. The Notices must be filed within thirty (30) days of the date stamped on the first page of the final order. The petitioner must either pay the court fees required by law or seek an order of indigency to waive those fees. The department has no funds to assist in this review, and any financial obligations incurred will be the party's responsibility.

DONE and ORDERED this 06 day of October, 2017,
in Tallahassee, Florida.



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Hearing Officer
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